University Hospitals Dorset NHS Foundation Trust

The Royal Bournemouth Hospital

Inspection report

Castle Lane East
Bournemouth
BH7 7DW
Tel:

Date of inspection visit: 28 September and 29 September 2022
Date of publication: 10/03/2023

Ratings

Overall rating for this service

Inspected but not rated

Our findings

Overall summary of services at The Royal Bournemouth Hospital

Inspected but not rated

University Hospitals Dorset NHS Foundation Trust provides acute and emergency services to people living in Poole, Bournemouth and East Dorset. University Hospitals Dorset NHS Foundation Trust provides a wide range of hospital and community-based care to a population of 771,000 based in the Dorset, New Forest and south Wiltshire areas.

Services include urgent and emergency care, medical care, surgery, critical care, outpatient services, maternity services, diagnostic services and services for children and young people. The trust provides 1,220 inpatient beds and 150 day care beds. There is a 24-hour emergency department at both The Royal Bournemouth Hospital and at Poole Hospital, which is the designated trauma unit for East Dorset.

On 1 October 2020, The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust and Poole General Hospital NHS Foundation Trust merged to form a new organisation. The trust provides a wide range of hospital and community-based care; and employs approximately 8,400 members of staff, both clinical and non-clinical.

The trust has not been rated since the merger in October 2020. The hospital's ratings were inherited from the previous provider.

We carried out a focused inspection with short notice on 29 September 2022. The inspection was carried out because we had concerns about care and treatment in some areas of medical care. We did not look at all key lines of enquiry but limited these to areas where concerns had been raised.

For a focused inspection, ratings can be applied to areas where enforcement action is taken.

Medical care (including older people's care)

Inspected but not rated

The service was inspected but not rated, except for the key questions of safe which was rated requires improvement.

We found:

- The service did not always have enough nursing and health care assistants to care for patients and keep them safe. Staff did not always complete and update risk assessments for each patient.
- Patient records were not always stored securely. Records of patients' care and treatment were not always fully completed.
- The service used systems and processes to safely prescribe, administer and record medicines. However we found the storage of medicines and their use by date was not always safe.
- Patients did not always receive adequate amounts of food and drink to meet their needs and improve their health.
- The service used systems and processes to safely prescribe, administer and record medicines. However we found the storage of medicines and their use by date was not always safe.
- The service was blocked by patients in beds who were medically fit for discharge due to a lack of community and social care packages in the region.
- Staff morale was low but still focused on the needs of patients receiving care.

However

- Staff understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff mostly identified and quickly acted upon patients at risk of deterioration.
- Staff assessed and monitored patients regularly to see if they were in pain, and mostly gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain. Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Is the service safe?

Requires Improvement

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff were provided with safeguarding training to the required level consummate with their roles.

Staff understood the different forms of abuse and what action to take to promote patient safety. They knew how to report safeguarding concerns and understood how to flag patients as safeguarding concerns on the IT systems.

Medical care (including older people's care)

The provider had a safeguarding team which staff could approach for additional advice. We observed staff from different professions coming together to discuss plans for a patient discharge to ensure patients were safe to return to their usual home.

The provider had an internal target of 90% of staff to be trained to Level 1 and Level 2 Safeguarding Adults. Adult safeguarding training levels across the trust were at 86.8% and 87.7% respectfully at the time of the inspection just below the trust target of 90%.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

Ward areas were clean and had suitable furnishings which were well-maintained.

The service generally performed well for cleanliness. The service performed a monthly audit where cleanliness was monitored. We saw an audit from September 2022 which showed on average the service scored 98.38% against the set cleaning criterion. Any criterion that were not met were flagged to the cleaning team.

Staff followed infection control principles including the use of personal protective equipment (PPE). The trust participated in the saving lives audit initiative that was launched by the NHS in 2009. This was designed to focus on high impact areas of patient care to help reduce the risk of healthcare associated infections. The trust results for hand hygiene showed an improving picture from July 2022 to September 2022 with the combined trust (Poole Hospital and Royal Bournemouth Hospital) scoring 96.7% compliance for hand hygiene audits in September 2022 for older people's medicine wards.

The trust had experienced an increased incidence of Clostridium Difficile (C. Diff) on the older person assessment unit at Royal Bournemouth Hospital. C.Diff is a type of bacteria that can cause diarrhoea. This was being monitored by the trust. It should be noted that there are a rising number of C.Diff cases nationally. It should also be noted, at the time of the inspection that University Hospitals Dorset remained below the national average of 45.3 cases per 100,000 bed days with 35.9 per 100,000 bed days reported.

The trust used isolation bays for patients with COVID-19 and where there were outbreaks, patients were cohorted together in bays. At the time of inspection (Sep 22) the trust there was an increase in patients with COVID-19. Patients were tested if they showed signs of having COVID-19 or they had been in contact or near to another patient with COVID-19.

Assessing and responding to patient risk

Staff did not always complete and update risk assessments for each patient. Staff mostly identified and quickly acted upon patients at risk of deterioration.

Staff used a nationally recognised tool to identify deteriorating patients and mostly escalated them as required. We were aware of some incidents where the deteriorating patient was not escalated in a timely manner which may have impacted on care. The tool included recording physical observations; for example, blood pressure, pulse and respirations. Staff told us they knew when they had to call for medical review.

Patients were not always reviewed by a consultant within 14 hours of being admitted to the trust as per NHS England Clinical Standard Two. The trust had systems to monitor the time to first consultant review and to see if patients had

regular ongoing review. We received trust level, site specific, data which showed that 77% of patients were reviewed within 14 hours during Monday to Friday with a lower percentage of patients reviewed on Saturday and Sunday. The data was taken between 28 March and 3 April during a 4-hour sample period. However from the seven files we sampled on the medical wards we saw that 100% of patients were seen in a timely manner.

The trust had an outlier's policy and deteriorating patients were monitored via a specialist team, 'Hospital at Night'. However some staff during the inspection told us they were not clear on the named doctors and the bleep numbers to use for medical outliers. Medical outliers are patients who may be on a surgical ward due to high occupancy levels within the trust. On the day we inspected the medical services at The Royal Bournemouth Hospital, there were 12 medical patients admitted to the Enhanced Surgical Care Unit.

Staff shared key information to keep patients safe when handing over their care to others. Patients were reviewed daily during the week by a mixture of board rounds and multi-disciplinary team meetings. At weekends patients were risk assessed as to whether they required a daily review and any deteriorating patients were escalated for doctor / consultant review by nursing staff. The number of medically fit patients waiting for discharge made it difficult to carry out board rounds daily.

There was not always enough staff to meet the fundamental care standards for patients or ensure that patients at high risk of falls were monitored. Staff knew about and tried to deal with any specific risk issues to patients to the best of their ability. During the inspection, we were told by staff that patients did not always receive the care that was required. This was, in part, due to the shortage of nursing staff and health care assistants which will be reported under the staffing section of this report. We were told patients were not always repositioned the optimal number of times during a working shift. Patients who are not repositioned at regular intervals could develop pressure ulcers. Staff did however have access to pressure relieving equipment for patients assessed as being at high risk of pressure ulcers and falls risk assessments were completed. The trust had responded to the falls risk by trying to increase staff knowledge around these areas and minimise the risk to patients where it was within its gift.

The service had 24-hour access to mental health liaison and specialist mental health support. However, the trust reported a significant increase in the number of patients being admitted with mental health issues and this was confirmed by staff on the wards. Some of these patients did not have any medical reasons for being in hospital for example dementia patients however a suitable placement could not be found for them in an appropriate setting elsewhere. This was also a national problem. These patients sometimes required specialist support such as one to one support by a registered nurse which increased the overall pressure on nursing establishment levels and often required agency and bank nurses which increased agency expenditure for the organisation. Some nurses felt they required additional training in order to provide this specialist support. Acts of violence and aggression towards staff was also on the increase. The number of patients with mental health issues impacted on the support the mental health team could provide to the wards. The Trust had limited access to external mental health beds and continued to work closely with external partners for timely access

There was an electronic prescribing and medicines administration system where medical staff completed all prescriptions. Medical staff told us the system would not allow them to proceed to any prescribing of medicines unless a VTE assessment had been completed and information about patient allergies had been recorded.

Medical care (including older people's care)

Nurse staffing

The service did not always have enough nursing and non-nursing staff to care for patients and keep them safe. Managers regularly reviewed and adjusted staffing levels and skill mix however the lack of staffing meant that it was often difficult to safely staff wards. Bank and agency staff had a full induction. Some staff were moved to wards they were not familiar with to help maintain safer staffing levels.

The service had a significant level of vacancy within the Health Care Assistant (HCAs) band. There was also a high level of vacancies for Registered Nurses (RNs). In older people services there were approximately 70 HCA vacancies and 42 RN vacancies across both Royal Bournemouth and Poole hospital as at July 2022. This impacted negatively on patient care. As stated previously in assessing and responding to risk, there was not enough staff to always provide one to one care for those patients requiring this. Staff talked about having to prioritise the care provided to patients in terms of what they could achieve giving the staffing levels and the needs of the patients that day.

The trust was aware that lack of RN and HCA staffing was an issue and it was recorded on the corporate risk register. Nationally there is a shortage of both health care workers and registered nurses. The lack of staffing problem was compounded by issues with staff retention. Existing staff were working in difficult conditions, where there was not always enough staff for the wards and therefore the job was more stressful. Staff reported they did not always feel supported as they were sometimes moved to wards where they were not familiar and did not have the support of regular colleagues. This was not good for staff retention. Trust level data stated turnover for staff was regularly between 12% and 14% between August 2021 and May 2022. It should be noted when planned staffing levels were challenged the trust used the principles defined in the 2021 NHSE COVID-19 ‘Principles for the management of demand outstripping the capacity of the nursing workforce on critical care units and adult in patient wards’.

Managers regularly reviewed and adjusted staffing levels and skill mix however this was often challenging. Fundamental care standards were not always being met. Matrons and Directors of Nursing had meetings at least twice daily to review nurse staffing across all hospital sites. The assessment of safe nurse staffing levels was carried out using a national tool. This information was reviewed alongside an assessment to ensure nursing staffing levels met patients nursing needs. The trust used reported incidents as one way to assess if fundamental standards were met, including those incidents considered as a ‘red flag’. During the period March to June 2022 data for older people wards showed there were 43 red flags raised for omission in fundamental care and 30 red flags raised for patient at risk as unable to provide enhanced care on a one to one basis. These are the incidents reported. Staff told us they did not always incident report due to pressures on their time and the fact that they were short staffed. Trust wide data shows there was an increase in red flag events to 459 which is 103 more than the same period the previous year.

Matrons used their professional judgement alongside the acuity and dependency of patients and the availability of staff to make decisions about the level of staffing at any given time. Nursing staff said there was an element of subjectivity in making these assessments and it was not always clear how patients’ acuity (how clinically unwell patients were) or the need for one to one nursing were considered. Some of the ways matrons addressed issues of safe staffing on wards was by asking non rostered staff to work clinically, moving staff to support areas that have safety concerns and authorising agency staff. When the trust was working at OPEL 4, staff whom were on internal study leave could be requested to work clinically,

The trust was trying to find innovative ways to attract staff alongside running recruitment fairs. They had various initiatives to attract candidates such as the Trainee Nurse Associate programme, which was designed to enable the growth of the Band Four workforce to registered nurse level. There was a scholarship programme for people with experience of unemployment and young people leaving school and college with an interest in a career in healthcare.

Medical care (including older people's care)

The trust had successfully recruited 200 internationally educated nurses and was looking to employ a further 140 nurses during 2022 and were on track to meet this target. Nationally the recruitment of nursing staff and health care assistants was a problem, however at the time of the inspection, the trust had higher than average vacancy rates for health care workers.

There were processes for ward managers to request bank or agency staff to improve staffing levels. These requests were signed off by senior leaders. The service used bank and agency nurses on the wards but requested staff that were familiar with the service.

It was not always clear to patients and visitors how well the ward was staffed as not all wards displayed this data.

Sickness rates were relatively high, due in part to COVID-19. The trust wide sickness figure as at August 2022 was 4.7%.

Medical staffing

The service did not always have enough medical staff with the right qualifications, skills, training and experience. The service had implemented measures to keep patients safe from avoidable harm and to provide the right care and treatment. Managers had reviewed staffing levels and were actively looking to recruit more medical staffing

The service did not always have enough consultants to provide daily ward rounds in the elderly care department. The service mitigated this risk by holding multi-disciplinary meetings daily and ward rounds every other day. Junior doctors were made aware of the wards where there was consultant cover so that if they required the consultant and there was not one on the ward then they had access to a consultant on a nearby ward. The problem was compounded by the number of medically fit for discharge patients that also required review.

We spoke with junior doctors working in older people's medicine who expressed concerns about on call rota, their workload and expectations to cover more than one ward. In September 2022, there was an external review of junior doctor staffing and their rotas after concerns were raised. The trust had not received the report at the time of our inspection, but the trust had started to consider how they could make improvements following verbal feedback. Consultants encouraged junior doctors to report when they had concerns about their work. Initial feedback from the external report did indicate there were shortfalls in junior doctor staff when compared to other similar sized trusts. We were told by the medical director that the organisation was going to recruit more junior doctors.

Managers made sure locums had a full induction to the service before they started work.

The service had a good skill mix of medical staff on each shift and reviewed this regularly.

The service had a consultant on call during evenings and weekends.

Records

Patient records were not always stored securely. Records of patients' care and treatment were not always fully completed. Records were easily available to all staff providing care.

Patient records were not always fully completed. We reviewed seven patient notes and found there was some incomplete documentation around patients food and drink intake. We also noted on the day of inspection, it was not recorded when patients were transferred to different wards. This meant it was difficult to assess when patients were moved although the trust did monitor this overall.

Medical care (including older people's care)

Records were not always stored securely. We saw doctors leaving handover sheets unattended and they did not always log out of computers they had been using. On Ward 5 at Royal Bournemouth Hospital, some patient records were not stored securely in the designated trolley but left on a desk.

When patients transferred to a new team, there were no delays in staff accessing their records.

Medicines

The service used systems and processes to safely prescribe, administer and record medicines. However we found the storage of medicines and their use by date was not always safe.

We found the storage of medicines was not always safe. We noted the temperature of medicine stored in refrigerators was not always recorded regularly. If fridge temperatures are above or below specified limits then the efficacy of the medicine can be affected.

The trust undertook regular medicine audits and the last audit identified issues around controlled drugs and out of date medicine. When we looked at medicines at the site, we identified issues with medicine that had passed its expiry date. The trust was working on improving communicating and following up actions from the medicine audit.

Staff followed systems and processes to prescribe and administer medicines safely. Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines.

Incidents

The service managed patient safety incidents well. Staff recognised what constituted an incident and near miss however stated they did not always have time to report incidents due to staff shortages. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. Staff mostly raised concerns and reported incidents and near misses in line with trust policy. The service used an electronic record system to report incidents. Incidents were escalated depending on the level of harm that had occurred. There were forums where learning from incidents were discussed and learning shared. staff said they did not always report incidents due to not always having time to complete the documentation.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong.

Staff learned from safety alerts and incidents to improve practice.

Is the service effective?

Inspected but not rated

Medical care (including older people's care)

Nutrition and hydration

Patients did not always receive adequate amounts of food and drink to meet their needs and improve their health.

Staff reported patients did not always receive optimal nutrition and hydration levels due to a lack of staffing. At the time of inspection, there was a national shortage of health care assistants and registered nurses and the trust was struggling to fill the vacant health care positions despite running numerous employment campaigns. The trust had created a role for ward host and hostesses on the wards to ensure patients were offered tea, coffee, water and other beverages at regular intervals. The wards which had these staff reported a positive impact on patient care. Ward host / hostesses also helped patient with ordering food and some could also assist with helping patients eat their food dependant on their training. If patients do not receive adequate amount of food and drink this could be detrimental to their recovery and could lead to additional health issues.

We reviewed fluid and nutrition charts on the ward and found there were four instances where some had not been completed fully.

Specialist support from staff such as dietitians and speech and language therapists was available for patients who needed it.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain, and mostly gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed patients' pain using recognised tools and gave pain relief in line with individual needs and best practice. However due to staffing and resourcing issues staff said some patients did not receive pain relief in a timely manner.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. We observed planned multidisciplinary meetings on an older people's ward which was attended by nurses and doctors. Staff were engaged and worked together to ensure safe discharges of patients as soon as this was possible. When delays were identified, actions were identified to solve barriers to getting patients home. This included writing to patients' relatives to explain the urgency of arrangements being agreed so that discharge was not delayed.

Staff worked across health care disciplines and with other agencies when required to care for patients.

Staff referred patients for mental health assessments when they showed signs of mental ill health, depression. There were patients at both sites who required a mental health placement bed in a hospital or in the community however these patients were residing at the hospital.

Patients had their care pathway reviewed by relevant consultants

Medical care (including older people's care)

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They mostly used measures that limit patients' liberty appropriately.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff implemented Deprivation of Liberty Safeguards (DoLS) in line with approved documentation but systems to keep up with timely authorisation of DoLS was not always efficient. We reviewed one set of patient records where a DoLS application had been made and saw staff used stickers in patient notes to highlight the application was made and when the authority to deprive a patient of their liberty on medical grounds expired. The application, including the assessment of the patient's mental capacity, was detailed and comprehensive. A copy of the application was sent to the local authority for approval. We were told nursing staff had to use their personal NHS email to submit this application. However, this meant that others, such as the ward clerk, had to make further enquiries if the nurse was not working the next day to ensure the correct paperwork was maintained. We did not see clear written evidence from the local authority to confirm that authority had been granted instead we saw a statement to that effect across the top of the application submitted.

The provider mostly used measures that limited patients' liberty in line with legislation. On one ward we found an additional folding screen covering the entrance to this ward. The folding screen was difficult to navigate for an able bodied person. The trust said this was to act as a visual deterrent to discourage patients who were living with dementia from wandering without supervision. The folding screen, while offering a visual deterrent, could also act as a barrier for patients who were not restricted by a DoLS from leaving the ward. At the time of the inspection there were five patients with a DoLS and the ward could accommodate 28 patients. The provider completed a risk assessment of the folding screen following the hospital inspection.

Staff received basic training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Due to the high number of patients that were on wards with mental health issues, some staff wanted to receive further training in order for them to feel safer when dealing with this cohort of patients.

Is the service caring?

Inspected but not rated

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We witnessed staff supporting a patient in a quiet and calm manner, speaking in a tone that was calming and patient.

We witnessed staff supporting a patient on a one-to-one basis, ensuring they remained safe whilst mobilising around the ward using redirection techniques when needed.

Medical care (including older people's care)

We witnessed staff responding to confused patients in a caring manner using appropriate language that met the needs of the individual.

Patients said staff treated them well and with kindness. We spoke with 11 patients who all said that staff were kind, caring and responded quickly when they called for support. Most of the patients spoken with said staff were rushing around, there were not enough of them and that they were doing their best despite this. We observed staff speaking to patients kindly. Patients said that staff were kind and kept them up to date with their treatment and discharge plan. Patients recognised how hard staff were working and appreciated their effort to make them as comfortable as possible

Staff followed policy to keep patient care and treatment confidential.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

Is the service responsive?

Inspected but not rated

Meeting people's individual needs

The service was inclusive and mostly took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff mostly made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. However, not all wards were designed to meet the needs of patients living with dementia. On some wards we saw that there were large clocks and information about the date and day of the week as well as information about the weather displayed. However, this was not consistent across all wards in older people's medicine.

Patient records we reviewed did not consistently demonstrate patients' communication needs were assessed in line with national guidance.

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports. The service had dementia champions and a dementia team. The dementia team were able to input into the patients care as well as take patients to the dementia garden and run events such as 'Bingo'.

The service had information leaflets available in languages spoken by the patients and local community.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed.

Patients were given a choice of food and drink to meet their cultural and religious preferences.

Staff had access to communication aids to help patients become partners in their care and treatment.

Medical care (including older people's care)

Access and flow

The service was blocked by patients in beds who were medically fit for discharge due to a lack of community and social care packages in the region.

The trust had problems maintaining flow from admission to timely discharge. This was a national problem at the time of the inspection due to a lack of community and social care packages across the country. In August 2022, the average number of beds per day occupied by patients with stays over seven and 14 days had been at its highest level in the past three years and the average number of patients who were ready to leave / had no reason to reside had increased to 237 patients. In real terms, this was the equivalent of nine 25 person wards being used for patients that had no medical reasons to be in hospital. These patients still required care from medical, nursing and health care staff. Long hospital stays could be linked to negative outcomes such as a decline in physical ability as well as an increased risk of picking up a hospital-acquired infection for frail elderly people.

People could mostly access the service when they needed it but did not always receive the right care promptly due to pressures on bed capacity. Patients were being moved sometimes multiple times and sometimes at night, in order to admit them to the right place once a bed became available. Some staff stated that the movement of some patients was not always risk assessed. The hospital has seen an increase of patients suffering mental health disorders who were residing in the hospital because there was a lack of mental health provision elsewhere and in the community. This coincided with an increase in violence and aggression towards staff.

The trust used an established tool to identify the capacity of wards and assessment units at any point in time. The trust tried to use these tools to best meet the needs of the patients. The trust had been consistently over 93% bed occupancy for the last six months. This made flow throughout the hospital difficult to manage. Hospitals cannot operate at 100% occupancy, as spare bed capacity is needed to accommodate variations in demand and ensure that patients can flow through the system. The National Institute for Health and Care Excellence Guideline 94 talks about 85% bed occupancy being recognised in literature as the ideal occupancy rate and states “high levels of bed occupancy may affect patient care as directing patients to the bed most suitable for their care is less likely to be possible”. When capacity within services was pressured, the service used areas that were not meant for patients.

The hospital monitored the demand on its service. The Operational Pressures Escalation Framework (OPEL) detailed how the trust identified and responded to pressures within its system daily, as well as at times of extraordinary pressure. The service had been at OPEL level three and four for the last six months. Level four is the highest OPEL level and means the trust is at high pressure. Each day bed meetings took place at 08:30 and 16:00, to review the flow of patients through the hospital. Those meetings were attended by bed managers and department nurses in charge at both sites. Some staff attended virtually.

The trust had some issues with discharging patients safely, for example, some patients had been discharged home without the relevant equipment ready in their homes to help with care. There had also been instances where the relevant discharge paperwork had not been provided to the relevant patient’s general practitioner which could impact on patients’ medicines and follow up appointments. The Integrated Care System was due to work on reviewing its discharge policies in the following months. A focus on discharge was required by the whole integrated care system in order to tackle the number of people who were being looked after in hospitals without any medical requirements and addressing the issues around hospital discharge.

The trust had a Same Day Emergency Care (SDEC) centre especially designed for patients aged 75 and over, to avoid admission and to help the patient to remain at home. There had been positive feedback from both patients and staff on

this service. There was however a barrier to accessing this service in terms of patient transport. Patient transport was commissioned in this area requiring a lead in time of four to six hours. This meant a patient in emergency department without any relatives to transport them home following treatment, would sometimes not be considered for this service if they arrived in the emergency department during the afternoon period.

Is the service well-led?

Inspected but not rated

Leadership

Leaders mostly had the skills and abilities to run the service. They understood and attempted to manage the priorities and issues the service faced. Some of the issues faced in terms of staffing and hospital flow were mostly connected to recognised national and system issues. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The Older People Medicine management team were visible and approachable for patients and staff. Staff told us they received strong leadership from their direct managers, matrons, ward managers and the heads of nursing. Nursing staff told us matrons had based themselves on wards to provide additional support to staff, which was appreciated. Medical staff felt the clinical director and medical director were approachable and supportive. Leaders supported staff to develop their skills and take on more senior roles.

Culture

Staff morale was low but still focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff told us morale was low. Staff explained they were passionate about the work they carried out however, working with too few staff was stressful and led to low job satisfaction. Due to low staff numbers, staff had to work in wards which they were unfamiliar with and this also negatively impacted staff morale.

Staff told us they felt supported by their colleagues and worked as teams to deliver care. However, staff told us they could not always meet patients' fundamental care needs and this was difficult to cope with. Staff said they were passionate about delivering compassionate care for all patients and found it hard when this was not possible because of staff shortages. We saw that staff were kind and compassionate towards patients and supportive of each other.

Senior nursing staff we spoke with discussed the impact on staff morale mainly caused by staff shortage. They explained they understood staff were concerned about being moved to areas they were not familiar with and acknowledged this happened most days. They spoke of the high number of healthcare assistants that had left the hospital. Information obtained from exit interviews suggested difficult working conditions as well as the need to have a better work life balance. Senior leaders spoke of the difficulties in the recruitment of new staff in a competitive market and the initiative they took to attract new employees. The trust had ongoing recruitment initiatives to attract more staff from the local area as well as from oversea recruitment. The trust had ongoing recruitment initiatives to attract more staff from the local area as well as from oversea recruitment.

Medical care (including older people's care)

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Poole Hospital and Royal Bournemouth and Christchurch Hospitals merged to form University Hospitals Dorset NHS Foundation Trust on 1st October 2020. The trust is currently going through an extensive building and reconfiguration programme at all sites which has seen a number of changes to the existing way of working. Most staff we spoke with felt the trust had engaged well with them regarding the plans. The Older Peoples Medical team were already working at both Poole and Bournemouth sites and we saw good examples of shared learning bringing positive improvements to both sites such as Ward Hosts for wards which was an idea originating from the Bournemouth site but now also in place at Poole hospital.

The trust collaborated with partner organisations to help improve services for patients. The trust is part of the Dorset Integrated Care System (ICS). Integrated care is about removing traditional barriers between services so people can access the support and care they need when they need it. An Integrated Care System brings NHS organisations, councils, public services and voluntary and community partners together to improve the health and wellbeing of everyone in their area. Dorset was part of the first pilot of integrated care systems in 2018. It was a government proposal for all areas across England to become an integrated care system by July 2022. One of the aims of the ICS is to tackle inequalities in outcomes, experience and access.

The trust continues to work as part of the Dorset Cancer Partnership and Wessex Care Alliance to ensure cancer treatment is prioritised. The trust works in partnership with Bournemouth University which has amongst its aims to develop training opportunities and meet future workforce training needs.

The trust engages with patients and staff via its website and email bulletins. It also has an on-line social media channel and monthly staff digital and printed publications. Some staff said due to staff shortages relatives and carers were not always kept up-to-date with patients care.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

MUSTS

Medicine core service

- The trust must continue to act to recruit to vacant roles and retain staff across the organisation to ensure there are sufficient staff deployed to meet the needs of patients and ensure the fundamental standards of care are met for all patients. Regulation 18 (1) 2 (a) and Regulation 14 (1) (b)
- The trust must ensure the management of outlier patients are effective and all staff are clear on the process to follow when patients require urgent or non urgent review. (Regulation 12 (2) (b)).

Medical care (including older people's care)

- The trust must ensure the safe storage of medicines and ensure that they are within their use by date. (Regulation 12 (2) (g)).
- The trust must ensure the safe storage of records. (Regulation 17 (2) (d).

SHOULDS

medicine core service

- The trust should consider assessing its wards to see if they meet with the needs of dementia patients.
- The trust should consider improving its system for the recording of deprivation of liberty orders.
- The trust should continue to work with all system partners and implement actions to address the capacity pressure in the hospital.

Surgery

Inspected but not rated

In the 12 months before our inspection The Royal Bournemouth Hospital carried out 10391 day case operations, 4460 elective (pre planned) operations and 2899 emergency operations. There were 9 surgical wards with 153 beds.

The service was inspected but not rated, except for the key question of safe which was rated requires improvement.

We found:

- The service did not always have enough staff to care for patients and keep them safe.
- The service did not always manage safety incidents well.
- Staff did not always feel supported and valued.

However:

- Staff assessed risks to patients, acted on them and mostly kept good care records.
- Staff treated patients with compassion and kindness, respected their privacy and dignity.
- Staff were focused on the needs of patients receiving care.

Is the service safe?

Requires Improvement ↓

Our rating of safe went down. We rated it as requires improvement.

Assessing and responding to patient risk

Staff identified and quickly acted upon patients at risk of deterioration. However, there was not always enough staff to complete and update risk assessments for each patient to remove or minimise risks.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. They used the National Early Warning Score 2 (NEWS2) to monitor and identify the acute deterioration of patients, including sepsis, and Situation Background Assessment Recommendations to ensure clear transfer of information between staff. Treatment was delivered to patients with presumed sepsis within recommended Sepsis Six pathway timelines. However, we were told staff were not always able to get a doctor to assess a deteriorating patient, especially if the patient was a medical outlier (a non-surgical patient bedded on a surgical ward).

Senior staff told us they were confident to challenge the decision if outlying was not appropriate for a patient, and they could escalate to the surgical team on call. However, staff told us patients were moved frequently at night and at weekends, when there were less senior staff to prevent this.

Staff completed risk assessments for each patient on admission, using recognised tools, and mostly reviewed them regularly, including after any incident. Some ward staff told us they were sometimes so short of staff on the ward, risk assessments were not always completed. We looked at the action plan from a falls audit on one ward. The plan

recognised that due to acuity of patients and staffing pressures there had been poor compliance in completing falls risk assessments. However, we did not see any evidence of this when we looked at patient files. Staff told us they mostly completed a falls risk assessment for each patient and completed body maps to detect and assess tissue viability including pressure sores.

Staff assessed new patients for their risk of developing venous thromboembolism (VTE). We requested the outcome of a VTE assessment tool audit, however we were told this was not available as data was still being collected. The trust had introduced a system for ward staff to ensure a VTE risk assessment was completed for each new patient and for patients following a change in their clinical situation. A daily email was sent to Band 6 nurses flagging patients whose VTE risk assessment had not been recorded, to ensure these were completed. In theatre, we saw staff check VTE assessment outcomes as part of their patient pre and post-surgery checks to ensure the correct prophylaxis was administered. There was an electronic prescribing and medicines administration system where medical staff completed prescriptions. Medical staff told us the system contained a failsafe mechanism that would not allow them to proceed prescribing medicines, unless a VTE assessment had been completed and information about patient allergies had been recorded.

According to the National Institute for Health and Care Excellence (NICE) quality statement, consultants must assess adults with a medical emergency as soon as possible and always within a maximum of 14 hours from the time of hospital admission (QS174). The trust gave us information, which showed this target had been met for 85% of patients admitted during the week and for 77% of patients admitted during the weekend (patients admitted between 28 March 2022 and 3 April 2022).

Staff in theatre completed the World Health Organization (WHO) surgical safety checklist. The checklist contains important safety checks that need to be performed before and after a surgical procedure to increase the safety of patients and reduce adverse events such as surgical site infections or retained instruments. The audit of the WHO checklist showed a compliance rate of 96.6% to 98.5% between October 2021 and September 2022.

Patients waiting for surgery were talked through the procedure they were due to undergo. We saw theatre staff checking the patient care plans and ensuring patient information was up to date. We observed the safety check of surgical instruments. We saw good communication between staff throughout the operation. At the end of the operation we saw staff reassess the clinical dependency of patients.

The service had 24-hour access to mental health liaison and specialist mental health support if staff were concerned about a patient's mental health, including those thought to be at risk of self-harm or suicide.

Staff mostly shared key information to keep patients safe when handing over their care to others. For example, when patients were transferred to other wards, up-to-date risk assessments and body maps were completed and handed over to the receiving ward. However, staff told us patients were sometimes moved at short notice during the night and up-to-date assessments were not always completed for these patients.

Shift changes and handovers included necessary key information to keep patients safe. Handovers took place at the beginning and end of each shift. However, staff on larger wards told us that attending handover at the end of their shift was problematic when they were short staffed as they needed to provide nursing care to patients.

Nurse staffing

The service did not always have enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels.

Surgery

The service had a significant level of vacancies for health care assistants. There was also a high level of vacancies for Registered Nurses. In addition to staff vacancies there was a general trend across the service of increased staff sickness rates. Sickness rates for nursing staff increased by around 1% in the 12 months before we inspected. In July 2022 the vacancy rate was 6.2% and turnover 14.6% with sickness absence at 5.6% across the trust.

High vacancy rates were discussed by senior leaders and hospital leaders at meetings. Minutes from meetings record there was a lack of healthcare support workers, and significant vacancies (240 across the trust) were having a negative effect on the care given to patients. In addition to this there was an inability for the nursing bank office to provide substantive replacement staff for each vacant shift, resulting in agency staff being employed. According to the ward nursing staff report, this led to an increased workload and delays in care delivery. Senior trust leaders spoke of the difficulties in the recruitment of new staff in a competitive market and the initiatives they used to attract new employees. The trust had ongoing recruitment initiatives to attract more staff from the local area as well as from overseas recruitment.

Staff told us the general level of care was lower than before the pandemic because they were trying to care for too many patients at once. Staff told us this impacted on their wellbeing and work home balance. They described feeling ‘shattered’ and ‘broken’ and said after their shift and on their days off they were too tired to spend quality time with family and friends.

The trust told us about a number of processes that were being used to monitor staffing levels. The processes used at the weekend varied slightly to those used Monday to Friday. At the start of each day matrons performed a quality and safety check on each ward, the check included understanding staffing levels and the acuity and dependency levels of patients on the ward. Each ward leader submitted an audit twice a day (6am and 6pm) that reflected staffing levels and patient acuity and dependency. The audit data was fed into a system that mapped staffing levels across the trust to ensure they matched the acuity and dependency of patients. Hospital leaders, and department leaders, including matrons, held a number of meetings throughout the day that focused on safe staffing levels.

If a ward was identified as having unsafe staffing levels, staff were moved there from areas of the hospital identified as having more staff. If wards or other areas had lower than safe levels of staff they escalated this using a system called a red flag. Red flags indicated that patient needs were not being, for example, omissions in medicines being administered, omission to assess and record vital observations and meeting patients’ fundamental needs (pain relief, repositioning, hydration and risk assessments).

Trust wide data for surgical wards showed 57 reported red flags from April to July 2022. The most commonly reported red flags were for a lack of health care assistants and other unfilled shifts requested through temporary staffing.

Staff told us the tool they used at the start of every shift to calculate how many patients were on each ward and how many nurses were required to care for them did not calculate the acuity of patients. This tool was used to feed into a second tool used by senior leaders to identify the areas of the hospital with the most patient need, so that staff could be moved from areas with higher staff ratios to avoid patient harm. They said the use of these tools meant they often worked in unsafe situations. Staff told us when they voiced their concerns over the continued use of these tools, they did not feel like they had been heard at trust’s executive level. They said this left them feeling unvalued.

Surgery

Staff were not always experienced, qualified or held the right skills and knowledge to meet the needs of patients. Matrons and Directors of Nursing met at least twice daily to review nurse staffing and skill mix across the hospital sites. Due to the trust's chronically low staffing levels, staff were often moved to work on wards outside of the specialism to cover areas of the hospital with the lowest staffing levels. This meant staff were not always competent to carry out their role as effectively in these settings

Senior nursing leaders told us they were mindful about moving staff to ensure they were not moved to areas where they did not feel competent to carry out their role. They told us staff were asked before they were moved and if staff did not feel they were able to work safely in another area, this would be respected. Some nursing staff told us they felt unable to refuse when asked to work on other wards for fear of reprisal. When staff were moved, senior nursing staff told us they tried to introduce staff to the ward manager of the ward, as they recognised walking on to a new ward and a new team could be daunting.

Matrons and leaders recognised the challenges of ensuring safe nursing levels and the impact moving staff around, had on morale. They expressed their concerns about health care assistants, nurses, and junior doctors being moved to cover absence on other wards, especially to cover areas outside of their speciality. Staff told us, not knowing where in the hospital you would be working before you went to work was stressful, as was working in areas of the hospital outside their specialism. They said this caused them stress because they did not have the skills and experience to deliver the care and treatment required. They also said this had an impact on continuity of care for patients.

Nurse to patient ratios did not always meet hospital standards. We looked at average staffing rates on wards for August 2022. On the Emergency Surgical Care Unit the fill rate of qualified staff was 90.6% and 86.5% of the template for health care assistants. On ward 7 (left and right) the fill rate was 93.35% for qualified nurses and 74.8% for health care assistants. Staff told us supernumerary staff, for example student nurses and nurses still on induction, were frequently used to provide patient care when wards were short staffed. This did not ensure staff with the right skills and competence were deployed consistently to meet the needs of patients.

Staff said that since the end of the second wave of the pandemic, a high percentage of patients had an increased clinical complexity, and that wards were consistently full and or had higher than planned bed occupancy. They said when they started a shift, if the staffing numbers matched the current template, one or more member of staff would inevitably be moved to other wards to cover, leaving them short staffed in an already challenged environment.

Poor staffing levels were having a negative impact upon patient safety and staff wellbeing. Staff told us they were consistently working with lower than planned numbers of staff. We saw a patient left on a bedpan for more than 10 minutes after they pressed their call bell. This was because all of the staff were busy caring for other patients. Although the patient had a falls risk assessment a delay for patients in these situations increases their risk of falling.

Patients and relatives told us there were not enough staff to always meet their needs. A patient told us about asking six times for pain relief before a nurse had enough time to dispense this to them, and that morning they had been asking for water for three hours before a nurse had time to get this. A relative told us they felt they had to be there all the time to speak and act for the patient as, "I do not know what would happen if we weren't here, as staff cannot act quickly enough as there aren't enough of them".

Low staffing numbers had a negative impact on all aspects of patient care. Staff told us due to low staffing levels areas of patient harm included: medicine being given late and medicine errors, poor pressure area assessment and care, risk

assessments not always up to date, and personal hygiene needs being met only when there was enough time. Information from the trust showed in October 2022 there were 23 incidents relating to pressure ulcers, 20 patient accidents / falls, and 8 incidents relating to medicines management. However, staff said they did not always have the time to record incidents on the electronic incident recording system, including fundamental standards not being met.

Ward staff told us they often missed breaks or cut breaks short to help alleviate pressure on other staff. Senior staff told us they were stretched too thin to provide clinical guidance to more junior staff. They described huge volumes of unanswered emails and completing staff rotas in their own time.

Theatre staff had mixed opinions or experiences about whether they were able to take breaks or work additional hours. They agreed they do not leave work late, unless by agreement, and additional hours worked are paid. In theatres and recovery, staff told us they were sometimes asked to stay late but that there was no pressure and it was 'down to them'. However, they were not always able to participate in meetings and training because they were required to look after patients.

In the 2021 staff survey results, 56% of staff felt they could not meet the conflicting demands on their time at work and 75% said there was not enough staff in the organisation for them to be able to do their job properly. Also, 36.8% said they felt valued by the organisation and 36.6% said they felt the trust was committed to helping them achieve a good work life balance. Over half of responders (57.2%) said they did unpaid work in addition to their contracted hours each week. Half of the staff group (53.1%) said they had felt unwell due to work related stress in the 12 months before the survey and most (85.4%) said they feel worn out at the end of a shift, with 71.7% saying they lacked energy to see family and friends. However, 89.6% of staff felt their role made a difference to patients.

Theatre lists were sometimes cancelled because there were not enough staff for operations to be performed safely. For example, the day we inspected theatres, nine theatre slots could not run because of a lack of staff. In addition, a lack of staff meant there was no cover for sickness absence or breaks and so staff would experience a delay in taking breaks, and potentially more patient operations would be cancelled.

We looked at the list of 13 planned theatre shifts that needed to be covered between 13 October 2022 to 19 October 2022. Up to 20, and average of 12 members of theatre staff were required to provide cover the gaps in the rota on each shift because of the low staff numbers.

Staff told us the number of newly qualified staff in theatre made it look like theatres had enough staff. However, these staff did not yet have the necessary skills and experience.

Medical staffing

The service did not always have enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

Nursing staff told us they were not always able to access medical advice for patients who were medical outliers because there were not enough doctors to cover the volume of patients. At times, this caused long delays in patients receiving urgent treatment, for example, patients being started on intravenous antibiotics.

We requested details for medical staffing levels for surgical services. However, this was not provided.

Surgery

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Patient notes were comprehensive and staff could access them easily. Most notes were paper-based, although vital observations were recorded using a digital recording system. There were back up processes to revert to recording these on paper templates in the event of computer failure.

We reviewed 12 patient records and found these were mostly completed in a timely way. However, we saw that information about patients' social situations was not always completed as part of the admission process. This information was important to enable staff to start discharge planning as soon as possible, including considerations about potential adjustments or packages of care that may be needed.

The trust performed regular internal audits of the legibility and completeness of documentation in the trust's orthopaedic operation notes. This is because historically operations notes were found to be illegible, lacked complete intraoperative events and procedures with unclear post-operative instructions, which led to confusion and delays in post-operative care. The purpose of the audit was to implement change in practice when need for improvement was identified. In the most up to date audit supplied by the trust 96 sets of notes for patients who underwent surgery in February and March 2021 had been reviewed. The outcome of this audit showed details of problems and complications were recorded for 58% of patients, and details of antibiotic prophylaxis (where applicable) for 28% of patients. This was an improvement from the previous audit which found only 15% of problems and complications had been recorded, and details of antibiotic prophylaxis (where applicable) had been recorded for 27% of patients.

We saw that notes were stored securely on the wards we visited. Notes were stored in designated locked trolleys and staff took care to return notes when they had completed their documentation of care and treatment they had delivered.

Incidents

The service did not always manage patient safety incidents well. Staff recognised but did not always report incidents and near misses. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. Ward staff told us because they were short staffed they did not always have enough time to complete incident forms. However, staff said they would always report a serious incident, for example a patient fall. Staff did not always receive feedback from investigation of incidents they had reported.

The trust used reported incidents as one way to assess if fundamental standards were met, including incidents considered as a 'red flag'. Ward staff said they did not always have time to report incidents, including when patients fundamental standards of care were not met, and some senior staff told us they were too 'stretched' in their role to review all incidents forms. One band 6 nurse had been allocated an incident to review but had not been given training to investigate incidents. Information from the trust showed that the number of incidents reported by staff was in decline. For example, across the trust reporting rates fell from 1145 in May 2021 to 935 in May 2022.

We saw evidence of learning from incidents. There was a process for a rapid review of some incidents, and these were discussed at weekly meetings for ward leads. Information from these meetings was cascaded down to junior staff along with actions from patient safety alerts. As a direct result of incidents that occurred we saw evidence that staff received

training in falls prevention, which included exploring themes of historic falls incidents to mitigate risk of future patient falls. We were shown a ward newsletter that contained details of incidents that had occurred on the ward and learning from these. The newsletter contained reminders for staff to complete pressure sore audits and body maps, as well as information about the adoption of a new transfer letter to be used for patient discharges.

In the 12 months before our inspection there was one never event (a never event is a serious incident or error that should not have occurred if proper safety procedures were followed) reported in surgery, which was a wrong site surgery. We saw evidence of learning being shared to reduce the likelihood of future avoidable harm. Managers shared learning about never events with their staff and across the trust.

Is the service effective?

Inspected but not rated

Competent staff

The service could not always ensure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support.

Managers tried to give all new staff a full induction tailored to their role before they started work. However, we were told that staff who were supernumerary because they were still on induction were sometimes counted in ward staffing numbers due to low staffing levels.

Managers supported staff to develop through yearly, constructive appraisals of their work. Senior hospital leaders said all staff receive an annual appraisal and there were systems to monitor compliance and remove obstacles preventing staff from participating in this process. In the 2021 staff survey 84.2% of ward and theatre nursing staff said they had received an appraisal in the last 12 months. Although only 16.5% felt their appraisal helped them improve how they did their job.

Outside of the annual appraisal process, managers could not always support nursing staff to develop through regular, constructive clinical supervision of their work. For example, matrons told us they did not always have time to support Band 6 and 7 nurses to develop in their roles because they were too stretched in their own role.

Managers could not ensure staff always received specialist training for their role. Clinical educators supported the learning and development needs of some staff. However, not all wards were allocated funding for clinical educators and sometimes clinical educators had to provide nursing care rather than support the learning needs of others. On the day of inspection, a matron told us they had taken someone off training to provide cover on the ward.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. We saw important staff messages on staff notice boards and staff told us they received emails about important information. Theatre and recovery staff were updated in daily safety briefings and in regular bulletins known as 'SPOTTED' (safety, patients, optimise, time, tissue, education and incidents).

Some junior doctors told us there was not always enough training or practical support to enable them to progress to become a surgeon. However, they told us this concern had been raised with the deanery and the trust were looking at ways this could be improved.

Surgery

Overall compliance with mandatory training was 89.5% with trust overall compliance standing at 83.7%.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients' liberty.

Staff mostly gained consent from patients for their care and treatment in line with legislation and guidance. When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions. Staff made sure patients consented to treatment based on all the information available. Consent for surgical procedures was confirmed as part of the safer surgery check and staff felt this process was well embedded. Staff clearly recorded consent in the patients' records in all of the records we reviewed. However, an audit of consent forms from November 2020 to December 2020 showed that none of the consent forms reviewed included all relevant risks of surgery. However, all other parts of the consent form were correctly completed. A re-audit in of consent forms from 1 March 2021 to 15 April 2021 saw an improvement of risks of surgery being documented (66%). There were no plans shared about repeating this audit.

Staff could describe and knew how to access the policy to get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. They understood how and when to assess whether a patient had the capacity to make decisions about their care. We saw patient files that showed the correct processes for assessing capacity had been followed and staff implemented Deprivation of Liberty Safeguards (DoLS) in line with approved documentation. However, each ward had a separate method of communicating DoLS authorisation to other members of their staff team. For example, on one ward they communicated patients' DoLS status into the ward handover book, on another staff copied all senior nurses on the ward into the DoLS authorisation email. A lack of cohesion in communicating important legal information could result in a patient being detained unlawfully.

Seventy sets of notes for patients with a DoLS from across the trust who were an inpatient between 15 March 2021 and 16 April 2021 were reviewed. The audit showed there were gaps in documentation relating to DoLs and 'Best Interest Decision' making in documentation. The action plan for the audit was to discuss the findings at the mental health steering board meeting in October 2022.

Audits of the use of the Mental Health Act for detaining patients were carried out to ensure documentation had been completed lawfully and learning could be shared when things went wrong.

We looked at patient files and saw that do not attempt cardiopulmonary resuscitation (DNACPR) to allow a natural death forms had been completed in collaboration with patients and or their relatives and using advanced decisions to refuse treatment. We reviewed 3 DNACPR forms and found them to be completed correctly and signed by the consultant. However, an internal 2021 audit of DNACPR and Allow A Natural Death (AAND) forms showed that these forms had not always been completed in line with hospital protocol for patients who lacked capacity. In 75% of these cases Mental Capacity Assessment form had not been completed and in 79% of all cases the DNACPR or AAND form had not been signed by the consultant with overall responsibility for the patient within 48 hours.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong.

Surgery

Is the service caring?

Inspected but not rated

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. We saw staff take time to interact with patients and those close to them in a respectful and considerate way. We saw staff caring for patients, checking if they were cold and wanted extra blankets, checking their temperature, and speaking with a caring tone. We saw them introducing themselves to patients and explaining the care they were going to be giving. Patients told us staff were discreet, for example, drawing privacy curtains and softly inquiring if they had finished with bedpans or urinal bottles.

Patients said staff treated them well and with kindness. Patients told us that staff were busy, “there were not enough of them, but they were always kind and caring” and “could not do enough for us”, and “I couldn’t be in a better place”.

Feedback from the trust wide Friends and Family Test for August 2022 showed that 89.7% of patients thought the care they received was either very good or good. Patients left comments like “I thought all the staff were wonderful despite working under very challenging circumstances” and “all staff were very pleasant and helpful”.

Staff told us they understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. We saw and heard nurses asking patients about their preferences.

We saw a nurse trying to leave the ward to go on an overdue break. As they were leaving a patient called to them, the nurse went straight to the patient to check they were okay, she spoke to them with tenderness and offered them reassurance and did not rush to get away.

Staff followed policy to keep patient care and treatment confidential whenever they could. We could hear a nurse and doctor talking to a patient about giving them a bowel examination. The patient was in a full bay of other patients. We heard the staff talking in soft voices to try and stop their interaction being overheard.

Is the service responsive?

Inspected but not rated

Meeting people’s individual needs

The service was not always inclusive as it did not always take account of patients’ individual needs and preferences. Staff did not always make reasonable adjustments to help patients access services.

Staff supported patients living with dementia and learning disabilities by using ‘This is me’ documents and patient passports. The service had dementia champions and a dementia team.

The service had information leaflets available in languages spoken by the patients and local community.

Surgery

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed.

Access and flow

The service was gridlocked by patients in beds who were medically fit for discharge. People could not always access the service when they needed it and receive the right care promptly.

It was recognised nationally that the health and care system was in gridlock. Large numbers of people were stuck in hospital longer than they need to be, due to a lack of available social care. The trust was experiencing significant problems with access and flow because of delays in discharging a large population of patients with no criteria to reside (medically fit and well). The month before we inspected, the average number of patients with no criteria to reside in the trust was 237. This was equivalent to 9 wards. Most of the patients with no criteria to reside on surgical wards were medical outliers. Following our inspection, we requested information from the Trust about the number of medical outliers on surgical wards. We were given information for 4 October 2022 which showed 56 patient outliers bedded on surgical wards. This equated to 18.8% of the trusts' surgical beds.

The reasons for delayed discharges were complex and included rehabilitation placements, domiciliary care packages, and places in residential homes not being available. Patient flow across the system in Dorset was significantly impacted by a shortage of staffed capacity in social care services. Senior trust managers told us they worked with their system partners to try and find solutions to delayed discharges for medically fit patients.

Some patients were being moved multiple times and sometimes at night, in order to place them on the right ward when a bed became available. Information from the trust showed from April 2021 to March 2022, 30 surgery patients had been moved onto 3 or more wards. Staff told us they did not have a tool to assess the clinical appropriateness of moving patients and sometimes felt these moves, especially at night, were unsafe. Tools to assess patients' clinical appropriateness for a bed move were available as appendices of the trust outliers policy. From April 2022 to September 2022, there were 231 patients from across the trust that were moved during the night time (between 10pm and 6am), recorded on the trust's system. The inability to effectively place patients in the right bed at the right time was on the trust's risk register.

NICE guidance (NG 94) refers to hospitals being at 85% capacity as ideal to maintain access and flow. The trust had been consistently over 93% occupancy for the six months before we inspected. The trust used an established tool to monitor the capacity of wards and tried to use it to meet the needs of the patients but were overwhelmed by the number of patients in the hospital. Trust managers told us the situation had led to an increase in patient harm and poor patient outcomes. They were holding talks with their system partners to look at how they could safely discharge patients with no criteria to reside.

Managers and staff started planning each patient's discharge as early as possible. The trust's discharge team were working hard to try and get patients without criteria to reside discharged but said the 'system' was not able to take them. They said due to delays in discharging patients some patients, at the end of their life, were being left to die in the side rooms of busy hospital wards instead of with dignity at home/in a residential home surrounded by their loved ones.

People could mostly access the service when they needed it but did not always receive the right care promptly due to pressures on bed capacity. Problems with access and flow had an impact on patients waiting for elective surgery. There were sometimes no beds available for patients before or after surgery. Theatre recovery staff told us it was often quite difficult to transfer patients who had been admitted for emergency surgery to wards once they were recovered from their anaesthetic.

Surgery

Initiatives had been introduced to reduce the length of time patients needed to stay in the hospital following surgery. For example, patients that needed toilet risers (a device that raises the height of the toilet to improve the accessibility of toilets to older people or those with disabilities. They can aid in transfer from wheelchairs and may help prevent falls) after surgery, were being assessed prior to surgery instead, to speed up the discharge process.

The hospital monitored the demand on its service using the Operational Pressures Escalation Framework (OPEL). The service had been at OPEL level three and four for the last six months before our inspection. Level four is the highest OPEL level and means the trust was at high pressure.

Managers worked to keep the number of cancelled operations to a minimum but were challenged by the chronically low staffing levels. Some staff told us theatre efficiency was not well managed. They told us that even if more operations took place, there was an issue with discharging patients back to surgical wards in a timely way.

Is the service well-led?

Inspected but not rated

Leadership

Surgery leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced within their remit. They were mostly visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles when they were able to.

Surgery care leaders had the skills, knowledge, and experience to run the service. They understood the challenges and issues faced by the surgical wards and theatres service. Staff told us their leaders were visible and approachable. However, some nursing staff told us they rarely saw senior leaders, apart from when they were being told they have done something wrong. They said no thought was given to when they were told they had done something wrong or why something might not have been done or done incorrectly. They were sometimes “told off” as they were leaving the hospital for the day or about to go on annual leave, and that consideration of the impact of the extremely understaffed shifts on the issues were not considered.

Ward and theatre staff received strong leadership from their direct managers, ward managers, matrons, and department leaders. They described their leadership team as approachable but not always visible, due to their high workloads.

Some of the senior ward and theatre staff told us that senior hospital leaders did not listen to their concerns and did not understand the challenges they faced in maintaining patient safety. Many senior nurses told us they could not provide safe or effective patient care because of chronically short staffing levels and this was contributing to low staff morale.

The visibility of executive leaders on inpatient wards we visited, was mixed. Some staff told us they saw executive leads while other were not sure they would recognise them if they turned up on their ward. However, we were told of one executive lead who had made tea for patients and staff at a time of particular operational pressures.

Some matrons said they did not have time to support the development of Band 6 and 7 nurses. However, some staff told us about opportunities for personal and professional development. The theatre department were developing progression pathways for staff. We spoke with staff who were being supported to complete their nurse training through an apprenticeship programme. Students felt well supported in their placements.

Surgery

Culture

Staff did not always feel respected, supported and valued. Staff morale was low but still focused on the needs of patients receiving care.

Staff told us morale was low. They said pressures from working with too few staff, staff leaving, cancellation of training and working in wards in which they were often unfamiliar, affected morale every day. Some of the conversations we had with staff were difficult to hear. Staff often became tearful or visibly upset when they were describing the way the hospital has changed since the pandemic and the conditions in which they were now working. They used words like "unvalued", "broken" and "exhausted" to describe how they felt.

Staff at all levels told us they felt supported by their colleagues and worked as teams to deliver care. However, staff told us they could not always meet the fundamental care needs of patients and this was difficult to cope with. Staff were passionate about delivering compassionate care for patients and found it hard when this was not possible because of staff shortages. We saw that staff were kind and caring towards patients and supportive of each other.

During the pandemic staff felt valued for working with low staffing numbers because it was recognised how much extra effort was exerted to cover absent staff, and if they worked additional shifts, they would receive a financial incentive. However, they said they were no longer thanked for consistently working with low staff numbers and the financial incentive to work extra shifts had been withdrawn. They said hospital leaders did not listen to their concerns about patient safety and their own wellbeing and they feared working on wards below the staff template had become the 'new normal'.

Senior nursing staff said they were losing staff because of the culture that normalised working with low staffing numbers and moving staff to different departments. For example, one health care assistant was moved to work on different wards eight times in a three-week period. They told us the stress and anxiety caused by staff not knowing where they would be working and or feeling they did not have the skills required to work on other wards was causing them distress. They said when they had raised this issue with senior hospital managers, they were made to feel like they were "causing trouble" or were "shot down in front of other staff". One senior nurse said, "the hospital don't care, we are just numbers, there's no recognition of the circumstances we are working in, we are told you just need to get on with it".

Other staff said they were fearful of repercussions if they spoke out about their working conditions. One member of staff said, "if you raise your head above the parapet you are bullied, told you are a troublemaker". However, one senior leader told us that they did not believe that staff were fearful of reprisals.

Staff said some of the culture problems developed during the pandemic when ward changes were made due to the unprecedented national healthcare emergency. Nursing and medical staff were not consulted or involved in the process, and staff began to be moved to other areas of the hospital. Some staff reported being forcibly moved to a specialist area without the required competencies to care for patients without adequate training and support.

Senior staff told us they used to have direct access to the hospital directors and could affect change, but a layer of management had been created because of the merger, that prevented these lines of communication and they no longer felt listened to. One person said they "do feel respected and listened to but don't feel heard". Some senior staff described hospital leaders as not having an ethos of listening to concerns about patient safety. They said the trust put financial constraints above patient safety and staff wellbeing

Most staff did not talk about the merger favourably. Staff said things like, "since the merger the hospital has lost its vision" and "we are forced to do things in a new way, but the old way kept our patients safer".

Surgery

Some staff said doctors did not understand the pressure nursing staff were under and could be 'cruel', for example, shouting at a nurse for not sitting a patient in a chair early enough in the day. However, some doctors told us they could see nurses were struggling to cope with their workload and they offered support when they could. They could also see nurse's wellbeing suffering.

Senior leaders told us about work they had done to improve culture by asking staff their thoughts on what changes they felt were needed within the trust. Some changes were introduced as a direct result of these listening events. For example, some staff were concerned about their shift patterns. As a consequence rotas were changed to fit in with staff preference, so rotas that did not contain night or weekend shift for people that wanted work to fit in with their family life. However, managers had not been able to make all of the requested changes, for example providing easily accessible areas for all staff to take breaks in.

New members of staff said trust was friendly place to work.

Management of risk, issues and performance

Surgery leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact.

The service had assurance systems and performance issues were escalated through clear structures and processes. There were processes to manage most current and future performance which were reviewed and improved through a programme of clinical and internal audit. Leaders monitored quality, operational and financial processes and had systems to identify where action should be taken.

There were arrangements for identifying, recording and managing risks, issues and mitigating actions. There was alignment between recorded risks and what staff said was 'on their worry list'. Plans to improve patient safety and patient outcomes were high on the agenda for senior staff.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the trust MUST take to improve:

Surgery

- The trust must continue to act to recruit to vacant roles and retain staff across the organisation to ensure there are sufficient staff deployed to meet the needs of patients. Regulation 18 (1)(2)(a).

Action the trust Should take to improve:

Surgery

- The trust should introduce a universal system for communicating DoLS authorisation to staff to avoid patients being detained unlawfully.

Surgery

- The trust should continue to provide training to staff on gaining consent that includes informing patients of all of the risks of surgery.
- The trust should develop systems so DNACPR forms are accompanied by a mental capacity assessment for patients who lack capacity.
- The trust should develop systems so DNACPR and AAND forms are completed by the responsible consultants within 48 hours.
- The trust should continue working with system partners to resolve problems with access and flow.
- The trust should continue to explore how culture can be improved.

Our inspection team

The inspection team comprised of four inspectors and one specialist advisor. We spoke to 62 members of staff, 16 patients, and 3 relatives. We looked at patient notes and observed a patient operation. We attended staff meetings. This was followed by interviews with key people using MS Teams. We also reviewed documentation, policies and procedures.

The inspection team was overseen by an inspection manager and overseen by Catherine Campbell, Deputy Director. You can find further information about how we carry out our inspections on our website: https://www.cqc.org.uk/whatwe-do/how-we-do-our-job/what-we-do-inspection.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing