

Worcestershire Acute Hospitals NHS Trust

Worcestershire Royal Hospital

Inspection report

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Ratings

Overall rating for this location

Requires Improvement 

Are services safe?	Inspected but not rated 
Are services effective?	Inspected but not rated 
Are services caring?	Inspected but not rated 
Are services responsive to people's needs?	Inspected but not rated 
Are services well-led?	Inspected but not rated 

Our findings

Overall summary of services at Worcestershire Royal Hospital

Requires Improvement ● ➡ ➡

Worcestershire Royal Hospital provides acute hospital services to a population of 580,000.

We inspected Worcestershire Royal Hospital critical care services only during this inspection. We used our comprehensive inspection methodology as this service had not been inspected since 2017 when we rated critical care at this location requires improvement. We carried out an unannounced visit to critical care services at Worcestershire Royal Hospital on 18 December 2023.

The trust has a countywide approach to critical care; and therefore, overall management of the critical care service is the same across the 2 sites that deliver this; the Worcestershire Royal Hospital and the Alexandra Hospital in Redditch. There are a total of 23 beds countywide with 8 beds at the Alexandra Hospital and 15 at the Worcestershire Royal Hospital. The service is funded for up to 15 level 3 beds across both sites and work with 4 at the Alexandra Hospital and 11 at Worcestershire Royal Hospital. Beds can be used or 'flexed' between level three and level 2 depending on patient need (level 3 beds require 1 nurse to each patient and level 2 beds 1 nurse between 2 patients). In addition, the trust has 8 high dependency (level 2) beds on the acute respiratory unit which is situated within the acute respiratory ward and 8 level 2 beds on the hyperacute stroke unit (HASU, within the acute stroke unit). We visited the HASU but as it did not have any high dependency patients at the time of our inspection, we have not included these findings in this report. To get to the heart of patients' experiences of care and treatment, we ask the same 5 questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led? Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate. Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity. with support from an offsite inspection manager, carried out the inspection on 18 December 2023. During the inspection we reviewed a range of documents related to running of the service including, staffing rotas, performance data, risk assessments and emergency equipment checks, policies and procedures, an independent website browser platform and servicing records of equipment. We spoke with 11 members of staff including service leaders and 3 patients and 2 relatives who had used the service. We reviewed 5 sets of patient records.

Critical care

Good  

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To get to the heart of patients' experiences of care and treatment, we ask the same 5 questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led? Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate.

Our rating of this core service at this location improved. We rated it as good because:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff mostly assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Most key services were available 7 days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.
- Leaders ran services well and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

However:

Critical care

- The trust was not compliant with National Institute for Health and Care Excellence national guidance around rehabilitation after critical care.
- There was no system in place to provide assurance that the management of sepsis was in line with the National Institute for Health and Care Excellence clinical guideline 'sepsis: recognition, diagnosis and early management' or the services own guidelines.
- Whilst all patients had a venous thromboembolism (VTE) risk assessment on admission the percentage of patients receiving a further VTE risk assessment after 24 hours had dropped to 83%.
- Information provided by the trust identified 62% of nursing staff and 67% medical staff had completed level 2 resuscitation and adult basic life support.
- The availability of a specialist critical care pharmacist did not meet the national critical care standards.
- There were insufficient physiotherapists to meet the national critical care standards to support the needs of the service.
- Admissions to the high dependency area of ARU were not timely. Patients should be admitted within an hour but in November 2023, this was not met for 4 patients with an average wait of 4 hours and 34 minutes.
- Where patients were due to be discharged to a ward as they no longer required a critical care bed; this was not done in a timely way due to capacity across the hospital.
- There had been a delay submitting and validating the Intensive Care National Audit and Research Centre data which meant information about performance and benchmarking the service was not assured.
- Staff did not routinely consider the need to undertake mental capacity assessments to identify capacity to consent to routine care and treatment and apply for Deprivation of Liberty Safeguards where applicable for certain restrictions for patients who no longer needed to be on intensive care; but were still located there due to hospital capacity.

Is the service safe?

Good  

Our rating of safe improved. We rated it as good.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Most staff had received and kept up to date with their mandatory training. The trust had a comprehensive mandatory training programme which met the needs of patients and staff. Mandatory training included modules on conflict resolution, equality, diversity and human rights, infection control, risk, health and safety and mental health.

The trust target for mandatory training was 90% but critical care had identified their target as 95%. Most staff had achieved compliance rates at or around the target. Mandatory training which fell below the required target was moving and handling level 2 (87%) and basic life support (62.3%); this was due to new staff starting who had not yet completed these modules. Information provided by the trust confirmed training had been arranged.

Critical care

Medical staff compliance with mandatory training was 94% which also met the trust target.

For the acute respiratory unit (ARU), 100% of administration and clerical staff and 92% of nursing staff had completed all required mandatory training. However, compliance for additional clinical service staff was 87.5% and medical staff 84% which did not meet the trust target.

Staff received online training on sepsis management which was developed by the trust. Sepsis training was undertaken during staff induction and for medical staff during teaching sessions. Staff completed updates every 2 years. Training included sepsis screening tools and use of sepsis care bundles. Sepsis management was included in the 'Guidelines for managing sepsis and septic shock in adults'. Information provided by the trust identified 96.6% of nursing and other clinical staff and 100% of medical staff within the critical care unit had received (or had updated) sepsis training in the last 2 years. For ARU 85% of all staff had completed the training.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. Information provided by the trust identified for the main critical care unit 94.3% of nursing and other staff had received training in dementia awareness and 100% of medical staff. Information provided for the ARU identified 92% of nursing and other staff had received dementia awareness training and 84% of doctors and consultants.

The Health and Care Act 2022 introduced a statutory requirement that regulated service providers must ensure their staff receive learning disability and autism training appropriate to their role. The trust was part of an integrated care system (ICS) implementation pilot to deliver Oliver McGowan Mandatory Training, which is standardised training developed for this purpose, to its staff. This training is about supporting people with learning disability and autistic people. This pilot required 10% of staff to complete tier 1 (online learning for non-patient facing staff) or tier 2 (face to face training for patient facing staff) at this time. The training will form part of the mandatory training matrix from September 2024 to capture staff who have not yet undertaken this. This meant at the time of inspection, not all staff had received this training however, the trust was underway to achieve this collaboratively with the ICS.

Managers monitored mandatory training and alerted staff when they needed to update their training.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training specific for their role on how to recognise and report abuse. Safeguarding training was part of the trust mandatory training programme. The trust target was 90% for safeguarding training; 96% of nursing staff had completed level 2 adult safeguarding and 100% of nursing staff had completed both level 3 adult and child safeguarding. Information provided for the ARU 100% of administration and clerical staff had completed level 1 adult safeguarding and 100% had completed level 2 child safeguarding; 96% of nursing staff had completed level 2 adult safeguarding and 93% of nursing and midwifery staff had completed both level 3 adult and child safeguarding. The trust had had a new cohort of international nurses who were working through their mandatory training and individual percentages had increased since the initial data was requested.

Medical staff received training specific for their role on how to recognise and report abuse. Information provided identified the trust target of 90% completion of safeguarding was met. Compliance with level 2 adult and child safeguarding was 94%, and level 3 child safeguarding was 100%. For ARU 96.5% of medical staff had completed level 2 adult safeguarding and 96.5% level 2 child safeguarding.

Critical care

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Information was included within the trust safeguarding policy and confirmed they would ensure all services were provided in a manner which did not discriminate in any unlawful or unprofessional way.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff were aware of safeguarding policies and procedures and could identify the process used to escalate any concerns.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Information was displayed to guide staff how to raise safeguarding concerns and seek advice when required. The matron was safeguarding lead within critical care and the trust also had a safeguarding team who were available to provide staff with advice and support to raise safeguarding concerns. If the matron was not on duty staff were also able to contact the on-call matron for advice. If a patient demonstrated signs of mental ill health staff could make a referral to the mental health team to ensure the patient was safeguarded.

Cleanliness, infection control and hygiene

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

All areas within the critical care service were clean and had suitable furnishings which were also clean and well-maintained. Nationally recognised cleaning materials were in use throughout the service and during the inspection we observed staff cleaning equipment after patient contact. We observed that labels to show when equipment was last cleaned were used continually throughout the service.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly in line with a cleaning schedule. An in-depth cleaning audit for the 11 December 2023 demonstrated 93% compliance included checking of ventilation grilles, extracts and inlets and over bed lighting.

Colour coded mops and aprons were in use throughout the service to reduce the risk of cross contamination.

Staff followed infection control principles including the use of personal protective equipment (PPE) which was available throughout the service. Staff had undergone specialist mask fitting testing and managers told us that bank staff were fit tested by the service and agency staff were tested by the agency as part of the service level agreement. This meant that everyone working in the unit had access to the most appropriate level of protective equipment when required.

Staff had completed training in infection prevention and control, level 2, 94% of the 61 members of staff had completed this training within the last 12 months at the time of the inspection.

We saw staff followed the 5 principles of hand hygiene, posters were displayed around the unit and there were sinks so that staff could easily wash their hands. Hand hygiene audits carried out by the service in September, October and November 2023 demonstrated that all staff followed hand hygiene practices in line with the National Institute for Health and Care Excellence (NICE) quality statement 61 statement 3 which required healthcare workers to decontaminate their hands immediately before and after every episode of direct contact or care. A minimum of 40 staff were reviewed each month and a dashboard showed staff the number of staff per job category that had been reviewed as well as a league table per job category this meant that managers could easily identify if there was a theme or trend emerging.

Critical care

Infection prevention and control audits were undertaken by the critical care service which monitored cleaning and decontamination, patient placement and assessment for the risk of infection, PPE and hand hygiene. An audit completed in November 2023 scored 86% which was below the level deemed acceptable by the trust. An action plan for improvement was introduced and an increased audit cycle was started by both the ward manager and matron in line with the management of infection prevention and control policy.

A decontamination of medical devices policy set out a reusable surgical instrument cycle as well as individual roles and responsibilities. Contact tracing decontamination records were kept by the service for reusable equipment such as a camera to help place a breathing tube into a patient's airway.

Stool charts were used for all patients and set out in the standard infection control policy for the service was a risk assessment for any patient with a stool that is soft or loose to prevent spread of infections.

The service had an infection, prevention and control link nurse programme in place in line with national expectations. Information provided by the service demonstrated that quarterly face to face meetings were held and information from the meetings were cascaded to all staff within the service. Information such as new emerging infections, waste management and bed cleaning were topics that had been discussed.

The service monitored infection rates in line with national expectations. Between December 2022 and December 2023, the service had 1 case of a blood stream infection recorded and 2 cases of the bacterial infection *Clostridium difficile*. A consultant microbiologist reviewed the case of blood stream infection and found there had been appropriate detection and management. The trust also provided an action plan which identified a risk assessment must be completed on the onset of diarrhoea and vomiting and timely stool sampling undertaken, this was discussed with all staff during safety huddles.

Two negative and positive pressure isolation rooms were in place within the service along with 3 double bedded pods with sealable doors.

Central venous catheter rated blood stream infection data was requested but the trust responded to say this information was not available.

A quarterly antibiotic point prevalence survey was carried out by the service and monitored the correct documentation of allergies, the length of intravenous antibiotic use, whether a 72-hour review had been carried out and whether antibiotic use was in line with guidance. In quarter 3 of 2023/24, 50% of the 9 cases surveyed had been reviewed at 72 hours. All 9 cases surveyed had antibiotics in line with guidance. Information sharing with staff including a highly visible notice board in a staff area was used to improve awareness and compliance. An antimicrobial stewardship policy set out the framework for compliance across the wider trust.

Audits completed for the ARU included the full ward of patients, therefore the data for patients with high dependency could not be extrapolated. emergency.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

Patients could reach call bells and staff responded quickly when called. Each side room and pod (cubicle space with a door) had call bells and alarms where staff and patients could get help quickly if needed.

Critical care

The design of the environment followed national guidance. There was secure access on to the unit and a one-way walkaround system was in place. Frosted and partial frosted windows were in place within the individual 'pods' to maintain privacy and dignity but also to support as much natural light entering the windows as possible. A white decoration scheme was in place throughout the service as well as green disposable curtains creating a calm environment.

Staff carried out daily safety checks of specialist equipment including emergency equipment and ventilation equipment and could access a 24-hour 7 day a week on call electrical and biomedical engineer service as well as onsite mechanical engineers if required.

The service had enough suitable equipment to help them to safely care for patients. Point of care testing for blood gas analysis, glucose and ketone analysis was within the service and available 24 hours a day 7 days a week. Equipment which was compatible with the magnetic resonance imaging machine for mechanically ventilated patients was also clearly labelled.

A stock of back up ventilators were held by the service and there was a lead consultant for equipment in line with national expectations. An equipment loaned out log was kept so that items could be tracked and returned. Portable appliance testing was in line with health and safety executive guidelines.

A programme of equipment replacement was in place. Information provided by the service demonstrated that each medical device was listed on a lifecycle refresh database and servicing, maintenance and repair was undertaken by a mixture of both equipment manufacturers and in house engineers. During the inspection, we found that service dates were within the correct timeframe and recorded appropriately.

Consumable equipment was monitored and stocked regularly. All consumable stock reviewed at the time of the inspection was within its expiry date and there were multiple computer desks, computers and treatment trolleys available for staff to use.

Staff completed training and were assessed to ensure they were competent in the use of equipment such as ventilators as part of the service 'step level training booklet' this was a portfolio that all new clinical staff completed over their initial 12-month induction period within the unit.

The service had plans in place to manage emergency situations with equipment, this included emergency oxygen cylinders attached to each bed in the event of a problem with the piped oxygen supply and an emergency oxygen shut off valve. A back up power supply in the event of power failure was in place and followed national expectations. Each bed had access to a backup computer system as well as a written power failure response pack. This set out a step wise approach for staff to follow in the event of power loss. Fire extinguishers were located throughout the service, these were sealed, tagged and had been checked and staff that we spoke with understood the fire escalation plan in place within the service, a written copy was available for staff at the main desk in the centre of the unit. This was in line with the local fire procedure and the trust wide fire safety strategy and policy.

Staff disposed of clinical waste safely and posters around sharp safety were visible throughout the service.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration but did not have a sepsis management tool and not all staff had received resuscitation training.

Critical care

Staff used a nationally recognised early warning clinical observation tool to identify deteriorating patients and escalated them appropriately. Patient records reviewed demonstrated that escalation was sought appropriately when required.

At the time of the inspection, there were no patients in the service suffering from suspected sepsis, therefore, we reviewed 3 patient records demonstrating the use of the sepsis pathway. Data reported that staff followed national guidance to treat patients with suspected sepsis in a timely manner, at the time of the inspection this was not audited. However, the service did not have a sepsis management tool in place for the recognition and rapid treatment of patients suspected to be suffering from sepsis. Staff we spoke with during the inspection and information provided by the service following the inspection indicated that there was a reliance on the recognition of sepsis during routine reviews of patients. This was not in line with the NICE clinical guideline 'sepsis: recognition, diagnosis and early management', particularly given some patients no longer required critical care and were awaiting discharge from the unit. This was also outside of the services own guidelines for the management of sepsis and septic shock in adults for the provision of intensive care services which stated "Emerging evidence that mortality rates from sepsis are improving. This would appear to be due to improved recognition of sepsis and illness severity by all clinical staff, and timelier, standardised management. There is consensus that early treatment with appropriate antibiotics and fluid resuscitation improves outcomes for patients".

The trust had a designated sepsis quality improvement project lead who was one of the critical care consultants. There were arrangements in place for the critical care electronic patient records to include an advanced septic screening tool which would identify clinical data every 15 minutes and identify a "sepsis risk score" the trust could then be more assured with their compliance with best practice for the management of sepsis and potential sepsis.

The service made sure there was at least 1 team leader on duty who was trained in advanced life support. Information provided by the trust demonstrated that of the 21 nursing staff, 14 (62%) and 12 of 18 medical staff (67%) had completed level 2 resuscitation and adult basic life support. The trust had identified a backlog in cardiopulmonary resuscitation training and had recently recruited 2 new resuscitation officers to support with clearing the backlog. Additional information provided by the trust identified, whilst not a critical care requirement for consultants 44 medical staff had completed advanced life support (ALS) training and all anaesthetic trainees have received ALS training.

The service had a critical care outreach team which operated for 12 hours a day 7 days a week. The team reviewed patients that had been discharged from the critical care unit to other wards in the wider trust for the first 72 hours and, any patient within the wider trust that was showing signs of deterioration. When the outreach team was not on duty, a night practitioner who was part of the corporate team with advanced practice skills was on duty to support wards with any patients who had deteriorated. At the time of the inspection the service was in the process of expanding the hours of the outreach team to 24 hours a day 7 days a week service.

Staff completed risk assessments for each patient on admission, using recognised tools such as the waterlow risk assessment to indicate risk of developing a pressure wound and the venous thromboembolism (VTE) risk assessment for blood clotting in a vein. These were reviewed regularly and were also reassessed after any incident such as a post fall risk assessment. Managers monitored the completion of risk assessments, in November 2023, 100% of the 21 cases reviewed by the service had a VTE risk assessment completed although 24-hour risk assessments had dropped to 83%. An action plan had been put into place to address this and further information provided by the trust identified that all patients now receive a 24-hour VTE risk assessment which is monitored through the electronic reporting system.

Staff knew about and dealt with any specific risk issues. An alcohol withdrawal risk assessment, smoking screening assessment and peripheral vascular devices assessment were all completed as required. Chronic health risk assessments were completed by doctors within the service and a clinical frailty score was assigned.

Critical care

A daily safety briefing took place within the service and was well attended. Important patient specific information such as allergies, airway problems, delirium and safeguarding issues were discussed along with risk in the unit, such as capacity or infection prevention and control issues. Key safety information, such as national patient safety alerts, location of emergency grab bag, registrar bleep handover were also discussed. In addition to this, 3 safety huddles took place throughout the day at times of staff handover.

Emergency trolleys were located within the service, they contained equipment to deal with a variety of emergencies including major haemorrhage and airway complications. Each trolley had been checked daily in line with service requirements for October, November and December 2023. An emergency intubation checklist was located on each trolley. This set out a clear step wise approach for staff to follow in an emergency, including the allocation of roles, equipment required and anticipatory problems. Posters were located on the storeroom doors to demonstrate the correct way of securing a breathing tube and how to correctly set up a particular type of nebuliser.

Point of care testing within the service was available 24 hours a day 7 days a week for blood gas analysis, glucose and ketone analysis.

Local safety standards for invasive procedures toolkit were located at the main desk within the service. This contained critical patient safety principles for different procedures to improve patient safety. The toolkit contained 8 different safety standards and procedures including central line, nasogastric tube insertion and percutaneous tracheostomy safety standards.

The service had 24-hour access to mental health liaison and specialist mental health support (if staff were concerned about a patient's mental health). Referrals were made by telephone which was followed by a face-to-face assessment. Dedicated mental health practitioners were assigned to the unit which meant the service had built good working relationships with staff from the mental health services. Staff we spoke with told us the service was easy to access.

Staff completed a combined nursing assessment upon admission which included gathering psychosocial information for all patients, not just those known or thought to be at risk of self-harm or suicide. This was important because it helped staff in the service gain a greater insight into the people they were caring for and served to highlight potential concerns that may benefit from additional support and intervention.

Staff shared key information to keep patients safe when handing over their care to others. Please see records section for further details.

Nurse staffing

The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction. However, allied health professionals staffing levels were not always in line with national standards.

The number of nurses and healthcare assistants matched the planned numbers. Nurse staffing numbers met core standards for intensive care units. Nurses on the critical care unit were allocated to one-to-one care for level 3 patients, one nurse provided care for up to 2 level 2 patients. Healthcare assistants were also on duty to help with personal care. Staffing rotas for the critical care department were reviewed during the inspection. These demonstrated that between 20 November and 17 December 2023 the planned levels of staffing matched the actual staffing levels for every early, late and night shift. During this time, we saw that out of a total of 84 shifts, bank staff supported the service on 52 occasions. No agency staff were used during this time.

Critical care

Staffing rotas for the ARU demonstrated that between the 20 November and 17 December 2023, the actual level of staff was below the planned level on 17 times out of 84 (20%). During the same period, agency staff filled 130 out of 544 shifts (24%).

Managers could adjust staffing levels daily according to the needs of patients and the level of care with which they required. This was in line with national standards which set out that all level 3 patients (those who needed support for 2 or more organs) had at least one registered nurse to one patient. Between the 20 November and 17 December 2023, the service provided information demonstrating the daily level of care each patient required and the adjusted staffing levels to match.

All shifts within each critical care unit had at least 1 supernumerary senior nurse (band 6 or 7). The matron was also supernumerary when on shift. We found that the availability of supernumerary nurses met best practice guidelines (core standards for intensive care units 2013). Nursing handovers occurred at least twice a day, during which staff communicated any changes to a patient's condition to ensure that actions were undertaken to minimise any risks.

Information provided by the trust identified there had been no unfilled shifts within either the main critical care unit or ARU. Information showed the number and skills of staff met the needs and numbers of patients requiring critical care.

Managers limited their use of bank and agency staff and requested staff familiar with the service. Bank staff were employed by the trust and had received all required mandatory training.

The critical care units also used agency nurses. The service had preferred agencies whose staff had received all the trust's mandatory training and competency assessments, including training to use the electronic patient medication system. Senior nurses told us they would where possible book the same nurses to cover shifts. Only if a shift could not be filled by one of the preferred agencies would the shift go out to be filled by other agencies. Between 20 November and 17 December, the number of actual nursing staff matched the planned number of nursing staff and there were no unfilled shifts during the same period.

Managers made sure all bank and agency staff had a full induction and understood the service. This included a local induction where staff were familiarised with the layout of the service, key pieces of equipment and policies and procedures. A short-term log in was provided to bank and agency staff so that they could record the care they had provided on the electronic patient record and raise safeguarding concerns and report incidents. The supernumerary nurse in charge worked closely throughout a shift with staff so that they had support if needed.

The service had a 12% vacancy rate for registered nursing staff and band 2 support staff combined. This equated to 11 whole time equivalent positions. Band 5 nursing staff comprised of 9.91 of whole-time equivalent positions whilst and band 6 nursing staff comprised of 3.06 whole time equivalent positions. This was offset by an increase of nearly 2 whole time equivalent positions of band 7 nursing staff.

The service had reducing vacancy rates and staff turnover. The matron for critical care services told us vacancies had decreased following a successful recruitment campaign. The service had several new nurses join the team with more commencing employment in January and February 2024. On the ARU the vacancy rate was 3.2%

The service had reducing sickness rates. Absence rates for November 2023 for the service were 4.7% of nursing, additional clinical services and administration staff. This had reduced from 8.06% in October 2023.

Critical care

The service had low rates of bank and agency nurses. If staffing levels were not met from their own staff working their contracted hours, the critical care staff were able to work overtime hours for the hospital's bank team.

The service did not always have sufficient allied health professionals to support the needs of the service. Insufficient physiotherapy and pharmacy establishment sat upon the service risk register however, no information was provided to demonstrate the actions and mitigations put in place to manage this risk. We requested information relating to the number of vacancies, sickness and turnover for allied health professional staff, but this was not provided. Therefore, it could not be determined whether the service was in line with national standards. The service had physiotherapists within the critical care unit over 7 days a week for respiratory patients. The pharmacy rota was across 5 days.

A dedicated pharmacist attended ward rounds twice daily 5 days a week and was a 0.5 whole time equivalent and there was also an on-call pharmacist for out of hours. This did not meet the national standard which set out that "there should be 0.1 whole time equivalent (WTE) pharmacist for every Level 3 bed and for every 2 Level 2 beds for a 5/7 a week service" and should be available seven days per week. The trust identified additional pharmacy staff were available.

However, staffing for other allied health professionals was in line with national standards. One critical care dietitian worked across 5 days a week and speech and language teams attended the unit twice weekly.

The service did not have a dedicated occupational therapist however, teams from the wider trust attended the unit to support patients with discharge when required. This was in line with national standards.

Mental health liaison teams were available by telephone referral. Staff told us they were usually available when contacted.

Medical staffing

The service had enough medical staff to keep patients safe.

Medical care within the critical care units was led by a team of 18 consultants who were anaesthetists that had an additional critical care qualification. Two critical care consultants were present on the critical unit daily Monday to Friday with the second consultant at the weekend working 8 to 1pm.

The ratio of consultants to patients was around 1:7.5. This met national recommendations of not more than 8 patients to each consultant.

Consultants were supported by registrars, junior doctors and advanced health practitioners for 7 days a week.

The critical care consultants undertook ward rounds twice daily in line with national expectations. This meant that patients' health and recovery was regularly assessed to ensure they received appropriate and timely treatment. (please see details on sepsis in assessing and responding to risk section above).

All potential patient admissions to critical care were discussed with a consultant and all new admissions were reviewed by a consultant within 12 hours of admission. Throughout the inspection we reviewed 6 patient records and found all had been reviewed within 12 hours of admission.

There were appropriate arrangements for medical cover overnight. A registrar or middle grade (doctor completing speciality training) doctor with intensive care experience was on duty between 5pm and 8am. In addition, a consultant was on call from home if required.

Critical care

Information provided by the service demonstrated that there were low vacancy rates for consultants (2.7 whole time equivalent) and trainee (qualified doctors of up to 6 years) grade medical staff and specialty grade (doctors with a minimum of 6 years qualification) doctors.

Sickness rates for medical staff ranged from 0.3% in September 2023, to 1.14% in November 2023.

Between 20 November and 17 December 2023, the number of actual medical staff matched the planned number of medical staff and there were no unfilled shifts during the same period. The service had low rates of bank and locum staff.

Critical care had 4 advanced critical care practitioners and 3 training advanced critical care practitioners who supported the service.

Despite the information provided by the service appearing to demonstrate adequate staffing levels, the service risk register contained a risk relating to low medical staffing levels. The service did not provide information other than the name of the risk, review date (April 2024) and moderate risk score (9) therefore it could not be determined whether this was historical or what actions if any had been taken to mitigate the risk.

Managers could access locums and bank staff when they needed additional medical staff and monitored patient acuity closely so that numbers could be increased if required.

Records

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

Patient notes were comprehensive, and all staff could access them easily. The service transitioned between February and September 2023 to complete electronic patient records including prescribing records, these were linked to the trust wide electronic system.

The service had a staff member responsible for carrying out patient record safety checks 5 days each week as a standard practice during the 'embedding' phase of the transition. The service was planning to move to an 'assurance' phase working with system owners to enhance audits and dashboard views. Information provided by the service demonstrated that six patient records between September and November 2023 were maintained to a good standard. The measures reviewed included the patient record contained the appropriate information, including oral care, a review by consultant was undertaken at appropriate times and relevant care bundles were completed. This mirrored what the inspection team found when reviewing 3 patient records during the onsite visit. Key pieces required for appropriate documentation such as whether the entries were signed, dated and legible were mandatory electronic fields and therefore automatically scored 100%.

Specific critical care assessment such as invasive ventilation, blood gases and continuous drug infusion flowsheets were in use within the electronic patient when relevant.

All 3 records reviewed during the inspection had a record of the time and decision being made to admit the patient into intensive care, this was in line with the NICE clinical guidance 50, 'recognition and response to acute illness in adults in hospital'.

Critical care

When patients transferred to a new team, there were no delays in staff accessing their records and the service used a formal handover document for people being stepped down from the critical care unit. This standardised the information provided and used a model called 'situation, background, assessment and recommendation' (SBAR). At the time of the inspection this was newly available electronically and so during the transition, staff also recorded the SBAR on paper so that there were no delays in staff taking over the care receiving the information.

Records were stored securely on computer systems which were password protected.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff stored and managed all medicines and prescribing documents safely. All medicines were kept in a secure (locked) room within locked cupboards and fridges. Controlled medicine storage was separated into suspension, oral and intravenous medicines, these were checked twice daily and contained double signatures in line with national expectations. Emergency medications were stored in the fridge and easily accessible. All medicine checks had been completed in line with expectations and fridge temperatures were monitored both by an automated system, which triggered an alarm if it went outside of a preset temperature range, and manually by staff who monitored a sensor inside of the fridge. An escalation process was in place which staff understood.

As part of the implementation of the new electronic prescribing and administration system within critical care, an audit of prescribing errors and pharmacist interventions was undertaken so that there was a baseline for the error rate post-electronic prescribing and medicine administration. At the time of the inspection, a re-audit was yet to be undertaken but managers explained that they expected a significant reduction in the minor error rate such as the recording of a year or ward on the record. This was mirrored when inspectors reviewed 6 patient records and found that they were completed accurately and kept up-to-date.

A quarterly safe and secure handling of medicines audit was completed by the service and demonstrated that compliance for quarter 3 of 2023/24 was 91%. A controlled drug audit for the same period achieved 96%. Results were presented to the medicines safety committee as part of the governance arrangements for the service and wider trust.

A dedicated pharmacy team which included pharmacy technicians visited daily and managed stock control including stock levels, rotation and expiry dates.

Staff followed systems and processes to prescribe and administer medicines safely and followed national practice to check patients had the correct medicines when they were admitted, or they moved between services. A dedicated pharmacist attended patient ward rounds daily as well as safety briefings to review patient medications. Lockable drawers were situated next to patients' beds where medication brought in from home could be stored safely.

An online drug locator system, emergency drug cupboard and 24 hour on call pharmacist were available in the wider trust which meant that the service could seek support in locating medications outside of the regular stock listing if ever required.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. All patients suffering from delirium or confusion were highlighted and discussed specifically at the daily safety briefing, this was in

Critical care

line with the analgesia, sedation, and management of delirium in critically ill patient policy. Both doctors and pharmacists carried out joint daily ward rounds where medications and sedation was reviewed, and delirium stickers were used to indicate nonpharmacological (nutrition for example and not medicines) management of patients unless the patient was a risk to themselves or others.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff that we spoke with during the inspection knew what incidents to report and how to report them. Staff had raised concerns and reported incidents and near misses through the wider trust electronic incident reporting system in line with trust policy. Between 1 July and 29 December 2023, 82 incidents had been recorded within the service. All staff including agency staff were provided a log in to the system so that everyone could report incidents.

Staff received feedback and looked at improvements to patient care. Feedback was shared through email, team briefs, quarterly staff meetings and daily safety briefings. There was evidence that changes had been made following incidents. Information provided by the service showed that all staff received feedback when an incident such as a medication error had occurred, guidelines and relevant information were reinforced by managers so that staff knew the correct procedures to follow.

Managers monitored themes and trends of incidents within the service. Before an incident was closed final approval was required which enabled the governance team within the wider division to identify any learning or information to be shared throughout the wider trust. The service also shared incident findings and learning with wider agencies and networks, such as the Medicines and Healthcare Products Regulatory Agency, National Tracheostomy Safety Project and the intensive care network.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if things went wrong. The service had had 3 incidents since May 2022 where duty of candour was formally required. Information provided by the trust demonstrated that contact was made with the patients' next of kin both verbally and in writing.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. We saw that in response to an incident the service had sought a specialist equipment provider and created a service level agreement so that a highly specialised piece of equipment could be easily obtained when required, throughout the process the patient and family had been involved.

The service had 1 never event in June 2023. This was a misplaced nasogastric feeding tube. The never event was investigated by the service and actions put in place to prevent it happening again. This included a multidisciplinary review, updates to the local safety standard for invasive procedures, discussion at the intensive care forum and patient safety committee, direct staff feedback, wider staff notification and involvement of educational training teams for simulation-based training in the future.

Is the service effective?

Good   

Critical care

Our rating of effective stayed the same. We rated it as good.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Critical care used a combination of guidelines from National Institute for Health and Care Excellence (NICE), Intensive Care Society, and Faculty of Intensive Care Medicine, to determine the treatment provided. Local policies were written in line with this.

The trust identified it was non-compliant with NICE clinical guideline 83 (critical care rehabilitation) due to the availability of critical care physiotherapists. However, we saw during our inspection that patients could access this resource as required.

There were care pathways to ensure appropriate and timely care for patients with specific conditions and in specific situations, such as if a patient was ventilated, had a tracheostomy or another type of breathing tube. Guidelines for delirium were followed and patients were screened routinely on admission and thereafter were screened daily and were discussed during handovers and ward rounds.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. Staff assessed each patient individually for risks and acted appropriately to ensure those patients had adequate support and access to an advocate should they wish. There were no patients admitted under the Mental Health Act (MHA) at the time of our inspection. The trust had a 24/7 mental health liaison service from whom staff could seek advice and support in the event a patient was admitted already detained under the Mental Health Act, or whom subsequently was assessed and detained under the MHA whilst in the critical care unit. All patients detained with a mental disorder for assessment and/or treatment under the MHA were allocated a responsible clinician who worked alongside the clinical teams caring for the patients' physical conditions. Safeguards were built into the detention under the MHA in the form of the patients right of appeal to a Mental Health Review tribunal. Mental Health Act administration was managed for the trust through a service level agreement with the local mental health NHS trust.

The service showed compliance to guidelines for the provision of intensive care units with regards to psychological health and cognitive impairment. A standard relating to delirium states 'All patients must be screened daily for delirium using a validated instrument; recommendation: Psychologists should organise short psychological assessments for all awake, alert patients in intensive care using a validated measure'. Data from the service reported patients were highlighted during daily safety briefings if they showed signs of delirium or dementia. The trust used validated tools to screen for these conditions. Where patients were assessed as delirious; pharmacological and non-pharmacological methods of treatment were used, and patients referred to the critical care follow up clinic which provided access to a clinical psychologist.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. During handovers all needs of the patients and families were discussed and appropriately managed.

Critical care

The guidelines for the provision of intensive care units also gave recommendations which were not mandatory but considered best practice. We found the trust was compliant with the recommendation that psychologists should consult with intensive care leadership on systemic issues influencing staff well-being. Additionally, psychologists should run or oversee staff support programmes including one to-one sessions, drop-in groups, or reflective rounds according to staff wishes and availability, as well as coaching sessions for senior managers.

The trust had a clinical psychologist for staff wellbeing which was available to all staff across the trust who were experiencing emotional distress that was impacting on their work. The trust provided protected time for individual support to staff to promote psychological wellbeing and discuss specific support needs. Critical care had a named clinical psychologist for wellness who visited the critical care units as it was understood that these areas of work provided additional stressors for staff, particularly following the COVID-19 pandemic. In addition, since 2020, critical care supported the 'Professional Nurse Advocate' (PNA) Training Programme. One of the key functions of this role was to focus on restorative clinical supervision. At the time of our inspection, critical care had 2 qualified active PNA leads and had 2 more attending the training course with the aim that by the end of 2024, 6 PNAs would be live. This team working collaboratively within the service linking with the trust wellness team and the psychologist for critical care.

The service showed compliance to other guidelines for the provision of intensive care units, such as 'All units must contribute data to the national potential donor audit'. The trust had a specialist nurse for organ donation (SNOD) who completed audits and collected data as part of their role. Data from the most recent audit, April to September 2023 showed 11 potential donors were identified with a 100% referral rate for potential donation after brain death / donation after circulatory death. All of family approaches were made in the presence of a SNOD, demonstrating further compliance to the requirement of the SNOD being involved at all stages of this process. The clinical lead for organ donation is a critical care consultant and provided regular feedback to the critical care team.

The critical care unit had recruited patients to a large clinical trial ongoing at the time of inspection which aimed to assess the benefits of using a particular medicine which may limit the damage sustained by a donor heart before it was transplanted.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. However, dietitian provision for the service was not always sufficient.

Staff made sure patients had support with nutrition and hydration to meet their needs. This included help for patients able to eat and drink and administration of nutrition and hydration for those who could not.

Staff used nationally recognised screening tools to monitor patients at risk of malnutrition. An oral care assessment and recording tool was used upon admission and repeated weekly to assess for issues within or around the mouth that may cause the patient pain, discomfort or hinder nutrition and hydration. A malnutrition universal screening tool was used to identify people at risk of malnutrition and a 24-hour fluid balance chart was completed for each patient to ensure suitable hydration.

During the inspection we reviewed 6 patient records and found that fluid and nutrition charts were fully and accurately completed.

Specialist support from staff, such as dietitians and speech and language therapists was available although staff reported difficulties in availability at some times, please see paragraph below. Critical care had a dietitian available 5

Critical care

days a week. Dietetic referrals were automatically flagged on the electronic patient reporting system meaning staff did not need to make referrals to dietitians, and speech and language therapists visited the service twice a week or more frequently if required. Staff had protocols in place which enabled them to start artificial enteral feeding through a tube, so as not to delay until a dietitian was available. The critical care dietitian was able to provide support and advice to staff for patients with complex or special nutritional needs (including artificial enteral feeding).

Between July and November 2023, 6 incidents relating to nutrition had been reported by the service these related to (3) reduced capacity of dietitian staffing resulting in lengthy delay in seeing patients with 2 of these instances causing delays to patients receiving Total Parenteral Nutrition (a specialist type of intravenous nutrition). A further 3 incidents related to delays or patients' meals not being delivered to the service.

Please see incident section of safe domain for never event relating to nasogastric feeding.

Pain relief

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

Staff assessed patients' pain using a recognised 0 to 3 verbal rating scale. This meant, if the patient was able to, they indicated the level of pain 0 = no pain and 3 = severe pain. Staff that we spoke with during the inspection were keen to make sure that all patients were not experiencing pain and explained how they would monitor patient's levels of pain in patients who were delirious or unable to express their pain verbally in other ways, such as from behavioural changes, facial expressions, increased perspiration or changes to heart and breathing rates so that pain relief could be given in line with individual needs and best practice.

A review of 6 patient records demonstrated patients received pain relief soon after it was identified they needed, or they requested it. Staff had prescribed, administered and recorded pain relief accurately on the electronic patient record.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

The service participated in relevant national clinical audits. The unit contributed to the Intensive Care National Audit and Research Centre (ICNARC) database. However, the last validated and publicly available report was dated 2018. Managers told us a report was available dated 1 April to September 2022, although data in this report had not been validated due to staff sickness. Information provided within the ICNARC report provides valuable information about care delivered and was benchmarked against similar units nationally.

Outcomes for patients were positive, consistent and met expectations, such as national standards. The data demonstrated the trust's critical care units performed the same or slightly better in all outcomes assessed. The ICNARC data showed patients who developed blood borne infections in critical care, non-clinical transfers from critical care and unplanned readmissions to critical care were better than the national average.

Managers and staff used the results to improve patients' outcomes. The trust provided examples which identified how patients' outcomes had been improved. This included for ARU assessing appropriateness of lung function test requests and compliance of non-invasive ventilation within the high dependency area in ARU to ensure national clinical and safety guidelines were met.

Critical care

The service had a lower than expected risk of readmission for both elective and non-elective care than the England average. There was a total of 5 patients who were readmitted to critical care service from a total of 529 patients admitted to critical care between 1 November 2022 and 31 October 2023.

Managers and staff carried out a programme of repeated audits to check improvement over time. However, at the time of inspection, compliance with sepsis management was not consistently monitored. Information provided identified development of audit to both check compliance with best treatment practice and improvement. The new electronic patient record had demonstrated scope for additional and comprehensive audits to provide assurance of effective patient management. Sepsis management was not consistently audited at the time of our inspection, which meant leaders could not assure themselves they were compliant with national standards. However, the trust was due to start these audits following our inspection using the newly implemented electronic patient records system (EPR). Other audits being developed included patient discharge letters and of lung protection ventilation.

Managers used information from the audits to improve care and treatment and when required improvement was checked and monitored. The trust's newly implemented EPR made the audit of records and practice easier and provide greater assurance best practice was followed. The first report following the implementation of the EPR identified improvements against Guidelines for the Provision of Intensive Care Services (GPICS) standards for patients seen by a consultant within minimum time from critical care unit to consultant review of 12 hours (94% compliance), and a minimum time from decision to admit, to arrival onto the critical care unit of 4 hours (90% compliance met).

Managers confirmed audits were ongoing and made sure staff understood information from the audits. Staff we spoke with knew about audit programmes and results and were involved in creating new ways of working to address any issues found through audit. Improvement was checked and monitored by the quality improvement team.

Managers and staff implemented local changes to improve care and monitored the improvement over time. The critical care unit were part of the Midlands Critical Care Network and benchmarked performance and patient outcomes across the Midlands critical care services. The trust shared examples of audits undertaken which included the nutrition audit (December 2023). The audit identified a need to update local feeding guidelines and new guidelines have now been produced to reflect required changes to ensure optimum nutrition.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staffs' work performance and held supervision meetings with them to provide support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Staff we spoke with were driven to improve their knowledge and skills to give patients better care. They said they were supported to identify areas where they felt they were less confident or required additional training.

Critical care had a practice development nurse, a role which was rotated between experienced critical care nurses. As part of the implementation of the new digital electronic patient records there were 2 additional practice educators' role which may provide additional practice educator support for staff.

Staff were routinely assessed for any deficit in training/competency by senior nurses and then supported to receive required training. Staff said their induction and preceptorship was thorough and supportive.

Critical care

Managers gave all new staff a full induction tailored to their role before they started work. Staff worked in a supernumerary capacity for at least 4 weeks (longer if they required additional support or worked on a part time basis) during which they were supported to complete their initial competencies and felt confident and competent to undertake on their role.

Managers supported staff to develop through yearly, constructive appraisals of their work. Managers and senior nurses said they ensured all staff received regular appraisal throughout the year and information provided by the service confirmed 100% of staff had received an annual appraisal.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work. Doctors spoke positively about the clinical supervision and training opportunities available to them within critical care. Information provided confirmed 100% of medical staff had received an annual appraisal.

The critical care service dedicated a critical care forum to paediatric resuscitation and trauma training using simulation-based training if staff were asked to support staff in other areas such as accident and emergency. Attendance at the forums was part of the medical job plan meaning it was required. In addition, all anaesthetic trainees (qualified doctors undertaking specialty training) were expected to be advanced life support providers (teaching advanced life support). This was monitored as part of the annual review of competency progression.

Staff had the opportunity to discuss training needs with their line manager. Nursing staff were allocated to 1 of 8 critical care teams managed by a team leader. The team leader and other senior nurses identified staff training needs and gave them the time and opportunity to develop their skills and knowledge. Critical care had a standardised training competency step training booklets, with all staff completing booklets 1, 2 and 3. Staff who were undertaking the critical care course then completed booklet 4. In addition, there was a team leader development booklet and a speciality service booklet 5. There were plans in place for booklet 5 to be the standardised booklet across West Midlands Critical Care Network.

Managers made sure staff received any specialist training for their role. Managers and staff were positive about access to undertake the critical care course. Senior managers and senior nurses supported nurses to attend the specialist critical care course when they had completed their critical care competency booklet 3. The critical care matron said they had continued to support nurses to complete the critical care course throughout the pandemic and as a result had maintained the high percentage of nurses who had completed the specialist course. The trust had 69% of nurses who had completed the critical care nurse training which was above the GPICS minimum requirement of 50%. At the time of the inspection, additional staff were due to start the next course.

Managers identified poor staff performance promptly and supported staff to improve. Where any poor performance had been raised, staff were supported to reflect on their practice and identify themselves what went wrong.

Agency staff were required to demonstrate competency through the agency before they were booked for a shift. A local induction was given to all bank and agency staff which included emergency equipment, fire procedures, incident reporting and familiarisation with the unit. Agency staff were able to access all policies and procedures and incident reports and safeguarding referrals through the electronic system with short term access. The nurse in charge worked closely with any agency staff to support them.

Multidisciplinary working

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

Critical care

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. There were 2 separate (the ward was split in 2 under 2 different consultants) twice daily ward rounds within critical care with input from doctors, nurses and physiotherapists 7 days a week. There were daily (Monday to Friday) microbiology ward rounds, during which the patients' microbiology treatment needs were discussed. This meant that daily expert advice was provided which reflected changing recommendations, local microbiology changes and any immediate changes needed to respond to national guidelines. Multidisciplinary team members, such as the pharmacists and speech and language therapists, had a hand over every time they visited the unit.

A full multidisciplinary team meeting with input from medical, nursing, dietitian, pharmacy, speech and language therapy and physiotherapy occurred daily from Monday to Friday.

There was a dedicated critical care pharmacist who provided medicines advice for patients receiving critical care. A speech and language therapist reviewed patients with a tracheostomy, with swallowing and speech and communication difficulties. Staff reported that the critical care unit provided effective care because of strong "team working".

There was a critical care outreach team 12 hours a day, seven days a week for the management of critically ill patients in the hospital. The critical care outreach team also reviewed the progress of all patients who were discharged from critical care within 12 hours.

Staff worked across health care disciplines and with other agencies when required to care for patients. The trust were part of the Midlands Critical Care Network and provided support to other trusts when additional capacity was needed.

Staff referred patients for mental health assessments when they showed signs of mental ill health or depression. Patients with needs (including their mental health) by the multidisciplinary team at least twice daily. Patients' mental health was also assessed as part of their follow up clinic appointment. Mental health liaison teams were available to assess critical care patients when required.

Seven-day services

Most key services were available 7 days a week to support timely patient care.

Staff on wards could call for support from the critical care outreach team 7 days a week. The outreach team was available during the day with a hospital at night team available to support timely care at night.

Consultants led daily ward rounds twice daily, including weekends. Patients are reviewed by consultants depending on the care pathway. There were at least 2 intensive care consultants present in the critical care department between 8am and 1pm, 7 days a week. Overnight on each unit, a registrar was on duty and a consultant was on call from home. Staff we spoke with said, when needed, the consultant would attend the units within 30 minutes; this met best practice guidance. Ward rounds took place twice a day, 7 days a week. All potential admissions were discussed with a consultant who reviewed the patients within 12 hours of admission.

Physiotherapy provided a seven-day service for critical care.

Radiology services were led by a consultant who was available for urgent x-rays and scans seven days a week and during the evening and overnight. The hospital pharmacy was open 7 days a week, although for reduced hours at the weekend. During the evenings, urgent medicines were available in an emergency medicines cupboard which could be accessed by senior staff on duty.

Critical care

Speech and language therapists and dietitians were not available 7 days a week and were only available 5 days a week.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support within critical care services. Posters were displayed on walls for staff and relatives explaining good handwashing to reduce the risk of cross infection.

Leaflets advising patients on healthy eating for weight control, coping with nausea and sickness and smoking cessation were available. A patient information booklet about moving on from the intensive care unit contained information about sleeping, body image, families and relationships and employment, hobbies and socialising. Signposting to support and information agencies was also listed, for example, asthma, psychology, heart, diabetes and substance misuse charities.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle. This included support with smoking and alcohol consumption as well as nutritional support.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. Mental Capacity Act 2005 training for medical staff was low.

Most nursing staff had received and kept up to date with training in the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DOLS). Medical staff compliance with the same training was lower. Information provided by the trust identified of the 69 eligible nursing and administration staff, 57 (91%) had completed the training. Of the medical staff, all the eligible 91 (100%) had completed the training. In the acute respiratory unit, 90% nursing and administration staff and 68% of medical staff had completed the training.

A specific delirium pathway set out a stepwise approach to the management of patients experiencing delirium which included involving the patient and family members, completing a patient diary and re-orientating them to time and place. All patient records had mandatory fields which asked when a patient lacked capacity to make their own decisions about care, were management plans consistent with patients and next of kin known wishes or had they not yet been established.

Staff did not ensure all patients who lacked capacity to consent were managed according to the MCA. Information provided by the service demonstrated it followed 'Midnight Law' developed by the Faculty of Intensive Care Medicine. This states that the DOLS legal standards do not need to be followed in the following settings: where the patient is so unwell that they are at immediate risk of dying anywhere other than in hospital; and the arrangements for delivering treatment to the patient are the same as they would be if the patient were able to agree to them. However, patients who did not meet the criteria for Midnight Law remained on the critical care unit. For example, who were due to be discharged to a ward but there were no ward beds available. These patients were still subject to some restrictions, such as not being able to freely leave the unit due to locked doors. Not all these patients had the mental capacity to consent to this restriction which meant in law; an MCA assessment should be undertaken; and where capacity to consent is not present; a DOLS application should be made to the local authority. This did not feature on the risk register. No MCA assessments or DOLS applications had been undertaken between December 2022 and December 2023.

Critical care

Where patients had the capacity to consent, staff gained consent from patients for their care and treatment in line with legislation and guidance. A review of records demonstrated that consent was recorded appropriately for patients that could give consent, and staff were observed during the inspection to be seeking consent before carrying out any care and treatment. Verbal consent was documented as part of the local safety standards for all invasive procedures such as insertion of a central venous catheter or chest drain.

Where patients lacked the capacity to make the decision but object to receiving psychiatric treatment, the MHA was the lawful route forward if that treatment was to be delivered against their will.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the MHA and MCA and they knew who to contact for advice. This included a mental health and a safeguarding referral team from within the trust. Staff that we spoke with during inspection told us they would seek guidance from the matron for the service or if out of hours through the wider site bleep.

Is the service caring?

Good  → ←

Our rating of caring stayed the same. We rated it as good.

Compassionate care

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

Staff were discreet and respectful when caring for patients. We observed staff spoke to patients in a respectful and friendly manner. Patients spoke positively of staff and feedback from patients and relatives as provided by the trust made positive comments on the caring and compassionate care they had received. Patients and relatives were given good emotional support. Throughout our inspection, we saw patients treated with compassion, dignity and respect.

Staff provided good care by understanding what was significant to patients and ensured they retained what was special in their lives. The team supported both patients and their relatives. We found the unit was calm, quiet and peaceful to aid patients rest and support their recovery despite being busy with 2 consultant teams undertaking ward rounds. Patients said staff treated them well and with kindness. Staff followed policy to keep patient care and treatment confidential. Staff spoke to patients in a caring manner, asking open ended questions to explore how patients were feeling. Staff took personal interest in patients, asking them about their home or social life. Staff understood and respected the personal, cultural, social and religious needs of patients and knew how they may relate to care needs.

Staff ensured patient confidentiality was always respected. Staff spoke discreetly and ensured that records were kept securely when not being reviewed or updated.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs.

Critical care

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. The nature of the care provided in a critical care unit means that patients cannot always be involved in decisions about their care. However, whenever possible, relatives were consulted on the patient's preferences and their views were considered.

Staff built up trusting relationships with patients and their relatives by working in an open, honest and supportive way.

A therapy dog visited critical care patients regularly, the therapy dog had been trained to help provide a relaxing and anxiety-relieving experience. Dogs are known to bring therapeutic benefits to patients. Long stay patients received visits from their own dogs. Staff knew how essential this is as for some patients, their pets were their closest loved ones. Patients and relatives were given good emotional support. A faith/ chaplaincy service was available to provide valuable support to patients and relatives. The hospital had a faith centre which patients' families could visit for prayer and emotional support. Following the deaths of patients on the critical care unit, sympathy cards were sent to the next of kin with contact details of the critical care nurse specialist, should they wish to speak to them.

After admission, the consultant covering the unit would arrange to meet with relatives to update them on the patient's progress. When necessary, further face-to-face meetings were organised. Patients were supported to stay connected to their family and friends. Visitors were encouraged and supported with visiting times that suited them.

Patients had their physical and psychological needs regularly assessed and addressed, including nutrition, hydration, pain relief, personal hygiene and anxiety.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. Patients within critical care services were very ill and did not always recover. Staff recognised patients and their loved one's concerns and provided support as when required, Staff facilitated communication between patients and their loved ones, carers and their pets using a variety of methods such as iPads. This enabled patients to communicate not only when they felt able to but also 24/7 rather than within predefined visiting hours.

Critical care unit staff supported patients and their loved ones with special occasions such as a wedding within the critical care unit. A patient on the critical care unit was able to 'attend' their daughter's wedding virtually on facetime. The patient had been supported by staff to have their hair and makeup done and was able to get dressed up for the wedding.

Critical care staff worked with specialist support to modify a patient's analgesia and oxygen requirements for a short period to ensure they were able to attend their mother's funeral.

Staff often facilitated long stay patients to experience the grounds and gardens outside the hospital to provide fresh air and a change of the environment.

During the festive period, staff ensure patients were taken to the hospital foyer to see the Christmas tree and experience the carol singers.

Critical care

Understanding and involvement of patients and those close to them

Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. Whenever possible, patients with capacity to give consent were asked for this before receiving any care or treatment, and staff acted in accordance with their wishes. Treatment was explained to patients and their loved ones. Patients told us: “They explained everything properly and this helped to calm my fears”.

The main critical care unit ensured each patient had a “Patient Diary” completed by staff and family to ensure there was a memory of the patient's journey. The diary also facilitated communication between staff and relatives when patients had difficulty communicating. Families told staff the diaries helped them to understand their loved one's care and what their day was like whilst they were able to read them in their own time and then ask questions if needed. Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. The staff also understood how difficult it was for patients to face their recovery after being critically ill and discussed with them and their families how they could make things easier while they remained in hospital.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. The use of electronic devices within critical care enabled multiple family members to be part of a virtual visit and consultant discussions which may not be logistically possible within the unit. This form of communication also minimised the risk of cross infection.

Staff supported patients to make advanced decisions about their care. The faith/ chaplaincy team supported bereaved families, providing emotional support and end of life blessings.

The critical care team worked with the specialist nurses for organ donation. When on-going treatment was decided to be futile the relatives were made aware of this, and the possibility of organ donation was discussed. We saw the staff support families during our inspection when a decision had been made to withdraw treatment. Staff told us that if agreement was made by the families to donate their loved one's organ(s) staff would support the family.

Patients gave positive feedback about the service. Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Patients gave positive feedback about the service, ‘thank you’ cards and letters were sent in by patients and relatives highlighting the caring work of the staff. Friends and family information for the last 12 months identified 100% of respondents who were either patients or relatives of patients on the main critical care unit would recommend critical care services to others. Friends and family information for the last 12 months identified 95% of respondents for the acute respiratory unit (please note this also includes the main ward as data could not be separated for the high dependency bays) would recommend the ward to others. The trust target was 95%.

The main critical care unit had a “Patient Focus Group” a service provided to patients and families following their Intensive Care follow up clinic appointment. This group aimed to provide critical illness survivors, their families, carers and staff members with a chance to meet up informally in person (and virtually by teams link up if more appropriate) to talk about their experience, ask questions and learn from guest speakers.

Following our inspection the trust provided additional information about the matron for critical care: “The commitment our matron has to continuously provided outstanding care for our patients is a theme that runs through all our feedback”. (Please see the well led section of this report which also identifies the critical care matron had received a staff recognition award for lifetime achievement for outstanding significance to the NHS).

Critical care

Is the service responsive?

Good  

Our rating of responsive improved. We rated it as good.

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services, so they met the needs of the local population. The trust critical care services were situated at the Worcestershire Royal Hospital and the Alexandra Hospital and provided a countywide approach to critical care services. There were a total of 23 beds countywide with 8 beds at the Alexandra Hospital and 15 at the Worcestershire Royal Hospital. The provision of critical care beds had increased to 15 funded level 3 beds with addition of the new pods. The 15 beds were divided into 4 level 3 beds at the Alexandra Hospital and 11 at Worcestershire Royal Hospital. Level 3 patients require advanced respiratory support alone or basic respiratory support together with support of at least 2 organ systems and all complex patients requiring support for multi-organ failure. Level 3 patients always require 1 to 1 care. This inspection reviewed critical care provision at Worcestershire Royal Hospital only. Managers told us they were able to flex capacity by staff working across both critical care units dependent on need.

The Acute Respiratory Unit (ARU) had 31 beds of which 8 were high care beds providing non-invasive therapy, with a further 4 flexible beds which could provide continuous positive airway pressure (CPAP) which is a machine that used mild air pressure to keep breathing airways open. CPAP was provided on ARU for patients with COVID-19.

Between 1 November 2022 and 31 October 2023, a total of 529 patients were admitted to the main critical care unit and 343 patients were referred to critical care outreach with 558 patients receiving an assessment (some patients may have been assessed on more than one occasion by outreach).

A patient environment operational group monitored facilities to ensure they conformed to professional standards. This group shared their findings with the trust board so that any issues or changes to requirements could be identified and effectively escalated. At the time of the inspection the service was exploring structural work of unutilised space to increase capacity for office and storage space within the unit.

Facilities and premises were appropriate for the services being delivered. The critical care unit and acute respiratory unit were designed in accordance with the standards, legislation and building regulations at the time of construction. The facilities in the main critical care unit had been updated to include additional pods (enclosed 2 bedded rooms) to reduce potential cross infection risks.

There were facilities for visitors to make hot drinks in a small kitchen area and in the waiting room outside the critical care unit. The critical care unit had 2 overnight en-suite bedrooms with a small kitchen available to family and friends whilst their loved ones were patients on critical care.

Staff told us and we observed during our inspection the critical care unit was quiet and calm with noise kept to a minimum. To monitor this there was a noise monitor which flashed when noise exceeded required maximum levels.

Critical care

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. All patients who are in critical care due to clinical need are exempt from mixed sex breaches. However, we found that critical care services were not always able to discharge patients who were now well enough to return to a ward in line with national guidance. This led to mixed sex breaches being recorded for these patients. This was due to a lack of capacity available on wards. Staff told us this was one of their biggest challenges and whilst staff tried their best to minimise mixed sex breaches they frequently occurred. For the period 1st December 2022 to 30th November 2023, 355 mixed breaches were reported for critical care services at Worcestershire Royal Hospital. Staff told us, when possible, they would move patients into the pods which were double rooms and used for single sex accommodation.

Whilst the breaches did occur within critical care, we acknowledge that this was due to a wider problem relating to patient flow throughout the hospital and impacted upon from outside factors within the overall provision of health and social care locally.

Staff could access emergency mental health support 24 hours a day 7 days a week for patients with mental health problems, learning disabilities and dementia.

The service had systems to help care for patients in need of additional support or specialist intervention. Once patients were discharged home, they were invited to a medically led critical care follow up clinic. The clinics were weekly and included both face to face appointments or virtual attendance depending on patients' needs and preferences.

Meeting people's individual needs

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

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports. Trained experienced staff supported patients with learning disabilities. The service had access to a trust wide learning disability liaison nurse who assisted with support and advice. To assist with promoting a calm environment the service used a "hospital passport" which contained details of the patients past medical history, their relatives, contact details, their likes and dislikes. In addition, the patient's relatives or carers were able to stay on the unit to provide additional support or comfort.

Staff we spoke with during the inspection undertook specific assessments to identify cognitive impairment. An abbreviated cognition test (a test to check for memory problems and/or cognitive impairment) was completed on patients' admission where appropriate. An initial medical admission assessment considered the neurological status of the patient including the Glasgow Coma Scale which looked at eyes, verbal and motor responsiveness and the daily nursing assessment record included questions about communication, whether the patient understood and could comprehend where they were and what was happening.

Patients had access to clinical psychologist teams for ongoing psychological support and treatment following discharge.

The trust policy entitled 'Trust policy for access and delivery of interpreting services' clearly outlined the purpose and scope of the Accessible Information Standard within it in a way that staff could understand and follow. The Accessible Information Standard is a law which aims to make sure people with a disability or sensory loss are given information they can understand, and the communication support they need. The trust website was accessible and gave options for alternative ways to access information both online and during appointments.

Critical care

Staff had access to communication aids to help patients become partners in their care and treatment. Within critical care, a range of aids were available to support communication, and orientation to space and time. For example, staff could use picture cards to support patients to communicate pain levels, basic care needs, such as dry mouth, and alphabet cards so patients who were unable to speak due to their presenting condition or a disability could spell out words. Patients with tracheostomies, if appropriate were provided with a special valve to help them speak, in addition to supporting swallowing and improving their sense of smell and taste.

The critical care units had some accessible technology and had plans to expand this; for example, voice activated intercoms with plans to upgrade these to also include touch vibration to support patients and visitors.

The service had information leaflets available in languages spoken by the patients and local community. The service was able to access and use information which had been translated into different languages

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Staff were able to use a translation service for patients for whom, English was not their first language or used British Sign Language.

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

Access and flow

People could access the service when they needed it and received the right care promptly. The service mostly admitted, treated in line with national standards, however, patient discharge was frequently delayed.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. The critical care unit bed capacity was managed county wide by the critical care medical and nursing staff who would flex capacity and staff between Worcestershire Royal Hospital or the Alexandra Hospital. This ensured an admission ready bed was available for prompt admission. If critical care services were at maximum capacity this would be escalated to the divisional management team (or on call executive team) with a view to prioritising critical care discharges. A critical care consultant or a divisional representative would attend the trust bed meetings (capacity hub) in person with a view to prioritising critical care discharges.

Guidelines set out in the Provision of Intensive Care Services Standards state: unplanned admissions to the critical care unit must occur within four hours of making the decision to admit. Information provided identified there were no delayed admissions to the main critical care unit in the last 3-month period (101 patients admitted all admitted within 4 hours).

A need for admission to the ARU was identified by respiratory clinical staff. Information provided by the trust identified there was frequently a delay admitting patients to high dependency area of ARU. ARU patients should be transferred to respiratory high care within an hour. Information provided by the trust identified in the last month this was not met for 4 patients with an average wait of 4 hours and 34 minutes.

The service moved patients only when there was a clear medical reason or in their best interest. Staff confirmed patients remained in critical care and the ARU whilst they required critical or high dependency care. Staff said very occasionally, “wardable” (level 0 or level 1 patients who do not require critical care) may be stepped down to an available bed in theatre recovery, when no suitable ward bed was available to facilitate a critical ill and unstable patient admission to

Critical care

critical care. Staff said this had happened on 2 occasions in the post-pandemic period. Any patient stepped down to recovery were nursed by theatre recovery staff and remained under the oversight of the critical care medical team until they were transferred to a ward bed. In the last month information provided by the trust identified no patients had been transferred to theatre recovery.

Staff tried to ensure, when possible, patients were not moved out of the critical care services at night. The number of patients transferred out of out of hours (between 10pm and 7am) between August and October 2023 from the main critical care unit was 19 patients and from ARU ward was 34.

Managers and staff started planning each patient's discharge as early as possible. There had been 29 patients transferred to other hospitals whilst some patients required specialist care others were admitted to Worcestershire Royal Hospital critical care unit as no capacity was available more locally to the patient. Seventy-eight patients transferred to other services from ARU (3 requiring additional mental health support), although the trust were unable to say what level of support the patient had received.

Managers monitored the number of patients whose discharge was delayed. Due to capacity challenges throughout the hospital frequently critical care services accommodated patients who no longer required a critical care bed. Staff reviewed all patients daily to ensure that they were being cared for in the most appropriate clinical area.

Staff identified they experienced delays discharging patients who no longer required critical care or high dependency care and their care could be provided within a ward rather than critical care). Information provided by the trust identified between 1 August and 31 October 2023, 54 discharges were delayed from critical care for more than 24 hours from a total of 106 patients. For the ARU there were 26 patients whose discharge was delayed by more than 24 hours between 1 August and 31 October 2023. Only one of those patients had care level 1 as their highest care level recorded during their admission. The average delay was 127 hours. Patients whose discharge was delayed continued to be supported by critical care staff.

Information provided by the trust identified that when patients were due to be discharged home direct from critical care, on rare occasions patients were accommodated in the critical care discharge lounge which had a kitchenette, toilet shower room and ensured critical care flow within the main critical care was not delayed.

Staff supported patients when they were referred or transferred between services. The trust critical care unit discharge policy identified all patients discharged by the critical care unit will be followed up by the critical care outreach service within 24 hours of discharge, Outreach services had seen all of patients discharged from the main critical care unit and they were seen within 24 hours of their discharge.

Managers monitored patient transfers and followed national standards.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Critical care

Patients, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas. We saw posters throughout the hospital advising how to make a complaint, raise concerns or leave a compliment. Patients we spoke with said they had had such information explained to them. Information on how to complain was also available on the trust's website. This included how to raise a concern through Patient Advice and Liaison Service (PALS) and how to make a formal complaint.

Staff understood the policy on complaints and knew how to handle them. Staff told us they knew how to acknowledge receipt of a complaint and escalate to the relevant manager on the unit for them to provide a response.

Managers investigated complaints and identified themes. In the last 6 months critical care had received 3 PALS concerns which were responded to within 1 working day and 1 which could not be resolved was escalated to a formal complaint, there had been 3 formal complaints (1 regarding communication, 1 regarding arrangements when discharged to another ward and 1 regarding accuracy of medical records). The service had also received 35 compliments.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. All complaints were responded to within the 25-working day target timescale.

Managers shared feedback from complaints with staff and learning was used to improve the service. Complaint investigations demonstrated staff appropriately communicated with complainants throughout the process. Apologies were given to complainants when required and complaint response letters were written in a kind and compassionate manner. Actions identified from complaints were shared with staff and actions logged for ongoing monitoring.

Is the service well-led?

Good  

Our rating of well-led improved. We rated it as good.

Leadership

Leaders presented as having the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

Critical Care was managed by the specialised clinical services division. The critical care management team managed the critical care units at both the Worcestershire Royal Hospital and the Alexandra Hospital to provide a countywide approach to critical care.

The Acute Respiratory Unit (ARU) was managed by Specialty Medicine Division. The critical care unit and ARU had a designated consultant clinical lead and a team of experienced senior nurses, who, with support from the matron led the nursing team. There was strong leadership with many new ideas, which had been implemented for improving patient care and patient outcomes.

The matron for critical care had a specialist qualification in critical care in addition to a management qualification and had overall responsibility for the nursing elements of the service. This met core intensive care standards. The critical care unit had supernumerary band 6 or 7 nurses in charge of each shift. The matron and senior nurses told us that they

Critical care

were supported by the divisional management and executive team who were approachable. Staff told us the matron attended the critical care unit most days when on duty. The leadership ensured there was shared learning and support for critical care staff. The leadership drove continuous improvement and staff were accountable for delivering change and were positive about changes because of the new electronic patient records. The leadership were responsive to improve care outcomes.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action. Leaders and staff understood and knew how to apply them and monitor progress.

The vision and strategic objectives of the critical care unit mirrored those of the trust. They identified:

“We work in partnership with our medical and surgical specialty teams and our tertiary services, including trauma, neurosurgical, renal and paediatrics to provide the best healthcare for our communities”.

As part of the strategy the service had successfully recruited 2 new consultants and were continuing to train new advanced critical care practitioners (ACCPs) and had positive nursing retention and recruitment. The critical care outreach service was to be expanded to 24 hours a day 7 days a week.

A vision had not been agreed within the respiratory specialty and was being drafted, however, there was a strategy for respiratory care which identified the significant changes over recent years. One of the main strategic objectives was based around recruitment and retention to help develop services with the changing needs of the local population and to create a sustainable workforce by enhancing Nursing and Allied Health professional roles.

Staff were aware of and understood the vision and values of the critical care unit and acute respiratory unit and behaviours that would achieve these values. Senior nurses told us they discussed the trust's values during unit meetings, handovers, recruitment interviews and staff appraisals.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

There was a positive culture throughout critical care services. Staff told us critical care was a friendly place to work and they liked coming to work. Several staff said: “This is the best unit I have worked in”; other staff also commented: “I am proud to work here”. Staff told us they would recommend it as a place to work and senior staff were supportive.

Staff we spoke with and observed were enthusiastic about their role within the service, proud to work there, supportive of colleagues and felt respected, valued and supported. Staff said they had undertaken development opportunities and were encouraged to share ideas for improvement.

Staff were encouraged to engage in continued professional development and had regular opportunities to meet with managers to discuss ongoing training and development.

Critical care

The trust had a vision, which promoted a culture of equality, respect, trust, dignity and openness. Staff said they were encouraged to complete incident forms or raise concerns. Staff felt concerns were adequately addressed and were appropriately responded to by managers. Staff were aware how to contact the Freedom to Speak up guardians and their duty to raise concerns about serious risks at work.

The trust had an active commitment to equality, diversity, inclusion and human rights. The annual Equality Diversity and Inclusion report published December 2023 report highlighted work undertaken that year to promote staff awareness, understanding and active involvement into providing care to people with disabilities.

Governance

Leaders operated effective governance processes, throughout the service. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The trust had a governance structure with trust wide meetings which included: infection control, information governance, improving safety, hospital flow delivery which reviewed all areas including critical care services.

The division of specialised clinical services had monthly governance meetings where risks, complaints, incidents, audits, performance, and quality improvement projects were discussed. The specialty medicine division had weekly meetings. In addition, there were monthly critical care meetings with a set agenda which included finance, activity, staffing and risks. The outcomes of these meetings were reported back to staff.

Critical care also had a monthly Intensive Care Unit forum which included representatives of critical care consultants, the critical care physiotherapy clinical lead, the lead pharmacy for critical care and the critical care matron. The agenda for the forum covered all aspects of critical care including a review of critical care deaths and was in addition to the quarterly morbidity and mortality review meetings.

Critical care had daily team meetings (safety huddles) which involved the multi-disciplinary team within the units. The inspection team observed a safety huddle at the time of the inspection and following issue of the draft report the trust provided a list of standing agenda items to be discussed at the safety huddles.

Critical care consultants were motivated and committed to improving the quality of the service that critical care provided. A root cause analysis was undertaken following each serious incident. The investigations undertaken were detailed and identified actions to reduce the risk of further similar incidents in the future.

Management of risk, issues and performance

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

The service received safety and quality information in a dashboard, which identified performance and could be reviewed by managers and staff. Performance data included incidents report (and broken down to categories, such as clinical incidents and level of harm). However, the dashboard provided identified “N/A” (not applicable) for sepsis screening audits, completion of the sepsis 6 tools and antibiotics administered within 1 hour. This meant there was no assurance of the timely and appropriate management of sepsis. The trust had plans in place to begin undertaking audits of sepsis management once the newly implemented electronic patient record was embedded.

Critical care

The division had monthly performance and planning review meetings which reviewed performance, activity, risks and staffing. Risks inherent in the delivery of safe care were identified on the risk register: for example, difficulties recruiting critical care nursing staff. Supporting actions were identified and discussed at governance and board meetings. The trust told us venous thromboembolism (VTE) was a key performance indicator that was monitored by the clinical governance group, reporting into quality governance committee and trust board through the integrated performance report. This allowed for any special cause variations to be investigated by divisional governance teams.

However, due to staffing problems, there had been a delay submitting and validating the Intensive Care National Audit and Research Centre (ICNARC) data. This meant information about performance and benchmarking the service was not fully assured.

There were 9 specific critical care risks included on the risk register these included: Insufficient physiotherapy and pharmacy establishment for critical care; Delayed discharges from the main critical care unit resulting in suboptimal patient care; risk of patient, equipment and staff harm due to lack of storage space on the critical care unit; Risk of harm to patients unable to access tertiary level care in timely fashion; Risk of patients not achieving best outcomes after ITU due to non-compliance with NICE CG83 (Critical Care Rehabilitation).

There were 3 identified risks for ARU. These were: risk of patient harm due to lack of respiratory physicians countywide causing delays and gaps in service; risk of fire on ARU due to high usage of oxygen and potential risk of harm for patients discharged home on incorrect oxygen prescription. However, there was no information identified which included timely access and discharge from ARU.

The trust had introduced electronic patient records and systems were being developed to enable information about patient care and outcomes to monitor performance.

ARU provided monthly updates to the Divisional Management Team which included medicines management, pressure ulcers, patient record reviews, falls, incidents, infection control update included hand washing audits in addition to infections identified, VTE compliance, observations and news completion, friends and family feedback, complaints, patient flow, staffing, mandatory training compliance.

Information Management

The service mostly collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were not always submitted to external organisations as required.

Information technology systems were used to monitor and improve patient care. Information was mostly available to enable managers to assess and understand performance in relation to quality, safety, patient experience, human resources, operational performance and finances.

Service performance measures were reported and monitored. Managers and senior staff had access to these reports. Relevant and appropriate service performance information was displayed on boards within the service so that staff and visitors could see immediately how well the service was performing.

The service shared data securely with external organisations in accordance with legislation.

Critical care

There had been a delay completing and validating all data for ICNARC due to long term absence. The trust provided assurance there was an action plan with other staff currently receiving training with a “catch-up ” plan identified.

Engagement

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

The trust undertook regular engagement activities including staff surveys, patient surveys, attending local community groups and working in collaboration with community and stakeholder organisations to develop services.

The trust used feedback from patients, including complaints, to develop services and new initiatives. For example, throughout 2023, the trust worked in partnership with a local support group designed to provide social support, motivation, and self-help for adults with Aspergers Syndrome. The trust sought feedback from the group about how they could improve patient experience overall; and were also working with this group and other local partners to develop an Autism policy for the trust.

One method the trust used to gain feedback was through an annual survey called ‘The Big Quality Conversation’. This sought feedback from patients, carers, and relatives and had a focus on health inequalities. In 2023, the trust received 889 responses which was a significant improvement on the previous year. The survey was available in 95 languages, in easy read format and a video using British Sign Language was created to explain the survey. In addition, the trust engaged with communities who may have found the survey more difficult to complete for example holding survey workshops at a local Deaf community group coffee morning, engaging with the local prison, and using trust learning disability specialist nurses to support people living with a learning disability.

The annual patient survey engaged with patients, relatives and carers who used services to enable understanding of what was important to them. It also helped identify how carers felt about their involvement in care planning and treatment, and helped better understand the experiences of people who may be living with health inequalities.

The critical care units had commissioned 2 information murals that will be displayed in the relatives waiting areas to share relevant information. Ongoing support and engagement was facilitated through their consultant led follow up clinics and patient focus groups.

Staff were encouraged to share their thoughts and ideas on how the service could improve. They felt included in plans and listened to.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

Staff were enthusiastic when speaking to us about improvements and appreciated having the opportunities to be involved in bringing about change. The service had several innovative practices for their commitment to learning and improvement of services. Learning from Excellence. The service found learning from excellence had a positive impact on clinician behaviour leading to improvement to improve services.

Critical care

IntelliSpace Critical Care and Anaesthesia (ICCA) is an advanced clinical decision support and documentation solution that helps services deliver quality care. The trust ICCA project team had won The National Leadership Awards, Digital Leaders Award for their “Vision and electronic patient records”.

The service were working towards providing simulation training for all staff to promote best practice and reduce clinical errors.

The service were working towards an improved information sharing approach following the implementation of electronic patient records which would provide real time data dashboards. The data to be displayed will align with performance standards set out in the Guidelines for the Provision of Intensive Care which meant staff and managers could be more responsive to monitoring performance and driving improvement.

The critical care matron had been awarded a staff recognition award for lifetime achievement for outstanding significance to the NHS.

Outstanding practice

- A trained therapy dog visited critical care patients weekly to help provide a relaxing and anxiety-relieving experience for patients.
- Long stay patients received visits from their own dogs.
- A patient on the main critical care unit was able to ‘attend’ their daughter's wedding virtually. The patient had been supported by staff to have their hair and makeup done and was able to get dressed up for the wedding.
- Critical care staff worked with specialist support to modify a patient's analgesia and oxygen requirements for a short period to ensure they were able to attend their mother's funeral.
- The main critical care unit ensured each patient had a “Patient Diary” completed by staff to ensure there was a memory of the patient's journey.
- The main critical care unit had a “Patient Focus Group” which aimed to provide critical illness survivors, their families, carers and staff members with a chance to meet up informally in person (and virtually by teams link up if more appropriate) to talk about their experience, ask questions and learn from guest speakers.

Areas for improvement

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

SHOULD

Critical care core service

- The trust should ensure that mental capacity assessments and applications to deprive people of their liberty are made in line with the Mental Capacity Act 2005 where patients are not subject to Midnight Law. Regulation: Consent 11(1).

Critical care

- The trust should have systems or processes to assess, monitor and identify improvements of the quality and safety of sepsis management. Regulation: Good Governance **17(2)(a)**.
- The trust should ensure patient venous thromboembolism risk assessments are completed as required. Regulation: Safe care and treatment 12 (2)(a).
- The trust should ensure the programme of staff training for resuscitation and basic life support is continued. Regulation 18: Staffing **18(1)**.
- The trust should ensure there is enough provision of specialist critical care pharmacist in line with national critical care standards. Regulation 18: Staffing **18(1)**.
- The trust should ensure enough provision of a critical care physiotherapists in line with national critical care standards. Regulation 18: Staffing **18(1)**.
- The trust should ensure timely admission to the high dependency area of Acute Respiratory Unit. Regulation: Good Governance **17(2)(a)**.
- The trust should ensure there are suitable arrangements to facilitate the timely discharge of patients who no longer require a critical care bed. Regulation: Good Governance **17(2)(a)**.
- The trust should ensure a critical care outreach service is in line with national guidelines. Regulation: Safe care and treatment 12 (2)(i).
- The trust should ensure timely and validated data is monitored to improve the quality and performance of the service, this may include submission to the Intensive Care National Audit and Research Centre. Regulation: Good Governance **17(2)(a)**.
- The trust should consider how the service follows national guidelines, such as National Institute for Health and Care Excellence clinical guideline 83 (critical care rehabilitation).

Our inspection team

Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity. We inspected this service using our comprehensive inspection methodology. Three inspectors and 2 specialist advisors, with support from an offsite inspection manager, carried out the inspection on 18 December 2023.