Weston Area Health NHS Trust

Weston General Hospital

Quality Report

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

We rated Weston General Hospital as requires improvement overall with the urgent and emergency care services rated as inadequate, medicine and older people as requires improvement and surgery and critical care as good.

There had been some progress since our previous inspection with surgery and critical care moving from requires improvement to good overall. Medical care also demonstrated improvement with safety and well led now rated requires improvement from inadequate. However, the ongoing pressures on the emergency department continued to be reflected in the ratings with safety remaining as inadequate and responsive and well led failing to improve also being rated inadequate. Patient flow had not been sufficiently improved since our last inspection and responsive in medical care was rated as inadequate.

As part of this inspection, CQC piloted an enhanced methodology relating to the assessment of mental health care delivered in acute hospitals; the evidence gathered using the additional questions, tested as part of this pilot, has not contributed to our aggregation of judgements for any rating within this inspection process. Whilst the evidence is not contributing to the ratings, we have reported on our findings in the report.

We had serious concerns that systems or processes to manage patient flow through the hospital were not operating effectively and did not ensure care and treatment was being provided in a safe way for service users. We served the trust with a Section 29A warning notice on 24 March 2017. The notice required the trust to make the significant improvements by 15 May 2017 in the following areas:

- Systems or processes to manage patient flow through the hospital must operate effectively to ensure care and treatment is being provided in a safe way for patients and to reduce crowding in the emergency department.
- Review the emergency department as the single point of entry to the hospital for both emergency and expected patients to reduce crowding.
- Ensure access to a specialist senior doctor to review patients overnight in the emergency department is timely and does not delay patient admission to wards.
- Ensure the use of the corridor in the emergency department is an appropriate and safe area for patients to receive care and treatment.

Our key findings were as follows:

- We found the trust had been under increasing pressure to manage flow in the hospital for several months and the emergency department was under sustained pressure from an increase in attendances.
- There was a lack of support for the emergency department from the wider hospital services and a lack of trust wide ownership around patient flow. This meant patients were frequently and consistently not able to access services in a timely way and some patients experienced unacceptable waits for some services.
- There was a fragile medical infrastructure in the emergency department with a crucial reliance on locum medical staff at consultant and middle grade positions. However, shortly after our on-site inspection a recent partnership with another local acute trust had secured some input for clinical leadership one day a week.
- The corridor area in the emergency department was frequently used when there were more patients than cubicles available. This was not a suitable or safe environment for patients to receive emergency care and treatment and was not fit for purpose.
- The trust mortality rate had been higher than the expected level for the recent reporting periods of July 2015 to June 2016. A review of mortality and an associated action plan were in place; however the lack of recorded minutes and actions in speciality mortality review meetings was of concern. It was unclear if learning was shared or action taken as a result of reviews of patient deaths.

Summary of findings

- Since our previous inspection there had been some changes to the executive team with some people now in permanent roles and others being interim positions. More changes were due in April 2017 with a new medical director and director of operations starting in post. While the current executives worked well together they had been drawn into managing operational pressures in the emergency department on a regular basis. The new executives could lead to further change and approach to a team already under pressure and 'wearing many hats' due to the small trust and less senior roles.
- A review of governance had begun to implement change but was immature and lacking in clinical leadership at directorate level to provide robust assurance.

Safe

- We rated safety as requires improvement overall with safety in urgent and emergency care rated as inadequate, in medicine it was requires improvement and good in surgery and critical care.
- Medical staffing levels and skill mix did not ensure safe care at all times in the emergency department and medical wards. There was a fragile medical infrastructure with a critical reliance on locum medical staff at consultant and middle grade positions.
- In the emergency department there was no clinical lead consultant medical leadership to focus direction and ensure safety was a high priority.
- There were risks to children that medical staff did not have the appropriate skills and capability due to the lower numbers seen of emergency cases of paediatric cardiac arrest or deteriorating child.
- The facilities in the emergency department did not all meet patients' needs and were inappropriate. The corridor area was not a suitable or safe environment for patients to receive emergency care and treatment and was not fit for purpose. This area posed environmental risks and was a poor patient experience.
- There had been little progress in reducing mortality at the trust. While an action plan was in place, progress with some areas was limited and there was a lack of attendance and accountability at the mortality meetings and learning points and actions were not evident in all specialities.
- Trust policy for the management of medicines was not always adhered to, for example checking of controlled drugs, recording of medicine refrigerator temperatures and recording of signatures of agency nurses and locum doctors.
- Pharmacy staffing levels did not meet service, clinical and medicines governance demands and achieve medicines related Commissioning for Quality and innovation (CQUINS) and Carter model hospital indicators and therefore protect patient safety.
- Mandatory training compliance required improvement, particularly in basic life support and dementia awareness. With doctors not reaching compliance targets more often than nursing staff.
- We found a fire exit in the stroke unit was blocked and could cause delay of evacuation in the event of a fire. The trust took action when we raised the issue but it continued to be poorly managed and had not been fully rectified on our unannounced visit. This was included on the risk register but not being managed effectively.

However:

- There had been no cases of methicillin-susceptible Staphylococcus aureus (MRSA) in the previous year.
- There were systems and processes in place to reduce the risk of cross infection and clinical areas and wards we visited were visibly clean.
- Sepsis screening and pathways were in place with early treatment seen to be improving. Within nine months, the number of patients with identified sepsis receiving antibiotics within one hour had increased from 11% to 78%.
- Staff took a proactive approach to safeguarding and were aware of local safeguarding procedures for both adults and children. Although there were some delays in investigations due to staffing pressures.
- A substantial amount of work had been carried out on National Safety Standards for Invasive Procedures (NatSSIPs). The changes were being embedded in to practice across all surgical departments.

Summary of findings

- A prevention and reduction for pressure ulcers action plan had been created in November 2016, the action plan was in its infancy, however, processes were being put in place to improve awareness and ensure safe management of pressure ulcers.
- Staff understood their responsibility to report concerns and incidents. The duty of candour was mostly understood by staff and staff openness and transparency about safety was encouraged.

Effective

- We rated effective as requires improvement overall with urgent and emergency care and medicine and older people rated as requires improvement and surgery and critical care as good.
- The hospital did not have an orthopaedic-geriatric service in line with national guidance due to recruitment problems.
- Not all patients with fractured neck of femurs were operated on within 48 hours of admission, or admitted to an orthopaedic ward within four hours in line with national guidelines.
- When benchmarked against other hospitals the trust performed worse than the England average in a number of national audit programmes including: the 2015 Bowel Cancer Audit where the hospital had a mixed performance compared to other hospitals. The trust scored 'E' for patients being directly admitted to the stroke unit. The heart failure audit for 2015 showed the trust was worse than the England and Wales average for three of the four standards relating to in-hospital care and four of the seven standards relating to discharge. The 2015 National Diabetes Inpatient Audit (NaDIA) scored better than the England average in five metrics and worse than the England average in 12 metrics. Quality improvements were not always sustained and audit findings were not shared and used effectively to improve quality and patient outcomes.
- The inability to recruit senior medical staff led to a lack of clinical leadership and did not provide sufficient support to junior doctors and ensure optimum patient safety at times of increased capacity.
- Multidisciplinary working was not all coordinated to provide effective care for patients. In the emergency department there were professional working relationship breakdowns between doctors and established routines which had not been effectively addressed. These impacted on patients as early speciality review was delayed and patients had to wait in the emergency department.
- A dietician audit identified poor performance for the completion of the malnutrition universal screening tool (MUST) assessments within 24 hours of admission, where the MUST was not always completed accurately.

However:

- Care and treatment was planned in line with current evidence based guidance. Clinical care pathways and toolkits were developed in accordance with national guidelines.
- Patients received effective care in the critical care unit with practices and protocols in line with guidance and patients had the outcomes that should be expected.
- There was an effective stroke pathway in place through the emergency department.
- Patients' consent to care and treatment was sought in line with legislation and guidance. Most staff had a clear understanding of the Mental Capacity Act 2005, Deprivation of Liberty Safeguards and patient consent.
- Patients had their pain assessed regularly and managed promptly to ensure they remained as comfortable as possible.
- Since the last inspection, the hospital had employed a dedicated acute pain nurse in line with the Royal College of Anaesthetists Accreditation Standards.
- There was strong multidisciplinary working across wards and departments.
- The Patient Reporting Outcomes Measures (PROMS) and the National Joint Registry for the period of April 2015 to March 2016 showed that more patients who had groin hernia operations felt better and fewer patients felt worse after their treatment than the England average.

Summary of findings

- The hospital performed well in the 2016 National Emergency Laparotomy Audit (NELA). The hospital achieved a green (>80%) rating for high-risk cases with a consultant surgeon and anaesthetist present in the theatre and of highest-risk cases admitted to critical care post-operatively.

Caring

- Caring was rated as good overall and good for each core service.
- Staff in the emergency department remained professional and capable while under considerable pressure in a full to capacity and pressured environment. They were seen to take the time to speak with patients and those close to them in a respectful and considerate way. We saw staff delivering compassionate care and treating patients with kindness, dignity and respect. Privacy and confidentiality was respected as much as was possible considering the constraints of the environment.
- Patients who were delayed in the emergency department received nursing care and support, and were transferred to beds for their comfort and food and drink provided.
- Patients on surgical wards commented on how the care from the nursing staff and allied health professionals was 'superb', 'exemplary 'and staff had a 'great sense of humour'
- In critical care we observed staff treating patients with kindness, warmth and emotional intelligence.

However:

- In critical care the patients' diaries were not being seen as belonging to the patient and were not being given to all patients or their relatives when they left the unit.

Responsive

- Overall, improvements were required to ensure that services within the hospital were responsive to patients' needs. It was rated inadequate in urgent and emergency care and medical care, and requires improvement in surgery and critical care.
- There was no sense of urgency to respond and promote discharge to initiate flow through the emergency department to the rest of the hospital to reduce crowding in the emergency department. The bed management meetings were not dynamic in ensuring flow of discharges and admissions were acted on by the wider trust and not all required staff attended.
- The emergency department was the single point of entry to the hospital for GP expected patients. There were no direct GP admission pathways in place and this further impacted on crowding in the emergency department on a regular basis.
- Lack of timely access to a specialist senior doctor to review patients overnight in the emergency department was at times leading to delays in patient admission to wards.
- Patients were not able to responsively access the care they needed. The trust did not consistently admit patients within 4 to 12 hours. This meant patients were in the emergency department longer, up to 20 hours and the department was much busier as a result.
- Patient flow within the hospital affected theatre utilisation and cancellation rates. The ambulatory emergency care unit and discharge lounge were underutilised and the medical assessment unit was ineffectively used.
- Medical patients were being cared for on surgical wards. The trust seemed unable to rectify this position and ensure patients received care on the appropriate ward for their speciality.
- The trust does not separately measure the time to initial assessment for ambulance cases; this was included in the overall time to initial assessment in the emergency department. The trust consistently performed within the target for the latest 12 months. There had been a recent increase in patients leaving the department without being seen.
- The hospital performed worse than the England average for length of stay in general medicine and surgery. The average length of stay for the trust was 10.1 days compared to the England average 3.6 days for medical patients and for surgery it was 3 days for elective patients, compared to 3.3 days for the England average. For surgical non-elective patients, the average length of stay was 6.3 days, compared to 5.1 days for the England average.

Summary of findings

- Too many patients were delayed in their discharge from critical care to a ward. These delays were worse than the national average. Some patients were discharged onto wards at night as a bed had become available, when night time discharge was recognised as less than optimal for patient's wellbeing and mortality

However:

- Despite the pressures and capacity issues the emergency department took account of patients' specific needs. Individual care needs and adjustments were put in place.
- Dementia was well considered across wards and units and patients were identified using a 'forget me not' magnet. There was an older people's mental health liaison nurse who provided support for patients living with dementia. Staff were positive about this role and felt staff and patients were well supported.
- The trust also employed a complex needs sister and a strategic lead for learning disability services. Staff notified these staff when a person with a learning disability was admitted and the strategic lead would then follow up the patient either in hospital or through discharge.
- The management of meals and support provided to patients during a meal time on Kewstoke ward (care of the elderly) was responsive, where patient individual needs were central.
- The dietetic department had expanded menu choices for those patients on a textured diet and had provided patients with their own specific modified menu so they could specify their own meal choices.

Well led

- Well led was rated as requires improvement overall. It was rated as inadequate in urgent and emergency care, requires improvement in medicine and older people and good in surgery and critical care.
- There was no visible strategy for securing permanent clinical leadership for medical staff within the emergency department.
- The governance and management systems in place to review the risks, quality and safety of the service were reviewed regularly but have not effected any changes to the circumstances of the emergency department.
- Staff in the emergency department told us their views were not considered and they did not feel involved in how decisions about their department were made. There was poor cooperation between levels and conflict between medical teams on the wards.
- Arrangements were not robust for managing risks with lack of assurance these were managed timely and effectively. Audit processes had limited follow through of actions and findings were not widely shared at directorate level or at ward level.
- In critical care we found a lack of multidisciplinary approach to leadership with medical staff not in regular attendance at governance meetings.
- Leadership engagement with speciality mortality reviews did not support learning to improve patient outcomes in some services.

However:

- In the critical care unit there were good assurance frameworks to demonstrate how the quality and safety of care was reviewed and understood, with a good culture of staff and patient involvement.
- There was strong visible leadership within the surgical directorate and a good culture of team working. All the staff worked together to assess and plan ongoing care and treatment in a timely way.
- There was a positive culture amongst staff within medical wards and units. Staff felt a sense of team work and worked hard together with a priority to provide safe and compassionate care to patients.
- A crowding dashboard plus action cards had developed and was available in the department for staff to know if the level of escalation due to crowding had been reached. This tool had no link to the OPEL tool to escalate for wider action.
- Leadership in the theatre departments was recognised by staff as strong leading to changes to the safety and the culture of theatres.

Summary of findings

We saw several areas of good practice including:

- The oncology and haematology department demonstrated outstanding practice with the way they assessed patient risk. Patients with a risk of neutropenic sepsis were easily identifiable through the use of a yellow jacket placed on patient notes.
- Patients living with dementia were situated in the bays or side rooms that were most visible to the nursing station. Staff who provided enhanced supervision to these patients were wearing yellow tabards and were easily identifiable. Staff were allocated to a patient or a group of patients in a bay and were not to be removed unless another staff member had taken over from them. We saw the hospitals own 'This is me' booklet in the notes of a patient living with dementia. This booklet had been completed by a relative of the patient and explained the patient in detail, what they liked to be called what they liked to do, what was their favourite food.

Importantly, the trust must:

- Ensure that there are sufficient numbers of suitably qualified, competent, skilled and experienced doctors deployed within the hospital. This includes sufficient medical leadership within the emergency department and suitable levels of staff to ensure the corridor is safely staffed.
- Take action to ensure that there are sufficient medical staff with sufficient skills in advanced paediatric life support in the emergency department.
- Take action to ensure that medicine systems in the emergency department are safe for controlled drugs including signature list for agency nursing staff and locum doctors, to cross reference who had prescribed and administered medicines.
- Take action to ensure that systems are in place to ensure patient flow through the hospital was responsive.
- Ensure patients are being admitted promptly once the decision to admit has been made. Take action to ensure that safety checks in the emergency department are completed.
- Take action to ensure that patients are cared for in a safe environment in the emergency department.
- Review the medical staffing and ensure safe levels of medical cover and support to juniors on the medical wards in evenings and weekends.
- Review the use of locum consultants and take action to ensure medical staffing is not vulnerable through recruitment of permanent consultant staff.
- Be assured junior medical staff are being provided with appropriate support and are competent in their roles.
- Ensure safe nursing cover is provided on Cheddar ward and agency usage is kept to a minimum.
- Take action to mitigate risks included on the risk registers effectively, reviewing regularly and managing those risks identified on a timely basis to ensure safety to staff or patients is not compromised.
- Manage quality and performance and ensure sustained learning and improvements from audits.
- Take action to continually maintain a clear path for evacuation in the event of a fire within the stroke unit by ensuring fire exits are not blocked.
- Take action to ensure patient flow from the emergency department through the medical wards to timely discharge is effective and timely in meeting the needs of patents and ensuring good quality care and treatment.
- Take action to address areas of concern and demonstrate patient outcomes monitored by the Summary Hospital – level Mortality Indicator (SHMI) are improved.
- Improve the quality, attendance, accountability learning points and actions from mortality and morbidity reviews in all specialities.
- Make sure the surgical directorate has an orthopaedic-geriatric service for pre and post-operative care.
- Ensure all patients that had fractured neck of femurs were operated on in line with national guidelines and admitted to an orthopaedic ward within four hours.
- Follow trust policy for the management of medicines, for example checking of controlled drugs, recording of medicine refrigerator temperatures and recording of signatures of agency nurses and locum doctors. (Accident and Emergency).

Summary of findings

- Review pharmacy staffing levels in order to meet service, clinical and medicines governance demands and achieve medicines related CQUINS and Carter model hospital indicators and therefore protect patient safety.
- Ensure multidisciplinary input and a collective approach to the running of the critical care unit. The medical team leaders must ensure they meet regularly with the senior nursing leadership to provide a multi-professional approach and contribution to all aspects of running the unit, including governance and provision of quality care.
- Address the poor access and flow of patients in critical care in order to reduce the delays to patients who are fit to leave the unit, reduce the risks of patients not having timely admittance, eliminate breaches in same-sex rules, stop the relocation to or delay of patients in the operating theatre recovery area, and reduce the number of patients who are transferred to a ward bed at night.
- Produce mortality and morbidity reviews for critical care where there is accountability for learning and change, and a demonstration as to how this has improved practice and safety.
- Review the provision for and quality of life support training in the trust to ensure there are a satisfactory number of staff with the right experience and training on duty at all times.

In addition the trust should:

- Consider a clearer approach to reflect incident trends and ensure use of the hazard line identifies trends and is supported by consistent processes.
- Ensure there is sufficient overview of the children's waiting area in the emergency department to ensure children's safety at all times.
- Review the storage arrangements for patients own medicines and possessions when they were receiving care and treatment in the corridor of the emergency department.
- Produce care pathways through the emergency department to support patient care. These should include frailty pathways for older people to ensure they receive timely care and treatment.
- Consider actions to address professional working relationship breakdowns between doctors and established routines which had not been effectively addressed. These impacted on patients as early speciality review was delayed and patients had to wait in the emergency department.
- Ensure national audit programmes and local audits effect change in practice.
- Ensure emergency department staff are aware of the vision and strategy for the emergency department or the strategic development of the service.
- Ensure the governance and management systems in place to review the risks, quality and safety of the emergency department service were reviewed regularly and effect changes to the department.
- Ensure the risk registers for the hospital were accessible so staff can be aware of what was included on the risk register or how to raise issues for the risk register. This will enable risks to be addressed.
- Reduce the in-use expiry date when glucagon injection is removed from refrigerated storage and record the date of opening of liquid medicines to ensure that these medicines are suitable for use. Ensure there is a robust system for checking expiry dates of medicines.
- Review the storage arrangements for patients own medicines when they were receiving care and treatment in the corridor in accident and emergency.
- Complete the medicines safety thermometer on all in-patient units on a monthly basis.
- Audit the pharmacy service against the Royal Pharmaceutical Society standards for hospital pharmacy.
- Review the medicines reconciliation service provided such that medicines are reconciled for patients in line with the NICE quality statement 120 and benchmarked requirements.
- Ensure stroke patients are provided with optimum care in an environment which is conducive to improve their outcomes and meet their individual needs.
- Review length of stay data and act to reduce this in line with national recommendations.
- Review the environment regularly to ensure safety is not compromised for patients. During our inspection we identified broken window restrictors and fire extinguishers which were not secured to walls.
- Review provision of seven day services to improve access to support at weekends and overnight.

Summary of findings

- Educate staff on the duty of candour so it is used consistently across the medical service.
- Provide regular appraisals and clinical supervision to all staff to ensure they are appropriately supported and competent in their job role in medicine and the emergency department.
- Remind staff of the procedures to follow in the event of a major incident and schedule regular practice.
- Ensure the discharge lounge has appropriate arrangements for nursing support within escalation extended hours when the day case unit is not open.
- Review the ward clerk staffing arrangements and extra resources available to ensure wards are appropriately supported for non-clinical duties.
- Maintain a record through minutes of weekly medical meetings in the stroke and care of the elderly specialisms to discuss best practice for patients.
- Remind staff of the importance to find the previous weight of a patient to enable them to identify weight changes at admission and comply with the malnutrition universal screening tool (MUST) guidelines.
- Improve mandatory training attendance rates across the surgical directorate.
- Improve compliance with completing the venous thromboembolism or blood clots (VTE) assessment tool.
- Review the storage of equipment in the day case unit clean utility room.
- Review length of stay for emergency and elective surgery patients so it is in line with the England average.
- Make sure complaints are documented at senior level as being handled in line with policy.
- Consider adding sepsis screening to the performance assurance framework, to continually audit sepsis recognition and treatment and monitor sepsis training.
- Review supernumerary nursing cover in critical care to address the Faculty of Intensive Care Medicine core standard for safe supernumerary levels.
- Make sure medical staff working in critical care have completed the update of their mandatory training.
- Ensure medical records in critical care clearly state who has created the record and who has attended ward rounds.
- Ensure all staff in critical care are aware of the difficult airways trolley.
- Ensure all equipment checks in critical care are performed and recorded when required.
- Review patient records to ensure the time a decision is taken to admit a patient to critical care is recorded and captured for audit work.
- Make sure any medicines not given to a patient in critical care have the reasons recorded on the prescription charts.
- Review the time taken with ward rounds in critical care and ensure this does not delay any requests for tests or procedures for patients while the round continues.
- Be assured that nursing staff in critical care providing direct patient care are at the right level of qualification.
- Review the provision of physiotherapy in critical care, which was not meeting best practice guidance. Also, review NICE guidance around rehabilitation and physiotherapy prescriptions.
- Develop a valid programme of audit for the medical teams in critical care in accordance with an audit calendar and suitable programme for critical care.
- Review how to address the lack of a clinical nurse educator role in critical care.
- Review the critical care risk register at a multidisciplinary critical care meeting.
- Ensure all staff in critical care have appropriate knowledge of Deprivation of Liberty Safeguards.
- Ensure the reports of the Intensive Care National Audit and Research Centre are received when they are available, and discussed at clinical governance reviews.
- Ensure any patient diary used with longer-stay patients is recognised as the property of the patient and returned to them or their relative when the patient is discharged from the critical care unit.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services	Inadequate 	We rated the service overall as inadequate because:

- Medical staffing levels and skill mix did not ensure safe care at all times. There was a fragile medical infrastructure with a crucial reliance on locum medical staff at consultant and middle grade positions. There was no clinical lead consultant medical leadership to focus direction and ensure safety was a high priority.
- There were risks to children that medical staff did not all have the appropriate skills and capability due to the lower numbers seen of emergency cases of paediatric cardiac arrest or deteriorating child.
- Equipment in the department was not consistently checked to ensure it was available and safe for use.
- Medicines were not all managed in line with local and national guidance.
- Multidisciplinary working was not all coordinated to provide effective care for patients. Delays were incurred by patients as early speciality review was delayed and patients had to wait for long periods of time in the emergency department.
- The flow of patients through the emergency department was not responsive to meet the needs of patients. The emergency department was the single point of entry to the hospital for both emergency and GP expected patients. There were no direct GP admission pathways in place. Crowding had taken place in the Weston Hospital emergency department on a regular basis which impacts on patient care.
- There was a lack of support for the emergency department by the wider hospital services and a lack of trust wide ownership around patient flow. Escalation processes in place to indicate action when the department was under pressure were not responsive and did not receive a wider hospital support.
- Patients were not able to responsively access the care they needed. There has been a decline in patients being admitted promptly once the

Summary of findings

decision to admit has been made. The trust did not consistently admit patients within 4 to 12 hours. This meant patients were in the emergency department longer, up to 20 hours and the department was much busier as a result.,

- Patients were frequently and consistently not able to access services in a timely way and some patients experienced unacceptable waits for some services.
- There was no sense of urgency to respond and promote discharge to initiate flow through the emergency department. Bed management meetings were not dynamic in ensuring flow was acted on by the wider trust.
- The facilities did not all meet patients' needs and were inappropriate. The corridor area was not a suitable or safe environment for patients to receive emergency care and treatment and was not fit for purpose. This area posed environmental risks and was a poor patient experience.
- Staff told us their views were not considered and they did not feel involved in how decisions about their department were made.
- Staff at department level were not clear about how governance impacted on their day to day work or created improvements in service. Mortality reviews for emergency department patients were not consistently undertaken to ensure learning from deaths in the department.

However:

- We observed that while under considerable pressure in a full to capacity and pressured environment, staff remained professional and capable. Staff took the time to speak with patients and those close to them in a respectful and considerate way. We saw staff delivering compassionate care and treating patients with kindness, dignity and respect. Privacy and confidentiality was respected as much as was possible considering the constraints of the environment.
- When patients were delayed in the department they received nursing care and support, they were transferred to beds for their comfort and food and

Summary of findings

drink provided. Patients and their relatives received regular communications and were kept informed about their care, treatment and condition.

- Patients had their pain assessed regularly and managed promptly to ensure they remained as comfortable as possible. The nutritional and hydration needs of patients were assessed and met.
- Staff took a proactive approach to safeguarding and were aware of local safeguarding procedures for both adults and children.
- Effective multidisciplinary working was evident within the emergency department between emergency department medical, nursing and allied health professional staff to ensure an effective delivery of care.
- Staff understood their responsibility to report concerns and incidents.
- There were systems and processes to reduce and control the risk of cross infection. We observed the department appeared visibly clean and cleaning staff were seen throughout the hospital.

Medical care (including older people's care)

Requires improvement

We rated this service as requires improvement because:

- Patient flow had not been sufficiently improved since our last inspection.
- There was ineffective patient flow through the hospital and regular delays to patient discharge. The ambulatory emergency care unit and discharge lounge were underutilised and the medical assessment unit was ineffectively used.
- There were regularly a high number of medical outliers so patients were not receiving care on the right ward.
- Medical staffing was vulnerable and junior doctors did not feel well supported. Medical wards could be left at risk during evenings and weekends when medical staff were required to support the emergency department. There was a high number of locum consultants with only four permanent consultants across the medical wards.

Summary of findings

- The high use of agency staff on Cheddar ward, due to vacancies, posed a potential safety risk to patients and did not ensure continuity of care.
- A fire exit in the stroke unit was blocked and could cause delay of evacuation in the event of a fire. This was included on the risk register but not being managed effectively.
- When benchmarked against other hospitals the trust were worse than the England average in a number of national audit programmes. Quality improvements were not always sustained and audit findings were not shared and used effectively to improve quality and patient outcomes.
- Directorate and executive leadership had undergone many changes to people in post, this negatively affected the quality of leadership and the ability to successfully drive improvements through.
- The stroke unit environment and availability of specialist equipment was not conducive to rehabilitation.
- Medicines were not always managed effectively. We found medications which had expired, medicines were not always reconciled for inpatient admissions and the medical safety thermometer was not completed by all wards on a monthly basis.
- We identified patient safety risks within ward environments, to include broken window restrictors and unsecured fire extinguishers.
- Staff mandatory training was not consistently meeting the trust's 90% target. Training for medical staff was particularly poor.

However:

- The oncology and haematology unit assessed patient risk for neutropenic sepsis and ensured this was clearly identifiable to staff.
- The management of meals and support provided to patients during a meal time on Kewstoke ward (care of the elderly) was very responsive, where patients' individual needs were met and accommodated and high standard of patient care was provided.

Summary of findings

- There was a well embedded culture for incident reporting. Staff regularly identified learning from incidents.
- Staff regularly reviewed and discussed risks to patients within safety briefings and handovers. There had been a reduction in falls showing improvement in patient harm free care.
- Multidisciplinary team working was evidenced, effectively contributing to patient care and treatment.
- Staff were confident in the processes for gaining consent, mental capacity assessments and deprivation of liberty safeguards.
- Patients were consistently positive about the care and treatment they had received, and we observed compassionate and kind care provided to patients.
- Staff were responsive to patient individual needs. This was particularly evident in their approach to patients living with dementia.
- There was a positive culture amongst staff and staff were complimentary about their local nursing leadership.

Surgery

Good

We rated the service overall as good with requires improvement for responsive because:

- Care and treatment on the wards and in the theatre departments was delivered safely and in line with policy and guidelines
- Patients were protected from abuse and avoidable harm.
- Surgical patients outlying on medical wards were cared for safely.
- There was strong visible leadership within the surgical directorate.
- Staff treated their patients with dignity, respect and compassion.
- There was a good culture of team working. All the staff worked together to assess and plan ongoing care and treatment in a timely way.
- With exception of some of the mortality and morbidity reviews, there was an effective governance framework which supported the delivery good quality care.

However:

Summary of findings

- Lessons were not always learned when things went wrong. We could not be assured that the trust had learnt from the high mortality rate.
- Patient flow within the hospital affected theatre utilisation and cancellation rates.
- Patients were cared for on medical wards and as in-patients on the day case unit.
- The hospital did not have an orthopaedic-geriatric service due to recruitment problems.
- Not all patients with fractured neck of femurs operated on within 48 hours of admission, or admitted to an orthopaedic ward within four hours

Critical care

Good

We rated the service overall as good because:

- The care and treatment delivered, and the practices and protocols around them were safe.
- There was a strong culture around delivering safe care.
- People were protected from abuse and avoidable harm.
- Care was effective and patients had the outcomes that should be expected.
- Staff were well trained and experienced at delivering care.
- Staff were caring, compassionate, and treated patients as individuals.
- The services met the needs of vulnerable people, and those with specific mental and physical needs.
- There were good assurance frameworks to demonstrate how the quality and safety of care was reviewed and understood.
- There was a good culture of staff and patient involvement in the unit.
- There had been patient-focused improvements in the unit from the committed staff team.

However:

- With a high mortality rate at this trust, the service was not demonstrating learning from reviews into patient deaths.

Summary of findings

- There were problems with patient flow in the rest of the hospital and this was affecting the ability to admit, transfer, and discharge patients in critical care at the right time.
- There was a lack of multidisciplinary or a collective approach to the leadership and management of the critical care unit.

Weston General Hospital

Detailed findings

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

Detailed findings

Contents

Background to Weston General Hospital

Weston Area Health NHS Trust provides acute hospital services and specialist community children's services to a population of 202,566 people (source: 2011 census), in North Somerset, with over 70% of people living in the four main towns of Weston, Clevedon, Portishead and Nailsea. A further 3.3 million day trippers and 375,000 staying visitors increase this base population each year.

It has three locations that are registered with the Care Quality Commission. These are Weston General Hospital, The Barn in Clevedon and Drove House which both provide special community children's services.

Deprivation is not compared to the England average in the 2016 Health profile; however, life expectancy is 9.1 years lower for men and 6.5 years lower for women in the most deprived areas of North Somerset in and around the coastal areas.

According to the last census in 2011 97.3% of the population of North Somerset was white with the Black and Ethnic Minority Group accounting for 2.7% of the population. 51.4% of the population is female and 48.6% is male.

The trust has a total of 270 beds spread across various core services (265 general and acute beds and five critical care).

As part of this inspection, CQC used Weston Area Health NHS Trust as a pilot site for testing a new methodology relating to the assessment of mental health care delivered in acute hospitals; the findings of this specific piece of work are included where relevant in the report but this has not contributed toour aggregation of judgements for any rating within this inspection process.

Our inspection team

Our inspection team was led by:

Chair: Professor Edward Baker, Deputy Chief Inspector, Care Quality Commission

Head of Hospital Inspections: Mary Cridge, Care Quality Commission

The team included CQC inspectors, a CQC Director of People, a CQC pharmacist and a variety of specialists including: accident and emergency nurse; accident and emergency consultant; accident and emergency doctor; medical nurse; medical doctor; theatre nurse, surgical doctor; surgery nurse; critical care nurse, critical care doctor, Director of Nursing, Medical Director one expert by experience.

Detailed findings

How we carried out this inspection

We carried out the announced part of our inspection between 28 February and 2 March 2017 and returned to visit some wards and departments unannounced on 9, 10, 13 and 14 March 2017.

During the inspection we visited a range of wards and departments within the hospital and spoke with clinical and non-clinical staff, patients, and relatives. We held focus groups to meet with groups of staff and managers.

Prior to the inspection we obtained feedback and overviews of the trust performance from local Clinical

Commissioning Groups and NHS Improvement.

We reviewed the information that we held on the trust, including previous inspection reports and information provided by the trust prior to our inspection. We also reviewed feedback people provided via the CQC website.

Facts and data about Weston General Hospital

Weston Area Health NHS Trust provides acute hospital services and specialist community children's services to a population of 202,566 people (source: 2011 census), in North Somerset, with over 70% of people living in the four main towns of Weston, Clevedon, Portishead and Nailsea. A further 3.3 million day trippers and 375,000 staying visitors increase this base population each year.

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The trust has a total of 270 beds spread across various core services (265 general and acute beds and five critical care).

NHS North Somerset Clinical Commissioning Group is the trust's main commissioner accounting for approximately 69% of trust healthcare income, with NHS Somerset accounting for circa 16% of income. In addition, the trust receives other non-patient related income including education and training monies.

There had continued to be some instability within the executive team since our previous inspection. The medical director and director of nursing had become permanent but the medical director was due to leave the trust in April 2017. The director of operations had been an interim post for the previous six months. Both of these posts were about to be replaced in April 2017 by permanent executive staff.

We inspected the trust as part of our in-depth hospital inspection programme in May 2015.

We rated the trust as requires improvement overall. Medical care was rated as inadequate, urgent and emergency care, critical care and surgery were rated as requiring improvement and maternity and gynaecology , services for children and young people, outpatients and diagnostic imaging and end of life care were all rated as good. We then carried out a focused unannounced inspection in 17 to 18 August 2015. This was to follow up on concerns raised about medical staffing and the support provided to junior doctors in the trust.

Our ratings for this hospital

Our ratings for this hospital are:

Detailed findings

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Inadequate	Requires improvement	Good	Inadequate	Inadequate	Inadequate
Medical care	Requires improvement	Requires improvement	Good	Inadequate	Requires improvement	Requires improvement
Surgery	Good	Good	Good	Requires improvement	Good	Good
Critical care	Good	Good	Good	Requires improvement	Good	Good
Overall	Requires improvement	Requires improvement	Good	Inadequate	Requires improvement	Requires improvement

Notes

Urgent and emergency services

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

Information about the service

The Emergency Department (ED) is the main emergency department for a local resident population which, in 2011, was estimated to be 202,566 people with over 70% of people living in the four main towns of Weston, Clevedon, Portishead and Nailsea. A further 3.3 million day trippers and 375,000 staying visitors increase this base population each year.

In May 2015 the Trust underwent a comprehensive inspection with a further follow-up visit in August 2015. The 'safe' domain for urgent and emergency services was rated as inadequate with an overall rating for the service of 'inadequate'.

The emergency department at Weston General Hospital includes a resuscitation area with four patient spaces (one of which was a paediatric space), a major injury and illness area with eight patient bed spaces, a minor injury and illness area with 13 assessment and treatment cubicles. In response to times of high demand and patient attendance the corridor surrounding the majors and resuscitation area is currently used for patients on trolleys. Curtains and signage had been put in place to use this area, which provides 12 spaces.

As the emergency department was not a designated trauma unit, severely injured trauma patients are usually taken by ambulance to a trauma unit or trauma centre in Bristol or Taunton depending on the location of the incident.

Between the years 2015 to 2016 Weston General Hospital emergency department had seen 54,326 patients, with the highest attendance being 173 attendances in one day. Over the past six years, emergency department attendances have risen by 5.9%.

Of the attendances between December 2015 to November 2016 14,993 (27.6%) of patients arrived by ambulance. The number of emergency department attendances that resulted in admissions was12,567 (23.1%), which means the trust are in the middle 20% of trusts. The percentage of attendances resulting in an admission reduced from 25.2% in 2014/15 to 24.3% in 2015/16.

The department sees children in a limited capacity with no paediatric consultant availability for children overnight and at weekends. The department saw 9,678 children between December 2015 and November 2016. Children requiring overnight admission are automatically diverted to the specialist children's hospital in Bristol or the children's unit at Musgrove Park Hospital in Taunton.

As part of this inspection, CQC piloted an enhanced methodology relating to the assessment of mental health care delivered in acute hospitals; the evidence gathered using the additional questions, tested as part of this pilot, has not contributed to our aggregation of judgements for any rating within this inspection process. Whilst the evidence is not contributing to the ratings, we have reported on our findings in the report.

This report is a reflection of our inspection of the emergency department as part of an announced follow-up inspection on 1 and 2 March 2017. We also

Urgent and emergency services

carried out an unannounced inspection on 10 March 2017. We spent time observing the care and treatment being provided and the management systems in place. We spoke with 38 staff, including managers, senior and junior doctors, nurses and agency staff, administrators, porters, volunteers and domestics. We also spoke with eight patients and two relatives, reviewed nine sets of care records and reviewed data collected before, during and after the inspection.

Summary of findings

We rated this service as inadequate because:

- Medical staffing levels and skill mix did not ensure safe care at all times. There was a fragile medical infrastructure with a crucial reliance on locum medical staff at consultant and middle grade positions. There was no clinical lead consultant medical leadership to focus direction and ensure safety was a high priority. Nursing leadership was strong but on a limited permanent workforce with a dependency on agency and bank staff.
- There were risks to children that medical staff did not have the appropriate skills and capability due to the lower numbers seen of emergency cases of paediatric cardiac arrest or deteriorating child.
- Equipment in the department was not consistently checked to ensure it was available and safe for use. This included daily checks of resuscitation trolleys, blood and ketone monitoring equipment.
- Medicines were not all managed in line with local and national guidance. The recording of medicines given and disposed of, fridge temperatures and records of those agency and locum staff prescribing and administering medicines was not consistent or sufficient to ensure safe practice.
- Multidisciplinary working was not all coordinated to provide effective care for patients. Delays were incurred by patients as early speciality review was delayed and patients had to wait for long periods of time in the emergency department.
- The flow of patients through the emergency department was not responsive to meet the needs of patients. The emergency department was the single point of entry to the hospital for both emergency and GP expected patients. There were no direct GP admission pathways in place. Crowding had taken place in the Weston Hospital emergency department on a regular basis which impacted on patient care.
- There was a lack of support for the emergency department by the wider hospital services and a lack of trust wide ownership around patient flow. Escalation processes in place to indicate action when the department was under pressure were not

Urgent and emergency services

responsive and did not receive a wider hospital support. As a result, there were patient delays in being seen and a lack of proactive engagement to address delays and pressure in the department.

- Patients were not able to responsively access the care they needed. There has been a decline in patients being admitted promptly once the decision to admit had been made. The trust did not consistently admit patients within 4 to 12 hours. This meant patients were in the emergency department longer, up to 20 hours and the department was much busier as a result.,
- Once assessed by the emergency department, access to a specialist doctor overnight to review patients for admission to a ward was limited and so delayed patient admission. Patients were frequently and consistently not able to access services in a timely way and some patients experienced unacceptable waits for some services.
- There was no sense of urgency to respond and promote discharge to initiate flow through the emergency department. Bed management meetings were not dynamic in ensuring flow was acted on by the wider trust.
- The facilities did not all meet patients' needs and were inappropriate. When patients did not have access to cubicle space they were cared for on a corridor. This practice occurred regularly enough for staff to consider it 'the norm'. The corridor area was not a suitable or safe environment for patients to receive emergency care and treatment and was not fit for purpose. This area posed environmental risks and was a poor patient experience.
- The culture of the service was top down from the executive level and directive with little input from a department level. Staff told us their views were not considered and they did not feel involved in how decisions about their department were made at an executive level and were not aware of any specific role they had in developing the department's future.
- Staff at department level were not clear about how governance impacted on their day to day work or created improvements in service. Mortality reviews for emergency department patients were not consistently undertaken to ensure learning from deaths in the department.

However:

- We observed that while under considerable pressure in a full to capacity and pressured environment, staff remained professional and capable. Staff took the time to speak with patients and those close to them in a respectful and considerate way. We saw staff delivering compassionate care and treating patients with kindness, dignity and respect. Privacy and confidentiality was respected as much as was possible considering the constraints of the environment.
- When patients were delayed in the department they received nursing care and support, they were transferred to beds for their comfort and food and drink provided. Patients and their relatives received regular communications and were kept informed about their care, treatment and condition.
- Patients had their pain assessed regularly and managed promptly to ensure they remained as comfortable as possible. The nutritional and hydration needs of patients were assessed and met.
- Staff took a proactive approach to safeguarding and were aware of local safeguarding procedures for both adults and children.
- Effective multidisciplinary working was evident within the emergency department between emergency department medical, nursing and allied health professional staff to ensure an effective delivery of care. There was an effective stroke pathway in place through the emergency department.
- Staff understood their responsibility to report concerns and incidents. The duty of candour was understood by staff, staff openness and transparency about safety was encouraged.
- There were systems and processes to reduce and control the risk of cross infection. We observed the department appeared visibly clean and cleaning staff were seen throughout the hospital.
- Sepsis screening and pathways were in place with early treatment seen to be improving. Within nine months, the number of patients with identified sepsis receiving antibiotics within one hour had increased from 11 % to 78%.

Urgent and emergency services

- Patients' consent to care and treatment was sought in line with legislation and guidance. Staff had a clear understanding of the Mental Capacity Act 2005, Deprivation of Liberty Safeguards and patient consent.
- The management of complaints enabled staff to learn from issues raised.

Are urgent and emergency services safe?

Inadequate

We rated safe as inadequate because:

- Medical staffing levels and skill mix did not ensure safe care at all times. There was a fragile medical infrastructure which was in disarray with a crucial reliance on locums. There were insufficient permanent consultants and substantial shortages of middle grade medical staff employed in the emergency department.
- There was no emergency department consultant medical leadership to focus direction and ensure safety was a high priority.
- There were risks to children that medical staff did not have the appropriate skills and capability due to the lower number of emergency cases of paediatric cardiac arrest or deteriorating child.
- The corridor area was not a suitable or safe environment for patients to receive emergency care and treatment and was not fit for purpose. While it was understood this area was used in response to increased demand and staff worked hard to provide care, this area was not safe, posed environmental risks and was a poor patient experience.
- Equipment in the department was not consistently checked to ensure it was available and safe for use. This included daily checks of resuscitation trolleys, blood and ketone monitoring equipment. This lack of daily check did not provide assurance that equipment was in place when needed in an emergency.
- Medicines were not all managed in line with local and national guidance. The recording of medicines given and disposed of, fridge temperatures and records of those agency and locum staff prescribing and administering medicines was not consistent or sufficient to ensure safe practice.
- Systems were in place to mostly ensure patients' information was kept safe however, the use of the corridor compromised patient information security.
- Mortality reviews for emergency department patients were not consistently undertaken to ensure learning from deaths in the department.

However:

- Staff understood their responsibility to report concerns and incidents. The duty of candour was understood by staff and staff openness and transparency about safety was encouraged.
- There were systems and processes to reduce and control the risk of cross infection. We observed the department appeared visibly clean and cleaning staff were seen throughout the hospital managing the cleaning rotas and staff followed hospital hygiene policies.
- Staff took a proactive approach to safeguarding and were aware of local safeguarding procedures for both adults and children.
- Sepsis screening and pathways were in place with early treatment seen to be improving. Within nine months, the number of patients with identified sepsis receiving antibiotics within one hour had increased from 11 % to 78%.

Detailed findings

Incidents

- The trust policy set out the procedures for managing incidents, these were investigated and learning from them shared. The department reported incidents through their electronic system when there were patient delays. Between February 2016 and January 2017, there had been 212 incidents related to delays in care.
- No never events had been reported for the emergency department. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- Nursing and medical staff felt there was a good incident reporting culture and they were actively encouraged to complete electronic incident reports. Staff were aware of their responsibility to report incidents and received learning from incident investigation through daily handovers and feedback through safety briefings.
- A hazard (telephone) line had been implemented for use by all staff to raise issues of concern. Staff told us that if they were busy and had a concern they would report by the hazard line. If they had more time they would report by the electronic system. This did not provide a consistent reporting process to ensure auditing of trends was accurate. The hazard line was anonymous and therefore tracking and investigation of incidents reported was at times difficult.
- In accordance with the Serious Incident Framework 2015, the trust reported 37 serious incidents (SIs) in Urgent and Emergency Care which met the reporting criteria set by NHS England between January 2016 and December 2016. Of these, the most common type of incident reported was 'environmental incident meeting SI criteria' (26), the next most common was 'treatment delay meeting SI criteria' (6). In January 2017, staff told us 21 serious incidents were recorded. Of these 20 were 12 hour breaches of the target for admission.
- The recently formed trust serious incident review panel ensured serious incidents were adequately investigated and lessons learned identified. All investigation reports and action plans were shared with the trust's lead commissioner.
- Safety data was monitored and incidents were investigated to enable risks to be identified and to provide an accurate picture of safety. The emergency department had a lead nurse for electronic incident reporting. One day each month the nurse had protected time to review and process all recorded incidents. Some delays were noted in the processing of the incident reports with some of December 2016 reports not yet processed. Staff told us this was a time issue as the department was very busy.
- Governance arrangements supported incident reporting safety across the division. Each weekday all incidents were risk scored by the governance team. An electronic governance system, which has the ability to record and monitor incidents has been operational since 2010. The system was extended to include the complaints and risk register module to provide comprehensive reporting to support greater triangulation of risk.
- Mortality reviews for emergency department patients were not consistently undertaken to ensure learning from deaths in the department. The trust told us the mortality group meets monthly to review patient deaths and look at learning outcomes. The trust was a recurring mortality outlier for Standardised hospital mortality indicators with little improvement for the period of October 2015 to September 2016.
- The trust confirmed 85% of deaths were reviewed and any concerns were escalated to matron or the medical

director. The emergency department mortality and morbidity lead was a consultant who confirmed there were no regular department meetings, the last one was 6th December 2016. We requested those notes which were not provided.

Duty of candour

- Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 is a regulation introduced in November 2014. This Regulation requires the trust to notify the relevant person that an incident has occurred, provide reasonable support to the relevant person in relation to the incident and offer an apology. The duty of candour was understood by staff. When things went wrong, patients were provided with a timely apology and support as needed. For staff openness and transparency about safety was encouraged.

Safety thermometer

- The Safety Thermometer was used to record the prevalence of patient harm and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline was intended to focus attention on patient harms and their elimination. Data collection took place one day each month. Data from the Patient Safety Thermometer showed that the trust reported no pressure ulcers, no falls with harm and no catheter urinary tract infections between December 2015 and December 2016 in Urgent and Emergency care.
- Staff told us that venous thromboembolism (VTE assessments) were undertaken if indicated as part of initial assessments. The trust told us VTE assessments were done by admitting teams at present, and not the emergency department. Audit results were not available from the emergency department.
- Safety monitoring for children did not take place. There was no specific paediatric safety thermometer and no audits took place of paediatric early warning scores. This may be problematic to complete if not enough children were in the department on the allocated day of data collection.
- The trust scored “about the same” as other trusts for all five A&E Survey questions relevant to safety.

Cleanliness, infection control and hygiene

- There were systems and processes to prevent and control the risk of cross infection. We observed the department appeared visibly clean and cleaning staff were seen throughout the department managing the cleaning rotas. The department displayed its own cleanliness rating of 95% of all areas cleaned.
- Staff wore the correct uniform and used personal protective equipment, gloves and aprons as needed. Staff followed the hospital policy of being bare below the elbow.
- All staff received mandatory and ongoing updates on infection prevention and control. Hand hygiene practice was consistent. Hand hygiene audits undertaken monthly showed a monthly variance between 90% and 96% completion. Hand wash facilities were available in the department and hand gel was available on entry to the department. Protective personal equipment was available throughout the department.
- There had been no cases of methicillin-resistant or methicillin-susceptible Staphylococcus aureus (MRSA and MSSA), or Clostridium difficile (C. diff) in the previous year. Screening for MRSA had not been consistently completed since April 2016 when the emergency department scored 100%. The screening completion had deteriorated each month and by January 2017 was down to 60%. Staff asked thought this may be a reflection of a wider use of contingent workforce staff, who may not be used to the trust procedure for screening.

Environment and equipment

- Equipment in the department was not consistently checked to ensure it was available and safe for use. Resuscitation trolleys reviewed were not checked daily to ensure that equipment would be immediately available in an emergency. There were gaps of days and weeks when the checks had not been recorded as undertaken. Bay number two resuscitation trolley had gaps of between 15 and 21 days during October 2016 and January 2017. In February 2017 there were 11 days unchecked. In bay number three resuscitation trolleys, January 2017 had 21 days unchecked and February 2017 seven days unchecked. This did not provide assurance that equipment was in place when needed in an emergency. We reviewed the checks at our unannounced inspection on the 10 March 2017 and saw daily checks had been completed since our announced inspection, with the exception of one day where a check was missed.

- The blood glucose monitoring machine had daily check gaps of 19 days in January 2017 and 12 days unchecked in February 2017. A further blood glucose monitor machine which needed quality control checks daily had these checks missing. In January 2017, 25 days had not been checked and February 2017, 17 days had not been checked. This was potentially unsafe practice. If the quality control was not checked daily, when used it might not give the correct reading leading to potential for incorrect treatment.
- A ketone machine should be safety checked weekly but had not been consistently checked over the previous three months. This was a potential safety risk as if not checked as planned readings from a patient might be inaccurate and impact on the treatment provided.
- The department was frequently crowded, with patients being held on a corridor until space became available in majors or minors. There was over reliance on the use of the corridor particularly in time of extreme pressure. Magnetic curtains were in place that could be removed by hand easily. These were seen to be in place when the corridor was in use and not in use. These were used to promote privacy and dignity when required rather than use free standing screens that could topple onto patients. The corridor area was used when all other areas were full and had a standard operating procedure in place for staff to follow to ensure safe staffing for patients.
- The corridor area was not a suitable area for patients. Whilst curtains were in place, there was no room for patients to be examined, the lighting was poor and staff told us some investigations were difficult, for example taking blood. There were no call bells so patients and staff would need to shout for assistance. There was no wall supplied oxygen or suction and so portable systems were used which increased the crowding. Any equipment which needed to be plugged in to the electricity supply had to be plugged in on the opposite wall and there were seven sockets available. This in turn created a trip hazard for staff and patients. There were no secure trolleys for records and so we saw each length of corridor had records left accessible. On the corridor labelled A-D space for a patient or resuscitation trolley to pass in an emergency was compromised, however, the resuscitation area was nearby for staff to assist with moving a patient.
- The mobile paediatric resuscitare in the emergency department had been identified as a risk as the equipment was 10 years old and could no longer be repaired should that be required. The paediatric resuscitare was functioning safely at the time of inspection and Matron confirmed the equipment replacement was ordered but not yet received. The emergency department risk register highlighted this as a high risk. With the control in place for this risk being using the mobile resuscitare based upon Ashcombe Birth Centre. Subject to demand and need this could be in use and was not an adequate mitigation. Using vital equipment from another critical area only places them at increased risk.
- The department had a dedicated mental health assessment room, which met the required standards. There were two doors, furniture was appropriate and an alarm system was installed. The emergency department was considered to be a place of safety by the mental health team. There was a 136 Suite (a place of safety area) available at a local acute trust but this was often in use so patients would remain at Weston Hospital emergency department. Staff confirmed this did happen, but only rarely.
- Servicing and maintenance of equipment kept patients safe. Equipment was serviced in accordance with manufacturers' and local requirement. The systems and management of clinical waste kept patients and staff safe.
- There was sufficient waiting room space at the main reception. The area was clean, water was available and there was waiting time information displayed. The waiting room for children was a separate room with no visibility by reception staff. Staff expectation was that parents would be supervising their children. No consideration was in place for if parents were to leave children unattended. The Standards for Children and Young People in Emergency Settings 2012 states that emergency settings accommodate the needs of children and comply with HBN22 standards. The HBN 22 standards note that the waiting area provided for children should be provided to maintain observation by staff.

Medicines

- Medicines were being stored securely, however not all medicines were managed in line with local and national guidance.

- Medicines administration records were well completed. Patient's allergies were recorded. Medicines which were needed 'as required' were recorded to include instructions for staff about doses and range of administration.
- Controlled drugs were stored securely. The access to the cupboard keys was only by authorised staff. However, the staff told us the trust policy was for the controlled drugs to be checked as an audit daily. This local policy had not been followed with gaps in November 2016 of nine days which were not checked, December 2016 10 days unchecked, January 2017 14 days unchecked and February 2017 five days unchecked. This was poor and unsafe practice and medicines might be missing and this might not be noticed.
- Records of medicines used and the medicines for disposal did not consistently provide an audit trail of all controlled medicines in the department. There were disposal and destruction processes in place for partially wasted or out-of-date controlled medicines. Out of 100 records reviewed within the controlled drug register there were two examples of where no dosage was recorded and eight examples of when the wastage was not recorded. This poor recording meant staff were not following their own policy to ensure safe medicine practice.
- There was no signature list for agency nursing staff and locum doctors, this meant that to cross reference who had prescribed and administered medicines was not possible and therefore did not provide an audit trail.
- Medicines such as refrigerated medicines were stored appropriately but were not consistently monitored to ensure safe storage. In December 2016 24 days, January 2017 27 days and February 2017 23 days the temperatures were not checked. Staff told us this was their responsibility to check but because of the busy nature of the department the checks were missed. This was poor practice and created potential risks if the fridge went out of temperature range (too hot or too cold); the medicines might not be effective and so potentially placed patients at risk.
- There was an open culture for reporting medicines incidents, these were investigated and were reported to the medicines management optimisation group. Learning from incidents was identified and the information disseminated across the organisation. Between January 2016 and January 2017 there had been 73 medicine errors reported in the accident and emergency department.
- The service had an in-house pharmacy service which provided a supply function and a clinical pharmacy service. Prescriptions for patients not admitted to the department were dispensed by the local on-site community pharmacy. Audits were carried out of the management of controlled drugs, these had the identified issues but no action had been taken. Audits were also carried out for medicines storage.
- The storage of FP10 prescriptions was secure and records were appropriately maintained for prescriptions used. Patient group directives were available to advise appropriately trained staff to administer some medicines. These directives were up-to-date and available on the trust intranet system. Emergency Nurse Practitioners had qualifications to nurse prescribe some medicines.
- Patients own medicines stayed with the patient stored with their belongings, controlled drugs were stored separately in the controlled drugs cupboard. For those patients who were receiving care and treatment on the corridor, there was no storage facility for belongings including medicines which was not safe practice.

Records

- Systems were in place to mostly ensure patients' information was kept safe however, the use of the corridor compromised patient information security. When the corridor was in use, patient's records were left unsecured on a desk at the end of each side of the corridor. These records could be accessed, picked up and removed by unauthorised persons which would compromise patient safety and confidentiality.
- We looked at nine sets of patient records; the completion of patient records varied but mostly was well completed, legible and signed. Staff carried out risk assessments for patients and developed management plans to ensure risks to patients' safety were monitored and appropriate action taken. The records included appropriate plans for patients with mental health, learning disability and dementia diagnosis. Records were either maintained electronically or in paper format. Nursing records and medical contemporaneous records were seen to be handwritten, signed and dated.

- Review of care and treatment provided had not been consistently audited to ensure a safe delivery of service. We reviewed the Emergency Department checklist; this data records the review of records to ensure they were complete. Areas looked at included vital signs recorded, tests undertaken, pain management and pathways of care undertaken. From October to December 2016 the data was recorded for 34 patients in total. The amount of patients records reviewed each month varied. In October 2016 four records were reviewed, November 2016 15 records were reviewed and December 2016, 15 records were reviewed.

Safeguarding

- Staff took a proactive approach to safeguarding and were aware of local safeguarding procedures for both adults and children. Staff we spoke with explained their responsibilities when identifying safeguarding risks and felt supported to raise any safeguarding issues to senior staff and external services. They spoke confidently about the process to follow and the scope of reporting. Staff training in safeguarding was provided and staff confirmed their attendance. Staff training records showed that in the emergency directorate, which included medical emergency staff training completion was 66%. Clinical emergency staff training completed was 92%.
- The emergency department risk register identified as a high risk that when paediatric patients present to the Emergency Department, processes in place to safeguard them were not always adhered too. An action plan was in place to address the risk. We spoke with staff who explained the process to follow; the recording process and the secondary follow up by paediatricians from the day unit daily to ensure that all children seen the day before had been reviewed.
- We were assured by a consultant that all children seen were discussed with a consultant before they left the department
- Staff received training in female genital mutilation to ensure actions were taken to support those patients. Further literature was also available.
- A trust had a lead nurse for domestic violence to ensure staff were aware of the signs and actions to take.

Mandatory training

- Each staff member on starting in the emergency department undertook an induction. This included fire safety, health and safety, safeguarding adults and children, patient handling, infection control and equality and diversity.
- A programme of mandatory training was provided for all staff. The trust set a target of 90% for completion of mandatory training including fire safety, safeguarding and resuscitation. The current level of achievement by the emergency department was 80%. Training identified as not being fully completed included conflict resolution, dementia training and training about the Mental Capacity Act and Deprivation of Liberty. Staff told us that because the department was so busy training, which remained a priority, was sometimes delayed.
- Training in the identification and management of sepsis had created positive responses to sepsis treatment. Dementia awareness training had been implemented and staff spoken with had completed this training including reception staff.

Assessing and responding to patient risk

- Patients in the emergency department were prioritised for safety through the use of initial assessment and observation tools. There was no rapid assessment and treatment area where doctors and nurses were allocated to identify and prioritise care and treatment. However, the system in place enabled initial triage to prompt rapid action if needed.
- On arrival by ambulance patients were seen and an initial triage of their needs was made. Following that triage, staff carried out comprehensive risk assessments for patients and developed management plans to ensure risks for each patient were monitored and maintained. Risk assessments included venous thromboembolism (VTE) and sepsis, pressure areas and environmental risks.
- Patients who arrived at the department having made their own way, presented to a reception desk in a main waiting room. A triage system was also in place and those patients identified as needing more urgent care were prioritised to see the emergency department doctor.

- Patients who were classed as having minor injuries were assessed and treated by the Emergency Nurse Practitioners who were trained to assess and treat patients and so reduce the waiting time in the department.
- The Trust has consistently met the standard for patients being initially assessed within 15 minutes. This 15 minute window includes all attendances to the emergency department, including emergency ambulance cases. In October 2016 the median time was 11 minutes, compared to 9 minutes in November 2015.
- We observed triage taking place in the minors area for those patients arriving independently and saw that all patients were triaged using the Manchester Triage system to determine each patients priority of need. All patients observed in this area were seen in less than 15 minutes.
- The national standard for the time patients should wait from time of arrival to receiving treatment is no more than one hour. The trust met the standard for all 12 months over the 12 month period between October 2015 and September 2016. In October 2016 the median time to treatment was 51 minutes. The trust was consistently performing much better than the England average over the latest 12 months. The trust does not separately measure the time to initial assessment for ambulance cases; this was included in the overall time to initial assessment in the emergency department. The trust consistently performed within the target for the latest 12 months.
- Patient's observations would identify if their condition deteriorated. A system of national early warning scores (NEWS) was used in the hospital to alert staff to any potentially deteriorating patient. This is a nationally recognised scoring system with risk allocated to physiological measurements. The scores alerted the nursing staff when there was a need to escalate a deteriorating or unwell patient to the medical team. We looked at records and saw these scoring systems were calculated and used to identify deterioration and appropriate action was taken under those circumstances.
- The risk of sepsis was assessed as a priority by using a sepsis screening tool as part of the NEWS record. Patients with suspected sepsis were treated through the use of a sepsis treatment pathway. Sepsis screening and pathways were in place with early treatment seen to be improving. Within nine months (April to December 2016) the number of patients with identified sepsis receiving antibiotics within one hour had increased from 11 % to 78%. This improvement was identified as being due to staff training and protocols which enables nursing staff to start the antibiotics. It was also seen that the band seven safety nurse on duty at night, followed up all sepsis patients to ensure early treatment.
- The trust confirmed they did not hold documentary evidence of NEWS training for emergency department staff. This had been identified as an area of improvement by the department clinical lead and this would be established in the coming weeks. However, we saw staff completing the NEWS records and using the scoring effectively.
- The trust had in place a critical care outreach team which we saw to be responsive. This team would attend anywhere in the hospital to support patients who needed critical care. We observed the team working in the emergency department to support a patient at risk of deterioration. Once the patient was stabilised and moved to critical care the team left. We saw they returned later to support another patient. The emergency department staff confirmed they were a crucial resource.
- There was no consultant with paediatric skills on duty overnight. One consultant had an interest in paediatric care. During the day, the children's day care unit was open and the paediatrician from that department was available for support. Out of hours and weekend this support was not available. Overnight that meant there was no consultant paediatric cover. However, whilst ambulances did not take patients to the emergency department overnight, walk in patients were still brought by their parents to the department at night.
- There were risks to children that medical staff did not have the appropriate skills as they were not consistently updated. The department saw 9,749 children between April 2015 and March 2016. Despite no ambulance arrivals bringing children the overnight data between January 2016 and December 2016 showed that between one and ten children were seen each night with the highest number being 13. Between January 2016 and December 2016 overnight the department accommodated 1,804 children with the largest number being below four years old. On the first night of our inspection there had been eight children under the age of 16 through the department. The emergency department risk register had identified that paediatric

patients could be at risk of harm in the event of a resuscitation event where it was determined that the clinician responsible was not identified and knew they were the responsible lead. We were told training scenarios for paediatric resuscitation and deteriorating children for both doctors and nurses had started with one being completed so far.

- We were told that whilst there were staff with advanced paediatric life support training in place on duty each night, the amount of children seen did not ensure that some medical staff out of hours felt confident and capable to manage an emergency paediatric situation. This was because they did not have sufficient practice. Medical staff confirmed their concern and felt that there should be a stronger paediatric service at night and one described the risks as 'scary.'
  - Trust records for the emergency directorate medical staff (middle grade and above) showed only 11 out of 24 staff had advanced paediatric life support (APLS) training completed. Support was provided to the Emergency Department by Seashore Paediatric Centre until 7pm Monday to Friday. We were provided with two weeks of rotas to demonstrate that with one exception there was a member of staff , either nurse or doctor, with APLS training completed on duty each night.
- Should a patient within the emergency department have a cardiac arrest, staff would commence resuscitation and also call the 'crash team' to provide resuscitation assistance. The resuscitation area had one space identified for children requiring urgent treatment. We saw this being used by adults when the department became busy. Pathways were in place for patients to be seen quickly by the imaging services and emergency surgery.
- A dedicated mental health assessment tool was being used to review and risk assess patients presenting with mental health conditions. Depending on the risk, a plan was put in place and appropriate actions undertaken by staff so patients could be managed safely. There was access to liaison psychiatric services and mental health support in working hours and on call out of hours.

Nursing staffing

- The hospital used the Shelford Safer Nursing Care Tool to calculate staffing levels. The Safer Nursing Care Tool has been developed to help NHS Hospital staff measure patient acuity and / or dependency to inform evidence-based decision making on staffing and workforce. The emergency department used a scoring system for acuity and dependency. The tool was used daily to review staffing levels based on the needs of the patients in the department.
- Staffing rotas demonstrated staffing levels were in line with the hospitals staffing measurement tool, with agency staff used when required to cover increased demand and vacancies. Emergency nurse practitioners were used to manage patients in the minors area. They were often based in the ambulatory emergency unit as the emergency department was full. As the use of the corridor fluctuated, the lead nurse of each shift monitored through the day and booked extra staff as projected increase in numbers of patients and patient dependency was identified. The agreed staffing ratio was one nurse to three patients on the corridor. An extra band seven nurse was also employed overnight to support staff in the department. Staff told us they considered staffing levels to be sufficient to meet the fluctuating levels of patients within the department. They told us they were always busy but felt the strong staff team enabled good care to be provided. Nursing staff were very proud of their ability to flex to meet capacity changes but found these times to be pressured.
- The planned levels of nurse staffing and the actual levels varied depending on whether there was an increased demand on that shift.

  Planned staffing levels were eight registered nurses and three Nursing assistants in the day. In addition, there were Emergency Nurse Practitioners on duty; three on Friday, Saturday, Sunday and Monday and two on Tuesday to Thursday. Overnight, there were seven registered nurses and one nursing assistant, plus a band seven sister who was supernumerary**.** We saw these levels were met or exceeded, this was in part due to increased overnight staffing levels which included planning for staffing the corridor, even when this was not in use. However, during our unannounced inspection we saw that even when the corridor was not in use; all staff were busy with the high dependency of patients in the department. Should the corridor have been in use, further staff would have been needed to ensure a safe level of staffing.
- There was not a full complement of substantive nursing staff. As of December 2016 the planned whole time

equivalent funded was 56 staff, there were 49 WTE staff in post. This is a shortfall of seven staff. There was funding for 46 registered nurses, with 39 in post, recruitment remained ongoing.

- During our inspection agency staff were seen on all days for example we saw that on the 10 March 2017 of the 11 nursing and health care assistant staff on duty, four were agency staff. They told us they had received a full induction and liked working in the emergency department as the team was supportive and welcoming.
- There are two Registered Paediatric Nurses working in the department; additionally, there were two nurses that had completed the paediatric high dependency care course. A senior band sister was employed for each night to ensure sufficient advanced paediatric life support skills. Overnight there was also access to outreach nurses within the hospital who had completed advanced paediatric life support training.
- Communication between nurses and between shifts ensured patient safety. Handovers took place between shifts and a daily huddle took place to ensure important information and changes were cascaded to all staff. All actions taken as a result were recorded to ensure an audit trail and any important outcomes cascaded to all staff.
- Staff sickness in the department was 6.47% in January 2017.

Medical staffing

- Medical staffing did not ensure safe care at all times. There was a limited, fragile medical infrastructure which had a crucial reliance on locums to cover vacancy gaps in middle level and registrar doctors. The risks associated with the lack of medical staff were noted as a high risk on the emergency department risk register. The decision was taken that junior doctors at FY2 level could only work when consultant was present in the department. In April 2016 the consultant workforce was expanded to roster consultants working for the whole day at weekends and therefore the only time the junior FY2 doctors had not been working was night time shifts seven days a week.
- There was no medical clinical leadership within the emergency department. The clinical lead for the emergency department has been a vacant post since 2015 and as yet had not been replaced despite continued attempts at recruitment. Recruitment from within the department had not been successful. The matron for the department had undertaken the role in the interim with the support of the medical director as an extension of their role. Matron did not have the input required to lead the medical team and was not part of the trust emergency department overview to monitor and affect change. The Clinical Lead (Matron) was not accountable for medical staffing this was the responsibility of the medical director. At the time the inspection the Clinical Lead (Matron) worked in conjunction with the Medical Director to provide clinical leadership across the emergency department. The medical staff in the emergency department lacked the directional leadership to make the changes needed to develop the service.
- There was not a full complement of clinical staff. As of December 2016 the planned whole time equivalent complement was 37 staff, the actual complement was 31 staff. There have been particular challenges in recruiting consultant and middle grade staff in emergency medicine, and these difficulties, had meant the department had been unable to provide consistent clinical supervision to foundation doctors at all times. This has led to a requirement to change junior doctors shift patterns in the emergency department to ensure appropriate clinical supervision could be provided. The risks associated with the lack of medical staff was noted as a high risk on the emergency department risk register and has been on the register for the previous six years.
- The Royal College of Emergency Medicine (RCEM) has a minimum recommendation of cover for 16 hours emergency consultant hours seven days per week. The consultant establishment at the time of inspection was 8.0 whole time equivalents (WTE). The substantive consultants in post were 3.0 WTE. The department had equivalent 6.0 WTEs with locums.
- The rotas showed there were between two and six emergency department consultants on duty throughout the day depending on the time of day. This equated to almost 16 hours per day. Consultant cover was available in the department until 11pm each day. There was then a consultant on call for advice and available to be called in. The department was staffed by locums, middle grade and senior house officer doctors overnight. We observed that despite their shift ending a locum consultant remained in the department due to the high dependency of patients.
- There were insufficient permanent middle grade medical staff employed in the emergency department.

There were currently 2.7 whole time equivalent staff employed which was going to drop to 2.4 whole time equivalent. From 5pm to 11pm a consultant was available and a registrar and senior house officer. The department was still considered safe if that shift ran short of a middle grade doctor. From 11pm the emergency department was staffed by middle grade doctors, (one registrar and one senior house officer or GP vocational training scheme). Medical staff confirmed that working with two doctors at night was a risk. This was because if one doctor was working in the minors area and one in the majors area, and a doctor was then called away this left the remaining department vulnerable. This also meant doctors did not get breaks and were under pressure. These posts were often filled by locum staff.

- Locum medical staff were used each month on a regular basis. These were temporary medical staff on short term contracts. We saw that from February 2016 to January 2017 the percentage had varied each month between 3% and 8%.
- In response to the lack of clinical leadership and shortfall in medical staff, Operation Seagull had been developed. This would be instigated in response to a threat of a short notice closure of the Emergency Department at Weston Hospital due to lack of sufficient medical staff on duty. The trigger for considering a closure of the emergency department would be less than two appropriately qualified doctors being on duty with the appropriate level of supervision according to grade. The plan sets out the command and control arrangements leading up to a short notice closure, including escalation, cascade and actions required to ensure a joint planned system response to a short notice closure of Weston emergency department. The trust considered that given current rostering, this presented a risk overnight and at weekends only. We were aware that over the recent Christmas holiday period this action was close to being triggered. At the time of inspection the covering of night shifts was problematic, with the three days of the following week not yet covered. The medical director explained that the middle grade doctors all had to have the sufficient skills and experience and had to have been trained to advanced paediatric life support training before considered for the shift.
- Arrangements for handovers and shift changes kept patients safe. There was an emergency department medical team handover at 8am and 10pm which included a discussion about general issues, safety concerns, patient review and staffing. The medical director attended the morning handover and this provided support to the matron as clinical lead.

Major incident awareness and training

- The trust had major incident and business continuity plans. Equipment for a major incident was secure and in a designated room. Staff training was provided and a nurse lead for the role was in place.
- Weston Area Health NHS Trust recognised its duty and responsibility as a Category 1 responder under the Civil Contingencies Act (2004). In addition, its responsibility for ensuring it met the legal requirements and care standards for Emergency Preparedness Resilience and Response (EPRR) and business continuity was detailed in the NHS Commissioning Board EPRR and Business Continuity Management Frameworks.
- The trust had the opportunity to test elements of this and the trust CBRN (Chemical, Biological, Radioactive, Nuclear) plan in a joint exercise with the Avon Fire and Rescue Service.
- The Winter Plan 2015/6 was activated with actions put in place to maintain a safe service despite sustained periods of high demand and operational pressure.
- Security was available in the department within minutes of being called. Two security staff were on duty at all times. When called they came from their office space or wherever they were patrolling. Staff showed us panic buttons throughout the department and confirmed security staff arrived promptly when called.

Are urgent and emergency services effective?

(for example, treatment is effective)

Requires improvement

We rated effective as requires improvement because:

- Implementation of evidence based guidance was variable. Pathways through the emergency department were not all sufficiently implemented to support patient

care. Pathways were not yet in place to ensure early transition through the department for patients receiving oncology care and there was no frailty pathway in place for older people.

- Multidisciplinary working was not all coordinated to provide effective care for patients. There were professional working relationship breakdowns between doctors. There were established routines which had not been effectively addressed and had an impact on patients. Delays were incurred by patients as early speciality review was delayed and patients had to wait in the emergency department.
- The hospital took part in some national audit programmes and also some local audits. Some areas of monitoring were below the national averages the audit results did not consistently effect change in practice.
- There were gaps in support arrangements for staff. The current level of appraisal completion was 74% for the emergency department.

However:

- Patients had their pain assessed regularly and managed promptly to ensure they remained as comfortable as possible.
- The nutritional and hydration needs of patients were assessed and met. When fluid support was clinically indicated this was seen to be undertaken promptly and reviewed as appropriate.
- Effective multidisciplinary working was evident within the emergency department between emergency department medical, nursing and allied health professional staff to ensure an effective delivery of care.
- There was an effective stroke pathway in place through the emergency department.
- Information needed to deliver effective care and treatment was well organised and accessible.
- Patients' consent to care and treatment was sought in line with legislation and guidance. Staff had a clear understanding of the Mental Capacity Act 2005, Deprivation of Liberty Safeguards and patient consent.

Detailed findings

Evidence-based care and treatment

- The emergency department used a combination of National Institute for Health and Care Excellence (NICE) and Royal College of Emergency Medicine (RCEM) guidelines to determine the treatment provided. There was a Clinical Audit Programme for 2016/17. The programme was based on the national requirements as well as locally driven priorities. Clinical staff undertook audits and quality improvement projects throughout the year.
- There were no direct admission pathways to an assessment unit in place. There was no clinical decision unit or medical assessment facility. This meant all patients being referred by their GP for either medical, surgical or oncology review were seen in the emergency department. The hospital had evolved clinical care pathways in accordance with national guidelines. These ensured patients received the most effective treatments, in a timely way, from the most appropriate teams for example stroke pathways and fractured neck of femur. The risk of sepsis was assessed as a priority by using a sepsis screening tool and pathway as part of the NEWS record. There were pathways in place for patients with specific, high priority needs. For example we saw the stroke pathway in place to be effective and promoted prompt action to get patients scanned and treatment started as soon as possible. All patients who needed X ray, scanning or investigations in other parts of the hospital were escorted by a porter and a member of staff to ensure their safety. However, we saw from the investigations into serious incidents that sometimes NICE guidance was not followed and this might pose a risk to patients.
- Trust protocols were available to staff via the intranet to support their practice. However, pathways were not yet in place to ensure early transition through the department for patients receiving oncology care and there was no frailty pathway in place for older people, a plan was in place but not yet implemented. Emergency department doctors could not refer patients to chest pain pathway unless the patient has been formally assessed by the medical team which slows down the patient journey.
- A programme of multidisciplinary audits was used to check care and treatment was being provided in accordance with national guidelines. These included the SHINE project (The SHINE project was currently being introduced and provided staff with a checklist to ensure patient-safety based actions were completed) and data collection to demonstrate improvements in sepsis management.

- Staff handovers considered and referred when appropriate to the psychological and emotional needs of the patient. Patients thought to be at risk of self-harm or attempted suicide were risk assessed and priority given to referral to the mental health services.

Pain relief

- Patients had their pain assessed regularly and managed promptly. In the six records seen which included pain reviews, those patients had an early pain score recorded and timely administration of pain relief where required. We saw that pain was reviewed; one patient's notes had five sets of pain scores in place. The pain scores used included a tool for patients who could not respond and included facial pictures for patients to point to. Patients we spoke with told us their pain had been well managed.
- The department used an assessment of acute pain in children which included an algorithm and protocols for pain relief to be given

Nutrition and hydration

- The nutritional and hydration needs of patients were met. Following assessment of each patient, if clinically indicated, intravenous fluids were prescribed and administered. This was seen to be undertaken promptly and reviewed as appropriate.
- We observed nurses, healthcare assistants and volunteer staff providing water, hot drinks and snacks for patients. Because patients were delayed in the emergency department for lengthy periods of time, food and drink were provided over a 24 hour period. Staff supported patients to eat and drink as required.
- Patients we spoke with told us they appreciated being offered drinks and snacks.

Patient outcomes

- The outcomes of patients' care were collected and monitored to measure the effectiveness of care and treatment. The hospital took part in some national audit programmes and also some local audits. The audit results did not consistently effect change in practice.
- The department had submitted data to national audits over the last two years, including the Royal College of Emergency Medicine (RCEM) severe sepsis and septic shock audit, asthma in children and assessing cognitive impairment in older people. Some areas of monitoring were below the national averages.
- In the 2013 RCEM audit for consultant sign-off, the trust was in between the upper and lower quartiles compared to other trusts for three of the four measures and was in the lower quartile for one of the four measures. The measure for which the trust performed in the lower quartile was: Consultant / associate specialist discussed the patient (0%). Consultants signed off all patients seen in the department with chest pain, who had returned within 72 hours and all children under one year who were showing symptoms of fever. All Junior (F2) doctors were required to speak with a consultant or registrar about patients discharged with anything other than minor illness or injury. The Trust participated in the consultant sign-off national audit in August 2016 but the results were not yet available.
- In the 2013/14 RCEM audit for asthma in children, the trust was in lower quartile compared to other hospitals for six of the ten measures and was in between the upper and lower quartiles quartile for four of the ten measures. We requested any action plans undertaken to address these shortfalls. None were provided.
- There was no trust participation in the RCEM Audit: Paracetamol overdose 2013/14
- In the 2013/14 RCEM audit for severe sepsis and septic shock, the trust was in the lower quartile compared to other hospitals for four of the 12 measures and was in the upper quartile for two of the 12 measures. One of the measures in the lower quartile included were antibiotics administered in the emergency department within 1 hour (8%). We saw department data which showed a significant improvement in antibiotics administered within one hour.
- In the 2014/15 RCEM audit for assessing cognitive impairment in older people, the trust was in the upper quartile compared to other hospitals for three of the six measures and was in between the upper and lower quartiles for two of the six measures. One measure was not available.
- The trust met the fundamental standard of having an Early Warning Score documented. The measures for which the trust performed in the upper quartile were: Early Warning Score documented (100%) Communication of assessment findings with admitting service – admitted patients only (100%) and Communication of assessment findings with relevant services – carer (all) (7%).
- In the 2014/15 RCEM audit for initial management of the fitting child, the trust was in the lower quartile

compared to other hospitals for two of the six measures and was in the upper quartile for one of the six measures. The trust did not meet the fundamental standard of checking and documenting blood glucose for children actively fitting on arrival. The trust recorded a figure of 0%. We requested any action plans undertaken to address these shortfalls. None were provided.

- In the 2014/15 RCEM audit for mental health in the ED, the trust was in the upper quartile compared to other hospitals for two of the six measures and was in the lower quartile for two of the six measures. The trust did not meet the fundamental standard of having a documented risk assessment taken. The measures for which the trust performed in the lower quartile were patients being assessed by mental health professional within one hour and details of any referral or follow-up arrangements documented. Staff told us the mental health service was responsive in attending and we observed that risk assessments were undertaken and used to manage effective care.
- The rate of unplanned re-attendance to the department has remained stable. Between November 2015 and October 2016, the trust's unplanned re-attendance rate to A&E within seven days was generally worse than the national standard of 5% and generally worse than the England average. In the latest period, October 2016, trust performance was 7.8% compared to an England average of 7.8%. The performance against this metric had remained fairly constant throughout this 12 month period.

Competent staff

- There was a focus on staff learning and development, with staff being supported to complete relevant qualifications. Staff explained that due to the department being busy, training was sometimes missed. Medical and nursing staff had started practicing a paediatric resuscitation scenario and scenarios of recognising a deteriorating child. However, only one of these training sessions had taken place so far.
- Emergency nurse practitioners (ENP) were employed in the minors department from 9am-11pm each day. ENPs were trained to assess and treat minor injuries.
- Staff told us they were provided with training to deliver effective care in their roles. Staff told us they were assessed as being competent before they were permitted to work unsupervised.
- An appraisal was used to identify learning needs, and a plan put in place to support staff to develop their practice. The trust had a medical appraisal process in place to support individuals in their professional development and the responsible officer in making revalidation recommendations. The current level of appraisal completion was 74% for the emergency department.
- Revalidation of medical staff is designed to assure patients, the public, employers and other health professionals that licensed doctors are fit to practice and fit for purpose. It is based on a system of appraisal delivered by trained appraisers. All consultants and staff grade doctors were required to have an annual appraisal which was structured around the four domains described in the general medical council's guidance on Good Medical Practice.
- From April 2016 a registered nurse or midwife was required to declare their professional fitness to practice as part of a triennial process. The trust has processes in place to support nurses to register. The arrangements enable registrants to provide evidence to the nursing and midwifery council, demonstrating that they continue to meet the professional standards which are a condition of their ability to practise.

Multidisciplinary working

- Effective multidisciplinary working was evident between emergency department medical, nursing and allied health professional staff. We observed board rounds taking place on wards which demonstrated patient focus working. We reviewed patients' notes and saw evidence of multidisciplinary team working.
- We observed multi-disciplinary working between the outreach team and intensive care staff. This multidisciplinary working took place in the emergency department to provide care and treatment to patients who were acutely ill.
- There were professional working relationship breakdowns between some department medical staff and the staff from the wards. There were established routines which had not been effectively addressed which had an impact on patients. Delays were incurred by patients waiting a speciality review by the ward medical teams. The delay resulted in patients having to wait in the emergency department for longer than should be necessary. No urgency was placed on their review to support prompt action to move patients

through the emergency department to a ward. We observed that speciality doctors did not visit the department until after 9am when some patients had already been waiting 12 hours. So whilst a registrar or senior house officer for the speciality may have seen the patient, admission to the ward was still not possible until the patients had been seen by a consultant. This did not support the multidisciplinary working of the department.

- The ambulatory emergency care unit was close to the emergency department and was available for patients who met the criteria for ambulatory care. This department was included in the emergency directorate. Emergency department staff would identify patients who were suitable to be treated in the ambulatory care unit based on overriding principles, criteria and risk assessment. The ambulatory emergency care department was also used for returning patients for follow up treatment and in this way prevented unnecessary attendance in the emergency department.
- We observed specialist nursing staff visiting the emergency department to review patients. These included respiratory nurses and tissue viability nurses.
- All the ambulance staff we spoke with told us they had good working relationships with the emergency department staff and found that even when pressured, which was most of the time, staff were cooperative.
- Service level agreements/ standard operating procedures were in place between emergency department and the ambulance service to ensure that all staff understood their responsibilities and the agreements in place.
- Emergency department staff had good access to the alcohol/substance misuse liaison team, this also included access to the psychiatric referral service. Staff spoke positively about access to the mental health team. They told us the mental health team were quick to attend and worked cooperatively with the emergency department to support patients with mental health issues.
- The AD action service for alcohol and drug misuse worked from ED each Monday and so was available for discussion, support and referral.
- Discharges from the emergency department took place at all times of the day and night providing it was safe for the patient.

Seven-day services

- Consultants provided cover within the department 24-hours-a-day, seven days-a-week with part of the night being covered by an on call consultant. There was an emergency department consultant in the department until 11pm. Overnight an emergency department registrar and senior house officer were working with a department consultant available on call if needed. These roles were covered by locum doctors.
- There was no consultant with paediatric skills on duty overnight and ambulances were aware of the need to take all emergency children to another acute trust. Children brought in by their parents were seen by staff who may or may not have the nursing competencies to treat children.
- Staff had access to mental health services for patients with physical and mental health needs out of hours. Pharmacy was available in daytime hours Monday to Saturday and an on call pharmacist was available Sundays and overnight.
- Imaging services were available 24-hours-a-day, seven-days-a-week to include x ray, ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), endoscopy and pathology'
- Allied health professions including therapists were available during working hours and an on call role was available at night and weekends.
- An admissions prevention team were based in the emergency department to support the patients to be discharged from the emergency department. On the first day of our inspection they supported three patients to be discharged. The emergency department fragility service worked with them to support elderly patients to be discharged safely.
- The emergency department could use the discharge lounge for patients waiting for transport or medication. This was open from 8am to 7pm and was not available out of hours or at weekends.

Access to information

- Staff had access to patient information to deliver effective care and treatment. During daytime the records department would deliver patient records to the emergency department. At night time the department receptionist would retrieve records. Notes for patients

who were admitted or transferred travelled with the patient. They were handed over to staff at the destination to ensure continuity of care and access to the history of their time on the emergency department.

- Information needed to support staff to deliver effective care and treatment was well organised and accessible. Treatment protocols and guidelines were either accessible from the trust's intranet site or available in the department in hard copy.
- Discharge letters were sent to GPs daily and included the relevant information for their advice and attention. Two systems were used depending upon the geographical location of the patient. Staff were clear of the systems used and were confident that whilst some delays were incurred when the discharge forms were not completed fully, no letters were missed.
- There was coordination between electronic and paper systems in use. Staff completed initial assessments on an electronic system with medicines hand written. When transferred all written documentation went with the patient.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients' consent to care and treatment was sought in line with legislation and guidance. Staff had a clear understanding of the Mental Capacity Act 2005 (MCA), Deprivation of Liberty Safeguards (DoLS) and patient consent. If it was identified by staff that patients may not be able to make their own decisions, staff would check if the patients had a power of attorney for health and welfare or any pre-existing advanced decision in place.
- For patients who lacked the mental capacity to make their own decisions, assessments of capacity were undertaken by nursing and medical staff. Once completed, decisions taken in the patient's best interest were clearly documented in each patient's records.
- The trust named nurse for safeguarding adults at risk had the responsibility for the delivery of MCA/DoLS training and offered bespoke training sessions, the trust wide training level was currently 75%. Staff confirmed that applications for deprivation of liberty safeguards were a rare procedure in the emergency department because of the design and function of the department.

Are urgent and emergency services caring?

Good

We rated caring as good because:

- Despite the difficulties of a very busy department staff took the time to speak with patients and those close to them in a respectful and considerate way. We saw staff delivering compassionate care and treating patients with kindness, dignity and respect. Privacy and confidentiality was respected as much as was possible considering the constraints of the environment.
- The trust's Urgent and Emergency Care Friends and Family Test performance was generally better than the England average for most of last year and a dip in scores had since levelled out.
- When patients were delayed in the department, they were transferred to beds for their comfort and food and drink provided. Nursing staff then maintained care until transfer could be agreed.
- Staff showed an encouraging and sensitive attitude to patients and those close to them. Patients told us they felt involved in the decisions about their care. Patients and their relatives received regular communications and were kept informed about their care, treatment and condition.
- Staff were able to sign post patients, carers and relatives to counselling and support services. The mental health team were available to advise staff if specific information was required for mental health and drug and alcohol addiction.

Detailed findings

Compassionate care

- Despite the difficulties of a very busy department staff took the time to speak with patients and those close to them in a respectful and considerate way. We saw staff delivering compassionate care and treating patients with kindness, dignity and respect. We spoke with five patients and two relatives who told us staff were kind and caring and they had been updated about any changes or delays. One patient told us that despite the staff being very busy they had all been wonderful.
- We observed doctors and nurses introducing themselves when they met patients and their families.

All patients were addressed by their preferred name. We observed staff respected patients' confidentiality, privacy and dignity. Curtains were always pulled closed and staff sought permission before entering. Voices were lowered when discussion took place. The use of the corridor to provide care was not conducive to privacy and dignity, but every effort had been made by staff by the putting up of curtains.

- When patients were delayed in the department, they were transferred to beds for their comfort and food and drink provided. We saw volunteer staff proving drinks to patients and relatives having checked first with staff that this was appropriate.
- The trust's Urgent and Emergency Care Friends and Family Test performance was generally better than the England average between December 2015 and November 2016. In latest period, November 2016 trust performance was 79% compared to an England average of 86%. The recent trend from July 2016 to October 2016 has been getting worse although it did level out in November 2016.
- Staff told us they understood and respected patients' personal, cultural, social and religious needs and took these into account when providing care and treatment. Care records recorded any personal, cultural or religious preferences to ensure staff were aware and could support the patients when needed.
- Multi faith prayer facilities were available to all patients and staff within the hospital.
- We saw that staff were understanding and displayed a non-judgmental attitude towards patients with mental health diagnosis. We observed that staff managed sensitively difficult situations for patients with mental health issues.
- Facilities for relatives were available to support those close to patients. A large bright room was available for relatives to have quiet and private discussions with doctors and time away from the department. There was no viewing room available for relatives to view their deceased family. Should family wish to see their deceased relative they were kept in the department, curtains drawn and managed in a dignified manner. Should there be a delay in family getting to the department; the patient might be transferred to the mortuary and the viewing room there used. Staff felt this was an adequate arrangement.

Understanding and involvement of patients and those close to them

- Staff showed an encouraging and sensitive attitude to patients and those close to them. Patients told us they felt involved in the decisions about their care, and relatives told us they were kept informed and updated with any changes to their relatives care. We observed staff worked collaboratively with patients to encourage their involvement and understanding through discussion and explanation.
- Patients and their relatives received regular communications and were kept informed about their care, treatment and condition. Staff made sure patients and relatives understood the assessments being done and the likely diagnosis and treatment plan by explanation and reassurance. Patients and relatives were given opportunities to ask questions and staff gave them time to do this.
- Staff empowered patients to manage their own health, care and wellbeing to maximise their independence. Should extra support be needed for the patient to understand, staff recognised this and sought the support needed.

Emotional support

- Emotional support was provided to patients and relatives. Staff were seen to be supportive of both patients physical and emotional wellbeing. We saw elderly patients were supported to have family with them and that family were offered the same level of emotional support.
- Clinical nurse specialists were available for specific health issues and were able to recognise and support specific emotional needs for their specialities. Some nurses within the trust had specific link nurse roles and could be accessed for staff to consider specific counselling and support services. For example, domestic violence services.
- Staff were able to sign post patients, carers and relatives to counselling and support services. The mental health team were available to advise staff if specific information was required for mental health and drug and alcohol addiction.

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

Urgent and emergency services

Inadequate

We rated responsive as inadequate because:

- The flow of patients through the emergency department was not responsive to meet the needs of patients. The emergency department was the single point of entry to the hospital for both emergency and expected patients. This means that all patients being referred by their GP for either medical, surgical or oncology review were seen in the emergency department. Crowding had taken place in the Weston emergency department on a regular basis which impacted on patient care.
- The facilities did not meet patients' needs and were inappropriate. When patients did not have access to cubicle space they were cared for on a corridor. This practice occurred daily and was 'the norm' instead as an action to be taken in excess situations. As previously described the environment was not suitable for patient care and was unsafe.
- There was a lack of support in the emergency department by the wider hospital services and a lack of trust wide ownership around flow. At this time data collected had not shown any significant improvements to support patients through the emergency department.
- Escalation processes in place to indicate action when the department was under pressure were not responsive and did not affect a wider hospital support.
- Patients were not able to responsively access the care they needed. There had been a decline in patients being admitted promptly once the decision to admit had been made. The trust did not meet the target for patients to be admitted within four to 12 hours of an admission decision being made. The method of calculation and process meant patients were in the emergency department longer, up to 20 hours and the department was much busier, extended care was needed to be provided by nursing staff and there was a reduced capacity to see more patients.
- Access to a specialist doctor to review patients overnight in the emergency department was limited and so delayed patient admission. There was no sense of urgency for planning to promote early discharge or initiate flow through the emergency department. Bed management meetings were not dynamic in ensuring flow was acted on by the wider trust.
- Patients were frequently and consistently not able to access services in a timely way. Patients experienced unacceptable waits for some services. The Royal College of Emergence Medicine quality indicators had not been met. The emergency department was consistently failing to meet the national standard requiring 95% of patients to be discharged, admitted or transferred within four hours of arrival. This target had not been met for the previous 18 months. In the month prior to inspection 23 January 2017 to 23 February 2017 the percentage of achievement with this standard varied. The lowest was 51% and the highest was 90%. The 90 % was achieved once. The majority of patients seen in this timescale varied between 60% to 70%.
- The trust does not separately measure the time to initial assessment for ambulance cases; this is included in the overall time to initial assessment in the emergency department. The trust consistently performed within the target for the latest 12 months. There had been a recent increase in patients leaving the department without being seen.

However:

- The emergency department took account of patients' specific needs. Individual care needs and adjustments were put in place.
- Whilst under considerable pressure in a full to capacity and pressured environment, staff remained professional and capable.
- The management of complaints enabled staff to learn from issues raised.

Detailed findings

Service planning and delivery to meet the needs of local people

- The emergency department and the trust were working to identify system-wide strategies to improve patient flow. At this time data collected had not shown any significant improvements to support patients through the emergency department.
- The clinical commissioning group currently had an eight week engagement in progress around the future of services at the hospital and would include the emergency department. GP access at the hospital was being piloted to establish if this would be effective. The pilot meant that for a limited time on selected days a GP would be available to see patients. At this time the pilot was unable to identify if this service would be effective.

- There was a mental health assessment room which allowed a private and safe area for mental health assessments to take place. Staff had easy access to the mental health support team and to drug and alcohol services. The emergency department recognised the environmental risk to patients who attempted suicide by hanging. The risks associated with ligature points were recorded on the emergency department risk register as a high risk and actions identified to minimise any risks. One specified bay was used for patients with risks to self-harm as the appropriate ligature risks had been removed. The waiting room was adequately sized to accommodate the numbers of patients and their relatives or friends. At no time did we see this room crowded. A separate room was available for children.
- A relatives' room was provided so relatives and friends of patients had somewhere quiet to sit and make drinks. On the reception door and in the waiting room there was information about current waiting times.
- There were in place existing arrangements for some patients to be directed to the local acute trusts. These included overnight children arriving by ambulance.

Meeting people's individual needs

- The emergency department took account of patients' specific needs. Translation services were available with the use of a language telephone service and a translator could be requested. Interpreters could be booked to visit the department. There was access to information leaflets for patients regarding a variety of medical conditions. Staff were not aware if these leaflets were available in other languages or formats.
- The needs of different patients were considered and work had taken place to deliver a dementia considered service. Dementia training was in place, both nursing and administrative staff confirmed they had completed this and had found it useful. We saw nursing staff interacting with patients who had a diagnosis of dementia in a supportive and appropriate manner.
- Individual care needs and adjustments were put in place. A clinical alert system was used for patients with a learning disability. The previous year 137 patients with a learning disability were admitted. The trust employed a complex needs sister and a strategic lead for learning disability services. Staff notified either of the staff when a person with a learning disability was admitted, either by bleep, phone message or email. The strategic lead would then follow up the patient either in hospital or through discharge.
- For patients with bariatric needs equipment was available on request. Most areas of the hospital were accessible for patients with limited mobility or who used mobility aids. Disabled toilets were available for patients and visitors.
- For those patients who were homeless and rough sleeping, if staff considered them to be at risk due to their health on discharge, they would contact the local hostel to ensure patient safety.
- Patients' spiritual and religious needs were considered. Staff knew how to contact the appropriate chaplaincy lead. There was a multi faith prayer room available in the hospital.
- Patients told us when they used the call bell staff came quickly. Call bells in most cubicles were provided to patients. However, no call bells were available to patients on the corridor and in the previous eye room, now used as a patient cubicle; these patients had to shout for assistance.

Access and flow

- The emergency department was the single point of entry to the hospital for both emergency and expected patients. Over the past six years, emergency department attendances had risen by 5.9%. The numbers of people attending the emergency department has continued to increase and during the period 2015 to 2017 there were sustained periods of peak demand that proved a real test to the trust.
- There were no direct admission pathways to an assessment unit in place. There was no clinical decision unit or medical assessment facility. This means all patients being referred by their GP for either medical, surgical or oncology review were seen in the emergency department which caused an increased pressure on the department. Patients were clerked there pending access to a ward, should a bed not be available, patients stayed in the emergency department.
- There was an ambulatory emergency care department available but numbers of patients seen and staff comments would indicate this was underused by the emergency department.
- Crowding has taken place in the Weston emergency department on a regular basis which impacted on

patient care. Crowding in an emergency department is a term used if ambulances cannot offload, there are long delays for high acuity patients to see a doctor, there are high rates of patients who leave before being seen, there are more trolley patients in the emergency department than there are cubicle spaces, or if patients are waiting more than two hours for an in-patient bed after a decision to admit has been made. Crowding was included as an issue on the Emergency Department Action Plan 2015, with actions to be taken to support the department and reduce crowding.

- We saw that the minors area was used as an overflow area for majors and the minors patients were assessed and treated in any free designated area available each day. When patients did not have access to cubicle space they were cared for on a corridor. Staff told us this practice occurred most days and was managed by the matron or nurse in charge. Staff expressed concerns that the use of the corridor was now 'the norm' instead as an action to be taken in excess situations. As previously described the environment was not suitable for patient care. The risks were recognised by the trust and recorded on the emergency department risk register as a high risk. The corridor was staffed by nurses on a one nurse to three patient ratio and staff told us that stable patients only were located on this corridor. Should a patient's condition deteriorate the nurses would swap the patient with a more stable patient in the major's area. No incidents had been reported as a result of this arrangement; however this is a poor patient experience.
- Escalation processes in place to indicate action when the department was under pressure were not responsive. A tool was used to measure the levels of pressure within the department and prompt escalation. This dashboard was not the same measuring tool as used by the bed management meeting. The bed management team used an operational pressure escalation levels (OPEL) system which was a national tool calculation of factors to identify the status of the hospital and if escalation of actions was needed. The highest levels of OPEL escalation were levels three and four which indicated a high level of pressure in the department. Between October 2016 and January 2017 the hospital had been in level three 49 times and level four 36 times. However, the level was not recorded at the weekend and so using the tool to look at overall trends had not been possible and did not give an accurate picture of the departmental pressure.
- There was a lack of support in the emergency department by the wider hospital services and a lack of trust wide ownership around flow. The trusts Royal College Emergency Medicine Action Plan 2016 noted an action of developing cross trust ownership of patients flow. Staff told us support to unblock the emergency department by doctors and nurses from the emergency department and wider hospital proactively working to see patients quickly and 'pull' patients through the emergency department did not happen.
- There was no sense of urgency and planning to promote early discharge or initiate flow through the emergency department. Bed management meetings were not dynamic in ensuring flow was acted on by the wider trust. There was no evidence the wider hospital was proactive in considering the pressure this lack of flow created in the emergency department. On our first day of inspection the department was considered by staff to be quiet during the day and busy overnight. There had been a total of 150 patients attending and 22 breaches of the four hour standard in the department.
- We attended bed management meetings to observe how the flow of patients through the emergency department into the wider hospital was managed. We saw that through the second day of inspection the flow of patients was hampered by few ward discharges which led to patients experiencing delays in the emergency department of over 12 - 20 hours. At 9am there were already eleven patients waiting in the emergency department for a bed to become vacant in the hospital. The first bed meeting at 10.30am noted that there were nine patients in the department from the night before. There were 24 four hour breaches since midnight. By 3pm, there were 42 patients in the department, five patients in the corridor, 28 four hour breaches and 17 patients with a decision to admit but no bed available. The trust had advised that 13 patients had been discharged into the wider hospital.
- We reviewed the data for the previous week to our inspection for patients who had been waiting in the emergency department for a bed at 8.30am to establish how the delays impacted on the department from the morning onwards. On Monday 20 February 2017 at 8.30am were 14 patients waiting for a bed, on Tuesday 21 February 2017 there were 21 patients waiting, on Wednesday 22 February 2017 there were 20 patients

waiting and on Thursday 22 February 2017 there were 23 patients waiting for a bed. This had the impact of the department starting each day, already under pressure for spaces to accommodate new patients.

- Bed meetings were led by the patient flow team with other key staff attending as required were dependent on the OPEL level. For bed meetings at OPEL level 1 and 2 the ED senior nurse and one matron from each directorate were required to attend. The trust schedule for attendance was for matrons to attend four out of five bed meetings at OPEL three and four. On 2 March 2017 we attended the10.30am and 3pm bed meetings and saw that the matron from ED and one other matron attended the meeting. The bed management staff told us they visited each ward to speak to the ward matrons about discharges to reduce matron time away from the wards. This did not provide matrons with the overview of the trust and the evidence of the patients being held up in emergency department. Following the first bed meeting we did not see activity or outcome in the emergency department which had resulted from recognising escalation and wider hospital action was needed to prompt flow. The bed management team said they had to wait for beds to become available instead of proactively looking for discharges and prompting and promoting discharges to be facilitated.
- The escalation tool used by the bed management team noted the department to be in a OPEL level two category, which was colour denoted as an amber risk. Recalculation following the 3pm meeting noted the risk to be level three and a red coded indicator. No changes in response had been noted with no further appropriate action taken to reflect this escalation during the bed meeting. There remained seven patients in the department waiting for a bed with no obvious actions being delivered at the bed meeting. We did not see any managers attending the department or any processes being put into action by the wider hospital to support the emergency department.
- **T**he trust did not meet all national standards and clinical indicators. The continued inability to achieve these standards indicated that flow has been an ongoing issue which has not been successfully addressed. The emergency department was consistently failing to meet the national standard requiring 95% of patients to be discharged, admitted or transferred within four hours of arrival. The trust did not consistently achieve the national standard for ambulance turnaround times. A “black breach” occurs when a patient waits over an hour from ambulance arrival at the emergency department until they are handed over to the emergency department staff. Between January and December 2016 there was an upward trend in the monthly percentage of ambulance journeys with turnaround times over 30 minutes. In January 2016 37% of ambulance journeys had turnaround times over 30 minutes; in December 2016 the figure was 56.4%. Ambulance turnaround times over 60 minutes increased in March 2016 and remained at a level around 70 until December 2016 when they were 93. We saw that the system for informing of arrival had been developed so that reception clerked the patient and delivered the patients’ paperwork to the emergency department staff. We did not observe any delays in the handover of patients to the department.
- There has been a decline in patients being admitted promptly once the decision to admit has been made. The trust did not meet the target for patients to be admitted within four to 12 hours of an admission decision being made. The trust’s performance showed an overall decline in performance from 0.6% in December 2015 to 3.6% in November 2016, the worst performance was 6.8% in September 2016. Between December 2015 and November 2016, 50 when patients waited more than 12 hours from the decision to admit until being admitted. The highest number of patients waiting over 12 hours was in November 2016 when there were 34. The trust has reported 54 trolley breaches since 20 December 2016.
- The measurement of the 12 hour standard was not a true indication of the length of time patients had been in the emergency department. The department leads explained they were following NHSI guidance that the 12 hour timescale started from the time of the speciality consultant assessment and not the time the patient was first seen in the department by the emergency department staff. This method of calculation and process meant patients were in the emergency department longer, the department was much busier, extended care was needed to be provided by nursing staff and there was a reduced capacity to see more patients. For example, an elderly patient arrived at 7.30pm in the department, was seen by the ED doctor at 9pm and appropriate tests completed, but was not seen until 9am the following day by the specialist consultant. At that point there was a decision to admit the patient

and the 12 hour clock started ticking. This meant the patient had been in the department for 14 hours before the wait for a bed began. Whilst those patients were made comfortable and received good care by the department staff, targets were breached and the overall experience for patients was one of delay. Patients spent longer in the emergency department compared to the England average. Between November 2015 and October 2016 the trust's monthly median total time in A&E for admitted patients was consistently higher than the England average. Performance against this metric showed an overall decline from 170 minutes in November 2015 to 192 minutes in October 2016.

- Access to a specialist senior doctor to review patients overnight in the emergency department was limited and delayed patient admission and so reduced flow through the department. The medicine team had one registrar and senior house officer (SHO) on duty overnight to cover the medicine wards and the emergency department, so if called they would need to prioritise the urgency. We saw the night medical team responding to a medical emergency and provided support for the emergency department. The surgical, orthopaedic and gynaecology surgeons also had one senior house officer in total overnight, therefore, calls to the emergency department would need to be prioritised. While patients may be seen overnight by the specialist registrar or senior house officer, the patient would still have to wait in the emergency department until the following morning to be seen by the speciality consultant for a definitive decision about admission.
- There had been a recent increase in patients leaving the department without being seen. Between November 2015 and October 2016 the trust's monthly median percentage of patients leaving the urgent and emergency care services before being seen for treatment was overall similar to the England average. There was a period between May 2016 and July 2016 when the performance was better than the England average and periods when it had been worse than the England average. In the latest month available (October 2016) the trust percentage of patients leaving the trust's urgent and emergency care services before being seen for treatment was 3.4% compared to the England average of 3.0%.
- There were difficulties with discharging patients from hospital back into the community. This impacted on patient flow through the hospital and the emergency department. This problem with discharge included to both home and discharges to community residential accommodation. This had a cumulative impact in the department and contributed further to crowding.

Learning from complaints and concerns

- Complaints were listened and responded to improve the quality of care. Complaints were handled in accordance with trust policy. The trust received a total of 216 formal complaints which represented a 9.2% decrease from last year's total of 238 for 2014/2015. There was evidence of a recent dip in complaints management which had been addressed by the trust, with actions being taken to ensure an increase in activity to address complaints.
- Complaints leaflets were seen to be accessible in the department for patients to use.
- The trust looked for trends in complaints to see if there were any recurring or growing issues that might need special attention. Complaints reviewed showed a higher level of complaints for communication care and treatment. Formal complaints were investigated by senior staff in the emergency department. Staff involved were included in the investigation process and given appropriate support where necessary.
- Learning from complaints was cascaded to staff and discussed at governance meetings, team meetings and, if safety related, during safety briefings.

Are urgent and emergency services well-led?

Inadequate

We rated well-led as inadequate because:

- Emergency department staff were not aware of the strategy for the emergency department or the strategic development of the service. Staff told us their views were not considered and they did not feel involved in how decisions about their department were made and were not aware of any specific role they had in developing the department's future.
- The governance and management systems in place to review the risks, quality and safety of the service were

reviewed regularly but had not effected any changes to the circumstances of the department. The department remained under pressure with poor performance outcomes.

- The risk registers for the hospital were clear to follow with detail on how risks were being reviewed and managed. Staff were not fully aware of what was included on the risk register or how to raise issues for the risk register and so could not be expected to address those risks.
- The emergency department had a lack of a complete leadership team, with limited capacity to lead effectively. The medical leadership in the emergency department was fragile and in disarray. There was no consultant lead and the clinical lead role taken by matron did not have enough authority to lead the medical team. At the time the inspection the Clinical Lead (Matron) worked in conjunction with the Medical Director to provide clinical leadership across the emergency department.
- Staff told us they enjoyed working in the emergency department. They felt respected and valued amongst their peers but did not feel valued, listened to or supported by the hospital leadership. The culture of the service was top down and directive with little input from a department level.
- The culture of the wider hospital to support the emergency department was not considered by staff to be proactive. As a result, patient delays in being seen and a lack of proactive engagement to address delays and pressure in the department. This impacted on patient flow and the safety of patients and staff in the emergency department.

However:

- All staff were absolutely clear that patient care was their priority and the needs and experience of patients in their care was their main concern. They were proud of the work they did and the resilience they had to the increasing demands on the department. Staff in the department appeared professional, they worked collaboratively and constructively to deliver good quality care under difficult and challenging circumstances.

Detailed findings

Leadership of service

- The emergency department had a limited leadership team, with limited capacity to lead effectively. The medical leadership in the emergency department was fragile and in disarray. There was no consultant lead and the clinical lead role taken by matron did not have suitable authority to lead the medical team. The current clinical lead for both medical and nursing staff was the matron. However, this role did not have any clear leadership pathways and the matron was not consulted, included or supported to lead the medical team. At the time the inspection the Clinical Lead (Matron) worked in conjunction with the Medical Director to provide clinical leadership across the emergency department.
- Nursing leadership was strong and all nursing staff told us they felt well led by the matron and nursing team.
- For a recent period of time the medical director had been supporting matron in the clinical lead role. The medical director was due to leave the trust in April 2017 and so this support would no longer be available. The impact of the decreasing medical team and the increasing reliance on locum doctors was detrimental on the attitude of staff and created anxiety about the lack of future leadership.
- The challenge of recruitment was ongoing and despite sustained efforts to recruit clinical leadership, this was unsuccessful. The medical staff currently in the department did not want to assume a lead role and so were not working as a cohesive team with the advantage of focus and direction of an identified lead. The interim clinical lead recognised that changes were needed to ensure good quality care and team working.
- The trust performed badly in the general medical council (GMC) survey of junior doctors in 2015. At a Risk Summit with Health Education South West (HESW) and the GMC in September 2015 it was agreed that the trust needed to strengthen clinical leadership and initiate cultural change in the emergency department. There was also a need to improve 'Out of Hours' clinical supervision arrangements for Foundation Programme Doctors in the emergency department to ensure that only those middle grades who met the minimum requirements set by the GMC provided support. Regular review of junior doctor supervision was carried out by the GMC to ensure the minimum requirements for trainees were being met.

Urgent and emergency services

Vision and strategy for this service

- The trust's vision was to work in partnership to provide outstanding healthcare to 'deliver your local NHS with PRIDE. To deliver joined up care which feels integrated for patients and their families.' The values included putting patients at the centre of care, including people and partnerships, reputation, innovation, dignity, excellence and quality. The trust strategic aims included safe care, transformation to include partnership working and sustainability.
- Within the emergency department staff were aware of the vision of the trust but not of the strategy for the emergency department or the strategic development of the service. They considered quality of care to be their priority. Staff told us their views were not considered and they did not feel involved in how decisions about their department were made and were not aware of any specific role they had in developing the department's future. Consultation was taking place about the future of the department; staff did not feel included in the discussions.
- There was no visible strategy for securing permanent clinical leadership for medical staff within the emergency department. Medical staff were not aware of any vision or strategy to address the staffing and capacity restraints for the future within the emergency department.
- The Boards of Weston Area Health NHS Trust and University Hospitals Bristol NHS Foundation Trust had agreed to establish a formal partnership arrangement, increasing the level of joint working between the two trusts. This new collaboration was being created as part of the NHS vision of developing networks between smaller and larger trusts and reflected the ongoing North Somerset Sustainability programme to build a strong future for Weston General Hospital.

Governance, risk management and quality measurement

- While there was a governance framework that focused on the delivery of safe, quality care, staff at department level were not clear about how governance impacted on their day to day work or created improvements in service. There were reporting structures from the department into the division and up to the board, and vice-versa. Feedback from the emergency department to the board was maintained through three committees, quality and governance committee, audit and assurance committee, finance and performance committee.
- Following the increase in demand and safety concerns in the emergency department, assurance of emergency department safety was provided at a further monthly clinical oversight group meeting, by way of a quality and safety dashboard and verbal feedback in relation to any patient safety events. The clinical oversight group was set up following the conclusion of a previous risk summit process to provide monitoring of improvements. Chaired by NHS Improvement, its remit was to oversee and assure the delivery of safe urgent and emergency care service. Despite the remit of this group the emergency department clinical lead for medical and nursing was not included or represented on this group. The department was represented by the medical director in the absence of a clinical lead.
- The emergency department task and finish group were created by the trust in response to specific circumstances regarding clinical and financial sustainability at the trust. The group had been set up with three specific objectives; they included Operation Seagull, innovative recruitment models and alternative overnight staffing models for the emergency department. This was a task group and fed back to the wider system sustainability board who remained the key local oversight group. There was no representation on this board from the emergency department clinical lead for medical and nursing or another representative from the department.
- The assurance to the trust board was through the emergency department quality and governance committee who had the responsibility to review all aspects of the department's quality and clinical governance. The committee should enable the trust's quality and governance committee to obtain assurance that standards of care were being met. This committee reviewed any matters relating to quality and clinical governance and management of clinical risk within the directorate.
- The governance and management systems in place to review the risks, quality and safety of the service were reviewed regularly but had not effected any changes to the circumstances of the department. The department

remained under pressure with poor performance outcomes. Significant issues which threatened the delivery of safe and effective care did not have adequate action to manage them.

- An electronic governance system facilitated the reporting and management of incidents. It has been extended to include the complaints and risk register module to provide comprehensive reporting to support greater triangulation of risk. Each weekday all incidents were risk scored by the Governance Team. Integration with other assurance reporting streams (for example concerns raised via the Patient Advice and Liaison Services and agency staff usage), took place and Executive and Operational leads were updated through the Senior Management Group meeting regarding any apparent trends. The Head of Governance and team co-ordinated Serious Incidents Requiring Investigation, and adverse incidents, which were reported and managed through the Directorate Governance Committees, Quality and Governance Committee and by the Trust Board.
- High risks recorded on trust and divisional risk registers did not demonstrate timely improvements. The trust risk register noted, as a high risk, the lack of patient flow with the number of beds not meeting demand for the number of people presenting at the emergency department, resulting in reduced patient flow, causing crowding in the emergency department, which could impact safety and quality of care. This issue had been included on the risk register on 1 March 2013 and was dated for review 2 December 2016. A further high risk was that as a result of patients not being medically assessed within an hour, patient safety was compromised as patients would not have an appropriate treatment plan, which delayed care and management. This was included on the risk register 12 April 2016 and was for review on 1 December 2016. For both risks controls had been listed to manage the risks. The risk registers for the hospital were clear to follow how risks were being reviewed and managed. Staff were not fully aware of what was included on the risk register or how to raise issues for the risk register and so could not be expected to address those risks. While these risks were recorded and reviewed there had been no change to the level of risk or action taken to ensure they were fully mitigated and the level of risk reduced to improve patient safety.
- The emergency department divisional risk register noted a high risk caused by management of patient flow within the trust which impacted on the ability to achieve the 95% four hour standard, included 1 May 2015. A further risk was noted 9 May 2016 that at times of escalation the emergency department became overcrowded and therefore patient care could become compromised. A further risk was corridor management noted as a moderate risk included on the register 9 May 2015 and time to triage and timely medical review included 12 January 2015.
- The trust invited the Royal College of Emergency Medicine to review the emergency department and make suggestions for improvement. The visit occurred in December 2015. An action plan was created in January 2016. Areas for action included leadership, management and culture within the emergency department, medical staffing within the emergency department, operational pressure and emergency department crowding.
- Actions were identified to progress the emergency department to a safer position. The trust continued to implement the plan with phasing of initiatives, as part of the Emergency Care Improvement Project. This combined the actions required of the trust and included work plans for emergency department clinical streaming, improving patient flow and improved discharge processes. The trusts Royal College Emergency Action Plan 2016 showed areas which were completed which included emergency nurse practitioner programme commenced. Areas of slippage included internal ownership and a shared vision within ED and crowding in ED.
- The trust had previously enlisted the support of the emergency care improvement programme with the improvement actions following the General Medical Council survey results.
- A local audit programme had been introduced and the areas of work had a strong focus on patient safety. There were assurance systems, which measured quality, effectiveness, safety and risk. However, work to meet the shortfalls did not achieve a sustained improvement in the service.
- Department governance in the form of staff meetings had been reduced due to the excessive demand on the department. Staff told us they had not had a staff meeting for the previous five months and no records

were available. Staff confirmed that should information, for example about incidents and learning, be shared with them it came through safety briefings and via the matron who ensured they were informed.

Culture within the service

- All staff were absolutely clear that patient care was their priority and the needs and experience of patients in their care was their main concern. They were proud of the work they did and the resilience they had to the increasing demands on the department. Staff in the department appeared professional, they worked collaboratively and constructively to deliver good quality care under difficult and challenging circumstances.
- Staff told us they enjoyed working in the emergency department. They felt respected and valued amongst their peers but did not feel valued, listened to or supported by the hospital leadership. The general feeling of the staff was that they felt isolated and unsupported and despite efforts made their situation had not changed.
- The culture of the service was top down and directive from the executive board and divisional leads with little input felt by staff from a department level. The culture of the wider hospital to support the emergency department was not considered by staff to be proactive. There was poor cooperation between levels and conflict between medical teams on the wards. As a result, patient delays in being seen and a lack of proactive engagement to address delays and pressure in the department. This impacted on patient flow and the safety of patients and staff in the emergency department.

Public engagement

- The emergency department engaged with patients in a number of ways. The main method of patient engagement was through the NHS friends and family test. Suggestion boxes were seen in the department asking for people to provide their view on the care and service provided. Staff told us they had not seen any outcome from these cards yet.
- We heard when patients and relatives commented to staff about any issues they had, staff listened attentively and reassured patients they would pass their comments on to the matron.

Staff engagement

- The staff survey showed that there was a lack of improvement. The trust noted they were committed to supporting staff and noted improvements in four key findings of, staff recommendation of the trust as a place to work or receive treatment, staff motivation at work, support from immediate managers and effective use of patient feedback
- Staff told us that communications with senior managers were good and that senior managers took action to support the health and wellbeing of staff.
- Whilst the future of the emergency department was under review, the staff of the emergency department did not feel engaged in that process. Their views had not been considered in the planning and delivery of services and in shaping the culture of the service.

Innovation, improvement and sustainability

- Improvements and developments remained ongoing to enable the emergency department to be as safe and effective as possible. Collaboration with external partners to help improve patient flow included implementation of a public address audible system to alert staff when assistance was needed to include the reception area. Reception staff told us this worked well.
- An ambulance intercom and information board was set up in the corridor to further improve safety. Staff confirmed this had improved the process of checking patients in.
- A crowding dashboard plus action cards had developed and was available in the department for staff to know if the level of escalation due to crowding had been reached. This tool had no link to the OPEL tool to escalate for wider action.
- An agency forecast predictor tool had been established and matron was seen to be reviewing when agency should be considered to meet the increase in patient demand.
- An emergency department tracker role had been implemented. This member of staff tracked bed vacancies and liaised with the bed management team. This role has not been fully recruited to and was currently in its infancy.

Medical care (including older people's care)

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

Information about the service

The medical care service at Weston General Hospital provides care and treatment for care of the elderly, gastroenterology, respiratory, cardiology, endocrinology, stroke, rehabilitation, short stay and acute medicine. Medical care is delivered under the emergency care directorate which is responsible for all unscheduled care.

There were 15,938 medical admissions between April 2015 and March 2016. Emergency admissions accounted for 8,444 (53.0%), 127 (0.8%) were elective, rather than urgently necessary, and the remaining 7,367 (46.2%) were day case attendances.

There are seven medical wards:

- Harptree (cardiology, endocrinology and short stay medicine)
- Berrow (respiratory and gastroenterology)
- Stroke unit
- Uphill (rehabilitation)
- Kewstoke (care of the elderly)
- Medical Assessment Unit (short stay)
- Cheddar (winter management).

In addition to the wards, there is a medical day care unit providing transfusions and infusions, an oncology and haematology unit, an endoscopy suite, a discharge lounge and an ambulatory emergency care unit for clinically stable patients from the emergency department or GP referral.

At our last comprehensive inspection in May 2015 medical care services were rated as inadequate overall.

As part of this inspection, CQC piloted an enhanced methodology relating to the assessment of mental health care delivered in acute hospitals; the evidence gathered using the additional questions, tested as part of this pilot, has not contributed toour aggregation of judgements for any rating within this inspection process. Whilst the evidence is not contributing to the ratings, we have reported on our findings in the report.

This report covers our findings as part of the follow-up inspection where we visited the hospital as part of an announced inspection on 1 and 2 March 2017. We also carried out an unannounced inspection on 9 March 2017. During our inspection we spent time on all wards and units across the medical care service. We spoke with 78 staff to include registered nurses, nursing assistants, therapists, pharmacists, doctors, domestics, porters and managers. We reviewed 16 care records. We obtained feedback through talking to 24 patients. Both prior, during and following the inspection we reviewed information and data from the trust.

Medical care (including older people's care)

Summary of findings

We rated this service as requires improvement because:

- Patient flow had not been sufficiently improved since our last inspection.
- There was ineffective patient flow through the hospital and regular delays to patient discharge. The ambulatory emergency care unit and discharge lounge were underutilised and the medical assessment unit was ineffectively used.
- There were regularly a high number of medical outliers so patients were not receiving care on the right ward.
- Medical staffing was vulnerable and junior doctors did not feel well supported. Medical wards could be left at risk during evenings and weekends when medical staff were required to support the emergency department. There was a high number of locum consultants with only four permanent consultants across the medical wards.
- The high use of agency staff on Cheddar ward, due to vacancies, posed a potential safety risk to patients and did not ensure continuity of care.
- A fire exit in the stroke unit was blocked and could cause delay of evacuation in the event of a fire. This was included on the risk register but not being managed effectively.
- When benchmarked against other hospitals the trust were worse than the England average in a number of national audit programmes. Quality improvements were not always sustained and audit findings were not shared and used effectively to improve quality and patient outcomes.
- Directorate and executive leadership had undergone many changes to people in post, this negatively affected the quality of leadership and the ability to successfully drive improvements through.
- The stroke unit environment and availability of specialist equipment was not conducive to rehabilitation.
- Medicines were not always managed effectively. We found medications which had expired, medicines were not always reconciled for inpatient admissions and the medical safety thermometer was not completed by all wards on a monthly basis.
- We identified patient safety risks within ward environments, to include broken window restrictors and unsecured fire extinguishers.
- Staff mandatory training was not consistently meeting the trust's 90% target. Training for medical staff was particularly poor.

However:

- The oncology and haematology unit assessed patient risk for neutropenic sepsis and ensured this was clearly identifiable to staff.
- The management of meals and support provided to patients during a meal time on Kewstoke ward (care of the elderly) was very responsive, where patients' individual needs were met and accommodated and high standard of patient care was provided.
- There was a well embedded culture for incident reporting. Staff regularly identified learning from incidents.
- Staff regularly reviewed and discussed risks to patients within safety briefings and handovers. There had been a reduction in falls showing improvement in patient harm free care.
- Multidisciplinary team working was evidenced, effectively contributing to patient care and treatment.
- Staff were confident in the processes for gaining consent, mental capacity assessments and deprivation of liberty safeguards.
- Patients were consistently positive about the care and treatment they had received, and we observed compassionate and kind care provided to patients.
- Staff were responsive to patient individual needs. This was particularly evident in their approach to patients living with dementia.
- There was a positive culture amongst staff and staff were complimentary about their local nursing leadership.

Medical care (including older people's care)

Are medical care services safe?

Requires improvement

We rated safe as requires improvement because:

- Medical wards were left vulnerable at evenings and weekends due to medical staffing. The medical staff supported the emergency department and therefore were not always available to support the medical wards. There was a high use of locum consultants, with only four permanent consultants, this impacted on the continuity of medical staffing.
- Vacant posts and therefore a high number of bank and agency nursing staff posed a safety risk to patients on Cheddar ward in the absence of a stable workforce on the ward.
- The environment of the stroke unit was not conducive to rehabilitation and did not have access to specialist equipment to safely support patients.
- There were safety risks within the ward environments, for example fire exits were blocked within the stroke unit and fire extinguishers were not always secured. The environment required maintenance, there was peeling paint and poor fixings, which posed an infection control risk.
- Staff were not always up to date with current systems, processes and practices to keep people safe. Mandatory training was not meeting the trust's 90% compliance target, with training for medical staff being particularly poor.
- Medicines were not always managed effectively. We found expired medicines or instances where dates were not correctly revised. Medicine reconciliations were not always reconciled for all inpatient admissions. There were gaps for some wards in the completion of the monthly medicine safety thermometer.

However:

- The oncology and haematology unit assessed patient risk for neutropenic sepsis and ensured this was clearly identifiable to staff.
- The culture to identify and report incidents was well embedded across staff groups. Learning from incidents and never events was shared with staff and improvements made.
- Risks to patients were regularly assessed and reviewed. Detailed safety briefings and handovers were completed between each nursing shift.
- There had been a reduction in falls. Systems were in place to reduce the risk of patients falling. Falls with harm were investigated to identify learning.
- Records were stored securely. Records reviewed were complete and up to date. We saw evidence of completed risk assessments.
- Staff were aware of processes to follow for safeguarding and were confident in identifying safeguarding concerns.

Detailed findings

Incidents

- Staff spoke confidently about their responsibilities and the process for reporting incidents. All staff groups reported incidents and lessons were learnt and improvements made when things went wrong. Staff told us they were encouraged to report incidents and had access to the electronic reporting system.
- Learning from incidents was shared amongst ward staff in the monthly ward newsletter or they could be included within an urgent bulletin to alert staff immediately of important learning. A recent incident had occurred when a patient on the stroke unit required insertion of a feeding tube, but this procedure was delayed because the patient was not screened for methicillin-resistant staphylococcus aureus (MRSA). Learning from this incident was disseminated to staff at the daily 'board round' and we witnessed staff checking to see screening for MRSA had been considered for patients with potential to require feeding tube insertion.
- There had been action arising from incidents involving pressure ulcers. Mirrors had been given to all staff to aid their assessment of skin damage and staff told us these were frequently used.
- A confidential line, called the hazard line, was a route to report incidents, particularly for medical staff. Medical staff spoke positively about this line which was used to report safety concerns such as faulty equipment or when resources were not available, for example if the tissue viability nurse was not available to review a wound. A monthly newsletter on items reported was sent to staff. Staff were aware of their responsibilities to still electronically report incidents in line with the trust's procedure for incidents involving patient harm or near misses.

Medical care (including older people's care)

- Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event. Between February 2016 and January 2017 one never event was reported for the medical care service. A guide wire was not removed following a chest drain insertion. Action was taken by the trust to review the equipment being used and disseminate safety checklist posters to remind clinicians to complete the checklist for all invasive procedures. During our inspection staff across all wards were aware of this event and the learning which resulted.
- The endoscopy department showed us how they had effectively responded to a never event in September 2015 where a foreign object was left inside a patient's abdomen. Following this never event, a checklist document was implemented for pre and post percutaneous endoscopic gastrostomy (PEG) insertion. The document included pictures and the name of equipment to start the procedure and the equipment left to be accounted for at the end of the procedure. This checklist required two signatures to confirm the checking process.
- The medical care service reported 40 serious incidents between December 2015 and November 2016, these incidents met the reporting criteria set by NHS England. Of these, the most common type of incident report was pressure ulcers where 27 were reported (67.5%). Additionally there were eight slips/trips/falls, four treatment delay and one healthcare associated infection incident.
- Staff investigated all instances of patient falls. The ward sister completed this if the patient did not experience harm. If the patient experienced harm, teams completed an immediate multidisciplinary assessment of the fall and a panel reviewed the analysis of the root causes to identify learning.
- Limited mortality review was added to the risk register in February 2016. When this risk was reviewed in December 2016 gaps in assurance commented how speciality reports were not robust in reporting on learning from mortality reviews.

Duty of Candour

- Regulation 20 of the Health and Social Care Act (2008) Regulations 2014 is a regulation which was introduced in November 2014. This Regulation requires the trust to notify the relevant person that an incident has occurred, provide reasonable support to the relevant person in relation to the incident and offer an apology.
- We spoke to staff in various roles. The understanding of duty of candour was variable, medical staff were aware, however nursing staff had an inconsistent knowledge. Staff were unaware of the trust providing any training or support for the duty of candour.

Safety thermometer

- Harm free care was being monitored and reported. The safety thermometer is a national improvement tool for measuring, monitoring and analysing patient harm and 'harm-free' care. Data collection takes place one day each month. Data from the patient safety thermometer showed the trust reported a prevalence rate for medical care of 36 pressure ulcers, two falls and three catheter urinary tract infections between December 2015 and November 2016. There were no apparent trends but there had been an increase in pressure ulcers over the last two months.
- Safety thermometer information was clearly displayed on each ward and visible to the members of public. Wards displayed the total number of pressure ulcers and falls that had occurred each month.
- Ward Wednesdays were weekly meetings held by senior nursing staff. Harm free care was regularly discussed at this meeting.
- The trust's October 2016 integrated performance report identified venous thromboembolism (VTE) assessment performance had not reached the required 95% threshold for six months. Action plans, including resourcing for auditing were implemented with ward based approach to ensuring assessments were completed. We looked at 10 VTE assessments within patient records and all were completed in full.

Cleanliness, infection control and hygiene

- Wards and units visited appeared visibly clean, although the environment was in need of repair or refurbishment for example peeling paint and poor fittings, which posed an infection control risk and difficulties in maintaining a clean environment. On wards cleaning rotas were completed for the week. Each ward had a rolling programme to deep clean a bay or side room between

the days Monday to Friday. A deep or enhanced clean was completed following any outbreaks of norovirus, methicillin resistant Staphylococcus Aureus (MRSA) or clostridium difficile.

- All staff received mandatory training and ongoing updates for infection prevention and control.
- Staff were observed to adhere to infection prevention and control practices. To include use of personal protective equipment such as gloves and aprons, hand hygiene immediately before and after direct contact or care, and followed policy being bare below the elbow.
- Hand hygiene audits were completed monthly on each ward and unit. Recent hand hygiene compliance was displayed on each ward. In January 2017 hand hygiene audits for the emergency directorate were 93% compliant.
- Antibacterial gels were readily available on the wards and in waiting areas for use by staff, patients and visitors. Signage was present to inform people of correct hand cleaning techniques.
- Cubicles (side rooms) were used to isolate patients at risk of or with known infection. Systems were in place to inform staff and visitors of the protective equipment required before entering the room and the level of isolation required for the patient.
- We observed staff cleaning equipment following use, however there was an inconsistent use of 'I am clean' stickers to indicate to other staff and patients the equipment was clean and safe to be used. During a ward handover the nurse in charge reminded nursing staff to use these stickers.
- We observed a meal time and hand hygiene was offered to all patients prior to eating, staff washed their hands and wore aprons.
- Infection rates were good across medical wards. Each ward was transparent about infection control rates and this was displayed on entrance to wards.
- Patients were screened for MRSA on admission to the medical assessment unit and then again at 30 day intervals. No blood stream MRSA was reported between December 2015 and November 2016.
- Between April and September 2016 four cases of methicillin sensitive staphylococcus aureus bacteraemia (blood stream infection) were reported within medical care wards or units.
- The trust reported five cases of hospital attributable clostridium difficile between April and September 2016. These included Berrow Ward and Draycoft Ward. When assessing against national guidance two of the five cases were assessed as avoidable, where lapses in care were identified due to possible cross transmission and lack of hand hygiene auditing. We reviewed copies of root cause analysis and action plans which identified improvements to practice and learning.
- Divisional matrons completed monthly audits inspecting 16 cleanliness elements. Between April and November 2016 wards or units average rating as amber (88-95% compliance) included Cheddar, Harptree and the Stroke unit. Berrow ward was rated red at 85% compliance. There were not specific action plans as a result of poor cleanliness compliance, however Berrow ward saw improved results of 94% across the months January, February and March 2017.
- The endoscopy department followed health technical memorandum for the management and decontamination of flexible endoscopes. A decontamination assurance report and scope audit was completed monthly. Reports for November 2016 to February 2017 identified 100% compliance with correct decontamination processes.
- In the endoscopy department precautions would be taken when seeing people with suspected communicable diseases, for example staff had masks fitted and checked for tuberculosis patients. If a patient had Clostridium difficile they would be placed at the end of the list and following the procedure the room would be deep cleaned.

Environment and equipment

- The design, use and maintenance of facilities did not always keep people safe. During our inspection we observed access to the fire exit on the stroke unit was hindered by stacks of chairs, bedside cabinets and equipment. On the same unit, during a meal time we observed the large meal trolley was plugged into the socket beside the fire exit and positioned obstructing the fire exit, along with the tray trolley. During the announced inspection immediate action was taken to clear the access to this fire exit when we raised our concerns. However, on our subsequent unannounced inspection, we saw this area was once again obstructed by chairs, bedside cabinets and tables. On a second unannounced inspection the fire exit was observed to be clear and the director of nursing informed us the matron would be checking this daily. The lack of space resulting in items blocking the fire exit was a result of six

additional beds being placed on the ward which had been recognised as a risk and added to the risk register on the 13th December 2016. The entry included comment how there was a threat to patient and staff safety as the fire escape was blocked. A general risk assessment of the stroke unit environment was completed in October 2016. The assessment included 'threats to patient and staff safety by ward environment ie fire escape semi-blocked (breach of fire safety order)' the controls included a fire risk inspection was undertaken but did not detail the inspection results. The risk had not been mitigated or resolved, and staff on the ward were not aware of actions thus the exits continued to be blocked.

- The stroke unit environment was not conducive to patient safety and quality care. It was observed to be a cramped, with six escalation beds within the ward taking the ward capacity to 26 beds, the impact was that the environment reduced the ability to provide safe and effective rehabilitation to stroke patients.
- Patients were not provided with essential safety equipment to meet their specialist needs. Patients who have had a stroke, frequently need specialist postural support during activities of daily living, to maintain their safety when seated and to facilitate rehabilitation. Therapists on the stroke unit had used the hazard line to report the lack of specialist seating and this had resulted in a business case for eight more chairs, a specialist shower chair and a stand aid. However, at the time of our inspection this business case was not yet approved and the equipment was not on order.
- Fire extinguishers were not always securely mounted on walls. In two instances on Kewstoke ward and Berrow ward we found fire extinguishers stored on fire extinguisher stands on the floor. This posed a risk of fire extinguishers being moved or picked up and thrown, which compromised the safety of both staff and patients.
- The environment in some areas appeared in need of maintenance. We identified two windows which had broken restrictors on Cheddar ward. We were unable to confirm how long these had been broken for but noted a number of windows were in poor condition. We informed the nurse in charge and on our unannounced the windows had been fixed and secured. Integral window restrictors remained functional at the time so there was not a risk to patient safety.
- Sluices and cleaning cupboards containing substances hazardous to health were not always locked and therefore could be accessed by patients and members of the public. However, we also saw good practice where substances were stored in locked cupboards or rooms.
- Random checks of equipment showed servicing was completed annually, this was clearly recorded on equipment. However, on the medical day case unit, five of the six infusion pumps were out of date for servicing, their last due dates for service ranged from February to August 2016.
- Resuscitation equipment was present on each ward and unit, located for immediate availability and tagged to maintain security. Nursing staff completed daily checks of the resuscitation trolley, ensuring the tag was in place and the defibrillator tested. Monthly a full check of the resuscitation equipment and drugs were completed to ensure expiration dates were valid. Following use of the resuscitation trolley a full check was completed by two nurses, confirming replenished equipment and drugs.
- The arrangements for managing waste and clinical specimens kept people safe. There was appropriate classification, segregation and storage of waste. Reusable sharps containment systems were in place for the safe disposable of sharps.
- Equipment to reduce the likelihood of patients falling was available for use on the wards. This included pressure sensor mats, hi-low adjustable beds and coloured socks to identify patients at high risk. Nurses told us they were also looking to buy toilet use alarms which clip to the patient and sound an alarm when a patient stands.
- Pressure relieving equipment was available on wards to include different mattress types, pressure relief seat cushions and heel pressure relief. On Kewstoke ward, nurses inspected every mattress once each month for signs of damage or disrepair, and checked pressure cushions in between patient use to ensure their ongoing suitability.

Medicines

- Medicines were stored safely in locked cupboards. Recording of fridge temperatures were completed daily; the clinic room temperatures were not recorded in line with trust policy. Clinic rooms were felt to be cool on Kewstoke, Uphill and Stroke unit.
- Controlled drugs were stored securely. The access to the cupboard keys was only by authorised staff. Daily and

weekly controlled drug checks were completed in line with trust policy. However, on Cheddar ward controlled drugs were not always checked every night as there were not always two permanent nursing staff due to the high use of bank and agency staff. Between February and March 2017 we found 13 dates where a check was not completed. This had been put on to the safety briefing each morning.

- Audits were reported via the medicines optimisation group. Pharmacy completed audits for controlled drugs management and medicines storage. The monthly medicine safety thermometer was a drug chart audit to include omitted doses and allergy recordings, this should be completed by wards monthly. The medicines optimisation group meeting minutes identified both medical assessment unit and Uphill ward had not completed this for nine out of the last reported 12 months cycle (December 2015 to November 2016).
- Medicines were not regularly reviewed to ensure they were in date and safe to use. The date of opening of liquid medicines were not recorded therefore when the expiry date of the medicine needed to be reduced it was not possible to determine whether these liquid medicines were suitable for use.
- Checking arrangements for medications were not always robust. In endoscopy the emergency medicine flumazenil injection had recently expired and was out of date in the antidote box, this was replaced with in date stock at the time of the inspection. In the discharge lounge expired pre-filled syringes of amiodarone injection 300mg (expired December 2016) and four adrenaline injection 1 in 10,000 (expired July 2016) these had been removed from the resuscitation trolley by the nurse at the time of our inspection.
- The in-use expiry date of glucagon injection (an emergency drug used to control blood glucose levels) had not always been recorded when it was removed from refrigerated storage, we saw this on Cheddar, Berrow, Stroke unit, MAU and oncology and haematology department. In accordance with manufacturer's guidelines glucagon should be stored in a medical refrigerator with a 36 month expiry date, however when kept with emergency drugs and therefore removed from refrigeration the expiry date should be reduced to 18 months. There was a risk the glucagon could be used outside of the shelf-life because the expiry date had not been revised and therefore staff were unaware of the expiration date.
- We observed three medicine rounds. In one instance the nurse wore 'do not disturb nurse on drug round' overalls. Medicines were administered to one patient at a time and nurses checked the patient wrist band prior to administering medicines. The nurses stayed with the patient until medicines were swallowed.
- The medicines procedures in the discharge lounge did not consistently ensure the safety of patients. In the discharge lounge, if patients required medicines, the nurse administered checking against inpatient prescription chart. This could not be done if the chart was held with pharmacy. Staff told us of an incident which occurred the day prior to our visit where a patient did not have their antibiotics administered as this was not on the discharge list and was not communicated to staff in the discharge lounge.
- Staff stated medicines were not always explained to patients, this would be done if patients received medicines on the ward, however if received when in the discharge lounge they were not confident this was completed regularly as the registered staff overseeing the discharge lounge were from the medical day case unit.
- We looked at 22 prescription charts and can confirm VTE risk assessments were completed, patient details were recorded on all prescription charts, allergies or no known allergies were documented on charts, PRN (as needed) medicines were prescribed with maximum dose, reason and frequency, and all prescriptions were signed and dated. Missed or omitted doses seen on inpatient prescription charts were regularly completed with a code, for example to indicate patient refusal. However, there were instances, particularly on Cheddar ward where the timed dose was just crossed with no explanation behind why it was omitted.
- Non-medical prescribers were working on the Medical Assessment Unit and could prescribe, within their competencies, for inpatients when doctors were not available outside normal working hours.
- The pharmacist did not see every medicine chart each day (Monday to Friday) as they were concentrating on their service on medicines reconciliation for each new admission. Medicine were not always reconciled in a timely manner on inpatients wards. Overall the trust were achieving 88% of admissions had medicines reconciled within 24 hours. This data was reflective on Monday to Friday working, and excluded weekends when pharmacy did not provide a service.

- An in-house pharmacy service provided a supply function and a clinical pharmacy service. Medicines for use outside the hospital for patients not admitted to the hospital, for example the oncology and haematology day unit, were dispensed by the local on-site community pharmacy.
- There was an electronic prescribing system for chemotherapy, whereby only consultants could prescribe the first dose. The system interfaced with the pathology laboratory so results were pre-printed on forms. Pharmacists had been trained to review the chemotherapy prescriptions to provide assurance of safety.
- There was an open culture for reporting medicines incidents, these were investigated and were reported to the medicines management optimisation group. Learning from incidents was identified and the information disseminated across the organisation.
- Medicines were appropriately disposed of. Controlled drugs were stored separately from those in use if they required disposal and there was an appropriate disposal kit. Expired stock medicines were returned to pharmacy.

Records

- Patient individual care records were stored securely when not in use, under key pad locks in note trolleys. Staff were mostly observed to close trolley lids between using notes. This ensured records were not accessible to the public or patients on the ward. Nursing care documentation was kept in folders at the end of patient beds so information could be accessed quickly. During our unannounced inspection on Berrow ward, the medical notes trolley was left unlocked and open in front of the nurse's station. Lists with patient identifiable information were on view on the nursing station worktop. We also found loose patient documentation sat under trolleys on some wards. In the ambulatory emergency care unit, one set of patient notes was left unattended on the reception desk when the unit no longer had administrative staff on duty for the day.
- We reviewed 16 patient care records across six different wards/units. Records were legible, up to date and complete, with dates and signatures to support records made. Care plans were simplistic but completed clearly and concisely identifying patient care needs with problem, goal and action.
- Records were well ordered, old nursing charts and assessments were archived so only the last two or three days were kept at the patient bedside.
- We saw evidence of well completed risk assessments these included VTE, pressure ulcers, nutritional risk assessments and falls. Therapy records had a clear assessment of the physical, social and emotional needs of the patient, with clear goals and reviews. Clear instructions were provided for the nursing team with regards to eating and drinking, moving and handling.
- Some staff commented negatively about how records lacked consistency and pathways were not always completed, and how "notes are chaotic". We were made aware of one incident on Uphill ward where notes had fallen accidentally in to the recycling bin, this had been attributed to the absence of ward clerks to support an efficient filing system.
- There was effective systems in place to record which patients have mental health, learning disability and dementia diagnosis. This was identifiable on the ward board, on patient boards at bed spaces and in patient records. In one patient record we saw evidence of a medical request for mental health assessment and input from mental health hospital liaison team was documented. This included recommendations for communicating with the patient.
- Documentation audits were inconsistently completed. Some wards completed adhoc audits but there was not a clear documentation audit process. When requesting evidence of these audits the trust responded saying there was historical data however none had been completed in the last 12 months, between March 2016 and February 2017.

Safeguarding

- There were reliable systems to escalate safeguarding concerns and ensure people were protected from abuse. Staff said they had good support and input from the trust's safeguarding adult lead who they could contact for advice and guidance.
- Staff were trained in safeguarding procedures to ensure their awareness and understanding of identifying and reporting safeguarding concerns. Data showed 92.1% of clinical staff were compliant with safeguarding training within the emergency directorate. Staff completed the level relevant to their role and clinical contact with patients for both safeguarding adults and safeguarding children.

- Staff spoken with showed an understanding of safeguarding, their responsibilities and the escalation process to follow should a safeguarding concern arise.
- Managed access and exits had been implemented in order to safeguard and ensure the safety of elderly patients on Kewstoke ward. Staff were able to enter or exit via swipe card and patients and visitors could request entry and exit. This was explained to both the patient and their relatives at the time of their admission.
- Staff spoken with were not consistently aware of female genital mutilation and had not received training on this topic.
- On Uphill ward, the ward sister described learning from a safeguarding incident involving a patient who had developed a grade four pressure ulcer under the edge of their plaster cast. This was investigated and following this process a plaster cast skin check was introduced to the nursing observations chart. Nursing staff on the rehabilitation ward described the importance of completing this check and we saw this had been consistently completed in the two care plans we reviewed.
- Following on from a safeguarding incident involving a patient in the ambulatory care unit who frequently forgot to bring her epilepsy medication with them to the hospital, a patient specific protocol was agreed that allowed staff to dispense this medication if they came to the hospital without it in the future.
- The safeguarding lead told us ward sisters did not always have time to complete safeguarding investigations, this meant safeguarding investigations were frequently delayed. Additional staff were not released from their clinical duties to attend investigator courses. Ward sisters were not part of the routine membership of the safeguarding committee, however staff who were invited to safeguarding meetings rarely attended as they could not be released from clinical duties.

Mandatory training

- The trust's 90% mandatory training target was not being met. In January 2017 the emergency directorate which includes the medical services, was 80.9% compliant, in particular medical staff compliance was low.
- The emergency directorate governance meeting minutes identified the underachievement of training compliance against the target level. Staff not being up to date with mandatory training was included on the emergency directorate risk register, as a moderate risk.
- All staff were required to complete mandatory training. This included; prevent, basic life support, conflict resolution, equality, diversity and human rights, fire safety, health and safety, infection control, information governance, mental capacity act, moving and handling, safeguarding adults, and safeguarding children.
- Staff spoken with were able to access training and felt the quality of the training provided them with the knowledge they required. Poor compliance with mandatory training was attributed to not having protected time to complete the training modules, which was not always possible on busy wards and units.
- Adult basic life support training was low; medical staff 50.6%, registered nurses 72.4%, allied health professionals 76.9% and additional clinical 77.5%.
- Dementia awareness had low compliance reported for medical staff 56.0%, registered nurses 68.8%, additional clinical 54.5% and administrative 80.5%. Allied health professionals were 92.3% compliant.

Assessing and responding to patient risk

- Risks were managed proactively. Risk assessments were completed and there was regular discussion of risks within ward safety briefings and nursing handovers. Ward white boards were used to indicate risks and needs for each patient, this included pressure ulcers, falls, dementia and diabetes. Patient at a glance boards were completed at each bed space, this included information for visual alerts, falls risk, food and fluid and mobility.
- Patients were risk assessed for pressure ulcers following clinical pathways to determine the risk level. On Harptree ward good practice was seen where a checklist had been devised to ensure all new patients received a pressure ulcer check within 30 minutes of admission to the ward. We were also told Harptree ward had an allocated pressure ulcer team within their nurse staffing.
- Pressure ulcers were on the risk register, added June 2014, and risk rated 15. There was a tissue viability team, however the team was small and was required to support the whole hospital. In the past, the trust had put changes and education in place and saw a decrease in pressure ulcers, however we were told this was not

sustained and as a result they have seen another increase and were working hard to further reduce pressure ulcers. Staff explained how a pressure ulcer video using a real patient had a positive influence on them and had provided good learning. Nurses were required to check every patient's pressure areas, once each shift, and document with signature to provide overview of skin integrity, risk and management. We saw evidence of this within patient records. A pressure ulcer admission checklist had been implemented to aim to assess skin integrity within 30 minutes of admission to ensure community acquired pressure ulcers are identified immediately.

- Pressure ulcer audits were completed monthly on each ward. On Harptree ward a high number of pressure ulcers had been reported, as a result a daily audit of pressures had been completed.
- A prevention and reduction for pressure ulcers action plan had been created in November 2016, the action plan was in its infancy however processes were being put in place to improve awareness and ensure safe management of pressure ulcers.
- The hospital was proud of the reduction they had seen in falls, although falls remained on the risk register. In 2015/16 527 falls were reported, in 2016/17 with only one month remaining in the financial year the hospital had seen a decrease to 388 falls. Falls with harm were investigated as a serious incident, the SWARM (interdisciplinary team undertake thoughtful analysis of events reported by frontline staff) completed, a root cause analysis and a report produced. This holistic analysis of falls enabled the hospital to understand the root cause of falls.
- Falls risk assessments were completed for patients. The trust had recently redeveloped their falls risk assessments to incorporate a more detailed understanding of the relative risks of patients in the ward settings. This was designed to enable staff to focus on those patients who posed the most serious risk of harm and would be used to determine which patients were in need of enhanced supervision. This new document was not yet in use on the medical wards but was being piloted on a surgical ward.
- The trust had developed a falls care bundle which incorporated four levels of risk. This bundle was in use on the wards, the ward sisters monitored compliance with the falls care bundle. The trust had developed draft policy for prevention and management of falls in adult patients in hospital and the safe use of bed rails with adult patients. This draft policy was first drafted in July 2016 and had been updated three times but was not ratified at the time of our inspection.
- During October 2015, the trust had undertaken a thematic review of all the patients who had fallen and sustained harm as a result. This review informed the action plan that had been worked on during the twelve months preceding our inspection. This had included 'hotspot' audits and environmental mapping of wards with high falls rates. These investigations revealed previously undetected falls risks such as a sloping floor in one bathroom and a blind spot caused by the afternoon sun in one bay where several falls had occurred. On the stroke unit, the audit process revealed falls were occurring during the time when staff were absent preparing afternoon tea.
- Education on falls was included within trust induction and new staff's supernumerary days included falls safety and analysis. Fall care bundles were in use on wards, bundles are interventions used together to significantly improve patient outcomes.
- There was no specialist nurse for patients who fall. This meant nursing staff did not have access to specialist advice when needed for this group of patients. There were no 'falls' champions, this was a deliberate choice as managers wanted all staff to take responsibility for reducing falls.
- Kewstoke ward (care of the elderly) staff told us how they had reduced the number of falls from approximately eights a month to four a month through changing of staff attitudes and looking at the allocation of staff. Nurses were now responsible for bays and worked as a 'tag team', whereby a nurse was not able to leave the bay until another nurse had replaced them. This ensured nursing staff were always present and was paramount for high risk fall patients or patients with challenging behaviour. This was particularly effective in keeping patients living with dementia safe.
- Staff told us acutely unwell patients would be prioritised, for example these patients would not be medical outliers and patients were in bays closer to the nursing station.
- Patients were identified as needed for one to one support. The trust had developed a draft policy and standard operating procedure for the management of patients requiring enhanced supervision, or 'one to one'

care and a draft risk assessment tool to support this. Nurses wore yellow tabards to indicate they were looking after one specific patient and could not be disturbed.

- Support was available if a patient deteriorated. There was on-site access to level two and three critical care. Support was provided to the medical wards from critical care outreach team who were available 24 hours a day. All staff were familiar with the process for summoning assistance for patients if they deteriorated or if they have a cardiac arrest. Staff told us help was available promptly when required.
- Patients were assessed using the National Early Warning System (NEWS). This system is designed to identify patients at risk of deterioration. On review of patient records we found patient observations were completed regularly using NEWS calculation to identify any patients at risk and escalation procedures were followed where applicable. Nursing staff were able to explain how to interpret patient scores. NEWS scores were confirmed at each patient handover and any high NEWS were reported to the whole team during the safety briefing.
- A trust wide NEWS audit was completed in 2016, this was not effective in providing assurance of patient safety due to low numbers to sample and it was found NEWS was not being consistently used to prompt the right action. Six medical wards were included in this audit. From review of data low scoring metrics across all wards included; when the NEWS trigger was revised this was not documented in the notes, where the NEWS scored three in one parameter or a total greater than four the frequency of observation was not increased and where high scores were recorded action was not taken. There were 14 patients identified with a NEWS score across ten wards and only eight patients had complete information available to audit. On review of this data the low numbers to audit on each ward did not provide an adequate data sample. Actions from the audit included each ward sister to develop an action plan and address any issues raised and to share learning with staff. We were not provided with evidence of these action plans across all wards.
- A sepsis screening tool and sepsis six pathway was used. If a patient was red flag for sepsis the sepsis six pathway was commenced. Overall, staff were aware of the sepsis screening tool and the actions they would take. A new sepsis tool was being trialled on Berrow ward (respiratory ward). The purpose of the tool was to avoid delay by empowering nurses to begin the sepsis pathway when needed without waiting for assessment from the medical team. Analysis of the trial had not commenced at the time of our inspection. Nurses on Harptree ward told us they were confident in initiating processes of bloods and relevant observations prior to medical input. The trust did not have a sepsis proforma in place although this had been discussed at the sepsis committee.
- In the oncology and haematology day case unit a yellow jacket was placed on patient notes to identify neutropenic sepsis risk, patients with a low level of neutrophils (white blood cells which fight infection) and therefore at a higher risk of developing serious infections.
- Due to pressures of escalation, escalation beds in the stroke unit were regularly filled with non-stroke patients. Pressures to use all available beds during periods of escalation meant the ring fenced bed for emergency stroke admissions was not always available. This has had direct impact on sentinel stroke national audit scores because stroke patients were being admitted to the medical assessment unit rather than directly to the stroke unit
- Nursing handovers ensured risks were appropriately explained to staff starting on shift or receiving a patient. We saw two detailed handovers between nurses from the emergency department to nurses on the medical assessment unit and on a ward. At the start of each shift the nurse in charge from the previous shift led a safety briefing to highlight awareness of specific safety risks pertaining to patients on the ward. We observed four safety briefings and the whole team were engaged in this process. The safety briefing included patient risk, changes to patient requirements and how to meet their needs to ensure safety. Patients with mental health needs or with challenging behaviour were also discussed. As required patients were discussed in detail.
- We were told urgent and un-planned medical admissions were mostly seen and assessed by a relevant consultant within 12 hours of admission, Monday to Friday. On weekends consultants reviewed emergency admissions every morning. If a patient was unwell or scored highly on the early warning scores, nursing staff would consult with medical staff to ensure the patient was seen urgently, consultants on-call could be contacted at evenings or weekends.

- Medical outliers received appropriate medical care and staff were aware of the escalation process should a patient deteriorate. We visited two medical outliers who were on the surgical assessment unit, both patients had been seen daily by medical staff, evidenced in their records. Specialist nurses and therapists also saw the patients where appropriate. Staff on the surgical assessment unit were aware of process should patient deteriorate to contact outreach team or medical staff.
- Safety of endoscopy procedures was supported by the use of a world health organisation (WHO) surgical safety checklist. We observed a procedure and saw the safety checks were completed thoroughly and recorded. The compliance with WHO was variable between May 2016 and January 2017, one month rated red, four months amber and four months green. Actions included reminding staff that all sections should be completed and signed.
- Patients were only seen in the endoscopy department if they were clinically stable. The department would prioritise patients. Should a patient in the endoscopy clinic become clinically unwell and require a hospital admission a patient would be reviewed by the endoscopist and on-call medical registrar and could be admitted straight to the wards. The endoscopy department would complete relevant paperwork and organise tests. The patient would be stabilised within the team and taken to theatre if required.
- Staff knew how to access specialist mental health support, this could be accessed if there were concerns or risks associated with a patient's mental health. This included the mental health liaison team, learning disability lead nurse and dementia lead. If a patient with a mental health diagnosis required enhanced supervision a one to one form was completed and reviewed and assessed by the matron to ensure appropriate staffing.
- Staff told us mental health was always covered in handovers, risk assessments were completed for individual patients dependent on their needs and the risk. We observed a patient being handed over from the emergency department whereby it was made aware the patient had learning disabilities. The nurse in charge confirmed they would contact the learning disability liaison team.
- An older people's mental health nurse liaison worked a clinical shift once a week on Kewstoke ward (care of the elderly). This was introduced four weeks prior to our inspection date. The nurse assessed patients and did planned assessments advising and monitoring on behaviour strategies and supporting relatives and staff in understanding and managing behaviour.

Nursing staffing

- Nursing staffing levels were reviewed regularly and increased in line with patient acuity and dependency. To ensure the right staff with the right skills were in place a safer nursing acuity tool was used. The medical matrons and assistant director of nursing met daily to discuss staffing and ensure safe staffing levels.
- Nurses in charge of rotas demonstrated a proactive approach to staffing. For example, Berrow ward implemented an escalation procedure document to increase registered nurse staffing when there were more than two non-invasive ventilation patients. On the stroke unit, the nursing team felt staffing requirements were also related to dependency and the team had begun to trial use of a dependency tool to inform the decision making process.
- At the time of our inspection nursing staffing levels were as planned. Information on staffing was displayed to the public on entrance to the ward. Staff considered nursing staffing levels to be safe, although they identified at times there were gaps in the rota and weekends were not always sufficiently staffed. There was a trust wide senior sister rota on weekends to support ward staff and the out of hours team could provide support as and when required.
- The increase in patients requiring enhanced supervision caused pressure within wards, nursing assistant staffing was increased for these instances and there were plans to train nursing assistants to ensure their competency in providing supervision.
- We were told the staffing rota was confirmed before opening escalation beds to ensure the additional patients did not compromise patient safety across the wards.
- In the emergency directorate between August and November 2016 the monthly percentage of planned versus actual staff, both registered and unregistered, was projected above 100%.
- There were nursing staff vacancies within the division. Across medical wards there was 28.52 whole time equivalent (WTE) vacancy which was a 12.43% vacancy

rate and turnover was at 9.27%. Additionally endoscopy had 1.96 WTE vacancy rate (11.11%) and the medical day unit and discharge lounge had 0.67 WTE 15.43%. The oncology day unit had no vacant posts.

- The staffing on Cheddar ward was an area of risk and had been added to the directorate risk register, there was no date to determine when this was added. Cheddar ward was initially opened as an escalation ward in August 2016. In September 2016 the ward was converted to a substantive ward with 20 beds and six escalation beds used at times of escalation. Recruitment for cheddar ward staff was ongoing and had been advertised since October 2016. There were 13.97 WTE vacancies a 53.97% rate. During our unannounced inspection on 09 April of four registered nurse posts two were agency and of five nursing assistant posts three were agency. Continuity of care was difficult to achieve on this ward. The hospital aimed to block book bank or agency staff, and where possible moved permanent staff from other wards to ensure a safe balance, however this did not resolve the high agency issues. Permanent staff on Cheddar ward shared concerns about the number of agency staff required to fill shifts, they explained how where possible regular agency and block bookings were conducted, however a stable staffing workforce would improve the quality of care being provided on the ward.
- When nursing staff called in sick, the on-site team made an assessment of what nursing cover was needed to fill the gap. Where possible, familiar agency and bank nurses were used to aid consistency. Staff told us these shortages were quickly filled. Similarly, if the acuity level on a ward changed, for example if a patient was admitted who required non-invasive ventilation, the on-site team made an assessment of the staffing need based on the change to the acuity level of the ward.
- The use of agency staff was an area of concern when speaking to staff. The emergency directorate agency usage between February 2016 and January 2017 was at 8.35%. Agency use had increased over the summer months and continued to remain high in to the winter. In the four month period August to November 2016 166.5 WTE bank or agency registered nurses and 174.94 WTE bank or agency unregistered staff were used to ensure staffing was as planned.
- We spoke to one agency nurse who had been inducted to the ward before their shift. They felt well supported by nursing and medical staff and had no concerns on the ward. They commented how there were good care plans and safety briefings.
- The registered nurse in the medical day case unit supported the discharge lounge nursing assistants should this be required. However, the day case unit was only open 9am-6pm, if the discharge lounge extended hours due to escalation then there would not be immediate support from a registered nurse available.
- Staff consistently commented how there was limited access to ward clerks which added additional administrative pressures to nursing and therapy staff, pulling them away from their clinical duties and patient care. This had been added to the directorate risk register in December 2016, however there was no work plan or business case for extra resources.
- There was not sufficient occupational therapy and physiotherapy staff to meet the needs of patients on the medical wards and the stroke unit. According to an internal report submitted in February 2017, the trust employed 0.21 WTE physiotherapists per five beds compared to 1.0 WTE physiotherapist per five beds as recommended by the British Society of Rehabilitation Medicine Standards of Rehabilitation Services 2009. For stroke physiotherapy, the trust employed 0.38 WTE physiotherapists per five beds compared to the recommended level of 0.81 WTE physiotherapists per five beds as stated in the Royal College of Physicians National Clinical Guideline for Stroke (2016). The skill mix of the physiotherapy team also differed to the national average with less band seven therapists and proportionately more band three therapy assistants. Similar staffing challenges were experienced by the occupational therapy teams. A business case for more physiotherapy and occupational therapy staffing had been submitted in 2015 but staffing concerns had not been resolved. The current therapy manager was in the process of compiling a subsequent business case for more staffing.
- Therapy staff on the stroke unit were rotational band five therapists, this meant there was not an experienced occupational therapist or physiotherapist at band six to guide less experienced therapists in specialist techniques required for management of stroke patients.
- Arrangements for nursing handovers and shift changes ensured people were safe. We observed four handovers,

two morning and two evening, across four different wards. The nurse in charge led the handover which began with a comprehensive safety briefing incorporating any risks of patients on the ward. A detailed handover sheet was used detailing patient information and risks. Following the safety briefing patients were handed over at the patient bedside.

Medical staffing

- Medical staffing was an area of risk for the trust and was a concern from management and staff. Medical cover was vulnerable, particularly in evenings and at weekends when medical cover was reduced and medical staff were required to cover medical wards and the emergency department. Staff felt safety was not compromised, however quality was compromised due to the staffing.
- The medical staffing skill mix, for 55 whole time equivalent medical staff in post, included 25% consultants, 6% middle career, 29% registrar and 40% foundation year one and two. The proportion of consultant staff reported to be working at the trust 25% was lower than the 37% England average, the proportion of registrars 29% was lower than the 37% England average and the proportion of foundation year one and two staff 40% was higher than the 20% England average. Therefore comparative to the England average there was a low number of consultants and a high number of juniors, therefore the staffing skill mix lacked senior posts and there were few senior posts to support the juniors.
- The trust reported consultant cover as approximately one consultant per ward per day. Consultants did not provide a seven day service, however were available on call out of hours (weekends, bank holidays and nights). The regularity of consultant review of patients varied between wards, some wards only received two complete ward rounds per week. Consultants would review acutely unwell or new patients daily.
- Patients on the medical assessment unit had daily consultant review, sometimes twice daily. Consultant presence was available between 9am and 5pm and they were on-call out of hours. The consultant completed post take rounds before 5pm and in mornings reviewed patients in the emergency department before reviewing patients in the medical assessment unit. Staff told us consultants responded in a timely manner if called out of hours.
- Monday to Friday medical cover for medical service included eight registrars, 10 foundation two and 10 foundation one between 9am and 5pm. Out of hours cover for medical services, at weekend and nights, was covered by a team of one registrar, one foundation two and one foundation one doctor. The foundation one doctor may also be required to cover surgical wards in the out of hours period. The registrar was also supporting the emergency department and reviewing GP expected patients and emergency patients to make the decision to admin to medicine. During our unannounced period the registrar and foundation doctor responded appropriately to a cardiac arrest in the emergency department, however exposed the medical wards if a patient should suddenly deteriorate.
- There was a high reliance on locum consultants. There were only four permanent consultants in post on the medical wards. Medical cover was regularly filled by locums or newly experienced staff. For example Uphill, Kewstoke and Draycott had no substantive consultant post.
- The use of medical locums in the emergency directorate between February 2016 and January 2017 averaged 8.35%.
- There were difficulties in attracting staff to medical roles within the trust. We were told there were recruitment campaigns and rotational contracts available.
- Junior doctors commented on the high workloads and pressures working within the trust. Support received was of variable degree and quality. Some junior doctors found this situation stressful and felt out of their depth whilst others strived in the environment and said it provided them with vast amounts of experience.
- Juniors felt registrars were unable to give them support on the medical wards during evening and weekends because the registrars were frequently called to the emergency department, this took time away from the medical wards.

Major incident awareness and training

- The trust had a policy for emergency preparedness recovery and response. Staff we spoke with were not aware of a policy or their role in the event of a major incident or emergency, therefore this was not practised.
- Staff told us they completed annual fire training and were aware of the evacuation procedures in the event of a fire, however there was not a regular fire practice.

Medical care (including older people's care)

- Orientation checklist for bank and agency staff included explanation of emergency procedures for example cardiac arrest bell and emergency bleep, and to explain fire procedures including exits, extinguishers and alarm break glass points.

Are medical care services effective?

Requires improvement

We rated effective as requires improvement because:

- When benchmarked, the trust were worse than the England average in several national audit programmes, for example the heart failure audit and national diabetes inpatient audit. Improvements to the sentinel stroke national audit programme were not sustained. We were not provided with assurance that audit findings were used effectively to improve quality and patient outcomes. Quality improvements when implemented were not always sustained.
- Junior doctors did not always feel well supported by senior medical staff.
- Staff support was variable, not all staff had received an appraisal in the last year and staff did not regularly receive clinical supervision.
- A dietician audit identified poor performance for the completion of the malnutrition universal screening tool (MUST) assessments within 24 hours of admission, where the MUST was not always completed accurately.

However:

- Care and treatment was planned in line with current evidence based guidance. Clinical care pathways and toolkits were developed in accordance with national guidelines.
- Patient consent to care and treatment was sought in line with legislation and guidance. Staff showed a clear understanding of the mental capacity act and deprivation of liberty safeguards.
- The multidisciplinary team effectively contributed to patient care and treatment in a co-ordinated approach.

Detailed findings

Evidence-based care and treatment

- The trust's policies, procedures, toolkits and pathways reflected best practice and evidence based guidelines. Staff told us they were able to access these on the trust's intranet. Toolkits used frequently were readily available on wards.
- A programme of local audits included cannula care, catheter care, hand hygiene, deteriorating patient, pressure area, falls, nutrition and cleaning. Individual wards monitored their performance and made changes where they saw low compliance. For example, Harptree ward had seen a decrease in pressure area compliance in February 2017 with 79.9% compliance, in response daily audits were being completed to ensure regular pressure area monitoring.
- Patients were not reviewed during a consultant delivered ward round at least once every 24 hours unless acutely unwell. Dependent on the ward arrangements patients were seen two times to five times per week. This was not in line with the Academy of Royal Colleges seven day consultant present care standards.
- The trust had guidance on quality standards for sepsis screening and management. Patients were regularly reviewed for sepsis and staff were aware of the escalation process. A sepsis screening tool and sepsis six pathway was used, this was a neighbouring trust's document copyright of the UK Sepsis Trust and adapted from National Institute for Health and Care Excellence (NICE) sepsis guidelines. Doctors could access sepsis guidelines using an app on their mobile phones.
- Within 72 hours of emergency admission patients over the age of 75, without a formal diagnosis of dementia, were screened using the national dementia Commissioning for Quality and Innovation (CQUIN) screening tool which included an abbreviated minimental (AMT) score assessment. If the AMT score was equal to or less than eight there was a clinical impression of suspected dementia, the GP would be asked to re-assess the patient's cognitive function. The AMT score was recorded on the discharge summary sent to the GP.
- Staff could refer patients to the diabetes team using the 'think glucose' referral form. The diabetes specialist nurse demonstrated how they followed NICE guidance, for example pre-operative and colonoscopy guidelines,

and patients meeting NICE criteria for insulin pumps. The diabetes specialist nurse told us they regularly attended the emergency department for admission avoidance.
- Posters and information relating to national safety standards for invasive procedures were displayed on wards to ensure staff understanding of current best practice.
- All medicine charts reviewed adhered to British national formulary and national guidelines.
- All patients were assessed for falls risk, with inpatients considered in line with NICE (2013) to be at high risk of falling if over 65 years and those between 50-64 years were judged by clinician higher risk due to underlying condition.
- Every week doctors in the stroke and care of the elderly specialisms met to discuss best practice for patients this included presentation of a case summary and relevant research. This meeting was not minuted so we were unable to see evidence of discussions.

Pain relief

- Patients had their pain assessed and managed in line with the core standards for pain management services in the UK (faculty of pain medicine, 2015). Patients told us they were frequently asked about their level of pain and medication was administered to control pain levels. Levels of patient pain and pain relief were discussed at nursing handovers.
- On review of patient records pain scores were recorded within the nursing NEWS chart for pain score at rest and on moving. We also saw evidence of pain documented in medical notes.
- A standardised pain assessment tool was used, with a scale from 0 to 10. The initial assessment enabled the nurse to talk to the patient to establish descriptions of pain. Following initial assessment a pain management plan was put in place.
- An abbey pain assessment was used for patients with communication difficulties. The abbey pain assessment tool reviews vocalisation, facial expression, changes in body language, behavioural changes, physiological changes and physical changes. Staff were also able to access picture boards to help assess pain.
- The safeguarding lead had identified that staff caring for patients living with dementia were not consistently assessing or treating these patients for pain. The safeguarding lead provided training regarding the use of a pictorial scale for pain assessment and the safe use of covert medicine administration. This had been used twice on Kewstoke following a best interest meeting involving patient families.
- A lead acute pain specialist nurse was available to support nursing staff and patients in pain management.

Nutrition and hydration

- Patients were screened for the risk of malnutrition using the standardised malnutrition universal screening tool (MUST) and management guidelines, these were based on British Association for Parenteral and Enteral nutrition, and modified for medical use. MUST online training was mandatory for all care staff. Nurses clearly explained the importance of monitoring and managing patients' nutrition and hydration and were familiar with the processes for doing this. Nurses were aware of complex risk factors affecting patients' nutrition and hydration and were confident to refer to the trust's dietitians.
- Twice daily nursing safety briefings and handovers referred to patient nutrition and hydration. For example one patient's urine output was being closely monitored to establish the levels of hydration.
- We reviewed 16 patient records and found MUST was used consistently and recorded correctly. There were omissions of patient's previous weight in some charts. Patients were risk assessed, for example one patient was a medium risk and therefore needed to be encouraged good nutrition and monitored, a food chart was in place for this patient. For patients on food charts, trays were collected at the end of meal times to record what and how much the patient had eaten.
- To monitor hydration 24 hour fluid input and output charts were completed. These were complete within patient records and used to inform further risk assessments.
- Special diets were available for patients to ensure they received appropriate nutrition. For example texture modified menus, gluten free and energy dense meals.
- Following a stroke, patients often have difficulty eating and drinking independently, and some patients require specific texture of food for safe swallowing. On the stroke unit, volunteers were available during meal times to assist patients to eat and they were familiar with the red tray system which identified patients who required assistance. However, on the day we visited the stroke unit, staff and volunteers were struggling to identify

which meals belonged to which patients, because patients had moved bays prior to the mealtime. We were told meal times were frequently chaotic on this ward. This meant there was a risk patients might not receive the correct texture of food, or the correct level of assistance during their mealtime.

- Dieticians told us to improve nutrition and hydration of patients they offered staff safe feeding training and managing behaviour whilst eating. They were also looking to introduce finger food, with a focus on Kewstoke and Uphill ward.
- The dietitians produced an audit of MUST which was delivered to the nutrition steering group. Dieticians told us this group was poorly attended and they felt MUST was not being taken seriously. For example they said staff made limited effort to find out a patient's previous weight, so there was rarely an identification of weight loss when a patient was admitted. Also Dietitian advice was not always taken, such as use of high-energy drinks not being used when recommended. We reviewed the November 2016 audit, poor performance was identified on medical wards for MUST being completed within 24 hours of admission, varying on medical wards between 26% on stroke unit and 65% on Berrow ward. The MUST was not always completed accurately varying from 5% on Kewstoke ward to 42% on Berrow ward, this was due to the continued absence of a record of patient weight three to six months ago resulting in an inaccurate MUST score.
- Nursing staff told us they were provided with guidance from the dietician on how to feed, flush and check the pH for nasogastric tubes. There was a trust policy to follow for the management of nasogastric tubes.
- Speech and language therapy completed patient swallow assessments to ensure safe oral intake. At weekends there were no therapy staff to complete these assessments, however all registered nurses in the stoke unit were trained to do swallow screen. Out of hours and at weekends these nurses were able to support other medical wards where required.
- In the discharge lounge we observed water was not readily available for patients, and patients were required to request a drink.

Patient outcomes

- We were not provided with assurance that audits were effectively reviewed, shared with the wider team or action taken to make improvements. There were instances where quality improvements had been made and evidenced, however this was not sustained and therefore a decrease in performance followed. For example the sentinel stroke national audit programme scores and local work on pressure ulcers.
- The trust followed a clinical audit programme for 2016/17, this included national audits of which eight were participated in by the emergency directorate and three were trust wide. Clinical staff also completed audits and quality improvement projects which were not included in the clinical audit programme.
- The relative risk of admission was reviewed between September 2015 and August 2016, this showed patients had a lower than expected risk of re-admission for both non-elective admissions (combined general medicine, stroke medicine and geriatric medicine) and elective admissions (combined clinical haematology, clinical oncology and general medicine).
- Weston General Hospital took part in the quarterly Sentinel Stroke National Audit Programme (SSNAP). On a scale of A to E, where A is best, the hospital achieved grade B in the most recent SSNAP dated April 2016 and June 2016. This showed an overall improvement in performance over the most recent year. However, during our inspection we spoke with the stroke lead and they reported variable performance in the SSNAP audit. Most recent data indicated the trust was now rated 'D' overall. The trust scored 'E' for patients being directly admitted to the stroke unit. Trust policy was to admit every patient under the stroke team to the stroke unit within four hours of presentation to the emergency department. In times of extreme pressure this was not always possible to achieve and patients went to the medical assessment unit when they were admitted to hospital. The trust was committed to ensuring that, where possible, a stroke admission 'hot bed' was available for use. However, staff told us the pressure to use all available beds during periods of escalation meant the admission 'hot bed' was not always held.
- In September 2016 the trust achieved the stroke target of 80% of patients diagnosed with a stroke spending 90% of their time on the stroke unit.
- During the three months preceding our inspection, the length of time stroke patients spent on another ward prior to be admitted to the stroke unit varied. The sentinel stroke national audit programme sets out the standard for patients to go to a stroke unit as their first ward within four hours of arrival to hospital. In

November 2016, 15% of patients spent more than one day on another ward, 31% spent one day on another ward, and 54% were transferred to the stroke unit on the same day of their admission. In December 2016 these figures were more favourable with 80% of patients admitted to the stroke unit on the same day as their admission to the hospital. However, in January 2017 the length of time stroke patients spent on another ward prior to their transfer to the stroke unit had increased. Data showed 15% of patients spent more than one day on another ward, 31% of patients spent one day on another ward and 54% of patients were admitted to the stroke unit on the same day as their admission. The longest time spent by a stroke patient on another ward prior to admission to the stroke unit was six days.

- The median time from clock start to thrombolysis between October 2015 and October 2016 remained in target with the exception of two months. Thrombolysis is a process of providing a timely clot busting drug to treat stroke caused by blood clots.
- The heart failure audit for 2015 showed the trust was worse than the England and Wales average for three of the four standards relating to in-hospital care and four of the seven standards relating to discharge. Input from a consultant cardiologist and from a specialist was at 25.0% of cases compared to 60.0% and 78.0%, respectively, for the England and Wales average.
- The 2015 National Diabetes Inpatient Audit (NaDIA) scored better than the England average in five metrics and worse than the England average in 12 metrics. Following poor NaDIA results the diabetes team rolled out a ward based diabetes programme aimed at registered nurses to cover the management of hyperglycaemia, hypoglycaemia and diabetes protocol. Change were made to medication charts to decrease prescribing errors with the word UNITS printed on medication administration record, new foot risk assessment tool was developed and introduced in March 2017 and teaching by tissue viability nurse podiatrist. Shared learning was included into the medicines management group which was attended monthly by district nurses.
- The trust participated in the 2013/14 Myocardial Ischaemia National Audit Programme (MINAP). The trust scored worse than the England average for two of the three metrics. However, data showed for one metric, although worse, 92% of patients were seen by a cardiologist or a member of team, this was just below the 94.3% England average. The MINAP scores were worse than the England average where 0% of patients were admitted to a cardiac unit or ward compared to 55.6% England average, this was due to there not being a cardiac unit within the hospital. The trust were better than the England average in the remaining one metric for patients referred for or had angiography.
- The lung cancer audit 2015 showed the proportion of patients seen by a cancer specialist nurse was 66.3%, which was worse than the audit minimum standard of 80.0%. For the remaining three metrics data showed the trust was better than or not significantly different from the national level.
- Six of the eight national cancer targets were achieved in August 2016. During August 2016 the trust treated 30.5 patients, of those 7.5 breached the 62 day target. However, the November 2016 emergency directorate performance assurance framework data was status 'red' for the metric NHS cancer plan 62 day standard.
- The endoscopy department was Joint Advisory Group (JAG) accredited, however this had been deferred as the recovery room was not big enough. New refurbishment was due to be started in June 2017 and completed by the end of November 2017. This will allow the recovery room to double in size and ensure clear separation of male and female patients.
- Endoscopy staff were involved in a JAG audit on patient comfort. The audit identified a high score for one doctor's patient comfort, therefore this doctor was encouraged to ensure patient comfort in subsequent practice.
- All asthmatic and chronic obstructive pulmonary disorder exacerbations should be followed up within 72 hours, as a British thoracic society recommendation. The respiratory nurse said this was not being achieved. However, there was no admin time available to monitor this patient outcome and therefore there was no evidence this was or was not being achieved.
- Respiratory discharge bundles, innovations to improve patient outcomes, were in place. These were used effectively to ensure patients were well informed about their medications and their appropriate use, to help improve their outcomes once patients left the hospital and reduce the likelihood of readmission. For example ensuring patients can use their inhalers, how to use their action plan, oxygen alert card and emergency drug pack, offering referral for smoking cessation and referral

to pulmonary rehabilitation. Patients received a follow up call within 72 hours of discharge to ensure they were managing their respiratory needs since discharge and identify any further support required.

- The Summary Hospital-level Mortality Indicator (SHMI) quarterly statistics published in December 2016 for the periods of July 2015 to June 2016 showed that the hospital was one of 11 hospitals that had a higher than expected number of deaths. The data for the periods of October 2015 to September 2016 were still higher than expected. The hospital identified seven quality improvement projects, and produced a mortality action plan.
- Therapists told us patients on the stroke unit were given rehabilitation programmes to sit out of bed in a chair for set times during the day. However, we looked in three sets of patient records and found the plan for sitting out was not clearly stated either in the patient's notes or at bedside. Records showed patients were not sat out consistently and sometimes went several days without being assisted out of bed.
- Physiotherapists used outcome measures to record individual patient progress. However these outcomes were not used collectively to benchmark the outcomes of the service as a whole.

Competent staff

- The trust ensured that nursing staff had the correct skills, knowledge and experience. Following a one week corporate induction, new staff completed competency work books and were supernumerary until observed and signed off as competent in clinical areas. The clinical specialist nurses also provided input and education at induction.
- Junior doctors did not feel well supported due to time and availability of medical staff. They felt at times they were performing outside of their level of competence, particularly when covering a large number of wards at evenings and weekends, this has a potential risk to impact on the safety of patients.
- Staff were not regularly supported in terms of annual appraisals. The emergency directorate in January 2017 was 74.6% compliant which was below the 90% trust target. Therefore there was not regular assessment of staff through a performance appraisal to ensure continued competency.
- Staff participation in one to one supervision was variable. Ward sisters told us they participated in monthly one to one supervision with matrons. However, other nursing staff did not participate in regular one to one supervision. The therapy manager told us all therapists participated in regular supervision, this took many forms and was not limited to one to one basis.
- Staff felt there were opportunities for training, to include external training, available for their continued professional development. Registered nurses told us they were supported with their revalidation process.
- Clinical nurse specialists felt they did not have time to provide the teaching and education to increase competency of staff, despite being passionate to do this. However, they provided support to nursing staff as required to help improve nursing skills in the specialist area. The respiratory specialist nurse provided monthly training to nursing assistants.
- Nursing staff on Berrow ward were in the process of completing non-invasive ventilation training as this patient group was regularly on the ward, the ward was 88% compliant in January 2017 and remaining staff were booked in for training.
- Since partnership with the mental health for older people's liaison nurse, skills of staff had increased, particularly with communication with confused patients and managing behaviour that challenges. On Kewstoke ward (care of the elderly) they were introducing weekly one hour dementia education sessions for nursing staff.
- A falls awareness day had been diarised for May 2017, to increase staff awareness and knowledge of falls.
- On the stroke unit, the nursing sister was new to post and had introduced a 'hot topic of the month' notice board and was planning to introduce a programme of learning sessions for the multidisciplinary team. Nursing staff on the stroke unit completed online stroke competencies training. A doctor on the stroke unit told us there were excellent opportunities for learning on this ward.
- The therapy manager told us staff were able to access external courses when they requested to do so. All external training requests for therapists had been accepted during the twelve months prior to our inspection.
- A nursing student told us they had received excellent support during their first placement on an acute medical ward. This student explained how they had been given lots of opportunities to learn skills and interact with the team and with patients. We observed

teaching to a second student nurse. The nurse providing the teaching took their time to ensure the student understood and explained why they were doing what they were doing.

- Skills and knowledge of nursing assistants in the discharge lounge were more aligned to admin rather than to care. The nursing assistant had never worked in direct care and did not have skills to carry out simple care such as emptying a urinary bag. They would contact the registered nurses in the medical day care unit should direct care be required.
- Orientation checklists were completed for registered bank and agency nursing staff. This included orientation around nursing documentation and medical records, how to find policies and procedures, competence of equipment and information of processes and emergency contacts. A check of registration details was completed for registered nurses.
- On wards staffing was arranged to buddy up agency staff with permanent staff. This was not always possible on Cheddar ward (winter management) where there was a high number of agency staff and therefore there was a risk surrounding the competency of staff, in particular their knowledge of patients with continuity of care and understanding of hospital and ward procedures.

Multidisciplinary working

- Staff and teams worked well together on wards to deliver effective care and treatment. The necessary staff were involved to assess, plan and deliver care.
- Junior doctors, senior nurses and therapy staff regularly attended board rounds to ensure they were multidisciplinary for care to be coordinated. However, consultants rarely attended board rounds, impacting on the medical senior leadership input in to the management of patients.
- The medical assessment unit had daily multidisciplinary team meetings, which included consultant, doctor, nurse in charge, senior sister, social workers and therapy staff. These meetings were used to discuss all patients on the ward and check social situation to pre-empt arrangement of packages of care.
- On the rehabilitation ward, some of the multidisciplinary team attended a meeting twice daily to discuss the progress of patients on the ward. We observed this meeting, occupational therapists, the ward co-ordinator, and the nursing sister attended. We saw that patient needs for discharge were discussed in depth and updates were provided regarding patient rehabilitation plans. Any concerns raised by patients' relatives were communicated to those staff present.
- Nurses, specialist nurse, therapists, registrar, community nursing and social workers held weekly multidisciplinary meetings on wards, this was effective to make decisions regarding individual patient treatment and care.
- Nurses felt they had an effective working relationship with medical staff, and were able to contact doctors for support both in an out of hours as required.
- Staff were confident in the critical care outreach team, who would respond immediately to deteriorating patients, for example if a patient with sepsis required immediate review.
- Specialist nurses provided support and training to nursing staff on the wards. They also linked positively with GPs.
- Staff were positive about their working relationship with pharmacy staff. They told us the pharmacy worked well with the nursing and medical team and could always be contacted and provided support.
- One consultant commented how endoscopy was very helpful and flexible.
- One doctor told us nurse to nurse handovers were well structured and informative, however doctor to doctor handovers were poor as there was no process in place to ensure the handover was effective.
- The cancer services told us they worked hard with radiology to try and prevent cancer breaches. They also said oncology links with neighbouring trusts was strong, allowing cross site working.
- There were established links to mental health, learning disability and dementia support. The mental health liaison nurse worked clinically one day a week on Kewstoke ward (care of the elderly), they were also available to support other wards.
- One junior doctor told us they had links with local trusts and could contact them for specialist advice, this was particularly used out of hours.
- It was reported how pharmacy staffing levels were also low, impacting on the ability to provide pharmacy support across all the medical wards.
- Volunteers supported nursing staffing, providing companionship for patients and helping with meal times.

- Clinical specialist nurses were part of the permanent workforce, however they had high workloads so were not always able to be as effective as they would like in their role. They said it was difficult to see patients regularly and therefore patient continuity was not always achieved.
- On the rehabilitation ward, we saw care plans were focussed on the specific needs of each patient. For example, a diabetic patient with memory difficulties was encouraged to manage their long term condition using memory aids. Staff on the ward were liaising with the community teams and the specialist diabetic nurse in the community to support the patient administer and manage their insulin post discharge.

Seven-day services

- Whilst care was provided seven days a week, ward rounds by medical staff did not take place at weekends. There was no consultant presence out of hours (evenings and weekends), however consultants provided on-call cover. Consultants reviewed new or unwell patients daily, other patients would be seen at least twice a week but not at weekends.
- The critical care outreach team were available 24 hours a day seven days per week. Staff reported the team to respond in a timely manner in the event of a medical emergency.
- Endoscopy provided a service Monday to Friday, with adhoc Saturday lists. There was an on-call endoscopy nurse covering 6pm to 8am and at weekends, emergencies were performed within theatres.
- The discharge team did not work weekends. We were told the trust were looking to implement discharge team cover at the weekends. Although new care packages would not be put in place at weekends to increase discharges, it will allow pre-planning and liaison with families to improve early discharges in the upcoming week.
- Clinical pharmacist visits took place Monday to Friday, and a pharmacist was available Saturday mornings. An on-call pharmacist was available out of hours. Registered nurses had access to an emergency medicine cupboard if a patient's requirement for medication could not wait for a pharmacist to be available.
- If a patient was suspected of having had a stroke, they were taken straight to the computerised tomography (CT) scanner by the ambulance personnel and met there by the stroke registrar and the specialist stroke nurse. The stroke specialist nurse then stayed with the patient during thrombolysis until skilled nurses were available on the stroke unit. This service was available Monday to Friday during normal working hours only. Out of hours and weekends if a patient was suspected of having a stroke, they were required to travel to neighbouring trusts where local arrangements had been made to ensure 24 hours a day seven days a week thrombolysis services.
- For emergency respiratory physiotherapy there was an on-call service available 24 hours a day, seven days a week.
- There was a weekend physiotherapy service available contracted for seven and a quarter hours on both Saturday and Sunday. The purpose of this service was to facilitate discharges from hospital. There was no weekend service for other therapies such as occupational therapy, speech and language therapy or dietetics. The SSNAP recommends nationally for seven day working to be available for at least two types of qualified therapy, including occupational therapy, physiotherapy and speech and language therapy.
- Diagnostics and Imaging services were available 24 hours a day seven days a week.
- For patients with mental health needs, the crisis team was available during weekends.
- The medical day case unit was open Monday to Friday from 9am to 5pm. The ambulatory emergency care unit was open 9am to 7pm Monday to Friday and 10am to 5pm over the weekends. They were available to admit patients from the emergency department, GP referral and ambulance services.

Access to information

- Staff had access to records, results and patient information to deliver effective care and treatment. Staff said information was exchanged in a timely manner. For example, when patients were admitted to the ward from the medical assessment unit a patient situation, background, assessment recommendations (SBAR) was completed and sent to the ward. The SBAR is a communication tool designed to support staff to share clear, concise and focussed information. The patient was also handed over verbally between nursing staff.
- Staff told us they could access test results quickly, for example immediately following procedures in the endoscopy department, a printed report was sent back to the ward with the patient.

Medical care (including older people's care)

- Discharge was communicated to GPs immediately following discharge via an electronic discharge summary. The discharge summary was also printed out and sent home with the patient, as well as a copy held on the patient record. GPs were able to contact the hospital via the bleep number should they have any concerns or queries, this diverted to the ambulatory emergency care doctor. The discharge summary contained details such as changes to medication or the requirement for ongoing investigations. This meant the community primary care services were aware of patients care needs when they were discharged from the hospital.
- Wards told us they phoned an external organisation to inform them of patient care and treatment needs following discharge, this information was relayed by the external organisation to community nurses who would be caring for the patient. The community nurses were able to contact the ward to confirm information.
- The wards would liaise with community mental health providers when patients with a diagnosis are discharged from hospital.
- We observed GPs phoning the respiratory specialist nurse directly to discuss discharged patients. The respiratory specialist nurse provided advice and information to the GP.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patient's consent to care and treatment was sought in line with legislation and guidance. Staff had a clear understanding of patient consent, the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS).
- The trust had in place a mental capacity act policy and adult restraint/restrictive holding policy. Staff said policies online were easy to follow. Mental capacity act training was mandatory for all staff.
- We observed staff asking patients for verbal consent before providing care and treatment.
- When reviewing patient care records there was always clear recording of consent by therapy staff, this was well embedded within this staff group. We also saw examples where patient refusal was clearly recorded, within MUST assessments and prescription charts.
- Staff regularly completed Deprivation of Liberty Safeguards (DoLS) on Kewstoke ward (care of the elderly) and there were seven in place at the time of our inspection. Staff were confident in their completion and felt they had adequate support. Staff reported very good support from mental health liaison team when patients were under DoLS.
- Nursing staff were able to undertake mental capacity assessments and could seek support from team members and doctors.
- The safeguarding lead informed us that nurses could access independent mental capacity advocates (IMCA) when required for patients with mental capacity concerns. However, they were not assured IMCAs were requested for all patients who would require an IMCA when a patient had a deprivation of liberty safeguards in place. On Kewstoke ward (care of the elderly) nurses referred patients to an external deprivation of liberty safeguards team who were responsible for arranging advocates for patients where applicable.
- We observed a multidisciplinary ward meeting and witnessed the team taking account of the results of a best interest meeting for a patient with cognitive impairment. This meant the rehabilitation plan was person centred and focussed on the direction decided by the patient and their family.
- We reviewed five do not attempt resuscitation records, these included reasons for not communicating with the patient, and relative discussions were documented in notes with corresponding dates.
- A consent audit was completed in endoscopy. The report for 2016 looked at two consent forms, one for patients unable to consent themselves and one for patients who have capacity to consent for themselves. The department identified areas for improvement to include ensuring the form was fully completed, recording the grade of clinician and providing a copy of the consent form to the patient.

Are medical care services caring?

Good

We rated caring as good because:

- Patients spoken with were consistently positive about the care and treatment they had received when on medical wards or units.
- We observed compassionate and kind care being provided to patients by staff.

- Privacy and dignity was always maintained and respected.
- Staff were responsive to patient communication needs and different methods were used to ensure the understanding of patients.
- Difficult and challenging behaviours were sensitively managed and staff were non-judgemental towards patients who have mental health, learning disability or are living with dementia.

However:

- Feedback from the trust's exit questionnaire identified a number of dissatisfied patients surrounding the communication they received from staff.
- During nurse to nurse handovers patients were not always acknowledged.
- Access to support services, psychological input and counselling was not readily available internally, however there were examples of patients being helped to access these services through external referral.

Detailed findings

Compassionate care

- Patients were treated with dignity, kindness and compassion. We observed staff interact with patients in a friendly and respectful manner. However, our observations found staff were particularly busy, this compromised the quality of care staff were able to provide. There was limited time to interact regularly on a one to one basis with patients.
- We saw therapy staff talking to patient with sensitivity, kindness and humour. We witnessed porters caring for patients when transferring patients. One porter checked a patient was warm enough and a second porter communicated with a patient in a friendly and engaging manner. Medical staff were observed introducing themselves and interacting with both the patient and their family or carers.
- A number of patients commented how they were aware wards were short staffed and staff had high workloads. This sometimes deterred patients from asking for help.
- We spoke with 24 patients who were all complimentary about the care they had received within medical wards and units. Comments included:
  - "The staff treated me with dignity and respect. They were very caring and made me feel completely at ease." Endoscopy unit.
  - "Excellent and didn't have to wait for anything" Berrow ward.
  - "We are all very comfortable with the level of care" Uphill ward.
  - "The staff are lovely, they couldn't be any nicer" Stroke unit.
  - "Very good. They look after me very well and always listen to me" Oncology and haematology day unit.
  - "Very happy with the care, I have no complaints" Kewstoke ward.
  - "Doctor very good and put me at ease." Ambulatory Emergency Care Unit.
- The NHS friends and family test was used to understand whether patients were happy with the service provided by asking if they would recommend the service to their friends and family. There was a 36% response rate between December 2015 and November 2016, which was better than the England average of 25%. The results for three months positively showed patients would recommend their friends and family; November 2016 98%, October 2016 93% and September 2016 96%.
- Inpatients were asked to complete an 'exit questionnaire' rating their experience of care between one (being the worst) to five (being the best experience). We reviewed the July to September 2016 quarterly exit card results report, this showed a number of positive comments about the care provided by staff. However, a number of patients commented on how dissatisfied they were with the communication from staff including doctors and receptionists and the waits and delays they experienced.
- An annual endoscopy patient satisfaction was completed. We reviewed the 2016 results where responses were overall very positive. There was a 51% response rate from 200 questionnaires. 96% of patients said the courtesy of the nurse who prepared them for the test was good and 92% felt the amount of information given to them by the nurse was good. For 95% of patients they were given enough privacy and 96% felt there privacy and dignity was respected whilst on the unit.
- Oncology and haematology day unit patient satisfaction survey was completed in April 2016 with a 65% response rate from 200 questionnaires. Overall results were very positive. When asked if you were involved as much as you wanted to be in decisions about your care and treatment 94 72% said yes definitely and 22% said yes to

some extent. All patients who provided an answer were happy with the care provided by the nursing staff. For 98% of patients they felt they were treated with respect and dignity.

- Staff maintained and respected patient privacy and dignity. Staff pulled curtains when treating patients and 'stop personal care in progress' signage was used consistently across wards and units. However, on Harptree ward there was no toilet or bathroom facilities in one of the bays, this meant patients had to leave the bay to use the facilities, compromising their privacy and dignity. We spoke to a nurse in charge who explained how this bay had previously been for high care patients and therefore facilities had not been required, a business case had been accepted to incorporate toilet and bathroom facilities within this bay.
- Staff were observed to respond to call bells in a timely manner. On the whole patients spoken with were happy with the response times from staff when using their call bells. However, one patient negatively commented on the response to call bells. They said "You have to pick your time to use it as staff won't come as they are too busy".
- Nursing staff were seen to sensitively manage difficult behaviours, and had non-judgemental attitudes to patients with dementia. They were attentive to patient needs, had a permanent smile on their faces and communicated clearly with patients.
- Patients who were mobile but not consistently able to recognise risks to their safety were well supported. Staff recognised patient confusion and with a gentle manner kindly assisted them back to their bed space, ensuring they were comfortable and settled.
- There was a calm and serene atmosphere on the oncology and haematology day care unit, this ensured comfort for patients while undergoing treatment.
- On the emergency ambulatory care unit, all members of the team described the importance of providing person centred compassionate care. Staff were passionate about the patient experience being a positive one.
- During handover, nurses shared information such as a patients preference for hot chocolate, and a patients preference to have medication crushed into a drink. These details meant nurses were able to give person centred care.
- Staff spoken with said they and their colleagues provided care to patients which was respectful and considerate. They had not observed disrespectful, discriminatory or abusive behaviours or attitudes, but would be confident in raising their concerns if this was identified.

Understanding and involvement of patients and those close to them

- Staff communicated with people in a way which ensured they understood their care and treatment, and patients told us they were involved in decisions made about their care.
- Interactions with patients during nurse to nurse handovers were variable. Nurses did not always acknowledge patients or engage them in the process, despite patients being awake. However, we also observed handovers where nurses introduced themselves and explained they were completing a handover.
- Staff could evidence how they would communicate with patients with communication needs on the account of mental health issues. Nursing staff displayed a sensitive approach when talking to patients with dementia diagnoses, communicating in a way the patient could understand.
- Barriers with communication were overcome to ensure patients understood their care and treatment, for example language interpreters were requested for patients who were unable to communicate in English.
- Visiting times were flexible to encourage relatives, friends and carers to visit the wards. This allowed support to be provided to patients by their loved ones and enabled friends and family to be involved in the care and treatment.
- The oncology and haematology unit invited patients to visit prior to their first treatment. This was completed in a small group and enabled patients to be shown around the unit. The chemotherapy programme was shown to patients through slide presentations. During treatment patients were able to bring one friend or relative with them to provide support. Patients were able to call in to the unit if they had any worries and were given an out of hours emergency number.
- 'This is me' is a document which gives details of patients likes and dislikes to help staff to provide personalised care whilst on the ward. Ward staff used this document consistently on Kewstoke ward and sometimes on the stroke unit.

Medical care (including older people's care)

Emotional support

- Staff spoken with understood the impact a person's care, treatment or condition will have on their wellbeing and on those close to them, both emotionally and socially. Staff spoken with were not always clear about the services available to provide counselling, psychology input or further support to patients, these were not always available internally. Counselling was not readily available to patients. When asking staff about the availability of counselling the consistent message was how a patient would be referred to the chaplain, however this is not specific to the patient's counselling needs.
- Clinical nurse specialists had expertise in areas, for example respiratory and diabetes. Clinical nurse specialists were seen on wards and there was evidence in records of their review with patients. Due to their knowledge of the specialities, they were competent in providing appropriate emotional support to patients and could sign post patients to external support services to be used following discharge.
- There was no psychology input for patients who had been diagnosed with a stroke or patients undergoing chemotherapy, however services could be accessed at a local trust. When patients were notified of life changing prognoses such as cancer, the nurses referred the patient to the specialist nurse for the specialty.
- Stroke patients were referred to external stroke network support groups for emotional support post discharge.
- Staff handovers routinely referred to the psychological and emotional needs of patients. Staff told us patients who were suspected or experiencing depression were referred to the mental health liaison team.
- Staff referred patients with severe mental health concerns to the mental health liaison team based at the hospital. For patients with anxiety and depression, nurses referred patients to the ward doctor.
- A chaplain on site could provide religious, spiritual and general support to patients. Staff told us they referred patients to the hospital chaplain. The chaplains assistant was regularly on the ward available to offer emotional support to patients.
- If patients required additional support, for example a substance support service, they were signposted to available external services.
- We witnessed an occupational therapist recommending to a patient a befriending service and explaining how this could provide friendly conversation and companionship.
- The hospital used volunteers, volunteers were a valuable resource to provide companionship and support to patients on the wards.

Are medical care services responsive?

Inadequate

We rated responsive as requires improvement because:

- There was ineffective patient flow across the hospital. This impacted on the ability to move patients effectively through the hospital.
- Departments were underutilised and pathways were not followed regularly to actively support and aid patient flow through the hospital. This included underutilisation of both the discharge lounge and ambulatory emergency care unit.
- The medical assessment unit was not able to be used effectively to discharge or move patients on quickly through the hospital due to the limited availability of beds on medical wards. During our inspection we saw patients length of stay which had exceeded 48 hours.
- Patients were not being regularly discharged before 12.30pm and therefore bed availability early on in the day was limited to move other patients through the hospital.
- The hospital performed worse than the England average for length of stay in particular for general medicine the average length of stay for the trust was 10.1 days compared to the England average 3.6 days.
- There were regularly a high number of medical outliers which meant patients were not receiving care on the right ward, however medical staff were appropriately reviewing these patients.
- The stroke unit was not planned to meet the needs of stroke patients. The environment was not conducive to rehabilitation, compromising the quality of care and treatment that could be provided to patients.

However:

- The management of meals and support provided to patients during a meal time on Kewstoke ward (care of the elderly) was responsive, where patient individual needs were central.
- Staff were responsive to meeting people's needs, they were able to accommodate patient's mental health, complexities and impairments.
- Referral to treatment times for admitted pathways for medical services were better than the England average.
- The medical service could evidence how they responded to complaints and how learning was identified and improvements made.

Detailed findings

Service planning and delivery to meet the needs of local people

- The needs of the local population were being considered to plan service and delivery, however there were instances where people's needs were not being met. For example the environment of the stroke unit was not conducive to rehabilitation. The ward was noisy and cluttered. There was limited space and privacy at the bedside which did not provide an optimal environment for patients or for rehabilitation. There was a small therapy gym on the ward that at the time of our inspection was being shared amongst other wards.
- Support and advice was available, as well as guidance about dementia services at the hospital and in the community. An increasing population of people living with dementia was recognised and medical care demonstrated some improvements to their service. We saw a dementia café on Kewstoke ward (care of the elderly) which was well equipped and used for positive engagement. This provided a quiet haven and brought calm and comfort to patients with dementia. The 'Dementia Support Group' met fortnightly at the dementia café, this was an open forum for people to discuss issues around dementia.
- The environment on Kewstoke ward (care of the elderly) used inconsistent dementia friendly signage and there was no colour differentiation.
- The environment of the rehabilitation ward was conducive to rehabilitation, with access to parallel bars, a rehabilitation assessment kitchen and a small patient day room with games and activities available.
- The oncology and haematology department was expecting increased capacity because local trusts were at maximum capacity and the population was expanding. The chair space and expansion potential was being scoped to confirm the numbers of additional patients the department can accommodate so they could meet the needs of the local population.
- Ambulatory emergency care unit was open 9am to 7pm Monday to Friday and 10am to 5pm over the weekends. This unit accepted clinically stable patients from the emergency department, ambulances or GP referral. However, we were unable to establish the pathways designed were appropriately in place between the emergency department and ambulatory emergency care unit
- Emergency nurse practitioners from the emergency department 'borrowed' treatment areas in the ambulatory emergency care unit when the emergency department was very full. These were usually non-medical patients who were ambulant and medically stable, for example patients with minor fractures. These members of staff tried where possible to work in pairs in order to avoid lone working when the staff in the ambulatory care unit had finished for the day. Chaperones for these patients were not always available.
- We found there was poor signage to the discharge lounge which made it difficult to find. There were also limited facilities in the discharge lounge if patients needed personal care, for example changing of incontinence aids. The discharge lounge included four adjustable chairs and the remaining chairs were ordinary dining chairs, there were no bed available should a patient need to lay down. Staff told us the discharge lounge was not used for patients living with dementia so patients were not disorientated, these patients would be discharged directly from the ward.

Access and flow

- There was an absence of patient flow within the medical care service, which consequently impacted on the emergency department. There was not a consistent message about flow within medicine with no clear vision and strategy, the outcome was a high number of patients waiting to be discharged. Discharging patients posed a challenge to the trust.
- The trust were frequently in operational pressure escalation levels (OPEL) of three or four. Between October 2016 and January 2017. Monday to Friday, there were 22.8 declarations.

Medical care (including older people's care)

- The medical assessment unit was not being used effectively. An effective medical assessment unit will be used for further tests, stabilisation and assessment before patients are discharged or transferred to the relevant ward. All patients came from the emergency department, however the medical assessment unit was regularly at full capacity which limited their ability to take patients from the department. On a medical assessment unit a patients length of stay should be limited to less than 48 hours. The hospital's medical assessment unit was typically an inpatient ward and patient stay was in some cases exceeding 48 hours. The data for the medical assessment unit reported an average length of stay of 2.1 days between March 2016 and February 2017. However, during the announced inspection we identified one patient who had been on the ward for 11 days, one patient had been on the ward for five days and another patient for four days. During our unannounced inspection the longest length of stay was a patient who had been on the ward for four days, we were told this patient required a side room for infection prevention and control reasons and a side room was not available on the ward. Seven patients had been on MAU for two days. The remaining 17 had been admitted to the ward the day prior or the day of our unannounced inspection.
- We were also told there was at times a back flow of patients from wards back to the medical assessment unit compromising the ability to move patients from the emergency department to the medical assessment unit in a timely manner.
- There were regularly a high number of outliers within medical care, a clinical decision was made on the suitability of outlying patients. Data for outliers showed between September and December 2016 there were 1,032 outliers in surgical directorate beds. At the time of our inspection there were a low number of medical outliers, however two surgical wards were shut due to an outbreak of contagious infection. We visited three outliers and confirmed they were reviewed daily by medical staff. Outliers would be visited following ward rounds, however if there was a potential discharge it would be requested for the outlier to be visited by medical staff before the ward round.
- The average length of stay for medical elective patients (for example planned admissions on the rehabilitation ward) between October 2015 and September 2016 was 6.3 days, this is higher than the England average of 4.1 days. For non-elective patients the average length of stay was 6.3 days, which was lower than the England average of 6.7 days. In particular for general medicine the average length of stay for the trust was 10.1 days compared to the England average 3.6 days. The trust reported February 2017 data where average length of stay was 3.3 days for finished consultant episode and 5.2 days for patient episodes under the care of one consultant.
- Escalation beds across the hospital were regularly filled during our inspection. Previously the trust used Cheddar ward as an escalation ward, however due to pressures for beds this ward was open permanently. The trust had an escalation policy which sets out the processes to follow when the hospital experiences pressure on acute beds and has difficulty admitting emergency and/or elective patients.
- During the unannounced inspection at 8.30pm the medical assessment unit had four beds free but these were already allocated for patients being transferred from the emergency department. We were told staff would try and move patients before 10pm to free up bed space in the medical assessment unit for emergency department admissions overnight. However, there was unlikely to be much movement due to the almost full capacity of the hospital.
- On 1 April 2017, during our inspection the hospital had made in total one discharge before 8.30am, two discharges at 12.30am and 19 discharges at 4.30pm. This indicated patients were not regularly discharged before 12.30pm and therefore there was not the early identification of available bed space on inpatient wards.
- There was not a clear oversight or monitoring of the number of patient bed moves so it was not possible for the trust to ascertain if patients were moved too frequently or at night. Staff told us bed moves at night were rare, and in particular patients living with dementia were not moved. The trust were able to collate data for the number of patients moving wards per admission between December 2015 and November 2016. Of the total admission 47% did not move wards, 27% moved once, 14% moved twice, 7% moved three times and 4% moved four times.
- There were difficulties in discharging patients. Staff reported delays were caused by transport, pharmacy

and awaiting social care assessments, packages and placements. During our inspection 14 out of 24 patients on Kewstoke ward (care of the elderly) were medically fit for discharge and awaiting packages or placement.

- On the whole we saw expected dates of discharges for patients were planned on admission to the ward, any change to the expected date and rationale was included within medical notes. We observed nursing handovers to discuss queries with discharges and reasons for delays.
- The trust monitored their 'green to go' patients, which was the total number of patients who were ready for discharge who had yet to be discharged, the goal was for 30 patients daily to remain in the hospital. Reviewing weekly data for a six month period between August 2016 and January 2017 the trust were consistently above the 30 'green to go' target, data ranged between 28 and 65 patients, with a median of 44.
- The trust also monitored delayed transfers of care, these were patients from the green to go list who were ready to go home or move to a care provider but were unable to be discharged due to a variety of reasons. Data reflected delayed transfers of care which were attributable to both the NHS and social care. For example in November 2016 13 patients had delays attributable to the NHS which included waiting for a nursing home, community equipment/adaptations and patient or family choice. There were 15 patients with delays attributable to social care to include completion of assessment, residential home, nursing home and care packages in their own homes.
- Discharge data showed the hospital were rarely meeting targets of 40 patient discharges per day set by commissioners. Between 1 November 2016 and 23 February 2017 there were 115 days, of which only 27 (23.5%) of days achieved the target of 40 patient discharges. For the same time period only 46% of days achieved the target for 20% of patient being discharged before 12pm.
- Patients exceeding seven days length of stay were discussed weekly between matrons and commissioners and chaired by the head of patient flow. These meetings were not minuted. We were told the names of patients who were identified as medically fit for discharge would be added to the 'green to go list' in the same afternoon.
- The medicines to take home discharge process had been reviewed and measures had been put in place, this had significantly decreased the length of time taken for pharmacy to dispense discharge medicines. Hospital wide data for January 2017 showed the average time from when inpatient charts were received in pharmacy until medicines had their final check was 74 minutes.
- We spent time with the integrated discharge team who supported wards to facilitate discharges, particularly with complex cases. The team did not work weekends, although the trust were looking to implement this cover to support discharge planning. The discharge team split their responsibilities to support wards and attended board rounds where possible. They made daily phone calls, or more if required, to local social services to move forward discharge plans. We observed a call between the integrated discharge team and social workers, which took place daily. This was a well-structured call and used the 'green to go' list to discuss each patient. The discharge case managers were clear on expectations from social workers and the next steps which required completing. The discharge team were knowledgeable about all patients on the 'green to go' list and pushed to move processes forward.
- On the rehabilitation ward, a new staffing model was being trialled. This included a band three ward coordinator whose role was to complete many of the administrative tasks required for patient discharge. The ward team anticipated this new role would ensure a more smooth discharge process as well as freeing up time for qualified nurses to spend with patients.
- Staff told us rapid discharge for end of life care was possible and there was good relationships with district nurses and specialist palliative care team to ensure appropriate set ups before patient is discharged home.
- There was a patient flow team. Staff told us there were not enough staff in this team to successfully support the medical wards with discharge. The team included the head of patient flow, a band seven senior nurse to provide clinical support and a band three patient flow co-ordinator.
- Bed meetings were held five times a day Monday to Friday, at weekends there were two virtual flow meetings held daily via teleconference. Bed meetings were led by the patient flow team, the attendees required were dependent on the OPEL level. Medical matrons were required to attend four out of five bed meetings in OPEL two or above, if OPEL level one they

were only required to attend at 8.30am, they were not expected to attend at 4.30pm regardless of OPEL level. Therefore at 4.30pm medical matrons did not have direct input in to the current flow of the hospital.

- There appeared to be at times disparity between information within the patient flow team and on the wards. For example the patient flow team informed us a medical outlier in the surgical assessment unit was not going to be moved as they were being transferred to a different hospital the following day, however immediately after we visited this patient and the nurse in charge informed us the patient was about to move to the ward.
- The ambulatory emergency care unit was underutilised. This meant the directorate was not making optimum use of the facilities available in order to improve patient flow through the hospital. Management acknowledged pathways between ambulatory emergency care and the emergency department required further embedding.
- Data provided evidenced the underutilisation of the ambulatory emergency care unit to pull patients from the emergency department. For November 2016 patients were pulled 113 times which was an average of 3.7 patients a day. In December 2016 125 patients with an average of four patients per day. In January 2017 there were 113 patients, 3.6 patients per day and in February 2017 there were 95 patients, 3.3 patients per day.
- Ambulatory emergency care can accept clinically stable patients referred by a GP or the emergency department. At the time of the inspection, when the emergency department was using corridors for patients, there was only one patient in the ambulatory emergency care unit under the care of one doctor and one nurse. Staff in this unit told us they regularly try and pull patients from the emergency department however, the emergency department do not complete the documentation to allow this patient move.
- Patients were considered suitable for the ambulatory emergency care unit if they required urgent assessment or treatment, or would benefit from an urgent general medical opinion not available in the community. During the three months prior to our inspection, 55% of referrals came from the wards within 72 hours of discharge, 32% of referrals to the unit came from the emergency department and 11% of referrals came from GPs. Referrals were also accepted from ultrasound department.
- One month prior to our inspection, the ambulatory emergency care unit had introduced a system whereby ambulance staff could phone during transit of the patient in order to speak to the doctor and determine whether the patient could be brought straight to the unit and bypass the emergency department. At the time of our inspection this new protocol had not yet been evaluated. On the day of our inspection, three patients had been brought directly to the unit following this process.
- The discharge lounge was underutilised and therefore patients remained on wards. Staff told us there were approximately six patients per day. The discharge lounge was open 9am until 6pm Monday to Friday. Hours could be extended 8am to 8pm particularly on Monday and Fridays with winter pressures. Data for a six month period showed 887 patients from 8724 discharges used the discharge lounge, this was a 10.16% utilisation.
- The oncology and haematology day unit was well utilised, each space could be used three times a day to deliver chemotherapy and transfusions.
- Between January 2016 and December 2016 there were two mixed sex breaches, one in the medical assessment unit and one in Harptree ward. All three were reported as incidents and were decisions made by management.
- The referral to treatment time for admitted pathways for medical services, between December 2015 and November 2016, was better than the England overall performance for all specialities. In November 2016 100% of patients were treated within 18 weeks compared to 89% England average.

Meeting people's individual needs

- The needs of different people, including those in vulnerable circumstances were recognised and responded to by staff. There was always consideration of patients with a mental health diagnosis, amongst other individual patient needs. These needs were clearly communicated between staff and recorded on ward white boards, patient boards and within patient records.
- Situation background assessment recommendations (SBAR) were completed and sent to wards before receiving a patient. This document informed the ward of any patient needs. For example mental health, learning disabilities or those living with dementia. On verbal handovers this was also discussed to ensure staff were aware of the patient's individual needs.

Medical care (including older people's care)

- For patients with communication needs, ward staff tried to find optimum ways to interact with the patients, for example some patients came with a document which detailed their preference for communication, sometimes staff used picture cards to compensate for a lack of verbal communication abilities.
- We were told about how staff communicated with a patient using a white board as the patient had hearing difficulties. Staff said they listened to patients and their relatives about the best way to communicate with patients, particularly at times when patients display challenging behaviour.
- Dementia was well considered across wards and units and patients were identified using a 'forget me not' magnet. There was an older people's mental health liaison nurse who provided support for patients with a dementia diagnosis. Staff were positive about this role and felt staff and patients were well supported.
- The 'this is me' tool was used where possible for patients who were unable to or struggled to express their identity, such as patients living with dementia. Staff explained how these documents were very useful to help them understand patients' identity and preferences.
- Reality orientation day date clocks were in view in all patient bays on Kewstoke ward (care of the elderly) and Uphill ward (rehabilitation). However, these were not in place on other wards where patients may benefit from the orientation, for example the stroke unit.
- We observed a meal time on Kewstoke ward (care of the elderly) where staff were responsive to different patient needs. Colour differential crockery and cups were used and adapted cutlery and plate rings were available, staff knew how and when these were used. Feeding cups were used to enable patients to eat soup independently. Patients were offered other food off the menu and small plates and portions were available so meals were desirable. Relatives were enabled to assist with supported eating or in the absence of relatives staff supported patients. We witnessed staff offering a choice of two puddings visually to a patient. Staff sat with and engaged with patients during supported eating enabling a calm and cheerful atmosphere within the ward. We spoke to a dietician who informed us of the project to improve meal time experience on this ward, which had been a success.
- Patients with a mental health diagnosis were identified and referred to the mental health liaison team. Once patients were stable they were visited by this team to ensure their needs were being met. Staff told us how mental health patients often had key workers and it was important to ensure the key workers understanding of how they could support the patient, for example taking medication.
- In the ambulatory emergency care unit, patients living with dementia or learning disability were encouraged to bring an escort with them. Volunteers at the hospital had made 'twizzle mitts' designed to help patients living with dementia to be occupied and to feel less restless.
- The needs of people who needed a translation service were met. The trust had agreements in place to use external providers of language translation services which were contactable through the patient advice and liaison service. Staff were aware of this service and told us this had been successful in the past. Staff also had access to information leaflets in different languages for patients to access regarding medical conditions.
- There was a multi-faith chapel which could be used 24 hours a day for individual prayer.
- Patients were assessed on admission for psychological, spiritual and emotional wellbeing, staff could refer patients to the chaplain.
- Bariatric patient needs could be accommodated. Staff were able to access bariatric equipment to include wheelchairs, beds, hoists, commodes, chairs and standing aids. Staff told us these were available in a timely manner.
- Nurses referred patients to the integrated discharge team if they had specific individual needs affecting the discharge process such as homelessness. Staff told us if patients had no fixed abode they will try and find a suitable placement. Social workers would be alerted if the patient refuses the placement and self-discharges.
- There was a hearing loop installed at the medical day case unit, this assisted people who had reduced ranges of hearing.
- Visually impaired patients could be provided with enhanced supervision, leaflets about medical conditions were also available in braille.
- Patient nutritional preferences were accommodated on wards and units. For example patients attending the medical day case unit were given a snack lunch. Staff were able to accommodate gluten free diets and textured diets.
- The nutrition and dietetic department helped ensure patients were provided with choice and preference, and

were able to identify this if they had communication difficulties. They produced pictorial snacks and drink menus which were in use on wards. In conjunction with the specialist palliative care team, they developed a care guide for nutrition in hospital in the last days and weeks of life. The key message from this document was to let the person choose, if, when and what they want to eat and drink. A nutrition and dementia carers guide was provided to carers providing practical advice on everyday eating and drinking.
- Staff could signpost patients to support groups, for example diabetes group, pulmonary rehabilitation clinics, and fatigue and breathlessness clinics. Patients could also be referred to psychology services.

Learning from complaints and concerns

- There were 54 complaints across medical care wards and units between 1 December 2015 and 30 November 2016. Common trends included discharge delays or inappropriate discharges and poor communication from medical and nursing staff to patients and their families. Where appropriate, learning from complaints was identified and actions taken. For example on Kewstoke ward a complaint was received where information was not appropriately sent to a care home on discharge, as a result a new discharge checklist was implemented to ensure a copy of the care plan and dressings to be sent with the patient on discharge if needed.
- Wards displayed information on who a patient should contact to raise a complaint, concern or comment.
- Patients told us they knew how to complain and had seen this information displayed on the ward or within information leaflets.
- 'You said we did boards' were displayed on wards reflecting learning and changes made from feedback, concerns or complaints. For example on Cheddar ward you said 'too much noise at night' we did 'turn main lights off at 10pm, offer ear plugs to patients, headphones for television and radio. Ensure patients comfortable and settled to encourage sleep overnight.'
- Patients on the stroke unit had raised complaints regarding the levels of noise in the ward environment. In response, the ward sister on the stroke unit had introduced a 'lights out' hour after lunch when all patients were encouraged to rest prior to visiting hours and all staff were encouraged to maintain quiet.
- On the medical day case unit, the matron had informed nurses of recent positive feedback received via the patient advice and liaison service office.

Are medical care services well-led?

Requires improvement

We rated well-led as requires improvement because:

- The governance structure was not felt to enable information to be effectively communicated from board level to ward level.
- The change in management at directorate and executive level did not ensure consistency within the medical service and negatively impacted on the quality of leadership.
- The absence of a clinical director and lack of medical leadership had not provided support to medical staff, particularly juniors.
- Arrangements were not robust for managing risks. Risks were identified on the risk register but there was a lack of assurance these were managed timely and effectively.
- Findings from audits were not widely shared at directorate level or at ward level, therefore there was a risk learning was not clearly identified to staff.
- There was limited follow through of actions put in place. A number of projects were in infancy or draft and there appeared a time lag in validating these.

However:

- Staff were complimentary about local leadership at ward level.
- There was a positive culture amongst staff within medical wards and units. Staff felt a sense of team work and worked hard together with a priority to provide safe and compassionate care to patients.
- The hospital sought public feedback, capturing experiences through survey questionnaires, this was used to help improve services being provided.

Detailed findings

Vision and strategy for this service

- Staff were made aware of the hospital vision and two year operational plan. This was displayed on staff notice boards.
- We were informed of the current vision and strategy for medical care which was largely in line with local area

sustainable and transformation plans (STPs) however, this was not widely shared with staff due to the infancy of decisions. Plans included the introduction of more speciality nurses to deliver specific services and the growth of the integrated discharge team to improve flow.
- Strategies were also in place for falls and dementia. Ward teams were engaged in developing these.
- Management expressed how a top priority was to improve patient flow through the hospital. However, we found satisfactory improvements had not been made since in the two years since our previous inspection.

Leadership of service

- Executive and directorate management leadership roles were unstable, with regular changes within posts. This did not allow for continuity of leadership within the directorate, appropriate support to staff or decisions to be followed through to completion.
- Medical care services were delivered under the emergency directorate governance structure. Two matrons, one for acute care and a second for care of the elderly and stroke, and a clinical lead were responsible for medicine. Medicine, along with emergency medicine, children's services and patient flow were managed by a general manager, deputy general manager and associate director of nursing. The clinical director post was vacant at the time of our inspection.
- Staff spoke positively about their local leadership at ward and unit level, to include ward sisters, matrons and the therapy lead. However, there appeared to be a disconnect with the executive team. For example one staff member commented how "working on the ground floor you are never asked what the problems are so executives are not aware of the challenges and complexities". A second staff member said there was a lack of leadership at executive level to drive forward improvements in medical care.
- Staff did not feel the presence of the executive team. Staff also said directorate management had been less visible due to being busy with escalation issues. The chief executive did not have a presence on wards, and a number of staff commented how they would not recognise the chief executive. However, weekly open sessions were available to ask the chief executive questions.
- Staff on the whole felt valued and well supported, particularly by ward senior teams. One staff member commented how the professionalism of directorate managers could be improved where body language and comments had made people feel uncomfortable.
- The medical staffing team lacked clear and consistent leadership in the absence of a clinical director. The high numbers of locum consultants was also not conducive to good leadership within the medical team. This was detrimental to the support being provided to junior doctors.
- Several members of staff in leadership roles told us their roles were too stretched and their duties too varied to be able to see through changes and service improvements to a satisfactory conclusion. For example, although several changes had been made to reduce falls, we were told the impetus for continual improvement was difficult to maintain without a falls lead for the trust.
- Nurses working only night times did not regularly meet with the medical matrons. The nursing sister on the stroke unit frequently came in to work early so they could talk to those staff who only worked the night shift.
- Some members of staff told us they did not feel supported by their immediate line manager.

Governance, risk management and quality measurement

- There was a disconnect with the governance within the medical service. Staff said there was a route for information and risks to be escalated from ward level to board level, however information was not always fed back down to staff effectively for them to know the outcomes.
- The endoscopy department was under the surgical directorate. Governance related to this department will be found in the surgery report. We saw an example monthly governance assurance report covering numerous metrics and any actions required.
- We were not provided with assurance risks were being mitigated. The emergency directorate maintained a risk register. We were unable to see previous actions for risks which had remained on the risk register for a number of years and remained unresolved. We also saw risks on the risk register, for example the increased beds in the stroke unit resulting in a blocked fire exit, which had not been effectively managed despite being on the risk register for over two months.

- Staff were clear about their roles and understood what they were accountable for.
- We spoke to the medical matrons who had a good awareness of the key risks within each of the medical wards. A governance structure was in place, however we were not assured it was well embedded across the trust. An emergency directorate governance meeting was held every two months. Standard items on the agenda included risk and incident management, national guidelines and trust policies, patient experience, clinical audit, infection control, safeguarding, staffing and staff management, education and training and quality and governance reports. We reviewed minutes for July, September and November 2016 and identified instances where reports and meeting minutes were not received by the governance committee and which would lead to gaps in assurance and a lack of information being fed up the governance structure to the trust board.
- Specialist governance meetings, which were multidisciplinary, were held for both medicine governance and stroke and care of the elderly governance. Mortality was mentioned within these meetings but not discussed in detail. The specialist governance meetings fed in to monthly acute care governance meetings. We were told this meeting had been in place for eight months, however there was poor attendance. The acute care governance meeting fed in to the emergency directorate governance meeting.
- Wards produced monthly ward assurance reports which were discussed at monthly meetings and presented to the emergency directorate governance meeting.
- Weekly physicians' cabinet meeting were attended by medical consultants. However, there were only four permanent consultants and therefore representation was not provided from all specialities.
- Cancer services had not held a cancer strategy meeting for five months with the last meeting in September 2016. It was commented this was due to the concentration on the pressures in the emergency department.
- Ward Wednesdays were attended by senior nursing staff from all medical wards, this weekly meeting concentrated on safety issues and allowed a forum for senior nurses to discuss concerns and learning.
- There was no audit lead to oversee quality and performance and it was unclear how audits were appropriately monitored. We were told the 'hub' and the relevant speciality had visibility of action plans from audits. This was not shared more widely, for example ward sisters were not aware of actions and audits were not always shared with the directorate governance team.
- Staffing shortages in therapies had been highlighted in the monthly department assurance report that fed into the Clinical Support Directorate Governance and Board Report during the three months preceding our inspection. However the lack of postural seating on the stroke unit was not raised. 'Environment and equipment' were highlighted as a risk but no specific information about this risk was included in the report. This means safety risks within therapies were not consistently discussed at directorate level.

Culture within the service

- There was a positive culture when visiting wards and units. Staff were proud of their inclusive ward teams and the care they were providing to patients.
- We spoke with staff groups which included porters, housekeepers, nursing assistants and nurses, who all enjoyed the environment they worked in, although recognised it was busy and there were pressures. Staff felt included and supported by ward staff irrespective of their role or frequency of time on the wards.
- Staff commented how there was a culture where they felt supported to raise concerns.
- Sickness for the emergency directorate between January 2016 and January 2017 fluctuated between 3.18% and 5.49%.
- Medical staff said due to Weston hospital being a small hospital there were limited opportunities for developing skills, this meant the hospital struggled to keep hold of senior house officers and registrars. Junior doctors experienced a high level of stress and commented how they would not recommend the hospital to others.
- There appeared to be a lack of collaborative working and a poor relationship between some services and departments. We were told about the ambulatory emergency care unit which was run by the medical teams and which appeared to be underutilised in seeing patients who presented in the emergency department who did not need emergency care. Talking to staff in both departments there were differences in what staff told us about how patients were being effectively pulled from the emergency department or about the pathways in place. There was limited proactive steps taken to identify and 'pull' patients from the emergency

department and therefore the ambulatory emergency care unit was being underutilised. Interface meetings with the two teams had stopped approximately 12 months prior to our inspection. This meant recent challenges of demand and capacity were not being successfully addressed using a collaborative approach at the hospital 'front door'. We were also told communication between critical care and medical consultants was poor, especially regarding transfer. This poses a risk of information not being shared appropriately and decisions not being made quickly to ensure the safe transfer of patients.

- In response to the increasing demands on staff on the stroke unit, the ward sister had introduced set times for breaks to encourage staff to take regular rest breaks.

Public engagement

- Wards and units sought patient feedback to help improve services. Patients and their families were asked to complete the friends and family test. Additional questions were also included questions captured information about the care provided and the communication received about care and treatment. Participation in the friends and families test was low on some wards. This meant teams did not always have a reliable method of understanding the quality of patient experience on their wards.
- Annual patient satisfaction surveys were used in endoscopy and oncology and haematology day unit.
- On entrance to wards 'you said we did' information was displayed. For example you said ' better mattress' we did 'new bed and mattress in trust'. The wards also provided information on who the public should speak to if they wanted to comment, raise a concern or complain.
- A customer satisfaction survey was available on the back of menus to allow patients to comment about their meal time experience.
- The layout of the medical day case unit had recently changed. During this process the nursing staff engaged with patients to gather their views regarding this change.
- Nursing staff facilitated a weekly carers group on the stroke unit, which was introduced at the end of January 2017. This meant patients, relatives and loved ones had opportunity to discuss their concerns and gather information as needed.
- Kewstoke ward were in the process of organising a carers group to offer support and advise, aiming to commence in March 2017.

Staff engagement

- There were not clear processes for regularly seeking staff views and experiences to help improve services. However, staff felt they could bring concerns or opinions to their monthly ward meetings, or send emails to their managers. One nurse told us how staff had been asked their opinion on diverting ambulances to other trusts overnight.
- Staff participated in the annual staff survey, however were not aware of results or outcomes from these surveys.
- Staff success was celebrated through the 'celebration of success annual awards', staff spoken with were proud of awards received either individually or as a team.
- The trust had planned a falls awareness day to engage staff regarding the prevention and management of falls on the wards.

Innovation, improvement and sustainability

- There was limited evidence of how the trust continually improved and ensured the sustainability of the medical service.
- It appeared the trust concentrated on specific drives for improvement at the point when poor performance was identified. These drives were not sustained to maintain levels of quality. Staff commented how there was continuous change within the medical service with limited positive outcomes. The absence of permanent medical staff specific to specialities meant there were difficulties in driving forward speciality specific protocols or processes for quality improvements.
- Kewstoke ward (care of the elderly) undertook a baseline dementia mapping exercise to enable service development plans and team education. The follow up of the dementia care mapping would be used to evidence positive changes to dementia care.
- A bid had been put in place to fund the engage project, to train volunteers to provide positive engagement with dementia patients.
- Plans were in place to launch a risk assessment tool to identify very high risk falls patients.
- Staff told us they were aiming to implement a meaningful risk assessment for enhanced supervision. An enhanced supervision policy was in draft format.

Medical care (including older people's care)

- Concerns were raised about the lack of thrombolysis outside of Monday to Friday and stroke pathways, and no dedicated therapy staff on the stroke unit. Staff were pushing to introduce a stroke steering group to help provide innovation and improvements within stroke. There were plans for the senior stroke team to visit a local acute trust's stroke ward to see what good looks like.
- Since out last inspection the ambulatory emergency care unit was appropriately refurbished and high care patients were no longer on Harptree ward.

Surgery

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

Information about the service

Weston Area Health NHS Trust provides a range of surgical services at Weston General Hospital, these include general surgery, urology, orthopaedic, breast, colorectal, and upper gastro-intestinal. Surgery is provided as both elective (planned) and in an emergency. The hospital also provides interventional radiology: a process of using minimally invasive image-guided procedures to diagnose and treat diseases.

The hospital had 10,143 surgical admissions between April 2015 and March 2016 of which 4,018 (40%) were emergency admissions, 4,789 (47%) were day admissions and the remaining 1,336 (13%) were elective.

The hospital has a main theatre unit with four operating theatres, and a self-contained 15-bed day case unit with two operating theatres. There are three surgical wards, Steepholm, a 22-bed ward, for patients having planned or elective operations/procedures and Hutton, a 27-bed ward, for patients having emergency operations/procedures. Waterside ward is a 12-bedded unit and is used for NHS and privately funded surgical patients.

Within the hospital's surgical directorate, there is a patient pre-operative assessment unit, a theatre receiving unit and an eight-bed surgical assessment unit (SAU). The SAU is combined with the Clinical Decisions Unit, which supports medical and surgical patients coming through the emergency department or via their GP.

During the inspection we visited, Hutton, Steepholm and Waterside wards, SAU, the pre-operative assessment unit, the theatre receiving unit, interventional radiology, the operating department and the recovery area. We spoke with anaesthetists, surgeons, senior nursing staff, nurses of all bands, allied health practitioners, administrative staff and staff in the medical engineering department. We spoke to 15 patients who accessed the surgical services at the hospital.

The hospital had previously been inspected in May 2015 and the CQC had rated surgical services as requiring improvement. Concerns were raised about patient's safety in theatres and leadership and governance across the surgical directorate.

As part of this inspection, CQC piloted an enhanced methodology relating to the assessment of mental health care delivered in acute hospitals; the evidence gathered using the additional questions, tested as part of this pilot, has not contributed toour aggregation of judgements for any rating within this inspection process. Whilst the evidence is not contributing to the ratings, we have reported on our findings in the report.

Surgery

Summary of findings

We rated this service as good because:

- Since our last inspection, a substantial amount of work had been carried out on National Safety Standards for Invasive Procedures (NatSSIPs). The changes were being embedded in to practice across all areas that carried out invasive procedures.
- The response rate for the friends and family test (FFT) was better than the England average. Feedback from all the patients we spoke to was very positive. Patients commented on how the care from the nursing staff and allied health professionals was 'superb', 'exemplary 'and staff had a 'great sense of humour.
- We saw how well staff cared for those patients and their families who were living with a diagnosis of dementia and mental health issues.
- We saw effective multi-disciplinary team working.
- We saw good care of surgical patients outlying on medical wards.
- A theatre scheduling group had been established which reviewed weekly theatre utilisation alongside a scheduling policy and utilisation of theatres had improved.
- The dietetic department had expanded menu choices for those patients on a textured diet and had provided patients with their own specific modified menu so they could specify their own meal choices.
- Staff had the skills and knowledge to lead the service. All of the staff we spoke with talked of how visible their senior nursing staff were from matrons, associate directors of nursing to the director of nursing.
- The ward areas had started a 'campaign' to encourage their team members to make sure all patients that could be either out of bed before a certain time in the mornings or if not be nursed at 30 degrees.

However:

- Mandatory training compliance required improvement, particularly in basic life support and dementia awareness.
- The surgical Mortality and Morbidity meetings were not well attended, and actions and learning points were not properly shared and followed up. Some of these meetings lacked evidence of discussion, learning points and accountability for actions
- Not all patients were operated on in a timely manner and in particular, patients with fractured neck of femurs were not always operated on within 48 hours of admission or admitted to an orthopaedic ward within 4 hours.
- Surgical services were under pressure due to increased medical patient admissions to the hospital; this led to surgical beds being occupied by medical patients. The result of this meant that sometimes surgery for some patients had to be cancelled.
- Staff found the clean utility room in the day case unit difficult to work in and they had concerns about the safety of drawing up medications in such a cramped location.
- The hospital did not have an orthopaedic-geriatric service due to recruitment problems.

Surgery

Are surgery services safe?

Good

We rated safe as good because:

- Since our last inspection, a substantial amount of work had been carried out on National Safety Standards for Invasive Procedures (NatSSIPs). The changes were being embedded in to practice across all departments and directorates that carried out any invasive procedure.
- There was a good culture of incident reporting across all departments and a hazard telephone line had been installed for doctors to report their immediate concerns.
- Staff were proactively working to reduce the incidents of hospital acquired pressure ulcers by looking at new ways of working, this included safety huddles, swarms and trolley dashes.
- Since our last inspection, practices in theatres and the transportation of used instruments was in line with national guidance.
- The arrangements for managing medicines kept patients and staff safe. Since our last inspection, processes in dispensing discharge medications had changed. This improved the length of time it took for patients to receive their medications and be discharged.
- The medical records that we checked were all legible, accurate complete and up-to-date. All the records we reviewed were stored safely in lockable notes trolleys.
- Infection control practices across the ward areas and theatre departments kept people safe, this included managing clinical waste and hand hygiene.
- Patient risk assessments were completed and regularly evaluated and there were clear processes to deal with patients when their medical condition was deteriorating.
- In a drive to reduce patient's falls and keep vulnerable patients safe and observed, the hospital used an ABC Behavioural Chart, which tried to identify triggers that might precede challenging behaviour.

However:

- Mandatory training compliance required improvement, particularly in basic life support and dementia awareness.
- Attendance at Mortality and Morbidity meetings required improvement with actions and learning points being properly shared and followed up.
- Expiry dates of medicines were not always checked regularly and dates were not consistently added when liquid medicines were opened.
- The medicines safety thermometer was not always completed on a monthly basis and not all medicines were reconciled for all in-patient admissions.
- Theatre equipment was stored in the clean utility on the day case unit and this made it difficult for more than one member of staff to prepare medications safely.
- Wards had minimal ward clerk cover and often the filing of notes fell to the nursing staff. This posed risks of records going missing or being misfiled.
- According to the hospitals performance assurance framework (PAF) patients did not always receive an assessment of venous thromboembolism and bleeding risk.

Detailed findings

Incidents

- People were protected from abuse and avoidable harm. Lessons were learned and improvements were made when things went wrong. There were systems, processes and practices in place to keep people safe, and these systems and processes were communicated to staff.
- Staff understood their responsibilities to raise concerns, to record safety incidents and near misses. All staff reported incidents directly onto an electronic reporting system. Once reported, incidents were reviewed by the appropriate clinical manager and where necessary investigated. Staff said they were able to get feedback on incidents they reported which were discussed at ward and theatre department level during ward huddles, team meetings, newsletters and email. Staff we spoke with on the wards and in theatres reported no barriers to reporting risks and incidents. Minutes from the surgical governance meetings showed incidents were discussed as part of the itemised agenda.
- A hazard telephone line had been set up for doctors to report any concerns they had during their shift. The doctors we spoke with reported this as a positive message from the hospital that their concerns were being listened to. We saw how dedicated phones were easy to access on the wards. Concerns reported on were followed up and an example of this related to hazard

phone calls which had identified a number of omitted Parkinson's medication. This had suggested a lack of staff awareness and the pharmacy team were looking at developing a project to raise staff awareness.

- There were no never events reported from the surgical directorate between January 2016 and December 2016. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- In accordance with the Serious Incident framework 2015, the hospital reported 16 serious incidents in surgery. The most common type of incident reported that met the criteria were pressure ulcers of which there were 11. The hospital had an in-depth and robust action plan which was discussed at 'Ward Wednesday'. This was a multi directorate meeting held weekly for all senior nurses across the hospital. We attended and observed how actions were identified, and disseminated to the senior ward leaders and dates were set for those actions to be completed. It was clear that the hospital were focussing on a change of attitude across all departments to pressure damage. Senior staff were implementing SWARMs which had previously been used for work the hospital had carried out in reducing falls. SWARMing was a way of addressing an event without unnecessary delay, when staff swarm or group together to determine the cause of the event and how it could be corrected.
- Mortality and Morbidity (M&M) meetings were held monthly, however discussions with staff at focus groups identified that often some of the meetings were not well attended. The minutes for the surgical M&M for September 2016 discussed a National Confidential Enquiry into Patient Outcome and Death (NCEPOD) classification of C: room for improvement, from NCEPOD's classification of care. Learning points had been documented but no actions were identified or disseminated and there had been no identified follow up of learning or future improvements to practice. Meeting minutes for October 2016 for a classification NCEPOD B: room for improvement, had no learning points, follow up or actions identified, this patient had sepsis as a contributory cause of death. A patient with a classification of NCEPOD: D room for improvement (aspects of clinical and organisational care that could have been better) was documented as being discussed at the joint meeting and a notes review was requested, however, nothing further was identified. We cross-referenced this to the minutes of the Anaesthesia and Critical Care Governance Audit and Safety Meeting and the minutes only identified missed opportunities. We could not be clear therefore that actions and learning had been discussed and accountability for actions agreed. We had requested further meeting minutes from the Surgical M&M (November 2016 and January 2017) but these were not available.

Duty of Candour

- Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 is a regulation, which was introduced in November 2014. This regulation requires the organisation to be open and transparent with a patient when things go wrong in relation to their care and the patient suffers harm or could suffer harm, which falls into defined thresholds. Staff we spoke with were aware of this legislation and demonstrated good understanding of their responsibilities to their patients under this legislation. Staff at all levels were able to describe what the duty of candour involved and the actions required, and where to look for guidance on the hospital's intranet.

Safety thermometer

- The service participated in the national safety thermometer programme and achieved consistently positive results. This was used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline was intended to focus attention on patient harms and their elimination.
- There was a public display at the entrance to all of the surgical wards, which identified how many avoidable patient harms had occurred in the previous month.
- Data from the Patient Safety Thermometer showed that the surgical directorate reported 15 pressure ulcers, three falls with harm and one-catheter urinary tract infection between December 2015 and December 2016.
- According to the hospitals performance assurance framework, patients did not always receive an assessment of venous thromboembolism (VTE) and bleeding risk. There was a fall in compliance from May 2016 and data in November 2016 showed the surgical

directorate was 53.9% compliant in VTE risk assessment. Action plans were put in place to address this and December 2016 to February 2017's data showed an improvement in compliance. We checked eight prescription charts all of which had fully completed VTE assessments.

- An increased incidence of pressure ulcers had been identified and this was an agenda item on the senior nurses 'Ward Wednesday' meeting. We attended this meeting where it was decided that across the hospital there would be actions taken to increase vigilance. Teaching trolley dashes and SWARMs (where staff swarm together to discuss the incident) were planned. Senior staff also discussed a need to increase staff vigilance to changes in a patient's skin condition and appearance by 'Reacting to Red' and 'Picking up on Purple' (all signs of underlying pressure damage).

Cleanliness, infection control and hygiene

- There were reliable systems in place to prevent and protect people from healthcare-associated infections. Between April 2016 and February 2017, there were no incidences of hospital-acquired methicillin-resistant Staphylococcus aureus (MRSA) or Clostridium difficile. There was one episode of methicillin-sensitive Staphylococcus aureus (MSSA) on Hutton ward in November 2016. We reviewed the MSSA bloodstream infection: post infection review toolkit. The review covered all aspects that could have been contributory factors to the development of an infection. Recommended actions to prevent occurrence were agreed and staff were allocated responsibility to ensure these actions were completed.
- Elective patients were screened for methicillin-resistant Staphylococcus aureus (MRSA) in the pre-operative assessment unit. The performance assurance framework for the surgical directorate recorded 100% compliance.
- Data received from Public Health England (PHE) for surgical site infection (SSI) rates for breast surgery during the periods of July 2015 to September 2016 recorded no SSI reported for inpatients or after discharge. Data for repair of neck of femur between the periods July 2015 to September 2016 showed 1.3% SSI rate which was less than the national average of 1.4% for the previous five years data. However, the SSI, PHE data for large bowel surgery rates between July 2015 and September 2016 showed a 14.3% infection rate, with a peak of infections during quarter one in 2016, and this was above the 11.8% five year average from October 2011 to September 2016.
- Staff on the wards and in the preadmission clinic decontaminated their hands in line with the World Health Organisation five moments for hand hygiene and National Institute for Health and Care Excellence (NICE) guidance (QS 61 statement three). This standard states that people should receive healthcare from healthcare workers who decontaminate their hands immediately before and after every episode of direct contact or care. All the patients that we spoke with told us that they saw staff decontaminate their hands before and after patient contact. The surgical directorate hand hygiene audits for October to January 2016 showed an average of 97% compliance which was above the hospital target of 90%.
- We checked three sets of notes for patients who had urinary catheters, these patients had their risk of infection minimised by the completion of catheter insertion and surveillance forms. These forms were all completed daily and specified procedures necessary for the safe insertion, maintenance and removal as soon as it was no longer needed.
- Practice in theatres during the pre-operative, peri-operative and post-operative phases was in line with National Institute for Health and Care Excellence (NICE) guidance (CG 74) and the prevention of surgical site infections. Staff wore theatre scrubs in the department, were bare below the elbow did not wear nail varnish and hand decontamination was carried out in line with NICE guidance.
- All ward areas appeared visibly clean. Equipment appeared clean and we saw green 'I am clean' labels placed on trolleys and equipment that had been cleaned and were ready for use. We observed staff clean equipment and apply these labels.
- Bed spaces were visibly clean in both the easy and hard to reach areas. Bed linen was in good condition, visibly clean and free from stains or damage to the material. Areas had a dedicated team of cleaners who ensured the areas were clean and tidy. Cleaning checklists were in place and included records of the double flushing of running water and housekeeping weekly plans. These were complete and up-to-date and audited weekly to

ensure the ward was cleaned regularly. The surgical directorate cleanliness audits for the periods, October 2016 to January 2017 averaged at 96%, which was above the hospital target.

- The arrangements for managing waste and clinical specimens kept people safe. Sharps bins were stored on purpose built trolleys to enable ease of use and transportation. Used sharps bins awaiting removal were closed, sealed and stored in the dirty utility. Disposable items of equipment were discarded appropriately, either in clinical waste bins or in sharp instrument containers. Nursing staff said these were emptied regularly and none of the bins or containers we saw were unacceptably full.
- The main theatres had a dedicated corridor where used instruments were taken out of the back of theatres. They were wrapped and sealed then stored on a trolley, which would be transported in a dedicated lift to be taken off site for sterilisation. This dedicated corridor was clean, free from dust and had no clutter. Each theatre had dedicated cleaning equipment stored outside the door made up and ready to be used.
- The trust was assured that when they outsourced their equipment sterilisation that decontamination of surgical equipment was in line with Health Technical Memorandum (HTM) 01-06. We saw a certificate to show that the company the trust used was SGS compliant for the collection, transportation, delivery, assembly, manufacture and supply of surgical and anaesthetic instruments.
- The hospital participated in Public Health England Surveillance and the Patient Led Assessment of the Care Environment (PLACE). The assessments involved local people known as patient assessors, assessing how the environment supported the provision of clinical care. Hutton and Steepholm wards scored 100% for cleanliness.

Environment and equipment

- Facilities and premises within the wards were designed in a way that kept people safe. Systems were in place to ensure the safe use, maintenance and replacement of equipment. There was a programme of regular portable appliance testing. The layout of the wards created an efficient flow. All areas were in good decorative order and well maintained and all equipment observed appeared fit for purpose.
- Metal frames were fitted to the inside of windows to restrict opening and prevent the risk of falling.
- There was appropriate resuscitation equipment throughout the hospital for use in an emergency. Resuscitation equipment on the wards and in the theatre departments were checked in line with hospital policy and were visibly clean and free from dust. We checked resuscitation trolleys in the day case unit and the ward areas, each trolley was sealed with a tamper evident seal and the records for daily and monthly checks were all signed and dated.
- We saw a range of equipment was readily available and staff said they had access to the equipment they needed for the care and treatment of patients.
- We reviewed the generator checks for April 2016 to March 2017 and found out of 28 checks 26 passed, two failed (and subsequently passed) as they were completed outside of the target date. We reviewed the annual ventilation inspection and verification reports for the theatres in the main department and the day case unit. All theatres were compliant with Health Technical Memorandum 03-01: Specialised ventilation for health care premises.
- All the equipment we checked had an in-date service. We were shown a spreadsheet that the day case unit had developed which tracked every piece of equipment's service date. We checked four pieces of equipment and all had in-date services.
- The Public Health England Surveillance and the Patient Led Assessment of the Care Environment (PLACE) assessment for the condition, appearance and maintenance rated Hutton ward at 96.88% and Steepholm ward, 93.75% and 'a well presented ward'.
- However, storage of some of the day surgery theatre equipment was located in the clean utility room on the day surgery ward. This created a cramped area for staff to draw up medications and staff we spoke to found this challenging if more than one member needed to draw up medications. We were told that this had been added to the departments risk register but staff were not aware of any action plans to address this.

Medicines

- The arrangements for managing medicines kept patients and staff safe. Staff had access to the hospital's medicines management policy. This defined the policies and procedures to be followed for the management of medicines and included obtaining, recording, handling,

using, safekeeping, dispensing, safe administration and disposal of medicines. Staff were knowledgeable about the policy and told us how medicines were ordered, recorded and stored.

- We reviewed ten prescription charts on the surgical assessment unit, Waterside ward, Hutton ward, Steepholm ward and the day case unit. Every chart had allergies and sensitivities documented and all prescriptions were clearly and legibly written and signed. All nursing entries were signed for and any omitted drugs were identified with the appropriate code. All prescriptions were prescribed correctly and adhered to national guidelines and the British National Formulary.
- Medicines were stored safely and securely in ward areas and in theatres. Medications were stored in locked cupboards or lockable medicine trolleys all of which were tethered to walls when not in use.
- Medicine refrigerators were available in all ward areas. Monitoring forms were in place and completed daily in line with the medicines policy/procedure. All minimum, maximum and current temperatures recorded were within range and we saw evidence when not in range that it had been reported to estates. We checked consumables in the ward area and in theatres and all were in date and stored correctly. Recording of medication fridge temperatures was completed daily and those we checked were signed and dated.
- Staff said there was an open culture for reporting medicine incidents. Staff told us that if there was a missing signature on the drug chart the nurse would be called at home to check if the drug had been given.
- Medicines incidents were investigated and reported to the medicines management optimisation group. The group held monthly meetings where medicine incidents and adverse events were reviewed. Themes and trends were identified and discussed and when necessary fed back to the relevant ward teams. Learning from incidents was also identified and the information disseminated across the organisation. The medicines management optimisation group published a monthly newsletter, which was circulated via e-mail.
- The Drug and Therapeutics Committee held meetings every two months to review formulary issues and prescribing trends.
- Authorised members of staff were responsible for the keys to the controlled drug cupboard and medicine trolleys. All treatment rooms were lockable with push button code access.
- The hospital had a controlled drugs policy, available on the intranet. A trained nurse signed all orders for controlled drugs (CDs) and all wastage was recorded in the ward CD register. CDs stock checks were completed nightly and weekly in line with policy by two trained nurses.
- We observed medication rounds on Hutton ward and saw how staff completing the round wore a red tabard in an attempt to reduce disruptions to their medication round and increase safety.
- The length of time taken for pharmacy to dispense the discharge medicines had significantly improved since new systems had been put into place. Wards had pre-labelled packs of commonly used medicines, which could be checked by two trained nurses and then supplied for discharge. This meant discharge medications could be supplied without the delay of the prescription chart going to pharmacy
- The hospital submitted data for medicines to the safety thermometer and its own database. The hospital database showed that in November 2016 all patients on Steepholm and Hutton wards and the surgical admissions unit had their medications reconciled, however the safety thermometer had not been fully completed for the four out of the last reported 12 months cycle (December 2015 to November 2016).
- Pharmacy did not provide a seven day a week service so medicine reconciliation only took place Monday to Friday. The pharmacy risk register stated that due to the lack of pharmacy staffing services expected by the pharmacy department could not always be completed and this included medicines reconciliation.
- However, not all medications we checked were in date, on the surgical assessment unit (SAU) and on Waterside ward, the date of opening liquid medicines had not been recorded on the bottles. On SAU we found expired drugs in the medication trolley and on Waterside ward an adrenaline and epinephrine injection vial had expired.

Records

- Patient records demonstrated a multidisciplinary collaborative approach to patient care and were well maintained and stored safely.

- We checked 15 sets of patients' individual records (nursing and medical) and all were legible, accurate complete and up-to-date. All clinical staff completed informative evaluation notes and reflected the needs of patients. We checked a range of information including pressure ulcer assessment charts, observation charts for the national early warning score (NEWS), malnutrition universal screening tool (MUST) food chart and care plans. Information was clear and concise and care plans were up-to-date. All early warning scores were completed and accurately recorded to reflect the routine observations undertaken to determine where intervention might be required.
- The service ensured that appropriate pre-op assessments were recorded. We checked three sets of records and could see that preoperative assessments were well documented.
- Medical records were stored in secure locked trolleys, which were close to the nurses' station.
- However although records were written in a way that kept people safe they were not always filed routinely. We asked staff about this and were told that wards had minimal ward clerk cover and often the filing of records fell to the nursing staff. This posed risks of records going missing or being misfiled.

Safeguarding

- There were arrangements in place to safeguard adults and children from abuse that reflected the relevant legislation and local requirements and all staff we spoke with understood their roles and responsibilities. The hospital had a safeguarding lead for adults.
- Ward staff we spoke with were aware of female genital mutilation (FGM). Although no staff members had come across this, they understood their responsibility to report concerns to the safeguarding lead or safeguarding team. Modern Slavery is now an element of abuse within safeguarding and detailed in the Care Act 2014. This was included in the hospital's safeguarding training.
- The majority of the surgical directorates safeguarding training was completed and was above the hospitals 90% target, with the exception of children's level 3, which was below the target at 88.4%.
- The hospital sent out a bi-monthly newsletter called 'The Safeguard', which was for adults and children. It gave updates, new legislation, advice and shared topical issues relevant to safeguarding adults and children.
- During the time of our inspection, the hospital had just secured a part-time pre-operative orthopaedic-geriatrician. This post had become vacant in January 2016 and the hospital had identified recruitment issues for this post in their Mortality Reduction Plan.
- However, there had been a seven-day delay in reporting a serious safeguarding incident on an in-patient surgical ward. We spoke with the lead for safeguarding who agreed that this was an unacceptable delay.

Mandatory training

- A programme of mandatory training was provided to all staff which included, infection control, basic life support, equality and diversity and human rights, information governance, fire safety, manual handling, and safeguarding. Mandatory training compliance across the surgical directorate averaged at 86% which was below the hospital target of 90% target from August to November 2016.
- On the day case unit health care support workers (HCSW) were only 60% compliant with their dementia awareness and both trained nurses and HCSW were below the hospitals 90% target for basic life support training. HCSW in theatres were only 57% compliant with their basic life support training. This continued on the wards with training for basic life support at 68% on Hutton ward. However, the pre-operative assessment unit scored 100% for all trained and healthcare assistants and the surgical assessment unit was 90% and above for dementia awareness and basic life support.
- Staff in theatres had an audit day every month where teaching took place; staff could also complete mandatory e-learning during this time. Staff on the wards told us mandatory training was difficult to complete on the wards due to pressures of the job, lack of available computers and time. This meant staff were often behind with their training.

Assessing and responding to patient risk

- Patient risk assessments were completed and evaluated and there were clear processes to deal with patients when their medical condition was deteriorating.
- There was a hospital wide standardised approach to the detection of the deteriorating patient and a clearly documented escalation response. All people admitted acutely were continually assessed using the National

Early Warning System (NEWS). This system was based on a simple scoring system in which a score was allocated to physiological measurements undertaken when patients present to, or are being monitored in hospital. We checked 14 set of NEWS scores and saw that scoring was entered correctly and with only one exception actioned appropriately.

- The trust had a major haemorrhage policy, which identified who was responsible for what actions. This included the availability of blood for transfusion and medications that should be administered. We asked the trust for evidence of scenario training but did not receive this information.
- Since our last inspection, a substantial amount of work had been carried out on National Safety Standards for Invasive Procedures (NatSSIPs) which set out the key steps necessary to deliver safe care for patients undergoing invasive procedures. NHS England published the NatSSIPs in 2015 to support organisations in providing safer care and to reduce the number of patient safety incidents related to invasive procedures in which surgical Never Events could occur. The NatSSIPs covered all invasive procedures including those performed outside of the operating department. We saw examples of scheduling and list management, handovers and information transfer from theatres to the wards and procedural verification and site marking.
- The NatSSIPs had enhanced the World Health Organisations (WHO) Surgical safety checklist by looking at additional factors such as the need for education and training. Local Standards for Invasive Procedures (LocSSIPPs) were being embedded into practice at the time of our inspection which included safety briefing, sign in, time out, sign out and debriefing. These included the key steps outlined in the NatSSIPs aimed at standardised practice across the organisation and the hospital had implemented 13 WHO safety checklists in areas such as the wards, endoscopy, interventional radiology and the contraception clinic. We observed the checklists being carried out in main theatres, the day case unit, the endoscopy unit and in interventional radiology and all steps were fully completed. The surgical directorate ensured compliance with the checklist by auditing monthly, the performance assurance framework (PAF) showed during the periods of November 2015-November 2016 main theatres were 100% compliant and the day case unit, although data for three months was not entered on the PAF, did not fall below 99%. Compliance was monitored in all areas and across the directorates by audit work, and we were told was reported through governance assurance reports.
- We saw risk assessments completed weekly for patients who were at risk of falling, who required bed rails and a manual handling plan. Skin assessments were completed every three days as advised in the patient's skin assessment documentation. If a patient was identified as high risk they would be placed on a pressure ulcer prevention chart which identified how often the patient should be turned.
- Staff used the hospital's ABC Behavioural Observation Chart for those patients who were under enhanced supervision. This tool helped staff understand and assess challenging behaviour, with the aim to understand it and pre-empt it by understanding any triggers that may precede challenging behaviour. This enhanced level of observation also helped reduce the risk of falls. This chart was completed hourly and then was reviewed by senior staff to determine if enhanced supervision was still required.
- The hospital was trialling safety huddles which identified patients who were at risk of pressure damage and falls. These huddles were multidisciplinary brief meetings held for each shift to target any vulnerable patient who may be at risk.
- Patients who were seen at the pre-operative assessment unit were assessed using the ASA (American Society of Anaesthesiologists) classification The hospital ensured that appropriate pre op assessment was recorded we reviewed three sets of notes and could see that preoperative assessments were well documented. All patients were assessed using the ASA classification, which was documented in the anaesthetic record sheet. The score was reviewed in line with the national ASA Classification System. For those with ASA II or higher the patient was reviewed by a senior anaesthetist. Staff in the pre-admission unit told us that if necessary patients would be referred back to their GP for further follow up and/or treatment.
- The hospital had a medical outlier plan for medical patients being cared for on surgical wards. Each surgical ward had a different consultants team allocated to care for the outlying patients. The plan included advice of what to do if patient numbers exceeded ten on any ward.

- Staff had access to a mental health nurse if they were concerned about risks associated with a patient's mental health; staff knew who this was and how to contact them.
- Staff we spoke to all knew how to escalate patients that were presenting with sepsis. The sepsis six pathway was in use on the wards. Staff received teaching on the escalation of patients who were scoring outside certain parameters on the national early warning score (NEWS) chart and this included when to commence the sepsis six pathway. However, we could not ascertain if specific teaching had been delivered and if so the numbers who had attended.
- According to the hospitals performance assurance framework (PAF) patients did not always receive an assessment of venous thromboembolism and bleeding risk. There was a fall in compliance from May 2016 and data in November 2016 showed the surgical directorate was 53.9% compliant in VTE risk assessment. As the national standard was 95% the clinical commissioning group (CCG) issued a contract performance notice in December 2016 and the hospital submitted action plans and improvement trajectory to the CCG in January. We reviewed the action plan and saw it had been updated in March 2017, all actions were either completed or on target. We reviewed data from December 2016 to February 2017's which showed an improvement in compliance

Nursing staffing

- We observed how shift handovers kept people safe and we attended a handover from the night staff to the morning staff on Hutton ward. The nurse in charge of the night shift gave a safety briefing. This tool was used so that staff could share information about potential safety problems and concerns on a daily basis. All staff on the ward were aware of patients who were at risk of falling, pressure area damage, who were confused and those requiring enhanced supervision. Once this had been completed staff went to their bays and had a more in depth handover for the patients in their care for that shift.
- In November 2016 the surgical directorate had a planned establishment figure of 211.52, whole time equivalent (WTE) registered nurses and an actual established number of 210.91 WTE in post. For unregistered nurses the planned number was 91.86 WTE versus an actual number of 114.02 WTE in post. Senior staff on Hutton ward told us that they had student nurses very keen to work as registered nurses and once qualified would take up any registered vacancies. We spoke with student nurses at focus groups who told us that they had obtained preceptorship posts on the ward of their choice once they had successfully completed their training.
- We reviewed the agency and bank usage in the surgical directorate and on Hutton and Steepholm wards we could see a high use of agency and bank, which had increased since December 2015. The high use of agency and bank rates did not reflect the vacancy rates but reflected how staffing was increased to ensure patient safety. The surgical directorate used the Shelford Safer Nursing care Tool to ensure that they had the right staff with the right skills in the right areas. We saw how the wards reviewed acuity of patients on a daily basis and this information was collated over a six month time frame to review staffing numbers. In February 2017 the hospital completed a Ward Based Establishment Review, in line with the National Quality Board recommendations of 'how to ensure the right people with the right skills are in the right place at the right time'. The review found that Hutton ward required an increase in their staffing levels. The report reviewed how Hutton ward had 25 pressure ulcers grade 2 or above and an increase in staff establishment would help reduce pressure ulcer incidence. The staffing review also identified how certain wards had an increase use of agency for enhanced supervision, the hospital identified that an increase in established staffing numbers would decrease the use of agency alongside implementation of new ways of working such as high visibility nursing. This was ongoing at the time of our inspection.
- Senior staff in the theatre departments told us they were well staffed and had recently had an establishment review. This allowed an extra budget to develop the team leaders, who were supported to go on management days to increase their management skills.
- Concerns were expressed about the quality of some agency staff who were not always equipped to perform at the required level of competency on the ward.

Surgical staffing

- There was a consultant general surgeon and orthopaedic surgeon cover at all times of the day and night, seven days a week. Surgical registrars provided on-call cover from eight to eight thirty, seven days a

week. There was an on call orthopaedic registrar 24 hours seven days a week. A trauma consultant covered theatres, Monday to Thursday afternoons and all day on Friday. Junior doctors provided on call for orthopaedics, general surgery and gynaecology seven days a week, 24 hours a day.

- Staff told us on the surgical admissions unit that reviews of patients and post take ward rounds were completed in a timely manner. We reviewed three sets of notes, which documented that each patient had been reviewed by a consultant and a specialist registrar on admission to the unit and during the post take ward round that day or the following morning.
- Up until January 2016 the hospital had an orthopaedic geriatric service with pre and post-operative cover provided by a part-time consultant and middle grade doctor. From March 2017 a part-time consultant would be starting to provide pre-operative care, the appointment for the middle grade doctor had yet to be filled.
- There was 34.22% vacancy rate for anaesthetists and this was reflected in the increased use of locums since August 2016. The surgical directorate informed us that after a recruitment drive all vacant posts were fully recruited into.

Major incident awareness and training

- The Emergency Preparedness Resilience and Response Policy was under review during the time of our inspection, this was due to be completed by March 2017. This policy included business continuity plans, emergency planning, information sharing and communicating with the public. Duties and responsibilities were outlined for managerial and senior staff and this was available on the hospital's intranet. Staff were aware of the plan on the intranet and told us that they would look to move patients to outlying hospitals and stop non urgent treatment and scans if necessary.

Are surgery services effective?

Good

We rated effective as good because:

- We saw effective handovers between theatres and ward staff. The theatre team had developed a streamlined handover based on the Situation, Background, Assessment and Recommendation tool (SBAR).
- Since the last inspection, the hospital had employed a dedicated acute pain nurse in line with the Royal College of Anaesthetists Accreditation Standards.
- Enhanced supervision staff were dedicated to care for vulnerable patients and wore a yellow tabard to identify their role.
- The dieticians worked in conjunction with the catering department to ensure that diets in acute settings met the British Dietetic association standards.
- We saw how well the physiotherapist and occupational therapist and the discharge team worked together on a daily basis to plan a patient's care and discharge.
- Staff told us that a reduced physiotherapy service was available over the weekends. In order to mobilise patients as soon as possible the physiotherapist for the trauma and orthopaedic wards was developing a competency based training package for the nurses.

However:

- Although some of the outcome measures remained below the national average, such as the National Hip Fracture Database the data from Public Health England shows an improvement since 2015.
- Not all patients with fractured neck of femurs were operated on within 48 hours of admission.
- The hospital performance assurance framework (PAF) data collection from May 2015 to November 2016 showed a steady decline in compliance to the venous thromboembolism or blood clots (VTE) assessment tool.
- Dieticians reported that the Malnutrition Universal Screening Tools (MUST) were not always completed well on the wards and the hospital did not audit compliance.
- We could not be assured that staff had specific sepsis training and if so what the compliance rates were.

Detailed findings

Evidence-based care and treatment

- Clinical effectiveness such as National Institute for Health and Care Excellence (NICE) guidelines, hospital policies and procedures were an itemised session on the agenda during the surgical directorate governance meetings.

- Care was provided in line with NICE clinical guidelines CG50, recognition of the deteriorating patient. All patients admitted were continually assessed using the National Early Warning System (NEWS). This system was based on a simple scoring system in which a score was allocated to physiological measurements already undertaken when patients present to, or were being monitored in hospital. The hospital carried out an annual audit for compliance in escalation of patient care using the NEWS scoring system. This had been instigated as an audit had not been carried out since 2011 and it identified that staff needed to document that a revision of observations had taken place. This was fed back to ward sisters and an action plan was to be developed, these results were shared with staff through ward emails and meetings.
- Staff were knowledgeable about and adhered to the Sepsis 6 protocol. Sepsis was audited as part of the hospitals CQUIN (commissioning for quality and innovation) programme. The information we received showed patients in the acute inpatient setting had timely identification and treatment for sepsis. The hospital had achieved its CQUIN target over the previous three quarters; however, this information was not included on the hospital's performance assessment framework so we could not assess performance over a prolonged period.
- We saw the safe handover of patients from theatres to recovery and recovery to the wards. The theatre manager had implemented a standardised approach to handover using the Situation, Background, Assessment and Recommendation communication tool. This communication tool ensured an effective and efficient way to communicate important information as recommended by the Institute for Healthcare Improvement. We observed how all members of the team had signed up to this safety standard.
- Staff we spoke to on Hutton and Steepholm wards told us they would speak to the mental health liaison nurse and the patients doctors should they suspect a patient was suffering from depression or decline in their mental health.
- We saw posters displayed around the ward to encourage staff to have their patients out of bed by 11am or their head positioned at 30 degrees. The overall aim was to reduce mortality from hospital-acquired pneumonia by simple measures such as raising their heads, good mouth care and mobilisation. This was communicated to staff verbally and by posters displayed around the wards. This was one of the hospital's quality improvement projects and from January to February Hutton ward audited compliance and could see that staff had made improvements. Every patient who had to be nursed in bed was nursed at 30 degrees and this was an improvement from the start of the project. All the patients that could get out of bed before 11am were doing so by the end of the audit.
- We saw good investigation into safety events by the use of root cause analyses(RCAs) However, recentguidelinesissued by the National Patient Safety Foundation highlighted the importance of emphasizing actions to address root causes. The study described the development of a new rapid approach to RCAs, called "Swarming". The hospital were implementing this approach to target pressure area care.
- Patients were assessed for risks of venous thromboembolism or blood clots (VTE) prior to their surgery and in line with the National Institute of Health and Care Excellence (NICE) guidance. There was evidence in patient records of the prescription and use of compression stockings and VTE prophylaxis medication. However, the hospital performance assurance framework data collection from May 2015 to November 2016 showed a steady decline in compliance to the tool and in October 2016 compliance was at 44.47%. An action plan was put in place and results had slightly improved

Pain relief

- Pain relief on the wards was well managed and we saw how quickly staff reacted to patients requesting pain relief. We saw how staff on Hutton ward explained the different sorts of analgesia to their patients and some of the side effects that may be experienced. Staff also explained what could be done to alleviate these side effects such as offering anti-sickness medication or laxatives when appropriate.
- Since the last inspection, the hospital had employed a dedicated acute pain nurse in line with the Royal College of Anaesthetists Accreditation Standards. The specialist nurse had taken on board issues of pain control in patients with dementia and the hospital used the Abbey Pain Score to assess measurements of pain in those patients who were non-verbal.

- There were various measures used to prevent and treat pain. We heard a nurse explaining to a student a pain scale used specifically for patients living with dementia, where changes in facial expression, body language and behaviour were critical in assessing pain.
- The National Early Warning System (NEWS) for patient observations was used which included pain as a parameter.

Nutrition and hydration

- Theatres and the ward areas ensured the effective management of nausea and vomiting. We saw staff enquire about patient's appetites and offer anti-emetic medication for patients who reported feeling nauseated. We also saw how staff returned to check that the medication had worked and if necessary offer an alternative anti-emetic.
- For patients able to take their own fluids, drinks were available on bedside tables and within reach.
- Dieticians had also developed nutrition guidelines and advice for patients living with dementia, their families and carers for example looking at the use of finger food.
- The dieticians told us and we saw evidence that the ward staff completed food record charts. We checked four sets of records for patients that required food charts and they were all fully completed.
- The dieticians worked in conjunction with the catering department to ensure that diets in acute settings met the British Dietetic association standards. Evidence had shown that patients who were on a textured modified diet were nutritionally vulnerable for a multitude of reasons over and above that of swallowing difficulties. The dietetic department addressed these issues and expanded the menu choices, provided patients with their own specific modified menu so they could specify their own meal choice and implemented texture appropriate snacks.
- We saw how hard the housekeeping staff worked to make sure patients received the appropriate food on the appropriate coloured trays to identify which patients required a special diet or assistance with eating their meals.
- Patients were advised about appropriate pre-operative fasting in the pre-operative assessment unit. Patients were fasted in line with hospital policy and lengths of fasting times reflected where patients were on the day's theatre list
- As part of the nursing inpatient admission documentation all patients should be screened using the Malnutrition Universal Screening Tool (MUST) a validated nutrition screening tool which identified patients who were malnourished or at risk of malnutrition. MUST online training was mandatory for all care staff, however, dieticians reported that the MUST was not always completed well on the wards. They produced an audit which was delivered to the nutrition steering group. Some of the findings were that, staff made limited effort to find out a patient's previous weight, so there was rarely an identification of weight loss when a patient was admitted. The dietitian could often find this easily when time was taken to look. Dietitian advice was not always taken, such as use of high-energy drinks which were not being used when recommended. Dieticians told us that they were providing training to ward staff to improve the use of this screening tool. The surgical performance assurance framework did not include data on the compliance of staff completing the MUST.

Patient outcomes

- The trust had a mixed performance for a number of national quality outcomes. However information about the outcomes of people's care and treatment was routinely collected and monitored action was taken as a result to make improvements.
- The trust submitted data to the National Joint Registry (NJR) and Patient Related Outcome Measures (PROMS), which helped the NHS measure and improve the quality of care patients experienced during and after elective surgery. The Patient Reporting Outcomes Measures (PROMS) and the National Joint Registry for the period of April 2015 to March 2016 showed that more patients who had groin hernia operations felt better and fewer patients felt worse after their treatment than the England average. The Hip Replacement (EQ VAS) indicator showed fewer patients felt better after treatment and more patients felt worse than the England average.
- Enhanced recovery programmes (ERP) for elective hip and knee replacements were followed to help improve patient outcomes. This started in the pre-operative assessment unit when patients were told the importance of pre-operative health, such as the importance of good nutrition, post-operative pain relief and what would be available, physiotherapy,

occupational therapy and discharge planning. One of the key messages was that patients would be getting out of bed within 24 hours of their surgery in line with the ERP guidance. The hospital took part in the pilot, orthopaedic dashboard called 'Getting it Right First time' in 2016. This work identified areas of unwanted variation in clinical practice and/or divergence from the best evidence. The audit tool showed that despite having an older than average population length of stay in 2014 to 2015 for primary hip replacement, fractured neck of femur, revision of hip replacements and primary knee replacements was less than or similar to the national average.

- In the 2015 Bowel Cancer Audit the hospital had a mixed performance compared to other hospitals. The length of stay of patients undergoing a major bowel resection was 73%, better than the national average and an improvement on the 2014 data of 47%. The risk-adjusted 90-day and two year post-operative mortality rate was within the expected range. The risk-adjusted 90-day unplanned readmission rate and the risk-adjusted 18-month temporary stoma rate in rectal cancer patients undergoing major resection were both within the expected range.
- Overall the hospital had performed similarly to other hospitals in the 2016 Oesophago-Gastric Cancer National Audit (OGCNCA) audit and similar in 2015 to their performance in 2014. In 2016 the age and sex adjusted proportion of patients diagnosed after an emergency admission was 13.9%. This placed the hospital within the middle 50% of all hospitals for this measure. The proportion of patients treated with curative intent was 36.7%, in line with the national aggregate.
- Overall the hospital performed well in the 2016 National Emergency Laparotomy Audit (NELA). The hospital achieved a green (>80%) rating for the following data: the crude proportion of cases with access to theatres within clinically appropriate time frames, of high-risk cases with a consultant surgeon and anaesthetist present in the theatre and of highest-risk cases admitted to critical care post-operatively. The risk-adjusted 30-day mortality for Weston General Hospital was within expectations. However the hospital received a red (<50%) rating for the crude proportion of cases with pre-operative documentation of risk of death.
- Between September 2015 and August 2016, patients at the hospital had a similar to expected risk of readmission for non-elective and elective admissions. The elective specialty Trauma and Orthopaedics had the largest relative risk of readmission.
- The hospital submitted data to The National Hip Fracture Database. Overall Weston General Hospital performed better in one, worse in one and in the middle 50% for four of the hip fracture audit metrics. In 2016 the mortality rate was 10.7% which was worse than expected but an improvement since 2015 which was 8.8%. The proportion of patients having surgery on the day of or day after admission was 75.3%, which was below the national standard of 85%; however, this was an improvement on the 2015 figures of 66.5%. The peri-operative surgical assessment rate was 83.8%, which did not meet the national standard of 100%, but was an improvement on the 2015 data of 74.3%. The data for the proportion of patients not developing pressure ulcers and length of stay fell in the middle 50% of hospitals, both of which was an improvement on the 2015 data. Patient's length of stay was 20.4 days, which was within the national average.
- The surgical directorate performance management review in October 2016 identified areas of underperformance as not all patients were admitted to an orthopaedic ward and operated on in a timely manner. The National Institute of Health and Care Excellence recommended that Patients with fractured neck of femurs should be operated on within 48 hours of admission. The proportion of patients having surgery on the day of or day after admission from July to November 2016 averaged at 83% which was just below the national standard of 85%. Increased mortality rates for this group of patients had been identified and was included in the hospitals mortality reduction plans.
- However, the Summary Hospital-level Mortality Indicator (SHMI) quarterly statistics published in December 2016 for the periods of July 2015 to June 2016 showed that the hospital was one of 11 hospitals that had a higher than expected number of deaths. The data for the periods of October 2015 to September 2016 were still higher than expected. The hospital identified seven quality improvement projects, and produced a mortality action plan with decreasing mortality from fractured neck of femurs identified as Red (Barriers- not

achieved). The plan identified an increase in mortality in January 2016 and that part of the improvement plan to improve this was the re-recruitment of the orthopaedic-geriatric service.
- The hospital told us they did not take part in the 2015 National Vascular Registry (NVR) audit or the Anaesthesia Clinical Services Accreditation scheme (ACSA).

Competent staff

- Annual appraisal and clinical supervision structures enabled staff and managers to identify training needs, develop competence and enhance clinical practice. The hospital overall appraisal rate in November 2016 was 82.13% which was below its 90% target. The surgical directorate appraisal rates for November 2016 were varied, with nursing and midwifery staff consistently under 80%. However all staff we spoke with all knew who their appraiser was, when they should have had or were due their appraisal. All training attended was documented on electronic staff records. Managers were informed of training completed and alerted to those staff requiring updates for mandatory training.
- Senior staff across the surgical directorate recognised the value of investing in their staff. Staff on the wards and in the theatre departments felt supported in accessing training and theatre staff were supported to attend external management courses. The theatre department had recently obtained funding for a training and development co-ordinator and had invested in sending another member of staff on a procurement course. Operating department staff in theatres were funded to attend a specific trauma course in fracture management, previously no staff had attended this and during the time of our inspection two staff had attended the course.
- Staff in all the theatre departments received regular teaching on the National Safety Standards for Invasive Procedures (NatSSIPs). This was a hospital wide project and was being cascaded across other departments where invasive procedures took place, such as the wards, sexual health department, outpatients and interventional radiology. Senior staff we spoke with all told us how well supported they had been to implement the safety procedures across their departments.
- The staff we spoke with knew who and how to contact the mental health liaison nurse and the lead for safeguarding and learning disabilities. We witnessed how staff had the skills, knowledge and experience to identify and manage issues arising from patients' living with a dementia diagnoses.
- Staff spoke highly of the induction process. After the hospital induction programme was completed staff were allocated supernumerary periods to complete further mandatory e-learning and familiarise themselves with their new environment. The hospital had a thorough and comprehensive learning and development guide, which had been updated in February 2017. This guide identified who needed what sort of training, how and where it would be delivered, what dates were available and how to book places.
- Senior staff on the wards told us that there was support from the human resources department and senior nurses at directorate level should any performance management issues need addressing.
- Staff we spoke to on the wards told us they did not have official sepsis training, however, the staff we spoke to all knew how to escalate patients safely to the critical care outreach team through the sepsis six pathway. Information we received suggested that teaching for sepsis was included in ward based teaching within the national early warning system. We could not be assured how the teaching was delivered and what numbers of staff had received it.

Multidisciplinary working

- Staff worked well together to assess and plan ongoing care and treatment in a timely way. We saw how well the physiotherapist and occupational therapist and the discharge team worked together on a daily basis to plan a patient's care and discharge. We saw how the physiotherapists were developing training to make sure that staff were confident to get patients out of bed post replacement surgery. The training was designed to make sure that rehabilitation continued at all times of the week.
- Theatre teams worked well together, we witnessed how prior to the start of the morning theatre a team brief was carried out with all of the team present, everyone was encouraged to participate. We were told that any member of the team could co-ordinate the briefing, which aimed to encourage ownership and involvement from all.
- The hospital pre-admission clinic started planning for elective patient's safe discharge at their first

appointment. Potential complications were then picked up on the daily whiteboard meeting. We observed these meetings on Hutton ward and for surgical patients outlying on Cheddar ward. These meetings involved a physiotherapist, the ward sister/manager, an occupational therapist and a member of the discharge team. These meetings discussed all delays or potential delays to discharge and plans were then developed and actions disseminated. All communications were documented in the patient's records.

- We saw how senior nurses from the rehabilitation team came up to the wards and assessed patients for their suitability for a transfer to the rehabilitation ward.
- We saw effective handovers between surgeons, anaesthetist and recovery staff. The theatre team had developed a streamlined handover based on the Situation, Background, Assessment and Recommendation tool (SBAR). This was to make sure all areas of pre, peri and post-operative care were handed over and information was communicated effectively, consistently and succinctly.
- Volunteers visited the wards weekly to sit with patients, and help during mealtimes, nursing staff found this a help and we witnessed good rapport between staff and the volunteers.

Seven-day services

- We checked eight sets of notes on the surgical admissions unit (SAU) and all emergency admissions had documentation to confirm that patients had a clinical assessment by a consultant within 14 hours. This was in line with NHS England's seven-day services priority standards, Time to First Consultant Review.
- On the surgical admissions unit there were two consultant ward rounds every day of the week. One took place in the morning and the second late in the afternoon when new patients were seen and patients admitted earlier were reviewed. There was a consultant general surgeon and orthopaedic surgeon cover at all times of the day and night, seven days a week. Surgical registrars provided cover from eight to eight thirty seven days a week. There was an on call orthopaedic registrar 24 hours seven days a week. A trauma consultant covered theatres, Monday to Thursday afternoons and all day on Friday. Junior doctors provided on call for orthopaedics, general surgery and gynaecology seven days a week, 24 hours a day.
- There was provision for emergency surgery for those patients who met the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) criteria as 'urgent'. During Monday to Friday, theatre teams were available on site from 6pm to 9pm and then on call from 9pm to 8am. During Saturday and Sunday theatre teams were available on site from 8am to 9pm and on call 9pm to 8am.
- Nursing staff told us that they felt more supported out of hours as senior nursing staff worked after 5pm and over the weekends to offer support and guidance.
- Staff told us that a reduced physiotherapy service was available over the weekends. This was for elective post-operative patients with intensive care physiotherapy available for urgent chest physiotherapy. In order to mobilise patients as soon as possible and reduce the post-operative side effects the physiotherapist for the trauma and orthopaedic wards was developing a competency based training package. This would give the nurses confidence and skills to assist patients out of bed on their first post-operative day (if appropriate). The overall aim was to reduce side effects and a patient's length of stay.
- The hospital did not provide an on-site seven-day pharmacy service. Services were Monday to Friday and an on-call pharmacist was available out of hours and the hospital had an emergency cupboard for staff to access medication out of hours.
- There was access to all key diagnostic services 24 hours a day, seven days a week to support clinical decision making, this included critical imaging and reporting within 1 hour, urgent imaging and reporting within 12 hours and when possible non-urgent within 24 hours.

Access to information

- Staff told us that the information needed to deliver effective care and treatment for was available in a timely and accessible way for example care plans, risk assessments patient records and test results.
- All the standard operating policies that were being developed in the theatre department either were or were in the process of being made available on the intranet. This was to reduce the duplication of paper copies and to make sure the most up-to date copy was available for staff.
- A red sheet of paper was placed in the patient record to help identify the most recent admission and make it easier and quicker to access the relevant areas.

- Patients who were not for cardio-pulmonary resuscitation had this clearly documented in their notes.
- The hospital told us that they placed an alert on the front of patient's records and on the electronic record if a patient had learning disabilities. However, they told us they did not have an electronic flagging system for those patients who were living with dementia, autism or mental health issues
- GPs had access to some CT (Computed Tomography) and MRI (Magnetic Resonance Imaging) scans. The possibility of further access was under discussion during the time of our Inspection and was discussed at the radiologist's consultant meeting.
- Nursing staff told us that they spent a lot of time filing notes due to reduced ward clerk cover. When they were not able to file notes in a timely manner, it increased the risk of them going missing. Patients told us that they felt nurses had too much paperwork to deal with.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff were aware of consent and decision making requirements of legislation and guidance, including the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS). Staff had attended mandatory training and knew what their responsibilities were and how to apply them within everyday practice when required.
- We observed staff obtain patient consent verbally for care and treatment throughout the patient pathway. Staff acted within the legal framework to obtain patient consent for treatment. Written consent was completed pre-operatively in the outpatient clinic and verbally checked again on admission and as part of the World Health Organisation (WHO) safe site surgery checklist.
- Patients and their relatives/carers living with dementia, learning disabilities, autism or mental health issues were given extra time during the pre-admission process to make sure the correct consent was obtained.
- We saw discussions and planning during the general surgery group meeting around the Royal College of Surgeons (RCS) consent guidance. The safeguarding team undertook an audit looking specifically at consent form 4, which showed a 95% correct completion compliance rate
- We looked at four medical records and saw consent documents were fully and clearly completed.
- There was a policy relating to Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) and staff were aware of their responsibilities. A full entry was made in the patient's medical notes as soon as a DNACPR order was made. This included the rationale behind the decision, together with a review date and any other relevant comments concerning the patient's individual circumstances. A copy of the DNACPR order was placed on the patient's case notes; it was the first document that was seen.

Are surgery services caring?

Good

We rated caring as good because:

- Feedback from all the patients we spoke to was very positive.
- Patients commented on how the care from the nursing staff and allied health professionals was 'superb', 'exemplary 'and staff had a 'great sense of humour'
- We saw how well staff cared for those patients and their families who were living with a diagnosis of dementia and mental health issues.
- Staff were seen treating patients with dignity respect and compassion.

Detailed findings

Compassionate care

- To capture feedback the hospital used the friends and family test (FFT) which captures real-time feedback and asks if patients would recommend the service to their friends and family. The response rate between the periods of December 2015 to November 2016 for the surgical directorate were better than the England average. Feedback showed high levels of recommendation and was as follows ;
  - Day case unit between 96% and 100%,
  - Hutton ward between 80% and 100%,
  - Steepholm ward between 75% and 100%
  - Waterside ward between 88% and 100%.

- We spoke to four patients on the surgical admissions unit (SAU). One patient told us how 'all the staff do an amazing job with the pressures they are under'. One patient told us how a porter was 'jovial and sensitive to my needs' during a delayed scan appointment.
- Patients spoke of how the physiotherapists and the nursing staff were 'superb', 'exemplary 'and had a 'great sense of humour'.
- We spoke to six patients on the day case unit. All patients praised the hospital and the care they received. One patient told us 'I cannot fault the care' another patent told us that 'the nurses have always been alert and helpful, always there'. Another patient told us that 'the doctors and nurses couldn't do enough for me and always made me smile'.
- During a procedure in interventional radiology, we saw how staff took the time to explain all of the procedure to a patient who was very anxious. The nurse and radiologist checked and double-checked that the patient understood exactly what was happening and this led to a calm and relaxed atmosphere.
- On Hutton ward staff members displayed understanding and a non-judgemental attitude towards patients who were living with mental health and dementia diagnoses. We saw how hard staff worked to try to ease the distress of one patient who continually called out.
- On every ward we visited, we saw how respectful the staff were to patients privacy and dignity. Patients in theatres and recovery had their dignity maintained at all times and curtains were always closed during any intervention. Patients waiting for operations in the pre-operative assessment unit, and had changed into their theatre gowns could wait in a private room. They were given the choice to sit in the waiting room to watch the television should they wish.
- We saw how patients had time to ask staff questions during medication rounds and how staff took the time to answer all their questions, offer alternatives and alleviate concerns.
- We observed how staff maintained patient's confidentiality during the morning whiteboard meeting. The team spoke with lowered voices and closed the bay doors when talking about the ward patients.
- Every ward had a whiteboard displayed, which identified 'You said', 'We did'. Each ward had identified a suggestion from a patient or their relative from either exit cards or a suggestion box.
- The hospital used the PLACE (patient-led assessments of the care environment) survey, which assessed the quality of the patient environment. Hutton and Steepholm wards were assessed with mixed results, Hutton ward scored 88.24% for dignity and Steepholm ward scored 66.67%.

Understanding and involvement of patients and those close to them

- Relatives were encouraged to visit their loved ones when appropriate. We saw a relative of a patient on Hutton ward helping their loved one eat and although this was out of the visiting hours it had been encouraged.
- Staff told us that relatives of patients living with dementia, mental health, autism or learning disabilities would always be welcome on the ward if it helped ease the anxieties of their loved ones.
- Staff on the pre-admission unit told us that when they had a patient attending who was living with dementia, mental health, autism or learning disabilities they would allow a double appointment. This was to make sure that all questions from patients and their relatives were answered, concerns alleviated and plans were put in place for a smooth admission to hospital.

Emotional support

- Patients had their physical and psychological needs regularly assessed and addressed, including nutrition, hydration, pain relief, personal hygiene and anxiety.
- During the whiteboard meeting on Hutton ward we saw how staff discussed concerns they had for a relative coping with a patient who was living with dementia, they discussed what plans could be put in place and how these referrals would take place to increase packages of care.
- For those patients who required help, referrals would be made to the mental health liaison team.
- The hospital had a multi-faith chapel which was accessible 24 hours a day. Staff had access to chaplaincy information through the hospital intranet, and the hospitals spiritual care policy. Information booklets explaining the chaplaincy services at the hospital were included in the patients 'Your Bedside Book'.
- The surgical admissions unit had a room that could be accessed for patients who were having private conversations with consultants, psychiatrists or the mental health team.

Surgery

Are surgery services responsive?

Requires improvement

We rated responsive as requires improvement because:

- Surgical services were under pressure due to increased admissions to the hospital; this led to surgical beds being occupied by other specialities. The result of this meant that sometimes surgery for some patients had to be cancelled.
- The average length of stay for surgical non-elective patients was 6.3 days, compared to 5.1 days for the England average.
- Due to bed availability, medical patients were being cared for on surgical wards and due to a recent outbreak of noro-virus, some surgical patients were being cared for on medical wards. While arrangements were in place for appropriate medical staff review this did not ensure optimum care and treatment.
- The hospital did not have an orthopaedic-geriatric service due to recruitment problems.
- Staff on the surgical admissions unit expressed their concerns that patients who had sustained a fractured neck of femur and were waiting surgery were temporarily cared for on the unit.
- Complaints were not always recorded and handled effectively at senior level.

However:

- The information about the needs of the local population was used to inform how services were planned and delivered. The hospital worked with the local clinical commissioning group (CCG) to explore new models and pathways of care delivery.
- A theatre scheduling group had been established which reviewed weekly theatre utilisation alongside a scheduling policy and utilisation of theatres had improved.
- We saw good care of surgical patients outlying on medical wards.
- We observed how daily white board multi-disciplinary meetings identified those patients who were at risk of an increased length of stay.
- Handovers and whiteboard meetings routinely considered the needs of those patients and their carers living with complex mental health conditions and dementia.
- The dietetic department had expanded menu choices for those patients on a textured diet and had provided patients with their own specific modified menu so they could specify their own meal choices.

Detailed findings

Service planning and delivery to meet the needs of local people

- Information about the needs of the local population was used to inform how services were planned and delivered. The surgical directorate had an operational plan for the next two years. This identified how the directorate would support the hospital-wide objectives.
- The hospital worked with the local clinical commissioning group (CCG) to explore new models and pathways of care delivery. One of the key areas of work identified was the implementation on Waterside ward of 12 protected beds for elective NHS orthopaedic patients, the aim of which was to reduce the number of cancellations.
- The facilities and premises in main theatres were appropriate for the services that were planned and delivered. There were four main theatres one of which was dedicated to emergency trauma cases. There were six trauma sessions per week, every afternoon Monday to Thursday and all day Friday and there were on call arrangements for out-of-hours surgery. All arrangements for trauma theatres were set out in the standard operating policy.
- During the time of our inspection, surgical in-patients were being cared for on the day case unit (DCU) due to the hospital being in escalation. The hospital had risk assessed the DCU and identified actions to reduce risks. A standard operating policy (SOP) identified that in-patients could be cared for safely on DCU, however the policy stated that only 10 beds across two bays could be accessed. An increase in this number of in-patients would only be considered if there were 15 patients or more in the emergency department corridors. The SOP identified inclusions and exclusions and if any decisions to override the criteria were made an incident form must be submitted. Whilst staff on DCU recognised it was a temporary measure they had done

everything to maintain patients' comfort and safety. Senior staff praised the positive attitude that DCU staff maintained throughout. Staff we spoke to on the unit took great pride in the positive feedback that patients gave them about their care on what in effect was a temporary ward. We spoke to two inpatients on the DCU and they felt that their care was 'excellent and they 'couldn't fault it'.

- Up until January 2017 the hospital had an orthopaedic-geriatric service. This service provided pre and post-operative orthopaedic-geriatric cover by a consultant in a part-time capacity and a part-time orthopaedic -geriatric middle grade doctor. Both of these had left and the hospital had been successful in recruiting a part-time consultant, the advertisement for the middle grade doctor was being re-advertised.

Access and flow

- The hospital did not meet all the measures and some people were not able to access care in a timely way.
- Surgical services were under pressure due to increased medical patient admissions to the hospital; this led to surgical beds being occupied by medical patients. The result of this meant that sometimes surgery for some patients had to be cancelled.
- Bed occupancy was recorded monthly and showed that the trust were red on their RAG (red, amber, green) status and during October and November 2016 the trust exceeded their capacity. In-patients being cared for on the day case ward and on medical wards reflected this in surgery and from October 2016 to December 2016 there were in total 830 outliers of medical patients in surgical beds. During this period, 118 operations were cancelled, 49% of these were due to a lack of inpatient beds.
- During our inspection, we were assured of the safety of surgical patients outlying on medical wards. Cheddar ward had surgical patients who were being reviewed daily by the critical care outreach team, not due to their acuity but to offer support and guidance to staff that were not used to caring for this group of patients.
- The hospital worked hard to try to reduce the numbers of operations cancelled and had inpatients cared for on the day case unit and during quarter three, 39 patients were cared for on medical wards. The hospital tried to cancel theatres the day before the list was scheduled to run and this included phoning patients on a Sunday if they were due for admission on a Monday. Quarter three (2015 to 2016) to quarter two (2016 to 2017) showed that the hospital cancelled 149 operations. Out of these 149 cancellations, only 6.7% were not treated within 28 days. With the exception of quarter one (2016 to 2017) these results were lower than the England average.
- Between December 2015 and November 2016 the hospital's referral to treatment time (RTT) for admitted pathways for surgical services had been about the same as the England overall performance. The latest figures for November 2016, showed 69.7% of this group of patients were treated within 18 weeks compared to the England average of 71.4%.
- Between September 2015 and August 2016 the average length of stay for surgical elective patients at the hospital was 3 days, compared to 3.3 days for the England average. For surgical non-elective patients, the average length of stay was 6.3 days, compared to 5.1 days for the England average. The top three elective specialties showed Trauma and Orthopaedics average length of stay was 4.1 days compared to an England average of 3.4 days. Urology and General Surgery were both below their respective England averages.
- Since our last inspection a theatre scheduling group had been established this reviewed weekly theatre utilisation alongside a scheduling policy. We saw a draft theatre operating policy which aimed to make sure all staff were aware of the 'systems, procedures and performance standards' that supported the running of the theatres. Ownership and responsibilities were acknowledged and theatre capacity and list scheduling were also identified. Theatre utilisation had been significantly less than the hospital target of 85% and scheduling meetings were implemented. The meetings aimed to look ahead six, three and one week to identify actions such as confirmation of theatre sessions, booking and confirmation of consultants and anaesthetists and the final lock down of the theatre list one week ahead before it went live. Once this list was locked down, only certain senior staff could alter it, when this happened the list changed colour to show that it had been updated. This ensured that all departments had the same colour and, therefore, the most up-to-date version. This worked well and could be seen in a slight improvement in theatre utilisation, however the target of 85% was not yet consistently achieved The aim was to increase theatre utilisation to 85% across day case and main theatres. Utilisation

across all of theatres for quarter three (2016 to 2017) was 77.3%, 73.6% and 81.5%. Staff told us this was for a number of reasons but mainly due to cancelled operations.

- There was provision for emergency surgery out of hours for those patients who met the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) criteria as 'urgent'.
- We observed how daily white board multi-disciplinary meetings, identified those patients who were at risk of an increased length of stay. The discharge team attended the meetings where actions were identified and plans were made in an attempt to increase patient flow out of the hospital. We saw how this was communicated to the associate director of nursing and we were assured that any reason for discharge delay was fully understood and communicated to senior teams. We could see from the SITREPs (situation report) delayed transfers of care information for September to November 2016, that delays were mainly attributable to social care delays in completion of assessments and placements in nursing homes.
- Staff on the surgical admissions unit expressed their concerns that patients who had sustained a fractured neck of femur and were waiting surgery were temporarily cared for on the unit.

Meeting people's individual needs

- The surgical services took account of peoples different needs including those in vulnerable circumstances.
- Signage was clear enough to be understood by people who were unfamiliar with the environment. The wards had clear information explaining how many staff were on duty and who was the nurse in charge. A good variety of leaflets were available including information about avoiding pressure ulcers, recovery at home, pain relief, delirium and patient transport. There were clear instructions displayed about making complaints or giving compliments, wards displayed thank you cards from patients and their relatives and carers. Boards displayed 'you said, we did' which highlighted suggestions made by patients and the actions the wards took.
- Staff told us that if they had any concerns for a patient's mental health then they knew how to make a referral to the mental health liaison nurse.
- We attended handovers and whiteboard meetings on Cheddar (where surgical patients were outlying), Hutton and Steepholm wards, which referred to the psychological and emotional needs of patients, as well as their relatives and / or carers. We saw how staff discussed extra help relatives may require due to emotional pressures of a sick relative.
- We witnessed how the surgical directorate supported their staff to deal with the number of cognitively impaired patients admitted to their wards. Extra staff were booked over and above their usual funded requirements and were dedicated to care for the safety of these vulnerable patients. Patients living with dementia were situated in the bays or side rooms that were most visible to the nursing station. Staff who provided enhanced supervision to these patients were wearing yellow tabards and were easily identifiable. Staff were allocated to a patient or a group of patients in a bay and were not to be removed unless another staff member had taken over from them. We saw the hospitals own 'This is me' booklet in the notes of a patient living with dementia. This booklet had been completed by a relative of the patient and explained the patient in detail, what they liked to be called what they liked to do, what was their favourite food.
- The largest ethnic minority groups in the area were Chinese, Indian and Black African/Caribbean. The hospital had an agreement to use external language translation services. This service was accessible via the trusts patient advice and liaison service.
- The hospital had a multi-faith chapel which was accessible 24 hours a day. Staff had access to chaplaincy information through the hospital intranet, and the hospitals spiritual care policy. Information booklets explaining the chaplaincy services at the hospital were included in the patients 'Your Bedside Book'.
- From 1st August 2016 onwards, all organisations that provide NHS care or adult social care are legally required to follow the Accessible Information Standard. The standard aims to make sure that people who have a disability, impairment or sensory loss are provided with information that they can easily read or understand and with support so they can communicate effectively with health and social care services. The trust developed a task and finish group, which met every weekly to make sure actions were being completed to achieve the standard. We saw evidence of some of the work that was undertaken, for example wards were using the 'This is

me' pathway for those patients living with dementia, visually impaired alert for the ward boards and patient bed spaces and easy to read leaflets on how to complain.
- However staff on Hutton ward told us that there were no resources available, e.g. pictures, to explain medical procedures or tests to patients with limited understanding or communication.

Learning from complaints and concerns

- The hospital had policies and processes in place to investigate, monitor and evaluate patient's complaints. However, complaints were not always recorded at a senior level as handled effectively, with a regular update for the complainant and a formal record kept.
- We reviewed data of complaints from September to November 2016. Out of the nine complaints for the surgical directorate, four had no actions or lessons learnt documented and were still open. The majority of the complaints that had been closed were done so within the hospitals target of 40 days. Complaints that had been closed had clear outcomes, lessons learned and apologies documented as given. The risk register identified timely complaint response as a risk, initially rated as 20 (red),during the time of our inspection it was still red but rated as 16 as some improvements had been made. The surgical directorate governance meetings minutes had complaints (patient experience) and compliments as a standard agenda item. We reviewed three sets of meeting minutes but there was very limited discussion documented.
- Information was displayed on how to make a complaint. We spoke with 11 patients none of whom had any complaints but all knew who to speak to should they need to raise one. There were leaflets displayed around the hospital and on the wards. The hospital intranet also had information on how to make a complaint.
- Staff on the wards were able to explain what they would do when concerns were raised by patients. They said they would always try to resolve any concerns as soon as they were raised, but should the patient remain unhappy, they would be directed to the clinical manager. Staff told us they were aware of complaints that had been made about their ward areas and any learning that had resulted was cascaded through departments by newsletters and staff meetings.

Are surgery services well-led?

Good

We rated well-led as good because:

- Staff had the skills and knowledge to lead the service. All of the staff we spoke with talked of how visible their senior nursing staff were from matrons, associate directors of nursing to the director of nursing.
- There was a clear strategy to deliver a safer environment for patients at the hospital. The senior management teams and the theatre department had identified areas of risk not only within the theatres and recovery but also across the hospital. A substantial amount of work had been, or was in the process of being completed, to drive improvements for all patients having invasive procedures.
- Staff in the theatre departments spoke of how strong leadership had made changes to the safety and the culture of theatres. Staff told us how well the safety standards had been set up and worked effectively even in the absence of the senior management team.
- There were satisfactory arrangements for identifying recording and managing risks and this was an improvement since our last inspection.
- The ward areas had started a 'campaign' to encourage their team members to make sure all patients that could be either out of bed before a certain time in the mornings or if not be nursed at 30 degrees. This was a drive across the hospital to decrease the numbers of hospital-acquired pneumonias and identified as part of the hospitals mortality action plan.

However

- Whilst the governance framework was effective enough to support the delivery of the strategy and good quality care, there were areas that required improvement. The main areas for improvement were learning from mortality and morbidity reviews.
- Audits of sepsis were carried out through CQUIN monitoring and not part of the hospitals performance assurance framework.

Detailed findings

Leadership of service

- Staff had the skills and knowledge to lead the service. All of the staff we spoke with talked of how visible, supportive, knowledgeable and experienced their senior nursing staff were from matrons, associate directors of nursing, the chief executive and the director of nursing.
- The surgical directorate were waiting for a new clinical director to start in post after the date of our inspection. We spoke with the surgical management team all had felt well supported by their previous clinical director.
- We spoke to student nurses on the wards and in focus groups, some had applied for jobs on the surgical wards that they had finally been placed on. All of the students spoke of how well supported they had been by their mentors.
- Staff in the theatre departments spoke of how strong leadership had made changes to the safety and the culture of theatres. Staff told us how well the safety standards had been set up and worked effectively even in the absence of the senior management team.
- Areas that were used for escalation were managed professionally with staff putting patients first. This was seen in the positive attitude of staff during disruption to their usual routine on the day case ward. Senior staff told us how proud they were of their department and team for managing so well over a drawn out period of escalation.

Vision and strategy for this service

- The surgical directorates' operational plan for 2017 to 2019 identified a need to develop a vision which encompassed the directorates objectives over the next two years. To ensure services are sustainable, affordable and efficient the directorate identified a need to work more collaboratively with the wider community.
- There was a clear strategy to deliver a safer environment for patients at the hospital. The senior management teams and the theatre department had identified areas of risk not only within the theatres and recovery but also across the hospital. A substantial amount of work had been, or was in the process of being completed, to drive improvements and we saw how committed the team were to improving safety for all patients having invasive procedures.

Governance, risk management and quality measurement

- The majority of the governance framework was effective enough to support the delivery of the strategy and good quality care; however there were areas that required improvement.
- There were satisfactory arrangements for identifying recording and managing risks and this was an improvement since our last inspection. We reviewed the surgical risk register; the majority of the risks we reviewed were current (had been reviewed 2 months prior to our inspection) and all appropriately identified and reflected what staff told us was on their worry list. Gaps in assurances had been identified with actions plans and who was responsible for what action. When risks were reviewed we could see an improvement in performance and safety, for example we could see how timeliness of dealing with complaints was identified as one of the department's highest risk. Action plans were put in place and with input from senior nursing teams the risk had started to reduce.
- Risk management was a standard agenda item at the surgical directorate governance meeting although we saw limited discussions around the risk register the minutes documented staff were urged to complete all risk assessments.
- Mortality rates not reducing in line with England targets was also identified on the register. Gaps in the controls that were in place had been identified such as the lack of assurance from governance reports around lessons learned. This risk was still current and was reflected in the quality of some of the M&M meetings and reflected how some of the staff felt.
- We reviewed the trauma and orthopaedic mortality and morbidity (M&M) meeting minutes and could see learning points and actions logged for each mortality and an updated action plan with an identified lead and date for each action. The urology department held joint M&M and governance meetings, we reviewed the minutes for these and could not see any action points or lessons learned and incidences of mortality were not always discussed. We could not be clear that during surgical M&M that actions and learning had been discussed and accountability for actions agreed. We requested further meeting minutes for November 2016 and January 2017 but were told these were unavailable.
- We reviewed the anaesthesia and critical care governance audit and safety meetings minutes. A joint M&M with the surgeons was part of the agenda and in January's minutes, there were no prepared

presentations of patient's deaths. In Decembers minutes a patient identified as National Confidential Enquiry into Patient Outcome and Death (NCEPOD): D room for improvement (aspects of clinical and organisational care that could have been better) had no learning points or accountability for actions documented.

- During our previous inspection, it had been highlighted that governance arrangements in the directorate had not been satisfactory. Notes were not secure at all times and incidents were not being reviewed in a timely manner. We saw this entered as a high risk on the register and we saw how the risk started to decrease. All the wards we visited had lockable notes storage containers.
- The theatre department had an effective governance framework to support excellent standardised delivery of care. There was a clear plan in place to develop Local Safety Standards (LocSSIPs) for Invasive Procedures based on the shared National Safety Standards for Invasive Procedures. Work had been carried out by senior teams in the theatre department to roll out standardised documentation for patients undergoing various invasive procedures across the hospital. This included, interventional radiology, all ward areas and the emergency department, the Wish clinic, outpatients, maternity and endoscopy. During the time of the inspection some areas were embedding this into practice, 13 checklists were in place, five of which were procedure specific. All of these areas carried out audits to check compliance and reported through their governance meetings. As identified by NHS England there were clear lines of responsibility for the creation, governance, oversight, compliance, audit and review of the LocSSIPs.
- The performance assurance framework collated the directorate audit data and was set out under the CQC's five key questions. The data for hospital acquired pressure ulcers was not RAG (Red, Amber and Green) rated on the copy we received although the directorate had identified an increased number of Grade 2-4 pressure ulcers. This increased incidence of pressure ulcers was an item discussed at the 'Ward Wednesday' meeting. This meeting was attended by all the senior nursing staff and was chaired by the director of nursing, actions were identified and allocated to staff and dates for actions to be completed by were agreed.
- The trust was on track with achieving their CQUIN targets for sepsis recognition and treatment and improved and consistent sepsis management for in-patients was identified on the trusts mortality reduction plan. However, the performance assurance framework did not show a specific audit of sepsis so we could not be assured of continual performance over a prolonged period.

Public engagement

- The CCG had commissioned Let your voice be heard on future services booklet. This explained all the options and ideas the trust were considering during the future sustainability and transformation plan (STP) enabling the public to feedback their views. The trust asked for the publics input in the forthcoming changes and we saw leaflets and 'Your view matters' posters around the hospital.
- The surgical directorate governance meetings had patient experience itemised on the agenda. Complaints and compliments were discussed and accountability for actions agreed. The group also looked at the response rates and the quality of the responses. From the minutes we reviewed we could not identify any recurring themes.
- On every ward we saw evidence of 'you said, we did', boards where patients and their relatives could make suggestions and see what actions were taken. These information boards displayed information about the ward and the care that was delivered. Patients, visitors and relatives could see the high levels of harm free care that was delivered across the surgical directorate.
- The surgical directorate participated in the friends and family test and whilst the results were high the response rate was low for the periods of November 2015 to November 2016 the response rate ranged from 32% to 44%.

Staff engagement

- Staff had regular ward meetings and newsletters and all felt that supported to express their opinions on the running and improvements in their areas.
- Staff told us that they were aware of the trusts whistleblowing policy and they felt comfortable in approaching senior team members if they needed to express a concern.
- Staff were encouraged to attend the regular open 'Ask James' sessions with the Chief Executive and to be exposed to wider issues affecting the hospital. There

were numerous ways staff and the public could ask questions about the recently announced partnership agreement with University Hospitals Bristol NHS Foundation Hospital.
- Staff took part in the yearly staff survey; the performance assurance framework showed only a 17% response rate for 2015's survey, it did not show 2016's response rates. Staff we spoke with were not aware of the results of the latest staff survey.

Culture within the service

- Across the whole of the surgical directorate we observed staff at all levels working with a positive can do attitude. We saw this attitude on the day case unit where beds were being used to care for in-patients; staff remained positive and were committed to ensuring their patients had the best experience. This was recognised and applauded at senior levels.
- We saw how leaders across the directorates worked together to increase the levels of safety for patients undergoing invasive procedures. This included leaders in theatres, wards, outpatients, clinics and interventional radiology.
- The culture across the surgical department encouraged an open and honest way of working and staff felt supported to express any concerns they had. During our inspection, there were discussions and consultations about the trusts future plans, this involved working in partnership with another local trust. The trust actively encouraged all staff to ask questions, offer ideas and express their concerns about the future plans.

Innovation, improvement and sustainability

- Ward leaders understood challenges to safe and good quality care. Wards staffed areas where vulnerable patients were cared for safely and innovatively, for example enhanced supervision nurses wore yellow tabards to identify their role.
- The ward areas had started a 'campaign' to encourage their team members to make sure all patients that could be either out of bed before a certain time in the mornings or if not be nursed at 30 degrees. This was a drive across the hospital to decrease the numbers of hospital-acquired pneumonias and identified as part of the hospitals mortality action plan.
- During the time of our inspection the Weston Area health trust and University hospitals Bristol NHS Foundation trust agreed to establish a formal partnership. This was seen as the first step towards a more integrated provision of care.

Critical care

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

Information about the service

The department of critical care at Weston General Hospital provides a service to patients who need intensive care (described as level three care) or high dependency care (level two care). Patients are admitted following complex surgery or in the event of medical and surgical emergencies. The critical care unit provides support for all inpatient specialities within the acute hospital and to the emergency department. The five-bed unit had three separate areas linked together. These consisted of two areas with two beds in each, and one single side room. The hospital had an outreach team reporting to the matron for critical care. This team provided critical care support, advice and guidance to staff caring for patients throughout the hospital and worked 24 hours a day, seven days a week.

In any given year, the critical care unit admits around 320 patients. In the six months from April to September 2016, just over half of the patients admitted had medical needs (54%). The other 46% of patients were admitted following surgical procedures (14% planned and 32% emergency/ urgent patients).

On this inspection, we met with the critical care team for a briefing on the afternoon of Tuesday 28 February, and visited the unit on Wednesday 1 and Thursday 2 March 2017. We spoke with a full range of staff, including the matron, senior sister, consultants, doctors, trainee doctors, and many of the nursing staff and healthcare assistants. We met the lead consultant intensivist for critical care and the lead consultant anaesthetist. We talked with the lead physiotherapist, the dietitian and a nurse from the outreach team. Patients who were able to talk with us, and their relatives and friends, told us about their experience of the unit. We observed care and looked at records and data. We spoke by telephone with the NHS Blood and Transplant specialist nurse for organ donation who worked with Weston Area Health NHS Trust on organ donation.

As part of this inspection, CQC piloted an enhanced methodology relating to the assessment of mental health care delivered in acute hospitals; the evidence gathered using the additional questions, tested as part of this pilot, has not contributed toour aggregation of judgements for any rating within this inspection process. Whilst the evidence is not contributing to the ratings, we have reported on our findings in the report.

Critical care

Summary of findings

We rated the service overall as good because:

- The care and treatment delivered, and the practices and protocols around them were safe.
- There was a strong culture around delivering safe care.
- People were protected from abuse and avoidable harm.
- Care was effective and patients had the outcomes that should be expected.
- Staff were well trained and experienced at delivering care.
- Staff were caring, compassionate, and treated patients as individuals.
- The services met the needs of vulnerable people, and those with specific mental and physical needs.
- There were good assurance frameworks to demonstrate how the quality and safety of care was reviewed and understood.
- There was a good culture of staff and patient involvement in the unit.
- There had been patient-focused improvements in the unit from the committed staff team.

However:

- With a high mortality rate at this trust, the service was not demonstrating learning from reviews into patient deaths.
- There were problems with patient flow in the rest of the hospital and this was affecting the ability to admit, transfer, and discharge patients in critical care at the right time.
- There was a lack of multidisciplinary or a collective approach to the leadership and management of the critical care unit.

Are critical care services safe?

Good

We rated safe as good because:

- There was an open approach to safety incidents, and actions taken when things went wrong.
- There was a strong safety culture.
- The unit and equipment was safe, and infection prevention and control was good.
- Mandatory training updates were close to trust targets within the nursing staff.
- People were protected from abuse and avoidable harm. Staff knew how to act to safeguard a vulnerable person.
- There were safe levels of nursing staff on the majority of shifts. As with all units, nursing staff were placed under pressure when there were unexpectedly high levels of patients with intensive care needs, but this was responded to using temporary staff safely and effectively.
- There were safe levels of medical staff cover for the service.
- There was assessment and response for risks to patients.
- There was a recently fully established critical care outreach team providing support to the rest of the hospital 24 hours a day, every day.

However:

- There remained a lack of demonstration of actions, accountability and learning from mortality and morbidity reviews.
- Although not unsafe, the clinical environment was out-of-date with modern building standards and lacked some optimal safety features.
- There was not always one supernumerary nurse in the establishment numbers for each shift. The senior sister worked as a supernumerary manager of the unit on Monday to Friday but there was no cover on the weekends or at night.
- Doctors were not achieving their mandatory training targets for updating required courses.
- Not all records doctors made were identifiable to them.

Detailed findings

Incidents

Critical care

- From a review of reported incidents, the safety performance of the critical care unit was good. There were low numbers of reported incidents of avoidable patient harm, unit-acquired infections, and errors leading to patient harm. There were no serious incidents in 2016.
- Staff were open and honest about incidents. All staff we spoke with said there were no barriers to reporting incidents or near misses. Staff described the nature of incidents they would report and said this would include recognition of a near miss. The incidents reported indicated that staff did appropriately categorise a number as near misses where appropriate. There was a wide range of incidents reported suggesting staff were proactive in their reporting. There was a good safety and learning culture on the unit. Staff said they were not blamed for errors or omissions leading to incidents or near misses. All staff we asked said when something went wrong or should have been better, they were not afraid to speak up.
- The critical care department had not reported a 'never event' in the last 12 months. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event. Never events that might occur in critical care departments include incidents such as wrong-route administration or other errors with medicines, and misplaced naso- or oro-gastric tubes. There had been no reports of these events or any of the others in the current NHS England schedule.
- Reviews of incidents were undertaken and used as a learning tool. The critical care assurance dashboard reported incidents (serious and otherwise) each month. The types of incidents were recorded, and actions required listed alongside, should any be required. Actions taken from the more serious incidents or near misses had included closer monitoring of controlled drugs, improved procedures for blood tests to avoid mix-ups of results, and closer attention to skin assessments and mapping.
- There was an open culture for reporting medicines' incidents. These were infrequent (17 in 2016, with the majority low or no harm), but those identified were investigated and reported to the medicines management optimisation group. There was identification of actions from these incidents, and the information, where it might be useful learning elsewhere, was reported across the organisation.
- Regular review of mortality and morbidity took place, but there was a lack of evidence of accountability to show lessons were learned and actions taken when something needed to change. Medical and senior nursing staff reviewed patient mortality and morbidity (M&M) at the monthly anaesthesia and critical care governance, audit and safety meetings. There was a good attendance of doctors/consultants and nursing staff at the M&M meetings. There were good records of discussions held demonstrating reviews into patient deaths and any other concerns. Deaths were classified by the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) categorisation. This ranged from category A, where everything that could be done for the patient was done, and E, where there were significant failings in care and treatment. There was discussion and consideration of failures, but learning points and actions, and who was responsible for delivering them, were not written down with any consistency. This meant there was insufficient evidence to demonstrate learning had taken place and change was recognised.

Duty of Candour

- There had been introduction and implementation of the duty of candour. Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 is a regulation introduced in November 2014. This Regulation requires the trust to notify the relevant person that an incident has occurred, provide reasonable support to the relevant person in relation to the incident and offer an apology. The trust had introduced this legal requirement to staff, and those we met had a reasonable understanding of what was required of them, and why it was important to be open and honest with patients and their relatives. Duty of candour was referred to in the trust's policy for incident investigations, and the content of the policy met the legal duties on staff to adhere to this requirement.

Safety thermometer

- There was a good safety performance on the unit. A patient had never had a fall on the unit that led to harm. There had been one pressure ulcer in October 2016 categorised as a grade two (which would not meet the

criteria of the NHS Safety Thermometer, which recorded the more serious grades three and four – see below). This pressure ulcer had resulted from irritation to skin on a patient's face from nasogastric feeding tubes. There had been actions taken to address this. New equipment had been purchased to help reduce the pressure to areas of the face from masks and feeding tubes used for long periods. The unit had produced a poster for staff to show them the method for securing nasogastric tubes to reduce the risks from pressure ulcers occurring. There had otherwise been no pressure ulcers in the period we reviewed, which was the five months of September 2016 to February 2017.

- The unit had contributed to the NHS Safety Thermometer. Avoidable harm to patients was low (good) within critical care. The trust reported data on patient harm each month to the NHS Health and Social Care Information Centre. This was nationally collected data providing a snapshot of patient harms on one specific day each month. It covered incidences of hospital-acquired (new) pressure ulcers; patient falls leading to harm; urinary tract infections; and venous thromboembolisms (deep-vein thrombosis). The main points were:
  - In the most recent published annual data for February 2016 to January 2017, critical care reported 100% harm-free care in 11 of these 12 months.
  - In the month where harm-free care was not 100%, this was due to a urinary catheter infection not acquired on the unit, but treated there.
  - There were no pressure ulcers, falls with harm or thromboembolisms in this 12-month snapshot period.
- There was a display of avoidable patient harm data for patients and visitors to see. The unit showed, in straightforward presentation, how long it had been since the last avoidable patient harm had occurred. This covered pressure ulcers, falls leading to harm, urinary catheter infections, and deep-vein thrombosis. Display of results is considered as best practice. It shows openness and transparency towards patients, visitors and others.

Cleanliness, infection control and hygiene

- The unit was visibly clean and tidy and well organised to allow for effective cleaning. The harder-to-reach areas, such as on top of equipment, and on curtain rails, were visibly clean, and dust-free to the touch. There was regular work undertaken by a member of the cleaning team, and a recent appointment had seen a dedicated cleaner secured for the unit. We observed the cleaner working diligently and carefully, and ensuring they were considerate around patients and equipment.
- Audit results were good for cleanliness, infection control and hygiene. Each month, audits measuring these were carried out in the unit. In the 10 months from April 2016 to January 2017 the results were as follows:
  - Hand hygiene was 100% in seven months, above 90% in two months and, due to staffing pressures on the unit from sickness absence, November 2016 was not audited.
  - Cleanliness audit was between 95% and 99% in all 10 months. In the last four months, the results were 98% or 99%.
- We observed good infection control practices. Staff washed their hands and used hand-sanitiser when required. There was good use of personal protection equipment, such as gloves and aprons to protect staff and reduce the risks of the spread of infection.
- Overall, rates for healthcare associated infections acquired in critical care were low. We looked back over the previous 10 months (April 2016 to January 2017) and there had been no incidences of unit-acquired methicillin-resistant Staphylococcus aureus (MRSA). There had been no incidences of methicillin-sensitive Staphylococcus aureus (MSSA) or Clostridium difficile. There had been one infection reported in a central line in January 2017. An investigation into this was underway at the time of our visit. Data reported by the unit to the Intensive Care National Audit and Research Centre (ICNARC: an organisation reporting on performance and outcomes for all intensive care units in England, Wales and Northern Ireland) reported no incidences of unit-acquired blood stream infections in the most recent available data (April to September 2016). Prior to this, the most recent incidences of unit-acquired blood stream infections were in the period January to March 2016, where two were reported. This was slightly above (worse than) the national average. Since this time, there had been no reoccurrence.
- There were no specialised isolation facilities on the unit to isolate patients with a known or potential infection. The unit managed patients in the one side room using barrier nursing precautions. Units built to the 2005 (most recent) Department of Health Building Note

guidance (HBN 04-02) should provide specialist isolation facilities with integral gowning and hand-washing areas, and air-change facilities. The critical care unit had, however, been built prior to these standards coming into use. Staff used the single side-room to restrict contact with patients with known or potential infections, and increased use of personal protection equipment for anyone entering the room. Staff told us they would restrict admission to the unit, use curtains and notices, and increase awareness of potential infection should they need to care for more than one patient in this way. The lack of isolation facilities was recorded on the unit risk register in accordance with the requirements of the Faculty of Intensive Care Medicine Core Standards for Critical Care standard 3.1.

Environment and equipment

- There was fully equipped, tamper-evident, and regularly checked resuscitation equipment on the unit. The regular checks were in accordance with the trust's resuscitation equipment policy. Equipment included a tested, charged and functioning automated external defibrillator. Twice a day, staff signed to say all the resuscitation equipment had been checked. We saw a few gaps in some of the daily checks, but these were either on just one day and not for longer periods, or one of the two checks each day. The trolley containing the equipment had been replaced since our last inspection with one now locked with a tag to demonstrate there had been no tampering with the equipment and medicines contained within it.
- The unit had suitable equipment for managing difficult airways, although not all staff were familiar with this. The trolley was located within the department next to the resuscitation equipment. Equipment was stored in different drawers of the unit in relation to the strategy being used for intubation with a patient. A member of the unit's nursing staff was unable to identify this equipment, and thought it was within the operating theatres, where it was previously located. This meant the member of staff might not have been able to locate this equipment as efficiently as possible in a medical emergency.
- The unit had a safe ratio of ventilators (breathing machines) to beds. There were five beds on the unit and each was supported by one ventilator and one additional ventilator kept clean and prepared for use at all times. There were arrangements with medical equipment providers to hire a ventilator should one require repair or maintenance to preserve six machines being available at all times. As one ventilator was no longer of the standard type for the unit, there had been approval of a business case for a new ventilator, and upgrade of all other ventilators. An order for the new ventilator had been placed.
- The environment was safe and fit for purpose. However, as an older unit, it did not conform to all requirements of the 2005 Department of Health Building Note (HBN 04-02) for critical care units. Any units built or refurbished after the guidance of HBN 04-02 was issued are expected to meet the recommendations of the Department of Health. The unit at Weston General Hospital was set up a number of years prior to this guidance. Nevertheless, there were measures to ensure the environment and equipment was safe. Some of the ways the unit already met the recommendations were:
  - The bed spaces as they were now configured were of a suitable size for giving up to five staff enough space to work safely with a patient in an emergency. All patients were visible from the staff's workstation area.
  - There were separate buttons for patient's general call bells and staff emergency calls.
  - The unit had the minimum safe level of infusion pumps (three) and syringe pumps (four) for each bed, and each bed had a feeding pump.
  - There was a good level of mobile equipment including two haemodialysis/ haemofiltration machines, an electrocardiography machine, disposable bronchoscopes, and a bedside echocardiography machine. There was a portable X-ray, ultrasound, defibrillator, non-invasive respiratory equipment (CPAP and BIPAP), vacuum dressings, and endoscopes available within the hospital.
- The ways the unit did not meet the recommendations were:
  - The equipment around the bed space was not located on ceiling-mounted pendants for optimal safety, and not all beds had electronic hoist equipment (two out of five beds did).

- There were insufficient oxygen, four-bar air, and vacuum outlets. The unit had two oxygen outlets, as opposed to three as a minimum; one four-bar outlet as opposed to two; and one medical vacuum outlet as opposed to a minimum of two.
- The bed spaces did not each have their own hand-washing sink. There was one sink in the side room and then one sink between two beds in the other areas. This was problematic for the unit when one of these had stopped working, as was the case on this visit and the previous visit – although this time the sink was fixed while we were there.
- All sockets had on/off switches, as opposed to being un-switched for additional safety, and no bed space had 28 sockets as recommended. Staff told us they rarely required this number of sockets, but had approved fused extension sockets if required.

- There were effective processes for managing and disposing of clinical waste. Single-use items of equipment were disposed of appropriately, either in clinical waste bins or sharp-instrument containers. There was a full range of disposable equipment in order to avoid the need to sterilise reusable equipment, and to reduce the risk of cross-contamination. We saw staff using and disposing of single-use equipment safely at all times. None of the waste bins or containers were unacceptably full.
- There were arrangements for essential maintenance and servicing of equipment. There was a service level agreement with another local NHS trust that provided these services. Each piece of equipment was on a trust register with a unique code. Dates for maintenance were recorded and followed by the equipment maintenance team (called the MEMO team). The register supplied to us demonstrated all equipment was within its servicing date. The unit's senior sister confirmed that any equipment that needed maintenance or repair outside of its usual date was usually attended to without delay. Equipment could be provided to replace it (borrowed or rented) at short notice until it was returned. However, the blood gas monitor in critical care had been broken for a number of days and staff had to leave the unit to get tests completed. It was uncertain when the machine was going to be repaired.

Medicines

- The clinic room was clean and most medicines were stored safely. However, we did find one of the two drug fridges unlocked, when they should be locked for safety. This issue had occurred previously, and been raised with staff before our visit. A notice with a requirement to lock the medicines' fridge was on the staff noticeboard. The drug fridge was not easily accessible to unauthorised people as it was within the clinic area, visible to all staff within the unit – although this area was not otherwise locked. Intravenous fluids containing potassium were stored separately from other fluids for safety. Strong potassium chloride injections were held securely as controlled drugs.
- Most but not all medicines that were checked were in date. The date of opening liquid medicines had not been recorded on the bottles. Therefore, when the expiry date of the medicine needed to be reduced following opening, it was not possible to determine whether these liquid medicines were suitable for use. The in-use expiry date of a glucagon injection had not been recorded when it was removed from refrigerated storage. This medicine can be kept for longer when refrigerated, but has a reduced lifetime when stored at room temperature. There were some pre-filled syringes in stock, which had expired the previous day (28 February 2017). These and the undated liquid medicines were removed as soon as it was pointed out to staff.
- Most temperature and safety checks were carried out, although a few were not completed. The temperature of the room in which medicines were stored was not recorded, as was required by the trust's policy. Recording of fridge temperatures was completed daily as required, although there were a few gaps on occasion in November and December 2016. Safety checks on the sealed crash bag were not carried out consistently as, for example, only three out of the seven checks had been recorded in the week ending 27 February 2017. Both fridges had been calibrated in February 2017 and were not due to be serviced again until February 2018.
- The management of controlled drugs was mostly carried out well, but with a few minor issues. Controlled drugs were stored securely. Access to the cupboard keys was only through authorised staff. Most daily and weekly controlled drug checks were completed in line with trust policy, but there were minor inconsistences. The policy stated pharmacy stock checks of controlled drugs took place once in a two-week period and were signed by two people. A stock check was carried out by nursing staff member once a week. Controlled drugs that required disposal always had two signatures confirming

the type of drug and amount. However, there were missing stock checks over the 2016 Christmas period and on 16 and 30 January 2017. There were also three missing signatures relating to who received controlled drugs.

- The service had an in-house pharmacy service providing a supply function and a clinical pharmacy service. A member of the pharmacy team came to the unit each day (Monday to Friday) to check and update stocks of standard medicines used, and any specific medicines required for a patient. Audits were carried out of controlled drugs and medicines.

Records

- Patients' individual care records were written and managed in a way that kept patients safe. Paper based records were used on the critical care unit, and all patient records were kept together in one set of notes. These records included consultants' notes, nursing assessments, discussions with relatives, and patient observations. Risk assessments were completed for venous thromboembolism (VTE), pressure ulcers, nutritional risks, and falls. Discussions during ward rounds were recorded and kept within the records. The only records not kept with the patient notes were the daily nursing observation charts. These were summarised when a patient was discharged, and important information handed over to the ward receiving the patient. However, these charts were stored securely within the hospital in case they needed to be referred to at some future point.
- Patients' records were mostly comprehensive. We reviewed four sets of patient records. These were mostly comprehensive, legible and complete. The only consistent omission from the records was the time of decision to admit the patient to the critical care unit. Therefore, it was not possible to determine whether the admission to the unit was within four hours of the decision. The Faculty of Intensive Care Medicine core standard 2.3 states that all patients should be admitted to critical care within four hours of the decision taken. It is recognised that minimising delays to treatment will lead to better outcomes for patients. There were some instances in the records where consultants were not printing their name after recording their notes. This meant it was not always clear to those outside of the team who had made the entry.
- Consultant notes demonstrated patients were reviewed as required, although ward-rounds had some omissions in recording attendance. Patient records demonstrated how each patient had been reviewed by a consultant on admission to the critical care unit or shortly thereafter, as is required. Consultant-led ward rounds were documented, although it was not always clear who attended as initials and not full names were noted when confirming attendance.
- Records documented daily bed checks by the nursing staff. These were recorded in individual patient's records to show the bed area was considered safe, and all equipment was appropriate and working correctly.
- Prescription charts and records were well completed, but with a few occasions when the reasons medicines were not given were not documented. In our review of four prescription charts, we found all prescriptions were signed and dated. The writing was clear and legible, patients' allergies were documented, and VTE prophylaxis was prescribed if indicated. However, when medications were not administered or omitted, reasons for this were not always recorded in the section provided.

Safeguarding

- Staff were trained to recognise and respond to concerns in order to safeguard a vulnerable person, although not all medical staff had up to date training. Safeguarding training covered vulnerable adults and children, so gave staff direction to safeguard any adults or young people admitted onto the unit. It also gave staff guidance to safeguard children of any age associated with a patient or visitor. Updating training was mandatory, with an expectation of all staff completing it as required. Training was designed for staff in accordance with their roles. Administration staff were therefore required to complete mandatory safeguarding training at level one, while clinical staff were required to complete training to level two. The results at the end of December 2016 for the nursing/support staff were:
  - Adult-related training was 100% at level one, and 100% at level two.
  - Child-related training was 100% at level two.
- The trust was not able to supply this information for the critical care medical staff separately, but for the medical staff in the anaesthetics division (where critical care doctors reported), statistics were as follows:

- Adult-related training was 75% at level one, and 75% at level two.
- Child-related training was 70% at level two.

- There were policies, systems and processes for reporting and recording abuse. The safeguarding adults' policy had been implemented in accordance with national guidelines. The policy had been updated in 2016 to take account of the statutory requirements of the Care Act (2014) which had superseded the government's 'No Secrets' paper of 2000. The children, young people, and unborn babies policy had been updated in 2014 to take account of the Working Together to Safeguard Children 2013 guidelines. The policies provided definitions of abuse, including references to modern slavery, and guidance about the meaning of neglect and acts of omission. The definitions of who might be at risk (for adults) linked with the provisions of the Mental Capacity Act (2005) in relation to deciding if a person was vulnerable due to their lack of mental capacity to make their own decisions. The policies clearly described the responsibilities for staff in raising and reporting concerns for both adults and children. There were checklists, contact numbers, and flowcharts for staff to follow to capture relevant information and inform appropriate people.
- Staff were aware of their responsibilities to report abuse, and how to find any information they needed to make a referral. Staff described those things they would see or hear to prompt them to suspect abuse of the patient or another vulnerable person (such as a child in the care of the patient or a visitor). They were aware of their statutory duty to record and report their concerns, and said there were no barriers to making referrals.

Mandatory training

- There was an improved performance from nursing staff in meeting the trust target for being up-to-date with the latest mandatory training courses. Compliance with the mandatory training requirements at the end of December 2016 for the nursing/support staff was 88%. This was just below the trust target of 90%. Staff were trained at induction in a wide range of statutory and mandatory subjects. They were expected to update this training at certain intervals set by the trust. Topics included areas such as infection control, health and safety, basic life support, equality, diversity and human rights. Notably, staff had achieved 100% compliance in drug calculations, learning disabilities, malnutrition screening and the two courses for PREVENT (counter terrorism awareness). The subjects that had the lowest compliance were:
  - Fire safety – 78%
  - Information governance – 78%
  - Adult basic life support – 81%
- The medical staff were significantly behind with their updates for mandatory training. Medical staff statistics were not provided just for critical care, but the results for the anaesthetics division (where critical care doctors reported) showed 57% were compliant with updating their training. The poorer areas were:
  - Only six or seven of the 20 doctors required had updated their dementia, conflict resolution, equality, diversity and human rights, and fire safety training.
  - Only two of the seven doctors required had updated their blood sample training.
- The only course with which doctors were compliant with trust targets was PREVENT awareness.
- There were concerns with the number of staff who had updated their training in life support and the quality of the courses on offer. There were varied responses from the nursing staff when asked about the quality of basic life support training at the trust. Some nursing staff told us it was not of the quality they expected, with others saying it was adequate. The trust did not provide immediate life support training, and as a result, all of the band six nurses had been booked to attend an externally provided advanced life support training course. These were taking place in 2017. The senior sister had undertaken and updated advanced life support training, but they were not on duty at all times. Only one of the six doctors required had updated their advanced life support skills, and six out of 20 had updated their basic life support skills.

Assessing and responding to patient risk

- Critical care staff responded well to patient risk through regular assessments and reviews. However, the relatively long time taken over the ward round meant some tests or procedures for patients could be subject to delay as the round continued. Ward rounds in critical care took place in the morning and evening. They were led by the consultant on duty. There was input to the ward rounds from unit-based staff including the junior doctors, the nurses caring for the patient, and the physiotherapist and pharmacist took part when relevant

matters were being discussed. The ward rounds we observed were, nevertheless, thorough, detailed, not rushed, and everybody was required, and encouraged, to contribute. However, we observed one test ordered early in the ward round was held until the ward round was completed, which was just under two hours later.

- The hospital, through recent recruitment, now met recommended practice with the provision of outreach services. Outreach services supported acutely and critically ill patients in the rest of the hospital. This included making early identification of deteriorating patients and requesting timely admissions to critical care. The Guidelines for the Provision of Intensive Care Services (Faculty of Intensive Care Medicine, Intensive Care Society, and others, 2015) recommended outreach services or their equivalent be provided 24 hours a day. It stated the hospital should "ensure an appropriate response always occurs and is available 24/7." The hospital had 24-hour cover from the critical care outreach team and experienced nurses provided the service 365 days a year.
- For patients assessed at high risk to themselves or others, there was some use of both physical and pharmacological restraint (use of medicines to sedate or reduce anxiety). This followed the trust's policy on safe and legal restraint. Patients were assessed for use of restraint, and this became part of their care plan if it was determined to be the safest and most appropriate course of action. If restraint was used in either physical or pharmacological form, it was explained to and discussed with the patient's family wherever possible.
- Critical care commenced the use of early warning score tools when patients they were caring for were fit for discharge to a ward. This was in order to hand the patient over to the ward with ward-based records already started. Early warning scores is a tool used with patients to alert staff to one or a combination of six vital signs being measured at a high enough level to require medical intervention. This could be from one or a combination of measures of, for example, high blood pressure, poor respiratory rate, or a poor level of consciousness. Patients receiving critical care were otherwise constantly assessed for these measures in the usual constant patient observation and monitoring procedures.
- Patients were monitored for specific risks associated with interventions in their care. For example, patients using a ventilator to support their breathing were assessed using capnography. This is the monitoring of the concentration or partial pressure of carbon dioxide in respiratory gases. Measure of carbon dioxide can point to a number of problems for a patient such as underlying lung or heart disease. It was available at each bed on the unit and was used for patients during intubation, ventilation and weaning, as well as during transfers, and tracheostomy insertions.
- There was access to liaison psychiatry for patients who had deterioration in their mental health. The unit had support from a mental health team based in the hospital. They were available Monday to Friday 8am to 8pm. Out-of-hours support was provided by the mental health intensive support team, run by the local mental health trust. This team would not be available on site, but would offer advice and guidance by telephone, and review and advise on any risks already known to them. There were contact details for other local support teams operating beyond North Somerset. Risks to patients were assessed alongside information from their families and carers. There was also support from a team working with patients with addictions, and staff would come to unit on request to provide input into patient care.

Nursing staffing

- There were safe nursing staff levels in critical care in line with professional standards, although one area of concern over nursing skills. Nursing numbers were in accordance with the NHS Joint Standards Committee (2013) Core Standards for Intensive Care. Therefore, patients assessed as needing intensive care (described as level three) were cared for by one nurse looking after that one patient at all times. High dependency patients, (described as level two), were cared for by one nurse looking after two patients. The nursing rotas demonstrated meeting this nursing ratio, although with an occasional shortfall due usually to the failure to secure an agency nurse. We were concerned at being told one of the healthcare assistants (band four) was caring for a level three patient. This was done, we were told, under close supervision, but this would have been in contravention of nursing safety standards, where this patient should be cared for by a registered nurse.
- The supernumerary staff did not meet recommended levels. The Faculty of Intensive Care Medicine Core (FICM) Standard 1.2.5 stated the unit, with 5 beds, should have one supernumerary registered nurse on duty at all times. There was, however, not always one

supernumerary nurse in the establishment numbers for each shift. The senior sister worked as a supernumerary manager of the unit on Monday to Friday but there was no cover on the weekends or at night.

- There were minimal vacancies in critical care, after recent recruitment. At the time of our inspection, there were vacancies for two band five nurses. The amounted to 1.6 whole-time equivalent staff and represented 9% of the band five posts. There was also a small shortfall in the whole-time equivalent for band six nurses. Overall, the vacancy rate on the unit was 7%.
- Critical care endeavoured to limit the use of agency staff and most unfilled shifts were covered by regular and hospital-based bank staff, rather than agency. However, due to unprecedented high levels of staff sickness at the end of 2016, use of temporary staff had been high. The FICM core standard 1.2.9 recommended agency staff did not exceed 20% of the nursing staff cohort on any shifts. This was to ensure the unit was predominantly staffed by experienced nurses at all times. The average use of agency staff in 2016 was 5.7%, but when removing the high points of October and November 2016, this reduced to 3.3%, which was more typical of the unit. With only a small number of beds, and therefore a small number of nursing staff, there was a higher risk in this unit of breaching the 20% rule with the use of one or two temporary staff. However, rates of use were generally low, and those nursing staff were regular workers and known to staff and the unit.
- Sickness levels for nursing staff were relatively low. In the six months from August 2016 to January 2017, sickness was 3.9% on average. This was increased by higher numbers than average in the second half of this period. This was against an NHS average of around 4%.
- There was good handover on the unit between nurses and nursing teams. Nurses safely handed the patients over to the new shift following a set protocol working through the patients' risks and care planning. A daily safety briefing took place in the morning. This included discussion of staffing levels, acuity (patients' needs), checking of the resuscitation equipment, the risk of pressure ulcers, and potential organ donation.

Medical staffing

- There was experienced clinical leadership. Critical care medical leadership was provided by an experienced consultant anaesthetist (the lead for anaesthetics in the trust) who was a Fellow of the Faculty of Intensive Care Medicine (FICM) and a consultant clinical lead intensivist. The six consultants working on the primary rota were combined consultant intensivists/ anaesthetists and therefore experienced in delivering care to some of the most critically ill patients in the hospital.
- The experienced consultant presence in critical care followed the recommendations of the FICM core standards. The standard 1.1.3 was for a consultant to patient ratio of one consultant to a maximum of 14 patients. With five beds in critical care, this standard was met. On weekends, there was one consultant on duty in the daytime, which continued to meet the recommended ratio. The consultants were on duty from 8am to 6pm (and often stayed later). They had no other commitments outside of critical care during that time, with the exception of support to a crash (emergency) call. Consultants would only attend a crash call off the unit if it were safe for them to do so. Consultants were on call within their rota when they were not present on the unit. They met the requirement to be able to be back on the unit within 30 minutes if this was required. This met the requirements of FICM standard 1.1.5.
- Consultants worked in a regular pattern during their rotation in critical care, and this provided consistency. Arrangements were for consultants to work on a five-day block pattern from Monday to Friday, and a new consultant to take the weekend shift. Most of the time, the weekend consultant would join the ward round on a Friday afternoon, to make sure they were familiar with the patients and their treatment plans. This pattern of work met the FICM standard 1.1.2.
- The number of trainee/junior doctors on duty met the recommendation of the core standards. During the weekdays and weekends in daytime hours, the unit's arrangements met the FICM standard 1.1.3 for there to be at least one junior doctor for a maximum of eight patients. There were eight junior doctors on the rota (a ninth due to start). The junior doctors were supported out-of-hours by the on-call anaesthetist team based in the hospital and the on-call consultant for critical care.
- There was support to trainee and new doctors. They were not included in the numbers of doctors, so not responsible for direct patient care, and did not hold unacceptable responsibilities. At the time of our inspection, there was a foundation year one and a foundation year two doctor working their rotation on

the unit to experience and learn critical care practices. As with the recommendations of the FICM core standard 1.1.3, they were not left as a sole resident doctor at any time.

Major incident awareness and training

- The hospital had the ability to increase its capacity more than twofold to care for critically ill patients in the event of a major incident (called surge capacity). This would involve using not just the critical care unit, but also the recovery unit and the anaesthetic rooms in the main theatre unit directly adjacent to the unit. Staff in theatres were trained in caring for critically ill patients and would be supported by the critical care team. The critical care unit also had the facilities to increase the bed numbers from five to six in an emergency. There was a spare ventilator and provision of oxygen and other facilities in one area of the unit where a bed could be accommodated.
- The critical care staff knew how to access the trust's major incident policy should one be declared, expected, or anticipated. There were action cards for the surgical directorate (in which critical care sat) and this included putting into action a strategy to transfer patients from critical care where possible and safe to do so.

Are critical care services effective?

Good

We rated effective as good because:

- The unit used good practice and followed the most up-to-date guidance and recommendations when providing care and treatment. This included the use of appropriate care bundles.
- Patients were assessed for risks, including delirium, over-long sedation, and invasive procedures.
- There was high-quality physiotherapy service, although without enough time to deliver best practice levels of therapy.
- Patients had a high-level of effective and quality care and treatment for pain relief, nutrition and hydration. The unit was supported by professionals in these disciplines.
- There were good outcomes for patients on this unit and when compared nationally. Mortality levels were close or below those expected.
- There were competent staff who were appraised each year and supported with training and development. Over 50% of the nursing staff had their post-registration qualification in critical care.
- There was strong multidisciplinary input in the unit, and from the critical care team towards the rest of the hospital.
- Staff were aware of the legal obligations around consent, the Mental Capacity Act, and the use of restraint in the best interests of a patient's care and treatment.

However:

- There was insufficient time for physiotherapy to meet recommended practice.
- There was limited input into audit work from the medical teams.
- There remained no nurse with the role as clinical nurse educator as recommended by the standards for intensive care.
- There was a variable knowledge about the appropriate use of Deprivation of Liberty Safeguards.

Detailed findings

Evidence-based care and treatment

- Patients were monitored by nursing staff using care bundles. Care bundles are recognised techniques and plans for specific procedures, such as insertion and management of the lines that carry medicines, or managing pressure areas. For each patient there was a set of care bundles completed and monitored each day. These included ongoing care for the prevention of ventilator-associated pneumonia, insertion and ongoing care of central venous catheter lines, venous thromboembolism risk assessments and prophylaxis (preventative measures), pressure ulcer management, and care of patients receiving renal dialysis.
- Critical care staff followed NHS guidance and good practice when monitoring sedated patients and to provide the right levels of sedation. Sedation is one of the most widely used procedures in critical care. It is used to help deliver care and treatment safely and try to ease the patient though a distressing time. Maintaining light sedation in stable adult patients in critical care has been shown to improve outcomes (Faculty of Intensive Care Medicine). Improvements include reducing the patient's length of stay, better evaluation of neurological conditions, and reduced levels of delirium. In critical

care, there was daily assessment of each sedated patient with sedation being withdrawn, continued or adjusted dependent upon how the patient responded. The objective for the unit was to limit the use of sedation to effective levels.

- The unit followed best practice for tracheostomy procedures. In order to keep up to date with current best practice, four of the unit's nursing staff attended a recent tracheostomy conference. This led to new developments in tracheostomy care being shared with the rest of the critical care team.
- There was assessment of delirium for patients admitted to critical care, as is best practice and recommended by the Faculty of Intensive Care Medicine (FICM). Delirium is a state of confusion and altered brain activity that can cause delusions and hallucinations in critical care patients. It is recognised as a relatively common experience. The unit followed the FICM core standard 1.3.3 in screening all patients for delirium with a standardised assessment tool, namely the confusion assessment method, often called CAM-ICU. Patients were screened on admission and a reassessment was carried out every 24 hours at least, or sooner should a patient's mental status appear to have deteriorated.
- Although there was high-quality care, there was an insufficient amount of time for physiotherapy to meet evidenced-based practice guidelines, and the rehabilitation needs of patients. The service provided to critical care was not funded by the hospital trust to meet the amount of time recommended by the Faculty of Intensive Care Medicine (FICM) Core Standards. Care was provided on a Monday to Friday from 9am to 1pm by a senior physiotherapist, supported by a team of staff covering absence and holidays. The senior physiotherapist wanted to deliver a strong focus towards rehabilitation, but they were restricted with time they were allotted, and therefore focussed upon respiratory therapy. Where it was required, each patient received respiratory therapy each day, but physical/ rehabilitation therapy was restricted to time allowed, and excluded any delivered on weekends. The FICM core standard 1.3.4 stated each patient should have a minimum of 45 minutes of each therapy required for a minimum of five days each week. This was also linked to the National Institute for Health and Care Excellence (NICE) quality standard for stroke patients. The senior physiotherapist was not able to meet this recommendation given the limited time they were given for patients within the unit.
- Patients were not being provided with a rehabilitation 'prescription' when they left the unit. NICE guidance 83: Rehabilitation after critical illness, requires patients to be given this document when they were discharged. This document, if produced, would provide the admitting ward or continuing healthcare professionals with the patient's future rehabilitation needs. This process was currently managed to an extent by the small team of physiotherapists at the hospital being in regular contact with one another, and providing a handover to the ward team when a patient was admitted following a stay in critical care. However, there was nothing provided for the patients beyond this.
- Critical care was following the guidelines of the National Safety Standards for Invasive Procedures, known as NatSSIPs. The work around introduction of the new safety standards had been led by the manager of the operating theatres and rolled out into critical care. There were new guidelines followed for invasive procedures such as insertion of chest drains, tracheostomies and central lines.
- Critical care met best practice guidance by promoting and participating in a programme of organ donation led nationally by NHS Blood and Transplant. As is best practice, critical care led on organ-donation work for the trust. In the NHS, there are always a limited number of patients suitable for organ donation for a number of reasons. The vast majority of suitable donors will be those cared for in a critical care unit. The trust had appointed the critical care consultant lead as the clinical lead for organ donation. There was a specialist nurse for organ donation employed by NHS Blood and Transplant (NHSBT). They were part of the South West NHSBT team and visited the unit when appropriate to do so. The trust participated in Organ Transplant Week with displays in the main entrance to the hospital.
- The hospital trust was part of the National Organ Donation programme. It followed NICE guideline CG135: Organ donation for transplantation, and had policies and strict criteria for organ donation. We reviewed data about organ donation work within the trust for the year from 1 April 2015 to 31 March 2016 and the most recent six-month report from April to September 2016. There had been 15 patients eligible for organ donation during

this 18-month period. Of these, there was an approach to five families (33%) to discuss donation. This was slightly below the UK average of 39% for approaching families to discuss donation. The specialist nurse was involved with four of these families (80%), against a national average of 83%. Evidence has shown there is a higher success rate for organ donation if a specialist nurse is involved with discussions with the family. In the 18-month period, none of these patients went on to be organ donors. In the previous year from 1 April 2014 to 31 March 2015, the trust had been involved with donation of seven organs from two patients.

Pain relief

- Those patients we were able to talk with said their pain was being well managed. When patients experienced physical pain or discomfort, staff responded in a compassionate, timely and appropriate way. Patients told us staff regularly checked to make sure they were comfortable. When a patient or a visitor used a call bell, these were responded to promptly by staff, who addressed patients' needs in relation to pain appropriately.
- In accordance with the Core Standards for Pain Management Services in the UK, there was access to a specialist acute pain consultant and specialist nurse. They were available to visit the unit when required and provided specialist input. One of the doctors told us about the high quality input from the team, with support and guidance when requested. Out of hours, the intensivist consultants and/or the hospital anaesthetist team on duty could provide pain advice and treatment.
- In accordance with the Core Standards for Pain Management Services in the UK, and the care pathways in critical care, patients had a pain assessment and management plan. This was using current and validated tools and treated patients as individuals. One area where staff knew to manage pain differently, for example, was for patients with impaired renal function (chronic kidney disease). The unit recognised how pain relief was problematic for patients with this condition. An assessment of the renal function of a patient was made in order to provide effective and appropriate pain relief with use of appropriate guidance.
- There was consideration for patients who were unable to communicate if they were in pain. The unit had a pain tool for use with patients with cognitive impairment, or staff could refer to the specialist pain team for advice. The pain tool was designed for patients who could not tell staff about any pain. It measured if the patient was indicating pain verbally, through their facial expressions or body movements, and any changes in their usual behaviour. Relatives of patients living with dementia were asked if any indications of pain detected in the patient might be usual behaviour, so this could be taken into account. Other measures considered were physiological changes, like temperature and blood pressure, and any physical changes such as skin damage or bruising.

Nutrition and hydration

- There was effective assessment and response to patients' nutrition and hydration needs. The patients' records we reviewed were well completed, and safe protocols were followed to ensure patients had the right levels of nutrition and hydration. Fluid balance was calculated, recorded in the patients' records, and analysed to deliver the appropriate balance. We saw records of appropriate adjustments in nutrition and hydration and consequent improvements.
- There was assessment and management of the risks to patients from acquiring pressure ulcers from dehydration or malnutrition. Staff evaluated the standard risks from a patient's sensory perception, moisture of the skin, activity, mobility, nutrition, and friction to the skin. The risks of dehydration, malnutrition and to the development of pressure ulcers were then addressed through use of preventative therapies or treatments.
- There was support to all patients admitted to critical care from a dietetics team. A dietitian was involved with the assessment, implementation, and management of an appropriate nutrition support route. The dietitian visited the unit each weekday, and all patients were assessed for effective nutrition. There was a weekly ward round with a consultant clinical biochemist to discuss patients who were being provided with total parenteral nutrition (fluids given to a patient through a vein).
- There was a multidisciplinary approach to nutrition and hydration. As well as the work of the dietetics team, there was coordination with the speech and language

therapists who would provide guidance and advice when this was required. This would include patients with swallowing difficulties, and being fed through a percutaneous endoscopic gastronomy (PEG).

- Nutrition and hydration for patients remained effective out-of-hours. The dietetics team had produced guidelines for nursing staff to use out-of-hours and on the weekends to ensure effective nutrition was commenced and continued. This included a process and set of rules (algorithm) to use when commencing a naso-gastric feeding tube with a patient. Any patient who had been admitted over a weekend was reviewed by the dietitians on a Monday, and anyone admitted at night on a Sunday to Thursday was reviewed the following morning.
- The dietetics team used recognised equations for calculating nutrition requirements for patients. These included the Mifflin St Jeor to calculate the Basel metabolic rate (minimal rate for expenditure of energy), Penn State equation (a temperature sensitive equation for ventilated patients) and the Henry equation (for non-ventilated patients). These equations determined the amount of calories to give to a patient based on how their body was functioning. The dietitian we met described how the unit recognised the importance of building up a person's strength carefully. The risks of 'refeeding syndrome', which could occur in patients who had been seriously ill or in a malnourished state, were taken into account when nutrient intake was reintroduced or increased. The risks of refeeding syndrome were recognised as making weaning from ventilators more difficult so needed careful management.
- There was additional help for patients who needed nutritional support. Nutrition careplans were drawn-up for all patients to identify who needed further supplements. Energy drinks and food supplements were prescribed and administered for patients who needed them. The unit also delivered trophic feeding when appropriate. This was the process of introducing minute volumes of enteral feeds in order to help stimulate and maintain a healthy gut.
- Patients could take their own food and fluids if they were able. For patients who could help themselves, drinks and meals were placed on patients' bedside tables. Staff ensured they were within reach, and assisted patients when they needed it.

Patient outcomes

- There was monitoring of patient outcomes compared against those achieved nationally, although at times with insufficient attention to from the senior medical team. Critical care demonstrated continuous patient data contributions to the Intensive Care National Audit and Research Centre (ICNARC) for at least the last five years. Data contribution therefore met the recommendations of the Faculty of Intensive Care Medicine Core Standards: a set of recognised guidelines for intensive care units to achieve for optimal care. This participation provided the service with data measured and compared against other units in the programme and those that were similar in size and patient type. Data returned to ICNARC was adjusted to take account of the health of the patient upon admission to allow the quality of the clinical care provided to come through the results. The critical care medical team acknowledged the value of the ICNARC report, but had not requested or seen copies of the most recent data. The first half of the 2016/17 year was available to them, but had not been requested or reviewed. The report was not being considered with a high-enough priority in governance reviews. In the sets of minutes from the governance meetings we reviewed (July, September and October 2017), it was not discussed.
- Almost all critically ill patients were cared for at this hospital and not transferred to another unit elsewhere for non-clinical reasons. Sometimes patients would be transferred for clinical reasons, as they needed more specialist care. Non-clinical transfers were usually due to a bed not being available. Research has recognised how it is sub-optimal to move a patient to another hospital critical care unit for non-clinical reasons without careful planning and management. According to ICNARC data, there had been two patients transferred to another unit for non-clinical reasons in 2015/16, but none in the most recent data from April to September 2016. The two transfers in 2015/16 fell below (better than) the average for similar units.
- Mortality levels for patients admitted to critical care had always been close to predicted levels, and mostly slightly better. The measure of the likelihood of a patient dying was provided by ICNARC data using a prediction model. This took physiology data from early in a patient's stay and used it to predict the probability that the patient would die before ultimate discharge from hospital. The latest ICNARC mortality prediction data

showed the unit had fewer deaths than predicted. In the 2015/16 year, the result was 0.92 – a number below 1 showed a result better than predicted levels. In the most recent data for April to September 2016, the result was 0.96.

- Few patients were readmitted to the unit within 48 hours. Statistics from ICNARC showed unplanned readmissions had been higher than average in the 2015/16 year, when an unprecedented number of four patients (6%) came back within 48 hours in the January to March 2016 quarter. This had reduced to a more typical number of no patients coming back within 48 hours in the April to September 2016 period (the latest available data). Prior to 2015, the unit had been below the national average for unplanned readmissions. Unplanned readmissions can indicate a patient was discharged too early. Due to the nature of critical care illness, it is recognised, however, that a number of these patients would return to the unit for conditions unrelated to their original admission.
- Although there was time lacking for physiotherapy, the treatment given to patients was of a high standard and followed best practice. Patients were given goals to achieve, linked to frailty measures and mobility scoring. Their mobility was monitored to look for progress and achievements. Where patients were able, a daily exercise regime was drawn up by the physiotherapist with descriptions of how the exercise should work. This enabled some patients to be able to work on their own progress and goals.
- There was regular and continual monitoring of care and treatment using audit, although this was achieved only by the nursing staff with any consistency. The medical staff did not routinely use audit, and only undertook ad hoc audits from time to time, usually with medical trainees or junior doctors with special interests. The nurses had an audit calendar, which they followed on a weekly basis. Their audits included catheter care, hand hygiene, pressure ulcers, and cannula care, among others. The majority of the audits were producing high levels of compliance most of the time. Where this was not the case, the results were included at the governance meetings and actions plans drawn up to make the necessary improvements.

Competent staff

- Most of the nursing and support staff in critical care had been assessed each year for their competency, skills, and development. By February 2017, 82% of the nursing and administrative staff had been through their annual performance review. The percentage had dropped from a high point in August 2016 when it reached 97%. The drop was due to staff absence and the difficult winter period.
- There was evaluation of medical staff for their competence. Since 2014, there has been a requirement of a doctor's registration to have an annual appraisal as part of the 'revalidation' programme (General Medical Council, 2014). We were not provided with the data for doctors working in critical care, but 91% of doctors in the surgical directorate (which included critical care) had been through an annual review by the end of December 2016.
- There was an experienced nursing team in critical care. The nursing staff were just above the recommendations of the Faculty of Intensive Medicine (FICM) core standard 1.2.8 in relation to nurses undertaking post-registration training. The core standard recommends more than 50% of nursing staff should have a post-registration qualification in critical care nursing. At the time of our inspection, there were 16 nurses (55%) with this qualification. Three staff were undertaking the training at the time of our inspection, which would raise the percentage to 66% once it had been completed.
- Nursing staff were supported with demonstrating their competence. As with doctors, nursing staff were now required to be revalidated for their competence, as part of their registration with the Nursing and Midwifery Council. Each nurse kept a portfolio of their revalidation evidence and senior staff offered advice and guidance when required. The critical care unit also held study sessions to help nurses with competencies and further learning. Senior staff within the unit were aware of which nurses were approaching revalidation, and provided learning and development support.
- As with our previous inspection, the unit still did not have a nurse providing clinical education in a protected role. The FICM core standard 1.2.6 recommended one dedicated nurse educator for around 75 staff. The unit employed just under half this number of nurses (29 at establishment levels), so the standard would be achieved with a nurse educator having around 40% of their time to dedicate to learning and development. There was, nevertheless, commitment to training and education within critical care and regular training by the lead sister.

- There were lead and champion roles provided by the nursing staff. Lead roles gave staff a subject to specialise in and provided other staff with guidance and support, particularly where the subject may not arise in everyday practice. This included subjects such as infection control, tissue viability, and palliative care. Proactive champion roles for nurses included subjects such as dementia, patient dignity and patient falls.
- There was a good induction and orientation programme for new staff starting on the unit. All non-experienced staff had a six-week induction period where they worked alongside other staff and completed induction training. Each new member of staff was provided with an orientation pack. New starters worked under the guidance of a mentor who was required to review their competencies as they worked through them.

Multidisciplinary working

- There was good input into patient care from many experienced staff providing multidisciplinary support. This included regular input from the pharmacist, physiotherapist, dietitian, and other specialist consultants and doctors when needed. There was input from a speech and language therapist when required. They provided support and helped contribute to patients being weaned from ventilators. Consultants and doctors from throughout the hospital specialities visited patients in the unit on a regular basis to liaise with the critical care team. We observed a multidisciplinary approach to a patient who required an endoscopic procedure within the unit. The team from the operating theatre assisted the consultant, efficiently delivered, and then removed the range of equipment needed for the process.
- There was a multidisciplinary approach to weaning plans for complex and long-stay ventilated patients. Weaning is the gradual decrease in duration of mechanical ventilation with the goal of the patient breathing independently as quickly and safely as possible. The senior physiotherapist was able to contribute/construct a suitable weaning plan in collaboration with a multidisciplinary team of doctors, nurses and other allied health professionals.
- There was support from a microbiologist (a healthcare scientist concerned with the detection, isolation and identification of microorganisms that cause infections). The microbiologist visited the unit each day and reviewed all patients with the medical team.
- There was support from the critical care team to the rest of the hospital. As well as the critical care outreach team, there was attendance by critical care doctors and consultants to patients outside of critical care. This was particularly apparent when we visited the hospital for an unannounced visit in the emergency department on a Friday night. There was a good response from critical care doctors who came to the emergency department to support staff and two critically ill patients.

Seven-day services

- A consultant intensivist was available in person or on-call 24 hours a day, seven days a week. They led the two ward rounds every day, unless the reduced needs of the patients led them to conclude the second weekend ward round could be omitted. When they were not on duty in the unit, there was good on-call cover from the consultant intensivist team. Consultants lived within a 30-minute journey of the unit when they were at home but on call. If they were not 30 minutes away, there was accommodation on site they were able to use.
- There were arrangements for pharmacist services across the whole week. On weekdays, the pharmacist team were available on site in the daytime. There were arrangements for the supply of medicines when the pharmacy closed. A pharmacist was available on call in the evenings, at night and on weekends.
- Access to clinical investigation services was available across the whole week. This included X-rays, magnetic resonance imaging (MRI) scans, computerised tomography (CT or CAT) scans, endoscopy, and echocardiograms (ultrasound heart scans).
- Therapy staff were available in person or on call across weekdays, but seven-day services were limited. If therapy staff were off duty, there was access to certain staff out-of-hours through on-call rotas. Otherwise, therapy staff, including physiotherapists, the dietitian, and speech and language therapists were available on weekdays. Physiotherapists were also on duty on weekends, but providing only respiratory physiotherapy. Nursing staff were able to provide patients with non-specialist rehabilitation physiotherapy on the weekends.

Access to information

- Information needed to deliver effective care was available and accessible. The unit had a range of care plans, protocols, and other patient documentation and paperwork was easy to locate. Access to patients'

diagnostic and screening tests was good, although as reported above, the blood gas analyser on the unit was broken down and had been for a number of days. The medical teams said there was usually good and quick provision of test results and urgent results given the right priority.

- There was a formal handover of information for a patient being transferred from critical care to a ward. The National Institute for Health and Care Excellence guidance (NICE 50) recommended a patient should have a formalised handover. The critical care service had established a standardised referral for transfer from the unit.
- Patient paper notes and records were usually available in good time. Staff said records available at the hospital were provided relatively quickly in emergency admissions (all patient records were on paper for patients coming from other wards or as new admissions). The notes were held in an electronic booking system, which tracked them when they moved around the hospital.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients gave their consent when they were mentally and physically able to do so. Staff acted in accordance with legislation and guidance when treating an unconscious/sedated patient, or in a medical emergency. Staff said patients and their families were told what decisions had been made, by whom and why, if, and when the patient regained consciousness, or when the emergency situation had been controlled.
- Staff followed the trust's consent policy when gaining consent. Gaining consent included that given in writing by the patient, given verbally or implied. Staff followed the policy as it related to gaining consent from a child. The critical care unit rarely admitted a child, but as with most critical care units, could admit patients from the age of 16 years. Staff knew that children over the age of 16 years were presumed to be able to give their own consent, unless staff believed they had insufficient maturity.
- Staff had a good understanding and application of the Mental Capacity Act 2005. They knew they were required to act in the best interests of patients who were unable to make valid choices. This inability to make decisions was due to the patient's lack of mental capacity at the time the decision was needed. Staff recognised how mental capacity could fluctuate in some patients. It could be found to have returned or deteriorated, so patients and assessments needed regular review.
- There was a varied understanding of the Deprivation of Liberty Safeguards (DoLS) among staff. Knowledge was better in the nursing team than among the medical team we talked with.. The lead sister for critical care described a process where they would recognise if a deprivation were occurring or likely to occur. In this situation, they would work with trust staff to apply to the local authority to authorise the deprivation. Alternatively, they would exercise the trust's right to have a trust-appointed urgent authorisation (providing an application went to the local authority alongside this). Any deprivation to protect or care for a patient without the mental capacity to make their own decisions would be undertaken in the patient's best interests. The medical team were not all clear of the circumstances when a DoLS was appropriate, and said they would look to others with specialist training for advice. The risk of this was from not recognising a deprivation of liberty was being carried out, or authorising one without the proper legal approvals.
- There were protocols for the safe and appropriate use of restraint. This would be recognised as a deprivation of a patient's liberty in certain circumstances. The trust had a policy covering use of restraint, and this included patients within critical care. The first priority and requirement for staff was to treat the patient's underlying condition. This may have required medical intervention, but might be resolved with therapeutic strategies. Clear strategies were outlined in the trust policy. Staff told us they would involve the use of restraint for a patient who lacked mental capacity to make their own valid decisions, when alternatives had been tried and were unsuccessful. This would be to prevent the patient from injuring themselves or others, or potentially limiting their own treatment and recovery. The options in critical care included chemical restraint – using medicines to calm patients, particularly during alcohol withdrawal of following a head injury. There was also physical restraint from the use of hand mitts to limit the risks of a patient trying to remove lines, masks and breathing aids. Staff told us the use of restraint would be used when it became part of their duty of care to protect the patient.

Critical care

Are critical care services caring?

Good

We rated caring as good because:

- Staff cared about their patients, treated them with dignity and respect, and as much as was possible, patients were involved as partners in their care.
- People said good things about the service. Comments we read and received were positive and spoke highly of the service.
- Patients said staff were caring and compassionate, treated them with dignity and respect, and were kind.
- Patients, their family or friends were involved with decision-making. They were able to ask questions and raise anxieties and concerns. They were given answers and information they could understand.
- We observed staff treating patients with kindness, warmth and emotional intelligence.

However:

- The patients' diaries were not being seen as belonging to the patient and were not being given to all patients or their relatives when they left the unit.

Detailed findings

Compassionate care

- All the patients and relatives we met spoke highly of the care they received. Due to the nature of critical care units, we often cannot talk to as many patients as we might in other settings. However, patients we were able to speak with said staff were kind and compassionate. Patients told us they felt safe and well supported. Patients and relatives said they felt there was a high standard of compassion among all the nurses and doctors. They recognised the anxieties the families had and tried to reassure them all the time. One relative told us "I can't find the words to express their kindness to all of us". Cards sent to staff on the unit included the following comments:
  - "Thank you for your professionalism, compassion and humanity. I cannot praise enough the care [their relative] received from you."
  - "Thank you for the care, attention and kindness you gave to Mum."
  - "I do not have sufficient words to express my gratitude, but thank you all so much for everything you did for me."
  - "Thank you for your skill and kindness."
- Staff took the time to interact with patients and those close to them in a respectful and considerate manner. Although all patients in critical care have almost constant nursing presence, staff demonstrated to us, this did not involve just task-based care, but also consideration and interaction. Staff took the time to find out non-clinical information about patients, and included this, for example, in their goals and objectives.
- We observed good attention from all staff to patients' privacy and confidentiality. There was sufficient bed space between beds (more space helps to increase auditory privacy). Nevertheless, staff continued to lower their voices to avoid others overhearing confidential or private information as much as was possible or practical. Staff held confidential, sensitive or possibly difficult conversations with patients' relatives in the visitors' room, although there was very limited provision of quiet spaces. All patients we spoke with said they were treated with dignity. They said staff drew curtains around them for intimate care or procedures and we saw this happening in practice.
- Patients were given as much privacy and dignity as was practical. The layout, facilities and size of the critical care unit meant there were often limited opportunities to provide single-sex areas. Staff therefore had limited opportunities to place patients separated by gender to enhance privacy and dignity. There was one side room, and staff said they would endeavour to admit patients to this more private area when possible or practical.
- Staff made sure patients and relatives knew whom they were and their roles on the unit. All healthcare professionals involved with the patient's care were expected to introduce themselves to patients and relatives, and explain their roles and responsibilities. Patients and visitors confirmed this was happening in practice, and all the staff they had met had told them who they were, and their role. We also witnessed staff introducing themselves in the patient interactions we observed, even if the patient was drowsy or confused.
- Visiting times could be flexible to provide support to patients and their loved ones. Staff confirmed this was the case, and the trust's website supported this, but, confusingly, there were set times advertised for visitors on a noticeboard in the unit. Those visitors we met said

they had been told there were no set times, but it was best to avoid the mornings due to ward rounds. They had been told they would always be admitted to the unit and not turned away. Families were able to telephone the unit for updates on a patient, and we heard staff being helpful, reassuring and informative with people on the telephone.

- Staff preserved a patient's dignity in intimate care, and made sure visitors were protected from observing treatment that might make them anxious. Visitors we met said staff indicated when they needed to provide intimate care or treatment for the patient. Visitors had been asked to step outside or to the visitors' room for a short time. Visitors said the staff explained politely why this was necessary and staff returned to invite them back to the unit when they had completed the care or procedure.

Understanding and involvement of patients and those close to them

- Staff communicated with patients and those close to them so they understood their care, treatment and condition. Patients were involved with their care and decisions taken where this was possible. Those patients who were able to talk with us said they were informed as to how they were progressing. They said they were able to make their own decisions, but given good information about their options. They were told about possible risks, advantages or consequences from any decisions they were asked to make. Patients and visitors said staff encouraged them to talk about anything they did not entirely understand, or where they wanted to have more information.
- Staff were trained or had support from specific colleagues to deal with people who needed additional help to understand. Staff had undertaken dementia-awareness courses to give them tools to use with people who could be anxious or confused. There was also support for people with learning disabilities. Staff used experienced and trained staff within the trust to provide specialist advice. Staff would also work closely with carers (including professional care workers), family and friends to help support patients. Staff told us they encouraged family and friends to get as much involved as they wanted to be, as this was always beneficial for patients who had limited cognition.
- Staff communicated with those close to the patient and kept them informed and involved. We met families who had visited their relative on a number of occasions. They had been impressed with the information the staff had given them at all stages in the patient's stay. They had been able to ask questions and ask for advice and guidance, which had been provided.
- Staff ensured visitors were identified and only gave them information they were entitled to have. Visitors used an intercom to say who they were at the main door to the unit, and staff would meet them when they were admitted. They would either be asked to wait in the visitors' room until their identity had been verified, or, if staff had met them before, they would be invited through to see the patient.

Emotional support

- There was support for critical care patients to be kept in touch with what was going on around them or tell them about what they might have missed when they were on the road to recovery. Critical care staff had recently introduced the use of a patient diary for longer-stay patients. Research has shown how patients sedated and ventilated in critical care suffer memory loss and often experience psychological disturbances post discharge. Diaries can provide comfort to patients and their relatives both during the stay and after the patient returns home. They not only fill the memory gap, but can also be a caring intervention to promote holistic nursing. We spoke with one family of a long-stay patient, who were starting to make entries in the diary. They recognised how this could prove supportive and practical. We were concerned that these diaries were not always going home with the patient or their relatives, and only given to the patient if they came back to collect them. These diaries should be the property of the patient at all times.
- Staff understood the impact a person's care, treatment or condition had on their wellbeing. This included an understanding of delirium, which can be a common effect on patients in critical care. Staff talked about patients they had met after being discharged from critical care and being able to tell them about some of the effects of the treatment, including confusion and delirium. They had been able to tell them they were not alone in experiencing this.
- Patients were encouraged to start to regain their independence as soon as they were able. There were patients in critical care who were well enough to be discharged to a ward, and in some cases, to go home. If

these patients were delayed with their discharge, we saw staff, particularly the physiotherapist, encouraging them to carry out gentle exercise as a way of helping both their physical, but also emotional state. It had been recognised that being able to make even small achievements in physical exercise had a strong positive emotional impact on patients in critical care.

- There was access to a team of chaplains, a visiting Roman Catholic chaplain, and seven lay volunteers for people of all faiths or none. The team was available in working hours and there was a 24-hour emergency service. There was a newly refurbished multi-faith chapel described as "a place for quiet reflection." All facilities were also available 24 hours a day all year round. The trust described their services as to:
  - "Offer support to all patients, visitors and staff at what can be a difficult and challenging time in people's lives."
  - "Stand alongside people, befriending, listening, offering support, showing concern and helping people reflect on their own situation."
  - "Meet people's religious needs where required through worship, prayer and sacrament."
- Staff offered and gave support to patients who suffered with anxiety or depression. For example, a patient we met disclosed how they suffered with anxiety, and the staff were aware of this following an assessment. They had suffered from anxiety while on the unit, and the nursing staff had been supportive and offered reassurance, which had significantly helped.

Are critical care services responsive?

Requires improvement

We rated responsiveness as requires improvement because:

- The response to patients did not always meet their needs or best practice. There were bed pressures in the rest of the hospital and too many patients were delayed in their discharge from critical care to a ward. These delays were worse than the national average.
- Some patients were discharged onto wards at night as a bed had become available, when night time discharge was recognised as less than optimal for patient's wellbeing and mortality.
- There was no follow-up clinic provided to patients. Despite research and guidance into the potential poor psychological outcomes for patients in or discharged from critical care, there was limited psychological support for patients, and then only when inpatients.
- The critical care unit facilities did not meet some of the recommendations for modern units, such no patient toilet or shower facilities, no separate entrances for patients and visitors, and limited facilities for visitors.

However:

- There was a good timely response from consultants and nurses when new patients were admitted to the unit..
- Rotas were organised so most patients should be seen by a consultant within 12 hours of admission.
- There was support for equality and diversity. There was no discrimination in any aspect of care delivered, or in policies supporting care. The needs of vulnerable people were met.
- There were very infrequent complaints, but any that were made and any other comments or concerns were listened and responded to and used to improve care.

Detailed findings

Service planning and delivery to meet the needs of local people

- The critical care unit demonstrated it did not always have enough beds to meet the needs of the local population. Some patients were transferred to other local NHS hospitals, and some were moved to recovery, or held in recovery as a bed in critical care was not immediately available. The unit was too frequently at 100% occupancy, which is recognised by the Faculty of Intensive Care Medicine as a strong indicator that the unit is too small.
- The critical care unit had been located within the hospital to manage certain risks. It was located immediately adjacent to the operating theatres to enable staff to respond to emergencies either within critical care or within the operating theatres. The Department of Health recommended critical care was co-located with the emergency department, but this was some distance away. This arrangement was not, however, untypical of other NHS hospitals, where critical care was more likely to be close to the operating theatres than the emergency department.
- There were limited services within the unit to meet the needs of patients and visitors. For example, there were

no patient toilets or showers for patients who were well enough to use these. There were limited facilities for visitors, and the waiting room was used for private and sometimes distressing conversations with relatives and friends. At this time, other visitors were asked to leave the room for a period. The visitors' waiting room had been refurbished with comfortable furniture. Comments from visitors about the overhead strip lighting being too bright had resulted in the unit obtaining a floor lamp to reduce the glare and intensity of the light. There were no facilities within the unit for visitors to be able to get a drink or food, but there were food outlets in the hospital – although not out of hours.

- There were no facilities within the hospital for relatives to be able to stay overnight. However, staff would help them find somewhere to stay in the local area, where, as a seaside town, there was a range of options and facilities.
- The critical care unit met some but not all the recommendations of the Department of Health guidelines for modern critical care units as they related to meeting patient needs and those of their visitors. The unit was built prior to these recommendations being made. Areas it met included:
  - Dimmable artificial lights.
  - Intercom-controlled entry with CCTV in use.
  - Bed spaces capable of giving reasonable visual and auditory privacy.
  - Natural daylight for patients, and they could see a clock.
  - Each patient having a high-backed chair at their bedside to enable them to sit out of bed safely.
  - There were toilets within the unit for visitors to use.
- There were some areas relating to the needs of patients and their visitors not meeting the guidelines. These included:
  - No toilet or bathroom facilities for patients.
  - Only one primary entrance/exit from the unit. There was a second exit but this led to the operating theatre recovery area. The Department of Health recommended patients and visitors should not share the same entrance and deceased patients should not be transported using the visitors' entrance.
  - No reception desk or visitor meeting point.
- As was not unusual in critical care in the UK, there was no access in the local area or region to a home ventilation and weaning service. This was a service designed for patients who had complex ventilation needs, and were able to be supported at home. However, this was not a service provided in the local or wider region, and these services remain a rarity in the UK.

Meeting people's individual needs

- The services reflected the needs of the local population. There were no apparent barriers to admission due to a patient's age or gender. The average age for patients admitted to critical care was 65 in 2015/16 and 67 in April to September 2016. This was slightly above the national average of 61 years, but not significant. Intensive Care National Audit and Research Centre (ICNARC) data showed a typical distribution of ages of patients admitted, and the unit, like other similar units, had treated patients in their 80s and up until their mid-90s. Typically, the majority of patients admitted were male (around 57%).
- The unit was relatively quiet for patients most of the time. Low levels of noise have been shown to be beneficial to patients in critical care, particularly those who are sedated lightly or otherwise. The unit had purchased 'noise ears' which were devices displaying noise levels in the shape of an ear and designed to alert staff to high levels of noise. These had yet to be placed up on the wall so they could be seen and be more effective in noise reduction.
- There were arrangements to provide patients with cognitive impairment with additional support. Most of the nursing staff had undertaken advanced training in dementia awareness, although this was poorly completed by the doctors (35%). Staff said they found keeping the unit calm and quiet helped. They looked to be reassuring and visible, so making sure the patient was able to see a member of staff close to them as much as possible. There were arrangements to find out as much about people as possible when they were patients on the unit. Carers and families were encouraged to provide staff with helpful guidance to provide the best support for patients with learning disabilities or other particular needs.
- The unit had equipment to meet patients' health needs that could be unrelated to their critical illness or condition. This included, for example, haemodialysis machines to provide treatment for patients with kidney failure. These machines were dual purpose in also

providing haemofiltration. Patients therefore needing renal replacement therapy for acute kidney injury were treated on the unit, and not transferred elsewhere for this specialist therapy.

- Patients and visitors were given printed information about critical care, which they could take away with them. There was a leaflet rack just outside of the visitors' room with a range of leaflets and information. This included a range of subjects including delirium – a common experience for some patients admitted to critical care, and nasogastric feeding techniques and why this was used. Patients and relatives were also signposted to services and support groups, such as ICU Steps – an organisation specialising in providing tailored support for critical care.
- Due to bed pressures in the hospital, there were frequent breaches in same-sex occupancy rules. Due to being unable to move a patient when they were ready to leave, critical care was rarely able to meet gender separation rules for patients who were fit for discharge, but still within the unit. A patient would strictly breach these rules when they were in a unit occupied by a patient(s) of the opposite gender and the first patient had been declared fit for discharge to a ward. Department of Health guidance recognised it was difficult to fulfil this criterion in units like critical care where emergency and complex care was required. Critical care had no patient toilets or washing facilities, and therefore no opportunity to provide these for different genders. The unit had two relatively discrete sides with two beds in each, and staff endeavoured to make these area same-sex, but with clear difficulties on such a small unit. ICNARC data showed around 80% on average of all patients were delayed in their discharge from critical care to a ward bed by at least four hours. The bed days of patients waiting more than eight hours to be discharged was, and had been for at least the last five years, more than twice the average of similar units. This meant the unit (technically) frequently breached the same-sex rules.
- There were communication aids for people who were not able to talk to staff and visitors due to the use of equipment in their treatment. The unit had Passy Muir valves, which had been used effectively to enable people to speak when fitted with a tracheostomy. There were wipe-clean boards for writing messages, and picture books if they were found to help.
- Critical care was not providing patients with access to a follow-up clinic. This service was recommended under the National Institute of Health and Care Excellent (NICE) guidance 83 recommendation 1.1.25, and the Faculty of Intensive Care Medicine (FICM) core standard 2.16. The FICM stated, "Critically ill patients have been shown to have complex physical and psychological problems that can last for a long time. These patients benefit from the multi-modal approach that an ICU follow-up clinic can deliver." The unit had recognised this and was looking at whether a 'post-ITU coffee morning' would provide some support to former patients, but had no plans for a full service.
- When needed, the hospital trust had facilities to provide translation services. The trust had engaged third-party services providing face-to-face, telephone, and written translation services. The trust recognised within its safeguarding policy, that children should not be used to provide translation for family members, unless in a significant emergency.

Access and flow

- There were an unacceptable number of patient discharges from critical care being delayed due to a bed on a ward in the hospital not being available. Similar to many critical care units in England, data from the Intensive Care National Audit and Research Centre (ICNARC) reported a high level of delayed discharges from critical care. There had been some improvement in this over the last five years from 2012, when the trend had been slowing. However, this improvement was reversed in the first six months of 2016/17 (April to September 2016) due to unprecedented pressure on the hospital for beds. In the years from 2012/13 to 2015/16, delays in discharges by more than eight hours had been around 10% on average. This was against a national average of around 5%. The rate had dropped to 9% in 2015/16. However, in the first six months of 2016/17, the rate had accelerated to affect 19% of patients. This was also against a national average of 5%. In raw data for December 2016, 25 of 28 patients were delayed by more than four hours. Evidence showed one patient had been delayed within critical care for nine days, in a unit with no toilets and showers, so requiring the patient to use one of the adjacent wards.
- The discharge of patients from critical care was not always achieved at the right time for the patient. The unit was above (worse than) national averages for

moving patients at night. Studies have shown discharge at night can increase the risk of mortality; disorientate and cause stress to patients; and be detrimental to the handover of the patient. Data from ICNARC for discharges made out-of-hours (between 10pm and 7am) showed the unit above the national average for night time discharges for similar units for the last five years going back from 2015/16. It appeared the rate was beginning to fall, and the 12 patients in the 2015/16 year had fallen to four in the six months from April to September 2016 (the most recent data from ICNARC). However, data from the trust for the month of February 2017 showed there were a further six patients discharged at night.

- The critical care unit had higher occupancy levels compared with recommended levels and national averages. The high occupancy levels were due to a lack of a ward bed into which to move a discharged patient, and, as with the national picture, an increasing demand for critical care beds. The Royal College of Anaesthetists recommended maximum critical care bed occupancy of 70%. Persistent bed occupancy of more than 70% suggested a unit was too small, and 80% or more was likely to result in non-clinical transfers that carried associated risks. Detailed occupancy figures for critical care for July to December 2016 (taken on the fourth Thursday of each month at midnight) showed the rate had been 100% in five of the six months. In the other month, it had been 80%. The average of this occupancy was 97% against an NHS average for the same six-month period of 82%.
- The majority of patients were reviewed in person by a consultant in intensive care medicine within 12 hours of admission to intensive care. The rotas for the consultants meant an intensivist was in the unit from 8am to 6pm. Patients admitted shortly after 6pm were therefore at risk of not having a consultant review within 12 hours. However, the nursing staff and junior doctors said if a patient was admitted, who clearly needed urgent review, the consultant on call would attend the unit.
- There were a low number of elective operations cancelled due to the lack of an available bed in critical care. However, the type of planned operations carried out at this hospital infrequently required a critical care bed. In data supplied to NHS England, the hospital cancelled three operations in December 2016, and none in the five months prior to this. None of these operations were cancelled for a second time in this period.
- There were too many critical care patients being nursed in the operating theatre recovery area. However, this was a response to endeavour to meet the needs of all the patients requiring critical care. Patients who were otherwise fit for discharge from critical care, but delayed due to no ward bed, were being moved into recovery to make a bed available in critical care. Patients were also transferred to or remaining in recovery post-surgery, while a bed was being made available in critical care. In 2016, there were five ventilated patients cared for in recovery. There were otherwise 36 incidences of patients being nursed outside of critical care in the seven months from August 2016 to February 2017. During our inspection, a patient was admitted to recovery to be supported by the critical care team, while the situation within the unit was reviewed.
- Despite issues with patient flow, patients were staying on the unit for a length of time similar to the national average for similar units, although this had recently increased. Research has found it is sub-optimal in social and psychological terms for patients to remain in critical care for longer than necessary. The unit submitted data on patients' length of stay to ICNARC. This provided national benchmarking against other units of a similar type and patient group. The length of stay in 2015/16 for surviving patients at 4.2 days was just slightly below (better than) the average of 4.4 days. In the six months from April to September 2016 (the most recent ICNARC data), it was 5.3 days, compared with the national average for similar units of 4 days. This was not an insignificant rise, which was linked to poor patient flow.
- The hospital bed management/site coordination meetings were taking into account the bed status within critical care, although the delayed discharge results remained poor and had not improved. Senior staff within critical care told us the level of priority given to critical care discharge had not improved within bed management planning. In order to keep critical care at the forefront of discussions, the critical care matron met with the bed management team every day to endeavour to prioritise those patients who were ready to transfer to a ward.

Critical care

Learning from complaints and concerns

- There was active learning from any complaints or concerns. As with many critical care services, there had been very infrequent complaints. No complaints had been received by this unit in 2016, and the last was at the end of 2015. This was a concern about a perceived lack of communication and issues with patient care. A letter of apology was sent to the complainant, and staff were informed of the issues raised in order to learn from how communication with relatives is essential to get right.
- People were able to find out how to make a complaint. There were leaflets for the complaint process with the other leaflets just outside the visitors' room. This described clearly how to complain and what could be expected by way of a response from the trust. The contact information for people to complaint, comment or thank the hospital, were shown on the trust website.

Are critical care services well-led?

Good

We rated well-led as good because:

- There was a detailed level of assurance around the safety, effectiveness, and quality of care within critical care produced by the nursing staff.
- There was a risk register used to record and monitor known risks to patient care and the environment.
- Staff felt valued and respected and there was a strong culture on the unit.
- Views of patients, visitors and staff had been used to improve care.
- There had been improvements to the unit and staff were aware of the unit's limitations. These were recorded on the risk register.

However:

- There was no over-arching strategy for critical care, although there were clear values for the nursing team.
- There continued to be a lack of multidisciplinary input into management of the critical care unit, and particularly evidence to demonstrate how the medical leadership participated in the day-to-day running of the service.

Detailed findings

Vision and strategy for this service

- There was no over-arching strategy for critical care for the medium or longer term. The trust had recently announced it was entering into partnership working with another large acute trust in Bristol. This partnership was likely to drive many of the decisions around care for the future, and staff in critical care were waiting to see how this developed. Nonetheless, staff were preparing a business case for redevelopment of the unit in 2018 and had a number of ideas and visions for the future.
- The critical unit had a philosophy for nursing care. This included treating people as individuals, patients expecting an equal and high standard of care, nurses advocating for patients' rights, encouraging family and friends involvement, being professional, and giving quality care, treatment, communication, empathy and understanding.

Governance, risk management and quality measurement

- The governance framework within the unit had much improved to support safe and quality care. The senior nurse was now producing an extensive monthly dashboard of critical care metrics (assurance reports), based upon the five key questions rated by the Care Quality Commission. These departmental assurance reports gave their own rating of aspects of care in the unit, and actions required where improvements were needed. These assurance reports were presented at the surgical governance meeting (the directorate in which critical care sat) on a monthly basis. All areas of critical care were reviewed. This included incidents, infection prevention and control, safeguarding, and the environment. The report highlighted delayed discharges and mixed-sex breaches. There were changes to guidance, policies and protocols, and issues with staffing, including training, appraisals, vacancies and sickness reports.
- There was representation for critical care in the wider directorate governance meetings. The matron presented and discussed the highlights of the critical care assurance report. The other item was a regular comment about the delays in discharging patients from critical care, but with no action recorded as to how this was going to be escalated for senior executive review. Critical care was also discussed at the anaesthesia and critical care governance, audit and safety meeting.

Although issues within critical care were discussed in the meeting, the agenda item 14: feedback from intensive care governance meeting was almost always recorded as 'nil'.

- Most issues raised through governance and audit work had clear actions set against them. Some actions in the November 2016 report in relation to incidents and medicines' errors did not have actions, but in the reports for December 2016 and January 2017, they were more thoroughly reported. Any serious incidents had actions highlighted in a separate section at the end of the assurance report. However, there was no follow-up report to demonstrate actions had been taken and led to results.
- There was limited input into critical care governance from allied health professionals. The surgical directorate governance meeting was attended by the pharmacy lead (they had attended one of three meetings for which we were provided minutes – July, September and October 2016) but there was no attendance from physiotherapy or dietetics. Due to time pressures, allied health professionals did not attend any other meetings associated with critical care.
- There was now a comprehensive risk register for the unit. This had been produced and was held by the senior sister, who was recorded as 'handler' for the risks contained. There appeared to be no input to the register from the medical team, and there was no discussion of the critical care risk register in any meetings attended by the medical team. The risk register was held by the senior sister. It was mentioned at the unit meetings, and referred to in the surgical governance meetings, but there was no evidence it was reviewed in detail.
- There were regular meetings on the unit between the nursing staff. These ranged from all-staff meetings for nurses and healthcare assistants (where as many staff as could be available attended) and meetings between the senior and junior sisters. These meetings were minuted and actions arising were recorded.

Leadership of service

- There was strong nursing leadership in the critical care unit. Staff said the senior nursing staff on the ward were experienced, knowledgeable, supportive and competent. Leaders were also approachable at all times. Staff felt able to openly discuss issues and concerns with senior staff and their managers. They believed they would be listened to, and actions taken when necessary if anything needed to change or be addressed.
- As with our previous inspection, there remained little evidence to support multidisciplinary management of the critical care unit. There were good relationships between the nurses, the doctors and the allied health professionals. However, there remained no clear multi-professional approach to internal management of the unit. The nurses had regular well-attended meetings together, and produced assurance reports and governance information. However, there was no documented input to this from the medical team. The senior nurses attended the anaesthesia and critical care governance, audit and safety meetings, but this was a wide-ranging meeting covering a wide range of services and subjects. There remained no regular meeting between the clinical lead for anaesthesia, the lead for critical care, and the senior nursing staff. There was no evidence this was leading to poor leadership, but equally, no evidence to demonstrate how the leadership understood the challenges to providing good quality care.

Culture within the service

- The culture within the unit encouraged candour, openness and honesty. It was centred on the patient and delivering the best care. Those staff we met said they felt supported within the unit to raise concerns or anxieties. Staff said they felt they supported one another well, and took time with new or unfamiliar staff. All those areas of concern for the leadership of critical care related to delivering the right response to the patient, and providing safe and quality care.
- Staff felt respected, valued, and thought morale within the critical care unit was generally good. However, they thought morale had dipped since the very recent announcement of partnership working with the local NHS trust. No information was yet available to staff as to what this partnership meant for them, and this was unsettling for some.
- There were facilities for staff to work and rest, although these were limited. In accordance with Department of Health guidance, there were staff offices and changing rooms. The senior nurse had an office, and staff said they were able to find somewhere for private conversations. There was a doctors' office and this

provided an area for the doctors to work in a quiet space. There was a staff rest room with an adjacent kitchen area for staff with access to hot and cold drinks and food storage/preparation areas. Staff facilities were separate from the unit to enable them to withdraw into some peace and quiet, although they were able to return quickly in case of emergency.

- There had been positive feedback from the local university who placed student nurses on the unit for orientation and training. The university had received positive feedback from its students, who had praised the support, guidance and attention they received from the critical care nursing staff.

Public engagement

- People's views were gathered through conversations, compliments, cards and any concerns or complaints to the service. Staff were confident that should any complaints or negative comments be received (which were rare), these would be discussed and, where possible, learning and actions taken. This had led to some changes in the unit, including a refurbished visitors' room.
- Information from people visiting the unit was reported back to staff and the directorate through governance reports. The recurring theme from this was for visitors to be able to access a TV, but this was an ongoing issue with the small dimensions of the visitors' room and no access to an aerial.
- There was information for visitors at the entrance to the visitors' room. There were helpful leaflets about many aspects of care provided to patients in critical care, including support networks and counselling services. There were notice boards for patients and visitors with information about the safety and effectiveness of the unit. People were informed about the high levels of harm-free care on the unit, and staff were proud to display this for visitors. There was other information about new ways of working, or how people were looked after in critical care.

Staff engagement

- Staff were engaged and informed about the planning and delivery of the service in critical care. There were monthly unit meetings attended by a wide range of nursing staff. The meetings were minuted and circulated. In the most recent meeting on 13 February 2017, 16 of the nursing staff were present, which was over 50% of staff. Staff were given advice, support and guidance on how to approach the upcoming inspection from the Care Quality Commission (CQC). Staff were encouraged to "just be you", and reminded how CQC had found them to be "pleasant, open, honest, supportive of their team and caring for their patients in relatives" at the previous inspection.
- Leaders understood the value of staff raising concerns. The trust had a whistle-blowing policy for staff to use if they wanted to escalate serious concerns to senior management or beyond to external bodies. However, those staff we met within critical care said they would be likely to raise any concerns they had with their own management in the first instance. They said they had not experienced a situation where their concerns had not been listened to and addressed.
- There was good use of message boards in the staff room and notice boards around the unit. There was information about incidents, rotas, reminders of key information, audits due, and training needing to be completed.

Innovation, improvement and sustainability

- There had been improvements in the unit focused around patient care. These included:
  - Procurement and delivery of a difficult airway trolley to support safer intubations. Previously the trolley was borrowed from the operating theatres. The availability of a trolley on the unit was following a recommendation of the National Confidential Enquiry into Patient Outcome and Death review of tracheostomy care 'On the Right Trach?' from 2014.
  - The unit had purchased its own disposable bronchoscopes for tracheostomies and bronchoscopies. This equipment was now available to staff at all times.
- Staff were focused on continually improving the quality of care. When incidents such as pressure ulcers occurred on the unit, staff found ways of working that led to sustainable improvements in equipment or techniques used. Staff had recognised and introduced the use of the patient diary, and this was enhancing the experience for both patients, and particularly their relatives and visitors.
- There were ambitions on the unit to enhance care. This small unit faced limitations in what it could provide in the space and facilities it had. However, the physiotherapist had ambitions to produce effective rehabilitation prescriptions. These were for patients to

be able to take on to the ward, home, or elsewhere in healthcare to be able to continue their rehabilitation following the intensive therapy they would have received in critical care.

- There were links with the local south west of England critical care Operational Delivery Network. Staff in critical care attended and participated in network meetings and accepted peer reviews of their unit from the network. This met the recommendation of the Faculty of Intensive Care Medicine core standard 2.14. These networks were set up by NHS England in 2013 to share practice more widely and learn from each other. The Weston team had presented a strategy to the network for an extubation tool produced by the lead physiotherapist for weaning after a patient's long-term use of a tracheostomy. This was now accepted as best practice for this process.
- Critical care had designed and brought into use a small crash bag. This was a portable set of equipment, which could be easily carried and was portable for use on the wards and in the emergency department. A member of the critical care team would take this bag with them to any crash calls within the hospital to ensure all equipment that might be required was immediately at hand.

Outstanding practice and areas for improvement

Outstanding practice

- The oncology and haematology department demonstrated good practice with the way they assessed patient risk. Patients with a risk of neutropenic sepsis were easily identifiable through the use of a yellow jacket placed on patient notes.
- Patients living with dementia were situated in the bays or side rooms that were most visible to the nursing station. Staff who provided enhanced supervision to these patients were wearing yellow tabards and were easily identifiable. Staff were allocated to a patient or a group of patients in a bay and were not to be removed unless another staff member had taken over from them. We saw the hospitals own 'This is me' booklet in the notes of a patient living with dementia. This booklet had been completed by a relative of the patient and explained the patient in detail, what they liked to be called what they liked to do, what was their favourite food.

Areas for improvement

Action the hospital MUST take to improve

- Ensure that there are sufficient numbers of suitably qualified, competent, skilled and experienced doctors deployed within the hospital. This includes sufficient medical leadership within the emergency department and suitable levels of staff to ensure the corridor is safely staffed.
- Take action to ensure that there are sufficient medical staff with sufficient skills in advanced paediatric life support in the emergency department.
- Take action to ensure that medicine systems in the emergency department are safe for controlled drugs including signature list for agency nursing staff and locum doctors, to cross reference who had prescribed and administered medicines.
- Take action to ensure that systems are in place to ensure patient flow through the hospital was responsive.
- Ensure patients are being admitted promptly once the decision to admit has been made. Take action to ensure that safety checks in the emergency department are completed.
- Take action to ensure that patients are cared for in a safe environment in the emergency department.
- Review the medical staffing and ensure safe levels of medical cover and support to juniors on the medical wards in evenings and weekends.
- Review the use of locum consultants and take action to ensure medical staffing is not vulnerable through recruitment of permanent consultant staff.
- Be assured junior medical staff are being provided with appropriate support and are competent in their roles.
- Ensure safe nursing cover is provided on Cheddar ward and agency usage is kept to a minimum.
- Take action to mitigate risks included on the risk registers effectively, reviewing regularly and managing those risks identified on a timely basis to ensure safety to staff or patients is not compromised.
- Manage quality and performance and ensure sustained learning and improvements from audits.
- Take action to continually maintain a clear path for evacuation in the event of a fire within the stroke unit by ensuring fire exits are not blocked.
- Take action to ensure patient flow from the emergency department through the medical wards to timely discharge is effective and timely in meeting the needs of patents and ensuring good quality care and treatment.
- Take action to address areas of concern and demonstrate patient outcomes monitored by the Summary Hospital – level Mortality Indicator (SHMI) are improved.
- Improve the quality, attendance, accountability learning points and actions from mortality and morbidity reviews in all specialities.
- Make sure the surgical directorate has an orthopaedic-geriatric service for pre and post-operative care.

Outstanding practice and areas for improvement

- Ensure all patients that had fractured neck of femurs were operated on in line with national guidelines and admitted to an orthopaedic ward within four hours.
- Follow trust policy for the management of medicines, for example checking of controlled drugs, recording of medicine refrigerator temperatures and recording of signatures of agency nurses and locum doctors. (Accident and Emergency)
- Review pharmacy staffing levels in order to meet service, clinical and medicines governance demands and achieve medicines related CQUINS and Carter model hospital indicators and therefore protect patient safety.
- Ensure multidisciplinary input and a collective approach to the running of the critical care unit. The medical team leaders must ensure they meet regularly with the senior nursing leadership to provide a multi-professional approach and contribution to all aspects of running the unit, including governance and provision of quality care.
- Address the poor access and flow of patients in critical care in order to reduce the delays to patients who are fit to leave the unit, reduce the risks of patients not having timely admittance, eliminate breaches in same-sex rules, stop the relocation to or delay of patients in the operating theatre recovery area, and reduce the number of patients who are transferred to a ward bed at night.
- Produce mortality and morbidity reviews for critical care where there is accountability for learning and change, and a demonstration as to how this has improved practice and safety.
- Review the provision for and quality of life support training in the trust to ensure there are a satisfactory number of staff with the right experience and training on duty at all times.

Action the hospital SHOULD take to improve

- Consider a clearer approach to reflect incident trends and ensure use of the hazard line identifies trends and is supported by consistent processes.
- Ensure there is sufficient overview of the children's waiting area in the emergency department to ensure children's safety at all times.
- Review the storage arrangements for patients own medicines and possessions when they were receiving care and treatment in the corridor of the emergency department.
- Produce care pathways through the emergency department to support patient care. These should include frailty pathways for older people to ensure they received timely care and treatment.
- Consider actions to address professional working relationship breakdowns between doctors and established routines which had not been effectively addressed. These impacted on patients as early speciality review was delayed and patients had to wait in the emergency department.
- Ensure national audit programmes and local audits effect change in practice.
- Ensure emergency department staff are aware of the vision and strategy for the emergency department or the strategic development of the service.
- Ensure the governance and management systems in place to review the risks, quality and safety of the emergency department service were reviewed regularly and effect changes to the department.
- Ensure the risk registers for the hospital were accessible so staff can be aware of what was included on the risk register or how to raise issues for the risk register. This will enable risks to be addressed.
- Reduce the in-use expiry date when glucagon injection is removed from refrigerated storage and record the date of opening of liquid medicines to ensure that these medicines are suitable for use. Ensure there is a robust system for checking expiry dates of medicines.
- Review the storage arrangements for patients own medicines when they were receiving care and treatment in the corridor in accident and emergency.
- Complete the medicines safety thermometer on all in-patient units on a monthly basis.
- Audit the pharmacy service against the Royal Pharmaceutical Society standards for hospital pharmacy.
- Review the medicines reconciliation service provided such that medicines are reconciled for patients in line with the NICE quality statement 120 and benchmarked requirements.
- Ensure stroke patients are provided with optimum care in an environment which is conducive to improve their outcomes and meet their individual needs.
- Review length of stay data and act to reduce this in line with national recommendations.

Outstanding practice and areas for improvement

- Review the environment regularly to ensure safety is not compromised for patients. During our inspection we identified broken window restrictors and fire extinguishers which were not secured to walls.
- Review provision of seven day services to improve access to support at weekends and overnight.
- Educate staff on the duty of candour so it is used consistently across the medical service.
- Provide regular appraisals and clinical supervision to all staff to ensure they are appropriately supported and competent in their job role in medicine and the emergency department.
- Remind staff of the procedures to follow in the event of a major incident and schedule regular practice.
- Ensure the discharge lounge has appropriate arrangements for nursing support within escalation extended hours when the day case unit is not open.
- Review the ward clerk staffing arrangements and extra resources available to ensure wards are appropriately supported for non-clinical duties.
- Maintain a record through minutes of weekly medical meetings in the stroke and care of the elderly specialisms to discuss best practice for patients.
- Remind staff of the importance to find the previous weight of a patient to enable them to identify weight changes at admission and comply with the malnutrition universal screening tool (MUST) guidelines.
- Improve mandatory training attendance rates across the surgical directorate.
- Improve compliance with completing the venous thromboembolism or blood clots (VTE) assessment tool.
- Review the storage of equipment in the day case unit clean utility room.
- Review length of stay for emergency and elective surgery patients so it is in line with the England average.
- Make sure complaints are documented at senior level as being handled in line with policy.
- Consider adding sepsis screening to the performance assurance framework, to continually audit sepsis recognition and treatment and monitor sepsis training.
- Review supernumerary nursing cover in critical care to address the Faculty of Intensive Care Medicine core standard for safe supernumerary levels.
- Make sure medical staff working in critical care have completed the update of their mandatory training.
- Ensure medical records in critical care clearly state who has created the record and who has attended ward rounds.
- Ensure all staff in critical care are aware of the difficult airways trolley.
- Ensure all equipment checks in critical care are performed and recorded when required.
- Review patient records to ensure the time a decision is taken to admit a patient to critical care is recorded and captured for audit work.
- Make sure any medicines not given to a patient in critical care have the reasons recorded on the prescription charts.
- Review the time taken with ward rounds in critical care and ensure this does not delay any requests for tests or procedures for patients while the round continues.
- Be assured that nursing staff in critical care providing direct patient care are at the right level of qualification.
- Review the provision of physiotherapy in critical care, which was not meeting best practice guidance. Also, review NICE guidance around rehabilitation and physiotherapy prescriptions.
- Develop a valid programme of audit for the medical teams in critical care in accordance with an audit calendar and suitable programme for critical care.
- Review how to address the lack of a clinical nurse educator role in critical care.
- Review the critical care risk register at a multidisciplinary critical care meeting.
- Ensure all staff in critical care have appropriate knowledge of Deprivation of Liberty Safeguards.
- Ensure the reports of the Intensive Care National Audit and Research Centre are received when they are available, and discussed at clinical governance reviews.
- Ensure any patient diary used with longer-stay patients is recognised as the property of the patient and returned to them or their relative when the patient is discharged from the critical care unit.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care (1) The care and treatment of service users must – (a) be appropriate, and (b) meet their needs. Due to bed pressures elsewhere in the hospital, patients in the critical care service were not discharged in a timely way from the unit onto wards when they were ready to leave. There was a lack of facilities in the critical care unit to care for people and meet their needs when they were ready to be discharged, but delayed. Patients were also discharged too often at night. Although it was being safely managed, it was unacceptable that patients were being transferred to the recovery area in the operating theatres to make a bed available in critical care, or waiting there while a bed was being made available.

Regulated activity	Regulation
Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment (1) Care and treatment must be provided in a safe way for services users. (2) Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include – (b) doing all that is reasonably practicable to mitigate any such risks;

Requirement notices

(c) ensuring that persons providing care and treatment to service users have the qualifications, competence, skills and experience to do so safely;

(d) Ensuring that the premises used by the service provider are safe to use for their intended purpose and are used in a safe way.

(g) the proper and safe management of medicines.

At times, morphine was prescribed as a variable dose within the emergency department. Records did not should how much was administered or what happened to any unused drug in accordance with safer management of controlled drugs legislation.

There was no signature list for agency nursing staff and locum doctors, this meant that to cross reference who had prescribed and administered medicines was not possible.

Pharmacy staffing levels were not sufficient to meet the needs of the service including clinical and governance demands and ensure achievement of medicines related CQUINS and Carter model hospital indicators and therefore protect patient safety.

Escalation processes in place to indicate action when the department was under pressure were not responsive and did not affect a wider hospital support.

Patients are not able to responsively access the care they need. There has been a decline in patients being admitted promptly once the decision to admit has been made. The trust did not consistently admit patients within 4 to 12 hours. The method of calculation and process meant patients were in the emergency department longer than required.

In Critical Care there were an insufficient number of senior nursing and medical staff trained or updated in life support skills.

There was an environmental safety risk for both patients and staff.

Fire exits were observed to be blocked on the stroke unit. This was raised with management and the blockage removed. However, on our unannounced inspection we

This section is primarily information for the provider

Requirement notices

found the exit to once again be blocked. There was a lack of assurance this information had been effectively communicated to staff and the safety risk was being managed.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance (1) Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part. (2) Without limiting paragraph (1), such systems of processes must enable the registered person, in particular, to - (a) assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity, (b) assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from carrying on of the regulated activity; (c)maintain securely an accurate, complete and contemporaneous record in respect of each service user The systems in place for checking emergency equipment was not robust. Daily checks of resuscitation equipment, blood and ketone monitor equipment were not consistently completed placing patients at risk in an emergency. Fridge temperatures and controlled drugs were not correctly monitored according to the trust's own policy. This lack of consistent monitoring may place patients at risk. Patient records were not all secure and posed a risk that patient confidentiality may be breached. This relates specifically to patients receiving care on the corridor.

This section is primarily information for the provider

Requirement notices

The management of flow through the emergency department and wider hospital does not consider the risks to patients by extended length of stay in the emergency department.

There was a lack of a multidisciplinary and collective approach to running of the critical care unit. The medical team leaders did not meet formally and regularly with the senior nursing leadership to provide a multi-professional approach and contribution to all aspects of running the unit, including governance and provision of quality care.

There was a lack of accountability for learning and change in mortality and morbidity reviews in all services. There was no evidence to show how reviews, learning and change led to improved practice and safety.

Systems and processes through regular audits did not ensure the monitoring and improvement of the quality and safety of the service.

Findings from audits were not being shared across the trust to ensure learning and drive improvements. The trust was regularly underperforming in national audits against the England average, and there was a lack of assurance of improvements from these audits.

Risks were being identified, however they were not being managed effectively and in safe timescale.

The increased beds on the stroke unit had been included on the risk register in December 2016, this identified a risk to patient and staff safety due to fire exits being blocked. This risk had not been managed and we identified blocked fire exits during our announced and one of our unannounced inspections.

Regulated activity	Regulation
Surgical procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment (1) All premises and equipment used by the service provider must be -

This section is primarily information for the provider

Requirement notices

(c) suitable for the purpose for which they are being used.

The use of corridor areas in the Emergency Department for patient care and treatment does not ensure patient safety. There is insufficient space, light and access to electrical supply.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing (1) Sufficient numbers of suitably qualified, competent, skilled and experienced doctors deployed within the hospital and This includes suitable levels of staff to ensure the corridor in the emergency department is safely staffed This also includes sufficient medical leadership within the emergency department. We were made aware that whilst there were staff with advance paediatric life support training in place on duty each night, the amount of children seen did not ensure the medical staff out of hours felt confident and capable to manage an emergency paediatric situation. The trust must ensure a consistent medical workforce and appropriate staffing levels to keep people safe and adequately support juniors. Medical staffing was vulnerable and there was a high reliance of consultant locums. There was a risk at evenings and weekends that the medical wards were not well supported by the medical team if they were also required to support deteriorating patients in the emergency department. The trust must ensure there is a safe level of nurse staffing on Cheddar ward. Cheddar ward did not have sufficient permanent staff and there was a high use of agency and therefore a lack of continuity, this posed a risk to patient safety.

This section is primarily information for the provider

Enforcement actions (s.29A Warning notice)

Action we have told the provider to take

The table below shows why there is a need for significant improvements in the quality of healthcare. The provider must send CQC a report that says what action they are going to take to make the significant improvements.

Why there is a need for significant improvements	Where these improvements need to happen
The trust must take action to address serious failings to ensure quality care and treatment and safety of patients.	Review the emergency department as the single point of entry to the hospital for both emergency and expected patients to reduce crowding. Ensure access to a specialist senior doctor to review patients overnight in the emergency department is timely and does not delay patient admission to wards. Ensure the use of the corridor in the emergency department is an appropriate and safe area for patients to receive care and treatment. Systems or processes to manage patient flow through the hospital must operate effectively to ensure care and treatment is being provided in a safe way for patients and to reduce crowding in the emergency department.