

Royal Liverpool and Broadgreen University Hospitals  
NHS Trust

# Royal Liverpool University Hospital

## Quality Report

Prescot Street  
Liverpool  
L7 8XP  
Tel: 0151 706 2000  
Website: [www.rlbuht.nhs.uk](http://www.rlbuht.nhs.uk)

Date of inspection visit: 15 - 18 and 30 March 2016  
Date of publication: 29/07/2016

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

## Ratings

### Overall rating for this hospital

Good



Urgent and emergency services

Good



Medical care (including older people's care)

Requires improvement



Surgery

Good



Critical care

Good



End of life care

Outstanding



Outpatients and diagnostic imaging

Good



# Summary of findings

## Letter from the Chief Inspector of Hospitals

The Royal Liverpool University Hospital is a large teaching hospital based in Liverpool and is one of two hospital sites managed by the Royal Liverpool and Broadgreen University Hospitals NHS Trust (the trust). The Royal Liverpool University Hospital is one of the largest hospitals in Merseyside and Cheshire, based close to the city centre, providing care and treatment to patients from across the North West of England, North Wales and the Isle of Man.

The Royal Liverpool University Hospital is the main site operated by the trust, with a total of 857 beds, 792 of which are inpatient beds and 65 are reserved for day case procedures. This hospital provides a range of services, including urgent and emergency care, critical care, a comprehensive range of elective and non-elective general medicine (including elderly care) and surgery, and a range of outpatient and diagnostic imaging services. The hospital also houses St Paul's Eye Unit which provides a range of outpatient services and elective and unplanned ophthalmology surgical services to patients locally, nationally and internationally. The unit sees in the region of 9,000 outpatients each month.

The trust started work on a new Royal Liverpool University Hospital in February 2014 and construction is underway, with the opening planned for 2017. The new Royal will be one of the biggest hospitals in the UK to provide all single en-suite bedrooms on each inpatient ward. There will be 23 wards, including a large clinical research facility and a 40-bedded critical care unit and the new Royal will have 18 state-of-the-art operating theatres. The emergency department will be one of the largest in the North West of England with its own CT scanner and special lifts for patients going straight to the operating theatres on the floor above.

The trust was inspected previously in November 2013 and December 2013, then again in June and July 2014. These inspections were conducted as part of the initial pilot phases of our new inspection methodology. No ratings were applied and this is the trust's first comprehensive inspection as part of our new methodology.

The announced inspection of the Royal Liverpool University Hospital took place on 15 – 18 March 2016. We also undertook an unannounced inspection on 30 March 2016 at the Royal Liverpool University Hospital. As part of the unannounced inspection, we looked at the emergency department, medical care wards, surgical care wards and the Academic Palliative Care Unit (APCU).

Overall we rated Royal Liverpool University Hospital as 'Good'. We have judged the service as 'good' for safe, effective, caring and well-led care and noted some outstanding practice and innovation. However improvements were needed to ensure that services were responsive to people's needs.

Our key findings were as follows:

### Cleanliness and infection control

- The trust had infection prevention and control policies in place which were accessible to staff.
- Staff generally followed good practice guidance in relation to the control and prevention of infection in line with trust policies and procedures.
- 'I am clean' stickers were used to inform staff at a glance that equipment or furniture had been cleaned and was ready for use.
- Almost all of the areas we visited were found to be visibly clean and tidy. However, the podiatry room within the Diabetes Centre was noted to have dust on the work tops and behind the examination couch and the refrigerator contained a box with mould on it.
- Infection prevention and control audits and hand hygiene audits were carried out on a regular basis. These identified good practice and areas for improvement. Key actions were identified to be implemented by staff.

# Summary of findings

- Between December 2014 and November 2015, the trust reported a total of 42 cases of clostridium difficile, 26 cases of methicillin-susceptible staphylococcus aureus (MSSA) and two cases of methicillin-resistant staphylococcus aureus (MRSA) infections, which meant that the trust did not meet the national standard.

## Nurse staffing

- The trust used recognised and validated tools to determine the required levels of nursing staff.
- The majority of areas were staffed with sufficient numbers of suitably qualified nurses at the time of the inspection. However, staffing throughout the medical services had been identified as an issue for the trust. At the time of our inspection we found some areas were still experiencing issues with capacity and ability to manage the wards with the correct staff mix.
- The trust had introduced a red flag system with criteria for staff to raise issues, such as ward staffing. This included a contact number for nurses to call if any situation where, based on professional judgement, patient care was deemed unsafe. The system also had set criteria to aid decision making for the nursing staff, for example a shortfall of more than eight hours or 25% of registered nurse time available.
- Any shortfalls in nurse staffing were generally filled with overtime, bank or agency staff. Matrons attended twice daily staffing huddles to ensure safe levels of nurses on the wards. Staffing was displayed on a live rota using a traffic light system. This included pre-booked staff being allocated to wards as needed.

## Medical staffing

- Medical treatment was delivered by skilled and committed medical staff.
- The information we reviewed showed that medical staffing was generally sufficient to meet the needs of patients at the time of the inspection.
- The medical staffing skill mix was sufficient when compared with the England average. Consultants made up 37% of the medical workforce at the trust which was similar to the England average of 39%. There were more registrar group doctors who made up 41% of the medical workforce compared with the England average of 38%. Of the medical workforce, 18% were made up of junior doctors, which was higher than the England average of 15%.
- There were generally low levels of locum use, with substantive staff preferring to work additional hours to fill any gaps in rotas.
- The Association for Palliative Medicine of Great Britain and Ireland, and the National Council for Palliative Care guidance states there should be a minimum of one whole time equivalent (WTE) consultant per 250 beds. The trust employed four WTE consultants at the time of the inspection, which was slightly more than recommended.

## Mortality rates

- Mortality and morbidity reviews were held monthly in most services and bi-monthly in outpatients and diagnostic imaging services. Patient records were reviewed to identify any trends or patterns and ensure that any lessons learnt were cascaded to prevent recurrence. However, these were not minuted in some areas.
- The Summary Hospital-level Mortality Indicator (SHMI) is a set of data indicators which is used to measure mortality outcomes at trust level across the NHS in England using a standard and transparent methodology. The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated at the hospital. The risk score is the ratio between the actual and expected number of adverse outcomes. A score of 1 would mean that the number of adverse outcomes is as expected compared to England. A score of over 1 means more adverse (worse) outcomes than expected and a score of less than 1 means less adverse (better) outcomes than expected. Between October 2014 and September 2015 the trust's score was 1.037, which was within the expected range.

# Summary of findings

- Critical care services provided continuous patient data contributions to the intensive care national audit and research centre (ICNARC) which allowed outcomes for patients to be benchmarked against similar units nationally. The most recently validated ICNARC data for the period July 2015 to September 2015 showed that the mortality ratio was within the expected range for comparable units. In addition, for the intensive therapy unit (ITU) the data showed that ventilated patients, patients admitted with severe sepsis and patients admitted following elective or emergency surgery, mortality was similar to or better than similar units nationally.
- Data for the high dependency unit (8H DU) in the same period showed that for elective and emergency surgical admissions the mortality was better than comparable units. However, for admissions with trauma, perforation or rupture, the mortality were worse than similar units.
- Evidence based pathways were in place for common causes of mortality in the trust using the Advancing Quality programme.
- The renal medicine service had developed a clinical pathway for new dialysis patients. The pathway was designed to address the high 90-day mortality rates by targeting: improved rates of transplantation; better enabling self-care; improved vascular access, better medicines management; earlier access to psychological support.

## Nutrition and hydration

- In all the records we reviewed, a nutritional risk assessment had been completed and updated regularly. This helped identify patients at risk of malnutrition and adapt to any ongoing nutritional or hydration needs.
- Staff in surgical services managed the nutrition and hydration needs of patient's well, both pre and post operatively. Patients were given information in the form of leaflets about their surgery and told how long they would need to fast pre-operatively.
- A coloured tray system and jug systems was in place to highlight which patients needed assistance with eating and drinking. In addition, there were special plates for certain groups of patients with an individual surgical need, such as smaller plates for patients' who needed to eat small amounts frequently.
- Staff consistently completed charts used to record patients' fluid input and output and where appropriate staff escalated any concerns.
- In order to meet the guidelines for the provision of intensive care services (GPICS) standard for dietetic support the unit should have 0.1 whole time equivalent (WTE) of a dietician per critical care bed. However, the current allocation for critical care was 0.04 WTE per critical care bed.
- The trust scored about the same as other trusts of a similar size in England for the one question related to nutrition and hydration in the Accident and Emergency (A&E) survey 2014.

## We saw several areas of outstanding practice including:

- The emergency department worked collaboratively with local support groups and charities to provide excellent in reach and outreach services to sections of the local population. This meant patients received the best possible care which met their individual needs.
- The emergency department's practice development team provided excellent support and education to the staff within the department. They were responsive and provided tailored training programmes in response to issues identified through incidents and debriefing sessions which ensured that the staff within the department were equipped with the skills and training necessary to provide high quality patient care.
- The emergency department provided an education programme and outreach service to local education establishments on the dangers of knife crime with the aim of reducing this particular type of crime in the local population.

# Summary of findings

- The critical care team led by a designated consultant was developing guidance for staff in the application of the Mental Capacity Act (MCA) 2005 and associated deprivation of liberty safeguards (DoLS) in the critical care setting. It was hoped that this guidance once approved would be adopted across both the local and national critical care networks.
- The electronic whiteboard system used across the trust provided staff with information as to the bed allocated to each patient and to whether patients had particular assessments completed, for example venous thromboembolism (VTE). The board was also used to highlight vulnerable patients. We viewed the whiteboard on ward 3X where staff were piloting an increased functionality such as access to the National Early Warning Score (NEWS), referrals, graphs of patient's results over time and interaction with medical staff via the white board. We found this to be good practice and innovative.
- The trust had a comprehensive end of life vision and strategy set out for 2013- 2018. Their vision was to deliver the highest quality healthcare driven by world class research for the health and wellbeing of the population. End of life services had partnered with Marie Curie Palliative Care Institute Liverpool (MCPCIL) to further research and develop end of life services and collaborated with the Cheshire and Merseyside end of life network group to share research findings. This collaborative working helped support the commissioning and provision of excellent and equitable end of life services for the people of Merseyside and the surrounding boroughs.
- The trust had developed and opened a new Academic Palliative Care Unit (APCU), providing a 12 bedded unit for patients who were at the end of life.
- The trust had a well-established and well-staffed palliative care directorate that worked closely with other organisations to improve the quality of end of life services in Merseyside.
- The palliative care service was embedded across the trust and held in high regard by all the wards we visited. Palliative care was integral to the trust and had a well-developed and substantial palliative care directorate that was part of the medicine division.
- The trust had a robust education and training programme in end of life care and a formal programme of study days which was co-ordinated by the Hospital Specialist Palliative Care (HSPC) team and provided in conjunction with MCPCIL.
- End of life services had a substantial care of the dying volunteer service to ensure that patients and their families were supported. The volunteer service were winners of the Deborah Hutton award in 2015.
- Through working in partnership with the MCPCIL they had developed and appointed two discharge co-ordinators and implemented a rapid discharge home to die pathway. This had achieved excellent results in ensuring end of life patients were supported to be discharged to their preferred place of care.
- Care provided to patients went beyond most people's expectations. Staff showed care and compassion and went the extra mile to ensure patients at the end of life were well cared for. Care for patients and their families was the responsibility of all staff and not just the HSPC team.
- The mortuary staff were able to carry out reconstruction and camouflage to deceased patients to ensure that bereaved families were able to view their loved one.

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

## **Importantly, the trust must:**

### **In all areas**

- The trust must ensure that fridges used to store medications in all areas are kept at the required temperatures and checks are completed on these fridges as per the trust's own policy.

# Summary of findings

- Where fridge temperature ranges are recorded outside the recommended minimum or maximum range, steps must be taken to identify if medicines stored in the fridges are fit for use.
- The trust must ensure that medicines, including controlled drugs and intra-venous (IV) fluids, are securely stored in line with legislation.
- The trust must ensure that emergency resuscitation equipment is readily available in each area, to provide timely access to emergency resuscitation equipment. At the time of the inspection we found equipment shared between wards which meant there may be a delay in accessing emergency equipment.
- The trust must ensure that all emergency equipment is checked regularly in line with trust policy and is ready for use in order to be able to respond safely in an emergency situation.
- The checking of medication, including controlled medication must be carried out consistently as per trust policy.
- The trust must ensure the expiration date of medicines is monitored. Drugs that are past their expiry date must be disposed of promptly.

## In Medical care

- The service must ensure controlled drugs are stored in line with the legislation on the Acute Medical Unit (AMU).
- The service must find an acceptable option to ensure its compliance with Health and safety best practice guidance for the storage of portable oxygen.

## In addition the trust should:

### In Urgent and emergency services

- Take steps to achieve national targets to see, treat and discharge 95% of patients within four hours of arrival.
- The service should take steps to ensure that patient records are updated in a timely way and reflect the care the patient receives.
- The service should ensure that risk assessments are completed as appropriate for all patients who require them.
- The service should improve the compliance with mandatory training and ensure that they are able to access department level data on the number of staff trained in advanced life support.

## In Medical care

- In order to maintain the security of patients, visitors were required to use the intercom system outside wards to identify themselves on arrival before they were able to access the ward and staff had access codes. The service should ensure that all of these doors are closed to prevent people from entering the ward without the knowledge of ward staff.
- The service should review the practice of leaving record trolleys containing patient notes opened or larger records unsecured on the trolleys.
- The service should review the lack of dedicated endoscopy nursing staff with specialist skills available out of hours.
- The trust should continue to review its management of patient flow and the issues of outliers to make sure patients are treated on wards suitable to meet their needs.
- The service should improve compliance with mandatory training.
- The service should review the Deprivation of Liberty Safeguards (DoLS) paperwork and the issue of nursing staff transcribing information from the medical notes as part of the assessment application process. The service should ensure information is correctly entered on the application forms and all the relevant information related to the patient has been captured.

# Summary of findings

## In Surgery

- The trust should keep revisions to the theatre lists to a minimum to help prevent potential errors.
- The trust should improve the levels of staff trained in resuscitating patients.
- The trust should ensure that patients belongings are safely stored particularly if bed shortages reduce storage capacity.
- The trust should review staff competencies in theatre recovery to ensure they have the necessary competencies to care for high dependency patients if required.
- The trust should manage serious complaints in a timelier manner.
- Checking and maintenance of equipment should be undertaken regularly.

## In Critical care

- The trust should take action to reduce the numbers of delayed and out of hours discharges from both level 2 and level 3 critical care facilities.
- The trust should take steps to improve records so that they are not untidy and it is easy to find notes related to the current episode of care.
- The trust should consider how it can develop and expand the critical care outreach service to provide cover 24/7.
- The trust should consider how it can improve the ratio of consultants to patients during the night when the unit is busy so that the ratio does not exceed 1:15.
- The trust should consider how it is going to meet the intensive care society standards for the provision of pharmacy, dietetic and other allied health professional support to the critical care service.
- The trust should take action to ensure that all critical care patients are managed in accordance with the national guidance and standards for critical care.
- The trust should take action to reduce the number of cancelled elective surgical cases.
- The trust should assure itself that the risks associated with storing patients' medicines in their rooms in the high dependency unit are managed safely.
- The trust should consider re-auditing capacity and demand in the unit as the last audit was conducted in 2014.

## In End of life care

- The trust should take action to change the care of the dying document as this does not allow for a person centred and individual care record. It is too close in nature to the Liverpool Care Pathway (LCP) document which was withdrawn from use.
- Action should be taken to ensure that the DNACPR's are completed accurately with the medical rationale for not attempting resuscitation and discussions with patients and family being recorded appropriately. Where a patient lacks the capacity to make decisions with regards to resuscitation then this must be fully documented and best interest decisions recorded.
- The trust should take action to assess all ligature risks in patient bathrooms and to ensure the safety of those patients with severe mental health conditions are protected. For example on APCU we found a ligature risk in the patient bathroom.
- The trust should take action to protect patient information at all times. For example, the seating area on the Academic Palliative Care Unit (APCU) is behind the reception desk and risks information being seen when the receptionist is using the computer.

# Summary of findings

- The trust should take action to provide a full seven day consultant service to enhance the care and treatment of patients who are at the end of life.
- The trust should take action to develop a formal handover guidance tool for nursing staff. For example we observed that on the APCU the nurse delivering the handover was using pieces of paper to handover the nursing details of patients instead of a guided handover tool.

## **In Outpatients and Diagnostic Imaging**

- The trust should ensure all equipment is portable appliance tested (PAT) and fit for use.
- The trust should ensure staff complete mandatory training when required.
- The trust should ensure procedural checklists in St Paul's Eye Unit have patient identifiable information on them.
- The trust should monitor patient waiting times following arrival in outpatient departments.

**Professor Sir Mike Richards**  
**Chief Inspector of Hospitals**

# Summary of findings

## Our judgements about each of the main services

### Service

#### Urgent and emergency services

### Rating

Good



### Why have we given this rating?

Urgent and Emergency services were good at the Royal Liverpool University Hospital with some elements that required improvement. Staff were able to report incidents and were knowledgeable about the types of incident they should report. We saw evidence that learning from incidents and complaints was routine and this learning was disseminated widely. Infection control was effectively managed and the department was visibly clean. Nursing and medical staffing was sufficient to meet patient's needs. Patients accessing the emergency department received effective care and treatment that followed national clinical guidelines and was tailored to their individual needs. This care was delivered by competent and professional staff. The department participated in local and national audits. Patients treated within the department had outcomes which were similar to patients treated in other trusts in England. Staff treated patients with kindness, dignity and respect and provided care to patients whilst maintaining their privacy and confidentiality. Patients spoke very positively about the manner in which staff treated them. The emergency department planned its services to meet the individual needs of the local population it served. There were a number of innovative outreach services provided by the department to ensure that patients received care which met their individual needs. However, some patients experienced delays in accessing these services due to pressures on the department. The department did not meet national targets to see, treat and discharge 95% of patients within four hours of arrival for seven out of twelve months we reviewed prior to the inspection.

#### Medical care (including older people's care)

### Requires improvement



Staff experienced difficulty managing their caseloads at busy periods and this was exacerbated by a high sickness rate. However, the trust had plans in place to improve recruitment. There were higher than average incidents of falls with harm than would be expected. Overall, mandatory training rates were below the trust's target. High bed occupancy and low discharge rates placed pressure on the system to

# Summary of findings

the extent that there were often times when beds were unavailable, resulting in patients sleeping in the assessment room. Staff used a range of risk assessment tools to ensure patients received the right level of care for their acuity in line with national guidance and best practice. Staff were knowledgeable in the procedures for safeguarding patients and staff reported incidents appropriately. Care was delivered that was kind, compassionate and ensured patient dignity was maintained. Patients were well informed and felt their input was valued when planning their care and treatment. Staff understood the vision and values of the service and there was a clear leadership structure in place. Monthly performance meetings were held and relevant issues were communicated effectively to staff.

## Surgery

Good



There was a good reporting culture of incidents. Investigations were carried out and lessons learnt were shared at ward meetings and displayed in ward and theatre areas. Staff were knowledgeable about safeguarding. They could give examples the types of things they should refer and they were aware of how to make a referral to protect vulnerable individuals from abuse. Nursing and surgical staffing needs were adequate to meet the needs of the patients. Patients were treated in line with best practice by competent and caring staff. Performance in national audits was generally better, or similar to other trusts. Patients were treated with dignity, respect and compassion and involved those close to them in a way that they understood. Services were planned to meet the needs of the local population, although bed shortages had meant some delays with the availability of surgical beds. Performance for national referral to treatment time (RTT) targets averaged 90% trust-wide from September 2014 to August 2015, which was above the England average for the whole period. There were good systems in place to meet the needs of patients whose circumstances made them vulnerable. The surgical division was well- led with a vision and strategy aligned with the trust. Staff felt well supported by their managers. Information and learning was shared at regular meetings at all levels. The wards and theatres we inspected were visibly clean.

# Summary of findings

## Critical care

Good



There were sufficient numbers of suitably skilled nursing and medical staff to care for the patients. We found a culture where incident reporting and learning was embedded and used by staff. There was strong clinical and managerial leadership at unit and divisional level. The unit had a vision and strategy for the coming years developed in accordance with the building of the 'New Royal' on the adjacent site. There was an effective governance structure in place which ensured that all risks to the service were captured and discussed. The framework also enabled the dissemination of shared learning and service improvements and a pathway for reporting and escalation to the trust board. Patients and their relatives were cared for in a supportive and sympathetic manner and were treated with dignity and respect. There were issues with access and flow within critical care, which were related to the wider access and flow pressures within the hospital. These regularly resulted in delayed discharges and the associated cancellation of elective surgery.

## End of life care

Outstanding



Palliative care was considered integral to the trust and had a well-developed and substantial palliative care directorate which was part of the medicine division. The trust had an embedded strategy for end of life care driven by effective leadership and delivered by committed staff who were highly satisfied with their workplace. Staff frequently went 'above and beyond' to deliver compassionate, high quality care that took into account patient's wishes. The service was complemented by a strong volunteer body who offered respite and emotional support, ensuring no patient died alone. The service was designed with consideration given to the needs of the local population, and the trust adopted a multidisciplinary approach with input from a variety of external stakeholders to ensure joined up continuity of care. End of life care audit data showed the trust performed excellently, scoring above the national average for each of the seven indicators. Staff were competent to perform their roles and received regular training to ensure competence was monitored and maintained. Medicines and other equipment were stored and monitored regularly to ensure patient safety. The service was well staffed, and had 86 link nurses across the trust to educate,

# Summary of findings

advise and support colleagues in end of life care on every ward. Incidents were reported and investigated appropriately by knowledgeable, trained staff and all learning was shared.

## Outpatients and diagnostic imaging

Good



Policies and procedures were in place for the prevention and control of infection and to keep people safe. Care provided was evidence based and followed national guidance. Staff were competent to perform their roles and worked together in a multi-disciplinary environment to meet patients' needs. Care that was planned took account of patients' wishes, and psychological and emotional support was available in a number of outpatient clinics. Patients had a choice of appointments and additional clinics were held in the evenings or at weekends to reduce waiting times. Between May 2015 and February 2016 the trust met the national standard for diagnostic imaging waiting times with the exception of January 2016. Quality and performance were monitored and there was evidence of continuous improvement and innovation.

# Royal Liverpool University Hospital

## Detailed findings

### Services we looked at

Urgent and emergency services; Medical care (including older people's care); Surgery; Critical care; End of life care; Outpatients and diagnostic imaging.

# Detailed findings

## Contents

| Detailed findings from this inspection                   | Page |
|----------------------------------------------------------|------|
| Background to Royal Liverpool University Hospital        | 14   |
| Our inspection team                                      | 14   |
| How we carried out this inspection                       | 15   |
| Facts and data about Royal Liverpool University Hospital | 15   |
| Our ratings for this hospital                            | 16   |
| Findings by main service                                 | 17   |
| Action we have told the provider to take                 | 133  |

## Background to Royal Liverpool University Hospital

The Royal Liverpool University Hospital is a large teaching hospital based in Liverpool and is one of two hospital sites managed by the Royal Liverpool and Broadgreen University Hospitals NHS Trust (the trust). The Royal Liverpool University Hospital is one of the largest hospitals in Merseyside and Cheshire, based close to the city centre, providing care and treatment to patients from across the North West of England, North Wales and the Isle of Man.

The health of people in Liverpool is generally worse than the England average. Deprivation is significantly higher than average 64.4% (303,377 people) and about 25,335 children (32%) live in poverty. Life expectancy for both men and women is lower than the England average.

The Royal Liverpool University Hospital is the main site operated by the trust, with a total of 857 beds, 792 of which are inpatient beds and 65 are reserved for day case procedures. This hospital provides a range of services, including urgent and emergency care, critical care, a comprehensive range of elective and non-elective

general medicine (including elderly care) and surgery, and a range of outpatient and diagnostic imaging services. The hospital also houses St Paul's Eye Unit which provides a range of outpatient services and elective and unplanned ophthalmology surgical services to patients locally, nationally and internationally. The unit sees in the region of 9,000 outpatients each month.

The trust started work on a new Royal Liverpool University Hospital in February 2014 and construction is underway, with the opening planned for 2017. The new Royal will be one of the biggest hospitals in the UK to provide all single en-suite bedrooms on each inpatient ward. There will be 23 wards, including a large clinical research facility and a 40-bedded critical care unit and the new Royal will have 18 state-of-the-art operating theatres. The emergency department will be one of the largest in the North West of England with its own CT scanner and special lifts for patients going straight to the operating theatres on the floor above.

## Our inspection team

Our inspection team was led by:

**Chair:** Bill Cunliffe, Secondary care clinician, NHS Newcastle Gateshead CCG and retired Surgeon/Medical Director

**Head of Hospital Inspections:** Ann Ford, Care Quality Commission

**Inspection Manager:** Simon Regan, Care Quality Commission

# Detailed findings

The team included 10 CQC inspectors, a senior analyst and a variety of specialists including: a director of nursing, a director, a governance specialist, a safeguarding adults and children lead, a senior associate for equality and diversity, a pharmacy inspector, an emergency department sister, a senior house officer in emergency medicine, a consultant anaesthetist, an advanced nurse practitioner for critical care, end of life

care consultant, a clinical nurse specialist in palliative care, a gastroenterologist, a matron for the complex health and social care directorate, a renal doctor, and infection prevention and control nurse, a lead nurse in the post anaesthetic care unit, a consultant ophthalmologist, a junior doctor and a student nurse. We also used two experts by experience who had experience of using healthcare services.

## How we carried out this inspection

The Royal Liverpool and Broadgreen University Hospitals NHS Trust (the trust) was inspected previously in November 2013 and December 2013, then again in June and July 2014. These inspections were conducted as part of the initial pilot phases of our new inspection methodology. No ratings were applied and this is the trust's first comprehensive inspection as part of our new methodology.

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

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

Before our inspection we reviewed a range of information we held about the trust and asked other organisations to share what they knew. These included Clinical Commissioning Groups, NHS England, Health Education England, the General Medical Council, the Nursing and Midwifery Council, the Royal Colleges and the local Healthwatch.

We held a listening event for people who had experienced care at either the Royal Liverpool University Hospital or Broadgreen Hospital on 8 March 2016 in

Liverpool. This event was designed to take into account people's views about care and treatment received at the hospital. Some people also shared their experiences by email and telephone.

As part of our inspection, we held focus groups and drop-in sessions with a range of staff in the trust including nurses, trainee doctors, consultants, student nurses, administrative and clerical staff, physiotherapists, occupational therapists, pharmacists, domestic staff and porters. We also spoke with staff individually as requested.

We talked with patients and staff from all the ward areas and outpatients services. We observed how people were being cared for, talked with carers and/or family members, and reviewed patients' records of personal care and treatment.

The announced inspection of the Royal Liverpool University Hospital took place on 15 – 18 March 2016. We also undertook an unannounced inspection on 30 March 2016 at the Royal Liverpool University Hospital. As part of the unannounced inspection, we looked at the emergency department, medical care wards, surgical care wards and the Academic Palliative Care Unit (APCU).

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

## Facts and data about Royal Liverpool University Hospital

The Royal Liverpool University Hospital is one of two hospital sites managed by the Royal Liverpool and Broadgreen University Hospitals NHS Trust. There are 896

beds across the trust in total but the Royal Liverpool University Hospital is the main site with 792 beds in total, 727 of which are inpatient beds and 65 reserved for day case procedures.

# Detailed findings

The Royal Liverpool and Broadgreen University Hospitals NHS Trust is one of the largest hospital trusts in the north of England serving more than 465,000 people in Liverpool and the wider North West of England.

Between 14 December 2014 and 13 December 2015 there were 114,376 emergency department attendances at this

hospital. In 2014/15 there were 94,959 inpatient admissions and 696,003 outpatient attendances across the trust. The trust employs over 6,000 members of staff and the full cost of providing services in 2014/15 was approximately £472 million.

## Our ratings for this hospital

Our ratings for this hospital are:

|                                    | Safe                 | Effective | Caring      | Responsive           | Well-led    | Overall              |
|------------------------------------|----------------------|-----------|-------------|----------------------|-------------|----------------------|
| Urgent and emergency services      | Good                 | Good      | Good        | Requires improvement | Good        | Good                 |
| Medical care                       | Requires improvement | Good      | Good        | Requires improvement | Good        | Requires improvement |
| Surgery                            | Good                 | Good      | Good        | Good                 | Good        | Good                 |
| Critical care                      | Good                 | Good      | Good        | Requires improvement | Good        | Good                 |
| End of life care                   | Good                 | Good      | Outstanding | Outstanding          | Outstanding | Outstanding          |
| Outpatients and diagnostic imaging | Good                 | Not rated | Good        | Good                 | Good        | Good                 |
| Overall                            | Good                 | Good      | Good        | Requires improvement | Good        | Good                 |

## Notes

1. We are currently not confident that we are collecting sufficient evidence to rate effectiveness for Outpatients & Diagnostic Imaging.

# Urgent and emergency services

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

## Information about the service

The emergency department at the Royal Liverpool Hospital is open 24 hours a day, seven days a week, providing emergency and urgent care and treatment for adults and a small number of children across Liverpool.

The emergency department is one of the biggest in the Merseyside area and has 16 major trolley spaces used to accommodate patients who are unwell, a separate minors area which can accommodate six patients on trolleys or in chairs at any one time and a separate waiting area with chairs for patients to wait. The department also has a clinical decision unit attached which has 12 beds. These beds are used to accommodate patients who are awaiting clinical decisions before being admitted or discharged from hospital. The department also has a six bedded resuscitation area which is used to treat patients with life threatening conditions.

At the time of the inspection the department was a designated trauma centre under a collaborative agreement with neighbouring trusts. The types of trauma injuries which were to be accepted at the trust were in the process of being changed and finalised at the time of the inspection. There were 114,376 emergency department attendances between 14 December 2014 and 13 December 2015, which equated to over 300 attendances per day on average.

As part of our inspection we visited the Urgent and Emergency Care services at the Royal Liverpool University Hospital during our announced inspection between 15 and 18 March 2016. We also carried out an unannounced visit to the department on 30 March 2016.

We spoke with 17 patients receiving care and treatment in the Emergency Department, relatives, observed care and treatment and reviewed 16 patient records, including observation charts, medication charts and full care records. We spoke 28 staff of different grades including nurses, doctors, health care assistants, reception staff, ambulance staff, senior managers and matrons.

We received comments from patients as part of a listening event prior to the inspection and from people who contacted us to tell us about their experiences. We also reviewed performance information about the trust.

# Urgent and emergency services

## Summary of findings

We rated Urgent and Emergency care services as 'Good' overall because;

- The emergency department was well led and staff were aware of the trust's vision and values.
- There were robust governance frameworks in place and risks were appropriately identified and monitored.
- There was clear leadership throughout the service and staff spoke positively about their leaders.
- There was an open culture in the department, with strong areas of innovation.
- Staff were able to report incidents and were knowledgeable about the types of incident they should report.
- We saw evidence that learning from incidents and complaints was routine and this learning was disseminated widely.
- Infection control was effectively managed and the department was visibly clean.
- Nurse and medical staffing was sufficient to meet the needs of patients.
- Patients accessing the emergency department received effective care and treatment that followed national clinical guidelines and was tailored to their individual needs.
- This care was delivered by competent and professional staff.
- The department participated in local and national audits. Patients had outcomes that were similar to patients treated in other trusts in England.
- Staff sought appropriate consent from patients before delivering treatment and care.
- Staff treated patients with kindness, dignity and respect and provided care to patients while maintaining their privacy, dignity and confidentiality.
- Patients spoke very positively about the way staff treated them.
- The emergency department planned its services to meet the individual needs of the local population it served.
- There were a number of innovative outreach services provided by the department to ensure that patients received care which met their individual needs.

However;

- Mandatory training uptake levels were low for some subjects. However the practice development team had taken actions to address this.
- Some patients experienced delays in accessing the service due to pressures on the department.
- The department did not meet national targets to see, treat and discharge 95% of patients within four hours of arrival for seven out of twelve months we reviewed prior to the inspection. However, the staff and senior management team in the department worked collaboratively to manage increased pressure and had effective measures in place to ensure patients received high quality care.

# Urgent and emergency services

## Are urgent and emergency services safe?

Good



We rated Urgent and Emergency care services as 'Good' for Safe because;

- Nurse staffing levels were sufficient to ensure safe patient care and senior managers had plans in place to fill existing vacancies.
- Medical staffing and skill mix was sufficient to ensure safe patient care.
- Staff were aware of how to report incidents and feedback was provided to staff.
- Lessons were learned from incidents and shared with staff to facilitate learning.
- Safety performance was monitored and safety thermometer data showed that rates of avoidable harm were within national averages.
- Staff were aware of how to raise and manage safeguarding issues.
- Infection rates were low and staff observed appropriate measures to protect patients from avoidable infections.
- The environment was suitable for the delivery of patient care and equipment was well maintained.
- Staff managed medicines well and completed patient records correctly, in legible handwriting.
- Staff displayed a good understanding of their roles in the event of a major incident.

However;

- Temperatures of fridges used to store medications were not always checked on a daily basis as the trust's policy required. When we returned for the unannounced part of the inspection we found that these fridges had been checked daily and staff told us that they had been reminded by senior managers that this daily task must be undertaken.
- Risk assessments designed to assess a patient's risk of falls were not always completed.
- During busy periods the updating of records was sometimes delayed and saw two cases where patient's records were not updated in a timely way.
- Mandatory training uptake levels were lower than the trust's target for some subjects.

## Incidents

- All staff had access to the trust wide electronic incident reporting system. Staff were able to demonstrate how they would report an incident using this system.
- Managers reviewed all incidents and we saw evidence that appropriate responsive actions were taken as a result of incidents.
- Staff told us they received meaningful feedback relating to any incidents they raised. This feedback included information about what action had been taken.
- Staff were aware of the types of incident they should report and were able to give us recent examples where they had reported them.
- There were 600 incidents reported in the emergency department between 1 September 2015 and 31 December 2015. The majority of incidents were in relation to the identification of pressure ulcers when a patient presented to the department and issues relating to aggressive and abusive behaviour. The majority of incidents reported were categorised as low. Incidents categorised as moderate or severe were reviewed and investigated robustly by senior nursing staff within the department and escalated to the governance team when required. We saw evidence that this happened in all three incident investigation reports we reviewed.
- There were no never events reported by the service in the twelve month period prior to the inspection. Never events are serious, wholly preventable incidents that should not occur if the available preventative measures had been implemented.
- There were six serious incidents reported through the NHS England Strategic Executive Information System (STEIS) between October 2014 and November 2015. All serious incidents were investigated using a root cause analysis approach. We reviewed a sample of two investigation reports which showed that a robust investigation had been undertaken and that actions had been identified and put in place to prevent recurrence.
- We saw evidence in these reports that staff at all levels were involved in the investigation process for all incidents including serious incidents. Staff told us they felt positive about being involved in the root cause analysis investigation process and they felt the process was constructive not punitive.
- Staff were able to tell us of recent examples where they had improved their practice because of an investigation. One example given was regarding an omission of a

# Urgent and emergency services

medication used to treat a blood condition. Staff were actively involved in the investigation of this incident and asked for their ideas on how to reduce the risk of a recurrence.

- Another example related to a registered nurse who suggested that an alert sticker should be developed to alert staff to patients who required certain groups of important medicines. This was following an omission of one of these medications. The senior management team worked with the staff member to develop this sticker and put the initiative in place. Since this initiative had been introduced the department noted a reduction in the number of omissions.
- Managers shared lessons learned from incidents with frontline staff through individual feedback, newsletters, communications on notice boards and staff meetings. The department also had an active practice development team who organised weekly teaching sessions on a variety of subjects including subjects highlighted through incident reviews.
- Learning from incidents was discussed within a weekly patient safety meeting and monthly divisional meetings. We saw evidence of lessons learnt being discussed at these meetings and these were then cascaded to the monthly ward sisters' and staff meetings.
- Staff were aware of duty of candour which 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. Staff gave examples of occasions when they had told patients something had not gone as planned and explained how they would exercise the duty of candour. We also saw evidence that the service had exercised its duty of candour in serious incident investigations.

## Safety thermometer

- The NHS safety thermometer is a national improvement tool for measuring, monitoring and analysing avoidable harm to patients and 'harm free' care. Performance against the four possible harms; falls, pressure ulcers, catheter acquired urinary tract infections (CAUTI) and blood clots (venous thromboembolism or VTE), was monitored on a monthly basis.

- The emergency department recorded and monitored data in line with this initiative and performance information was displayed within the department for patients and staff to view.
- We reviewed information for 12 months prior to the inspection and this showed that the department performed within the expected range for falls with harm, catheter urinary tract infections and new pressure ulcers.

## Cleanliness, infection control and hygiene

- The department effectively managed cleanliness, infection control and hygiene. Rates of infections were low and staff followed measures to protect patients from infections.
- All areas of the department were visibly clean and well maintained.
- Staff were aware of current infection prevention and control guidelines and were able to give us examples of how they would apply these principles.
- There had been two cases of MRSA bacteraemia infections identified between March 2015 and January 2016. Both of these cases had been subject to a full root cause analysis investigation and appropriate actions were identified to minimise the risk of a recurrence and put in place.
- Cleaning schedules were in place, with allocated responsibilities for cleaning the environment and decontaminating equipment. The schedules were regularly completed to indicate cleaning had taken place.
- There was adequate access to hand washing sinks and hand gels.
- Staff were observed using personal protective equipment, such as gloves and aprons, and changing this equipment between patient contacts. We saw staff washing their hands using the appropriate techniques and all staff followed the 'bare below the elbow' guidance.
- Patients with an infection were isolated in side rooms, where possible. Staff identified the rooms with signs. Information about control measures were clearly displayed.
- When side rooms were not available, staff told us that patients were placed in curtained areas, which were identified with signage. We observed that these curtained cubicles displayed appropriate signage and staff used separate equipment in these areas. All areas

# Urgent and emergency services

which were used to accommodate patients with an infection were appropriately cleaned at the level stipulated in the trust's infection control processes. This included deep cleaning of areas when these areas had been exposed to certain groups of infections.

- At the time of the inspection, we did observe one patient with symptoms of vomiting who was not isolated appropriately in a corridor area while waiting for a trolley space in the department. When this was highlighted to staff they immediately arranged for an appropriate area for this patient to be isolated.
- The department undertook screening for infections, including MRSA, when patients had been in the department for over four hours. This meant that staff could identify and isolate patients early to help prevent the spread of infections.
- We observed that cubicles and trolley spaces were cleaned between uses including during busy periods.

## Environment and equipment

- Equipment in all areas of the department was visibly clean and well maintained.
- Staff told us they had easy access to the equipment they needed to care for patients.
- Records indicated that staff carried out regular checks on key pieces of equipment. Emergency resuscitation equipment was in place and records indicated it had been checked daily, with a more detailed check carried out weekly as per the hospital policy.
- There were adequate arrangements in place for the handling, storage and disposal of clinical waste, including sharps. We saw that waste was being segregated and disposed of appropriately.
- Bariatric equipment used for obese patients was readily available.
- Appropriate equipment was available for paediatric patients including all equipment which could be required specifically for children.
- Resuscitation trolleys were secured with a tamper evident tag system.
- The admission route for patients was set up so patients arriving by ambulance were seen and triaged in a designated bay area by designated staff. However, when this area was full to capacity some ambulance patients were accommodated in the corridor area.
- There was an x-ray department situated next to the unit for easy access which also provided portable x-rays.

- Portable appliance testing (routine testing of electronic devices) was up to date for all electrical equipment we reviewed.
- Security staff were available on site 24 hours a day and were able to be contacted by telephone, if required. Staff also had an emergency alarm which they could activate in the event of an emergency which alerted security wherever they were in the hospital.

## Medicines

- Medicines, including controlled drugs, were appropriately stored and access was restricted to authorised staff. However, we found three boxes of local anaesthetic injection and some intravenous fluids had been left in trolleys which were accessible to the public. This was highlighted to staff who immediately put measures in place to secure them.
- Emergency medicines were readily available and there was a procedure in place to ensure they were fit for use.
- Medicines fridges were secured. However, temperatures had not been maintained in the recommended range. In the majors area records showed eight instances where the temperature had been minus one Celsius in March 2016. Records showed this had been reported on two of the eight occasions but the nurse in charge of the ward was unaware there had been a problem with the fridge. In addition, there were five instances where the temperature had been minus one Celsius in February 2016 and no action had been documented as being taken. In the resuscitation area, records showed temperatures were over the maximum recommended range on five occasions in March 2016 and 10 occasions in February 2016. Again, records stated 'reported', but staff were unaware who it had been reported to or what action had been taken. This meant staff were not following trust policy or national guidance, and we could not be sure medicines stored in these fridges were fit for use.
- Patient Group Directions (PGDs) were in use and there was a procedure in place to review them. PGDs are written instructions which allow specified healthcare professionals to supply or administer a particular medicine in the absence of a written prescription. PGDs were being used by the emergency nurse practitioners in the minor's area to support patient access to medicines in a timely way. However, we found some had not been signed by staff that were using them.

# Urgent and emergency services

- Hospital prescription pads were in use in the walk-in area and these were stored securely.
- Controlled drugs were stored appropriately in locked cupboards in line with legislation. Records indicated these medications were checked on a daily basis. Controlled drugs require additional checks and special storage arrangements because of their potential for abuse or addiction and also require clear and precise documentation of any wastage.
- There were appropriate processes in place for ordering medications and stock reconciliation and a designated pharmacist assisted the department with this. Staff also had 24 hour access to pharmacy support, if required.
- We observed nurses administering medications to patients and they undertook appropriate checks including checking the patient's name, date of birth and allergy status.
- Discharge medications and prescriptions were managed well. Prescriptions for these medications were completed legibly and records for take home medications were amended accordingly. Discharge notifications were provided to patients and to their GPs, where appropriate.
- Guidelines on the use and preparation of medication were readily available including specific guidelines for children.
- Staff were aware of how to refer a safeguarding issue to protect adults and children from suspected abuse.
- The trust had an internal safeguarding team who could provide guidance and support to staff in all areas. This team were easily accessible by telephone and we observed them attending the department throughout the inspection to assist and advise staff on safeguarding issues. The team were only available during weekdays between 9am and 5pm. Outside of normal working hours and at weekends, staff had access to senior nurses within the hospital management team to seek advice and guidance on safeguarding issues.
- One of the two matrons within the department had a lead role for safeguarding and monitored all paediatric attendances on a weekly basis to identify any issues of a safeguarding nature.
- The emergency department records contained a safeguarding trigger area to prompt staff to consider safeguarding issues. We reviewed three children's records specifically in relation to the safeguarding trigger part of record and in all three records the safeguarding trigger section was completed appropriately.
- Safeguarding training formed part of the trust's mandatory training programme. Data provided by the trust showed that there was good compliance with safeguarding training at all levels across urgent and emergency care services. Compliance with training for safeguarding adults' and children level 1 was 93.5% which was above the trust's target of 90%. In addition, safeguarding adults and children level 2 (84.9%) and level 3 (80%) were all above or in line with the trust's target of 80%. There were two staff required to have child safeguarding level 4 and both had completed it at the time of the inspection.
- Staff were able to explain the application of the law and their responsibilities in relation to female genital mutilation. There was also clear guidance available in the emergency department in relation to this subject.
- Staff were knowledgeable about child sexual exploitation and trafficking, and considered this as part of their patient assessments. The practice development team had also arranged recent training on this subject for staff and staff were provided with prompt cards containing the possible signs and indicators of child exploitation and trafficking.

## Records

- The department used paper based patient records and some electronic records. Records were stored securely and were easily accessible.
- We reviewed 16 patients' electronic records during our visit and found that records relating to patient treatment were legible and easy to follow. We found that patients' nursing records were kept up to date and fully completed in most cases. However, we found that, during busy periods the updating of records was delayed. We found two cases where patient's records were not updated in a timely way; the delays ranged from between 30 minutes and two hours.
- The nursing records section of the records contained a falls risk assessment section. This was not completed in each of the eight records where the assessment was applicable.

## Safeguarding

- The trust had safeguarding policies and procedures in place which were readily available on the trust's intranet site.

# Urgent and emergency services

- The department had an identified nurse who led initiatives for domestic violence issues. Staff considered domestic violence in their patient assessments and were aware of signs and indicators of domestic violence.
- Staff told us they received feedback from all safeguarding concerns and referrals they raised. This was cascaded from the trust safeguarding team to frontline staff and their managers.

## Mandatory training

- Mandatory training compliance was reviewed regularly by the practice development lead nurse and the two matrons within the department. There were 12 mandatory training subjects which staff within the department were required to complete on a yearly basis on a rolling programme in two blocks (clinical core skills and core skills). Clinical core skills included areas such as infection control and prevention for care staff, falls prevention, and, diet and nutrition. Core skills included areas such as safeguarding, health and safety, and fire safety.
- Training data for urgent and emergency services showed that compliance with core skills training was 76.4% at the time of the inspection and 80.5% for clinical core skills. Both were below the trust's target of 95%.
- Basic life support (BLS) training was also provided by the trust as part of mandatory training. Data showed that 89% of staff in urgent and emergency services had completed the training at the time of the inspection, which was below the trust's target of 95%. In addition to this figure, an additional 52 staff within the department had undertaken immediate life support and a further 239 staff within the trust had undertaken Advanced Life Support. Unfortunately the trust was not able to provide us with the exact figure for the number of staff who had undertaken this training within the department.
- Managers within the department and the practice development team were aware of the low compliance rates with some subjects and had taken steps to address it. We reviewed action plans with up to date actions in place to address this issue. One of the key actions listed was the development and implementation of two new trainers within the department to deliver training on an ongoing basis; this was in place at the time of the inspection. The practice development team provided us with the active training

records and schedules in line with this plan; which showed that the majority of staff were booked on to training places in the near future. This issue was also being monitored by the department's matrons.

- Staff told us they were encouraged to attend mandatory training and that the practice development team reminded them when their mandatory training was due for renewal.

## Assessing and responding to patient risk

- Patients who self-presented to the department were seen by a receptionist and were booked in and directed to the waiting room where they were triaged by one of two nurses.
- Patients arriving by ambulance were alerted to the ambulance triage area nurse and triaged in a designated ambulance triage bay. When this bay was full to capacity, patients who arrived by ambulance waited in the corridor area while accompanied by ambulance crews. This area was not staffed by emergency department staff at all times during the announced part of our inspection. This meant patients sometimes experienced a delay in being assessed by an emergency department member of staff.
- We highlighted this to managers within the department and when we returned for the unannounced part of the inspection we found that this area was staffed by emergency department nurses. We also found that this had ensured that patients entering this area were consistently seen within minutes of arrival by a member of the emergency department team. At the time of the unannounced part of the inspection all nine patients who were accommodated within this area were seen by a member of the emergency department team within five minutes.
- The trust used a recognised triage system for the initial assessment of all patients. Triage ensures that patients are directed to the appropriate part of the department and seen in a specified time frame decided by their clinical condition. Serious life-threatening conditions are also identified or ruled out so that the appropriate care pathway can be commenced without delay.
- The Royal College of Emergency Medicine (CEM) recommends that a face to face assessment of patients should be carried out by a clinician within 15 minutes of arrival or registration. We found that 17 out of 23 patients we reviewed had a face to face assessment within 15 minutes of their arrival. The median time to

# Urgent and emergency services

initial assessment for patients presenting to the department by ambulance between October 2013 and October 2015 was consistently lower (better) than the England average for all months.

- There were 255 black breaches from November 2014 to October 2015. Black breaches occur when the time from an ambulance's arrival to the patient being handed over to the department staff is greater than 60 minutes. The service and trust were working closely with the ambulance service to address this issue and held regular meetings to work on improvements to this figure. One example of this was the development of an ambulance triage bay which allowed ambulance patients to be brought directly through to the department into a designated area and received speedy assessment by department staff. The time that ambulances waited was also monitored at department and executive level on a daily and weekly basis.
- An early warning score (EWS) system was in use in the department. The EWS system was used to monitor a patient's vital signs and identify patients at risk of deterioration and prompt staff to take appropriate action in response to any deterioration. Staff carried out monitoring in response to patients' individual needs to identify any changes in their condition quickly.
- We reviewed two patients with a diagnosis of sepsis. Both of these patients received timely care and treatment in line with the sepsis pathway. The trust had designated sepsis nurses who would attend the department to assist with the management of patients with sepsis. This ensured that patients received timely and appropriate care in relation to sepsis. The department also had a grab bag system for patients with sepsis. This grab bag contained key items required in the treatment of sepsis.
- We observed patients being accommodated in the main corridor of the department during all three days of our visit. The time these patients were resident in the corridor ranged from ten minutes to just over two hours. The corridor was not equipped with the same equipment you would find in a designated emergency department space including a lack of piped oxygen and suction and monitoring equipment, which may have been required in an emergency situation. These patients were however accompanied by ambulance crews in all cases and had access to portable oxygen, suction and monitoring equipment.

- On admission, staff were required to carry out risk assessments to identify patients at risk of specific harm such as pressure ulcers, self-harm and risk of falls. If staff identified patients susceptible to these risks, they were required to place patients on the relevant care pathway and treatment plans. We found that patients were placed on the pathway which related to the risks identified including self-harm and pressure care. However, we observed five patients who were admitted with a history of falls. All five of these patients did not have the falls risk assessment section of their records completed. Staff told us that a falls risk assessment would usually be completed when a patient was transferred to an inpatient area.
- Due to pressures on the department, patients remained in department for longer periods than expected during the inspection. A matron for the department told us this was a challenge and that the department were working with their practice development team to work with staff to identify when was the most appropriate time to complete risk assessments for these patients.

## Nursing staffing

- The staffing levels expected on a day time shift for the department were 17 registered nurses and two health care assistants.
- The staffing in the department was sufficient, with some periods of reduced staffing in areas because of last minute sickness and unexpected events. Regular staffing meetings were held including a matron huddle where matrons and a manager of the day assessed staffing across the hospital and moved staff, where appropriate, to mitigate risk. When moving staff was not possible, managers attempted to reduce the risks associated with this by utilising bank and agency staff and permanent staff undertaking extra shifts.
- We reviewed three months of rotas which showed staffing levels were within recommended guidelines for most shifts. On the shifts where the staffing figures fell below the recommended guidelines; this was due to short term and last minute absence. Managers had responded appropriately to try to address these staffing deficits.
- There was evidence that managers planned staffing while taking into account the skill mix and competencies of the staff on duty.
- The department openly displayed the expected and actual staffing levels on a notice board and staff

# Urgent and emergency services

updated them on a daily basis. The staffing numbers displayed on the boards were correct at the time of the inspection and reflected the actual staffing numbers in all areas.

- We observed one nursing staff handover which was comprehensive and well structured. Safety information was handed over as part of this so that staff were aware of any issues which could affect patient safety.
- The vacancy rate for nurses in the emergency department was 9.8% and the turnover rate was 10% at the time of the inspection. This means that in one year 10% of the nursing employees moved on and were replaced by a new employee. A lower turnover is an indicator of stability in the workforce and means that key skills and experience are retained.
- The senior management team for the department had developed and implemented a nurse staffing action plan which detailed how and when recruitment had taken place. This allowed the management team to track how vacancies were being filled. This plan showed that by July 2016 the department would have its full complement of nursing staff pending pre-employment checks and induction training.
- The department completed a twice yearly nurse staffing audit using a recognised workforce planning tool. The tool calculated the workforce and skill mix required to provide the nursing care needed in the department during the audit period.

## Medical staffing

- The medical staffing skill mix was sufficient when compared with the England average. Consultants made up 25% of the medical workforce in the department which was 2% higher (better) than the England average of 23%. However, there were less registrar group doctors who made up 38% of the medical workforce compared with the England average of 39%. Of the medical workforce, 28% were made up of junior doctors which was higher than the England average of 24%.
- Consultants worked on a rota basis to provide cover on weekdays between 9am and 12am. From 12am until 9am the most senior doctor on duty would be a registrar grade doctor (very experienced senior doctor). Consultant cover after 12am was available on an on call basis.

- Junior and registrar grade doctors told us they were well supported by their seniors and consultants and were able to access senior advice and support, as they needed.
- Nursing staff told us that they were able to access medical assistance and advice easily.
- We saw evidence that patients were seen promptly by medical staff if flagged up by the nurse following triage and also when additional reviews were requested by nursing staff.

## Major incident awareness and training

- The trust had a major incident policy in place which was available on the trust intranet site. Staff were able to tell us how they would access this policy and showed a good understanding of the policy.
- The department had a comprehensive plan for the recent Ebola health alert and had held a simulated training exercise in response to this alert.
- There were designated store rooms for major incident equipment.
- Staff received major incident training including participation in simulated training exercises.
- Staff could describe processes and triggers for escalation. They described to us the arrangements to deal with casualties contaminated with hazardous materials (HAZMAT) such as chemical, biological or radiological materials.
- Action cards to guide staff on what to do during a major incident were easy to follow and fit for purpose detailing roles and responsibilities.
- The department also held easy to follow pocket guides and hand held radios which were to be used in the event of a major incident.
- There was a designated folder on major incident procedures available in the staff offices in the department.

## Are urgent and emergency services effective?

(for example, treatment is effective)

Good



We rated Urgent and Emergency care services as 'Good' for Effective because;

# Urgent and emergency services

- Patients accessing the emergency department received care and treatment that was evidence based and followed national guidelines
- The department performed well in audits relating to the management of sepsis. This was seen as a priority within the department and results of audits showed that patients received prompt evidence based treatment when they presented with signs of sepsis.
- The department participated in local and national audits. Action plans were formulated in areas that needed improvement and progress on these actions were monitored.
- Evidence based pathways were used and staff placed patients on these pathways as soon as possible.
- Patients had appropriate access to pain relief when required and their nutritional and hydration needs were identified and addressed appropriately.
- Data from national surveys showed that patients treated within the department had outcomes which were similar to patients treated in other trusts in England.
- Patients received care and treatment from competent staff who worked well as part of a multidisciplinary team.
- Staff sought appropriate consent from patients before delivering treatment and care.
- Staff were knowledgeable about the Mental Health Act and considered this, where relevant.

However;

- The unplanned re-attendance rate for urgent care services within the trust within seven days was consistently higher (worse) than the England average between October 2014 and October 2015.

## Evidence-based care and treatment

- The emergency department used both National Institute for Health and Care Excellence (NICE) and College of Emergency Medicine (CEM) guidelines to guide the care and treatment they provided to patients.
- A range of evidence based clinical care pathways were available and were put in place for patients with relevant conditions. These included fracture neck of femur, sepsis, stroke and overdose of paracetamol. These pathways included prompts and treatment steps for staff to follow. Patients were placed on appropriate pathways as soon as their condition was diagnosed

which ensured that they received timely and appropriate interventions. The pathways were regularly reviewed on a trust wide basis and reflected current guidance from NICE.

- Policies and procedures reflected current national guidelines and were easily accessible via the trust's intranet site.

## Nutrition and hydration

- The department had facilities for making drinks and food, including sandwiches, were available if needed. A hostess service was provided by catering staff on numerous occasions throughout the day. This was provided on a trolley basis and relieved pressure on the nursing staff and ensured patients received regular food and drink.
- Staff identified patients who were not able to eat and drink and assistance was provided as they required.
- We identified three patients who required their fluid balance recording and in all three of these cases the fluid balance chart was completed appropriately.
- The trust scored about the same as other trusts of a similar size in England for the one question related to nutrition and hydration in the Accident and Emergency (A&E) survey 2014.

## Pain relief

- In the A&E survey 2014, the department scored about the same as other trusts in England for all indicators relating to timely access to pain relief.
- We observed that pain relief was routinely offered on triage to walk in patients experiencing pain.
- In all nine records we reviewed, which indicated patients required analgesia, this was prescribed appropriately.

## Patient outcomes

- The department scored about the same as others of a similar size in England for all three questions in the A&E survey, 2014.
- The department participated in local audits regularly and provided evidence of improvements to patients' care as a result of these audits.
- The department participated in the national Royal College of Emergency Medicine (CEM) audits. CEM audits allow trusts to benchmark their practice against national best practice and encourage improvements.
- The trust participated in the consultant sign off audit, 2013. The trust scored about the same or better than other trusts in England for all standards in this audit.

# Urgent and emergency services

- The trust participated in the national Royal College of Emergency Medicine (CEM) 2013/14 severe sepsis and septic shock audit. The trust scored about the same or better than other trusts in England for all standards apart from one standard which related to administration of antibiotics in one hour. The trust had an action plan in place to address this and were continually auditing their performance in relation to sepsis locally.
- The unplanned re-attendance rate for urgent care services within the trust within seven days was consistently higher (worse) than the England average between October 2014 and October 2015. This meant that more patients re attended A&E in this trust than others in England. The trust had regular directorate and service level meetings where measures to reduce the re-attendance rates were discussed. A number of measures were in place to reduce this rate including outreach programmes for vulnerable patients, which offered support in the community to reduce the risk of re-attendance.

## Competent staff

- We found that 83.3% of nursing staff within the department had received their annual appraisal against a trust target of 90%. However, at the time of our inspection there were still two weeks left until the end of year deadline for appraisals. The matrons in the department told us that they had plans in place to provide appraisals to the remaining staff who were currently working in the department during this time. An appraisal gives staff an opportunity to discuss their progress and any concerns or issues with their manager.
- Both nursing and medical staff were positive about learning relevant to their role and development opportunities.
- Medical and nursing staff told us clinical supervision was available and they felt adequately supported.
- New nursing staff received emergency department specific competency based training. They were supported by a mentor and were supernumerary for a period of time which varied depending on their previous experience and learning needs.
- The trust had implemented a trust wide education initiative called “the RLB Nurse Programme”. This programme aimed to develop registered nurses by supporting them to achieve specially designed competencies required for them to deliver safe and

excellent care. The programme included a competency-based portfolio which included reflective practice and a one-day study day which introduced the concepts of human factors in relation to patient safety.

- The department had developed an in-house emergency department handbook to guide staff on best practice and common emergency department situations.

## Multidisciplinary working

- We saw evidence that there was effective communication and collaboration between multidisciplinary team members within the emergency department, other specialities and external stakeholders. This included engagement with external charities and support organisations to ensure that patients received the best possible support and care.
- Staff handover meetings took place during shift changes to ensure all staff had up-to-date information about risks.
- Nursing staff told us they had good relationships with consultants and doctors of different disciplines. We observed the senior consultants leading the department working closely with the shift coordinator to facilitate patient care and flow.
- Staff told us they received support from pharmacists, physiotherapists, occupational therapists, social workers and diagnostic support.
- The rapid assessment and interface discharge (RAID) team who were employed by a neighbouring trust; provided mental health services and worked closely with staff to ensure patients were supported on discharge. Staff told us that they had ready access to this team and experienced minimal delays in accessing their support. We saw examples of the department staff working with this team to facilitate the safe discharge of a patient.
- Staff working for two ambulance services told us they felt the staff in the department communicated effectively with them.

## Seven day services

- Access to radiology services was available 24 hours a day, seven days a week including CT scanning.
- Consultants provided on call cover for 24 hours, seven days a week. A middle grade or registrar doctor was also present in the department 24 hours each day, seven days per week.

# Urgent and emergency services

## Access to information

- The information needed for staff to deliver effective care and treatment was readily available in a timely and accessible way.
- The records we reviewed were easy to locate and easy to follow. This meant staff could access all the information needed about patients easily including tests results and other clinical diagnostic information.
- Policies and procedures were accessible to staff on the trust's intranet.
- A range of evidence based clinical care pathways were available and accessible to staff when patients presented with particular conditions. For example, fracture neck of femur, sepsis and stroke.
- Medical staff produced discharge summaries and sent them to the patient's general practitioner (GP) in a timely way. This meant that the patient's GP would be aware of their treatment in hospital and could arrange any follow up appointments they might require.
- We saw patients being transferred from the department to medical and surgical admission units. The information provided in these handovers was accurate and detailed, which ensured the receiving staff had all the relevant information they needed.

## Consent, Mental Capacity Act and Deprivation of liberty safeguards

- Staff sought consent from patients prior to undertaking any treatment or procedures and documented this clearly in patient records, where appropriate.
- Staff had the appropriate skills and knowledge to seek consent from patients. Staff were able to clearly articulate how they sought informed verbal and written consent before providing care or treatment.
- Staff had a good understanding of the legal requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.
- Staff gave us examples of when patients lacked the capacity to make their own decisions and how this would be managed.
- Staff had awareness of what practices could be deemed as restraint and displayed an understanding of the deprivation of liberty safeguards and their application.
- A trust-wide safeguarding team provided support and guidance for staff in relation to any issues regarding

mental capacity assessments and deprivation of liberties safeguards during working hours. Outside of normal working hours, staff were able to seek advice and support from the senior nurse on site.

## Are urgent and emergency services caring?

Good



We rated Urgent and Emergency care services as 'Good' for Caring because;

- Staff treated patients with kindness, dignity and respect. Care was delivered to patients whilst maintaining their privacy and confidentiality.
- Patients spoke very positively about the way staff treated them. They told us they were involved in decisions about their care and were informed about their plans of care.
- Staff took their time to support patients and ensure they knew what was happening.
- Staff showed that they understood the importance of providing emotional support for patients and their families.
- Patients and their families told us they felt well supported and involved as partners in their care and treatment.

However;

- The NHS Friends and Family Test results showed that the percentage of patients who would recommend the department to their friends and family was below the England average for 11 out of 12 months between December 2014 and December 2015.

## Compassionate care

- We observed staff treating patients with kindness and compassion. Staff took time to interact with patients and treated them with dignity and respect.
- We observed that curtains were closed around patient's bed areas when staff were providing care. There were private rooms available where staff could speak to patients privately, if required, in order to maintain confidentiality.
- We spoke with 17 patients, who all gave us positive feedback about how staff treated and interacted with them.

# Urgent and emergency services

- We saw that staff interacted with patients compassionately including during busy times.
- Data provided by the NHS friends and family test (FFT) showed 2% of patients responded to this test which was lower than other trusts in England which had an average response rate of 3%. This showed that less than 88% of patients would recommend the emergency department to their friends and family for eleven out of twelve months between December 2014 and December 2015.
- The trust scored about the same as other trusts for all standards related to compassionate care in the 2014 A&E survey.

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

- Staff respected patients' rights to make choices about their care and treated patients as partners in their care. Staff communicated with patients in a way they could understand.
- Patients and their families told us that staff kept them informed about their treatment and care. They spoke positively about the information staff gave to them verbally and in the form of written materials, such as discharge information leaflets specific to their condition.
- Patients told us the medical staff fully explained the treatment options to them and allowed them to make informed decisions.

## Emotional support

- Staff understood the importance of providing patients and their families with emotional support. We observed staff providing reassurance and comfort to patients and their relatives
- Patients and relatives told us that staff supported them with their emotional needs.
- Chaplaincy services were available on site to provide additional emotional support and staff were able to tell us how they would access these for patients.
- Staff confirmed they could access management support or counselling services after they had been involved with a distressing event. Staff were included in debriefing sessions which were facilitated by the practice development team following traumatic events.
- The department worked closely with a local project which supported patients who had experienced

domestic abuse. This collaboration provided in reach by the project workers to the department to provide support and safe places for patients experiencing domestic violence.

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

Requires improvement



We rated Urgent and Emergency care services as 'Requires Improvement' for Responsive because;

- We found the trust was not always accurately recording the time of patient's journeys including the decision to admit timings and as a result, the data may be misleading. This meant that we were not assured that patients were moving through the department in a timely manner. We raised this with the senior management team and they addressed this appropriately.
- The department frequently experienced issues with access and flow and there was overcrowding in the department during our visit.
- The total time that patients spent within the department was consistently worse than the England average.
- The department did not meet national target to see, treat and discharge 95% of patients within four hours of arrival for seven out of twelve months we reviewed prior to the inspection but performance was consistently above the national average.

However;

- Complaints were well managed and action taken as a result of them was evident.
- The trust had an escalation plan in place and staff at all levels followed the steps set out in this policy.
- The emergency department planned its services to meet the individual needs of the local population it served.
- There were a number of innovative outreach services provided by the department to ensure patients received care which met their individual needs.

# Urgent and emergency services

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

- Throughout our inspection the department was overcrowded and on occasions there were not sufficient trolley and cubicle spaces. At these times of peak demand ambulances queued in the department's corridors.
- Of the patients attending the emergency department, 0.8% were under the age of 16. The department stocked all equipment required for the treatment of children in an emergency situation. The department provided emergency care and treatment to children in life threatening situations, who could not be immediately transferred to the neighbouring specialist children's hospital. In all other situations children who presented to the department were either redirected or transferred to the neighbouring children's hospital after staff had undertaken assessments to ensure that they were stable for transfer.
- Staff told us that there had been an increase in knife crime in the local area. In response to this the department had developed an awareness program on the dangers of knife crime and delivered this to local schools and education establishments.
- The department had a link nurse with a specific responsibility for equality and diversity. This nurse's role was to disseminate any relevant developments or news in relation to the equality and diversity agenda.
- We spoke with staff from ethnic minority backgrounds. All three staff told us they felt supported in their roles and had not been discriminated against in the course of their employment.

## Meeting people's individual needs

- There were adequate facilities to allow access and use by disabled patients. Including wide corridors and rails in disabled bathrooms.
- Information leaflets about services available and discharge advice were readily available in the department. Leaflets could also be provided in different languages or other formats, such as braille and audio, if requested.
- Staff told us that they could access a language interpreter if needed and were able to show us how they would do this.
- Access to psychiatric support was readily available from the rapid assessment and interface discharge (RAID) team which was provided by a neighbouring trust.

- Staff could access appropriate equipment such as specialist commodes, beds or chairs to support the moving and handling of bariatric patients (patients with obesity).
- The department had a designated homelessness link nurse who provided support and advice to homeless patients who presented to the department. This link service also worked closely with external charities and support organisations to ensure patients who were homeless received the best possible care and support.
- The department also had a comprehensive strategy to help and support individuals experiencing domestic violence. This included working with charities and support organisations to provide in reach and outreach services to victims of domestic abuse.
- There was a pathway for patients with dementia which guided staff on how best to treat and meet the needs of these patients this pathway would follow the patient throughout their hospital journey.
- The department also had a pathway to guide the treatment and care provided to patients living with a learning disability. Staff also had access to a specialist learning disability team for advice and support.

## Access and flow

- There is a Department of Health target for emergency departments to admit, transfer or discharge patients within four hours of arrival. From July 2014 to November 2015, the trust only met this target for two months out of twelve. For seven out of 14 months the department saw less than 95% of patients within this four hour target. However the department did perform above the England average for most months and performance was generally above 90% for patients within four hours of arrival.
- From August 2014 to November 2015, the percentage of emergency admissions waiting four to 12 hours from decision to admit until being admitted was reported as being below (better) than the England average. This meant that on average patients waited less time when being admitted to hospital than in other trusts of a similar size in England.
- We found that 16 out of 20 patient records reviewed showed there was a delay between the patient arriving in the department and being booked into the department at which time the four hour target starts being monitored. This delay ranged from 10 minutes to 1 hour 50 minutes. We raised this with the senior

# Urgent and emergency services

management team. We found the department had implemented measures to address this on our return unannounced visit. These measures included reception staff approaching ambulance staff when they arrived and holding regular meetings with managers within the ambulance services.

- We found that 20 out of 22 patient records we reviewed showed there was a delay between the point at which the emergency department doctor decided to admit a patient and the recorded decision to admit time on the trust's electronic system. This ranged from 1 to 8 hours. We raised this with the trust's senior management team. When we returned for the unannounced visit we found the trust had implemented measures to address this. These measures included the decision to admit time being monitored and inputted by the patient flow team and not the emergency department staff. The trust had also commissioned yearly audits to review the accuracy of the decision to admit data.
- Strategic data showed the percentage of patients leaving before being seen between April 2014 and September 2015 was consistently better than the England average, apart from September 2014 where the trust performed about the same as the England average and May 2015 where the trust performed better than the England average.
- From September 2013 to September 2015, the total time patients spent in the emergency department (average per patient) was consistently higher (worse) than the England average. This meant that, on average, patients spent more time in this emergency department than at other departments of a similar size across England.
- The department had a specific ambulance triage bay to assess ambulance patients with designated nursing staff to manage this area. During the inspection we observed that this area was used to accommodate patients already within the department and not patients from ambulances. This was due to increased demand within the department and a lack of available trolley and cubicle spaces. As a result ambulance staff waited in the corridor with patients. Matrons within the department told us that this would only occur when the department was at full capacity and would be in line with the trusts escalation policy. We observed that when this occurred during the inspection; members of the senior team attended the department and helped to facilitate the movement of patients from this area to accommodate the patients waiting in the corridor.

- The trust had two escalation processes in place for periods when there was increased demand. One of these processes was a hospital wide policy and process and one was specifically for the emergency department. The purpose of these policies and processes was to ensure the effective management of the trust's bed capacity and to give staff clear processes and triggers to follow in times of increased demand.
- We found that the actions set out in the internal emergency department escalation policy were followed when increased pressure was experienced in the emergency department.
- The trust had also implemented an alert to the executive team if any patients were in the department for over ten hours.
- There were bed meetings held five times a day. These meetings were attended by senior nursing staff from the ward areas, patient flow team and the emergency department team. These meetings were well structured and provided the staff who attended with meaningful data and updates on potential inpatient bed availability.
- The department had an observation unit which was used to accommodate emergency department patients who were awaiting clinical decisions or required additional periods of observation or therapy support. This can help prevent unnecessary admissions to the acute inpatient wards and ensure that patients are treated in the most appropriate environment. We visited this unit and found that it was used for this purpose and all patients had appropriate management plans in place.
- We observed numerous patients experiencing long waits to be seen and be allocated inpatient beds.

## Learning from complaints and concerns

- Information on how to raise a complaint and contact details of the patients advice and liaison service (PALS) team was prominently displayed around the emergency department.
- Staff understood the process for receiving and handling complaints, and were able to give examples of how they would deal with a complaint from a patient.
- The trust recorded complaints on the trust-wide system. The matrons were responsible for investigating complaints and the department had a lead matron who reviewed all complaints to identify themes and trends.

# Urgent and emergency services

- We reviewed two complaint records and found they had been appropriately documented and tracked. The complaints had been responded to in a timely manner in both cases and apologies had been offered, where appropriate.
- Information about complaints was discussed during staff meetings to facilitate learning. The practice development team also facilitated workshops and teaching sessions on subjects raised through patient complaints.

## Are urgent and emergency services well-led?

Good



We rated Urgent and Emergency care services as 'Good' for Well-led because;

- The trust's vision and values were embedded and staff embodied these values in their daily working lives.
- There were robust governance frameworks in place and managers were clear about their roles and responsibilities.
- Risks were appropriately identified, monitored and there was evidence of action taken, where appropriate.
- There was clear leadership throughout the service and staff spoke positively about their leaders.
- Managers were visible and staff felt able to approach them.
- Staff told us the culture within the service was open and they felt very well supported.
- There were areas of strong innovation and leaders within the services were working to continually improve services.

### Vision and strategy for this service

- The trust's vision was to deliver the highest quality of healthcare driven by world class research for the health and wellbeing of the population. This was based on a number of strategic themes including improving patient experience, making the trust one of the most sought after places to be treated, improving the quality of life for patients by providing excellent, safe and accessible healthcare, developing a world-class workforce, to achieve international recognition for research and innovation and bringing new therapies from the bench to the bedside.

- Staff were aware of the trust vision and strategic themes and were able to articulate the vision and values for the trust. This vision was embedded in the trust and services strategies.
- The trust's values were based on five qualities they expected to see all staff display in their daily working lives which were; patient centred, professional, open and engaged, collaborative and creative.
- All staff were aware of these values and embodied these values in the behaviour we observed during the inspection.

### Governance, risk management and quality measurement

- There was a robust governance framework within the emergency department. Senior managers were clear on their roles in relation to governance and they identified, understood and appropriately managed quality, performance and risk.
- There was a risk register in place and there was a clear alignment of risks recorded with what staff told us was concerning them. Managers regularly reviewed, updated and escalated the risks on these registers, where appropriate. There were action plans in place to address the identified risks. There was a system in place that allowed senior staff in the department to escalate risks to trust board level through various meetings.
- Audit and monitoring of key processes took place in the department to monitor performance against objectives. Senior managers monitored information relating to performance against key quality, safety and performance objectives through performance dashboards and meetings.
- There were regular monthly clinical governance meetings and we saw minutes from this meeting. The subjects discussed included current risks, themes and trends of incidents and recent incidents.
- There was a lead matron and doctor with a responsibility for governance and quality. They would review incidents and complaints to identify any themes and areas for improvement.

### Leadership of the service

- The leadership in the department reflected the vision and values set out by the trust. Staff spoke positively about their managers and leaders. Leaders were visible, respected and competent in their roles.

# Urgent and emergency services

- There were clearly defined and visible leadership roles in the department. Staff told us their managers and senior leaders were visible and approachable. Staff identified members of the executive and senior management team and told us they were frequently in the clinical areas and spoke with staff regularly. Staff particularly spoke positively of the Chief Nurse and Business Manager.
- Both matrons were visible during our visit. Staff spoke positively of their matrons and senior sisters.
- Medical staff told us their senior clinicians supported them well and they had access to senior clinicians when they required.

## Culture within the service

- There was an open, patient centred culture within the department where staff were encouraged to raise any concerns about safety.
- All staff we spoke with told us they felt respected and valued.
- All staff told us they would feel secure raising a concern or issue with their managers.

## Public engagement

- Staff told us they routinely engaged with patients and their relatives to gain feedback from them. Information on number of incidents, complaints and the results of the NHS Friends and Family test was available in the department.

- The department participated in the NHS Friends and Family test, which gives people the opportunity to provide feedback about the care and treatment they received.

## Staff engagement

- Staff participated in regular team meetings led by the department's managers.
- Staff told us they received support and regular communication from their managers in the form of emails, newsletters and individual interactions.
- All staff we spoke with told us they felt they had opportunity to discuss any developments or changes within the hospital.
- The trust also engaged with staff via newsletters and through correspondence displayed on notice boards in staff areas.

## Innovation, improvement and sustainability

- The department had won a number of awards for a handbook which had been developed in house. This handbook was available as a mobile device application.
- Staff and managers were continually striving to improve the care and treatment patients received.
- Staff told us they were able to suggest improvements to managers and they considered and implemented them where possible.
- Leaders were working to continually improve services. We saw evidence of this in the form of benchmarking meetings with other local trusts and with external stakeholders.

# Medical care (including older people's care)

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

## Information about the service

Medical care services at Royal Liverpool University Hospital provide care and treatment for a wide range of medical conditions, including general medicine, cardiology, respiratory, gastroenterology and renal.

The hospital provides services to a population of 465,000 and between September 2014 and August 2015 had around 44,388 admissions of which 31% were general medicine admissions and 39% were gastroenterology admissions.

We had previously inspected the service on 30 June and 1 July 2014 although no ratings were given. At this inspection we found that improvements had been made in response to our last inspection findings.

We visited Royal Liverpool University Hospital as part of our announced inspection on 16 and 17 March 2016. During our inspection we visited wards 6X,6Y( respiratory medicine), 2Y(acute stroke unit),2A (acute frailty unit),2B,2X (gerontology), 3X,3Y( isolation and infectious diseases),5X,5Y (gastroenterology), 7A,7B (endocrinology) acute medical unit (AMU), 9 ( regional nephrology unit), 7Y (haematology), endoscopy unit, heart emergency centre (HEC) and coronary care unit.

We reviewed the environment and staffing levels and looked at care records and medication records. We spoke with six family members, 16 patients and 85 staff of different grades, including nurses, doctors, therapists, ward managers, matrons, domestics, ward hostesses and senior managers who were responsible for medical services.

We received comments from people who contacted us to tell us about their experience, and we reviewed performance information about the service. We observed how care and treatment was provided.

# Medical care (including older people's care)

## Summary of findings

We have rated medical care services as "Requires Improvement" overall. This is because;

- Staffing throughout the medical services had been identified as an issue for the trust. At the time of our inspection we found some areas were still experiencing issues with capacity and the ability to manage the wards with the correct staff mix.
- The service was performing worse than expected for the number of falls with harm.
- Not all records were kept in locked trolleys or in a locked room to ensure confidentiality.
- At different times during our inspection access controlled doors were not always closed which may allow people to enter the ward without the knowledge of ward staff.
- There were six wards that were sharing resuscitation equipment with the ward next door which may cause a delay in accessing emergency resuscitation equipment.
- We observed emergency suction machines were located in the corridors of wards 6X and 6Y, with a number of oxygen cylinders also stored on 6Y. Staff told us that, due to the design of the hospital, piped oxygen was only available to two patient beds in each bay. As these were respiratory wards, the additional oxygen cylinders were needed, but there was no dedicated storage facility. Health and safety best practice guidance is that oxygen cylinders should be stored securely in a well-ventilated storage area or compound when not in use.
- Bed occupancy rates and discharges had an impact on the flow of patients throughout the hospital due to the demand for medical services. There were times when bed capacity was insufficient to meet patient demand. Between January 2015 and December 2015, bed occupancy rates for medical services ranged from 95-100% and evidence has shown that when bed occupancy rises above 85% then it can start to affect the quality of care to patients and the orderly running of the hospital.
- At our last inspection we found "outliers" were a concern. At this inspection we found that improvements had been made with the tracking of

outliers but they were still a concern for the trust. For example, on the acute stroke ward we found that more than half of patients were gerontology (elderly care) not patients who had suffered a stroke.

- Data provided by the trust showed that for 33 days out of the six months prior to our inspection patients had needed to sleep in beds on the acute medical unit (AMU) due to a lack of beds elsewhere in the hospital.
- There were many patients who were medically fit to leave hospital but were unable due to other factors including waiting for social care packages.

However;

- There was clear evidence of local and national audit practice within medical services. Outcomes throughout the service were above or in line with the expected national average.
- Pain relief was reviewed regularly for efficacy and changes were made, as appropriate, to meet the needs of individual patients.
- Patients received compassionate care and their privacy and dignity were maintained. People we spoke with during the inspection were complimentary about the staff that cared for them.
- Staff morale was good overall and the medical division leadership were visible and working hard to engage with staff and work towards resolving the staffing and capacity issues.
- All staff knew the trust's vision and were aware of the strategy for the medical division. There was a clear governance structure and learning was discussed at key meetings.
- There was a risk register for medical services which was being managed proactively by managers in the different directorates. Staff were aware of key risks and felt informed about key issues affecting the service such as staffing and the new building.

# Medical care (including older people's care)

## Are medical care services safe?

Requires improvement



We rated medical care services as 'Requires Improvement' in Safe because:

- Staffing throughout the medical services had been identified as an issue for the trust. At the time of our inspection we found some areas were still experiencing issues with capacity and the ability to manage the wards with the correct staff mix.
- The service was performing worse than expected for the number of falls with harm.
- Not all records were kept in locked trolleys or in a locked room to ensure confidentiality.
- At different times during our inspection access controlled doors were not always closed which may allow people to enter the ward without the knowledge of ward staff.
- There were six wards that were sharing resuscitation equipment with the ward next door which may cause a delay in accessing emergency resuscitation equipment.
- We observed emergency suction machines were located in the corridors of wards 6X and 6Y, with a number of oxygen cylinders also stored on 6Y. Staff told us that, due to the design of the hospital, piped oxygen was only available to two patient beds in each bay. As these were respiratory wards, the additional oxygen cylinders were needed, but there was no dedicated storage facility. Health and safety best practice guidance is that oxygen cylinders should be stored securely in a well-ventilated storage area or compound when not in use.
- There was a wooden controlled drugs cupboard which was not in line with legislation on the acute medical unit (AMU).

However;

- The wards and areas we visited were well maintained within the limits of the age and condition of the building.
- Records were completed appropriately and we were able to follow and track patient care and treatment easily.

- There were systems for reporting actual and near miss incidents across medical services. Staff were familiar with and encouraged to use the trust's procedures for reporting incidents.
- At our last inspection we found there was limited allocated space between beds in the Heart and Emergency Centre which posed a risk should patients need emergency equipment by the bed. At this inspection we found that the centre had been relocated and provided appropriate space between beds.

## Incidents

- There were systems for reporting actual and near miss incidents across medical services. Staff were familiar with and encouraged to use the trust's procedures for reporting incidents. Staff understood their responsibilities to raise concerns and record safety incidents.
- There had been one never event reported between October 2014 and September 2015 in medical services. Never events are serious, wholly preventable incidents that should not occur if the available preventative measures had been implemented. The incident related to the wrong blood type transfused to a patient. The incident had been fully investigated and changes made to practice. For example staff were aware of the incident and were aware filling in patient details on the blood sample bottle should not be completed until after withdrawal of the sample and two samples were required prior to a blood transfusion.
- From January 2015 to December 2015 medical services at the trust reported 18 serious incidents out of a trust wide figure of 50 including 14 slips, trips or falls with harm and six pressure ulcers. Just over a third of all serious incidents occurred in Medicine. It was not possible to disaggregate the data by hospital site. All serious incidents had been investigated and action had been taken to prevent re-occurrence. The trust reported 6015 incidents for the division of medicine from January 2015 to December 2015 which were rated as low or moderate harm. This indicated that the service had a positive culture of reporting incidents.
- Learning from incidents was discussed during team meetings, sisters meetings and divisional meetings.
- Staff were aware of the need to be open and transparent under the duty of candour regulation. The duty of candour is a regulatory duty that relates to openness

# Medical care (including older people's care)

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.

- Multidisciplinary mortality and morbidity reviews were held and medical services had identified key themes, for example delays in escalation and delayed discharges. The themes were discussed at the ward managers and team meetings to identify learning for each ward.

## Safety thermometer

- The trust submitted data as part of the NHS Safety Thermometer. The NHS Safety Thermometer is a national improvement tool for measuring, monitoring and analysing avoidable harm to patients and 'harm free' care. Performance against the four possible harms; falls, pressure ulcers, catheter acquired urinary tract infections (CAUTI) and blood clots (venous thromboembolism or VTE), was monitored on a monthly basis. From September 2014 to September 2015 there were 22 pressure ulcers reported across all medical care services, 40 falls that resulted in harm and 19 catheter-acquired urinary tract infections had occurred during this period.
- Ward managers had actions in place for improvement which had resulted in an improvement in performance against previous months. The service had developed a "falls action plan". Falls champions had been implemented by the falls team to be a resource for staff and patients.
- The inpatient eye ward had a 'How are we doing' wall mounted board which displayed figures for VTE, falls and Clostridium Difficile (C Diff). The ward had no complaints in the previous month and 100% harm free care record.
- Results of the NHS Safety Thermometer were displayed on every ward and area we visited. The results related to that individual ward or area.

## Cleanliness, infection control and hygiene

- The wards we inspected were visibly clean and organised. All staff we spoke with were aware of, and adhered to, current infection prevention and control guidelines such as the 'bare below the elbow' policy. We observed staff using appropriate hand-washing techniques and protective personal equipment, such as gloves and aprons, whilst delivering care.
- Wards used 'I am clean' stickers to inform colleagues at a glance that equipment or furniture had been cleaned.

- There were sufficient hand washing sinks and hand gels. Hand towels and soap dispensers were adequately stocked.
- Between December 2014 and November 2015, the trust reported a total of 42 cases of clostridium difficile and 26 cases of Methicillin-Susceptible Staphylococcus aureus (MSSA) Two Methicillin-Resistant Staphylococcus Aureus (MRSA) infections were reported between December 2014 and November 2015, meaning the trust did not meet the national standard.
- Side rooms were used as isolation rooms for patients identified as at an increased infection control risk. There was clear signage on each room, to ensure staff and visitors were aware of the increased precautions they must take when entering and leaving the room. We observed staff adhering to the necessary precautions to minimise the risk of cross infection.
- The service had two infectious disease wards which were equipped to manage conditions that required isolation ranging from influenza, infectious diseases to the Ebola virus.
- Cleaning schedules had been completed and cleaning materials were securely locked away.
- Hand hygiene audits were completed in line with the World Health Organisation (WHO) 'five moments of hand hygiene' which describes the key points at which hand hygiene should be completed by health care staff. All wards we visited were compliant in hand hygiene.
- Patients we spoke with on the ward reported that they were happy with the overall cleanliness of the wards and reported that staff always washed their hands before any care or treatment was given.
- Ophthalmic inpatients told us they saw staff cleansing and washing hands between each patient. There was evidence of barrier equipment outside the single rooms on ward 9Y. Gloves, aprons and hand gel were well stocked.
- Staff consistently followed hand hygiene practice and 'bare below the elbow' guidance. Personal protective equipment (PPE) such as aprons and gloves were readily available and in use in all areas.
- Infection prevention and control audits and hand hygiene audits were carried out on a regular basis on each ward. These identified good practice and areas for improvement. Key actions were identified to be

# Medical care (including older people's care)

implemented by staff, for example a reminder was sent to staff to ensure there was an extra focus on hand washing before and after patient contact. Compliance levels across the wards were mostly good.

## Environment and equipment

- At our last inspection we found there was limited allocated space between beds in the Heart and Emergency Centre which posed a risk should patients need emergency equipment by the bed. At this inspection we found that the centre had been relocated and provided appropriate space between beds.
- The wards and areas we visited were well maintained within the limits of the age and condition of the building. A new hospital building was under construction on the current hospital site.
- In order to maintain the security of patients, visitors were required to use the intercom system outside wards to identify themselves on arrival before they were able to access the ward and staff had access codes. During different times on our inspection we found that not all of these doors were closed which may allow people to enter the ward without the knowledge of ward staff.
- There were systems in place to maintain and service equipment. Regular portable appliance testing (PAT) had been carried out on electrical equipment and electrical safety certificates were in date. On one ward we found one piece of equipment which had been incorrectly labelled. When we raised this with the manager in charge of the ward at the time of our inspection we were shown evidence that the equipment had been serviced correctly. Hoists had been serviced appropriately. Equipment at the Royal Liverpool site had been appropriately maintained, and electrical equipment had been PAT tested. We checked a range of equipment on the Acute Medical Unit (AMU), wards 2A, 2X, 2Y, 6X and 6Y. Equipment we checked included vital sign monitors, infusion pumps, defibrillators, emergency suction pumps, airflow machines, air mattress pumps, manual blood pressure monitor and hoists. All the equipment checked with two exceptions, which we reported immediately, were in-date with PAT testing.
- Resuscitation equipment was available to all the wards we visited. Resuscitation equipment trolleys were locked with tamper seals in place. Emergency drugs were available and within the expiry date. Checks of the equipment had been completed on a regular basis.
- We reviewed the location of all the resuscitation trolleys at the trust. Six wards shared equipment with the ward next door. Wards 2X and 2Y shared a resuscitation trolley. At the time of our inspection, the trolley was located on ward 2Y. Depending on the route taken, and at a brisk walk from the furthest patient bay, we measured that it could take approximately 30 seconds to one minute to locate the resuscitation trolley on the other ward. This may impact on the ability of the service to provide timely access to emergency resuscitation equipment.
- We observed emergency suction machines were located in the corridors of wards 6X and 6Y, with a number of oxygen cylinders also stored on 6Y. Staff told us that, due to the design of the hospital, piped oxygen was only available to two patient beds in each bay. As these were respiratory wards, the additional oxygen cylinders were needed, but there was no dedicated storage facility. Health and safety best practice guidance is that oxygen cylinders should be stored securely in a well-ventilated storage area or compound when not in use. Staff told us the new hospital has been designed to include piped oxygen to all beds.
- Results from the Patient Led Assessments of the Care Environment (PLACE) in 2015 showed ratings from 99% to 100% in services across the trust for condition, maintenance and appearance. The trust also performed above average for food, well-being and facilities for the past three years.
- We received concerns that the air ventilation system on the infectious diseases wards was not fit for purpose. Following discussion with managers and a site visit we found that regular maintenance had taken place and a replacement part was on order but it was not impacting on the efficacy of the ventilation system. The service had put in place a planned upgrade of some of the ventilation systems which was part of a rolling programme depending on room availability.

## Medicines

- We spoke with one patient and looked at five sets of records in terms of medication. We found that patients were given their medicines in a timely way, as prescribed, and records were completed appropriately.
- Medicines were appropriately stored, prescribed and administered. Controlled drugs were stored securely and stock recorded appropriately.

# Medical care (including older people's care)

- The monitoring of medicine fridge temperatures was completed daily. However, staff only recorded the current temperature and not the minimum and maximum (range) in line with trust policy. All recorded current temperatures were noted to be within the recommended range.
- Ward staff and managers were able to describe how to report serious incidents involving medicines, and we saw examples of how learning from incidents was shared.
- Emergency medicines and equipment were available, and there was a procedure in place to ensure they were fit for use.
- Medicines were stored safely and securely across the trust, including intravenous fluids; however on AMU we found a wooden controlled drugs cupboard which was not in line with good practice standards.
- There was an open culture around the reporting of medicine errors. The medicines safety officer had oversight of incidents across the trust and we saw examples of learning from frequent errors being shared across the trust, for example involving insulin.
- The trust used an electronic prescribing and medicines administration (EPMA) system, which had a number of benefits in terms of the safety and quality of services provided for patients. However, the system was not in use in the accident and emergency (A&E) department or on the medical admissions unit. The use of paper charts alongside or instead of EPMA meant there was an increased risk of medicines being missed, duplicated, or incorrectly transcribed when patients were transferred to other wards. We did see any reported incidents related to incorrect medicines transcribing

## Records

- The service used paper based records to record care and treatment for patients. We looked at 24 sets of records. All of them contained entries that were dated; there was evidence that care plans were appropriately completed for patients and there was clear evidence within the records that consent had been obtained when needed. We observed that the records were clear, legible and up to date. Records included fully completed and easily accessible risk assessments in areas such as nutrition, pressure relief and pain management control. This allowed staff to carry out their required clinical activities for patients.

- Wards had lockable patient note trolleys. On ten out of seventeen wards we visited we observed that these trolleys containing patient notes were left opened or larger records were left unsecured on the trolleys. This increased the potential for patient confidentiality to be breached.

## Safeguarding

- There was a trust-wide safeguarding policy in place, which was accessible to staff on the intranet and staff knew where to locate a copy if required. The policy covered a range of issues which included domestic abuse, sexual abuse and female genital mutilation.
- Safeguarding procedures were in place and staff knew how to refer a safeguarding issue to protect adults and children from abuse.
- The trust had a safeguarding team which provided guidance during the day in the week. Staff had access to advice out of hours and at weekends.
- Safeguarding training formed part of the trust's mandatory training programme. Data provided by the trust showed that there was good compliance with safeguarding training at all levels across medical services trust-wide. Compliance with training for safeguarding adults' level 1 was 93.3% and for safeguarding children level 1 it was 93.3%, which were both above the trust's target of 90%. In addition, safeguarding adults and children level 2 (85%) and level 3 (83%) were all above the trust's target of 80%. This information covered medical services trust-wide and we could not disaggregate it specifically for staff at the Royal Liverpool University Hospital.

## Mandatory training

- Staff received mandatory training on a rolling programme in two blocks (clinical core skills and core skills). Clinical core skills included areas such as infection control and prevention for care staff, falls prevention, and, diet and nutrition. Core skills included areas such as safeguarding, health and safety, and fire safety.
- Training data for medical services trust-wide showed that compliance with core skills training was 84.2% at the time of the inspection and 82.9% for clinical core skills. Both were below the trust's target of 95%. This information covered medical services trust-wide and we could not disaggregate it specifically for staff at the Royal Liverpool University Hospital.

# Medical care (including older people's care)

- Basic life support (BLS) training was also provided by the trust as part of mandatory training. Data provided by the trust showed that 89.9% of staff across medical care services trust-wide had completed the training at the time of the inspection, which was slightly below the trust's target of 95%. This information covered medical services trust-wide and we could not disaggregate it specifically for staff at the Royal Liverpool University Hospital.

## Assessing and responding to patient risk

- A national early warning score system (NEWS) was used throughout the trust to alert staff if a patient's condition was deteriorating. This was a basic set of observations such as respiratory rate, temperature, blood pressure and pain score used to alert staff to any changes in a patient's condition.
- Early warning indicators were regularly checked and assessed. When the scores indicated that medical reviews were required, staff had escalated their concerns. There was a medical emergency outreach team which was used for patients whose early warning score was above a certain level (a score of seven or above). Repeated checks of the early warning scores were documented accurately.
- Upon admission to medical wards, staff carried out risk assessments to identify patients at risk of harm.
- The falls team were involved in undertaking pro-active ward visits to review patient's assessment and work with staff to increase knowledge, understanding and ownership of the risk reduction strategy for falls.
- Intentional observation rounds were carried out by nurses every two to four hours depending on individual need to assess patient risk on an ongoing basis. These observation rounds helped to ensure that vulnerable patients were provided with regular help and support and ensure early response time to a patient's changing condition.
- The trust undertook a modern matron ward round every month where the allocated matron visited the ward area to look at leadership, documentation, patient safety and nutrition and infection control. We saw examples of the ward round and staff were able to describe actions taken as a result of the ward rounds such as improvements in communication with relatives.
- The service had introduced a "safety passport" for patients who were identified as needing extra support such as being at risk of falls. This document was

provided during admission for patients with a seven step approach to patient safety. It included information on key possible risk areas such as advice on the prevention of falls, medicines and pressure sores. The document included contact numbers for patients to contact the trust. This included an urgent patient safety concerns helpline for patients who had urgent concerns about their care.

## Nursing staffing

- Staffing levels were reviewed every six months using the 'safer nursing care tool' (SNCT). This is an evidence based tool which allows nurses to assess patient acuity and dependency and to determine the recommended number of staff. Each ward had a planned nurse staffing rota and any shortfalls in staff numbers were reported on a daily basis to senior managers.
- Medical wards displayed nurse staffing information on a board at the ward entrance. This included the planned and actual staffing levels. This meant that people who used the services were aware of the available staff and whether staffing levels were in line with the planned requirements.
- Nurse staffing establishment levels across all wards was variable. All wards we visited had vacancies being filled by either staff working extra hours or agency staff. Staff on half of the wards we visited reported concerns about staffing levels. All managers reported staffing levels to be a risk and staffing was on the risk register. There were actions identified to mitigate the risk, such as a rolling programme of recruitment. The divisional risk register reported concerns about the effect nursing vacancies was having on patient care. Data provided by the trust showed the number of vacancies had reduced but outlined once recruited, although establishment would improve, many of the staff could be newly qualified so would require more support and guidance which may impact on patient experience and patient safety.
- We visited ward 6Y which reported some serious concerns re staffing and reviewed recent staffing rotas. We raised this with the Director of Nursing who provided us with assurance on actions that had been taken to address the staffing issues.
- Data provided by the trust showed ward 3Y had four whole time equivalent vacancies in January with a further three qualified staff vacancies expected before

# Medical care (including older people's care)

the end of March 2016. This had been identified as a risk by the trust with a potential safety issue if the service was unable to recruit to the posts. Action plans were in place to mitigate the risk.

- The average percentage of qualified nursing and unqualified nursing shifts filled during January 2016 ranged from 104% to 78% for qualified staff and up to 130% for unqualified staff. The staff fill rate data supplied from the trust which showed the planned verses actual levels of staff on the wards, identified that generally shifts were being covered by the correct number of nursing and non-nursing staff during each shift. However, to ensure the fill rate of staff was adequate, extra healthcare support workers were used on the ward which may impact on the appropriate skill mix of staff and potentially not the correct level of staff on the wards to care for patients.
- Senior managers met daily to discuss staffing and ensure there was adequate cover and skill mix of staff across medical services. Managers informed us that, to ensure patient safety, extra bank health care workers were used to fill the shortfalls and provide assistance to the nursing staff. However, this could risk an imbalance of skill mix and did not mitigate the need for trained nurses to be on shift to provide the care and treatment needed for patients. The trust had introduced ward nursing red flag system with criteria for staff to raise issues re ward staffing. This included a contact number for nurses to call if any situation where, based on professional judgement, patient care was deemed unsafe. The system also had set criteria to aid decision making for the nursing staff, for example a shortfall of more than eight hours or 25% of registered nurse time available.
- Managers told us they were having difficulty in providing the correct expected staffing levels on medical wards due to a high level of staff nurse vacancies and a sickness rate ranging from 5.8% on cardiology, 4.4% on respiratory and 7% on gerontology. At the time of our inspection data provided by the trust showed there were 120 registered nursing staff vacancies.
- We spoke to patients on the ward and some expressed that the staff were very busy and sometimes too busy to talk.
- Safety huddles between ward staff took place twice daily. These huddles provided vital information to staff

to ensure patients remained safe. The huddles discussed patient conditions, any safeguarding concerns, falls, pressure ulcer care, incidents and any important information about the ward.

- We observed a ward handover on ward 9Y, where information was shared with the incoming shift that was thorough and comprehensive, ensuring patient safety.

## Medical staffing

- Rotas were completed for all medical staff which included out of hours cover for all medical admissions and all medical inpatients across the wards. All medical trainees contributed to this rota. The information we reviewed showed that medical staffing on the medical care wards was appropriate at the time of the inspection.
- There were consultants on the acute medical unit (AMU) from 8am until 10pm every day. The AMU consultants carried out morning ward rounds, as well as providing consultant review on the AMU between 1pm and 10pm every day.
- Certain specialties provided separate on call rotas including infectious diseases, diabetes, cardiology and clinical pharmacology.
- A night team was available all week between 9pm and 9am including medical staff and advanced nursing practitioners.
- Consultant cover was available on call from home between 10pm and 8am.
- The percentage of medical staff who were consultants working in the hospital was 37% which was slightly below (worse) than the England average of 39%. The percentage of registrars was 41% which was higher (better) than the England average of 38%. The percentage of junior doctors was 18% which was higher (better) than the England average of 15%. Middle grade levels were 3% which was lower (worse) than the England average of 9%.
- We observed a ward round which we noted was very informal with no formal documentation. Staff confirmed that the handover could be very busy with lots of interruptions. Medical staff told us they were in the process of moving to electronic handovers. An effective handover is important to ensure that any actions identified are implemented and that all the relevant information is available for staff to support their patients.

# Medical care (including older people's care)

## Major incident awareness and training

- The infectious disease ward was part of the emergency preparedness arrangements and had a dedicated unit set up to manage an Ebola outbreak.
- There were documented major incident plans within medical care areas and these listed key risks that could affect the provision of care and treatment. There were clear instructions for staff to follow in the event of a fire or other major incident.
- Staff were aware of what they would need to do in a major incident and knew how to find the trust policy and access key documents and guidance.
- Staff in medical care services had been involved in major incident simulation exercises.
- The service had escalation beds in place to help manage winter pressures.

## Are medical care services effective?

Good



We rated medical care services as 'Good' for Effective because:

- There was clear evidence of local and national audit practice within medical services. Outcomes throughout the service were above or in line with the expected national average.
- Pain relief was reviewed regularly for efficacy and changes were made, as appropriate, to meet the needs of individual patients.
- Risk assessments were carried out for various potential hazards including falls, use of bed rails, pressure ulcers and nutrition (Malnutrition Universal Screening Tool or MUST). Patients at high risk were placed on care pathways and care plans were put in place to ensure they received the right level of care.
- Multi-disciplinary working was well established and the service was proactive in its approach to providing seven day services.

However;

- We saw examples of Deprivation of Liberty Safeguards (DoLS) paperwork but the completion and application was variable.
- We found dedicated endoscopy nursing cover was not available out of hours but was covered by general nursing staff.

## Evidence-based care and treatment

- Staff provided care to people based on national guidance, such as National Institute for Clinical Excellence (NICE) guidelines, and were aware of recent guidance changes.
- Evidence based pathways were in place for all common causes of mortality in the trust using the Advancing Quality programme. The trust monitored adherence with these pathways including monitoring all patients using the National Early Warning Score (NEWS) system. Data provided by the trust showed 97% compliance with the trust standard for observations of patients.
- The service had introduced an assessment triage tool, as a result of an out of hour's ophthalmic emergencies audit to ensure that treatment was provided in line with best evidence based practice.
- There was evidence of regular audit meetings and they were able to demonstrate specific improvements to the quality of care provided for patients. An example of this was the introduction of the frailty pathway.
- The trust contributed to all the national clinical audits it was eligible to. Clinical audit is a quality improvement process for healthcare practitioners and providers, which aims to enhance the care of patients by systematically reviewing medical practice against explicit criteria, modifying it where necessary.
- Patients had an individualised care plan that was regularly reviewed and updated in the majority of the records we reviewed. All the care plans we looked at were reviewed and updated.
- Patients at high risk were placed on care pathways and care plans were put in place to ensure they received the right level of care. The risk assessments included falls, use of bed rails, pressure ulcers and nutrition (Malnutrition Universal Screening Tool or MUST).
- We reviewed 24 patient records and found that care plans contained the necessary information to ensure that patients were not at risk and care was managed safely.

## Pain relief

- Pain relief was reviewed regularly for efficacy and changes were made, as appropriate, to meet the needs of individual patients.
- We saw that the level of pain patients were in was recorded on early warning scores documentation.
- We did not see any evidence that there were any specialised tools in place to assess pain in those who

# Medical care (including older people's care)

had a cognitive impairment such as dementia or a learning disability. General pain assessment was carried out on initial admission to the ward and as part of the nursing processes.

## Nutrition and hydration

- A coloured tray and jug system was in place to highlight which patients needed assistance with eating and drinking. Smaller trays were used for patients requiring a special diet.
- Ward housekeepers used mobile electronic devices to capture patient's meal choices. This also incorporated information on specific dietary requirements.
- The majority of patients we spoke with said they were happy with the standard and choice of food available.
- Fluid balance charts were fully completed and records showed that patients had had an assessment of their nutritional needs using the Malnutrition Universal Screening Tool (MUST) and were referred to a dietician where necessary. The 'MUST is a validated nutritional screening tool and is a simple five step tool designed to identify adults at risk of malnutrition and to categorise than as being at low, medium or high risk.

## Patient outcomes

- The service had implemented a specific initiative to improve the detection and the treatment of sepsis. We were provided with the service clinical audit report which demonstrated regular auditing (and reporting back) of services throughout the medical directorate to reduce the associated risks of sepsis.
- The Myocardial Ischaemia National Audit Project (MINAP) is a national clinical audit of the management of heart attacks. The MINAP audit 2013/14, showed a mixed response for the service. The number of patients diagnosed with a non-ST segment elevation myocardial infarction (N-STEMI - a type of heart attack) seen by a cardiologist prior to discharge was better than the national average at 97% (the national average was 94%). Seventy-four percent of patients with an N-STEMI were admitted to a cardiology ward. This was better than the national average of 55%. The percentage of patients who were referred or had an angiograph (an investigation that looks into the blood vessels of the heart) was 65% which was worse than the England average of 78%.
- The Sentinel Stroke National Audit Programme (SSNAP) is a programme of work that aims to improve the quality of stroke care by auditing stroke services against

evidence-based standards. This highlighted that the service performed well in the July to September 2015 quarter. The trust scored in the top 80% in all but two of the team centred and patient centred domains. The trust scored in the lower 50% in the three quarters from January 2015 to September 2015 for the provision of speech and language therapy.

- The 2013/14 heart failure audit showed the hospital performed better than the England average for all but one of the indicators (discharge planning).
- Medical services participated in the joint advisory group on gastrointestinal endoscopy (JAG) and were JAG accredited. The JAG ensures the quality and safety of patient care by defining and maintaining the standards by which endoscopy is practiced.
- In the national diabetes inpatient audit 2013, the trust had a mixed performance with 12 positive findings and nine negative findings.
- The readmission rates for the hospital were slightly worse than the England average for all elective medical procedures. For non-elective medical procedures at trust level, the relative risk of readmission was slightly higher (worse) for general medicine compared to the England average but slightly lower (better) for cardiology and gerontology.
- The service had developed a clinical pathway for new dialysis patients. The pathway was designed to address the high 90-day mortality rates by targeting: improved rates of transplantation; better enabling self-care; improved vascular access, better medicines management; earlier access to psychological support.
- The service had developed per-Oral Endoscopic Myotomy (POEM) for achalasia (a disorder of the gullet). Patients were able to be discharged the same day as the procedure. This was an alternative method of performing a myotomy (cutting the muscle) other than the surgical route. Data provided by the trust showed a success of over 90% comparable with the established surgical procedure.
- The respiratory directorate implemented a series of consultant rota improvements that enabled the delivery of a seven-day led consultant ward round on their respective wards. Data provided by the trust showed an improvement in length of stay by 75% from an average of 12-14 days reduced to four days.

# Medical care (including older people's care)

## Competent staff

- Staff told us they were well supported with mandatory training and staff appraisals. However data provided by the trust showed a mixed response to appraisals. In some areas medical staff had completed 100% compliance such as respiratory and general medicine. In other areas such as gastroenterology nursing staff had achieved 37%, respiratory 8% whilst in the infectious disease directorate the nursing staff had achieved 72% and gerontology nursing staff 75% of staff had received an appraisal in the last twelve months. The trust's target was 95%. Action plans were in place to improve the uptake of appraisals. The use of appraisals is important to ensure that staff have the opportunity to discuss their development needs or support required to help them carry out their job role.
- There were systems in place to ensure staff were enabled to deliver effective care and treatment. Locality managers held the training needs analysis for the locality and were aware of the skills and knowledge required to ensure the staff were able to care for their patients.
- The trust was in the process of revising its process for identifying training needs across all staff groups. A pilot training needs analysis had been undertaken and further plans were in place to develop the process and ensure that staff identified and received the training and development required to carry out their job role.
- The trust Medical Emergency Team (MET) held current Advanced Life Support certificates to ensure they were skilled to manage emergency care appropriately. In addition, there were a further 235 members of staff across medical care services trust-wide who had received immediate life support (ILS) training.
- Each ward had a number of link nurses, these were nurses trained to offer advice and guidance to other staff in infection control, pressure ulcer care, tissue viability and end of life care. There were also lead nurses available in these areas for support and guidance, if required.
- The service had an end of life link nurse per ward whose role included raising awareness of end of life processes, and educating and supporting the nursing team.
- Dedicated endoscopy nursing cover was not available out of hours but was covered by general nursing staff. The lack of dedicated staff with specialist skills may impact on the ability of the provider to deliver a high quality service out of hours.

- All the medical wards had a buddy system for support, for example. Cardiology had a buddy system with the infectious disease ward.
- We saw evidence of regular ward training for example on ward 6Y training was held on a Wednesday afternoon depending on workload.
- Qualified staff told us there were formal systems for clinical supervision. Data provided by the trust confirmed this. The purpose of clinical supervision is to provide a safe and confidential environment for staff to reflect on and discuss their work and their personal and professional responses to their work.
- Staff we spoke with confirmed they had an adequate induction. Newly appointed staff said their inductions had been planned and delivered well. Managers confirmed that there were systems in place to allow staff to work as unqualified staff until the necessary training and induction had been completed.
- Advanced nurse practitioners and senior nurses in a number of directorates and specialities such as AMU had undertaken training to become non-medical prescribers.

## Multidisciplinary working

- Effective multidisciplinary team (MDT) working was well established on the medical wards and evident from discussions with staff, observations of inspection and reviews of records. There was a joined-up and thorough approach to assessing the range of people's needs and a consistent approach to ensuring assessments were regularly reviewed by all team members and kept up to date.
- MDT meetings took place regularly and were attended by the ward manager, nursing staff and therapy staff such as a physiotherapist and occupational therapist.
- The medical services had recently been awarded regional funding to further develop their virtual MDT meeting. The MDT covered patients who presented with complex co-morbidities and who presented a diagnostic challenge and so were unsuitable for other specialty MDTs.
- Meetings on bed availability were held up to four times a day to determine priorities, capacity and demand for all specialities. These were attended by both senior management staff and senior clinical staff including representatives from the local ambulance trust.

# Medical care (including older people's care)

- We observed two handovers, which included healthcare assistants, nurses and medical staff. There was effective communication and were well structured.

## Seven-day services

- Consultant cover was available on site from 8am to 9pm seven days per week.
- Diagnostic services were available 24 hours a day, seven days per week.
- We found the trust had been proactive in the development of seven day services in line with NHS England launching the ten clinical standards in December 2014. The four clinical standards that had been prioritised were: time to first consultant review, access to seven day diagnostic services, and timely 24/7 access to consultant directed interventions and twice daily consultant review.
- Data provided showed the trust was 89% compliant in delivering consultant-led ward reviews over seven days with plans to achieve 100% by end of 2016.
- The trust was proactively engaging with NHS and local partners as well as other acute trusts within Liverpool to develop a patient-centric delivery programme to achieve seven day services across the city. There were links with social services in place to ensure the clinical teams were fully supported seven days per week.
- Physiotherapy services were available seven days per week. Data provided by the trust stated the service was struggling to provide speech and language therapy over seven days because of staffing capacity.
- Pharmacy services were available 24 hours a day seven days per week.

## Access to information

- Trust policies were regularly reviewed and covered most aspects of clinical management. These were accessible via the hospital intranet for all staff.
- Staff had access to the information they needed to deliver effective care and treatment to patients in a timely manner including test results, risk assessment and medical and nursing records.
- There were sufficient computers available on the wards we visited which gave staff access to patient and trust information.
- Policies and protocols were kept on the hospital's intranet which meant all staff had access to them when required.
- The electronic whiteboard provided staff with information as to the bed allocated to each patient and

to whether patients had particular assessments completed, for example VTE. The board was also used to highlight vulnerable patients. We viewed the whiteboard on ward 3X where staff were piloting an increased functionality such as access to the NEWS scores, referrals, graphs of patient's results over time and interaction with medical staff via the white board. We found this to be good practice and innovative.

- Ophthalmic imaging services provided instant electronic images of the eye that could be viewed from any trust terminal, either at the main site or at the Garston Health Centre and gave clinicians the ability to provide more rapid diagnoses.

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

- The majority of staff knew about the key principles of the Mental Capacity Act 2005 (MCA) and how these applied to patient care. Staff understood the application of considering capacity, consent and deprivation of liberty and ensuring adjustments such as access to specialist support, flexible visiting, and carer support were applied.
- Staff had knowledge and understanding of procedures relating to the Deprivation of Liberty Safeguards (DoLS). DoLS aim to make sure that people in hospital are looked after in a way that does not inappropriately restrict their freedom and are only done when it is in the best interest of the person and there is no other way to look after them.
- We saw examples of Deprivation of Liberty Safeguards (DoLS) paperwork but the completion and application was variable. Nursing staff described how they transcribed information from the medical notes as part of the assessment application process. This meant that there may be an increased risk in information not being correctly transferred to the application forms and all the relevant information related to the patient may not have been captured. This meant that patients were at risk of being inappropriately restricted. We looked at ten records and found inconsistent compliance with documentation for best interest or written evidence of involvement of nominated advocates for individuals with no next of kin. In one record we found that there was no completion of a mental capacity assessment. We found areas of good practice on ward 2B where staff were fully compliant with the process to follow for MCA/DoLS

# Medical care (including older people's care)

- Staff knew the principles of consent and we saw written records that consent had been obtained from patients prior to procedures.

## Are medical care services caring?

Good



We rated medical care services as 'Good' for Caring because:

- Patients received compassionate care and their privacy and dignity were maintained. People we spoke with during the inspection were complimentary about the staff who cared for them.
- We saw staff interactions with people were person-centred.
- Patients were involved in their care, and were provided with appropriate emotional support.
- The NHS Friends and Family Test (FFT) showed the majority of patients who responded would recommend the service to their friends or relatives. The FFT response rates were in line with the national average.

### Compassionate care

- Staff assisted patients quickly and with patience, showing them respect and protecting their dignity by closing doors and curtains.
- All the patients we spoke with were positive about their care and treatment. We observed a student nurse checking on a patient in a side room and the interaction was kind caring and positive.
- We saw that the majority of people had access to call bells and staff responded promptly.
- The NHS Friends and Family test (FFT) average response rate for the hospital was similar to the England average of 36%. The FFT asks patients how likely they are to recommend a hospital after treatment. Results showed that performance at ward level is generally good and patients would recommend the medical care services to their friends and relatives. Data provided by the trust showed that in November 100% of people identified they would recommend wards 3A, 6X 3Y, 7B and 6A. We noted that three wards had scored below average on several occasions during the period December 2014 and

November 2015. Ward 7A recorded a score of below 90% for the four months prior to November 2015. Local action plans were in place as part of the regular performance reviews.

- In the cancer patient experience survey for inpatient stay 2013/14, the trust performed in the top 20% of trusts in England for 10 questions, in the middle 60% for 21 questions and in the bottom 20% for three questions. Areas of good performance included trust in medical staff, staffing levels and quality of communication and response to questions by medical staff. Areas of below average performance included communication to patients and availability of support groups.
- The trust consistently performed better than the England average in all four parts of the patient-led assessments of the care environment (PLACE) in 2013, 2014 and 2015. These were cleanliness, food, privacy, dignity and wellbeing and facilities.
- The trust performed about the same as similar trusts in all areas of the 2014 CQC inpatient survey for all but one question. For the question "did nurses talk about you as if you weren't there" the trust performed better than other trusts.
- We spoke to two ophthalmic inpatients who were happy with the care they had received. We were told patients were treated with kindness and compassion.
- Ward 9Y had a 'How are we doing' board on the main corridor. Positive feedback from patients was 96%.

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

- Patients had a named nurse and consultant. Patients we spoke with were clear who was looking after them and the name of their consultant.
- Patients said they had been involved in their care and were aware of the discharge plans in place.
- The majority of patients we spoke with said they had received good information about their condition and treatment.
- The gerontology team provided support for older adults and their relatives, specifically around discharge. This meant additional support was available, including signposting to other agencies to involve patients and families in safe discharge from hospital.
- Patients who required extra support to make their needs known had a 'this is me' document in their records. This

# Medical care (including older people's care)

was completed with the patient and those close to them to ensure it expressed their preferences. We observed the card being used on the wards we visited to help meet the needs of patients.

- An inpatient told us that staff always introduced themselves and involved them in discussions regarding their treatment. They felt safe on the ward and relatives had been allowed to stay overnight to ensure their security. They stated the level of care was “outstanding”.

## Emotional support

- Half of the staff said they had sufficient time to spend with patients when they needed support, but other staff felt that recent workloads meant this did not always happen.
- Chaplaincy services were available for patients 24 hours a day, seven days per week.
- Assessments for anxiety and depression were recorded for all patients to recognise if a patient required additional emotional support.
- Nurse specialists would provide specific support for patients, for example the falls and dementia nurses offered additional emotional support for patients and their families.
- Counselling services were available to patients to support them to come to terms with their condition for example on the haematology wards.
- A patient receiving ophthalmic oncology treatment, and an inpatient on ward 9Y, told us the service had been recommended to them and so they had travelled from the South of England to receive care at St Paul's eye hospital.
- Oncology patients had access to specific information leaflets, were given an audio copy of their consultation and had access to a specialist nurse via a dedicated telephone number.

## Are medical care services responsive?

Requires improvement



We rated medical care services as ‘Requires Improvement’ for Responsive because;

- Bed occupancy rates and discharges had an impact on the flow of patients throughout the hospital due to the demand for medical services. There were times when bed capacity was insufficient to meet patient demand.

Between January 2015 and December 2015, bed occupancy rates for medical services ranged from 95-100% and evidence has shown that when bed occupancy rises above 85% then it can start to affect the quality of care to patients and the orderly running of the hospital.

- At the time of the inspection, 168 patients were ready for discharge of which 69 were primarily within the trust's control.
- At our last inspection we found “outliers” were a concern. At this inspection we found that improvements had been made with the tracking of outliers but they were still a concern for the trust. For example, on the acute stroke ward we found that more than half of patients were gerontology (elderly care) not patients who had suffered a stroke.
- Data provided by the trust showed that for 33 days out of the six months prior to our inspection patients had needed to sleep in beds on the acute medical unit (AMU) due to a lack of beds elsewhere in the hospital.
- There were many patients who were medically fit to leave hospital but were unable due to other factors including waiting for social care packages.

However;

- The trust had implemented a number of schemes to help meet people's individual needs, such as a yellow symbol to indicate that a patient was at risk of falls and a tree symbol for people living with dementia.
- People were supported to raise concerns or complaints. Complaints were investigated and lessons learnt were communicated to staff.
- The trust had a wide range of services in place to meet the needs of its population across a large geographical area. It was noted that the service had worked within its commissioning arrangements to streamline some services and make best use of resources.

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

- We found the trust had a wide range of services in place to meet the needs of its population across a wide geographical area. It was noted the service had worked within its commissioning arrangements to streamline some services and make best use of resources.
- The service hosted the regional Haemophilia centre, taking referrals for patients with bleeding and clotting

# Medical care (including older people's care)

disorders from across the North West region and North Wales. The service had proactively worked with partners and patients to redesign the service and introduce a single point of access.

- The medical service had worked with its partners in Merseyside to introduce the frailty unit and pathway to support frail older people with complex needs in the most appropriate setting either in the acute or community setting. The plan involved partnership working with other agencies to ensure patients were quickly seen and safely discharged. The plan highlighted the actions and responsibilities to be taken by each service to ensure continuity of services.
- Medical services had a designated GP phone line. This enabled GPs to refer patients directly to the acute medical unit and avoid accident and emergency admissions.

## Access and flow

- Bed occupancy rates, delayed transfers of care and discharges had an impact on the flow of patients throughout the hospital due to the demand for medical services.
- At our last inspection we found outliers were a concern. We found patients who were not on the appropriate ward were not reviewed by their specialist medical team in a timely manner and the systems did not ensure that patients were allocated an appropriate consultant or that teams were fully aware of the location of patients under their care. This meant that patients were at increased risk of inappropriate care or treatment due to less frequent specialist review. At this inspection we found the medical services had produced an Admissions, Discharges & Transfer Whiteboard System, which was a touch-screen system for 'real-time' tracking of patient admissions, discharges and transfers to improve bed capacity monitoring. If a patient could not go to the appropriate speciality ward, an electronic referral to the appropriate consultant was instigated in the Acute Medical Unit.
- At this inspection we found "outliers" were now geographically more equitable across the wards and people were being managed more effectively. However the issue of outliers was still a concern for the trust. "Outlying patients" was a process by which patients are relocated to a ward which is not the most suitable location for their condition to improve patient flow. It is important that these patients receive regular senior

medical review; to ensure that they are receiving the appropriate, specialist care that they require. The information provided by the trust showed there was a shortage of medical beds and a number of patients were placed on wards not best suited to their needs.

- The trust had a patient flow and escalation policy that was being followed to ensure patient care and treatment was not affected and meetings were held several times a day to discuss patient flow and bed availability throughout the hospital. We observed a bed flow meeting which was well run and proactively trying to manage bed flow in the trust. There was a patient flow team (discharge team) consisting of bed managers, discharge facilitators, night managers, and social services to facilitate discharges from hospital. The patient flow management team aimed to place each patient in the appropriate bed for their problem or, when this was not possible, ensure they were looked after by the right consultant. At the end of every shift they checked to see which beds were available and moved patients as required.
- On the day of our inspection the regional dialysis unit had two patients who had been defined as ready to step down to another ward but no beds were available. The lack of suitable beds may impact on the trust's ability to provide high quality care for patients in the most appropriate setting. We found occasions when ward 3X could not move patients from the infectious diseases unit to general wards. We noted that extra beds had been provided on ward 2A in escalation bays to manage the demand on beds at the trust. On the acute stroke ward we found that more than half the patients were gerontology (elderly care) not stroke patients. Staff told us it was regularly not possible to admit patients immediately into the stroke unit and they may receive their emergency treatment in the Emergency Department.
- On the acute medical unit (AMU) we were told the assessment room was often unavailable due to the number of patients in beds on the unit. We found two patients who had been on the unit for over 48 hours without moving to a ward. Data provided by the trust showed that for 33 days out of the six months prior to our inspection patients had needed to sleep in beds on the AMU due to lack of beds elsewhere in the hospital.
- At the time of the inspection, 168 patients were ready for discharge; of which, 39 were due to NHS community, 60 related to social care assessment and place of care.

# Medical care (including older people's care)

However, for 69 of those, the trust held primary responsibility for the delay. Data provided by the trust indicated that on average 140 patients were ready for discharge each day.

- Between January 2015 and December 2015, bed occupancy rates for medical services ranged from 95-100% above the national benchmark of 85%. This meant there were more patients needing medical beds than were available. Evidence has shown that when bed occupancy rises above 85% then it can start to affect the quality of care to patients and the orderly running of the hospital.
- Medical services consistently performed above the England average when compared with similar trusts in meeting 18 week referral to treatment times (RTT) for all specialities. From April 2015 to October 2015 the trust had achieved 100% for dermatology, gerontology and rheumatology with cardiology achieving 98% and gastroenterology achieving almost 100%. Endoscopies were carried out within six weeks.
- There was a focus on discharge planning for patients on all wards we visited. Staff discussed discharges at daily board rounds and bed management meetings. Once patients were discharged, discharge summaries were provided to patients and sent to their general practitioner.
- Between September 2014 and August 2015, hospital episode statistics (HES) showed that the average length of stay for elective medicine at the hospital was more than three times higher than the national average for a number of specialties including clinical haematology and gastroenterology (the overall trust average was 10.8 days compared to the England average of 3.8 days). For non-elective medicine the rates were variable with a slightly worse length of stay for general medicine of 7.8 days but slightly better for cardiology at 5.6 days (the England average was 6.8 days).
- Data showed the majority of wards did not routinely move patients after midnight with the majority of wards moving under five patients a month. However, this was in contrast to the AMU results which showed an average of 200 patients per month moved after ten o'clock at night.
- The in-patient coordinator for endoscopy had transformed the care of patients already in hospital needing endoscopy. They enabled the consent

processes, ensured good communication, appropriate patient preparation and facilitated urgent endoscopy through in reach into the AMU. This helped with the overall access and flow within the trust.

- The service had introduced an initiative to target admissions into the trust whereby particular care homes who sent in a significant number of patients were targeted for help. The service had also developed close liaison with the community to facilitate timely discharge.

## Meeting people's individual needs

- The trust used a yellow symbol to indicate when a patient was at risk of falls. These symbols were placed on the bedside board of the patient, and displayed on the hospital smart board to alert staff of the risk and ensure appropriate care was given. All staff we spoke with were able to explain the symbol's use, and from the smart board, could see at a glance how many patients were at risk of falls.
- The trust had implemented the sticker scheme, where a tree symbol was used as a visual reminder to staff of patients who were living with cognitive impairment. Nursing assessments identified patients living with dementia or learning disabilities and care was provided to meet their needs. Staff could give examples of how they had supported patients living with learning difficulties. A quality mark on ward 2B had been awarded for the dementia friendly environment. These ensured patients received appropriate care, reduced the stress for patients, and increased patient safety.
- The service used a health passport document for patients with learning disabilities. Patient passports provided information about the person's preferences, medical history, and support needs.
- Translation services and interpreters were available to support patients whose first language was not English. Staff confirmed they knew how to access these services. This service was available seven days a week, 24 hours a day. Patient information was available upon request in various different languages.
- We saw that nursing and therapy staff liaised with other agencies, families and carers to maintain routines and support patients in vulnerable circumstances.
- The trust had developed a teenager and young adult unit on ward 7Y to cater for patients aged between 16 and 25. The ward was in the process of upgrading a day room on the unit to cater for young people.

# Medical care (including older people's care)

- Leaflets were available for patients about services and the care they were receiving. Staff knew how to access copies in an accessible format, for people living with dementia or learning disabilities, and in braille for patients who had a visual impairment.
  - Medical services had access to a substance misuse support team seven days per week which offered support to staff caring for people who needed this support. This service also provided an outreach service for detox at home. There was also an outreach service for patients with no fixed abode.
  - "Diabetic boxes" were available on all wards to respond to patients experiencing deterioration in their condition. A diabetic menu was also available for inpatients, and there was a range of patient information specific to diabetes.
  - A comprehensive Spiritual Care Service operated 24 hours a day, seven days a week, for patients (and staff) on both the Royal Liverpool and Broadgreen Hospital sites. The department of Spiritual Care was managed through the Division of Medicine by the Divisional Director of Operations. There was also a team of volunteers supporting both the Roman Catholic and Anglican chaplains in order to ensure all inpatients could have access to spiritual care whilst an inpatient.
  - Staff treated patients in a discreet and dignified manner. Suitable arrangements were in place for single sex accommodation, with separate male and female bays on the wards. However we found the limited space and the design of the ward meant that it was hard to maintain privacy and dignity for example female patients may have to walk past male patients to use washing and toilet facilities. A relative told us they had a conversation with staff on the corridor which they felt was not private. We raised this with the staff at the time of our inspection who said this was not usual practice and for longer more sensitive conversations the staff would use a private room. The trust had had one mixed sex breach in the twelve month period prior to our inspection.
  - Throughout our visit we found that orientation around the ward areas was not easy. There was no clear signage to help confused patients identify their individual bays Toilet signs were not compliant with dementia friendly guidelines.
  - Staff confirmed patients had access to both psychiatric and counselling services for patients as and when required.
  - A checklist had been introduced when patients transferred to a ward to ensure all their individual needs were met.
- ## Learning from complaints and concerns
- Staff understood the process for receiving and handling complaints and were able to give examples of how they would deal with a complaint effectively. Managers discussed information about complaints during staff meetings to facilitate learning.
  - Patients and those close to them told us they knew how to make a complaint or raise a concern if they needed to. 'Patient information' leaflets were available on all the wards we visited explaining the complaints procedure and how to access the Patient Advice and Liaison Service (PALS). The leaflets included information written in a number of different languages in terms of how to request information in alternative formats.
  - The service recorded complaints on the trust-wide system. Data showed there had been 103 complaints in the year 2015 raised related to medical services compared with the trust total of 419. The highest proportion of complaints was regarding communication with staff members or aspects of clinical treatment such as delays in treatment or discharge. In response to a complaint from a patient, regarding the lack of choice of food, a full nutritional support review was carried on ward seven as part of the trust quality programme. Joint action plans were developed with the ward manager, dietician, ward hostess and quality matron to ensure all nutritional needs were reviewed and appropriate plans were in place.
  - Wards also displayed the compliments they received on information boards.

## Are medical care services well-led?

Good



We rated medical care services as 'Good' for Well-led because;

- All staff we spoke with knew the trust's vision and were aware of the strategy for the medical division. There was a clear governance structure and learning was discussed at key meetings.

# Medical care (including older people's care)

- There was a risk register for medical services which was being managed proactively by managers in the different directorates. Staff were aware of key risks and felt informed about key issues affecting the service such as staffing and the new building.
- The majority of staff said they felt supported and said that, despite the demand issues over the last six months, they felt managers had tried to manage the situation and were aware of the issues in the medical division.
- The trust was proactive in promoting research and innovation and there was a culture of striving to improve service delivery.

However;

- There were issues with access and flow through the service. Managers were working in partnership with other agencies to improve it.

## Vision and strategy for this service

- The trust's vision was "to deliver the highest quality of healthcare driven by world class research for the health and wellbeing of the population." Staff at all levels within medical services were able to tell us about the trust values. The trust's objectives were based on this vision and set strategic goals, which were cascaded down to the service and individual objectives for staff. The vision for the trust was displayed around the hospital for patients, visitors and staff.
- Medical care services had produced their own strategy in line with the trust vision and had plans in place which identified challenges and objectives, for example to complete staff recruitment and manage patient flow. The divisional strategy had been launched at an away day in February 2016 and a monthly update was written by the Medical Chief of Service.

## Governance, risk management and quality measurement

- There was a clear governance structure, and meetings were held on a monthly basis to discuss service performance. Monthly performance reports (dashboards) were produced at directorate and divisional level. The service used the performance dashboard to measure key quality indicators in terms of meeting standards. Improvements in performance were

ongoing and the managers of the service were clear of the work needed to improve performance. Three monthly directorate reviews were carried out by the division managers.

- We reviewed the division of medicine dashboard report for January 2016 which indicated quality indicators for the wards were 93% which was above the internal target of 90% set by the division.
- The medical division used a risk register to monitor risks, and mitigation actions were recorded with progress and review dates. Items on the register reflected those highlighted by the senior staff. For example, staffing levels across the service was identified as a risk and an action plan including a recruitment drive was on-going to address the issues. Senior staff knew there was a risk register and ward managers were able to tell us what the key risks were for their area of responsibility.
- Staff were able to tell us how their ward performance was monitored through the "perfect ward" meetings and regular ward sister and matrons meetings. We saw copies of the monthly Nursing Quality Indicator (WQI) audits which were comprehensive and covered a range of areas such as infection prevention control, falls prevention and record keeping.
- Managers responsible for the running of the service undertook the root cause analysis (RCA) of incidents. We reviewed the RCA reports for the most recent serious incident. This was comprehensive and had clear outcomes and action plans for learning from the incident. Staff confirmed that lessons had been learnt from the incident.
- The monitoring of complaints, incidents, audits and quality improvement projects were raised at board level. Within the trust, monthly key performance indicators were collected for the executive board and for the clinical commissioning group's quality accounts. One of the ward quality indicators was the use of the dementia support pack.
- We had received concerns regarding the provision of the vasculitis service. Senior managers informed us the trust had carried out an independent service review and plans were now in place to recruit to increased consultant cover and an action plan was in place to develop further the multidisciplinary team (MDT).

# Medical care (including older people's care)

## Leadership of service

- Staff reported there was very clear leadership from managers at all levels. Staff could explain the leadership structure within the trust and within medical services.
- The majority of nursing staff spoke positively of the ward managers and matrons, and told us that they received good support.
- We observed ward managers and matrons present on the wards and interactions were positive and supportive.
- In the 2015 national staff survey, staff scored being supported by their managers out of five. This score was 3.79 which was above the national average of 3.66.
- Doctors told us senior medical staff were accessible and responsive and they received good leadership and support.
- We saw several examples of good leadership on the medical wards including the AMU and ward 7Y which were well organised with very clear leadership. Although the wards were busy, morale was good and staff felt the leaders were visible and were working hard to address the issues.

## Culture within the service

- Staff said they felt supported and able to speak up if they had concerns. They said there had been challenges with staffing and capacity but felt things were improving and staffing levels had improved.
- In the 2015 national NHS staff survey the trust scored 3.82 out of five which is above the national average of 3.76 for staff who would recommend the trust as a place to work or receive treatment. This was a further increase on the previous 2014 survey.
- We noted that the national staff survey showed that staff motivation at work had improved compared with the previous survey to 3.84 but was still below the national average of 3.94.

## Public engagement

- Trust board meeting minutes and papers were available to the public online which helped them understand more about the hospital and how it was performing.
- The hospital participated in the NHS Friends and Family test giving people who used services the opportunity to provide feedback about care and treatment. The Friends and Family test showed the majority of medical wards scored over 95% of patients who would recommend the hospital to friends or a relative.

- Carer questionnaires were provided within information packs. These were also supported with telephone surveys providing individual patient feedback.
- The trust was working with the local voluntary groups as part of Downs's syndrome awareness week and was also planning events as part of dementia awareness.

## Staff engagement

- The Director of Nursing held 'cake, coffee and chat' meetings on a monthly basis for nursing and allied health professional staff to discuss any issues, ideas or concerns.
- Staff participated in the staff survey. This included how staff felt about the organisation and their personal development. In the 2015 staff survey 84% of staff felt they had received job relevant training, learning or development in the last 12 months which was better than the national figure of 81%.
- Staff we spoke with felt they were equipped for their role and had clear roles and responsibilities.
- Staff told us they were well supported with mandatory training, clinical supervision and staff appraisals. However some staff told us it had been difficult to get time to complete training recently due to the pressure on staffing.
- The intranet hosted a newsletter to ensure that staff were aware of the current priorities and what was happening within the trust.

## Innovation, improvement and sustainability

- An analysis of the 2015 staff survey results showed 71% of staff at the trust, who responded, felt they were able to make suggestions to improve the work of their team or department. This was better than the national average of 69%.
- We found many examples of innovation and collaborative working. The trust was working under significant capacity demand pressures and was striving to sustain the level of care whilst looking at new ways of working.
- The trust had introduced the frailty pathway with partner organisations integrated working collaborative.
- The medical services had worked with the wider trust "innovation support framework" to produce a touch-screen system for 'real-time' tracking of patient

## Medical care (including older people's care)

admissions, discharges and transfers to improve bed capacity monitoring. This project had won an in-house staff award and was short-listed for a regional innovation award.

- The medical services had recently been awarded funding to further develop their ad-hoc virtual Multi-Disciplinary team (MDT) meeting.
- The service had also developed a “New Starter Dialysis Pathway” which has been recognised by a national funding competition to implement a clinical pathway for new dialysis patients.
- The trust had also been shortlisted nationally for awards relating to sepsis with the Patient Safety Congress and a nationally recognised external nursing award.
- The service was closely involved with the development of the new building and was looking to review its patient pathways as part of the transition to the new building.
- The service had a research lead in each division to drive improvements and there were a number of joint posts with the local academic institution.

# Surgery

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

## Information about the service

The Royal Liverpool University Hospital is one of two sites operated by the Royal Liverpool and Broadgreen University Hospitals NHS Trust.

The Royal Liverpool University Hospital is the main site which houses 219 surgical beds. The hospital provides a range of elective and unplanned surgical services across different specialities including, orthopaedics, ophthalmology, vascular, urology, breast, pancreatic, liver, general surgery, upper gastro – intestinal, colo-rectal and renal transplants. The hospital also houses St Paul's Eye Unit which provides elective and emergency ophthalmic surgical services.

There are 12 theatres, one of which is an emergency theatre that is open 24 hours a day.

Hospital episode statistics (HES) data showed that 31,760 patients were admitted to the Royal Liverpool University Hospital for surgery between March 2015 and February 2016.

As part of our inspection, we visited theatres and surgical wards including pre-operative and post-operative areas.

In total, we spoke with 19 patients. We observed care and treatment and looked at care records for 22 patients. We also spoke to approximately 50 members of staff from a range of different grades including surgeons, anaesthetists, doctors, nurses, allied health professionals, ward managers, housekeepers, ward clerks, matrons, theatre staff, the clinical director, the chief of services, the divisional director of operations and the divisional chief nurse.

We received comments from our listening event and from people who contacted us to tell us about their experiences. We reviewed performance information about the trust.

# Surgery

## Summary of findings

We rated surgical services at the Royal Liverpool University Hospital as 'Good' overall because;

- There was a good reporting culture of incidents throughout the surgical division. Investigations were carried out and lessons learnt were shared at ward meetings and displayed in ward and theatre areas.
- Staff were knowledgeable about safeguarding. They could give examples the types of things they should refer and they were aware of how to make a referral to protect vulnerable individuals from abuse.
- Nursing and surgical staffing needs were adequate to meet the needs of the patients. When patients were delayed leaving the recovery areas, additional staff were sourced.
- Care and treatment was provided in line with best practice and national guidelines with regular audits both locally and nationally.
- Performance in national audits was generally better, or similar to other trusts.
- Patients' nutritional, hydration and pain needs were managed individually by competent staff who worked as part of a multi-disciplinary team.
- Patients were cared for by competent staff as part of multi-disciplinary teams.
- Staff sought consent from patients before delivering any care and treatment.
- Patients were treated with dignity, respect and compassion and involved those close to them in a way that they understood.
- Specialist services, including counselling, were available to support patients and their families.
- Performance for national referral to treatment time (RTT) targets averaged 90% trust-wide from September 2014 to August 2015, which was above the England average for the whole period.
- There were good systems in place to meet the needs of patients whose circumstances made them vulnerable.
- Information for patients was available in a variety of formats, dependent on the individual need and spiritual support was available if required.

- The surgical division was well-led with a vision and strategy aligned with the trust. Staff felt well supported by their managers. Information and learning was shared at regular meetings at all levels.

However;

- The checking of equipment was not robust. There were omissions in daily record checks of equipment, medication and fridge temperature ranges and a lack of consistency in the labelling of equipment that had been electrically safety tested.
- Some wards shared emergency resuscitation equipment which meant there may be a delay in accessing emergency equipment.
- Performance in the 2014 National Emergency Laparotomy Audit (NELA) was worse than the England average.

# Surgery

## Are surgery services safe?

Good



We rated surgery as 'Good for Safe because;

- There was a good reporting culture of incidents throughout the surgical division. Investigations were carried out and lessons learnt were shared at ward meetings and displayed in ward and theatre areas.
- Staff were knowledgeable about safeguarding. They could give examples the types of things they should refer and they were aware of how to make a referral to protect vulnerable individuals from abuse.
- Nursing and surgical staffing needs were adequate to meet the needs of the patients. When patients were delayed leaving the recovery areas, additional staff were sourced.
- Care records we looked at were structured, legible, complete and up to date.
- The trust collected and displayed NHS safety thermometer data showing performance against expected ranges.
- The wards and theatres we inspected were visibly clean and we observed staff following hygiene guidance.
- Nursing and surgical staffing needs were adequate to meet the needs of the patients. When patients were delayed leaving the recovery areas, additional staff were sourced.
- The surgical division responded to patient risk as needed.

However;

- The checking of equipment was not robust. There were omissions in daily record checks of equipment, medication and fridge temperature ranges and a lack of consistency in the labelling of equipment that had been electrically safety tested.
- Some wards shared emergency resuscitation equipment which meant there may be a delay in accessing emergency equipment.
- Some intra-venous fluids were not stored securely, which meant they could be tampered with; we highlighted with the trust who rectified the issue immediately.

## Incidents

- The trust used an electronic system to record incidents. Staff could describe the process for reporting incidents and felt confident in doing so. Staff could request feedback from incidents and they were discussed in weekly meetings across the trust to share and learn lessons from incidents.
- Staff were aware of the types of incident they should report and were able to give us examples, such as pressure ulcers and patient falls.
- There were two never events in surgical services between November 2014 and the time of the inspection. Never events are serious, wholly preventable safety incidents that should not occur if the available preventative measures are in place. The first never event occurred in November 2014 which related to wrong site surgery in ophthalmology. An investigation was carried out using a root cause analysis (RCA) process. An action plan was developed with set targets and objectives to ensure the incident would not be repeated. This included supervising trainee surgeons, additional training for all staff and weekly audits in the use of the '5 steps to safer surgery' World Health Organization checklist, and improved access to patients case sheets in the department. A report was provided to the patient and support offered to all staff concerned.
- The second never event occurred in December 2015 which related to a retained object during surgery. The investigation was not complete at the time of the inspection and as a result, the report and associated learning was not available. However, senior managers told us that staff had been made aware of this error and steps had been taken to prevent recurrence whilst awaiting the final outcome and any additional measures that needed to be implemented.
- There were 13 serious incidents reported between February 2015 and February 2016, which included five pressure ulcers (four grade 3 and one grade 4) and three falls that caused harm. We reviewed a sample of investigation reports which showed that actions had been identified and put in place to prevent recurrence. Actions taken following incidents were recorded on the trust's electronic reporting system and lessons learnt were shared at ward meetings. There were also examples of learning displayed on the ward 'quality boards' at the time of the inspection.

# Surgery

- There were a total of 422 incidents reported for the surgical division between September 2014 and December 2015, most of which were graded as low or very low.
- We reviewed an incident that occurred in the St Paul's Eye Unit in February 2015. The incident related to a medication error that happened during surgery. An investigation took place using a root cause analysis process. We saw that steps had been taken to prevent recurrence and lessons learned from the incident were shared within the department, division and escalated to the board for information. Actions to prevent recurrence included the creation of a written procedure, which was regularly audited.
- Mortality and morbidity reviews were held monthly. Patient records were reviewed to identify any trends or patterns and ensure that any lessons learnt were cascaded to prevent recurrence.
- Staff were familiar with the term '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). A trust-wide audit of duty of candour was reported in July 2015. It included the review of sets of case notes from 17 surgical patients. However, evidence of verbal communication to alert patients to the error was documented in only nine of the records audited.

## Safety thermometer

- The NHS safety thermometer is a national improvement tool for measuring, monitoring and analysing avoidable harm to patients and 'harm free' care. Performance against the four possible harms; falls, pressure ulcers, catheter acquired urinary tract infections (CAUTI) and blood clots (venous thromboembolism or VTE), was monitored on a monthly basis.
- For the surgical division, trust-wide there were ten pressure ulcers, 12 falls and one CAUTI reported between September 2014 and September 2015 which was within the expected range. However, the data was for surgical services trust-wide and not specifically for the Royal Liverpool University Hospital.
- The trust completed assessments for venous thromboembolism (VTE) Between April 2015 and

January 2016. However, the trust only achieved their target of 95% in three of the ten months (April, June and July). In the remaining seven months, performance varied between a low of 89.9% and a high of 94.2%.

## Cleanliness, infection control and hygiene

- All areas that we inspected were visibly clean and tidy. We saw that 'I am clean' stickers were in place to inform colleagues at a glance that equipment or furniture had been cleaned and was ready for use.
- Patients awaiting surgery were screened for infections, such as methicillin-resistant staphylococcus aureus (MRSA), during pre-operative assessments.
- There were no cases of MRSA reported in the six months prior to the inspection. However, from April 2015 to January 2016, there were seven instances of clostridium difficile (c.diff) infections. In addition, from June 2015 to December 2015, the trust's incident reporting system showed there were five incidents of Glutamate Dehydrogenase (GDH) Toxin B, one incident of Methicillin Susceptible Staphylococcus Aureus (MSSA), one incident of Carbapenemase Producing Enterobacteriaceae (CPE) and one for Escherichia coli (E. Coli).
- There were sufficient hand washing sinks and hand gels. Hand towels and soap dispensers were adequately stocked in all areas.
- Cleaning schedules were in place and personal protective equipment (PPE) was available outside ward bays and side rooms. From 'cleaning performance standards' monthly compliance was generally greater than the 95% target in all surgical ward areas and greater than the 98% target for theatres. No areas were below 90%.
- Staff were aware of, and adhered to, current infection prevention and control guidelines such as the 'bare below the elbow' policy. We observed staff using appropriate hand-washing techniques and PPE, such as gloves and aprons, whilst delivering care.
- Staff generally followed the correct dress code and gowning procedures in theatre areas. However, we saw one theatre nurse who didn't and was caring for patients in the recovery area wearing jewellery. We raised the issue with senior members of staff and the issue was addressed.
- A range of cleanliness and infection control audits were undertaken across surgical services. These included audits of PPE, the environment, isolation, hand hygiene,

# Surgery

sharps, waste, linen and patient – led assessment of the care environment (PLACE). Between July 2015 and December 2015, the majority of scores were greater than 80% for compliance with the required standard. When an area scored less than 100%, feedback was given to senior staff on the ward or department and performance was monitored in future audits.

- Audits in relation to carbapenemase-producing enterobacteriaceae (CPE) (a bacteria that causes infections) risk assessments were carried out by the trust in November 2015. The results showed compliance was generally poor. For example, there were low levels of compliance on ward 8A (13%), ward 9A (25%) and ward 8Y (28%). There were only three wards (4A, 4B and 5A) that scored over 50% compliance. The highest performing area was ward 4A with 84%.

## Environment and equipment

- The wards and theatres we visited were generally well maintained, free from clutter and suitable for treating surgical patients. However, on ward 9A, which was a renal transplant ward, staff, reported an ongoing problem with asbestos in the building. Access to areas for dialysis was restricted at the time of inspection, to three areas out of an available seven.
- Entry to ward and theatre areas was via a controlled access system in order to monitor staff, patients and visitors.
- Processes were in place to maintain equipment, although there was a lack of consistency with labelling of equipment and as a result, it was unclear how ward staff could be assured that the equipment had been serviced or electrically tested. For example, on ward 8X, ophthalmology equipment displayed a sticker for portable appliance testing (PAT) as due in June 2014 and a blood pressure machine as due in June 2015. In addition on ward 9Y, there were three infusion pumps that were not marked. One infusion pump and a machine used to record patient vital observations had passed their due date for routine maintenance.
- Staff told us they had access to the equipment and instruments they needed to care for patients. However, we had some concerns about the accessibility of resuscitation equipment on six of the surgical wards. Some of the resuscitation trolleys were shared between wards and we identified that in some instances, to access the equipment, the trolleys would have to be

moved through a minimum of two sets of double doors, some of which included controlled access via a swipe card system. There was a risk that this could cause delays in an emergency situation.

- Records indicated that staff carried out regular checks on key pieces of emergency resuscitation equipment with a cursory check completed daily and a more detailed check weekly in line with hospital policy. Emergency equipment on resuscitation trolleys were secured with a plastic tamper tag to avoid them being tampered with. However, we broke the seal on the trolley on ward 5B and found that some items were past their expiry dates; these included needles that expired in 2012, an airway that expired in 2013, a mask and a catheter that expired in February 2016. It is unclear why the equipment was still present as the completed checklist indicated that these had been checked in line with trust policy. This was raised with the ward manager at the time who addressed the issue immediately.
- Bariatric equipment, which was used for obese patients was in place and readily available if required.
- The eye theatres within St Paul's Eye Unit had the ability to track instruments used during surgery electronically. Bar coded equipment could be recorded onto the computer system which was touch sensitive, thus maintaining safety and hygiene.
- Most areas that we visited had secure areas for the storage of hazardous materials or equipment. We found that equipment and material was generally stored appropriately, however; on ward 9Y, the sharps box was not dated on the medication trolley and there were cleaning tablets left out in an unlocked dirty utility room. The unlocked treatment room, on ward 9Y, contained cannulas and the unlockable linen store included cleaning tablets. On ward 5B, the unlocked sluice included cleaning fluid that was not locked away. In addition. On ward 5B, the dirty utility, usually accessed by a key pad was not locked. The room included intra venous (IV) fluids.
- In the patient-led assessment of the care environment (PLACE) 2015, wards 9A and 9Y scored 100% for condition, appearance and maintenance

## Medicines

- Most medication was prescribed electronically via a trust wide computer system, excluding a few things such as intra venous (IV) fluids and warfarin (a drug to help prevent blood clots).

# Surgery

- Medicines, including controlled drugs were generally stored securely in line with legislation and records indicated that stock checks were completed regularly. Records indicated that in the majority of cases, daily checks of controlled drugs were carried out and random samples of medication were also checked. However, on ward 4B there were 10 occasions, between January 2016 and March 2016 where checks, of controlled medication didn't take place. Reasons recorded for these included things such as "no keys" and "staffing levels".
- We found that two wards stored intravenous fluids, including potassium, in an unsecured room. These rooms were located close to the entry and exit doors to the wards and were freely accessible to patients and members of the public. Some of the intravenous fluids that were stored in these areas contained potassium which could be harmful if incorrectly administered. It also presented a risk that they may be tampered with. This issue was highlighted to the trust who took immediate action to ensure all intravenous fluids were stored securely.
- On most wards that we visited, medical gases were stored securely except on ward 8X where oxygen was stored in an unlocked clinic room and on ward 4B where some portable oxygen cylinders were stored in an unlockable room or unsecure on the corridor.
- Medicines that required storage at temperatures below 8°C were appropriately stored in medicine fridges. Records indicated that fridge temperatures were checked daily to ensure medicines were stored at the correct temperatures on most of the wards. However, on ward 8X, the fridge that stored nutrition and drinks for patients, in the treatment room only displayed the temperature rather than the range. This was also the case for the fridge where insulin was stored. In addition, checks had not been recorded at weekends since 29 March 2016. Staff told us that pharmacists checked the temperatures on that ward, and they didn't know what to do if the temperature was not right or had gone out of range. Medicines stored at incorrect temperatures may be unsuitable for administration. There was also no recording of ranges in other wards that included 5A and 4B.
- One patient had been self-administering their medicines on ward 5A. However, we found no formal assessment of their ability to do so had been undertaken or documented. This was not in accordance

with the trust policy. The ward pharmacist had identified the patient was taking a different dose to that confirmed by their GP. We raised this with the ward manager who rectified the situation.

- On ward 9A there was a patient's own medication stored in the controlled drug cabinet but there was no record of the medication being in there and the patient was no longer on the ward. This was addressed on-site and the medication removed.
- We observed staff undertaking medication rounds appropriately. As part of the medication round, staff wore red tabards to alert staff and patients that they were dispensing. The aim of this was to help prevent distractions and potential errors during the administration of medication.
- We reviewed five medication records and all sections had been completed appropriately.
- Discharge medications were managed well, including nurse led discharges in some areas.

## Records

- Patients' records were paper-based except for prescribed medication and risk assessments, such as those for venous thromboembolism (VTE) that were stored electronically.
- We looked at the care records for 22 patients. These were structured, legible, complete and up to date.
- Patients' clinical notes were stored in unlocked trolleys close to the nurses stations. This increased the potential for patient confidentiality to be breached.
- Risk assessments were completed for patients, however when requested; trust were unable to provide blank risk assessments and surgical care pathways.
- Patient records showed that nursing and clinical assessments were carried out before; during and after surgery and that these were documented correctly.
- Standardised nursing documentation was kept at the end of patients' beds. Observations were well recorded and the observation times were dependent on the level of care needed by the patient.
- Trust-wide case note audits were carried out in 2015. The breast unit had an initial compliance level of 28%. A subsequent re-audit resulted in a compliance of 79% that was deemed as acceptable. An ear, nose and throat (ENT) audit was 70% compliant with a re-audit compliance of 100%. There was no compliance in urology or vascular surgery with action plans in place.

# Surgery

## Safeguarding

- The trust had safeguarding policies and procedures in place and there was a safeguarding lead that could provide guidance and support to staff in all areas.
- Staff could give examples the types of things they should refer and they were aware of how to make a referral to protect vulnerable individuals from abuse.
- Staff told us that they received feedback from safeguarding concerns and referrals they raised. This was cascaded from the trust safeguarding team to front line staff through their line managers.
- Safeguarding training formed part of the trust's mandatory training programme. Data provided by the trust showed that there was good compliance with safeguarding training at all levels across surgical services. Compliance with training for safeguarding adults' and children level 1 was 93.7%, which was above the trust's target of 90%. In addition, safeguarding adults and children level 2 (82.8%) and level 3 (89.4%) were all above the trust's target of 80%. This information was for surgical services trust-wide and we could not disaggregate it specifically for staff at the Royal Liverpool University Hospital.

## Mandatory training

- Staff confirmed that they received induction and mandatory training specific to their role.
- Mandatory training was delivered on a rolling programme in two blocks (clinical core skills and core skills). Clinical core skills included areas such as infection control and prevention for care staff, falls prevention, and, diet and nutrition. Core skills included areas such as safeguarding, health and safety, and fire safety.
- Training data for surgical services showed that compliance with core skills training was 83.3% at the time of the inspection and 84.5% for clinical core skills. Both were below the trust's target of 95%. This information was for surgical services trust-wide and we could not disaggregate it specifically for staff at the Royal Liverpool University Hospital.
- Basic life support (BLS) training was also provided by the trust as part of mandatory training. Data provided by the trust showed that 88.8% of staff across surgical care services trust-wide had completed the training at the

time of the inspection, which was below the trust's target of 95%. This information was for surgical services trust-wide and we could not disaggregate it specifically for staff at the Royal Liverpool University Hospital.

## Assessing and responding to patient risk

- Staff knew how to highlight and escalate risks that could affect patient safety, such as staffing and delays in obtaining beds for patients. Matrons and ward managers monitored and dealt with these risks on a daily basis through the matron's 'safety huddles' which took place two or three times daily.
- On admission, to surgical wards, staff carried out risk assessments to identify specific risks such as venous thromboembolism (VTE), pressure ulcers and falls. If a risk was identified, the relevant care pathway was implemented.
- An early warning score system was in use in all surgical areas. The trust implemented the national early warning score (NEWS) (a system to identify the early signs of a patient's condition deteriorating) in March 2015. An audit was carried out in January 2016. The results showed that, of the surgical wards audited there was generally a high compliance with the requirements. For example, 96% of observations had a corresponding NEWS score, 94% of NEWS scores were correctly calculated, nurses in charge were aware of NEWS of 1 or above in 85% of cases and the escalation plan had been appropriately followed on 92% of occasions. However, only 59% of observations were performed at the required time. There were plans to complete audits of all surgical areas and develop an action plan following a review of the completed audit cycle.
- Outlying patients is a process by which patients are relocated to a ward which is not the most suitable location for their condition to improve patient flow. It is important that these patients receive regular senior medical review; to ensure that they are receiving the appropriate, specialist care that they require. We reviewed the clinical records of four patients who were outlied to a surgical ward. We found that all four patients received daily review by a specialist consultant and that they had received adequate and timely care throughout their inpatient stay. Each ward included a 'live' interactive whiteboard to show the availability of beds in all areas. This was updated by staff when patients were admitted, moved, transferred or discharged.

# Surgery

- We reviewed the falls risk assessments for three patients and found that these were completed correctly and appropriately in all three cases.
- As part of the inspection, we noted that theatre lists were reviewed frequently, including on the day of surgery and patients were often prioritised due to clinical need which led to a change in the order of patients on the lists. Whilst we understood the need for the prioritisation, we were concerned that this practice could lead to errors if there were multiple changes to a list. We raised this with the trust that who were aware of the changes. They verbally outlined the action plan to try and keep revisions to the list to a minimum. We were told that they were proposing to 'lock down' the theatre lists in advance but no less than 24 hours prior to surgery.
- As part of the inspection, we observed theatre teams undertaking the 'five steps to safer surgery', which included the use of the World Health Organization (WHO) checklist. We found that the checklist was followed professionally by staff and it was well structured.
- Between January 2015 and December 2015, monthly audits, of the WHO checklist, were above the trust target of 85%, except for March 2015 (73%), July 2015 and August 2015 (both 83%). An action plan was in place, for the surgical division trust-wide and reviewed monthly as required.
- The surgical department within St Paul's Eye Unit had created and implemented a comprehensive surgical safety checklist which took account of the World Health Organization (WHO) guidance in relation to safer surgery. We saw this in use in the theatres in the eye hospital at the time of the inspection.
- In the Clinical Eye Research Centre, a variant of the WHO checklist had been developed for patients undergoing eye injections. The checklist was comprehensive and sticky-backed in order to attach to patients notes. However, there was no area on the checklist to add the patient's details which meant it was possible the completed checklist could be attached to the wrong notes.
- We spoke with three nurses within St Paul's Eye Unit who explained what actions would be taken if a patient in their care deteriorated, which included calling the medical emergency team (MET).
- There were clear escalation plans in place to deal with any potential delays in the discharge of patients from theatre recovery areas. The escalation plans outlined the process and procedures to be followed at all times of the day and at weekends.
- The theatre manager within the St Paul's Eye Unit was able to tell us who the Radiation Safety and Laser safety officers were.

## Nursing staffing

- There were processes in place to ensure sufficient numbers of trained nursing and support staff in ward areas and theatres, to provide safe care and treatment.
- Noticeboards with the expected and actual staffing numbers were displayed in all ward areas inspected. Staffing levels were adequate in areas visited at time of inspection with the support of bank and agency, for example on ward 9Y.
- Staffing levels were reviewed every six months using the 'safer nursing care tool' (SNCT). The SNCT is an evidence based tool which takes into account patient acuity and dependency to determine the required number of staff.
- We reviewed a safe staffing report for February 2016 which showed the average fill rate for registered nurses, during the day, was 91.8% and 89.3% at night time. However, on ward 4A, the fill rate for registered nurses was 67.8% but fill rates for care workers was 128.3%. In addition, on ward 8Y, the registered nurse night fill rate was 69.4% with a care worker fill rate of 90.7%. The colour coded RAG (red, amber, green) system highlighted any rates of 90% or above as within the accepted range. The average sickness rate, across the trust was 5.1% with a target of 3.8%. Although the sickness level for ward 5A was 11.8%, fill rates were within accepted levels.
- The service leads told us that a ratio of 1:8 (one nurse to eight patients) was maintained throughout the division.
- Any shortfalls in nurse staffing were filled with overtime, bank or agency staff. Matrons from surgical and medical areas attended twice daily staffing huddles to ensure safe levels of nurses on the wards. Staffing was displayed on a live rota using a traffic light system. This included pre-booked staff being allocated to wards as needed.
- Nurses also used a 'red flag' system, whereby a senior nurse could be contacted if there were particular concerns, which included staffing.

# Surgery

- In theatres, staffing numbers were determined in line with the Association of Perioperative practitioners (AfPP) guidelines i.e. two scrub practitioners, one anaesthetic practitioner, one health care assistant circulating nurse and one recovery nurse.
- Handovers occurred at shift changeover times and included all information needed to continue care appropriately.
- The St Paul's Eye unit used agency staff when necessary at a rate of 1-2 per week, usually required to work in theatre. The matron told us that where possible they used the same agency staff regularly.
- When a child or young person was attending the hospital for eye treatment, an agency nurse was employed who had specific paediatric training. Advice had been sought from the local children's hospital regarding appropriate agency staff.

## Surgical staffing

- There were processes in place to ensure sufficient numbers of trained surgical staff in ward areas and theatres, to provide safe care and treatment.
- Medical rotas showed there were appropriate levels of cover in all areas. The majority of doctors we spoke to felt there were sufficient surgical staff for the demands of the division. However, one junior doctor felt there had been gaps in cover on the wards, although this had improved.
- The division operated its surgical medical cover using similar methods throughout the different specialties with consultant on site presence from 8am to 6pm (5pm in some specialties), Monday to Friday.
- Surgical cover outside of these hours was provided by an on-call surgical consultant and specialist registrar availability for all specialties out of hours from 5pm to 8am. There was on site presence from (foundation training) F2 doctors, which also formed the general surgical on-call element.
- General surgery, trauma and orthopaedics, urology and the vascular unit had a 'consultant of the week' who took initial responsibility for all admitted and referred patients and performed a 'post take' ward round each day. In addition, sub-specialty consultants in areas such as hepato-pancreato-biliary (HPB), upper gastro – intestinal (GI) and colorectal were available to provide cover for pathway specific patients.
- Weekend ward rounds were performed by all surgical specialties with post take consultant ward rounds for all

newly admitted patients and any the medical or multi-disciplinary team (MDT) had concerns about. Weekend cover was provided by an on call surgical consultant and specialist registrar.

- There was 24/7 resident anaesthetic cover at the hospital for medical and surgical emergencies; two anaesthetic junior doctors were also on site at night and on weekends and bank holidays. Two consultant anaesthetists were on call outside of normal working hours to support the junior doctors. On weekdays an on-call consultant anaesthetist was resident from 8am to 8pm to support other anaesthetists and to provide emergency cover.
- The trust provided a hospital at night service with coverage to the surgical division by a specialist registrar covering trauma and orthopaedics, and general surgery. There was also senior house officer (SHO) and (foundation training doctor) F1 coverage for the surgical wards. This was complimented by nurse practitioner coverage 24 hours per day who operated doctor's bleep filtering out of hours, weekends and public holidays.
- We observed an early morning surgical handover. Doctors of all grades attended and we found it to be well-structured, clear and comprehensive. All patients were reviewed thoroughly and appropriately.
- There were low levels of external surgical locum use with 279 hours used between March 2015 and March 2016.
- Where possible surgeons worked together to cover leave and absence and there were low levels of cancelled theatre lists as a result.

## Major incident awareness and training

- There was a documented major incident and business continuity plan in the surgical services, and this listed key risks that could affect the provision of care and treatment. Copies were available for staff in ward areas.
- There were protocols in place to defer elective surgical activity to prioritise unscheduled emergency procedures when required.
- Staff were aware of the escalation plans and would contact managers for support depending on the incident.

# Surgery

## Are surgery services effective?

Good



We rated surgery as 'Good' for Effective because;

- The surgical division provided care and treatment that followed evidence-based practice and national guidelines.
- Performance in national audits was generally better, or similar to other trusts.
- Patients' nutritional, hydration and pain needs were managed individually by competent staff who worked as part of a multi-disciplinary team.
- Patients were cared for by competent staff as part of multi-disciplinary teams.
- The risk of readmission was similar to the England average for all non-elective specialities.
- Staff sought consent from patients prior to delivering care and treatment.

However;

- Performance in the 2014 National Emergency Laparotomy Audit (NELA) was worse than the England average.
- The risk of readmission was higher (worse) than the England average for all elective specialities and nearly double the expected range for general surgery.

### Evidence-based care and treatment

- Patients received care and treatment that was delivered in line with evidence-based practice and national guidelines such as those from the National Institute for Health and Care Excellence (NICE) and the relevant Royal Colleges.
- Policies and procedures reflected current guidelines and staff told us they were easily accessible via the trust's intranet.
- Staff on the surgical wards used care plans and recovery pathways, in line with national guidance. We reviewed 22 patient care plans and saw that these were fully completed in all cases and staff updated them appropriately.
- Standard operating procedures were in place to ensure the smooth transition of patients between theatres, wards and critical care areas.

- Site specific audits were requested for each hospital delivering surgical services, however; the trust were unable to provide.
- When considering the order of theatre lists, a patient's medical condition was taken into account. For example, patients with a diagnosis of diabetes were allocated first on operating lists in line with best practice guidance.
- Medical staff completed venous thromboembolism (VTE) assessments when required and recorded them on the trusts electronic system. Prevention options, including the use of anti-embolic stockings were discussed with patients where appropriate.
- The trust completed a Clinical Audit Assurance Report, quarterly. In September 2015, the monthly casenote storage audit for wrong site surgery was rated as green assurance; whereas there was amber assurance for unilateral site surgery, surgical site infection in vascular surgery and general surgery consent audits.

### Pain relief

- Staff on the surgical wards and in theatres were supported by a specialist pain management team if required.
- Patients were assessed pre-operatively for their preferred post-operative pain relief and staff used pain scores to monitor pain symptoms at regular intervals.
- Patient records showed that patients received the required pain relief and were treated in a way that met their needs and reduced discomfort.
- Patients told us staff gave them pain relief medication when needed.

### Nutrition and hydration

- Staff managed the nutrition and hydration needs of patients well both pre and post operatively.
- Patients were provided with information prior to admission which told them how long they would need to fast before surgery to avoid complications.
- Patient records included an assessment of a patient's nutritional requirements as well as fluid and food charts which were reviewed and updated regularly. Records showed regular dietician involvement with patients who were identified as being at risk of dehydration/malnutrition.
- Patients with difficulties eating and drinking were placed on special diets and those who required support and assistance with eating and drinking were identified

# Surgery

by symbols on the patient information boards. In addition, on one ward, patients living with dementia, who had completed 'this is me' records, had food choices displayed above their bed.

- In addition, there were special plates for certain groups of patients with an individual surgical need, such as smaller plates for patients' who needed to eat small amounts frequently.
- There was a choice of meals to choose from on a daily basis that the housekeeping staff ordered, with patients, via an electronic system.
- A range of snacks were also readily available throughout the day, in particular for patients following surgery.
- In the patient-led assessment of the environment (PLACE) 2015, wards 5A and 5b scored 92% for food.

## Patient outcomes

- The surgical division participated in national and internal audits to monitor patient outcomes. Outcomes for patients receiving treatment in the service were mostly similar to or better than the England average.
- The surgical division participated in a number of national clinical audits including the national hip replacement audit, national bowel cancer audit and the national emergency laparotomy audit.
- There was good performance in the national bowel cancer audit in 2014, which showed that the all indicators were better than the England average, with the exception of the number of patients experiencing a length of stay above five days, which was marginally higher (worse) than the England average.
- The Liverpool Lung Cancer Unit (which was a partnership with a neighbouring trust) performed well in the 2014 lung cancer audit, with a multidisciplinary team (MDT) discussion rate and a computerised tomography (CT) rate before bronchoscopy above 99%, which were both higher (better) than the England and Wales average.
- The trust participated in the 2014 National Emergency Laparotomy Audit (NELA). The results showed some areas of poor performance. For example, less than half of patients received a consultant surgeon review within 12 hours admission or a pre-operative review by a consultant surgeon and anaesthetist. In addition, less than half of patients had a consultant surgeon or anaesthetist present at their procedure and less than half of patients aged over 70 had an assessment by a medical crises in older people (MCOP) specialist. There

was an action plan in place that, at the time of inspection. This plan included a wide range of trust services that included use of the Enhanced Peri-Operative Care for High-risk patients (EPOCH) trial and trust SEPSIS campaign.

- The trust performed better than the England average for seven out of eight indicators in the 2015 hip fracture audit although the trust's own performance had deteriorated in four of the areas from the previous year. The trust had an action plan, as part of the hip fracture database, to transfer patients from the emergency department to the acute orthopaedic ward in four hours by 'ring fencing' beds, and then supporting early discharge systems, however; this was overdue review. There was also an action plan regarding compliance with NICE Care guideline124: Cognitive assessment & recording in fragility fracture patients. This included the education and supervision of junior doctors and the development of a discharge summary, however; it was overdue a review.
- Performance in the Patient Reported Outcome Measures (PROMs) audit for the 2014/15 financial year was similar to the England average for groin hernias and slightly worse than the England average for hip replacements and knee replacements.
- There were patient-led care pathways in place, such as the accelerated post-operative recovery pathway in colorectal surgery. Prior to its implementation, recovery used to be 10 to 14 days, whereas it was approximately five days at the time of the inspection.
- The risk of readmission was similar to the England average for all non-elective specialities at the hospital. However, it was higher (worse) than the England average for all elective specialities and nearly double the expected range for general surgery.
- The average length of stay for the hospital was higher (worse) than the England average across all specialities for elective and non-elective surgery between September 2014 and August 2015.
- There was benchmarking of outcomes of surgical procedures, for example care of patients with fractured neck of femur (hip) was compared to another trusts, although no results were provided.

# Surgery

## Competent staff

- Newly appointed staff had an induction and their competency was assessed before working unsupervised. Agency and locum staff also had inductions before starting work.
- Data provided by the service showed 92.1% of staff had completed their annual appraisals during the year (April 2015 to March 2016) against a trust target of 95%. These figures were for surgical services trust-wide and could not be disaggregated specifically for the Royal Liverpool University Hospital.
- The appraisal rate for staff employed in the St Paul's Eye Unit at the time of inspection was 97%, which was above the trust target of 95%.
- There were training sessions available to support doctors and nurses to revalidate. For example, staff were supported to attend study days and develop their skills in areas such as palliative care, catheterisation or cannulation.
- In theatres, staff rotated to cover all specialities including in the emergency theatre.
- There were service level agreements in place, with neighbouring educational establishments, for the training of band 4 health care assistants to be trained as registered nurses.
- The trust had a nursing accreditation programme, the 'RLB Nurse Badge'. This was a programme to develop registered nurses by achieving a number of competencies recorded in a portfolio as well as a study day that included a human factors approach.
- The trust had introduced human factors training and confirmed 180 people had received the training at the time of the inspection.
- There were 208 members of staff across surgical care services trust-wide who had received immediate life support (ILS) training.
- We requested evidence of the competencies for staff working in theatre recovery areas to establish if they were competent to care for level two patients (high dependency patients). However the trust were unable to provide this information at the time of the inspection.

## Multidisciplinary working

- There was effective internal multidisciplinary team (MDT) working that included physiotherapists, occupational therapists, dieticians and pharmacists as well as doctors and nurses.

- A mental health liaison team of professionals from the rapid assessment and interface discharge (RAID) team who were employed by a neighbouring trust were available and responded in a timely manner when requested.
- Records indicated that a range of professionals and family members/carers were consulted as part of discharge planning processes. There was good external MDT working which included community nurses and GPs.
- Patient records showed that there was regular and routine input and reviews from allied health professionals such as physiotherapists, as well as nursing and medical staff.

## Seven-day services

- Acute and emergency surgical services were available seven days a week. Medical and anaesthetist cover was provided outside of normal working hours and nursing staff told us they felt well supported during these periods.
- There was a 24 hour service with dedicated emergency and trauma theatres so any patients admitted over the weekend that required emergency surgery could be operated on promptly.
- There was also a designated emergency surgical assessment unit available to assess patients who may require emergency surgery. The unit was open 24 hours a day, seven days a week.
- Junior and middle grade doctors provided out of hours medical care to patients on the surgical wards during out of hours periods. There was also on-call cover provided by consultant surgeons who could be contacted by telephone.
- Microbiology, imaging (for example x-rays and scans), physiotherapy and pharmacy support was available on call outside of normal working hours.
- Junior doctors told us that they felt that they had adequate access to urgent imaging outside of normal working hours. This meant that patients could have scans and x-ray's urgently if required at all times of the day.

## Access to information

- Staff told us that information about patients they cared for was easily accessible. Staff could access information such as policies and procedures from the trust's intranet.

# Surgery

- Patient information that was required to deliver care and treatment was readily available and accessible.
- Staff recorded details about the care they delivered in paper records but some information such as diagnostic results and venous thromboembolism (VTE) assessments were recorded electronically.
- All records we looked at were complete, up-to-date and easy to follow.
- Information about quality and performance were displayed both for patients and for staff.

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

- Staff had the appropriate skills and knowledge to seek consent from patients or their representatives. Staff were clear about how they sought informed verbal and written consent before providing care or treatment.
  - Patient records showed verbal or written consent had been obtained from patients before planned care was delivered.
  - The trust had audited consent processes across a number of surgical specialities and theatres. The audits looked at eight standards which included things such as whether serious occurring risks were documented on consent form and whether confirmation of consent has been completed. Compliance with the audit standards were generally good. When specific areas fell below the standards required, an action plan was developed and a re-audit date set to check for improvements.
  - Staff understood the legal requirements of the Mental Capacity Act 2005 and deprivation of liberties safeguards (DoLS).
  - If patients' lacked the capacity to make their own decisions staff made decisions about care and treatment in the best interests of the patient and involved the patient's representatives and other healthcare professionals appropriately.
  - Capacity, consent and DoLS were considered and adjustments, such as access to specialist support, flexible visiting, carer support and environmental considerations were applied for patients living with a cognitive impairment, such as dementia, or for those patients living with a learning disability.
  - Staff confirmed that mental capacity (MCA) training was included as part of safeguarding training, which was mandatory but they told us it was only a minor component.
- We were shown an example of a patient who lacked the capacity to make their own decisions and records indicated that a 'best interest meeting' had taken place and an alternative consent form was used. However, an example was also provided of a patient who had been assessed as lacking capacity, with a DoLS in place, was administered medication for a procedure but there was no evidence in the patients records that this had been discussed with the family in a 'best interest meeting'. The electronic incident reporting system did however record the medication error and stated that the family had been informed.
  - Interpreters were available and pre-booked if a patient whose first language was not English required consent for a procedure.
  - Risk assessments were carried out for the use of bed rails. However; the form was not robust in facilitating patients' consent that they were in agreement of having the bed rails in place.

## Are surgery services caring?

Good



We rated surgery as 'Good' for Caring because;

- Patients, and those close to them, were positive about the care provided by the staff in the surgical division, and the hospital.
- Patients felt they were supported, involved and received information in a manner they understood.
- Staff treated patients with dignity and respected their privacy.
- We saw that staff were kind and compassionate whilst delivering care and treatment.
- All staff were polite and helpful and we saw respectful interactions between staff, patients and those close to them.
- Specialist services, including counselling, were available to support patients and their families.

However;

- Feedback was sought from patients' and families via the NHS Friends and Family Test (FFT) but there were mixed results across the wards.

# Surgery

## Compassionate care

- We observed compassionate care and positive interactions in all areas inspected, including wards and theatres.
- Staff treated patients, and their families, with respect and dignity. They were aware of patients care needs and communicated in an appropriate and professional manner.
- We spoke to 19 patients (including their relatives). They described care as being exemplary with excellent care from all staff. This included porters, doctors, trained and student nurses. Patients' said that staff were always respectful and one patient compared their ward to a hotel.
- All staff introduced themselves and communicated well to ensure patients fully understood.
- The results from the NHS friends and family test (FFT) between January 2015 and November 2015 showed improvements. For example, on ward 8A, there were 46% of patients that would recommend the ward, in February 2015 as opposed to 100% in August 2015. On ward 4A, the percentage that would recommend ranged between 67% in January 2015 and 97% in March 2015 and on 9Y, the percentages ranged from 88% in May 2015 to 95% in October 2015. Response rates ranged from 27% to 44%. There were boxes, to provide feedback for the FFT in areas we visited.
- In the patient-led assessment of the care environment (PLACE) 2015, ward 9A scored 92% for privacy and ward 9Y scored 98%, which was positive.
- At St Paul's Eye Unit we saw that privacy and dignity was maintained for the patients attending the hospital for eye surgery. The day unit had separate areas for male and female patients waiting for surgery and during recovery post-operatively.
- We saw positive patient interactions in the recovery area of the ophthalmology theatres. Staff were sensitive to patients' needs and interacted appropriately. Relatives were kept informed in the waiting area for their progress.

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

- We observed staff interacting positively with patients and those close to them across surgical services. Staff spoke to families sensitively and appropriately dependent on individual need.

- Staff respected patient's choices and delivered their care with an individualised person-centred approach. Patients care records were individualised to take into account personal wishes.
- Patients and those close to them told us they received information about care and treatment in a manner they understood.
- Ward staff helped families to complete 'this is me' documentation, for patients living with dementia. The documentation included patient's preferences, for example food likes and dislikes.

## Emotional support

- We observed staff providing reassurance and comfort to patients. Patients told us they were supported with their emotional needs.
- There were counselling services available for both patients and staff.
- A mental health liaison team of professionals were available and responded in a timely manner when requested.
- Clinical nurse specialists, such as breast care nurses and stoma nurses, were available to provide support to patients in times of need.

## Are surgery services responsive?

Good



We rated surgery as 'Good' for Responsive because;

- Surgical services were planned to meet the needs of the local population.
- Performance for national referral to treatment time (RTT) targets averaged 90% trust-wide from September 2014 to August 2015, which was above the England average for the whole period.
- The number of cancelled planned operations was lower than the England average.
- There were good systems in place to meet the needs of patients whose circumstances made them vulnerable.
- Information for patients was available in a variety of formats, dependent on the individual need and spiritual support was available if required.
- Details about how to access the complaints process were available in ward areas and low level complaints were managed in a timely manner,

However;

# Surgery

- An increased demand for hospital beds meant there had been instances where patients were delayed in transferring from recovery areas in theatre, following surgery, to surgical beds.
- The average length of stay was higher than the England average for both planned and emergency surgery.

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

- Surgical services were planned to meet the needs of local people. There were service level agreements in place with neighbouring independent health providers to meet the demands of the local population.
- Arrangements were in place with neighbouring trusts to allow the transfer of patients for surgical specialties not provided by the hospital. The trust was part of the Cheshire and Merseyside major trauma network collaborative between local NHS trauma units at other hospitals within the network.
- Routine engagement and collaboration took place with staff from neighbouring specialist trusts, such as on-site outpatient clinics and regular multidisciplinary team meetings.
- There was an emergency theatre available for emergency general and trauma surgery that was staffed 24 hours, seven days per week so that operations could be performed for patients that required emergency surgery at any time of the day or night.
- A range of elective surgical procedures were available, some of which were able to be done as day case procedures (meaning that patients could be discharged on the same day as the procedure).
- Patients who were booked for planned surgery attended health checks prior to the operation to assess their fitness for surgery and check all discharge processes were in place such as arranging dressings or future appointments.
- Some pre-operative assessments took place in the main outpatient department, whereas some specialties had provision in ward areas such as breast surgery.
- The areas we visited were compliant with same-sex accommodation guidelines, although, due to bed shortages, we observed two female patients waiting for surgery in a day room (9Y) that was close to a bay of male patients. When patients had to wait for a bay pre-operatively, there was no area to store their personal belongings and patients had to change in the public shower rooms.
- There were service level agreements in place with neighbouring independent health providers that allowed for patient choice in accessing some elective procedures.

## Access and flow

- Patients could be admitted for surgical treatment through a number of routes, such as pre-planned surgery, via accident and emergency or via GP referral.
- Patients admitted via accident and emergency were reviewed in the emergency surgical assessment unit. Elective patients were reviewed by the surgeon and anaesthetist on the day of surgery to ensure medically fit for the procedure.
- Since our last inspection, the trust had introduced a 'live' interactive whiteboard' which could be accessed from a tablet, as part of a trust-wide system, as well as the wall display boards. The whiteboard held information electronically about which patients were in each bed on each ward at a glance. This information was used in the twice daily matron 'huddles' to monitor staffing levels. There were outliers identified in surgical beds (patients from other departments) From December 2015 to February 2016, there was between 0.7% and 1.4% of patients per month highlighted as outliers. This was a total of 233 patients over the three month period. The number of surgical inliers (patients identified as surgical patients but for a different speciality than the ward they were on) for the same time period was 23,586.
- Ward 4X was open, as needed to increase the number of available beds in other wards of the hospital. It was utilised as a discharge area for patients waiting to leave. They had been given all documentation and any medication prior to arrival but could be provided with drinks and meals prior to leaving.
- Between January 2015 and October 2015, eight patients stayed overnight in the recovery area. Each of these were recorded as incidents and investigated. Six of these incidents were for patients who required level two (high dependency) care. On each occasion a level two bed had been identified before the operation commenced but then it had been used for another patient before the end of the operation. This was either due to an emergency patient attending the trust and requiring level two support; or, a patient listed to leave level two areas became unwell and needed to stay. In

# Surgery

these cases, an overnight stay in recovery was deemed the safest option. Staff with the appropriate qualifications and skills were assigned to support and care for those patients.

- In addition, there were two occasions when patients requiring level one care had stayed in the theatre recovery area overnight. Whilst this was not ideal, on both occasions the trust was at high escalation with the full capacity protocol in place. In addition, there were five patients that were required to stay overnight in theatre recovery areas during the inspection due to a lack of high dependency (level 2) beds in the hospital.
- Performance for national referral to treatment time (RTT) targets averaged 90% trust-wide from September 2014 to August 2015, which was above the England average for the whole period.
- There were high volume cataract theatre list initiatives being performed in order to meet the national 18 week referral to treatment target. This maximised the use of theatre time but increased the number of theatre support staff required to function.
- Extra theatre lists were implemented to cope with demand and there was a service level agreement with a neighbouring independent healthcare provider to help meet the demands of the local population.
- The trust theatre utilisation (efficiency) target was 80%, in line with national guidelines. From April 2015 to March 2016, the trust's average utilisation was 85%, although urology was 68%, transplant surgery was 75% and ear, nose and throat (ENT) was 77%. All theatres were above the target, except the day case theatre which was being utilised for 55% of the time along with theatre three at 72%. One theatre was used for emergencies only.
- The day case surgery rates were requested, however; the trust was unable to provide.
- Between January 2015 and February 2016, 102 patients were delayed in being discharged due to waiting for care packages. This resulted in 410 lost bed days, which was approximately four days per patient.
- Discharge planning began prior to surgery, where possible with accelerated pathways in place and nurse led discharges in some areas. However, the numbers of discharge summaries completed within 24 hours, for the surgical division, from in-patient areas between April 2015 and January 2016 was between 76% and 81% which was below the trust's target of 95%.

- The percentage of patients whose operation was cancelled and were not treated within 28 days was lower (better) than the England average between 2013/14 and 2015/16.
- The proportion of cancelled operations as a percentage of elective admissions was lower (better) at this trust compared to the England average over the same period.
- In 2015-2016 financial year there were 68 cancelled ophthalmic operations in the eye hospital out of 7,321 which equated to 0.9%.
- Two ophthalmology consultants were based at St Paul's Eye Unit and regularly performed high volume surgical lists in order to reduce waiting lists. If sufficient theatre staffing was available it was possible to treat 10 -15 patients on a list instead of the traditional five to six.

## Meeting people's individual needs

- There were good systems in place to meet the needs of patients whose circumstances made them vulnerable.
- Patients living with a cognitive impairment, such as dementia, were assessed within the general multi-disciplinary team, nursing and medical processes. Staff used a 'this is me' document for patients admitted to the hospital with dementia. Patients or their representatives completed this document and included key information such as the patient's likes and dislikes. This document was also completed during the pre-operative stage of a patient's care to ensure any reasonable adjustments which were needed were put in place.
- The hospital had implemented a sticker scheme. This was a discreet symbol used as visual reminder to staff that patients were living with dementia or were confused. This was to ensure that patients received appropriate care, reducing the stress for the patient and increasing safety.
- There were volunteers available for activities such as arts and crafts, dominoes, card games and reminiscence games.
- In the patient-led assessments of the care environment (PLACE) 2015, wards 5A and 5B scored 55% for dementia care, ward 9A scored 80% and ward 9Y scored 82%. There was a dementia steering group in place and a patient experience sub-committee who were involved in developing an action plan.
- There were 'hearing loops' readily available on all the wards we visited for patients with hearing impairments.

# Surgery

- Face to face interpreters and telephone interpreting services were available through an external provider, for patients whose first language was not English. At the time of the inspection, we saw a patient, in theatres with an interpreter present, prior to surgery. There were also wireless headsets allowing patients to continue consultations, for example, if in a bed, whilst receiving interpreting services.
- Information leaflets about services and treatments were available in all ward areas we visited. Patient information was available, on request, in a variety of formats such as large print, braille or in other languages.
- An eye clinic liaison officer supported patients in the eye hospital who were either partially sighted or blind. The role included visiting wards to provide staff with information and training for patients who were partially sighted or blind.
- Patients living with a learning disability were assessed within general and medical process. Staff used a learning disability passport to highlight key information such as the patient's likes and dislikes. This document was also completed during the pre-operative stage of a patient's care to ensure any reasonable adjustments were put in place.
- There was a diabetic service available Monday to Friday. Specialist diabetes nurses provided clinical support on the wards, which included general advice and guidance on medication.
- There were other specialist nurses, including advanced nurse practitioners, breast care and stoma care nurses, available as needed.
- A mental health liaison team of professionals were available and responded in a timely manner when requested.
- Accessibility to all facilities and areas was good and staff could access appropriate equipment such as beds to support bariatric patients (patients who are clinically obese).
- There was a spiritual care service with a purpose built chapel that was available 24/7. The chaplains were supported by volunteers who were provided with details of patients admitted and then visited them to offer their services. There were also volunteers from other denominations.

## Learning from complaints and concerns

- Information about complaints procedures were available in all wards we visited. There were details on cards and leaflets about the patient advice and liaison service (PALS). There were also details of any recent complaints displayed.
- Staff understood the process for receiving and handling complaints and were able to give examples of how they would deal with a complaint effectively.
- Complaints were recorded on the trust-wide system. Local ward managers were responsible for investigating complaints in their areas.
- In surgery, there were a total of 68 formal complaints made in 2015. Trust-wide, surgical low level complaints were dealt with in a timely manner, however; more serious complaints were consistently below the trust target of 90% for response within the required timescale. Between April 2015 and January 2016, responses within the required times were between 43% and 69%.
- Lessons learnt from complaints were shared at ward meetings. An example of learning from a medication error was highlighted. Staff members unable to attend the meetings were sent the minutes via email and also a copy was available on the staff 'quality board'.

## Are surgery services well-led?

Good



We rated surgery as 'Good' for Well-led because;

- The vision and strategy were aligned with the trust and there were future plans to collaborate with other organisations.
- The surgical division was well-led with support from senior management.
- Staff were clear about the trust vision and carried the values with them on a card attached to their badges.
- A governance framework was in place and risks were identified in a register that was regularly monitored and reviewed.
- There were clear leadership roles across the division and managers were visible.
- Staff were positive about their managers; they felt they could approach them to raise any concerns and were supported by them.

# Surgery

- Staff attended weekly ward meetings where information was cascaded and shared learning took place.

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

- The trust's vision was: "Delivering the highest quality healthcare driven by world class research for the health and well-being of the population".
- The surgical division vision was aligned with the trust strategy. The trust vision was based upon values of being creative, patient centred, collaborative, open and engaged and professional.
- Staff were aware of the trust vision and carried a card attached to identification badges that included the values.
- We reviewed the surgical division performance review (March 2015) which outlined objectives and future strategies to improve the quality of care for the local population. There were plans in progress for the move to the new hospital site and the future development of surgical services. This included assessment of staffing needs and also using technology support systems to ensure privacy and safety of patients that will be accommodated in single rooms.

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

- A clinical governance system was in place within the surgical division that allowed risks to be escalated to divisional and trust board level through various committees and steering groups.
- Senior managers were clear about their roles and there was evidence that quality and risk were managed appropriately.
- There was a risk register in place for the surgical division that was reviewed at monthly governance meetings and updated as needed. Staff were aware of how to record and escalate key risks on the risk register. The risk register showed that key risks were identified and control measures were put in place to mitigate risks.
- Surgical division meetings included a patient's story as a way of driving service improvement.
- Trust-wide information from governance meetings was cascaded to the surgical division governance meetings. It was evident that this information was shared and discussed from meeting minutes we reviewed.
- The division's clinical effectiveness team monitored the audit programme. They produced quarterly reports and action plans where required. They also oversaw projects as part of the cost improvement programme.

- Senior staff facilitated weekly safety 'perfect ward' meetings with ward managers. Any incidents could be shared and lessons learnt were cascaded to ward staff.
- Staff also attended quarterly shared learning events and managers undertook governance walkabouts, which occurred informally in ward settings.

## **Leadership of service**

- There were clearly defined and visible leadership roles across the surgical division. The senior management team included a divisional director of operations, a clinical director, a chief of service and a divisional chief nurse. The leads were supported by a team of matrons and ward and theatre managers.
- Leaders were visible, in all areas, on a daily basis. Matrons attended 'safety huddles' that included the medical division, two or three times daily to discuss nurse staffing to ensure safe numbers of staff for the acuity of patients.
- Medical and nursing staff understood management reporting structures and told us they were well supported by their managers.
- Staff received weekly emails from the executive team and we were told they had visited the hospital on occasions at weekends.

## **Culture within the service**

- The culture of the surgical division was aligned with the trust values. There was an open and transparent culture that encouraged the reporting of incidents in order to learn from them and improve quality for people in the local population.
- There was a positive attitude and culture within the surgical care group where staff valued each other. Staff from all specialities reported good team working and a sense of pride in serving the local community.
- Many of the staff we spoke to had been employed for several years at the trust and demonstrated strong commitment to the hospital.
- In the 2015 national NHS staff survey the trust scored 3.82 out of five which is slightly above the national average of 3.76 for staff who would recommend the trust as a place to work or receive treatment. This was an increase on the previous 2014 survey. This information was trust-wide and not specific to surgical services.
- We also noted that the NHS staff survey showed that staff motivation at work had improved compared with

# Surgery

the previous survey from 3.73 to 3.84 out of 5 however this was still below the national average which had also risen from 3.85 in 2014 to 3.94 in 2015. This information was trust-wide and not specific to surgical services.

## Public engagement

- The surgical division participated in the NHS Friends and Family Test (FFT) and information about how patients and those close to them could provide feedback was displayed in ward areas.
- A patient experience sub-committee had been established to gain feedback from patients and covered subjects such as patient meal experiences.

## Staff engagement

- Staff participated in weekly ward meetings in all areas. If they were unable to attend, the meeting minutes were displayed in staff offices and also emailed to staff members.
- Staff received trust-wide information in a monthly newsletter as well as being displayed on 'quality boards' in order to share ward and division information.

- Staff were supported by their managers using the trusts 'Red flag' system. Ward or theatre staff were able to seek assistance when an issue needed escalating, for example staffing numbers or accessing pain relief. Staff who reported using the 'red flag' said managers responded promptly and appropriately.
- There was evidence of regular team briefing among the theatre staff at St Paul's Eye Unit. Staff explained that they were informed of actions and information via daily huddles.
- There was a staff counsellor available if required.

## Innovation, improvement and sustainability

- There were new care pathways being trialled, such as for reversal of ileostomy, trans endoscopic micro (TEM) surgery and pancreatectomy.
- The theatre complex included a vascular hybrid theatre that combined surgery and imaging in a less-invasive manner.

# Critical care

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

## Information about the service

The critical care service at the Royal Liverpool Hospital is delivered in three separate facilities within the Liverpool Royal Hospital site. There is a 17 bedded intensive therapy unit (ITU) for level 3 patients situated on the ground floor. In addition to this there are a further four level 3 beds available on the 11th floor in the post-operative critical care unit (POCCU). On the eighth floor of the hospital there is a 14 bedded high dependency unit on the 8th floor (8HDU) which cares for level 2 patients. The critical care service is for adult patients only and admits around 1,400 patients a year and is an active member of the Cheshire and Merseyside Critical Care Network (CMCCN). Children's services are provided by the local children's hospital.

A new hospital build is underway on a site adjacent to the existing Royal Liverpool Hospital and this will include a new purpose built critical care unit comprising over 40 beds. Completion is expected in the Autumn of 2017.

For the purpose of management and governance, the critical care service sits in the surgical division and the theatres/critical care and anaesthesia directorate.

As part of the inspection we spoke with relatives, patients and staff of all grades including nurses, doctors, consultants and allied health professionals. We also looked at policies, procedures, medical records, performance and quality data.

## Summary of findings

We have rated critical care services as "Good" overall. This is because:

- There were sufficient numbers of suitably skilled staff to care for patients.
- We found a culture where incident reporting and learning was embedded and used by staff.
- There was strong clinical and managerial leadership at unit and divisional level. The unit had a vision and strategy for the coming years developed in accordance with the building of the 'New Royal' on the adjacent site.
- There was an effective governance structure in place which meant that all risks to the service were captured and discussed. The framework also enabled the dissemination of shared learning and service improvements and a pathway for reporting and escalation to the trust board.
- Patients and their relatives were cared for in a supportive and sympathetic manner and were treated with dignity and respect.

However,

- There were issues with access and flow within critical care, which were related to the wider access and flow pressures within the hospital. These regularly resulted in delayed discharges and the associated cancellation of elective surgery.

# Critical care

## Are critical care services safe?

Good



We rated critical care services as “Good” for Safe because;

- There were sufficient numbers of suitably skilled staff to care for patients.
- There were systems in place for reporting and learning from incidents. This included evidence to support that learning had taken place as a consequence of incidents being reported and investigated.
- Staff had a good approach to hand hygiene and we saw them regularly washing their hands appropriately, using anti-septic hand gels and wearing personal protective equipment when delivering clinical and personal care.
- There was an internal system for raising safeguarding concerns. Staff were aware of the process and gave examples of what constituted abuse.
- There were high levels of compliance with safeguarding training for adults and children at all levels.
- A range of acute care initiatives had been introduced to assist with the early detection, recognition and timely response to the acutely ill patient and those at risk of deterioration.

However,

- The environment did not meet current building guidance but this was being addressed with the construction of a new purpose built critical care facility within the new hospital, which was due to be opened in 2017.
- On the high dependency unit (8HDU) it was common practice for patients’ drugs to be kept in the top drawer of the observation trolley, which meant that the drugs were unlocked and were easily accessible.
- Patients’ hospital notes were generally untidy with loose pages and it was often not easy to locate the current episode of care within the record.
- The intensive care society standard for consultant to patient ratio states that the ratio should not exceed from 1:8 up to 1:15. With only one consultant on at night there were times when this standard was not being met.

## Incidents

- The hospital had a policy and electronic system for the reporting and management of incidents and related investigations.
- Staff knew about the incident reporting system and were able to give examples of when they had used it. This included describing what constituted a reportable incident.
- There had been one never event in December 2015 which related to a misplaced naso-gastric tube. Never events are serious, wholly preventable incidents that should not occur if the available preventative measures had been implemented. A comprehensive investigation was undertaken using a root cause analysis (RCA) approach. A series of actions were put in place to address the identified issues. For example, the hospital guidance for managing naso-gastric tubes was reviewed and updated in accordance with the latest national patient safety agency (NPSA) guidance. It should be noted that the hospital guidance in place at the time of the incident did reflect national guidance, although it had passed its review date. In addition, the practice based educators in critical care developed and delivered an educational training programme for nursing and medical staff on the management of naso-gastric tubes. This included a poster algorithm, which we saw displayed throughout the critical care units. When we spoke with staff they were aware of the incident and the steps taken to prevent reoccurrence.
- For the period January 2015 to December 2015, data provided by the trust showed there were 452 incidents in critical care. These included a range of events such as medication errors, staffing levels, documentation, delayed discharges greater than 4 hours, identification of pressure ulcers, medical device problems, equipment and control of infection.
- Of the 452 reported incidents, the majority were categorised as minor or no harm to the patient. There were 39 categorised as moderate or above harm. None of the incidents were categorised as serious.
- Minuted monthly critical care mortality and morbidity meetings were held in the department. We were told that incidents that had occurred since the previous meeting were discussed. However, although requested we did not receive copies of the mortality and morbidity meeting minutes, so were unable to confirm this point.
- Incidents were also shared and discussed at daily safety huddles and a range of critical care meetings. For

# Critical care

example the critical care audit and governance meeting. We saw evidence that learning was taken from incidents and their associated investigations. For example, the clinical educators delivered training for staff developed as a consequence of learning from incidents.

- We asked staff about their understanding of the principles of 'duty of candour'. Staff responded by saying that it was their responsibility to be 'open and honest'. 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 an example of how the trust had discharged their responsibility. An investigation following a never event reported that the patient's family were immediately informed of the incident and subsequently the outcome of the root cause analysis.

## Safety thermometer

- The NHS safety thermometer is a national improvement tool for measuring, monitoring and analysing avoidable harm to patients and 'harm free' care. Performance against the four possible harms; falls, pressure ulcers, catheter acquired urinary tract infections (CAUTI) and blood clots (venous thromboembolism or VTE), was monitored on a monthly basis.
- The number of pressure ulcers, falls and CAUTI's were relatively low for critical care services. In the period September 2014 to September 2015 critical care services reported three pressure ulcers, two falls that resulted in harm and one CAUTI.
- Up to date, safety thermometer data was displayed in the corridor outside the clinical areas. Alongside was also displayed the staffing information for the day and night shifts, in terms of actual versus planned numbers of trained nurses and health care assistants on duty.

## Cleanliness, infection control and hygiene

- Clinical areas, offices, corridors, store rooms and staff areas were visibly clean.
- The trust had infection prevention and control policies in place which were accessible to staff.
- As part of the inspection we observed staff washing their hands appropriately, using anti-septic hand gels and wearing personal protective equipment when delivering clinical and personal care. We saw staff adhering to the 'bare below the elbows' policy when in the clinical areas. We saw the results of weekly hand hygiene audits

which showed varying levels of compliance from 51% to 100%. However, the list of results for the intensive therapy unit (ITU), high dependency unit (8HDU) and the post-operative critical care unit (POCCU) did not detail any actions to improve in non-compliant areas.

- The most recently validated intensive care national audit and research centre (ICNARC) data for ITU (July to September 2015) showed that the unit generally performed within the expected range for unit acquired infections, when compared to similar units.
- The most recently validated ICNARC data for 8HDU (July to September 2015) showed that there were no cases of unit acquired infections in the blood for elective and emergency surgical admissions.

## Environment and equipment

- None of the existing critical care areas complied fully with the latest available health building guidance for critical care (HBN 04-02). However, there were plans for this to be addressed when the new unit opens in 2017, which we were told is being built to the latest specification.
- The ITU had four purpose built isolation rooms, with gowning and handwashing ante-spaces. The rooms also had variable air flow pressures to facilitate both protective and source isolation.
- The level 2 patient area (8HDU) had been built within the footprint of what was previously a ward so that it met the patients' need for single sex accommodation
- All bed spaces were fully equipped with the equipment required to care for a critically ill patient.
- We saw that resuscitation equipment; including defibrillators and difficult airway management trolleys were available. Records indicated that these were all checked daily.
- The critical care service had a full time operating department practitioner who worked closely with the electro-biomedical engineering (EBME) team to ensure that all the equipment was serviced and maintained to the required standard. Detailed records were kept of all equipment alongside a service and maintenance database.
- A business case was being developed to replace out of date equipment including ventilators in readiness for the move to the new unit in 2017.

# Critical care

## Medicines

- Trust policies were regularly reviewed and covered most aspects of medicines management. These were accessible via the hospital intranet to all staff.
- The unit used an electronic prescribing system, which was accessed at the bedside. This system had a number of benefits in terms of safety and quality for patients.
- Patients had access to a specialist critical care pharmacist. There was just one whole time equivalent (WTE) pharmacist for all critical care beds, which was below recommended standards, and they were also responsible for the total parenteral nutrition (TPN) pharmacy team. The intensive care society standard for critical care pharmacist allocation is 0.1 WTE per level 3 bed and 0.1 WTE for every two level 2 beds. Based on this calculation, there should be 2.8 WTE dedicated pharmacists allocated to critical care services.
- The critical care pharmacist did not attend the morning ward round but did visit every patient every day. Clinical pharmacist attendance at multi-disciplinary ward rounds increases the effectiveness of the service as recommended in the Intensive Care Society core standards.
- There were 38 reported incidents relating to medicines in critical care from January 2015 to December 2015. These predominantly related to administration errors. Medication errors were reviewed by the medicines safety group.
- We saw that on 8HDU it was common practice for patients' drugs to be kept in the top drawer of the observation trolley. This meant that the drugs were unlocked and were easily accessible. We brought this to the attention of the staff on duty who said because patients were being cared for in side rooms, any risks associated with this practice were balanced against any potential delays in running to get drugs when they were required, often in a hurry.
- Records indicated that drug fridge temperatures were monitored and recorded daily.
- Medicines management was regularly audited across the Trust and action plans were developed where improvements were required. Audits included delayed and omitted medicines, controlled drugs, medicines storage, medication errors, antibiotic formulary adherence and prescribing quality. The pharmacy department reported omitted medicines directly to each ward manager daily by email, so action could be taken locally to minimise inappropriate omissions.

- The three critical care areas were subject to monthly antibiotic point prevalence audits. All antibiotic prescriptions were reviewed by a specialist pharmacist on a designated date each month to determine the appropriateness of agents prescribed for the management of infections. The report for December 2015, which showed the past six months results, indicated that there was an issue with the completion of 'indication' in the patient records. Without reference to why the antibiotic was being prescribed it was not possible to ascertain the appropriateness of the agent being used. The audit report did not contain any actions arising as a consequence of the findings.

## Records

- We looked at three sets of notes on ITU and two sets on 8HDU. The critical care notes were kept separately from the rest of the general hospital notes. The critical care paper records comprised a range of clinical records, assessments and plans. These included for example, nutritional risks, falls assessments, pain scores, capacity assessments, physiotherapy treatment plans and skin care bundles. All entries were completed, signed and dated although the legibility of handwritten notes varied.
- We saw that hospital notes were generally untidy with loose pages and it was often not easy to locate the current episode of care within the record.
- Although entries in records were usually signed and dated, the authors name was not always printed alongside the signature. Some entries were also missing the author's professional registration number. For example, General Medical Council (GMC) or Nursing and Midwifery Council (NMC) registration numbers.
- Physiological parameters were recorded by the nurse looking after the patient on a large chart located close to the bedside. This brought together all the patient monitoring and observations onto one chart so that ventilator settings, fluid balance and vital signs could all be reviewed in one place.

## Safeguarding

- There were trust-wide safeguarding policies and procedures in place which were readily available on the trust's intranet site.
- There was an internal system for raising safeguarding concerns. Staff were aware of the process and gave examples of what constituted abuse and neglect.

# Critical care

- The trust had an internal safeguarding team who could provide guidance and support to staff in all areas. This team were accessible by telephone when required.
- Safeguarding training formed part of the trust's mandatory training programme. Data provided by the trust showed that there was good compliance with safeguarding training at all levels. Compliance with training for safeguarding adults and children level 1 was 92.5%, which was above the trust's target of 90%. In addition, safeguarding adults and children level 2 (83.8%) and level 3 (100%) were all above the trust's target of 80%.
- All band 6 and 7 staff undertook adult safeguarding at level 3.

## Mandatory training

- A mandatory training record was held for every staff member.
- Staff told us that they were encouraged to attend mandatory training and that the practice educators reminded them when their mandatory training was due for renewal.
- Staff received mandatory training on a rolling programme in two blocks (clinical core skills and core skills). Clinical core skills included areas such as infection control and prevention for care staff, falls prevention, and, diet and nutrition. Core skills included areas such as safeguarding, health and safety, and fire safety.
- Data provided by the trust showed that compliance with core skills training was 89.3% at the time of the inspection and 89.2% for clinical core skills. Both were below the trust's target of 95%.
- Compliance with mandatory training was closely monitored for all staff. Records were held at divisional and local level. The practice based educators were readily able to provide details on the progress and compliance rates for varying mandatory training courses. For example, on 8H DU 88% had completed conflict resolution and 89% had completed immediate life support training (ILS). The practice based educators on ITU were also similarly able to access training compliance numbers.
- In addition, ILS courses had been completed by 95% of the staff on ITU and 89% on 8H DU. The education team

and outreach nurses had also completed advanced life support training. Compliance with basic life support at the time of the inspection was 93%, which was marginally below the trust's target of 95%.

## Assessing and responding to patient risk

- A range of acute care initiatives had been introduced to assist with the early detection, recognition and timely response to the acutely ill patient and those at risk of deterioration. These included, implementation of the national early warning score (NEWS) and associated acute care guidance and policies. NEWS is a system that scores vital signs and is used as a tool for identifying patients who are deteriorating clinically. The charts in use on the ward areas included an early detection and treatment of sepsis pathway as well as the NEWS scoring system and escalation plan.
- The trust complied with National Institute for Health and Care Excellence (NICE) guidance 50, 'Acutely Ill Adults in Hospital, recognising and responding to deterioration'. There was an outreach service but this was currently only provided from 8am to 5pm Monday to Friday. When the outreach team was not available, arrangements were in place for the respective medical teams supported by nurse practitioners to respond to a patient as required. These arrangements were outlined in the NEWS documentation.
- In addition to the critical care outreach team there was also a ward based medical emergency team (MET) that operated 24/7 and responded to calls from the wards for things such as cardiac arrests.
- For patients on the Broadgreen hospital site undergoing elective surgery there was a four bedded post anaesthetic unit (PACU), which provided immediate post-operative monitoring. The PACU was staffed by nursing staff from the Royal Liverpool critical care unit establishment. In the event that a patient deteriorated on the Broadgreen Hospital site to the extent that they were assessed as needing critical care then there was an emergency transfer policy. The policy included an algorithm for staff to follow which set out the steps required to ensure a safe and timely transfer to the Royal Liverpool Hospital.

# Critical care

## Nursing staffing

- The critical care matron kept a close overview of the staffing establishment and understood exactly what the staffing situation was at the time versus the establishment for each band of staff across each of the three critical care areas.
- The staffing establishment was calculated using the intensive care society 'Levels of Critical care for Adult Patients' guidance and the 'Safer Nursing Care Tool', which was based on the Department of Health's classification of critical care patients, published in 2000.
- A report produced in December 2015 set out the establishment versus the actual head count across all bands for the three critical care areas. This showed improved numbers of staff across all bands with the actual head count exceeding the establishment figure across bands 5 to 7. For example in ITU, the establishment for band 5 nurses was 78.8 whole time equivalent (WTE) but the head count showed 81 WTE.
- One of the biggest risks on the critical care risk register was the use of agency nursing staff. This had at times exceeded the 20% standard recommended in the intensive care society standards. This had occurred 11 times since January 2016. More recently, the trust had revised their recruitment policies and protocols to try and expedite the recruitment of staff. As a result, staffing numbers had increased and improved. At the time of inspection we were told that there were no vacancies on POCCU, four vacancies on 8HDU and 14 vacancies on ITU, although seven nurses had just been appointed to ITU and were awaiting a start date. We were told that every attempt was always made to use 'regular' agency staff whenever possible. Agency nurses had to demonstrate their critical care competencies before being allowed to work in the 'numbers' for a shift. If the staffing numbers fell short of what was safely required, even with agency staff, then beds were closed. This had happened six times since January 2016.
- At the time of the inspection, there were adequate and appropriate numbers of suitably skilled and qualified nursing staff on duty to ensure that patients received safe care and treatment. There was a supernumerary shift co-ordinator in both level 2 and level 3 clinical areas.
- Nurses were supported to deliver care and treatment by both clinical and non-clinical support workers. The units were fully established for these grades of staff.

- In terms of allied health professionals, the most recent critical care network report showed that appropriate numbers and grades of respiratory physiotherapy, pharmacy, medical engineering and housekeeping were in place.
- We observed a nursing handover and saw that a structured handover took place between the two shifts; this included a bedside nurse to nurse handover.

## Medical staffing

- Critical care had a designated consultant clinical director.
- From 8am to 6pm there were two consultants assigned to the ITU and one assigned to the level 2 beds on 8HDU.
- When assigned to a critical care area, consultants had no other clinical responsibilities within the hospital. From 4.30pm to 8am there was one consultant covering all critical care (both ITU and 8HDU). They had no other assigned duties whilst on call and if not resident could attend the units within 30 minutes. The intensive care society standard for consultant to patient ratio states that the ratio should not exceed from 1:8 up to 1:15. With only one consultant on at night there were times at night when this standard was not being met.
- For trainee doctors, there were three shifts worked on critical care: days (8am to 6pm), long day (8am to 9.30pm) and nights (8pm to 9am).
- For ITU, as a minimum there were two trainees on long day shifts, one on days and three on nights. This included at least one airway trained doctor on a long day and night shifts.
- For 8HDU, the minimum trainee staffing levels were one trainee on a long day and one trainee on nights. Though in practice there were often additional trainees on duty during the day shift.
- Two senior clinical fellows (ST7) covered alternate "clinical weeks" on ITU 8am to 6pm. The "non-clinical weeks" included on-call shifts (4.30pm to 8am, non-resident) alongside the on-call critical care consultants.
- We attended a medical handover which was well structured and followed a set method with a standardised handover sheet. The handover was undisturbed with no distractions.
- The trainees we spoke with said they felt well supported and there was a good balance between work and teaching.

# Critical care

## Major incident awareness and training

- Critical care services had detailed plans for responding to the increased demands that a major incident would make on the service, while continuing to provide care for existing patients. The plans took account of national legislation and guidance such as the Civil Contingencies Act (2004) and the NHS Emergency Planning Guidance (2005).
- There was a major incident policy in place which was accessible on the trust intranet.
- Staff could not recall having had any specific training on the management of a major incident.

## Are critical care services effective?

Good



We rated critical care services as “Good” for Effective because;

- Care was delivered in line with evidence- based, best practice guidance.
- The service benchmarked its performance against comparable units through data submissions to the Intensive Care National Audit and Research Centre (ICNARC).
- As part of their individual care plan all patients in critical care were assessed in respect of their pain management in accordance with the Core Standards for Pain Management Services in the UK.
- Ward rounds took place each day that involved medical, nursing, pharmacy and other allied health professionals as required.
- Guidelines were in place for initiating nutritional support for all patients on admission to ensure adequate nutrition and hydration.
- There was a critical care outreach service provided and a documented discharge pathway in place which included referral of all discharged critical care patients to the outreach team so that they could assess and monitor their progress and recovery.
- There was a consultant lead for mental capacity and deprivation of liberty safeguards who was working at a local and national level to develop guidance for staff working in critical care regarding the application of

deprivation of liberty safeguards for critical care patients. This was innovative work as the applicability of the Mental Capacity Act 2005 in a critical care setting was generally little understood.

However,

- The critical care service was not fully compliant with NICE guidance 83, “Rehabilitation after Critical Illness”.
- Whilst there was evidence of multi-disciplinary working, the ward rounds did not always include all relevant members of the multi-disciplinary team.

## Evidence-based care and treatment

- The critical care service used a combination of national and best practice guidance to determine the care they delivered. This included guidance from the Intensive Care Society and the National Institute for Health and Care Excellence (NICE).
- The critical care units were also subject to an annual peer review by the Cheshire and Merseyside Critical Care Network (CMCCN). The purpose of the reviews was to demonstrate evidence at unit level of the range of standards applicable to critical care as outlined in their service specification. The most recent review from February 2015 showed good levels of compliance across the service specification with only a few recommendations. At the time these included a focus on reducing the agency nursing usage and re-implementation of the trust wide critical care delivery group.
- There was a range of local policies, procedures and standard operating protocols in place, which referenced evidence based guidance and these were easily accessible via the trust-wide intranet.
- The critical care unit was not fully compliant with NICE guidance 83, ‘Rehabilitation after Critical Illness’. This was because the units did not have a rehabilitation prescription document but this has not been regularly used. To rectify this, nursing and physiotherapy staff across the network were working together to review the documentation with the aim of developing rehabilitation documentation that better reflected the patient journey. Another factor in not meeting the guidance was because the staffing levels of allied health professionals allocated to the rehabilitation pathway fell below those levels recommended in the intensive care society standards. For example, for 37 beds the Intensive Care Society standards recommends 8.14 WTE

# Critical care

occupational therapists and there were 0.8 WTE in post. The standards also recommend 3.7 WTE speech and language therapists for 37 beds and there was only 1.5 WTE.

- There was a dedicated band 7 lead nurse for audit who was supported by a consultant lead for ICNARC and audit.
- There was a programme of local audit activity and where an audit identified a shortfall in compliance or performance an action plan or improvement project was developed and implemented. Some of the audit activity we saw related to compliance with care bundles, blood transfusions, 12 lead ECG, delirium screening, tracheostomy, central line insertion and the effectiveness of naso-gastric nutrition within the first seven days of a stay in critical care.
- Some of the local audit programme results were as follows;
- ITU transfusion audit showed 100% compliance with triggered transfusion for haemoglobin results of less than 7.0 – 100% documentation of indication for transfusion when a patient was bleeding. However, for patients with a higher transfusion trigger there was inconsistent documentation of targets and triggers.
- An audit into the effectiveness of naso-gastric feeding pathway in the first seven days of critical care showed low levels of compliance. For all audits where the results demonstrated non-compliance there was evidence of action plans being developed and implemented.

## Pain relief

- In accordance with the Core Standards for Pain Management Services in the UK, developed by the Faculty of Pain Management of the Royal College of Anaesthetists with input from CQC, acute pain management was supervised by consultants and specialist nurses with the appropriate training and competencies.
- As part of their individual care plan all patients in critical care were assessed in respect of their pain management. This included observing for the signs and symptoms of pain. Staff also utilised a paper based pain scoring tool.
- There was access to the acute pain management team for support and guidance especially for those patients with complex pain.

## Nutrition and hydration

- Guidelines were in place for initiating nutritional support for all patients on admission to ensure adequate nutrition and hydration.
- Nutritional risk scores were updated and recorded appropriately in the patient notes we reviewed.
- There was strict fluid balance monitoring for patients, which included hourly and daily totals of input and output.
- In order to meet the guidelines for the provision of intensive care services (GPICS) standard for dietetic support the unit should have 0.1 whole time equivalent (WTE) of a dietician per critical care bed. However, the current allocation for critical care was 0.04 WTE per critical care bed.

## Patient outcomes

- The intensive therapy unit (ITU), post-operative critical care unit (POCCU) and high dependency unit (8HDU) demonstrated continuous patient data contributions to the intensive care national audit and research centre (ICNARC). This meant the care delivered and mortality outcomes for patients were benchmarked against similar units nationally. The most recently validated ICNARC data showed that the mortality ratio was within the expected range for comparable units.
- We were provided with the latest validated and published ICNARC data for the period July to September 2015, which benchmarked the ITU and 8HDU against comparable units nationally.
- For the period July 2015 to September 2015, the ITU data showed that for ventilated patients, patients admitted with severe sepsis and patients admitted following elective or emergency surgery mortality was similar to or better than similar units nationally, although the mean average length of stay was longer (worse) than the national average. In terms of unit acquired infections in blood, for ventilated patients the unit performed within the expected ranges for similar units nationally but for elective and emergency surgery there were no cases of unit acquired infections in blood.
- For the period July to September 2015, the 8HDU data showed that for elective and emergency surgical admissions the mortality and length of stay was similar to, or slightly better than comparable units. However, for admissions with trauma, perforation or rupture, the

# Critical care

mortality and length of stay for the period was worse than similar units. There had been no instances of unit acquired infections in blood for any emergency or elective surgical admissions to 8HDU.

- The latest available ICNARC data showed that the unit was performing within the expected range for early readmissions and post unit hospital deaths, when compared with similar units. Early readmissions are classified as being unit survivors that are subsequently readmitted to the critical care unit within 48 hours of discharge and post unit deaths are classified as being unit survivors that die before ultimate discharge from acute hospital, (excluding those discharged for palliative care).
- Sedation breaks were implemented where appropriate. A sedation break is where the patient's sedative infusion is stopped to allow them to wake and this has been shown to reduce mortality and the risk of developing ventilator related complications. The sedative is then re-started if the patient becomes agitated, in pain or in respiratory distress.
- We saw that the critical care outreach team collected data on their activity which was collated and presented monthly at the critical care morbidity and mortality meetings. The data included numbers of referrals, the reasons for referral, the breakdown of referrals by speciality and the final outcome. The most recently available report on critical care outreach activity for January 2016 showed 26 acute referrals and 21 referrals for specialist advice. Of the 26 acute referrals eight resulted in admission to critical care (five at level 2 and three at level 3). The team also saw 64 patients in January 2016 who had been discharged from critical care to the ward. Forty-seven of whom were discharged home, two died and 14 remained in hospital.

## Competent staff

- Staff were appropriately trained, competent and familiar with the use of critical care equipment.
- The critical care units had three designated full time clinical practice nurse educators in post. Two were based in ITU and one based in 8HDU. The practice based educators supervised all new starters in critical care. The national competency framework for critical care nurses was implemented. New starters had eight weeks working supernumerary (supernumerary means they were not included in the daily staffing numbers so that they could learn without specifically being assigned

patients to care for as an inducted member of staff would) although this was increased or even decreased according to individual competency and need. Fourteen staff a year had the opportunity to undertake the critical care course held in conjunction with a local university. The percentage of trained nurses who had completed the critical care course in ITU, POCCU and 8HDU was 71% at the time of the inspection.

- The practice based educators were also involved in additional training for unit staff including equipment study days, multi-disciplinary simulation training (intubation, dislodged tracheostomy tube, anaphylaxis and cardiac arrest). Additional days were also planned for training on dialysis and haemo-filtration. The practice educators also had a role in setting up specific training arising from incidents within the units and were responsible for overseeing the placements of student nurses.
- When agency nurses were used, the unit tried to obtain nurses who had regularly worked on the unit to provide some consistency. Agency staff had their competencies assessed before they worked unsupervised.
- Trainee medical staff stated they were well supported and had an appraisal and revalidation process in place with good opportunities for training.
- All nursing staff were subject to an annual check of their registration with the Nursing and Midwifery Council (NMC).
- At the time of the inspection, 85% of nursing staff had received their annual appraisal against a trust target of 95%.

## Multidisciplinary working

- Consultant led multi-disciplinary ward rounds took place each day. Although members of the multi-disciplinary teams attended at some point during the day, they did not always attend at the same time. For example, the critical care pharmacist did always make the ward round.
- There was also evidence of multi-disciplinary working around the discharge of patients involving medical, nursing and allied health professional staff.
- There was evidence that nursing and medical staff worked together as a team for the benefits of their patients. We saw minutes of multi-disciplinary meetings held regularly.

# Critical care

- There was an outreach team available Monday to Friday from 8am to 5pm and they worked closely with the critical care team both in following up recently stepped down or discharged patients and in discussing deteriorating patients on the wards.
- The outreach team also worked in conjunction with respiratory physiotherapists and the medical emergency team (MET).

## Seven-day services

- A consultant intensivist was available seven days a week, including outside normal working hours.
- The physiotherapy team provided a seven day service to the critical care unit during the day with an on call service out of hours.
- Dietetic, pain management, speech and language therapy, and pharmacy services were available Monday to Friday, 9am to 5pm and via on-call at weekends.
- Imaging and diagnostic services were provided during the working week and then on-call out of hours and at the weekend.

## Access to information

- Critical care related notes were kept in a separate file located by the patient's bedside. The main hospital patient records were also kept but in the records were checked were often untidy and contained loose leaves of paper.
- The only electronic records were those relating to the prescribing and administration of medicines. These were accessed via a bedside laptop. This electronic prescribing system was also used on most of the wards, which enabled safer transfer and management of medicines information on discharge.
- All the patient's physiological parameters, assessments, fluid balance and ventilator settings were recorded on a large critical care observation chart situated by the bedside.
- In accordance with NICE guidance CG50 (Acute illness in adults in hospital: recognising and responding to deterioration), the critical care team and the receiving ward team ensured that there was a formal documented and structured handover of care. This promoted a clear and accurate exchange of information between relevant health and social care professionals.
- The hospital had introduced an electronic whiteboard system that enabled staff to track the status of patients

and their journey through the hospital. Although the three critical care areas had been 'measured up' to be added to the system, they had not yet been connected to the wider hospital electronic whiteboard system.

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

- Staff demonstrated an understanding of the issues around consent and the capacity to make their own decisions, for patients in critical care.
- There was a consultant lead for mental capacity and deprivation of liberty safeguards (DoLS) who was working at a local and national level to develop guidance for staff working in critical care regarding the application of deprivation of liberty safeguards for critical care patients. This was innovative work as the applicability of the Mental Capacity Act 2005 in a critical care setting was generally little understood. It was hoped that the guidance being developed, once approved, would be adopted more widely across the critical care networks and would provide some much needed support and clarity for staff and patients in respect of this important legislation.
- There was an assessment of mental capacity/delirium recorded in the patient record. This was called the 'CAM-ICU' and was used in conjunction with the Richmond Agitation Scale, which measured the agitation or sedation level of a patient. Care plans stated that the CAM-ICU should be completed twice every shift. Examination of the patient records showed that this was carried out twice daily. The rationale being that delirium prolongs critical care and has long term sequelae. Early detection means earlier treatment. The CAM-ICU is an adaptation of the Confusion Assessment Method by Inouye (1990), the most widely used tool for diagnosing delirium by non-psychiatric clinicians. The CAM-ICU utilises yes/no questions for use with non-speaking mechanically ventilated patients.
- Staff were able to explain the use of do not attempt cardio-pulmonary resuscitation (DNACPR) forms. There were no DNACPR forms being used for any patients on the unit at the time of inspection.

# Critical care

## Are critical care services caring?

Good



We rated critical care services as “Good” for Caring because;

- Critical care services were delivered by caring, compassionate and committed staff.
- We saw patients, their relatives and friends being treated with dignity and respect.
- Staff demonstrated that they understood the impact of critical care interventions on people and their families both emotionally and socially.
- There was a well-established programme of follow up clinics for former critical care patients, which was helpful in managing both on-going physical and psychological issues.

### Compassionate care

- We saw that staff took the time to interact with people being cared for on the unit, and those close to them, in a respectful and considerate manner.
- Staff were encouraging, sensitive and supportive in their attitude.
- People’s privacy and dignity was maintained during episodes of physical or intimate care. Privacy curtains were drawn around people with appropriate explanations given prior to care being delivered.
- We spoke with the relatives of patients on all three clinical areas. They were universal in their praise for the medical and nursing staff. They told us they had been kept informed of everything that was going on with their relative.

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

- Staff communicated with patients and those close to them so that, where possible, they understood their care and treatment.
- Initial and on-going face to face meetings were implemented by nursing and medical staff to keep people informed about their relative’s care and treatment plans.
- The unit was using patient diaries, where appropriate. Usually for patients who are sedated and ventilated. Intensive care patient diaries are a simple but valuable tool in helping recovering patients come to terms with

their critical illness experience. The diary is written for the patient by healthcare staff, family and friends. Research has shown that patient diaries often help the patient better understand and make sense of their time in critical care and help to prevent depression, anxiety and post-traumatic stress. In addition to using patient diaries the critical care outreach team were also filming patients as part of the patient stories project. Where patients talked about their experience of critical illness and the care they received on the units.

- We saw blank copies of a relative satisfaction survey that was being used to evaluate and improve the way that staff dealt with visitors and relatives. The survey asked question about first impressions and the environment, communication and support. At the time of the inspection the analysis and results of the last relative survey was not yet available.

### Emotional support

- Staff demonstrated that they understood the impact of critical care interventions on people and their families both emotionally and socially.
- There was a senior nurse for organ donation in post who worked closely with the critical care team in managing the sensitive issues related to approaching families to discuss the possibilities of organ donation.
- A follow up clinic for patients discharged from critical care was started 10 years ago. The process started with a visit from the critical care outreach team (CCOT) once the patient had been discharged from critical care but remained a hospital in-patient. The outreach team was able to explain what had happened to the patient in critical care, to help them make sense of their experiences. In many cases this resolved any issues arising from the ITU admission and patients did not need and did not request to attend the follow up clinic. Those who were troubled or who wished to attend the follow up clinic after discharge were identified, and invited by letter to attend approximately 10-12 weeks after their discharge from hospital. Patients who had suffered head injuries, drug or alcohol overdoses and those with chaotic lifestyles were not invited except by the request of the patient. During the clinic, the events of the patient’s critical care stay were discussed and the context of their experiences discussed. If a ‘patient diary’ had been completed then this was reviewed and the patient and their family were offered a re-visit to the ITU, once again, to provide context for their experiences.

# Critical care

Physical symptoms were reviewed and specialist referrals made. For example, psychological symptoms were assessed to try and identify those patients likely to develop post-traumatic stress disorder. The unit had established a direct referral pathway to individual psychologist support. This valuable intervention may assist in preventing the likelihood of persistent on-going psychological problems.

- The CCOT had evaluated the impact and perceived benefits of the follow up clinic service. They retrospectively surveyed 101 patients who had been invited to a follow up clinic between the end of 2012 through to the end of 2014. The methodology involved the completion of a short postal survey to which there was a 49.5% response. The general findings were that there was variable recall about the post ITU visit of the outreach team; almost all attendees (88%) found the follow up clinic beneficial; having questions answered (96%) and talking through their experiences (80%) were rated highly as reasons that patients found the clinics beneficial; patient diaries were judged to be important. The reasons for non-attendance were cited as transport difficulties, recovery going well and conversely being too unwell.

## Are critical care services responsive?

Requires improvement



We rated critical care services as “Requires Improvement” for Responsive because;

- The issues specifically related to the access and flow of patients which resulted in delayed discharges and associated cancellations of elective surgery.
- For the period July to September 2015, 67% of patients admitted to the level 3 intensive therapy unit (ITU) experienced a delayed discharge. For the same period 85% of patients experienced a delayed discharge from the high dependency unit (8H DU). For the post-operative critical care unit (POCCU) in the same period 82% of patients experienced a delayed discharge.
- POCCU also kept details of the number of cancelled elective cases in their monthly activity analysis. For the period July to September 2015 the figures showed 12

cancelled elective cases and 37 cases where a critical care bed had been booked but on the day of surgery there was no bed available and the surgery had gone ahead.

- There was a particular problem with ward patients remaining long after they had been judged ready for discharge as a consequence of delays in community funding, placements and support.

However,

- In the new hospital being built on an adjacent site, the new critical care unit will bring together the level 2 and level 3 patient areas into one purpose built setting and it has been planned to comply with the latest building standards and maximise the use of natural light and ventilation.
- There was a critical care outreach service provided Monday to Friday 8am to 5pm.

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

- The new hospital was being built on a site adjacent to the existing hospital. The new build had been designed to provide patients with an improved experience, a better and easier layout, green space, and a more attractive and welcoming building and site.
- We were told that the critical care unit will bring together the level 2 and level 3 patient areas into one purpose built setting. The clearer layout will make it easier for patients and visitors to find their way around. External views will provide a point of focus. Artistic features will help people find their way around the hospital and create an interesting and attractive environment. The new hospital will comply with current space standards and will maximise the use of natural light and ventilation. The new hospital will provide 100% single bedrooms with en-suite facilities.
- There were bed management meetings held throughout the day to monitor and review the flow of patients through the hospital and this included the availability of critical care beds.
- There were facilities for relatives to stay on the unit if they wished to and overnight, if needed, in a close by bedroom.
- There was a critical care outreach service. The critical care outreach team was a nurse-led service. It expanded from 3.0 to 4.0 WTE band 8A nurses in July 2016. The team were experienced critical care nurses with an MSC

# Critical care

degree in Advanced Clinical Nursing Practice. The team was supported by a Medical Lead, who was a Consultant in Critical Care Medicine. The critical care outreach service was provided Monday to Friday, 8am to 5pm. Out-of-hours (5pm to 8am Monday –Friday and anytime at weekends) referrals to critical care outreach were made directly to the ITU doctor via a baton bleep. It was hoped that the service would expand to cover seven days at some point.

## Meeting people's individual needs

- Care plans demonstrated that people's individual needs were taken into consideration whilst delivering care and treatment.
- Interpreting services were available within the hospital if required.
- The critical care service had developed dementia champions and all staff undertook dementia training (e-learning) as part of their mandatory training subjects.
- Leaflets were available for patients about critical care services and the care they were receiving. Staff knew how to access copies in an accessible format, for people living with dementia or learning disabilities, and in braille for patients and relatives who had a visual impairment.

## Access and flow

- Patients were reviewed in person by a consultant within 12 hours of their admission.
- There was a matron's huddle held each morning where access and flow pressures and staffing issues could be quickly shared and discussed by all matrons within the hospital.
- For information on the access and flow of patients through critical care we looked at a number of sources. For the intensive therapy unit (ITU) and the high dependency unit (8HDU) we looked at their validated intensive care national audit and research centre (ICNARC) data. For the post-operative critical care unit (POCCU) we looked at their monthly activity analysis. It was understood that the POCCU was to start submitting its own specific ICNARC data returns but it was too early for a separate ICNARC report to have been validated.
- In terms of responding to patient need, the critical care team had looked at capacity and demand during the months of June and August 2014, which were considered to be normally quiet months. The intensive care society standard states that 'admission to intensive care should take place within four hours of the decision

to admit'. Minimising delays to definitive treatment is associated with better outcomes for patients. The standard also expects that critical care units should be in a position to accept 95% of all emergency referrals. For the audit period of June and August 2014, the ITU accepted 98.9% of emergency referrals and, 82.2% of admissions were admitted without a significant delay. So, in conclusion, during the period of the audit the ITU was able to admit nearly all emergency referrals, although there were unacceptable delays in admission for some patients.

- In terms of the broader picture for all the critical care beds there were 1,282 admissions between April 2013 and March 2014. Of these 1,065 were discharged and 877 of those experienced a delayed discharge (82%). For the period April 2014 to March 2015, there were 1,399 admissions, Of the 1,202 of those that were discharged, 1,026 (85%) experienced a delayed discharge.
- Looking in more detail at the most recently validated ICNARC data for the ITU, July to September 2015, there were 166 admissions. Of those, 111 (67%) experienced a delayed discharge from ITU. The delay was generally less than 24 hours (46%) although for a small number was as long as four to five days. For 31 patients (19%) their discharge occurred out of hours (after 10pm and before 7am).
- For the same period, July to September 2015, in 8HDU, there were 178 admissions. Of these, 151 (85%) experienced a delayed discharge from 8HDU. For 53% of patients being discharged, their delay was less than 24 hours although for a small number the delays were much longer. For example five patients waited longer than five days. In addition,
- 20 patients (11%) experienced an out of hours discharge (after 10pm and before 7am).
- Looking at the POCCU monthly activity analysis for the same period, July to September 2015. There were 144 admissions of which 118 (82%) experienced a delayed discharge. In addition, 41 patients (28%) also experienced a delay in their admission, although only nine patients (6%) had to wait longer than four hours for admission. The reasons for the delays in admission were categorised as waiting for the previous patient to be discharged, waiting for the cleaning team and unplanned admissions.
- POCCU also kept details of the number of cancelled elective cases in their monthly activity analysis. For the period July to September 2015 the figures showed 12

# Critical care

cancelled elective cases and 37 cases where a critical care bed had been booked but on the day of surgery there was no bed available and the surgery had gone ahead. These patients were not looked after post-operatively on the POCCU but were looked after in a non-critical care environment such as the ward they had been admitted to.

- For non-clinical transfers out of both the ITU and 8H DU, the trust performed better than comparable units. For the period July to September 2015 there were no non-clinical transfers.
- In the event that no critical care bed was available for a patient in theatre, there were occasions when patients were cared for in theatre whilst a bed was awaited. We asked the trust for details of how many patients were ventilated outside critical care in such circumstances but was told that this data was not held.

## Learning from complaints and concerns

- The hospital had clear policies and protocols for the management of complaints and concerns. These included defining who was responsible for managing complaints, the timescales for investigations and responses to complainants and the governance pathways through which complaints were reported from ward to board.
- Learning from complaints, concerns and compliments was triangulated within the division alongside other patient experience and feedback via multi-disciplinary and team meetings.
- The trust's website contained information on how to raise a concern both informally and as a formal complaint.
- The noticeboards in the critical care unit relative's rooms displayed a range of helpful and supportive information and contact details, including how to make a complaint or raise a concern.
- We had no specific complaints data relating to critical care in terms of numbers and specific lessons learned though staff told us that there were very low numbers of complaints for critical care. The trust wide analysis of complaints received reported that critical care was not one of the top clinical areas complained about.

## Are critical care services well-led?

Good



We rated critical care services as “Good” for Well Led because;

- There was strong clinical and managerial leadership at unit and divisional level.
- There was a detailed business plan and strategy for critical care services, which set out the threats, risks and opportunities for developing the service going forward.
- There was an effective governance structure in place which ensured that risks to the service were captured and discussed. The framework also enabled the dissemination of shared learning and service improvements and a pathway for reporting and escalation to the trust board.
- The critical care service engaged with staff and patients to inform the improvement and development of its delivery.
- Staff told us they were proud to work in critical care and recommended the trust as a place to work or receive care and treatment.

However;

- There were issues with access and flow within critical care which meant patients frequently experienced delays in being discharged. Managers within critical care reviewed the flow on a daily basis in an attempt to alleviate the bed pressures by working with their peers within the wider hospital.

## Vision and strategy for this service

- There was a detailed business plan and strategy for critical care services, which set out the threats, risks and opportunities for developing the service going forward. The new Liverpool Royal Hospital, due to open in late 2017, will include a purpose built critical care facility that will bring together the level 3 and level 2 patients into one location with improved access to theatres and scanning.
- Plans for actually opening the new unit, including moving patients, whilst continuing to provide a critical care service were still being developed and tested.

# Critical care

- In the shorter term, there was a plan to open two more level 3 beds in 2016 in the existing hospital, which would increase the overall number of critical care beds to 37.
- We saw business and workforce planning documentation that looked to model the staffing requirements for the developing critical care service. Business plans included prioritising the challenges and risks to the service, the impact of those risks on the quality of patient care and the mitigating actions being undertaken to address. For example, delayed discharges from critical care leads to cancelled elective surgery and increased on the day cancellations. This in turn has an impact upon readmission rates and patient experience. The surgical division was developing a plan to improve the numbers of delayed discharges but this would only be achieved with close multi-disciplinary working to include commissioners.

## Governance, risk management and quality measurement

- There was an effective governance structure in place which ensured that risks to the service were captured and discussed. The framework also enabled the dissemination of shared learning and service improvements and a pathway for reporting and escalation to the trust board.
- A range of meetings were regularly held, including mortality and morbidity, staff meetings for all grades and critical care delivery group meetings. We asked to see copies of the mortality and morbidity meetings to try and establish how learning was taken and shared. However, the documents we received comprised a list of patients that had died either in critical care or within 30 days of their discharge from the unit. The documents gave no indication of who attended the meetings, the discussions that took place and any learning that was taken and shared.
- Critical care risks were brought together on a local risk register. We saw a copy of the register dated January 2016. The register recorded two medium risks and three low rated risks. The medium rated risks related to the percentage of agency nursing staff being used and the cancellation of elective surgery cases owing to a lack of availability of critical care beds. The low rated risks related to pressure ulcers, the failure of a nitric oxide delivery device and the misplacement of a naso-gastric

tube. For each risk on the register there were details of the issues alongside the existing controls in place to mitigate the risk. It was not clear from the document how often the risks were reviewed and updated.

- There was an acknowledgment and understanding of the access and flow pressures in critical care. Senior staff worked daily in collaboration with peers across the hospital to monitor, anticipate and try to alleviate the flow of patients through the critical care units and the wider hospital.
- The unit was subject to annual peer review benchmarking by the Cheshire and Merseyside Critical Care Network against the present evidence base and agreed standards for critical care provision. The most recent review by the network had been in February 2015. The results of this last review showed high levels of compliance with the standards with only a few recommendations.
- Sickness and absence rates were closely monitored alongside the management of competency and capability.

## Leadership of service

- The critical care unit had designated consultant and nurse matron clinical leads.
- In addition the critical care areas were staffed and led by a team of experienced senior nurses.
- There was clear and strong leadership at unit and divisional level with staff who had the skills, integrity, capacity and capability to lead the service effectively. Senior managers were visible in critical care areas, leading and providing support to the teams.

## Culture within the service

- Staff were open, honest and happy to tell us what it was like to work in critical care. They told us they were proud to work in critical care and recommended the trust as a place to work or receive care and treatment.
- Staff were encouraged to report incidents and raise concerns.
- There was evidence of collaborative working and positive relationships with other departments within the hospital.
- The trust commissioned a review into the culture within its hospitals, which was published in August 2015 by the King's fund. The results were broken down at divisional level and showed that in the surgical division, in which

# Critical care

sits critical care, that the aspects of organisational culture that scored highest were for values, team working, objective sharing and compassion. The aspects that scored less well related to feedback and support,

## Public engagement

- The trust website included details about the critical care service provided at the Royal Liverpool Hospital.
- The trust website also hosted a section on the 'New Royal', which provided information for the public on the development of the new hospital being built. This included a purpose built 40 bedded critical care unit with a plan for all patients to be cared for in single en-suite rooms.
- Whilst the unit did display information about visiting times, we heard from both staff and relatives that visiting was at the discretion of the nurse in charge and exceptions were often made to allow relative's to visit their loved ones.

## Staff engagement

- Senior staff had been involved with the development of the new critical care unit being built. They visited other units to gather information and lessons learned so that they could feed this intelligence into the planning of their new unit. There were on-going negotiations and discussions about the actual design of the facility. For example, the new unit was designed on the basis that all patients would be cared for in single rooms. This clearly has implications in critical care for patient safety, staffing and observation. As a result, senior staff were exploring the options of having sliding entrance doors to patient rooms that could be left open to improve observation.
- Staff were also involved in planning the logistics of the move from the existing three critical care facilities into the new 40 bedded unit.
- Staff in critical care expressed the view that they were well supported and had access to training and

development. This was in contrast to the wider trust staff survey results for 2015, which reported the percentage of staff appraised in the past 12 months was lower than the national average by 2%. The number of staff having high quality appraisals within the past 12 months was also reported as being lower than the national average, with staff rating appraisal quality as 2.93 out of five with the national average being 3.05. These views were also in contrast to the findings of the King's Fund report of 2015 into organisational culture.

## Innovation, improvement and sustainability

- There was a consultant lead for mental capacity and deprivation of liberty safeguards who was working at a local and national level to develop guidance for staff working in critical care regarding the application of deprivation of liberty safeguards for critical care patients. This was innovative work as the applicability of the Mental Capacity Act 2005 in a critical care setting was generally little understood. It was hoped that the guidance being developed, once approved, would be adopted more widely across the critical care networks and would provide some much needed support and clarity for staff and patients in respect of this important legislation.
- When asked about innovation and improvement, the critical care service put forward several changes to practice that have improved the service that they provide to their patients. These included the following; calcium replacement based on ionised calcium levels, development of a diagnostic algorithm for thrombocytopenic patients, the use of focussed echocardiography in haemodynamically unstable patients and the introduction of a multidisciplinary tracheostomy study day which is held bi-monthly and has been accredited by the Royal College of Anaesthetists and won an award from Health Education North West.

# End of life care

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

## Information about the service

The trust provided a consultant led Hospital Specialist Palliative Care (HSPC) team. The HSPC team is a resource which is available to all clinical areas within the hospital providing specialist palliative care, advice and support for adult inpatients that are affected by cancer and other life limiting illnesses.

The HSPC team provides an advisory and supportive service whilst the medical and nursing management of the patient remains the responsibility of the ward teams. The trust has a bereavement team that can provide support to relatives following the death of those close to them. There are also well organised links with charitable and voluntary organisations providing hospice care, counselling and bereavement support.

The trust end of life service worked in partnership with Marie Curie Palliative Care Institute Liverpool (MCPCIL) to further research and develop end of life services and collaborated with the Cheshire and Merseyside end of life network group to share research findings.

Through working with MCPCIL and international collaboration the trust had developed an Academic Palliative Care Unit (APCU), which is a 12 bedded unit specifically for patients approaching the end of life.

We visited the trust as part of our announced inspection on the 15 to 18 March 2016 and our unannounced inspection on the 30 March 2016. During this inspection we visited

APCU and wards where the trust had identified patients as palliative or end of life. In addition we visited the chapel, multi faith room, bereavement office, hospital mortuary and the deceased viewing room.

We observed how care and treatment was provided, and spoke with members of staff across all disciplines including, the chief executive, the senior management team, the lead specialist palliative care nurse, consultants, specialist palliative care nurses, bereavement services, mortuary staff, chaplaincy, nursing staff, medical staff, allied health professionals and portage team.

We spoke with a total of 19 patients and their families to collect their views on the care and treatment they had received whilst in hospital.

We received comments from people who contacted us to tell us about their experience, and we reviewed performance information about the trust.

# End of life care

## Summary of findings

We have rated end of life services as “Outstanding” overall. This is because;

- The palliative care service was embedded across the trust and held in high regard by all the wards we visited. Palliative care was integral to the trust and had a well-developed and substantial palliative care directorate that was well staffed and managed as part of the medicine division.
- The trust had a comprehensive end of life vision and strategy set out for 2013-18. Their vision was to deliver the highest quality healthcare driven by world class research for the health and wellbeing of the population.
- We saw a clear governance structure from ward and department level to the board. Good governance was a high priority and was monitored through a number of groups. The trust is one of only 14% of trusts that took part in the national end of life care audit that have an end of life strategy group.
- The Association for Palliative Medicine of Great Britain and Ireland, and the National Council for Palliative Care guidance states there should be a minimum of one whole time equivalent (WTE) consultant per 250 beds. The trust employed four WTE consultants at the time of the inspection, which was slightly more than recommended.
- There was comprehensive leadership within the palliative care department with clearly defined responsibilities. These included the Chief Executive who was the executive board lead for end of life services. The palliative care directorate was made up of a large senior management team, including a clinical director who was a professor of palliative medicine, palliative care consultants and specialist palliative care nurses.
- We found that there were high levels of staff satisfaction from managers to ward staff working within end of life care. Staff were proud of their service, and spoke highly about their role and responsibilities, expressing that they only had one chance to get it right.
- The trust, with Marie Curie Palliative Care Institute Liverpool (MCPCIL) and international collaboration from Germany and Australia had developed an

Academic Palliative Care Unit (APCU) which opened in January 2016, providing a 12 bedded unit for people who were at the end of life. Through working in partnership with the MCPCIL they had developed and appointed two discharge co-ordinators and implemented a rapid discharge home to die pathway. This had achieved excellent results in ensuring end of life patients were supported to be discharged to their preferred place of care.

- Data from the national end of life audit showed excellent performance against clinical and organisational key performance indicators, scoring above the national average in every indicator. The trust was one of the best performing trusts in the country in the audit.
- Staff were committed to providing high quality compassionate care to people and their families which went above and beyond their medical needs. We were told of numerous examples where the service had gone the extra mile, which included facilitating a wedding on the ward to enable a dying person to get married in the last days of their life. The ward laid out a large buffet for the guests with tables and flowers.
- The trust was committed to ensuring that the needs of the wider population were addressed and took part in network audit projects with the wider community to develop standards and guidelines to support specialist palliative care professionals.
- The HSPC team exceeded their target of seeing 90% of new patients within 24 hours. In January 2016 they saw 98.1% of patients within this timeframe despite an increased number of referrals (161).
- There were many well trained care of the dying volunteers to support patients and their families at the end of life. Offering a period of respite to families or just sitting with patients who had no close family to ensure they had comfort and support in their last hours of life.
- Comfort packs that were hand made by the local community which included toiletries were provided to family members who wished to stay overnight with patients.
- There was a focus on staff development, education and training from the HSPC team and through the MCPCIL which provided nursing and medical staff

# End of life care

with the skills necessary to provide high quality care to end of life patients. The trust was one of only 22% of trusts that took part in the 2015 end of life audit that provided an end of life care session as part of a trust mandatory training programme to promote and to educate staff in end of life care.

- There were robust systems in place to audit the quality of end of life services that were regularly reported and monitored from the ward to board.
- The monitoring of complaints, incidents, audits and quality improvement projects were raised at board level. Complaints that concerned any patient who died within the trust was dealt with by the HSPC team senior managers, even if they had not been referred to HSPC. This ensured timely, sympathetic letters were sent to bereaved families ensuring all their questions were answered.
- Staff were encouraged and knowledgeable in the incident reporting process and where incidents had been reported, they were investigated and learning shared. Incidents relating to end of life care were low.
- End of life services were adequately staffed, with a well trained workforce that received regular appraisals. The hospital specialist palliative care team (HSPC) delivered an annual training programme for registered nurses and there were approximately 86 end of life link nurses employed across the trust, with each ward having at least one end of life link nurse to support, advise and educate staff in relation to end of life care.
- There were good levels of compliance with mandatory training, including safeguarding training across all levels for adults and children.

However,

- Although a new care of the dying document was being used across the trust; it did not provide a wholly personalised person centred individual care record that could encompass all the expressed needs and wishes of a patient and their family within the care of the dying document. However, we saw evidence that patients at the end of life were receiving appropriate support and compassionate care.
- The trust used a Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) form. The trust DNACPR was

a red form that was generally appropriately stored at the front of the patient notes. However, we found that not all DNACPR forms were completed accurately on the wards with regards to completing the rationale for the DNACPR.

# End of life care

## Are end of life care services safe?

Good



We rated end of life services as 'Good' for Safe because;

- Staff were encouraged and knowledgeable in the incident reporting process and where incidents had been reported, they were investigated and learning shared. Incidents relating to end of life care were low.
- Staff were knowledgeable about their role and responsibilities regarding the safeguarding of vulnerable adults, and were aware of the process for reporting safeguarding concerns.
- End of life services were adequately staffed, and well trained. The hospital specialist palliative care team delivered training on an annual training programme for registered nurses that included symptom control, the use of syringe pumps, and end of life care.
- The staff on APCU followed good practice guidance in relation to the control of infection in line with trust policies and procedures.
- There were good levels of compliance with mandatory training, including safeguarding training across all levels for adults and children.
- Medicines on the Academic Palliative Care Unit (APCU) were stored, disposed of, and administered appropriately by a team of well-trained nursing staff.
- There was good evidence of nursing care documentation including dates and signatures. Records on the APCU were stored securely in the main office.
- The Association for Palliative Medicine of Great Britain and Ireland, and the National Council for Palliative Care guidance states there should be a minimum of one whole time equivalent (WTE) consultant per 250 beds. The trust employed four WTE consultants at the time of the inspection, which was slightly more than recommended.

However;

- There was a reception area in the APCU with seating behind the reception desk, which due to its close proximity, risked allowing visitors to breach confidentiality and observe the receptionists visual display unit.

## Incidents

- There were systems and processes in place to report incidents using an electronic Hospital Incident Reporting System (HIRS). Staff were able to explain the process of using the system and describe the types of incidents that would be reported.
- Feedback from incident reporting was optional, however lessons learnt from incidents was cascaded to all staff through handovers and team briefings.
- The trust reported that there had been no never events (a serious event that is a wholly preventable patient safety incident that should occur if the preventative measures have been implemented) reported which related specifically to end of life (EOL) services from January 2015 to January 2016.
- Incidents reported relating to EOL were very low. We reviewed the incidents reported from January 2015 to January 2016 and found that the main reasons for incidents reported were due to the discharge of patients. We saw that one patient returned to hospital due to the ambulance crew not being able to gain access to the patient's home. Following this incident the discharge co-ordinators discussed and identified any access issues with patients and their families, and liaised with the ambulance crews to ensure patients returned home safely and as planned. We observed an example of this occurring during the inspection.
- The senior management team for EOL reviewed incidents weekly to ensure all incidents were reviewed to ensure actions could be taken. Incident feedback was discussed as part of the EOL meeting's agenda. We saw from minutes of meetings that incidents were discussed at all levels.
- Mortuary staff said they would report incidents to highlight issues or concerns. The mortuary manager described times where death certificates were not completed on time due to the doctor's strike. We saw from the incident reports that this had been highlighted to the hospital management.
- Senior staff we spoke with demonstrated an understanding of their individual responsibilities in relation to the duty of candour, and an awareness of the trust policy to be open and honest with patients and families about incidents. The duty of candour is a regulatory duty that relates to openness and

# End of life care

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.

- In the mortuary, deceased patients with similar names were identified by using orange magnets on the fridge doors to highlight patients with similar or same names. This was replicated on the names board and an orange tag used on the fridge body tray to minimise any errors in identifying patients.

## Safety thermometer

- The NHS safety thermometer is a national improvement tool for measuring, monitoring and analysing avoidable harm to patients and harm free care. Performance against four possible harms, falls, pressure ulcers, catheter acquired urinary tract infections (CAUTI's) and blood clot (VTE) was monitored on a monthly basis.
- End of life services had recently opened an Academic Palliative Care Unit (APCU) on the 18 January 2016. The unit was opened to provide 12 beds for patients who were at the end of life. Since opening 100% of patients had received a venous thromboembolism (VTE) assessment, and there had been no CAUTI's.
- The number of falls since the APCU opened was very low, with a total of four falls being reported. The unit had put up signage in bathrooms to alert patients to the risk of falling. A passport had been developed for patients who were at risk of falls which provided the patient and staff with information relating to the patients' safety. We observed a morning handover and found that patient risks were discussed.

## Cleanliness, infection control and hygiene

- The staff on APCU followed good practice guidance in relation to the control of infection in line with trust policies and procedures. There was a sufficient number of hand wash sinks and hand gels. Hand towels and soap dispensers were adequately stocked. We observed staff following hand hygiene, bare below the elbow, and using personal protective equipment, where appropriate. The unit scored 85% in the January/February 2016 hand hygiene local audit against a trust target of 100%. Managers informed us that extra training had been provided in hand hygiene to improve future performance. We observed good practice in hand hygiene on the wards we visited.

- On APCU there had been no infections reported relating to Methicillin-Resistant Staphylococcus Aureus (MRSA) and Methicillin-Susceptible Staphylococcus Aureus (MSSA).
- Two hourly environmental checks were completed on APCU and records were completed to ensure the environment remained clean for patients, families and staff. The unit appeared visibly clean; curtains were disposable and had recently been changed in February 2016. All areas of the department were well organised and tidy. This was audited weekly by managers and by infection control monthly and we found records to be up to date and 100% complaint. All staff on APCU had attended health and safety and infection control training in December 2015.
- Side rooms were available for patients with infections. The APCU had four side rooms for patients that required barrier nursing. We observed that patients with infections were cared for and treated in side rooms if it was required.
- The mortuary completed a weekly cleaning schedule, which included, for example, the cleaning of hydraulic trolleys, steel areas, fridges, and floors. We reviewed the cleaning schedule from 4 January 2016 to 13 March 2016 and although mostly complete, the cleaning schedule contained two omissions in signing to report all areas had been cleaned. The mortuary appeared visibly clean and free from hazards.
- For those deceased patients who had an infection, they were identified by using a hazard tape on the body bag, the zips were sealed and written details relating to the infection were placed in a pocket on the body bag. Deceased bodies with infection were stored separately in the mortuary fridges.
- To minimise the risk of infection due to a vascular access device, (inserted into veins via peripheral or central vessels for diagnostic or therapeutic reasons) there was an intravenous access team who were available to support with specified procedures necessary for the safe insertion and maintenance with vascular access devices. We found from the records we reviewed that cannulation was provided by trained staff and clear labelling was placed in patient records.

## Environment and equipment

- In order to maintain the security of patients on APCU, visitors were required to use the intercom outside the unit to identify themselves on arrival before they were

# End of life care

able to gain access. Upon entering the unit there was a large reception area with seating. However, the seating was behind the receptionist and due to close proximity enabled visitors to observe the receptionist's visual display unit; therefore information displayed could be seen by visitors. This was subsequently a potential confidentiality risk.

- The APCU was a newly designed area that was generally suitable for provision of safe care and treatment. However, in the assisted bathroom there was a potential ligature point as the long orange emergency pull cord could be isolated from the call bell by using a hand rail and could be used as a ligature. We raised this with managers at the time of inspection.
- The unit had four side rooms and two, four bedded bays. Patients were offered side rooms if they wished and one was available. Staff informed us that not all patients wanted to be cared for in side rooms and preferred the company of others.
- All patients who required pressure redistribution equipment were placed on the appropriate equipment with weekly audits carried out to ensure the safety of patients. A tissue viability nurse was also available to provide advice and guidance as necessary.
- In response to a Medicines Healthcare Products Regulatory Agency (MHRA) safety alert regarding incidents involving syringe pump drivers, the trust had a standardised syringe driver to avoid potential errors. We observed that syringe drivers had a rolling programme of maintenance and all were within the service framework. A stock of syringe drivers were kept on APCU, the Hospital Specialist Palliative Care Team (HSPC) and one syringe driver was kept available to the night duty manager.
- On APCU, equipment was stored in the appropriate place in locked rooms and equipment had received Portable Appliance Testing (PAT). We found a vacuum cleaner and a scrubbing machine that had not been tested and these were immediately removed for testing once we identified the issue with staff.
- We reviewed service records for the mortuary for equipment such as the cold rooms and mortuary trolleys and were told these were serviced within the manufacturer's recommendations.

- The mortuary was secured to prevent inadvertent or inappropriate admission to the area. Fridges were lockable if required to reduce the risk of unauthorised access, and we found that fridge temperatures were recorded daily.
- The bereavement office had two rooms for bereaved families to sit prior to viewing the deceased. The rooms had large glass windows so that they could view the deceased from there if they wished. The rooms were well furnished with large fish tanks and offered disabled access.
- The porters used a covered body trolley to transport deceased patients from the ward to the mortuary. The trolley was cleaned between use, and had a weekly steam clean. We reviewed records between January and February 2016 and found them to be up to date.
- Resuscitation equipment was available on the APCU. Records indicated that daily checks had been completed since the opening of the unit in January 2016.

## Medicines

- The trust used electronic medicine administration records to record medication prescribed and given to patients. We reviewed seven prescription charts and found that all end of life medications for regular administration were prescribed and administered accordingly.
- APCU had appropriate storage facilities for medicines, and had safe systems for the handling and disposal of medicines. All ward based staff reported a good service from the pharmacy team.
- There were suitable arrangements in place to store and administer controlled drugs. Stock balances of controlled drugs were checked by two nurses daily. We reviewed records on APCU from January 2016 to March 2016 and drug balances were accurately recorded.
- On APCU there was a controlled drug desaturation kit for discarded drugs once they were not in use following the death of a patient.
- Medicines requiring cool storage at temperatures below eight degrees centigrade were stored in fridges. Daily temperatures checklists were consistently completed on ward APCU from January 2016 to March 2016.
- Anticipatory end of life medication was prescribed appropriately and pharmacy staff informed us that they

# End of life care

could respond to requests for end of life medication for patients going home within an hour if needed. The end of life team and ward staff confirmed that pharmacy provided a quick turn round of medication, if required.

- All nursing staff on the APCU had been trained in the use of the syringe drivers. The use of syringe drivers was supported by the Hospital Specialist Palliative Care team (HSPC) and was available to support staff daily. Staff reported no issues in receiving syringe drivers as needed.
- In 2011, the national Patient Safety Agency recommended that all Graseby syringe drivers should be removed by the end of 2015. Subsequent syringe drivers were available to deliver subcutaneous medication. Syringe drivers were kept on the APCU for use on the unit, and the HSPC had stocks for the rest of the hospital. The duty night manager had access to a syringe driver if it was required outside of normal working hours.
- The HSPC delivered syringe drivers to wards, when required and ensured that it was correctly set up and retrained staff in its use as necessary. We observed a specialist palliative care nurse provide advice and guidance to nursing staff on the use of a syringe driver.
- The trust was undergoing the recruitment process to appoint a consultant pharmacist in end of life to further enhance the quality of end of life services.
- Doctors reported that they were supported by the HSPC, with reviews and advice on prescribing during the working day and there was an advice line for use out of hours. We observed that patient records contained the necessary out of hours advice telephone numbers if needed.
- We spoke to pharmacy staff with regards to how well drug stocks were being controlled, and were informed that morphine was the first line of prescribing, so the current national shortage of diamorphine was not a cause for concern. However, staff we spoke with were not aware of any organisational plan for the national shortage of cyclizine.
- The HSPC nurses were not trained in being non-medical prescribers to grant supplementary and extended prescription rights to assist the medical personnel. Their role was to provide advice and training and to support clinician and nursing staff where needed. The HSPC nurses told us that it would detract from educating the medical staff and deskill them if they were to be prescribers.

## Records

- The trust used paper based records to record care and treatment for patients. Information relating to tests and investigations were stored on an electronic system.
- From the 36 care records we reviewed there was good evidence of nursing care documentation including dates and signatures of reviewing professionals. Records on the APCU were stored securely in the main office.
- Work had been undertaken by the trust following the review of the Liverpool Care Pathway in 2013 with its recommendations for replacement with individual care plans by July 2014. The trust had implemented a new care for the dying patient document and ward staff were supported by the HSPC team to accurately complete the document. HSPC nurses reviewed these documents daily to ensure compliance with completion and provided on the spot training to staff to ensure they were accurate. Staff we spoke with confirmed that the HSPC nurses were available as and when required to provide support and guidance.
- We observed from the patient records that the HSPC nurses placed stickers in the patient notes to inform staff of their contact details and telephone numbers for advice and guidance out of hours. We found that wards were using the new care of the dying document, and there was evidence that the HSPC team reviewed patients daily.
- The trust used a Do Not Attempt Cardio Pulmonary Resuscitation form (DNACPR). The purpose of a DNACPR decision is to provide immediate guidance to those present (mostly healthcare professionals) on the best action to take (or not take) should the person suffer cardiac arrest or die suddenly. The trust DNACPR was a red form that was stored at the front of the patient notes and captured data with regards to the rationale for not attempting resuscitation. We reviewed DNACPR forms of 36 patients and found that they were mostly stored correctly in the front of patient notes. However, we found in two patient records that they had more than one DNACPR in the front of the file. Expired or cancelled DNACPR's should have been stored at the back of the patient records as it stated on the DNACPR form.
- Effective recording systems in the mortuary were in place to ensure that deceased bodies were correctly admitted and located in the department and the correct release book signed by the undertakers and mortuary staff when removing deceased patients from the

# End of life care

mortuary. We observed undertakers receiving a person from the mortuary, and saw that patient identities were double checked and all paperwork signed appropriately.

- A policy was in place to ensure that potential tissue donors were identified and referred to the national referral centre. An integrated care pathway document was completed upon a patient's death that included a form to complete for tissue donation. From the records we reviewed we saw evidence that this form was faxed to the relevant authority. The mortuary manager informed us that they carried out corneal retrieval and operated a 24 hour service.
- The trust was working with community partners to develop an electronic records system to enable sharing of records to further enhance the care of patients who were admitted and discharged to the hospital. This sharing of records would help ensure continuity of patient care once discharged from hospital and provide the HSPC team with up to date information when a patient was admitted.

## Safeguarding

- Trust-wide policies and procedures were in place, which were accessible to staff electronically for safeguarding vulnerable adults and children. Staff were aware of the process for referring a safeguarding concern and advice and support was accessible 24 hours a day, seven days per week. The APCU had a folder on the unit to support staff with safeguarding concerns.
- Safeguarding training formed part of the trust's mandatory training programme. Data provided by the trust showed that there was good compliance with safeguarding training at all levels across end of life services. Compliance with training for safeguarding adults' and children level 1 was 91.5% which was above the trust's target of 90%. In addition, safeguarding adults and children level 2 (82.3%) and level 3 (90%) were all above the trust's target of 80%.
- Staff were knowledgeable about their role and responsibilities regarding the safeguarding of vulnerable adults, and were aware of the process for reporting safeguarding concerns. Staff told us they felt confident to raise concerns and make safeguarding referrals, and felt well supported to do this.

## Mandatory training

- Staff received mandatory training on a rolling programme in two blocks (clinical core skills and core

skills). Clinical core skills included areas such as infection control and prevention for care staff, falls prevention, and, diet and nutrition. Core skills included areas such as safeguarding, health and safety, and fire safety.

- Training data for end of life services showed that compliance with core skills training was 90.9% at the time of the inspection, which was slightly below the trust's target of 95%. However, 100% of staff were up to date with clinical core skills, which was above the trust's target. End of life training was delivered as part of the mandatory clinical core skills training for all staff across the trust.
- Basic life support (BLS) training was also provided by the trust as part of mandatory training. Data provided by the trust showed that 97% of staff across end of life services had completed the training at the time of the inspection, which was above the trust's target of 95%.
- The HSPC team delivered training on an annual training programme for registered nurses that included symptom control, the use of syringe pumps, and end of life care.
- The palliative care directorate had a system to identify the mandatory training needs for all the palliative care staff. The system used a RAG rating system (red – amber – green). Green to show those staff that were up to date with their training, through to red to show mandatory training had expired. Managers monitored mandatory training requirements to ensure training was up to date.
- The portage department had a planner on the office wall which highlighted when training was required for the porters. We saw evidence that the porters had up to date training in relation to the transportation of deceased patients.

## Assessing and responding to patient risk

- The trust used the National Early Warning Score (NEWS) to recognise that a patient's condition was deteriorating. The NEWS score is a simple scoring system in which a score is allocated. It uses six physiological parameters to form the basis of the scoring system, these include, respiratory rate, oxygen saturation, temperature, systolic blood pressure, pulse rate and level of consciousness. Patient documentation was transferred to the care of the dying guidance document when there was recognition the patient was expected to die within hours or days.

# End of life care

- For patients where the progression of their illness was clear, the amount of intervention was reduced to a minimum following a multi-disciplinary discussion. Care was based on ensuring the person remained as comfortable as possible, at all times. Proactive, anticipatory care plans were put into place to ensure that all staff were aware of the best ways to manage symptoms relating to their illness.
- Ward staff had the contact details of the HSPC and confirmed the team responded promptly when needed.
- On APCU risk assessments were completed to ensure patients at risk of falls were minimised. A passport had been introduced that detailed risks to the patient.
- We observed a morning handover with the medical team, and found patient risks were discussed to ensure staff were aware of any risk or deterioration in a patient's condition. However, there was no formal handover sheet for staff and instead they had written details regarding patients on pieces of paper. This meant important information may not be handed over.

## Nursing staffing

- Staffing for end of life care was the responsibility of all staff and not restricted to the HSPC team. The HSPC team included a clinical service lead, six palliative care nurse specialists, two end of life discharge co-ordinators to ensure that patients at the end of life received sufficient care and treatment. The palliative care specialist nurses worked on a rota basis seven days per week, providing two specialist nurses every weekend to ensure patients and staff were well supported.
- The APCU had one vacancy for a member of the nursing staff and cared for patients on a ratio of 1:6 patients in the day and 1:4 patients at night. The unit was working towards providing three nurses both day and night to consistently provide a staffing ratio of 1:4 patients.
- The trust had approximately 86 end of life link nurses providing at least one end of life link nurse per ward whose role included raising awareness of end of life processes, and educating and supporting the nursing team.

## Medical staffing

- Specialist palliative care, advice and support was available 24 hours per day seven days per week. Out of hours was provided by an on call system. We reviewed that contact details for out of hours was provided in the patients records so medical and nursing staff knew who to contact if required.

- The trust had four specialist consultants in palliative medicine who worked 9am-5pm, Monday to Friday and Sunday morning, providing clinical sessions with patients across the wards and provide advice and guidance to medical and nursing staff. On APCU a consultant, a speciality doctor and a junior doctor reviewed patients daily.
- The Association for Palliative Medicine of Great Britain and Ireland, and the National Council for Palliative Care guidance states there should be a minimum of one whole time equivalent (WTE) consultant per 250 beds. This trust has 896 beds which equates to in excess of three WTE consultants. The trust employed four WTE consultants at the time of the inspection, which was slightly more than recommended, which is positive.

## Major incident awareness and training

- There was a trust major incident plan which listed the key risks that could affect the provision of care and treatment.
- Staff we spoke with could describe the actions they would take in the event of a fire and received training in fire and health and safety.
- In the event of a major incident, the mortuary had a major incident plan explaining the process to be followed following major trauma incidents, chemical incidents, radiation incidents and biological incidents. The mortuary manager was able to explain the process to be followed in the event of a major incident.

## Are end of life care services effective?

Good



We rated end of life services as 'Good' for Effective because;

- The Hospital Specialist Palliative Care Team (HSPCT) provided a fully operational face to face service seven days a week.
- We saw that patients were triaged twice daily to ensure patients were seen in order of urgency and ensured those patients with complex or difficult symptom management were seen by a palliative care consultant.
- The team saw all referrals and did not screen patients without seeing them. Following referral the patient's needs were assessed and advice would be discussed with the clinical staff responsible for the patient's care.

# End of life care

- The trust contributed to the 2013 National Care of the Dying Audit for Hospitals (NCDHA) and the 2015 end of life care audit, to compare end of life provision with that of other healthcare providers. Data from the 2013 and 2015 audit showed the trust achieved excellent performance in terms of the clinical and organisational key performance indicators, and had developed action plans in response to the NCDHA, to further improve performance.
- The HSPCT met their 24 hour response time target, to meet with patients who were referred due to being end of life. They also had a high profile on the wards and were well embedded in all specialities across the trust as a member of the multidisciplinary team.
- The HSPC team aimed to see at least 90% of patients within 24 hours. In every month from August 2015 to January 2016 the HSPC team recorded that they exceeded the percentage of people seen. In January 2016 they saw 98.1% of patients within 24 hours despite seeing an increased number of referrals (161).
- The HSPC team had close links with community partners, general practitioners, district nursing teams and with social care services to ensure that each were aware that a patient being discharged had continuity of care.
- There were approximately 86 end of life link workers within the trust, and the HSPC team provided them with regular training.
- The mortuary was available 24 hours per day, seven days per week so that if families requested to view a deceased patient it could be arranged at a time to suit the family.

However;

- The trust had responded to the national recommendations of the Liverpool care pathway (LCP) review which led to its withdrawal, and replaced it with a care of the dying patient guidance document. The LCP was withdrawn and priorities of care were introduced that included patients should have individual plans of care. The new document being used was nearly identical to the original Liverpool care pathway document including in structure, format and style. The trust reported that the new document had been reviewed by the ethics governance team, and had differences to the LCP. For example, the document explicitly stated nutrition and hydration should be given as tolerated. However, although good outcomes for

patient's were evident, the new document retained the tick box achieved and variance model of the LCP and made it difficult to provide an individualised, tailored approach to end of life care planning.

- We reviewed DNACPR documentation across medical wards, and found that they were generally reviewed and endorsed by a senior clinician, legibly signed and filed in the front of the patient notes. However, we found that in eight records there was no clear medical rationale documented as to not attempting resuscitation.
- The National Institute for Health and Care Excellence (NICE) recommends that a tailored individual approach to prescribing anticipatory medicines should be used in treating pain in end of life patients. However, the trust used a treatment algorithm which prescribed all of the PRN (medication given when necessary) anticipatory medication for patients in the last few days of life to ensure that there is no delay in responding to a symptom if it occurred, such as pain, agitation, respiratory tract secretion, nausea, vomiting and dyspnoea. Although this approach conflicted with the NICE 2015 guidance, we saw that patients were provided with the appropriate medicines. Staff confirmed that anticipatory medicines were only given when there was a clear rationale for starting the dose; it was targeted at specific symptoms, and they were regularly reviewed.

## Evidence-based care and treatment

- The trust had participated in the National Care of the Dying Audit of Hospitals (NCDHA).

The findings from the 2013/14 audit showed the trust achieved all seven of the organisational key performance indicators, and achieved excellent performance in terms of the clinical key performance indicators, scoring 84% and above in each indicator, which was above the national average in every indicator.

- The trust had developed an action plan in response to the NCDHA. Key actions were addressed in the plan which we found to have been implemented. For example one action point was 'people approaching the end of life and their families and carers are communicated with and offered information in an accessible way in response to their needs and preferences'. There was evidence that this had been addressed as patients and their families told us that sensitive communication had taken place, and there

# End of life care

were numerous leaflets which explained end of life care. The HSPC team also provided training to all staff to support them with ensuring the needs of end of life patients were met.

- The findings for the 2015 End of Life Care Audit: Dying in Hospital, which replaced the NCDAH were published at the end of March 2016. The audit showed that the trust again achieved excellent results in all of the clinical and organisational key indicators. For example, where a death was expected this was documented in 100% of cases (excluding unexpected deaths) compared with a national average of 93%. The trust also scored 100% in patients being regularly reviewed, and discussions taken place with family, compared to a national average of 91% and 95%.
- The HSPC nurses used current evidence based research to underpin their clinical practice and undertook within their role some responsibility for training and development of staff.
- The trust had developed a briefing paper to offer assurance to the Executive Team at RLBUHT that they were delivering best care for the dying patient. The briefing paper was developed working with colleagues at the academic institute to ensure clinical excellence was underpinned by international best evidence and research. The briefing paper set out an action tracker to monitor performance against actions needed.
- The trust had responded to the national recommendations of the Liverpool Care Pathway (LCP) review which led to its withdrawal, and replaced it with a care of the dying patient guidance document. The document included a tear off information sheet for the families following discussion with a clinician. The information sheet explained that the plan of care was based on the principles of the Liverpool care pathway and quoted a positive aspect of the LCP. The review recommended that the use of the LCP should be phased out and replaced with a personalised end of life care plan for each individual.
- We reviewed the care of the dying patient guidance document and found that it was almost identical to the original LCP document including structure, format and style. It contained the same many tick boxes to report whether a goal relating to a particular need had been achieved or there was a variance (not achieved) with separate multi-disciplinary team (MDT) notes to report information. The executive lead also told us that the document was not radically different to the LCP. Senior managers told us that the care of the dying document had been reviewed by the ethics governance team, and had differences to the LCP. For example, the new document explicitly stated nutrition and hydration should be given as tolerated.
- The National Institute for the Health and Care Excellence (NICE), care of dying adults in the last days of life published in December 2015, provided guidance to healthcare professionals and other care providers involved in the care of a person who is nearing the end of life. The guidance states that information should be gathered, for example on the person's goals and wishes, and the views of those important to the person with regards to future care. The care of the dying document used a tick box to report if the patient knew they were dying and whether the family knew the patient was dying, and there was no free text boxes to capture important personal details, for example, their wishes or goals, favourite foods or flavours or any expressed views they had. Tailored decision making of patients would be recorded in other nursing documentation or the MDT notes and not in the relevant sections of the document. Recording notes in the MDT section could risk that on each review certain needs and preferences may not be discussed as there was no format or prompts to follow to aid clinicians in discussing patient needs, wishes and preferences.
- We reviewed five care of the dying documents of patients who had recently passed away and found that all demographic information was completed, and generally the tick boxes had all been completed. However, the free text MDT notes areas were less predominately completed with detailed ongoing individualised needs, which suggested that the format did not lend itself to an individualised tailored approach to care planning.
- Despite this, there was good evidence in patient records that the trust was responsive to the needs of patients. For example, patients were being supported with their nutrition and hydration, there was evidence that communication with patients and families was taking place, there was good access to spiritual care, patients were regularly checked for pain relief, patient skin integrity was checked regularly, and were on the correct pressure relieving equipment, and highly trained, experienced palliative care staff monitored patients daily to ensure the best outcomes for the dying patient.

# End of life care

- The trust had taken action towards achieving the five priorities for care of the dying person set out by the leadership alliance for the care of dying people. For example, it was clear from the ward referrals to HSPC that there was an understanding and recognition from nursing and medical staff of patients who may die in a few hours or days on the wards and the importance of involvement from the HSPC. We also found from our conversations with patients, families and staff that sensitive communication, involvement and support had taken place.
- Action had been taken towards ensuring the implementation for the ambitions for palliative and end of life care, which set out the ambitions for local action to provide better care for patients at the end of life. For example, good end of life care should include bereavement. We found that support was available 24 hours per day seven days per week to support patients and families. The trust also had a well-developed care of the dying volunteer service to help and support patients at the end of life and their families. The volunteer service at the trust had won the Deborah Hutton prize in 2015 which is an award that celebrates individuals or groups who provide practical care and support to people affected by cancer, beyond the expectations of their role.
- The HSPC team saw 1,562 patients in 2014/15. This was approximately 95% of patients who died within the trust. Of these patients 38% (n=591) were non-cancer patients which demonstrated a balanced split between cancer and non-cancer patients being referred and seen by the team.
- Referrals to the HSPC team from the hospital were received either electronically, by telephone, bleep, or via on the spot referrals if the HSPC team were on the ward. Nursing and medical staff on the wards we visited told us that the team responded quickly to referrals and aimed to see them within 24 hours. We saw that patients were triaged twice daily to ensure patients were seen in order of urgency and ensured those patients with complex or difficult symptom management were seen by a palliative care consultant. The team saw all referrals and did not screen patients without seeing them. Following referral the patient's needs were assessed and advice would be discussed with the clinical staff responsible for the patient's care. The HSPC

team had a high profile on the wards and were well embedded in all specialities. Staff told us that the HSPC team regularly attended wards to discuss if any patients were likely to be end of life.

- At the time of inspection there was no automatic system that alerted the HSPC team of newly admitted patients. However, the HSPC reported they had good links with the community teams and the local hospice and received telephone calls to alert them that an end of life patient was being admitted. We observed a palliative care discharge co-ordinator directly communicating with the community team and saw that dialogue between the hospital and the community was professional and patients' ongoing care was discussed fully.

## Pain relief

- The National Care of the Dying Audit of Hospitals (NCDAH) 2013/14 showed the clinical protocols for the prescription of PRN (as required) medicines prescribed for the five key symptoms which may develop at the end of life were achieved at a better rate (84%) than the national average (51%) for England. In the 2015 end of life care audit, the trust performed better than the national average in all medicines prescribed for the five key symptoms which may develop at the end of life.
- The care of the dying document used by the trust contained a section to review pain six times daily and contained a symptom control guidance document with clear guidance to follow if a patient was experiencing pain.
- The National Institute for Health and Care Excellence (NICE) 2015 recommended that a tailored individual approach to prescribing anticipatory medicines should be used in treating pain in end of life patients. However, the trust used a treatment algorithm which prescribed all of the PRN anticipatory medication for patients in the last few days of life. We were informed by senior management that this was done to ensure that there was no delay in responding to a symptom if it occurred, such as pain, agitation, respiratory tract secretion, nausea, vomiting and dyspnoea. Medical staff we spoke with were aware of this prescribing method conflicting with the NICE 2015 recommendations for tailored prescribing of anticipatory medicines by clinicians. We were informed by nursing staff that patients were prescribed all anticipatory medicines but only received them when it was deemed appropriate. We saw from

# End of life care

the electronic prescription records that patients were provided with the appropriate medicines and staff confirmed that anticipatory medicines were only given when there was a clear rationale for starting the dose; it was targeted at specific symptoms and they were regularly reviewed.

- Patients we spoke with on the wards told us that they had been given pain relief as required and no patients reported to be in great pain.
- The HSPC team provided advice and guidance to medical and nursing staff in regards to pain management.
- The APCU were trialling the use of a pain and symptom assessment document that tracked patient's pain scores, the action route taken and the outcome.

## Nutrition and hydration

- The NCDAH 2013/14 showed that the clinical protocols for the review of the patient's nutritional requirements and review of the patient's hydration requirements were achieved at a better rate (88% and 96%) than the England average (41% and 50%). In the 2015 end of life care audit the trust performed better than the national average for the assessment of patient's ability to eat (75%) and drink (75%). The national average was 39% and 67%.
- All wards had access to specialist advice from dieticians if required.
- On APCU regular mouth care was maintained every two hours to ensure that patients were comfortable and families told us they were encouraged to support with this if they wished.

## Patient outcomes

- Monthly performance for the HSPC team was monitored and recorded for clinical effectiveness and quality using the Palliative Care Assessment tool (PACA). We reviewed performance data supplied from the trust and it was clear that from August 2015 to January 2016 there had been a steady increase in the number of referrals each month. In August there had been 95 referrals and in January 2016 this has increased to 161 referrals.
- The HSPC team aimed to see at least 90% of patients within 24 hours. In every month from August 2015 to January 2016 the HSPC team recorded that they exceeded the percentage of people seen. In January 2016 they saw 98.1% of patients within 24 hours despite seeing an increased number of referrals (161).

- The number of patients who were discharged from their service back to the ward was low in comparison to the amount of referrals. In January 2016, 21 patients (13%) were discharged from their service. This showed the wards had a good knowledge and understanding of the HSPC role and function and could generally appropriately identify the patients who were at the end of life.
- The HSPC team aimed to ensure 98% of patients referred had a plan of care or advice from the HSPC team. From August 2015 to January 2016, all patients (100%) had a plan of care or advice from the HSPCT.
- The team completed a snap shot audit from the care of the dying document to ensure all patients who were at the end of their life received an assessment and symptom control for the five symptoms which could develop in the last hours or days of life. The audit looked at pain, agitation, nausea, vomiting and respiratory tract secretions. In December 2015, the data showed, in 16 documents reviewed, 100% of patients at the end of their life had received an assessment and symptom control for all five symptoms that could occur. The audit was completed again in January 2016 and found, from 22 documents reviewed, 95.7% of patients at the end of life had evidence of an assessment and symptom control.
- The service contributed data to the National Minimum Data Set (MDS) for palliative care in 2014/15. From the data return for the reporting period it showed that 1,298 patients had been referred to palliative care, which was above the national median of 1,079 patients. The percentage of patients seen with a non-cancer diagnosis was 41.2% compared to a national median of 27.3%, and the average length of care was 5.5 days compared to the national median of 8 days.
- The trust took part in a regional Care Of the Dying Audit (CODE) to seek the perspectives of the bereaved relatives and to establish the quality of care and support provided to people in their last days of life and their families. The key findings for the trust showed that 82.9% of bereaved relatives perceived that they had confidence and trust in the medical and nursing staff. 73.5% of bereaved relatives felt that nursing and medical staff did enough to control pain compared to 64.1% in other hospitals. Areas for improvement from the audit included, only 25.7% of bereaved relatives perceived that the patient, and their own religious and spiritual needs were not met, and 36.9% of potential

# End of life care

participants could not be sent a CODE questionnaire as the hospital did not contain the next of kin details. We reviewed that an action plan had been developed in February 2016 to address these issues.

## Competent staff

- The hospital specialist palliative care team were well qualified to degree level and attended relevant courses to extend and update their skills and knowledge.
- A full preceptorship programme was offered to all newly registered nurses.
- The specialist palliative care nurses had completed their advanced communication training.
- The HSPC team and the staff on APCU received an annual appraisal which gave them the opportunity to reflect on their performance and set objectives. All the specialist palliative care nurses were up to date with their annual appraisals and training.
- The HSPC team delivered training to the nursing staff and held foundation training in diagnosing the dying, advance care planning, communication skills, symptom management and syringe driver usage and provided input into mandatory training for all staff.
- There were approximately 86 end of life link workers within the trust, and the HSPC team provided them with regular training. They provided a cascade model of education on the wards along with four study days per year of which staff were expected to attend at least 50%. This included training in symptom management, oral care, and communication. The HSPC staff reported that there could be some issues with staff not being released to attend due to ward pressures.
- Team meetings were held monthly and provided updates on audits and an element of learning and teaching.
- Most nursing staff on the APCU had been end of life link nurses and the health care workers had completed the care certificate and had received training with regards to end of life provided by the HSPC team.
- An education programme was offered through the Marie Curie Palliative Care Institute Liverpool (MCPCIL), with training based upon common core principles and competencies for social care and health workers working with adults at the end of life, and focused on what healthcare workers needed to be able to do within

their role to do their job effectively and competently. In partnership with MCPCIL the HSPC team held seminars inviting guest speakers to share knowledge and experience.

- There were opportunities for the HSPC nurses to develop, and one specialist nurse had been seconded to the MCPCIL to carry out a research project.
- The HSPC nurses were not non-medical prescribers. Their role was to provide advice and training and felt that by being non-medical prescribers could deskill the medical teams on the wards.
- The HSPC nurses took the opportunity on wards they visited to deliver training to staff in small three to five minute sessions to staff, where for example they had not completed documentation appropriately or needed support and advice.
- The end of life volunteer service reported that they had very good training from the HSPC team and had monthly group supervision provided by the team.

## Multidisciplinary working

- Multi-disciplinary team (MDT) working was integral to the delivery of effective end of life services at the trust. The records we reviewed showed that patients regularly had input into their care from other health professionals, including physiotherapy, occupational therapy, speech and language therapy, and dietician services.
- There was a weekly HSPC MDT meeting to discuss treatment and plans for new and current patients. This was also attended by the chaplaincy team who then visited patients and offered them non-clinical spiritual support.
- The HSPC team had close links with community partners, general practitioners, district nursing teams and social care services to ensure each were aware that a patient being discharged had continuity of care. We observed an end of life patient being discharged from APCU and found that the HSPC staff contacted all community partners to inform them of the discharge arrangements and ensured all onward care was in place before proceeding.
- The HSPC staff attended other speciality site specific multi-disciplinary meetings including respiratory, gastroenterology, and haematology meetings.

# End of life care

- At a strategic level, the end of life steering group had representatives from many disciplines and included the Chief Executive, Chief Nurse, Medical Director, Chaplaincy, MCPCIL, Family and Friends Co-ordinator and Bereavement Officer.

## Seven-day services

- The HSPC provided a fully operational face to face service seven days a week, 365 days per year, from 9am-5pm. However, direct consultant doctor review was available Monday to Friday in normal business hours and Sunday mornings. Evenings and weekends were being covered by medical junior doctors.
- There were two HSPC nurses at weekends to ensure there was adequate end of life care within the hospital. Between the hours of 5pm - 9am specialist palliative care advice was available via an out of hours telephone helpline through the Marie Curie Hospice Liverpool. This helpline allowed healthcare professionals on the wards to speak directly with the registrar or, if necessary, the consultant on call to obtain the advice they needed overnight. We found telephone numbers were in patient records to inform staff of the protocols for out of hours.
- The trust informed us that they had an aspiration to provide a full seven day consultant service to further enhance the care and treatment for patients who were end of life as, at the time of the inspection, there was no formal consultant reviews of patients over the full weekend unless it was required.
- Staff reported that there were no issues with accessing diagnostic services, which were available 24 hours per day, seven days per week.
- The mortuary was available 24 hours per day, seven days per week so that if families requested to view a deceased patient it could be arranged at a time to suit the family.

## Access to information

- All staff had access to the information they needed to deliver effective care and treatment to patients in a timely manner including test results and records.
- There were sufficient computers available on each ward we visited which gave staff access to patient and trust information. Staff informed us that they had no issues in accessing the electronic system.
- On the majority of wards there were paper based files containing relevant information to protocols and procedures, team briefings and reading material.

- We observed the use of the electronic white board in the APCU office. The board provided staff with information as to the bed allocated to each patient and to whether patients had particular assessments completed, for example VTE. The board was also used to highlight vulnerable patients. We observed a handover and found this to be an effective system to use to discuss each patient.
- The HSPC staff used stickers in patient records to highlight they had reviewed end of life patients. The stickers included telephone numbers to support staff if they required advice and support. We reviewed records and found these to be used on each occasion a patient was reviewed by the HSPC team.
- All policy and procedures relating to end of life were easily accessible to the staff using the trust intranet. In addition wards held the telephone numbers of the HSPC so advice and guidance could be sought if required.

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

- Ward staff knew about the key principles of the Mental Capacity Act 2005 (MCA) and how these applied to patient care. Staff understood the application of considering capacity, consent and deprivation of liberty and ensuring adjustments such as access to specialist support, and flexible visiting. However, we looked at 36 patient records across the medical wards and bereavement office and found that in eight records, documentation was not always clearly completed with regards to mental capacity where required. Despite this, when best interest decisions were recorded, we found them to be appropriately documented.
- Staff on a ward we visited demonstrated that they had a good knowledge of capacity protocols, for example, they were able to explain that if a patient lacked the capacity to make decisions for themselves, they would consult with family or in the absence of any family would consult with an independent advocate.
- Staff had knowledge and understanding of procedures relating to Deprivation of Liberty Safeguards (DoLS). DoLS are part of the Mental Capacity Act 2005. They aim to make sure that people in hospital are looked after in a way that does not inappropriately restrict their freedom and are only done when it is in the best interests of the person, and there is no other way to look

# End of life care

after them. This includes people who may lack capacity. We saw from completed DoLS paperwork that they had been completed accurately and a copy kept in the patient records.

- We reviewed DNACPR documentation for 36 patients including those who had recently died and found that they were generally reviewed and endorsed by a senior clinician, signed legibly, and filed in the front of the patient notes. However, we found discrepancies in six records where not all DNACPR forms had signatures for the person who led the discussion with the patient and relatives, or whether the discussion had been held. The form clearly stated that if any of the boxes were unticked then a reason should be stated.
- We found that in eight records the document did not give a clear medical rationale for not attempting resuscitation. For example, in one record on the GP Assessment Unit (GPAU) the reason for DNACPR was due to 'dementia' and there was no evidence of a clear discussion before this was put in place. Other examples showed the rationale as 'would be futile and unkind' and 'family aware no treatment available'.
- We noted that in one patient's records there were two slightly different versions of the DNACPR in use. One form required clinicians to complete the date in which the discussion took place with the family, and who the discussion was led by. The other form did not contain this information.
- The DNACPR used in the trust only covered patients whilst in hospital; therefore once the patient was discharged it required a GP to complete another DNACPR once they were back in the community. The trust was in the process of moving towards a new unified DNACPR, which would mean this would not need to be readdressed once discharged. This new documentation was being trialled on the APCU before a rolling programme commenced.
- An audit of DNACPR took place in February 2016 which looked at 10 standards in completion of the DNACPR document. The audit found that the trust was overall 92% compliant in the use of the document. Results from the audit highlighted the lessons to be learnt which included ensuring all staff were aware of the patients with DNACPR's in place and the need for the senior nurse to also complete the form alongside the doctor.

Outstanding



We rated end of life services as 'outstanding' for caring because;

- Staff at the trust provided compassionate and highly personalised care to patients approaching the end of life.
- We saw that staff were committed to providing high quality care to people and their families which went beyond more than their physical needs. We observed staff spending time with patients, and built a good rapport with them. We saw that patients were comfortable and cared for; one family member reported that her mother was no longer scared now she was on the ward.
- One member of staff said 'ownership of end of life care was the responsibility of all staff on the ward and not only those working directly in end of life care, and we all go the extra mile to support the patients and their families'.
- We were told numerous stories that demonstrated the compassion, kindness and thoughtfulness of the staff working on the wards. For example, staff told us about a wedding that took place on the ward to support the dying wishes of a patient and how pets had been brought in to comfort dying patients. We were also told about how they arranged for a football club to show a dying patient their trophy and have photographs taken.
- The trust took steps to ensure that no one would die alone. There were many well trained care of the dying volunteers to support patients and their families at the end of life. This allowed for a period of respite to families or just for them to sit with patients who had no close family to ensure they had comfort and support in their last hours of life.
- Feedback from patients and families was positive about the care they received.
- Comfort packs that were hand made by the local community which included toiletries were provided to family members who wished to stay overnight with patients. Relatives spoke highly of the comfort packs and described them as showing 'great thought and care'.

## Are end of life care services caring?

# End of life care

## Compassionate care

- We spoke with 19 patients and relatives during the inspection to gather their views on whether end of life services met their individual needs. Patients and relatives told us conversations were held regularly where they were updated on their progress or condition. They felt the staff were compassionate and caring in their approach. On ward APCU a relative told us they were very satisfied with the care provided. They informed us that 'the staff are always attentive and around'. 'They make sure the patients are comfortable'. 'The doctors have kept us informed of everything, each step of the way'. 'They are respectful of mum not wishing to discuss her condition; she has always been a private person'. One family member reported that her mum doesn't feel scared now she is on this ward.
- One relative was complimentary about the friends and family suite. 'It's lovely and provided me with everything I needed'.
- Patients were treated with dignity, respect and compassion on the wards. We found staff to be caring and compassionate and understood the need for sensitive communication with patients who were approaching the end of life. We observed patients on the wards who looked well cared for, and interactions between staff and patients were caring and respectful. Staff knocked on the door before entering the room and respected patient dignity. Staff spent time getting to know each patient and were observed to have a good rapport and understanding of the patients' needs and wishes.
- Hospital staff demonstrated a strong commitment to empathy and enhancing the environment for dying patients and their relatives. Side rooms were available for people if they wished, and families were actively encouraged to participate in providing care (e.g. mouth care). We observed ward staff on the APCU spending time listening to patients and their relatives, checking facts and information to fully ensure they understood their needs. From the observations it appeared clear that the nursing team had a good rapport with the patients and took time to spend with patient to provide the care they required.
- On APCU there was a large family room and a quiet room for families to meet, and were permitted and encouraged to stay overnight. Staying overnight was permitted throughout the hospital. However, wards had little space for fold out beds and so the provision of recliner chairs were used so family members could be made more comfortable. Alternative accommodation off the hospital site could be made, however this incurred a cost to relatives.
- Staff demonstrated flexibility and kindness when meeting people's wishes. They told us that they had been able to facilitate a wedding on the ward to enable a dying person to get married in the last days of their life. The ward laid out a large buffet for the guests with tables and flowers.
- The HSPC team reported that the trust had enabled the wish of a dying patient to see her pet dog as a comfort to her in the last few days of life. On the respiratory ward they described a time when a football club brought in the European cup to show a dying patient. The patient had her photographs taken with the team and passed away 'happy' four hours later.
- Staff on ward 6Y explained that ownership of end of life care was the responsibility of all staff on the ward and not only those working directly in end of life care and go the extra mile to support the patients and their families.
- We were also informed that a patient had a Chinese New Year celebration on APCU with all the family in attendance using the family room.
- From the discussions we had with patients and their families they were all very complimentary of the nursing and medical team. Patients and relatives reported the staff were 'very attentive', 'they care for everyone', and they were 'angels'. We observed that the staff on the wards had excellent relationships with the patients and with their families. Discussions were open, honest, and very friendly.
- Staff ensured that the needs of a patient were met as the family had requested the patient's body faced Mecca when they passed away.
- Porters attended the wards quickly when notified a patient had died and required moving to the mortuary. The manager of the portage service reported the care standard from everyone within the trust in relation to end of life patients was excellent.
- We visited the mortuary and bereavement office, and the staff we spoke with demonstrated a caring attitude to deceased patients. The environment for families to view their deceased was calm and welcoming.
- Mortuary staff reported deceased bodies were properly prepared on the wards with a high regard to dignity and respect and transported quickly to the mortuary.

# End of life care

- Belongings of the deceased were given back to the relatives in bags that had been hand made by children from the local community. The bags had an attached label with the person's name that had made it.
- Comfort packs that were hand made by the local community which included toiletries were provided to family members who wished to stay overnight with patients. Relatives spoke highly of the comfort packs and described them as showing 'great thought and care'. On APCU there was a guest shower room in order for relatives to be able to freshen themselves following an overnight stay.

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

- Patients and families were encouraged to participate through feedback and surveys, and a care of the dying evaluation had recently been completed.
- Patients who were at the end of life were identified by experienced consultants. Referrals were then made to the HSPC team to support the care of the dying patient. All staff we spoke with reported that the HSPC staff provided an excellent service in providing advice and support to patients.
- Patients we spoke with reported they had been involved in making decisions about their care and their wishes had been taken into account. Patients reported staff explained procedures before they were carried out and were understanding of their needs.
- From observing a ward handover it was clear that patient preferences for their preferred place of care was taken into consideration and staff ensured that they involved the necessary personnel to ensure the patients preferred place of care was achieved.
- There was a selection of patient information materials available to support patients and their families in understanding end of life care. We saw these were available around the hospital. Examples of leaflets were 'An explanation of the plan of care in the last hours and days of life' and 'on experiencing grief'. We observed relatives being shown a leaflet about hydration and nutrition and information on end of life care. Staff showed sensitivity and excellent communication skills in discussing end of life care with relatives.
- The trust had employed two discharge co-ordinators in end of life care to enhance the process of patients' wishing to leave hospital. We observed on the ward that these discharge nurses were committed and passionate

about ensuring patient's wishes with regards to place of care were met. We observed that the co-ordinator kept everyone informed of developments with regard to discharge and involved the patient and relatives in discussions.

- There was an end of life volunteer service which provided patient and families with support. Volunteers would sit with patients to offer families a break and would stay with patients who had no family available to ensure they had company in their last hours or days of life.
- Following the death of a patient, families were offered advice, guidance and counselling sessions to support them through their grief.
- The mortuary had flexible out of hours viewing times and could arrange for deceased patients to be released quickly if required.

## Emotional support

- The hospital specialist palliative care team provided emotional support to relatives. We saw records of this in patients' records.
- Staff were caring to relatives regarding providing comfort, food and drink, and ensuring relatives were kept informed of any developments in a patient's condition. Relatives informed us the nursing and medical teams were 'doing everything they can and the best they can'.
- Relatives we spoke with were satisfied with the information and the emotional support they received from the staff.
- We observed staff taking time to talk and listen to patients and provide reassurance and comfort. Staff took time to understand the needs of the patients to enable them to best address their concerns. One Patient told us, "The information from doctors and staff has been good. They are caring people and I have been kept updated daily".
- The hospital offered a comprehensive spiritual care service which was a multi-faith team who provided support to patients and those close to them. There was a chapel and a multi-faith room with prayer mats for patients, families and staff to use. Holy Communion services took place six times a week and the services in the chapel were held four times a week.

# End of life care

- There was a bereavement support service to provide relatives with help and emotional support following the death of a patient.
- Counselling services were offered throughout the journey of patients and relatives. We found that relatives were offered support on the wards, through to the mortuary and bereavement service.
- In the National Care of the Dying Audit - Hospitals (NCDAH) the trust scored better than the England average for access to information relating to death and dying. We reviewed literature on wards and the bereavement office and found there to be a wealth of information for patients and families in regards to advice and support available, which included counselling services, coping with dying and grief.

## Are end of life care services responsive?

**Outstanding**



We rated end of life services as 'Outstanding' for Responsive because;

- An Academic Palliative Care Unit (APCU) opened in January 2016 providing 12 end of life beds for patients. The unit was developed to support the trust's vision to provide a model of best end of life care and to drive up the quality of end of life services. The trust had engaged advisors from Australia and Germany to support with the project, and MCPCIL to help develop the research and academic element to the unit.
- The hospital specialist palliative care (HSPC) service was widely embedded in all clinical areas across the trust and had been involved in planning and delivering end of life services.
- All staff we spoke with, including comments from focus groups, spoke highly of the direct support and advice received from the hospital specialist palliative care team.
- The chaplaincy team was made up of four people, two Catholic and two Anglican or Free Church, and covered a 24 hour service, seven days per week providing support to patients, families and staff. The service also had 64 spiritual volunteers to support patients at the end of life. The Chaplaincy team worked closely with other religious faiths to ensure all patients' religious wishes were adhered to.

- The HSPC team took part in a partnership programme with Marie Curie to implement a rapid discharge home to die pathway. The programme resulted in the creation of two discharge co-ordinators for end of life care to enable patients at the end of life to return home quickly. In January 2016 there were 161 referrals of which 87% were discharged to their preferred place of care. The trust target was 70%.
- The trust was committed to ensuring that the needs of the wider population were addressed and took part in network audit projects with the wider community to develop standards and guidelines to support specialist palliative care professionals.
- There were very few complaints relating specifically to end of life care. The senior managers of the HSPC team reviewed all complaints where a patient had died, even if they had not been referred to the HSPC team, to ensure that the response to the complaint was thorough and expressed empathy and sympathy to the bereaved relatives.
- The end of life discharge co-ordinators liaised directly with the ambulance service when completing rapid discharges, especially where there was a chance the patient may die in transit. In these cases the discharge co-ordinators or another member of the HSPC team would travel in the ambulance to accompany the patient home to ensure a safe transition from hospital to home.

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

- The HSPC service was widely embedded in all clinical areas across the trust and had been involved in planning and delivering end of life services. All staff we spoke to including comments from focus groups spoke highly of the direct support and advice received from the hospital specialist palliative care team.
- An Academic Palliative Care Unit (APCU) opened in January 2016 providing 12 end of life beds for patients. The unit was developed to support the trust's vision to provide a model of best end of life care and to drive up the quality of end of life services. The trust had engaged advisors from Australia and Germany to support with the project, and Marie Curie Palliative Care Institute Liverpool (MCPCIL) to help develop the research and academic element to the unit.
- The APCU was a newly designed area and was bright and well organised. There was a large family room with

# End of life care

seating, a quiet room, an oasis room for alternative therapies, and a large adapted bathroom for patients and visitors in wheelchairs. Following feedback from patients and visitors, a full length mirror had been installed and soap dispensers fitted at wheelchair height to enable the facilities to be used more effectively.

- The APCU was set up to provide side rooms and single sex bays. At the time of inspection there had been no mixed sex breaches. Patients were offered side rooms if they wished and family members were able to stay overnight. Food and drinks were offered to relatives so they didn't have to leave their relative to go and eat.
- Family members wishing to stay over on general wards were provided with recliner chairs and accommodation was available close to the hospital if they wished.
- Comfort packs were given to families who wanted to stay overnight. The packs were beautifully presented in bags made by local children and contained the necessary items to stay overnight. The trust audited the responses regarding the comfort packs to ensure this met the needs of the families. We reviewed 25 comments regarding the packs and all were very positive and complimentary about the service received.
- The trust had a significant multi-professional approach specialist palliative care service which was a formal directorate within the trust showing that end of life services were a core part of the trust's service.
- Performance in the National Care of the Dying Audit for Hospitals (NCDAH) 2013 and the 2015 end of life care audit placed them as one of the leading trusts in end of life care in the country.
- Monthly strategy meetings with regards to end of life care took place which included the local clinical commissioning groups to discuss service planning. We reviewed minutes from an end of life steering group that clearly identified the planning of a new electronic palliative care co-ordination system to allow for electronic records to be shared.
- The trust was committed to ensuring that the needs of the wider population were addressed and were part of the Cheshire and Merseyside palliative and end of life network audit group. This group was a multidisciplinary group that represented hospitals, the community, and hospice settings to use audit projects to develop standards and guidelines to support specialist palliative care professionals.

- The HSPC team took part in a partnership programme with Marie Curie to implement a rapid discharge home to die pathway. The programme resulted in the creation of two discharge co-ordinators for end of life care to enable patients at the end of life to return home quickly. We observed an end of life discharge co-ordinator providing a seamless transition between hospital and the patients preferred place of care, liaising with both hospital and community professionals to ensure patients left hospital safely and timely.

## Meeting people's individual needs

- The HSPC team had a flexible referral process, and all staff across the trust reported the team responded promptly to referrals, usually the same day. We saw evidence that the team reviewed patients daily and their contact details were placed in the patient records in order for staff to contact the team if a patient's condition deteriorated and they required their advisory service.
- Patients who were at the end of life and had only hours or days to live had a full, comprehensive multi-disciplinary assessment under the care of the dying patient guidance document. The assessment took into account the patients' needs and was reviewed daily. A full, formal multi-disciplinary review took place every 72 hours. From the records we reviewed we saw this was completed.
- From listening to a morning handover, the nursing and medical staff demonstrated they understood the needs and wishes of the patients and their families. Each patient was discussed and any changes or risks were identified and discharge arrangements made. Staff informed us this was an effective way to share information to ensure patients' needs were met.
- Where appropriate and with consent of the patient, NHS continuing healthcare (CHC) funding was applied for by the HSPC discharge co-ordinators. This enabled patients to receive the appropriate support in their own home or care setting. A fast track pathway tool was used to ensure that patients with a rapidly deteriorating condition were supported in their preferred place of care as quickly as possible. Staff we spoke with were knowledgeable about the different types of care available within the locality.

# End of life care

- Interpreter services were available via a language line to support patients whose first language was not English. Staff were able to describe a time when they had used the service for a patient to help them fully understand their care and treatment plans.
- Alternative therapies were available to patients on APCU. There was an oasis room on the unit which enabled patients to have a massage and aromatherapy and for those patients requiring support with moving and handling there was a specialist palliative care occupational therapist.
- For those patients that had only a few hours to live and wished to return home, a member of the HSPC team would travel in the ambulance to provide the support and reassurance the patient needed.
- On APCU there was a large kitchen area off the main unit, where food was prepared and was available to patients and their families. There was no set time for patients to eat so they could eat when they wanted to. A hostess spoke to each patient to discuss their preferred menu choices and time they preferred to eat. Food and drink was also offered to families who were staying over with patients.
- Details of procedures for care before and after death were documented in order to ensure that all spiritual and physical care was carried out to take into account their cultural and religious beliefs. Families informed us that conversations had taken place to take into account any spiritual needs, and they had been offered the chaplaincy service.
- Staff told us that they always ensured patients had someone with them in their last hours of life. The palliative care team had a team of 22 volunteers to help care for and support patients and their families at the end of life. The service had a counsellor to offer professional support to families. The volunteers sat with the patients to ensure the dying person was not alone, this offered a period of respite for the families. The volunteers used small cards to update families of any important messages or discussions.
- For those patients living with dementia or a learning disability, there were link nurses to support patients, families and staff.
- For those people living with dementia, a 'this is me' booklet was used to support communication between patients and staff. The booklet was completed by close family members expressing likes and dislikes and history of the patient.
- The chaplaincy team was made up of four people, two Catholic and two Anglican or Free Church, and covered a 24 hour service, seven days per week providing support to patients, families and staff. The service also had 64 spiritual volunteers to support patients at the end of life. The Chaplaincy team worked closely with other religious faiths to ensure all patients' religious wishes were adhered to. A list of new patients was reviewed daily and volunteers would visit the patient and relatives to discuss their individual needs. Dependent on the urgency of the individual's needs the chaplain was able to see patients within 20 minutes, if required. Staff informed us that chaplains were visible on the wards and attended quickly if required.
- A chaplain attended the palliative care multi-disciplinary team meeting every week to discuss feedback about end of life patients, and attended quarterly chaplaincy meetings for Merseyside to help develop the service.
- The HSPC team had a family and friends co-ordinator who contacted families for bereavement follow up and to discuss tissue donation.
- We observed the electronic call bell system being used on APCU. Managers informed us they aimed to answer call bells within one minute. From our observations call bells were answered quickly by ward staff.
- The mortuary had a viewing area for families to spend time with the deceased patient. There were two bereavement rooms with all doorways into the mortuary ante room and viewing rooms being wide enough to accommodate wheelchairs.
- The mortuary had 75 fridges for storage of deceased patients, five of which were for bariatric patients.
- The mortuary team were able to complete reconstructive and camouflage work on deceased patient's bodies who had suffered major trauma so that bereaved relatives were able to view them.

## Access and flow

- The HSPC team kept records of those wards which generated the most referrals. The respiratory medicine ward (6X) produced the most referrals (7.2%) followed by the Acute Medical Unit (6.9%) and gastroenterology/hepatology generating 6.1% of referrals. The HSPC team reported they visited acute admitting wards and top referring wards daily to ensure they were aware of any

# End of life care

potential referrals or patients needing specialist palliative care advice and support as the need arose. Staff on the wards we visited confirmed that the HSPC staff visited regularly.

- The HSPC team were committed to ensuring patients were discharged from hospital to their preferred place of care. They had a target that 70% of patients would be followed through to discharge to their preferred place of care. This ensured continuity for the patient and their families. From August 2015 to January 2016 the HSPC team achieved above 87% in every month, and in December 2015 achieved 100% of patients being followed through to their preferred place of care.
- As part of the HSPC team there were two end of life care discharge co-ordinators who were responsible for actively organising and facilitating timely and well co-ordinated discharges from hospital. They performed comprehensive, holistic assessments of a patient's current, on-going and anticipated needs, ensuring appropriate equipment, medication and care services were promptly organised and activated to ensure patients at the end of life were discharged safely. From April 2015 to December 2015 the discharge co-ordinators had fully arranged and co-ordinated 254 discharges.
- We reviewed information provided by the trust relating to two pathways for discharging end of life patients. For those patients who were considered to die imminently and either the patient or their family had expressed a wish for the patient to die in an alternative setting, then a rapid discharge pathway was considered. Rapid discharges took place within 4-24 hours. From February 2015 to November 2015, 40 patients were discharged on this pathway. For those patients who were progressively deteriorating but not imminent, the discharge took place as quickly as possible but generally within two to seven days. From January 2015 to December 2015 there were 78 patients discharged on the complex fast track pathway. Only 21 patients took longer than seven days to be discharged.
- We were informed that equipment for end of life patients could be arranged to be delivered within 24 hours, and pharmacy could have medication ready in one hour for patients who were on the rapid discharge pathway. Delays to discharge were reported to be due to problems with care providers and care homes of choice not having vacancies.

- The end of life discharge co-ordinators liaised directly with the ambulance service when completing rapid discharges, especially where there was a chance the patient may die in transit. In these cases the discharge co-ordinators or another member of the HSPCT would travel in the ambulance to accompany the patient home to ensure a safe transition from hospital to home.
- We observed a rapid discharge of a patient co-ordinated by a discharge co-ordinator and found they worked quickly and efficiently, liaising with all relevant individuals to ensure there was a seamless transition from the hospital to the preferred place of care.

## Learning from complaints and concerns

- Patients and relatives we spoke with knew how to raise concerns or make a complaint. We observed there was information on wards to inform people of the process and this information was available as an easy read document and was available in different formats.
- Any informal complaints would be dealt with on the wards face to face, and the HSPC team would attend to meet with the family to discuss their concerns.
- There were very few complaints relating specifically to end of life care. A thorough review of complaints within medicine had been completed in 2014/15 which included the key themes relating to end of life care and an action plan was completed. The key themes relating to end of life care included aspects of clinical treatment, attitude of staff and communication.
- The senior managers of the HSPC team reviewed all complaints where a patient had died, even if they had not been referred to the HSPC team. This ensured the response to the complaint was thorough and expressed empathy and sympathy to the bereaved relative. Responses were written and sent to the Chief Executive to be reviewed before being sent. Complaints were discussed weekly at patient experience meetings and learning shared through quality governance meetings. Managers informed us that outcomes from complaints were used to inform teaching. We reviewed letters sent out to bereaved families and found they were sent via the Chief Executive and offered deepest sympathy and regard for duty of candour.
- At the time of inspection we were informed there had been no complaints made with regards to the APCU.

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

# End of life care

Outstanding



We rated end of life services as 'Outstanding' for Well led because;

- The palliative care service was embedded across the trust and held in high regard by all the wards we visited. Palliative care was considered integral to the trust and had a well-developed and substantial palliative care directorate which was part of the medicine division.
- The trust had a comprehensive end of life vision and strategy set out for 2013- 2018. Their vision was to deliver the highest quality healthcare driven by world class research for the health and wellbeing of the population. End of life services had partnered with Marie Curie Palliative Care Institute Liverpool (MCPCIL) to further research and develop end of life services.
- There were systems in place to audit the quality of end of life services that were regularly reported and monitored from the ward to board. The monitoring of complaints, incidents, audits and quality improvement projects were raised at board level.
- We saw a clear governance structure from ward and department level to the board. Good governance was a high priority and was monitored through a number of groups. The trust is one of only 14% of trusts that took part in the 2015 end of life care audit that have an end of life strategy group.
- There was comprehensive leadership within the palliative care department with clearly defined responsibilities. These included the Chief Executive who was the executive board lead for end of life services.
- The trust had a well-established and well-staffed palliative care directorate that worked closely with other organisations to improve the quality of end of life services in Merseyside. The palliative care directorate was made up of a large senior management team, including a Clinical Director who was a professor of palliative medicine, palliative care consultants and specialist palliative care nurses. The trust had developed an Academic Palliative Care Unit (APCU) with international collaboration which opened in January 2016, providing a 12 bedded unit for people who were at the end of life. The unit was staffed by passionate and

caring staff who prided themselves on providing high quality care for patients who were at the end of life. The unit provided the opportunity for academic research alongside MCPCIL to further enhance end of life services.

- There was a focus on staff development, education and training from the HSPC team and through the MCPCIL which provided nursing and medical staff with the skills necessary to provide high quality care to end of life patients. The trust was one of only 22% of trusts that took part in the 2015 end of life care audit that provided an end of life care session as part of a trust mandatory training programme to promote and to educate staff in end of life care.
- We found that there were high levels of staff satisfaction from managers to ward staff working within end of life care. Staff were proud of their service, and spoke highly about their role and responsibilities, expressing that they only had one chance to get it right.
- End of life services had a substantial care of the dying volunteer service to ensure that patients and their families were supported. The volunteer service were winners of the Deborah Hutton award in 2015.

## Vision and strategy for this service

- The trust had a comprehensive end of life vision and strategy set out for 2013- 2018. Their vision was to deliver the highest quality healthcare driven by world class research for the health and wellbeing of the population. End of life services had partnered with MCPCIL to further research and develop end of life services and collaborated with the Cheshire and Merseyside end of life network group to share research findings. This collaborative working helped support the commissioning and provision of excellent and equitable end of life services for the people of Merseyside and the surrounding boroughs.
- The trust had set out corporate and quality end of life objectives to ensure the service was forward thinking and improved the quality of care to end of life patients. The approach encompassed working with other organisations to such as MCPCIL to support training and the development of end of life services.
- The palliative care service was embedded across the trust and held in high regard by all the wards we visited. Palliative care was integral to the trust and not just an add on service and had a well-developed and substantial palliative care directorate which was part of the medicine division.

# End of life care

- The vision and values for end of life care were delivered by passionate, caring professionals who wanted to make a real and sustained difference to patient care.
- Staff we spoke with across the trust felt that they were equipped for their role in supporting people at the end of life.

## Governance, risk management and quality measurement

- The palliative care directorate had a risk register that monitored and reviewed any risks relating to the service it provided. We reviewed the risk register relating to the palliative care directorate and it showed there were no high to moderate risks associated to the service. The risks identified on the register were low to very low risks, these included the need for a palliative care unit within the trust, based upon a population based needs assessment and the media interest around the Liverpool care pathway (LCP). All risks had been updated in January 2016 and actions highlighted.
- Although a new document which had replaced the LCP was being used across the trust; it did not provide a truly personalised person centred individual care record that could encompass all the expressed needs and wishes of an individual within the document. However, we saw evidence that patients at the end of life were receiving appropriate support and compassionate care.
- We saw a clear governance structure from ward and department level to the board. Good governance was a high priority and was monitored through a number of groups. The end of life strategy group met monthly and minutes and associated actions were monitored by the patient experience committee, with a report presented to the quality governance committee as assurance that performance against agreed targets and objectives were being achieved. The trust is one of only 14% of trusts that took part in the 2015 end of life care audit that have an end of life strategy group. We reviewed the forward plan for 2015/16 strategy group and found that clear objectives and timescales were set.
- The results from the 2013 NCDH and 2015 end of life care audit were found to be excellent and higher than the England average. A comprehensive action plan had been developed to further improve results in the next round of the audit.
- There were systems in place to audit the quality of end of life services that were regularly reported and monitored from the ward to board, which included

meetings with the chief executive. The monitoring of complaints, incidents, audits and quality improvement projects were raised at board level. Within the trust, monthly key performance indicators were collected for the executive board and for the clinical commissioning group's quality accounts.

- There was a focus on staff development, education and training from the HSPC team and through the MCPCIL which provided nursing and medical staff with the skills necessary to provide high quality care to end of life patients. The trust was one of only 22% of trusts that took part in the end of life care audit that provided an end of life care session as part of a trusts mandatory training programme.

## Leadership of service

- There was comprehensive leadership within the palliative care department with clearly defined responsibilities. These included the Chief Executive who was the executive board lead for end of life services. The palliative care directorate was made up of a large senior management team, including a Clinical Director who was a professor of palliative medicine, palliative care consultants and specialist palliative care nurses. A vacancy was yet to be filled for a palliative care consultant pharmacist. The Directorate Manager and Clinical Director were also Associate Director and Director at the MCPCIL.
- The end of life team demonstrated effective leadership, and the leaders understood the challenges to provide high quality palliative and end of life care across the trust.
- Ward staff felt the HSPC team were visible, approachable and supportive, supporting the staff to care for patients at the end of life.
- Staff on APCU reported they regularly saw the senior management team who were supportive of their needs.

## Culture within the service

- The HSPC team were passionate about their roles, and told us how important end of life care and palliative care was. The senior management team wrote to bereaved families even if the patient had not been referred to their service, as they identified that the importance of getting it right for patients and families was paramount. Lessons were learnt from any mistakes made.

# End of life care

- The Chief Executive held monthly 1:1 sessions with the senior leaders of the HSPC team and reported there was an open door policy and would see the senior team as required.
- The HSPC nurses reported they were well supported by their managers.
- Staff we spoke with felt able to raise concerns, and the trust had introduced a red flag system to enable staff to raise any concerns. For example if staffing on the wards was not adequate the staff were able to raise the issue. We found posters on the wards we visited highlighting the red flag programme.
- Staff were observed to be open and honest with patients. Staff told us that they wanted to get it right for the patients as they only had one chance to do so.

## Public engagement

- We saw evidence of the service actively seeking input from patients and their families, and acting to address concerns when they were raised.
- The service took part in the Care Of the Dying Evaluation (CODE) which sought the views of bereaved relatives and actions taken to improve performance.
- A member of the HSPC team had been seconded to take part in a 'patient stories' research project to evaluate the needs of the bereaved relatives to ensure the service was appropriately meeting their needs.
- An audit focus group had been set up through the Cheshire and Merseyside strategic clinical network to invite the public to have discussions on standards and guidelines on a combination of clinical and non-clinical topics such as hydration, delirium, hypercalcaemia and bereavement.
- Invitations were sent to bereaved families to ask them to take part in a bereavement services guideline development group to help the HSPC team support the bereaved relatives.
- The trust encouraged people who used services, and those close to them to provide feedback about their care.

## Staff engagement

- Staff we spoke with reported that they were listened to, and senior managers attended the wards to discuss problems.
- The intranet hosted a newsletter to ensure staff were aware of the current priorities and what was happening within the trust.

- The trust held listening events for the staff to put forward ideas.
- Most staff felt respected and valued by the trust. There were schemes in place to recognise the good work staff had done. We were informed the bereavement officer had recently won the employee of the month within the trust.
- We found that there were high levels of staff satisfaction from managers to ward staff working within end of life care. Staff were proud of their service and spoke highly about their role and responsibilities, expressing that they only had one chance to get it right.

## Innovation, improvement and sustainability

- The trust had a well-established and well-staffed palliative care directorate that worked closely with other organisations to improve the quality of end of life services in Merseyside.
- The development of an Academic Palliative Care Unit (APCU) with international collaboration opened in January 2016, providing a 12 bedded unit for people who were at the end of life. The unit was staffed by passionate and caring staff that prided themselves on providing high quality care for patients who were at the end of life. The unit provided the opportunity for academic research alongside MCPCIL to further enhance end of life services.
- The HSPC team had appointed two discharge co-ordinators so that palliative and end of life patients reached their preferred place of care as quickly as possible. They worked closely with community partners to ensure that patients received care to meet their needs once discharged from hospital. Through working in partnership with the MCPCIL they had implemented a rapid discharge home to die pathway and achieved excellent results in ensuring end of life patients were supported to be discharged to their preferred place of care.
- Complaints were dealt with sensitively and compassionately by the senior management from the HSPC team, even if the patient was not known or referred to the HSPC. This ensured high quality responses were given to bereaved families.
- End of life services had a substantial care of the dying volunteer service to ensure that patients and their families were supported. The volunteer service were winners of the Deborah Hutton award in 2015.

## End of life care

- The trust was working towards a fully functional Electronic Palliative Care Co-ordinating System (EPACCS) across relevant sites to enable service providers across boundaries to share information.
- The trust had a robust education and training programme in end of life care and a formal programme of study days which was co-ordinated by the HSPC team and provided in conjunction with MCPCIL.
- In partnership with MCPCIL the HSPC team hosted monthly seminar meetings, and invited guest speakers to share their work and experience. The trust told us that they had guest speakers from Uganda and Germany.
- The HSPC team had recently appointed a practice educator to further enhance education and training and a pharmacy consultant was to be appointed.
- The HSPC team supported the mortality peer review process, attending complex mortality peer reviews, helping to identify lessons to be learnt and supporting any education and training issues. We saw evidence that there was a clear process to be followed with eleven steps to follow in the peer review process. The process was used to highlight concerns and learning points.
- The trust had developed the Academic Palliative Care Unit with support from international hospitals in Germany and Australia to support international benchmarking and quality improvements in hospital palliative care.

# Outpatients and diagnostic imaging

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

## Information about the service

A range of outpatient and diagnostic services are provided by the Royal Liverpool and Broadgreen University Hospitals NHS Trust at the Royal Liverpool University Hospital and Broadgreen Hospital. A number of outpatient appointments are also offered at community locations. There is a laboratory service provided off-site.

The main outpatient and diagnostic imaging departments at the Royal Liverpool Hospital are located on the ground floor. The Royal Liverpool Hospital also has a Diabetic Centre, St Paul's Eye Unit and the Linda McCartney Centre which provides a clinical service for breast cancer screening and diagnosis.

Royal Liverpool Hospital offers a combination of consultant and nurse-led clinics for a full range of specialities, including: cardiology, respiratory, haematology, ear nose and throat (ENT), diabetic, orthopaedic and fracture clinic, ophthalmology, sexual health and therapy services.

Hospital episode statistics data (HES) September 2014 to August 2015 showed 868,990 outpatient appointments were offered across the trust with 455,965 offered at the Royal Liverpool University Hospital.

Royal Liverpool University Hospital offers a comprehensive range of diagnostic and interventional radiography services to patients including: general x-ray, computerised tomography (CT) scans, magnetic resonance imaging (MRI), nuclear medicine, ultrasound and mammography.

We visited the Royal Liverpool Hospital as part of a comprehensive inspection of the trust between 15 and 18

March 2016 and we inspected a number of outpatient and diagnostic services including ear, nose and throat (ENT), fracture clinic, cardiovascular, ophthalmology, haematology, radiology and diagnostic imaging services.

We spoke with 30 patients and relatives and 82 staff including: nursing, medical, allied health professionals and managers. We received comments from people who contacted us about their experiences. We also reviewed the trust's performance data and we examined ten individual care records.

# Outpatients and diagnostic imaging

## Summary of findings

We rated Outpatients and Diagnostic imaging as 'Good' overall because;

- Radiation incidents were reported internally and externally as required. Internal investigations were conducted using a root cause analysis approach and lessons learned were shared with staff.
- Policies and procedures were in place for the prevention and control of infection and maintenance contracts were in place to make sure specialist equipment was serviced regularly.
- Records we reviewed were of a good standard and policies and procedures were in place to keep people safe.
- Patients attending outpatients and diagnostic imaging departments received care and treatment that was evidence based and followed national guidance.
- Staff worked together in a multi-disciplinary environment to meet patients' needs. Specialist nurses were available in a wide range of specialities.
- Outpatient and diagnostic services were delivered by caring, committed and compassionate staff.
- Care was planned that took account of patients' needs and wishes and psychological and emotional support was available for patients in a number of outpatient clinics.
- Patients had a choice of appointments and additional clinics were held in the evenings or at weekends to reduce waiting times.
- The trust met national referral to treatment standards for incomplete pathways between September 2014 and November 2015, however, this dipped slightly in December 2015 and January 2016.
- Between May 2015 and February 2016, the trust met the national standard for diagnostic imaging waiting times, with the exception of January 2016.
- Managers had a good knowledge of performance in their areas of responsibility and understood the risks and challenges to the service.
- Quality and performance were monitored through outpatient and radiology dashboards and weekly performance meetings.

- Patients' views were actively sought and there was evidence of continuous improvement and innovation.

However;

- We found that while staff were aware of their roles and responsibilities in relation to safeguarding patients, mandatory training rates did not meet the trust target and compliance with resuscitation training was variable across the departments.

# Outpatients and diagnostic imaging

## Are outpatient and diagnostic imaging services safe?

Good



We rated Outpatients and Diagnostic imaging as 'Good' for Safe because;

- Radiation incidents were reported internally and externally as required and internal investigations were conducted using a root cause analysis approach.
- The incidents we reviewed documented action plans, which included the sharing of lessons learned with staff. Staff knew how to report incidents and could describe a change in practice following an incident.
- Mortality and morbidity meetings took place within the diagnostic imaging department.
- Policies and procedures were in place for the prevention and control of infection and maintenance contracts were in place to make sure specialist equipment was serviced regularly.
- Records were of a good standard and clinic appointments were not cancelled due to unavailability of medical records.
- Policies and procedures were in place to keep people safe and staff knew how to manage patients who became unwell in the department.
- Medicines were stored securely in line with legislation.
- Staff were aware of their roles and responsibilities in relation to safeguarding patients.

However;

- Not all controlled drugs were checked daily in line with trust policy.
- Although resuscitation equipment was available, daily checks were not consistently completed.
- Mandatory training rates did not meet the trust target and compliance with resuscitation training was variable across departments.

### Incidents

- Incidents were reported using an electronic reporting system. Staff could describe how to use the system and the types of things that would constitute an incident. However, some staff said they didn't receive feedback.
- Staff could describe previous incidents and gave an example of a change in practice as a result of lessons

learned. An example of this was that nursing staff remained in consultation rooms with patients following an incident where a patient fell in an outpatient clinic at Broadgreen Hospital.

- In the 12 months prior to the inspection, there had been no never events in outpatient or diagnostic services at the hospital. Never events are serious, wholly preventable patient safety incidents that should not occur if the available preventative measures have been implemented.
- There were three serious incidents reported between October 2014 and September 2015. All three incidents were investigated using a root cause analysis (RCA) approach and all documented high level action plans and evidence of shared learning. An investigation using a RCA approach was also conducted for all diagnostic incidents within the imaging department.
- Data from the trust showed there were 18 radiation errors recorded between 01/03/15 and 29/02/16. The trust used a 'pause and check' process which aimed to ensure that the right person got the right x-ray on the right part of the body.
- Minutes from the Radiation Safety Group meeting held in December 2015 indicated incidents were reported internally and externally, as required.
- Mortality and morbidity meetings took place bi-monthly within the diagnostic imaging department and alternated with audit meetings.
- Many staff across outpatients and diagnostic imaging did not recognise the term 'Duty of Candour' but they could describe the principle of it. 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.

### Cleanliness, infection control and hygiene

- Most of the areas we visited were visibly clean and tidy, however, the podiatry room within the Diabetes Centre was noted to have dust on the work tops and behind the examination couch and the refrigerator contained a box with mould on it. We advised staff of this during our inspection.
- Policies and procedures for the prevention and control of infection were in place and staff adhered to "bare

# Outpatients and diagnostic imaging

below the elbow” guidelines. Hand gel was readily available in all clinical areas and we observed staff using it. Posters displaying hand washing techniques were observed above most handwashing sinks.

- Stickers were placed on equipment to inform staff at a glance that equipment had been cleaned and we saw evidence of this being used across the departments we visited.
- Arrangements were in place for the handling, storage and disposal of clinical waste. Sharps bins were noted to have been signed and dated when assembled. Processes were in place for the disposal of plaster waste in the fracture clinic.
- Staff in radiology could describe the process when patients attended with suspected communicable diseases or requiring isolation including the use of protective equipment, deep cleaning following the procedure and scanning patients at the end of the list, if possible.
- Hand hygiene audits completed between October 2015 and January 2016 indicated that most areas consistently achieved above 90% compliance with some areas such as St Paul’s outpatients and pre-operative clinic, vascular clinic and genito-urinary medicine consistently achieving 100%, however, compliance in gastroenterology clinic and therapies ranged from 30%-69% and 45%-57% respectively.
- Between September 2015 and January 2016 hand hygiene audits within diagnostic imaging radiology showed the breast unit consistently achieved 100% compliance. However, x-ray services ranged from 26.3% to 97.6%. Copies of the audits were displayed in the reception area of the x-ray department and on the corridor outside the main outpatients department to inform patients of the results in each clinic.
- Within the imaging department curtains were used to screen patients in the waiting areas. All curtains were labelled to identify when they had been changed and staff were aware of the schedule for replacement.
- In the eye research centre we observed a staff member cleaning the treatment room in-between patients, during an injection clinic. Surfaces including worktops and treatment chairs were wiped. The room had a clean air facility which provided 15 changes of air per hour, however the door into the corridor was left open and patients waiting for their appointment were seated in the corridor outside the door.

## Environment and equipment

- Emergency resuscitation equipment was in place, trolleys we reviewed were visibly clean and weekly checklists completed. Oxygen, suction and defibrillator checks were performed daily. However, this was not consistently completed in all areas. For example, between 18 January 16 and 16 March 16 the daily checking within N clinic had not been documented on three occasions and on two occasions in Interventional Radiology.
- Maintenance contracts were in place to ensure specialist equipment was serviced regularly and faults repaired and we saw evidence of quality assurance for diagnostic equipment.
- We observed some equipment that was not in date with portable appliance testing (PAT). PAT is the term used to describe the examination of electrical appliances and equipment to ensure they are safe to use. This equipment included an infusion pump (service was due November 2015) and an Angio-jet machine (due to be calibrated November 2015) stored in the clean utility area of Interventional Radiology. A blood pressure machine in use in N clinic, which is one of the vascular and orthopaedic clinics found on the ground floor of the hospital, was also noted to have a review date of April 2015.
- Clear signage and safety warning lights were in place in the x-ray departments to warn people about potential radiation exposure.
- Occupational exposure to radiation was monitored for radiology staff. This ensured that the amount of radiation staff were exposed to as part of their work was checked. The nuclear medicine department had a voice activated device that monitored hand radiation contamination outside their staff room.
- Personal protective equipment was available. This was checked and cleaned weekly and wiped down after use.
- The emergency oxygen cylinders in both N clinic and interventional radiology were noted to have expired on 2 October 15 and 16 December 12 respectively. This was highlighted to staff during our inspection and immediate action was taken.
- There were separate areas for handling radioactive injections for PET (positron emission tomography) and other nuclear medicine studies. The areas ensured that any potential spills were contained and patients were injected in a small designated area that was regularly monitored for contamination.

# Outpatients and diagnostic imaging

## Medicines

- Medicines in outpatients and radiology were stored securely in locked cupboards or refrigerators, as appropriate, and in line with legislation. However, we found 15 drugs that had passed their expiration date in ENT clinic, such as Trimovate cream, Clotrimazole cream, Clotrimazole solution, Lidocaine spray, Lidocaine injection and adrenaline injections. We advised staff of this immediately and the items were removed.
- Temperature readings of fridges that store medicines and vaccines should be between two and eight degrees and any deviations and corrective action should be recorded. However, no checklist was available in the interventional radiology department to indicate the fridge temperature had been monitored.
- Controlled drugs were used in the orthopaedic and fracture clinic and interventional radiology and records indicated they were checked daily. However, in interventional radiology records showed that this had not been done on five occasions between 4 January 2016 and 17 March 16.
- Prescription pads were stored securely and their usage was tracked.
- Some staff within the sexual health clinic were registered nurse prescribers. Nurse prescribers are specially trained nurses allowed to prescribe any licensed and unlicensed drugs within their clinical competence.
- Radioactive injections were delivered to the nuclear medicine department directly from the radiopharmacy in patient-specific labelled syringes which reduced potential dosage errors.

## Records

- If patient records were unavailable a temporary record was prepared, this meant that clinic appointments were not cancelled due to missing records. New patient referral letters were incorporated and any previous investigation results and letters were available electronically for patients attending a follow up appointment. All new documentation was filed in original notes when available.
- Between 1 September 2015 and 1 February 2016 data from the trust showed that with the exception of three dates the number of temporary records required on a daily basis was less than 1%.

- We reviewed nine sets of patient records in the outpatients department. All records had patient identification details on each page, numbered pages and entries that were signed and dated. Consent was documented and care plans present as appropriate.
- The St Pauls eye research centre saw 5,600 patients for intravitreal injection from April 2014 to April 2015. During the visit the patients appeared to progress through the department and a series of baskets containing case notes followed the patient. The baskets were not labelled and notes were stacked and haphazard. The sister agreed that this was a risk and gave an example where a patient had received the wrong injection, though this was historical information. Problems with administration staff support was listed on the ophthalmology risk register and at the time of the inspection, meetings were taking place to address the issue.

## Safeguarding

- Safeguarding policies and procedures were in place across the trust. These were available electronically for staff to refer to. Staff were aware of their roles and responsibilities and knew how to raise matters of concern appropriately, including issues relating to domestic violence, child sexual exploitation and Female Genital Mutilation (FGM).
- There was a trust-wide safeguarding team in place that provided guidance to staff during the day in the week. Staff had access to advice out of hours and at weekends.
- Staff described how they had dealt with safeguarding incidents and how advice had been accessed from the safeguarding team.
- Safeguarding training was incorporated within core skills training and therefore specific training figures could not be obtained. However, compliance rates for core skills training were 88% for outpatient services and 89% for diagnostic and therapy services, including imaging and laboratory services across the trust.

## Mandatory training

- Mandatory training was available via on-line courses, as well as face to face, and included subjects such as infection control, fire safety, equality and diversity and information governance.
- The trust target for mandatory training was 95% and data from the trust indicated training rates for staff

# Outpatients and diagnostic imaging

within outpatients clinics across the trust was 88% overall, however, specific subjects such as resuscitation and conflict resolution showed a compliance rate of 78%.

- Data for diagnostic and therapy services including imaging and laboratory services showed a training rate of 88% however rates of compliance with resuscitation training for imaging was 77% and clinical haematology and pathology were 39% and 45% respectively.

## Assessing and responding to patient risk

- Clear signs were in place informing patients and staff about areas where radiation exposure took place.
- Imaging requests for inpatients were completed electronically. Requests from general practitioners were a combination of electronic and paper referrals and any paper requests required a GP stamp to confirm the referrer for the procedure to be completed.
- Forms were completed for women of child bearing age before exposure to radiation in case of pregnancy. Completed forms were signed by the patient and then scanned into the medical records.
- Safety procedures were observed in radiology to ensure the right patient got the right scan at the right time. Staff in radiology were observed obtaining name, address and date of birth of patients on arrival which related to the 'know your patient' initiative as well as a requirement of the Ionising (Medical Exposure) Regulations (IR (ME) R 2000).
- Staff in interventional radiography and the cardiac catheter laboratory used the World Health Organisation (WHO) Surgical Safety Checklist. This aimed to reduce harm during operative procedures by using consistently applied evidence-based practice and safety checks to all patients. Audit of adherence to the WHO Surgical Safety Checklist in cardiac catheter laboratory and interventional theatre showed compliance of between 90-100% for each stage of the procedure in December 2015 and 100% in February 2016. Data for January 2016 was not available.
- Checklists for procedures were in use in St Paul's eye clinic, however, no space was available on the documentation for patient details, which meant even if the checklist was completed, this could not be attributed to an individual patient.
- In addition, there were Argon and Yag lasers used for treating patients as outpatients in St Paul's Eye unit. There was no checklist in place to identify patients prior

to treatment. As this was an outpatient area, no wristbands were in place, staff explained they checked the patient by DOB and address but this was not recorded.

- Details of Medical Physics support were observed on the radiation protection notice board within radiology.
- Radiation Protection Supervisors were appointed in each clinical area within the diagnostic and imaging departments and staff could identify these personnel.
- Any patients attending the imaging department on a trolley were monitored by a health care assistant.
- Patients attending for a positron emission tomography (PET) scan were monitored at all times via CCTV in the waiting and scanning areas as the radiation risk to staff was high. There was medical presence in the department at all times and a resuscitation trolley was situated in the scanning room if a patient became unwell.
- In the computerised tomography (CT) department, the scanning control room had two-way mirrors on two walls allowing staff to monitor patients both during the scan and in the bedded waiting area.
- Staff were able to describe the procedure if a patient became unwell in their department, including calling the Medical Emergency Team (MET).

## Nursing staffing

- Outpatient clinics were staffed by a combination of specialist and outpatient nurses and staff worked across both the Royal Liverpool University Hospital and Broadgreen sites.
- Outpatient nurse staffing was planned in advance to manage the workload and band 6 team leaders met weekly to review any additional staffing requirements for the following week. This was also reviewed on a daily basis as required.
- Staff told us all outpatient nurse vacancies had been recruited to. However, sickness rates among outpatients nurses across trust-wide was 13.5% in February 2016. This was recorded on the departmental risk register and an action plan was in place, which included continuous recruitment and completion of return to work interviews following an episode of sickness.
- A Band 7 clinic manager post covered both the Royal Liverpool University Hospital and Broadgreen sites. The post was vacant during our inspection, however, staff told us this had been recruited to.

# Outpatients and diagnostic imaging

## Medical staffing

- The radiology department was staffed by consultant radiologists and due to an increase in imaging complexity and activity, a shortage of radiologists was recorded on the risk register. Monitoring of activity was continuing and a workforce review was in progress.
- Between 5pm and 9am all diagnostic imaging was reported by registrars in the radiology collaborative hub based at Broadgreen Hospital, however, all images were reviewed again the following morning. On call consultant cover was also provided 24 hours per day, seven days a week. There was also a resident Consultant Radiologist reporting in the Royal Liverpool University Hospital until 8.30pm each evening Monday to Friday.
- There was a sufficient number of medical staff to support outpatient services. We found that the majority of clinics were covered by consultants and their medical teams
- The ocular oncology service in St Paul's Eye Unit was being managed by one consultant. The service saw patients that were suspected of having; or, being treated for ocular cancer. With only one consultant in post there was a potential to fail to meet national cancer standards. The targets were being met by staff working additional hours to support the service. The risk was recorded on the risk register and a business case had been submitted to increase the workforce.

## Allied Health Professionals

- Radiographers provided a 24 hour, seven day service. The trust had six band 6 radiographer vacancies and seven band 5 radiographer vacancies at the time of our inspection; however, recruitment was in progress.
- Across all therapy professions 8.8 whole time equivalent vacancies were reported at the time of our inspection, however managers described how they were developing roles internally to address this issue.

## Major incident awareness and training

- The trust had a major incident policy which listed key risks that could affect the provision of care and treatment. Staff members were aware of the policy and how to locate it on the trust's intranet.
- Within the nuclear medicine department actions in the event of a major spill incident formed part of the departments Local Rules.

## Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

- Patients who attended outpatients and diagnostic imaging departments received care and treatment that was evidence based and followed national guidance.
- Staff worked together in a multi-disciplinary environment to meet patients' needs. Specialist nurses were available if required.
- Staff were competent to perform their roles and were supported by the trust to develop.
- Information relating to a patient's health and treatment was available from relevant sources before a clinic appointment and staff had regional access to previous x-ray images. Information was shared with the patient's GP following hospital attendance to ensure continuity of care.
- The radiology and diagnostic service was provided seven days a week.
- The rate of follow up appointments in relation to new appointments was slightly higher than the England average between September 2014 and September 2015.

## Evidence-based care and treatment

- Care and treatment within the outpatient and diagnostic imaging department was delivered in line with evidence-based practice. Policies and procedures followed recognisable and approved guidelines such as those from the National Institute for Health and Care Excellence (NICE).
- Staff described the use of NICE protocols and guidelines for emergency bone scans and the use of radium for bone pain in radiology and guidelines were used by therapists for patients diagnosed with osteoporosis.
- Audits of compliance with Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER) were completed and Radiation Safety Committee meetings were held twice a year to monitor radiation safety throughout the trust.
- Diagnostic reference levels (DRL's) audits took place to ensure patients were being exposed to the correct amount of radiation for an effective, but safe scan for each body part.

# Outpatients and diagnostic imaging

- We reviewed minutes from Radiation Protection Supervisor meetings which reviewed radiation incidents and issues and observed an action plan to maintain quality assurance.
- Audit and staff meetings were held in radiology to share information and promote shared learning.
- An audit programme was in progress assessing compliance in relation to a number of activities including the WHO checklist, consent for procedures and infection control.

## Pain relief

- Entonox pain relieving gas was administered in fracture clinic when patients needed it. The trust had a policy for administration; however, we did not see any patients requiring it during our inspection.
- Analgesia could be prescribed for patients requiring pain relief. This was available in the outpatient department and was prescribed as a single dose prescription using a patient specific direction.

## Patient outcomes

- The trust's rate of follow up appointments in relation to new appointments was similar to the England average between September 2014 and September 2015. This information was trust-wide across outpatient and diagnostic services and not specific to the Royal Liverpool University Hospital.
- Staff told us discrepancy meetings were held in radiology. The purpose of the meetings was to facilitate collective learning from radiology discrepancies and errors and therefore improve patient outcomes and safety. However, meeting minutes were not available.
- Diagnostic imaging scans reported by registrars from the radiology hub were reviewed to ensure accuracy.
- Sexual health clinic staff were involved with national benchmarking. This allowed the service to identify best practice and continuously improve by comparing performance with other similar services.
- The cardiorespiratory department were accredited with the British Society of Echocardiography.

## Competent staff

- Competency assessments were in place in the outpatients department, for example in the Ear, Nose and Throat (ENT) clinic and induction processes were in place for new staff.
- Staff identified their training needs through the trust's annual appraisal process and data from the trust

indicated that appraisal rates for outpatient services across the trust for the period April 2015 to December 2015 ranged from 89.4% for additional clinical services, 90.7% for nursing and midwifery registered staff to 100% for administrative and clerical staff compared to the trust target of 95%.

- Appraisal rates for the imaging reporting unit ranged from 50% for additional professional scientific and technical staff, 95.4% for allied health professionals to 100% for healthcare scientists for the same period.
- Staff told us they felt supported to develop in their roles with several providing examples of internal and external opportunities for study up to and including Masters Level.
- Managers described how they managed poor performance including the provision of a support framework to individual members of staff.

## Multidisciplinary working

- The diagnostic imaging and outpatients departments were staffed by a range of professionals working together as a multi-disciplinary team to provide a comprehensive service to patients.
- Specialist nurses were in post and provided a wide range of nurse-led clinics including breast clinic, haematology, diabetes and HIV.
- A one stop clinic was provided in the breast clinic in the Linda McCartney Centre, so that following consultation and examination; patients could undergo investigations such as mammogram, ultrasound and aspiration according to clinical need and receive results within the same visit. This ensured patients received prompt results, which helped to reduce anxiety and also prevented the need for patients to return for several appointments.
- The sexual health clinic also provided a one stop service so that patients could attend for clinical examination, investigation and obtain medication if required within one clinic appointment.
- Radiologists were available at pre-determined times during the working day to discuss individual patient cases with colleagues
- Monthly team meetings were held within the Therapy department involving all disciplines to exchange information.
- The sexual health clinic was the main HIV centre for the region and held monthly regional multi-disciplinary meetings to discuss complex cases.

# Outpatients and diagnostic imaging

- Letters were sent from the outpatients department to patient's GPs to provide a summary of the consultation and radiology results were sent electronically or faxed.
- The counsellor based in the eye outpatients department had links with the trust clinical psychology department and attended meetings and training. Staff could then remain current and competent and also have peer support in their role.

## Seven-day services

- The diagnostic and imaging departments provided services such as blood tests, x-ray and scanning at the weekend. Magnetic Resonance Imaging (MRI) was provided at the weekend by staff working additional hours on a voluntary basis and interventional radiography was available as an on call service.
- St Paul's eye unit offered clinic appointments on a Saturday and additional clinics were scheduled at weekends within general outpatients on occasion. An additional orthopaedic clinic had been held on Saturday 27 February.

## Access to information

- The radiology department used a nationally recognised system to report and store patient images. The system was used across the trust and allowed local and regional access to images. Previous images could also be viewed by staff.
- Staff told us that appointments were not cancelled due to unavailability of records, as a temporary record was raised that included new patient referral letters. Previous investigation results and letters were available electronically for patients attending a follow up appointment.
- Between 1 September 2015 and 1 February 2016, data from the trust showed that, with the exception of three dates, the number of temporary records required on a daily basis was less than 1%.
- Staff were able to access information such as policies and procedures from the trust's intranet.

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

- Staff in outpatients and diagnostic imaging worked on the principle of implied consent. If written consent was required for more complex procedures this was obtained in outpatients clinic by medical staff or nurses who had received additional training.

- Procedures were in place to accommodate patients who lacked capacity to consent to their own treatment.
- In St Paul's eye unit eye orthoptists were also able to obtain patient consent for procedures in Botox clinic.
- During the inspection, in the computerised tomography (CT) department we observed a patient being asked to consent to treatment. The patient refused but appeared to lack capacity give consent so the staff member checked for a Deprivation of Liberty Safeguard authorisation in their health record. The ward was contacted, as no record was present. The radiographer then acted appropriately and returned the patient to the ward until the appropriate documentation had been put in place.

## Are outpatient and diagnostic imaging services caring?

Good



We rated Outpatients and Diagnostic imaging as 'Good' for Caring because;

- Outpatient and diagnostic services were delivered by caring, committed and compassionate staff. We observed how staff interacted with patients and their families and found them to be polite, friendly and helpful.
- Reception areas in main x-ray and M and N clinic had measures in place to respect patient confidentiality at check in.
- The patients we spoke with were positive about the way staff looked after them. Care was planned that took account of patients' needs and wishes.
- The trust had a number of clinical nurse specialists available for patients and their families to talk to about their condition.
- Psychological and emotional support was available for patients in a number of outpatient clinics.

## Compassionate care

- Patients and relatives told us that staff introduced themselves and they were treated with kindness and compassion.
- We witnessed reception and nursing staff being polite and helpful both in person and during telephone contacts.

# Outpatients and diagnostic imaging

- The main x-ray department and reception desk in N and M clinic had signs asking patients to respect patient confidentiality and wait to be called forward.
- Outpatient x-ray had changing rooms that led straight into the scanning room so that patients did not need to wait in an open waiting room in a state of undress.
- The trust had a Chaperone policy and with the exception of one male consultant, all staff in the breast clinic were female to ensure that chaperones were the same gender as the majority of service users.
- We spoke with patients and families who told us that privacy and confidentiality were respected.
- The NHS Friends and Family Test, which assesses whether patients would recommend a service to their friends and family, showed that between 1 April 2015 and 10 March 2016 94% of outpatients from across the trust were likely or extremely likely to recommend the service.

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

- We saw positive interactions between staff, patients and those close to them.
- Patients were informed following diagnostic investigations when they should contact their GP for the results.
- Some patients reported receiving copies of GP letters following their consultation, however, notices were displayed around the outpatient department advising patients how to request a copy if required.
- Patients told us they understood when they would receive their tests results and next appointment and how they could contact the service by telephone if needed.

## Emotional support

- The trust had a wide range of clinical nurse specialists available for patients to talk to about their condition.
- Patients told us they were always involved in discussions and decision-making regarding their treatment plan.
- We observed information given to patients verbally and in written format regarding their condition and treatment.
- Counselling services were available for patients and their families attending St Paul's eye unit and health advisors were available to support patients who attended the sexual health clinic.

## Are outpatient and diagnostic imaging services responsive?

Good



We rated Outpatients and Diagnostic imaging as 'Good' for Responsive because;

- Patients had a choice of appointments and additional clinics were held in the evenings or at weekends to reduce waiting times.
- Pagers were available in general outpatient clinics to allow service users to leave the waiting area and be recalled when it was time for their consultation.
- Virtual clinics had been set up in orthopaedics and for glaucoma patients in St Paul's eye unit.
- Staff described how people in vulnerable circumstances were accommodated in the department and how their appointment could be escalated if required.
- Access to interpreter services could be arranged by telephone for those patients whose first language was not speak English and provision was made for bariatric patients.
- Within the outpatient areas there was a range of information leaflets and literature available for patients to read about a variety of conditions and support services available.
- The performed above the England average for 18 week referral to treatment standards for non-admitted pathways between September 2014 and November 2015.
- The trust performed above the England average for referral to treatment times for incomplete pathways between September 2014 and November 2015, however, this dipped slightly in December 2015 and January 2016.
- Between May 2015 and February 2016 the trust met the national standard for diagnostic imaging waiting times with the exception of January 2016.

However;

- The 'did not attend' (DNA) rate was higher (worse) than the England average at all sites within the trust; however, the trust used a text service to remind patients a week and also a day before their appointment.
- Laboratory reporting times were significantly below the nationally recommended turnaround time in January

# Outpatients and diagnostic imaging

2016 with 37% of cases reported in 10 working days compared to a target of 90%. At the time of our inspection a recovery plan was in place. Data for February 2016 showed that reporting rates had increased and between 69% and 80% of cases had been reported within 10 days.

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

- We observed clear signposting through the hospital to the outpatients and diagnostic imaging departments.
- Patients told us they received instructions with their appointment letters and were given written information, as needed.
- Waiting areas had sufficient seating available with access to toilets and drinking water. However, some seated waiting areas in outpatient clinics such as N clinic and St Paul's eye clinic were along corridors which were crowded due to limited space and paint work on the walls and ceiling in Ear Nose and Throat clinic (ENT) was noted to be flaking off. It was not that a new hospital was under construction on an adjoining site and a move was scheduled for 2017.
- The central room in ENT clinic where naso-endoscopy procedures were carried out connected to four examination rooms and staff told us that staff would use this as an access route rather than walking around to the main corridor, thus potentially compromising patients' privacy. Similarly the outpatient department in St Paul's eye unit consisted of seven adjoining treatment bays, which did not ensure privacy or confidentiality.
- A shuttle bus service was available on request from the car park to the hospital if required.
- A self - check in facility was in use the main x-ray and computerised tomography (CT) reception to improve patient flow; however this service was only available to patients with a pre-arranged appointment.
- The main x-ray department and reception desk in N and M clinic's had signs asking patients to respect patient confidentiality and wait to be called forward. Both N and M clinic are vascular and orthopaedic clinics.
- Patients were provided with a voucher for refreshments if clinics were delayed more than 45 minutes.
- Pagers were available in general outpatient clinics, St Paul's outpatient department and the therapies department to allow service users to leave the waiting area and be recalled when it was time for their consultation.
- Additional clinics were held in the evenings or at weekends to reduce waiting times for patients. For example, an orthopaedic clinic had been held on Saturday 27 February 2016 prior to our inspection.
- Virtual clinics had been set up in orthopaedics and for glaucoma patients in St Paul's eye unit. A virtual clinic is a pre-arranged contact with a patient by telephone or video-link that eliminates the need for a face to face consultation.
- The Roald Dahl Centre was a nationally accredited Comprehensive Care Centre and provided a service for patients with bleeding disorders, Haemophilia and Sickle Cell disease.
- Local opticians could refer patients electronically using the EPOC (Effective Practice and Organisation of Care) system directly to the hospital eye service, cutting out the need for a GP appointment for a referral.
- The eye clinic in south Liverpool was able to perform many routine services such as pre-operative assessment, biometry fields and optic nerve scans. Approximately 115 patients were seen at Garston Health Centre each week allowing greater access and choice for patients.
- There were twice weekly thyroid clinics that offered diagnosis and treatment with radioisotopes as an alternative to surgery.
- The radiopharmacy and nuclear medicine departments had developed a diagnostic test to image patients for prostate cancer. The Royal Liverpool Hospital was one of only two sites in the UK where this test was available.
- The patients waiting area in nuclear medicine was segregated into seated and bedded areas to protect the privacy and dignity of patients.

## Meeting people's individual needs

- Staff described how people in vulnerable circumstances were accommodated in the department and how their appointment could be escalated if required.
- We observed a family attending an appointment with a relative who was living with a learning disability was seen immediately on arrival. The family told us they had never waited in the outpatients department and could not praise the hospital enough.
- Access to interpreting services could be arranged by telephone for those patients whose first language was not English. The trust used headsets for this service as

# Outpatients and diagnostic imaging

opposed to relying on the telephone speaker. This allowed patients and staff to move around the department rather than being limited to one consultation area.

- If staff were alerted to a patient's requirements, face to face translators could be booked in advance; however, we did not see this system in use as we did not observe any patients requiring translation services during our inspection. The self-check in facility prompted patients to choose which language they wanted to use for the process.
- Provision for bariatric patients was available in some clinical areas such as a couch and chairs in orthopaedic clinic. An air mattress was available within the diagnostic imaging department to assist with patient transfers.
- Male patients who attended the breast clinic were taken straight to a consultation room from the waiting area.
- Within the outpatient areas there was a range of information leaflets and literature available for patients to read about a variety of conditions and support services available. They were only in English but could be ordered in other languages or alternative formats if required.

## Access and flow

- The trust performed above the England average for referral to treatment times for non-admitted pathways between September 2014 to November 2015. Non-admitted pathways means those patients whose treatment started during the month and did not involve admission to hospital. This information was trust-wide and not specific to Royal Liverpool University Hospital.
- The trust performed above the England average for incomplete pathways between September 2014 and November 2015. However, performance dipped slightly in December 2015 and January 2016. Incomplete pathways are waiting times for patients waiting to start treatment at the end of the month. This information was trust-wide and not specific to Royal Liverpool University Hospital.
- The percentage of people seen by a specialist within two weeks of urgent GP referral was slightly higher (better) than the England average between Q3 2013/14 and Q2 2015/16 with the exception of a dip in performance in Q2 and Q3 2014/15. This information was trust-wide and not specific to Royal Liverpool University Hospital.

- The percentage of people waiting less than 31 days from diagnosis to first definitive treatment was slightly lower (worse) than the England average for each quarter from 2014/15 onwards.
- The percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment was higher (better) for the trust compared to the England average each quarter between Q3 2013/14 and Q2 2015/16. This information was trust-wide and not specific to Royal Liverpool University Hospital.
- Between May 2015 and February 2016 the trust met the national standard for diagnostic imaging waiting times (that is less than 1% of patients waiting more than six weeks) with the exception of January 2016 which showed 1.9% of patients waited longer than 6 weeks.
- Data from the trust showed that in March 2016 46% of inpatient radiology examinations and 26% of outpatient radiology examinations were reported on within one day and 98% and 79% respectively were reported on within seven days. The figures for CT scan reporting were 94% of inpatient examinations and 38% of outpatient examinations were reported on within one day and 99% and 85% respectively were reported on within seven days. This information was trust-wide and not specific to Royal Liverpool University Hospital.
- Information from the trust showed that laboratory reporting times were significantly below the nationally recommended turnaround time in January 2016. In the week commencing 4 January 2016, 37% of cases were reported in 10 working days compared to a target of 90%. At the time of our inspection a recovery plan was in place which included investment in equipment and increasing consultant reporting sessions. Data for February 2016 showed that reporting rates had increased and between 69% and 80% of cases had been reported within 10 days.
- The trust had a number of patients who failed to attend for their appointments. The 'did not attend' (DNA) rate was higher than the England average at all sites within the trust. The trust used a text service to remind patients a week and also a day before their appointment. An '18 week pathway improvement workstream' had been initiated, which included a project to improve patient contact options, including use of a web form to request appointment changes.
- Patients told us they had a choice of appointments and 'hot' clinic appointments were available within vascular clinic.

# Outpatients and diagnostic imaging

- Between September 2015 and December 2015 the percentage of clinics cancelled within six weeks ranged from 2% to 3% and clinics cancelled over six weeks ranged between 2% and 4%. The main reasons for cancellation were annual leave, study leave and sickness. This information was trust-wide and not specific to Royal Liverpool University Hospital.
- Patients told us some clinics regularly ran late and appointments were running 30 minutes late in St Paul's eye unit outpatients department on 16 March 2016 during our inspection. Display boards were in operation to advise patients of delays as well as verbal notification provided by staff. However, staff and managers told us that information regarding waiting times following arrival was not routinely collected.

## Learning from complaints and concerns

- Initial complaints were dealt with by clinic managers in the outpatients department in an attempt to resolve issues locally; however, if this was unsuccessful, then information was provided about the Customer Relations Team previously known as the patient advice and liaison service (PALS).
- Staff we spoke with knew how to sign post patients to the Customer Relations Team and information notices regarding the Customer Relations Team and PALS were observed on notice boards in outpatient areas.
- The trust had a complaints policy and we reviewed 120 formal complaints received by the outpatients and diagnostic imaging departments at the Royal Liverpool University Hospital between 1 January 2015 and 31 December 2015. Of the complaints reviewed, 36 related to communication difficulties and/or staff attitude and 15 related to delayed or cancelled appointments.

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

Good



We rated Outpatients and Diagnostic imaging as 'Good' for Well-led because;

- Managers had a good knowledge of performance in their areas of responsibility and understood the risks and challenges to the service.
- Leaders in the department were visible and approachable..

- Quality and performance were monitored through outpatient and radiology dashboards and weekly performance meetings.
- There was an open and honest culture within the service, morale was good and staff felt included in the planning of the new hospital.
- Patients' views were actively sought and there was evidence of continuous improvement and innovation.

However;

- Not all staff were aware of the trust's vision.
- Minutes of clinical governance meetings held in radiology and outpatient departments were not available.

## Vision and strategy for this service

- The trust vision was "Delivering the highest quality of healthcare driven by world-class research for the health and wellbeing of the population". Not all staff were aware of the vision, but could describe the values such as being open and engaged and creative.
- Outpatients and diagnostics were led by general managers and a number of department specific operational and clinical leads.
- Staff told us that managers and clinical leads were visible and approachable.

## Governance, risk management and quality measurement

- Clinical governance meetings were held monthly in radiology to review incidents; however, meeting minutes were unavailable.
- Quarterly clinical governance meetings were held within the Sexual Health clinic when the department closed to patients. This also provided an opportunity for staff education and training.
- Radiation safety group meetings were held twice a year to ensure that clinical radiation procedures and supporting activities in the trust were undertaken in compliance with ionising and non-ionising radiation legislation.
- Managers told us that Radiation Protection Supervisors meetings were reinstated in November 2015 and we reviewed meeting minutes from November 2015 and January 2016, which detailed discussion regarding radiation procedures, incidents and protocols.
- The radiology and outpatients department recorded risks on the departmental risk register.

# Outpatients and diagnostic imaging

- Quality and performance were monitored through outpatient and radiology dashboards and weekly performance meetings. Patients waiting over 18 weeks were identified and oversight was provided by clinicians to ensure priority was given to most clinically urgent patients.

## Leadership of service

- Managers had a good knowledge of performance in their areas of responsibility and they understood the risks and challenges to the service.
- Staff felt supported by their local managers and said the executive team were visible.
- Regular weekly and monthly team meetings took place in outpatients and radiology.

## Culture within the service

- There was an open and honest culture within the service and staff were candid about the challenges they faced.
- Morale was reported as good in the areas we visited and we observed good team working.
- Staff in several outpatient and radiology areas told us they felt “part of a family” within their smaller areas, however, still part of the wider department.

## Public engagement

- The views of patients were actively sought within outpatients and diagnostic imaging using the NHS Friends and Family Test and the patients listening board. The patients listening board encouraged patients to attach comments on “post-it notes” on to a board within the departments with suggestions to improve or compliment the service.
- Sexual health clinic ran a continuous survey of patients’ opinion using an iPad. This was offered to patients in the waiting room and results were collated monthly. We reviewed comments received between January 2016 and March 2016 and all patients were positive regarding their experience and the approach of staff.

## Staff engagement

- Results of the 2015 NHS Staff Survey showed the trust scored higher than the national average for acute trusts for staff recommending the organisation as a place to work or receive treatment. This related to staff satisfaction with the quality of work and patient care they are able to deliver and for effective team working. However, the trust scored lower than the national average for staff motivation at work.
- Staff we spoke to felt included in the planning of the new hospital and many had visited the site to review progress and look at their individual departments.
- Physical and psychological support services were available to staff and staff were aware of how to access them.

## Innovation, improvement and sustainability

- The sexual health service was the main human immunodeficiency virus (HIV) centre for the region and had presented papers at national conferences including ‘Developing a new virtual HIV Network: our region’s experience’. The service was also involved in ongoing recruitment for research projects such as a randomised control trial of human papilloma virus vaccine (HPV) for treatment of genital warts.
- A specialist ocular oncology service was provided within St Paul’s eye unit and the Clinical Eye Research Centre worked closely with a local academic establishment.
- The endocrine service within nuclear medicine had developed a nurse-led neuro-endocrine service and been awarded Team of the Year 2014.
- The nuclear medicine and radiopharmacy teams had developed a diagnostic agent for imaging prostate cancer. The teams had again been nominated for team of the year at the trust awards.

# Outstanding practice and areas for improvement

## Outstanding practice

- The emergency department worked collaboratively with local support groups and charities to provide excellent in reach and outreach services to sections of the local population. This meant patients received the best possible care which met their individual needs.
- The emergency department's practice development team provided excellent support and education to the staff within the department. They were responsive and provided tailored training programmes in response to issues identified through incidents and debriefing sessions which ensured that the staff within the department were equipped with the skills and training necessary to provide high quality patient care.
- The emergency department provided an education programme and outreach service to local education establishments on the dangers of knife crime with the aim of reducing this particular type of crime in the local population.
- The critical care team led by a designated consultant was developing guidance for staff in the application of the Mental Capacity Act 2005 and associated deprivation of liberty safeguards in the critical care setting. It was hoped that this guidance once approved would be adopted across both the local and national critical care networks.
- The electronic whiteboard system used across the trust provided staff with information as to the bed allocated to each patient and to whether patients had particular assessments completed, for example venous thromboembolism (VTE). The board was also used to highlight vulnerable patients. We viewed the whiteboard on ward 3X where staff were piloting an increased functionality such as access to the National Early Warning Score (NEWS), referrals, graphs of patient's results over time and interaction with medical staff via the white board. We found this to be good practice and innovative.
- The trust had a comprehensive end of life vision and strategy set out for 2013- 2018. Their vision was to deliver the highest quality healthcare driven by world class research for the health and wellbeing of the population. End of life services had partnered with Marie Curie Palliative Care Institute Liverpool (MCPCIL) to further research and develop end of life services and collaborated with the Cheshire and Merseyside end of life network group to share research findings. This collaborative working helped support the commissioning and provision of excellent and equitable end of life services for the people of Merseyside and the surrounding boroughs.
- The trust had developed and opened a new Academic Palliative Care Unit (APCU), providing a 12 bedded unit for patients who were at the end of life.
- The trust had a well-established and well-staffed palliative care directorate that worked closely with other organisations to improve the quality of end of life services in Merseyside.
- The palliative care service was embedded across the trust and held in high regard by all the wards we visited. Palliative care was integral to the trust and had a well-developed and substantial palliative care directorate that was part of the medicine division.
- The trust had a robust education and training programme in end of life care and a formal programme of study days which was co-ordinated by the Hospital Specialist Palliative Care (HSPC) team and provided in conjunction with MCPCIL.
- End of life services had a substantial care of the dying volunteer service to ensure that patients and their families were supported. The volunteer service were winners of the Deborah Hutton award in 2015.
- Through working in partnership with the MCPCIL they had developed and appointed two discharge co-ordinators and implemented a rapid discharge home to die pathway. This had achieved excellent results in ensuring end of life patients were supported to be discharged to their preferred place of care.
- Care provided to patients went beyond most people's expectations. Staff showed care and compassion and went the extra mile to ensure patients at the end of life were well cared for. Care for patients and their families was the responsibility of all staff and not just the HSPC team.
- The mortuary staff were able to carry out reconstruction and camouflage to deceased patients to ensure that bereaved families were able to view their loved one.

# Outstanding practice and areas for improvement

## Areas for improvement

### Action the hospital **MUST** take to improve

#### In all areas

- The trust must ensure that fridges used to store medications in all areas are kept at the required temperatures and checks are completed on these fridges as per the trust's own policy.
- Where fridge temperature ranges are recorded outside the recommended minimum or maximum range, steps must be taken to identify if medicines stored in the fridges are fit for use.
- The trust must ensure that medicines, including controlled drugs and intra-venous (IV) fluids, are securely stored in line with legislation.
- The trust must ensure that emergency resuscitation equipment is readily available in each area, to provide timely access to emergency resuscitation equipment. At the time of the inspection we found equipment shared between wards which meant there may be a delay in accessing emergency equipment.
- The trust must ensure that all emergency equipment is checked regularly in line with trust policy and is ready for use in order to be able to respond safely in an emergency situation.
- The checking of medication, including controlled medication must be carried out consistently as per trust policy.
- The trust must ensure the expiration date of medicines is monitored. Drugs that are past their expiry date must be disposed of promptly.

#### In Medical care

- The service must ensure controlled drugs are stored in line with the legislation on the Acute Medical Unit (AMU).
- The service must find an acceptable option to ensure its compliance with Health and safety best practice guidance for the storage of portable oxygen

### Action the hospital **SHOULD** take to improve

#### In Urgent and emergency services

- Take steps to achieve national targets to see, treat and discharge 95% of patients within four hours of arrival.
- The service should take steps to ensure that patient records are updated in a timely way and reflect the care the patient receives.
- The service should ensure that risk assessments are completed as appropriate for all patients who require them.
- The service should improve the compliance with mandatory training and ensure that they are able to access department level data on the number of staff trained in advanced life support.

#### In Medical care

- In order to maintain the security of patients, visitors were required to use the intercom system outside wards to identify themselves on arrival before they were able to access the ward and staff had access codes. The service should ensure that all of these doors are closed to prevent people from entering the ward without the knowledge of ward staff.
- The service should review the practice of leaving record trolleys containing patient notes opened or larger records unsecured on the trolleys.
- The service should review the lack of dedicated endoscopy nursing staff with specialist skills available out of hours.
- The trust should continue to review its management of patient flow and the issues of outliers to make sure patients are treated on wards suitable to meet their needs.
- The service should improve compliance with mandatory training.
- The service should review the Deprivation of Liberty Safeguards (DoLS) paperwork and the issue of nursing staff transcribing information from the medical notes as part of the assessment application

# Outstanding practice and areas for improvement

process. The service should ensure information is correctly entered on the application forms and all the relevant information related to the patient has been captured.

## In Surgery

- The trust should keep revisions to the theatre lists to a minimum to help prevent potential errors.
- The trust should improve the levels of staff trained in resuscitating patients.
- The trust should ensure that patients belongings are safely stored particularly if bed shortages reduce storage capacity.
- The trust should review staff competencies in theatre recovery to ensure they have the necessary competencies to care for high dependency patients if required.
- The trust should manage serious complaints in a timelier manner.
- Checking and maintenance of equipment should be undertaken regularly.

## In Critical care

- The trust should take action to reduce the numbers of delayed and out of hours discharges from both level 2 and level 3 critical care facilities.
- The trust should take steps to improve records so that they are not untidy and it is easy to find notes related to the current episode of care.
- The trust should consider how it can develop and expand the critical care outreach service to provide cover 24/7.
- The trust should consider how it can improve the ratio of consultants to patients during the night when the unit is busy so that the ratio does not exceed 1:15.
- The trust should consider how it is going to meet the intensive care society standards for the provision of pharmacy, dietetic and other allied health professional support to the critical care service.
- The trust should take action to ensure that all critical care patients are managed in accordance with the national guidance and standards for critical care.

- The trust should take action to reduce the number of cancelled elective surgical cases.
- The trust should assure itself that the risks associated with storing patients' medicines in their rooms in the high dependency unit are managed safely.
- The trust should consider re-auditing capacity and demand in the unit as the last audit was conducted in 2014.

## In End of life care

- The trust should take action to change the care of the dying document as this does not allow for a person centred and individual care record. It is too close in nature to the Liverpool Care Pathway (LCP) document which was withdrawn from use.
- Action should be taken to ensure that the DNACPR's are completed accurately with the medical rationale for not attempting resuscitation and discussions with patients and family being recorded appropriately. Where a patient lacks the capacity to make decisions with regards to resuscitation then this must be fully documented and best interest decisions recorded.
- The trust should take action to assess all ligature risks in patient bathrooms and to ensure the safety of those patients with severe mental health conditions are protected. For example on APCU we found a ligature risk in the patient bathroom.
- The trust should take action to protect patient information at all times. For example, the seating area on the Academic Palliative Care Unit (APCU) is behind the reception desk and risks information being seen when the receptionist is using the computer.
- The trust should take action to provide a full seven day consultant service to enhance the care and treatment of patients who are at the end of life.
- The trust should take action to develop a formal handover guidance tool for nursing staff. For example we observed that on the APCU the nurse delivering the handover was using pieces of paper to handover the nursing details of patients instead of a guided handover tool.

# Outstanding practice and areas for improvement

## **In Outpatients and Diagnostic Imaging**

- The trust should ensure all equipment is portable appliance tested (PAT) and fit for use.
- The trust should ensure staff complete mandatory training when required.
- The trust should ensure procedural checklists in St Paul's Eye Unit have patient identifiable information on them.
- The trust should monitor patient waiting times following arrival in outpatient departments.

## 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<br>Surgical procedures<br>Treatment of disease, disorder or injury | <p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <p><b>How the regulation was not being met:</b></p> <p>The provider did not do all that was reasonably practicable to mitigate risks. This is because:</p> <p>Checks on fridges used to store medications in all areas were not always completed as per the trust's own policy.</p> <p>Where fridge temperature ranges were recorded outside the recommended minimum or maximum range, steps were not always taken to identify if medicines stored in the fridges were fit for use.</p> <p>Medicines, including controlled drugs and intra-venous (IV) fluids, were not always securely stored.</p> <p>At the time of the inspection we found equipment shared between wards which meant there may be a delay in accessing emergency equipment.</p> <p>Emergency equipment, including resuscitation trollies were not always checked regularly in line with trust policy and in some cases, despite them being checked, there were out of date items present.</p> <p>The checking of medication, including controlled medicines were not always carried out consistently as per trust policy. Out of date medication was identified in some areas.</p> <p>HSCA 2008 (Regulated Activities) Regulations 2014, Regulation 12 (2) (b)</p> |