

Dorset County Hospital NHS Foundation Trust

Dorset County Hospital

Quality Report

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Date of inspection visit: 8 - 10 March 2016
Date of publication: 16/08/2016

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

Ratings

Overall rating for this hospital

Requires improvement



Urgent and emergency services

Requires improvement



Medical care (including older people's care)

Good



Surgery

Good



Critical care

Good



Maternity and gynaecology

Requires improvement



Services for children and young people

Good



End of life care

Requires improvement



Outpatients and diagnostic imaging

Requires improvement



Summary of findings

Letter from the Chief Inspector of Hospitals

Dorset County Hospital is the single site acute hospital provided by Dorset County Hospital NHS Foundation Trust; it has been a foundation trust since 2007. The trust provides acute and some community services to a population of around 250,000, living within Weymouth and Portland, West Dorset, North Dorset and Purbeck. It also provides renal services for patients throughout Dorset and South Somerset to a total population of 850,000. The geographical spread of the community means the trust also deliver services in Weymouth, Bridport, Sherborne and Blandford Community Hospitals.

Dorset County Hospital has approximately 400 inpatient beds. We inspected the following core services at Dorset County Hospital : Urgent and emergency care, medical care, surgery, critical care, maternity and gynaecology, children and young people, end of life care, outpatient and diagnostic services. We inspected satellite outpatients, day surgery and renal dialysis at two other NHS locations.

We inspected this hospital as part of our planned, comprehensive inspection programme. We carried out an announced inspection visit to the hospital from 8 to 10 March 2016, and additional unannounced inspection visits between 16 and 21 March 2016. During this time we also visited outpatients, day case surgical services and dialysis services provided at two other trust sites.

Overall, we rated this trust as 'requires improvement'. We rated it 'requires improvement' for safe, effective, responsive and well led services, and 'good' for caring services.

We rated, medical care, surgical services, critical care, and services for children and young people as good. Urgent and emergency care, maternity and gynaecology, end of life care and outpatient services were rated as requires improvement.

Our key findings were as follows:

Are services safe?

- The majority of staff understood when to report an incident, these were investigated and lessons learnt shared. However, in outpatients and diagnostic imaging staff felt discouraged from using the system as they did not always receive feedback and lessons learnt were not always shared. Some staff in the surgical specialty were still using were using a supplementary paper-based system which was outside of the trust policy. There was a high level of harm-free care. Staff were aware of the Duty of Candour legislation and the service had a system for tracking incidents that triggered a Duty of Candour response.
- Systems were in place to enable staff to assess and respond safely to deterioration in patients' health.
- Medicines were generally stored and managed appropriately other than the small amount of emergency medicines stored insecurely in the emergency trolleys. Some Patient Group Directions (PGDs) for medicines held in departments were out of date and not authorised, although updated at trust level. PGDs are instructions that permit authorised staff to give medicines to patients without the patients having an individual prescription. PGDs need to be accurate and authorised to protect staff and patients, Staff had not followed trust policy for updating PGDs in some departments.
- The mandatory training target set by the trust at 85% had not been met across all areas of the trust.
- Safeguarding training compliance had increased to meet the target. Staff were aware of the safeguarding of vulnerable adults and children. Child safeguarding checks were always undertaken, and processes were in place to escalate concerns to the local authority if needed.

Summary of findings

- Regularly serviced and maintained equipment was available for patient's use in most areas, with a prompt response from the maintenance team when equipment required repair. Some equipment in the emergency department was not clean or fit for use.
- Patient records were not always secured safely, in lockable storage equipment to ensure confidentiality.
- There were not always enough nursing, midwifery, therapy and medical staff with the right skill mix to provide safe care. Staffing levels had been reviewed, but changes to staffing levels identified as necessary from the reviews had not been fully implemented at the time of the inspection. The trust had a lower proportion of middle grade doctors than the national average, which put pressure on the medical teams. The trust was working to improve this.
- Staff adhered to the bare below the elbow policy and maintained safe standards of infection prevention. The trust scored higher than the national average for cleanliness in the patient-led assessments of the care environment (PLACE), scoring 99%. The hospital's infection control team carried out audits which led to improvements in standards of hygiene. However, the procedure for using the mortuary trolley did not adhere to infection control policies or procedures.
- Some parts of the environment in emergency department were in need of repair and made cleaning difficult. The critical care unit (CRCU) environment was non-compliant with Department of Health's Health Building Notes (HBN) 04-02.
- In the operating departments, staff did not consistently complete the 'Five Steps to Safer Surgery' checklist to minimise the risk of patient harm.

Are services effective?

- Most services followed pathways and protocols based on national guidance, such as the National Institute for Clinical Excellence (NICE) guidelines. Generally, patients' care was planned and delivered in line with current evidence-based standards. There was monitoring of performance against national targets and the results of audits were used to improve treatment.
- However on the maternity unit care and treatment did not consistently take account of current guidelines and legislation. For example we found some women did not have ongoing mental health checks throughout pregnancy, the maternal pulse was not consistently recorded on commencing a CTG trace for foetal wellbeing, and CTG traces were not reviewed in line with best practice guidelines.
- The trust was recently more focused on improving end of life care for patients. But there had been a slow response to best practice guidance and the results of successive national care of the dying audits. The Achieving the Five Priorities for Care of the Dying Person care plan was in the process of being introduced, and its use was yet to be audited.
- The majority of staff were trained and had the skills and knowledge required to undertake their role. There were educational opportunities available for all grades of medical and nursing staff. There were arrangements in place for the supervision and appraisal of staff. Although not all staff on the CRCU and in diagnostic and imaging had received an annual appraisal.
- On the maternity unit, most of the consultants performed a limited number of caesarean sections, which had the potential to impact on their competence. Also in maternity consultants did not always give adequate supervision to junior registrars. There was little communication from the consultants to the nurses looking after the gynaecology patients and their attendance was described as "variable".

Summary of findings

- Patient's consent for treatment, observation or examination was sought by staff. When people lacked mental capacity to make decisions, staff understood their responsibilities around making best interest decisions. Staff were aware of the impact of the Mental Health Act (2005) and the Deprivation of Liberty Safeguards. However, not all 'Do not attempt cardiopulmonary resuscitation' forms were supported by mental capacity assessments when it was stated patients lacked capacity.
- The trust was still working towards a full 7-day service. There was access to physiotherapy, pharmacy and microbiology seven days a week. The critical care outreach team was only available Monday to Friday 8am -8pm and there was no formal 'hospital at night' service. While staff said there was good access to the palliative care team and said they were helpful and supportive, there was not a face-to-face specialist palliative care services, seven days per week. Women who were at risk of miscarriage were only offered scans between Mondays and Fridays. Women were required to attend the emergency department or were referred to a neighbouring trust out of hours.
- Pain management was variable across the hospital. Patients who had undergone surgery told us their pain levels were regularly assessed and they received adequate pain relief. Pain assessment tools were not used for patients who had difficulty communicating verbally and patient's pain was not being routinely monitored or managed effectively in CRCU
- Information was not always provided to the patients GP in a timely manner. There had been a delay in providing discharge letters and clinic letters for cardiology patients, and clinic letters for dermatology and haematology patients.
- There was effective multidisciplinary working with staff working together to provide patient care in a coordinated way.

Are services caring?

- Patients and their relatives were positive about the caring attitude of staff and said staff treated them with dignity and respect.
- Patient surveys showed that staff were caring and protected people's privacy and dignity. The hospital's 'patient-led assessment of the care environment' (PLACE) audit score for privacy and dignity was 92%, above the national average of 86%. Friends and family test were generally positive with the majority of people happy to recommend the hospital.
- Patients said they felt involved in their treatment and had been able to make their own decisions.
- The multi-faith chaplaincy service was available to provide emotional and spiritual support if requested. Patients also said staff helped them emotionally with their care. However, there was no psychology service at this trust so critical care patients with complex emotional needs could not be referred for formal psychological support.

Are services responsive?

- The hospital often faced challenges with patients flow through the hospital and the number of available beds. The bed occupancy was consistency above the England average. The staff took a flexible approach to managing this situation including opening additional beds when able to do so. Other initiatives to improve the access and flow of patients through the hospital and, to promote shorter lengths of stay included the hospital@home service. Discharge planning was instigated at the time of admission. Ward staff and the discharge team worked with partners to improve the coordination of patient discharges and transfers.
- Improvements were needed in the responsiveness of critical care, and maternity and gynaecology services. There were delayed transfers from the critical care unit, which was not a suitable environment for patients ready for care on a ward. Mixed sex breaches were not identified and reported in line with national guidance.

Summary of findings

- Services were planned to meet the needs of the local population and in coordination with other health and social care services. These included the services provided in the hospital site and those provided at other locations such as dialysis services in satellite units. Patients with respiratory problems had access to the Dorset adult integrated respiratory service (DAIRS) a small outreach service that coordinated care between the hospital and patients' own homes. There was a day surgery unit in Weymouth, and a one stop breast clinic for timely and accurate diagnosis for patients awaiting breast cancer diagnosis. Outpatient clinics and diagnostic imaging were available at community clinics.
- There were translation services available for patients whose first language was not English. Sign language interpreters were also made available. Patient information was available and could be provided in other languages on request.
- Staff understood how to provide support to vulnerable people, including those living with a dementia or a learning disability or difficulty. There was no specialist liaison nurse for learning disabilities.
- Staff tried to resolve patients' concerns before they became complaints. Complaints were taken seriously, and changes made in response to patient feedback. There were improvement plans improving timeliness of responses, in agreement with complainants

Are services well led?

- Service leads had identified priorities for improvement, although the strategic vision was in part dependent on the Dorset Clinical Services Review. Strategies were also driven by the recent Vanguard project for more coordinated acute services across Dorset.
- Service leads had articulated a vision and the priorities for end of life care services, but these had not been implemented. The leadership and governance processes for end of life care services had not been sufficient to ensure that necessary action plans were implemented in a timely way, and that quality, performance and risks were effectively monitored and managed.
- Staff were aware of the trust's vision. All staff were passionate about improving services and providing a high quality service. Most staff felt both the trust and local leadership teams were visible and supportive. The exception was the maternity and gynaecology service where consultants did not all work well as a team and working relationships were strained. In some areas, managers were put under pressure to work clinically and were then not able to complete all aspects of their role, including quality assurance.
- There was strong patient and staff engagement including 'experience based design' surveys to find out how people felt about their care and treatment. Many of the wards displayed recognition awards for teams and individual staff.
- There was a governance structure for the services and services participated in audit programmes. A recent trust wide review had demonstrated that the governance processes including the reporting and escalation process needed strengthening. At local level the clinical governance teams had oversight of audit, performance, risks, quality and finance. A newly formatted risk register had been introduced, the completion and use of these registers was variable. Not all risk registers included all the risks and lacked evidence of mitigation and review.

We saw several areas of outstanding practice including:

- The hospital@home service provided a valuable service supporting medically fit patients to have earlier discharges to their homes. This service was provided 24/7 and helped improve access and flow in the hospital as well improve outcomes for patients.
- The support for renal dialysis patients was outstanding, with individualised care for patients to receive home dialysis and holiday dialysis when appropriate and safe.

Summary of findings

- The genitourinary medicine service was a well-led, patient focused service that had identified the needs of the patient groups it served, many of whom were vulnerable. There was excellent multi-disciplinary working with external agencies and robust clinical standards in place, which they service, audited themselves against, always looking for how they could improve the service. Outpatient clinics and advice sessions were held, where possible, at venues that encouraged attendance from patients who had the greatest need for the service but could not or found it challenging to attend a hospital.
- The two bereavement midwives made home visits following a stillbirth or neonatal death. They made follow up visits to tell the parents post-mortem results in person and offered to provide antenatal care for women in any subsequent pregnancy. They also set up the monthly 'Forget Me Not' bereavement support group in a local children's centre. They set up and closely monitored a private social media page for women who had lost a baby during pregnancy or after birth.
- A gynaecology specialist nurse ran the 'Go Girls Support Group' along with a former patient, to provide support for women diagnosed with a gynaecological cancer.
- Midwives ran specially designed antenatal, breastfeeding and smoking cessation sessions for 'Young Mums'. They were also offered separate tours of the maternity unit.
- There were several examples of patient involvement in the codesign and improvement of services and excellent use of experience based design (EBD) methodology.

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

Importantly, the trust **must** ensure:

- All equipment is clean and fit for purpose and ready for use in the emergency department. A clear process must be implemented to demonstrate the mortuary trolley has been cleaned, with appropriate dates and times recorded.
- The five steps to safer surgery checklist is appropriately completed.
- The management and administration of medicines always follows trust policy.
- Patients in the minor operations room (used as a majors cubicle) in the emergency department have a reliable system in place to be able to call for help from staff.
- There are sufficient therapy staff available to provide effective treatment of patients.
- The numbers of nursing on duty are based on the numbers planned by the trust all times of the day and night to support safe care.
- Sufficient palliative care consultant staffing provision in line with national guidance and to improve capacity for clinical leadership of the service
- The number of midwives is increased according to trust plans and in line with national guidance, to support safe care for women.
- Staff attend and or complete mandatory training updates.
- Turnaround times for typing of clinic letters are consistently met, monitored and action taken when targets are not met across all specialities within the trust.
- All patient records must be stored securely to maintain patient confidentiality.
- Risk registers at local, directorate and divisional level are kept up-to-date, include all factors that may adversely affect patient safety. And progress with actions is monitored.

Summary of findings

- There is implementation of clear and measurable action plans for improving end of life care for patients. There is monitoring and improvement in service targets and key performance indicators, as measured in the National Care of the Dying Audits.
- Care and treatment in all services consistently takes account of current guidelines and legislation and that adherence is audited.
- Consultants supervise junior registrars in line with RCOG guidance.
- Continue the development of governance processes across all specialties and divisions, with a standardised approach to recording and reporting. Ensure the information is used to develop and improve service quality.
- Regular monitoring of the environment and equipment within the emergency department, and action taken to reduce risks to patients.
- Mixed sex breaches in critical care must be reported within national guidance and immediately that the breach occurs.

In addition the trust should ensure :

- All staff report incidents and feedback is given to the member of staff reporting the incident, and learning from incidents is shared with staff and across teams when relevant.
- The trust electronic incident reporting system is fully implemented throughout the surgical specialty.
- Management and specialist staff have the time to undertake their roles
- Resuscitation trolleys are tamper evident.
- Staff follow trust procedures when patient group directions are updated, so it is clear they are authorised for use,
- A recognised pain assessment tool is used in critical care to assist in the monitoring and managing pain for patients.
- Pain score appropriate tools are used for non-verbal patients across the hospital.
- Discharge letters are sent to GPs in a timely way and patients are given a copy .
- Standards of cleanliness are maintained in all outpatient areas.
- Patient outcome data is recorded and analysed to identify improvements to services for patients.
- Staff working in outpatients always follow the trust interpretation policy for patients who are non-English speaking.
- Nurse staffing on the children's unit is reviewed in line with The Royal College of Nursing (2013) guidelines in terms of numbers or ratios of nurse to healthcare assistants.
- Review of medical staffing in line with British Association of Perinatal Medicine (2010 Standards) requirements for sufficient medical staff on the neonatal unit at all times, including overnight (9pm to 8am).
- Compliance with Facing the Future-Standards for acute general paediatric services (RCPCH, Revised 2015) requirements for consultant paediatrician present and readily available during the times of peak activity, seven days a week.
- Increased compliance with recording of key metrics in outpatient services, such as the time the patient is seen, to enable data analysis to be more meaningful when used to monitor service quality.
- Daily recording of data on missing notes for outpatient clinics, which is audited and actions taken.

Summary of findings

- Face-to-face specialist palliative care service, 7 days per week, to support the care of dying patients and their families.
- The critical care unit access is secure to maintain infection prevention and control and the safety of vulnerable patients on the unit.
- Service leads review how they use data to improve patient outcomes
- The development of critical care 'follow up' clinics, in line with national guidance, in consultation with stakeholders and commissioners.
- All maternity guidelines are reviewed to ensure they are up to date
- Pregnant women's mental health is assessed throughout pregnancy using a tool as recommended by NICE 'Antenatal and Postnatal Mental Health' guidance.
- The use of a NICE recommended CTG evaluation tool which should be entered into the woman's notes every time the trace is reviewed.
- The use of a software package, with an individualised growth chart designed to more accurately detect foetal growth problems which are associated with stillbirth.
- The development of a midwifery led birthing unit, in line with National Maternity review recommendations.
- The use of the modified 'Sepsis 6 care bundle' in the maternity units.
- The use of the Stillbirth Care Bundle developed by NHS England to ensure that all known measures are taken to reduce the chances of stillbirth.
- Improved rates of dementia screening to ensure that all emergency admissions over 75yrs are screened and then appropriately assessed.
- A robust system to support lone workers in the community.
- Identify and develop a quality dashboard to monitor the quality of the services.
- Implementation of nursing staffing acuity tool in child health.
- Supervision for staff involved in children's safeguarding.
- The arrangements for children attending appointments in general outpatient clinics are reviewed
- All staff caring for dying patients undertake mandatory training in end of life care, so that they have the necessary knowledge and skill to deliver end of life care in line with the 'achieving the five priorities for care of the dying person'.
- Cleaning between cases in day surgery is sufficient and there are effective arrangements to prevent cross infection.
- Nursing handover on Day Lewis ward are arranged to respect patients' privacy and dignity.
- There are arrangements for more timely discharges earlier in the day (before lunchtime) and more effective use of the discharge lounge by all ward teams.
- Governance arrangements provide sufficient overview of the quality and risks across outpatient services.
- The emergency department environment is reviewed to make it more child friendly.
- There are ongoing risk assessments and improvements in the environment of the critical care unit, taking into account the guidance set out in HBN 04-0.

Summary of findings

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service

Urgent and emergency services

Requires improvement

Rating



Why have we given this rating?

We rated the service in the emergency department (ED) as good for effective, caring and responsive but it required improvement for safe and well-led. The department was visibly clean, but the fabric of the building required some maintenance, which made cleaning difficult. Equipment was available, but was not always clean and fit for purpose. It was not clear who had responsibility for cleaning or checking some equipment. There was no regular monitoring of the environment and equipment to identify risks to patients. Following the inspection, we received a cleaning rota from the trust. There was some monitoring but this was not always effective. Maintenance was slow. There was not a patient call system in all treatment rooms. The service had identified improvements were needed in the coordination of governance processes. Risks were not always identified or adequately managed. The ED was well led clinically by senior doctors, but nursing leadership was stretched. The matron did not have sufficient time to work clinically and had a dual post as service manager which detracted from the quality assurance role, and led to fragmented nursing leadership and risks within the department not being identified. The department had a culture of safety where incidents were reported Learning was shared and changes made as a result of this. Staff adhered to infection control procedures. Medicines were mostly appropriately managed and stored. The department had appropriate medical staffing levels that included a consultant present for 12 hours a day and senior medical cover for 24 hours per day. There was an appropriate number of suitably trained and skilled nurses in the department; this included a lead nurse for children. There was a matron and service manager in a dual role, a consultant nurse, as well as skill mix of emergency nurse practitioners, advanced nurse practitioners and children's lead nurse. There were a low number of nursing vacancies within the

Summary of findings

department. Agency staff were seldom used. However, when agency staff were used, an appropriate induction to the unit was not always provided.

The safeguarding requirements for children, young people and vulnerable adults were understood, and there were appropriate checks and monitoring in place.

The department provided effective care that followed national guidance and this was delivered to a high standard. Pain relief was offered appropriately and the effectiveness of this was checked. Multi-disciplinary work was in evidence and the department ran its services seven days a week.

Patients gave positive comments about the care they received, especially the attitude of the staff. Patients and relatives told us they were treated with compassion, dignity and respect, and staff treated them with kindness and courtesy. Patients were kept informed of treatment options and were involved in decisions about their care.

The hospital was not consistently meeting the national emergency access target of 95% of patients who required hospital admission to be transferred to a ward or discharged from ED within four hours. Patients were however, mostly assessed and treated within standard times. Overall the trust performance had been in line or better than the England average. There was good support provided for patients with a mental health condition and patients living with dementia.

The departmental strategy and vision was not recognised by all staff, although the service had involved senior staff in away days and meetings about developments in the service. The culture within the department was one of accessible leadership with mutual trust and respect, leading to the maintenance of an effective team. There was appropriate monitoring of incidents and performance by senior staff.

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

Good



Overall, we rated medical care as 'good'. We found that medical care (including older people's care) was good for effective, caring, responsive and well led and 'requires improvement' for safe.

Summary of findings

Staff managed most aspects of medicine administration, storage, disposal and recording safely. However, we found that hard copies of Patient Group Directions (PGDs) for medicines on the satellite renal dialysis unit were out of date or not authorised. Staff had not followed trust policy for updating PGDs. Resuscitation trolleys were not tamper evident, creating a risk of incomplete equipment in an emergency.

Patients and relatives told us staff were caring and compassionate, and treated them with respect. They felt involved in their care and recommended the hospital to others based on their own experiences. Staff helped them with pain relief. Medical services sought patient views both routinely on discharge and to help improve treatment pathways. Groups of patients took part in focus groups to share their specific experiences of care.

Staff had a good understanding of how to care for vulnerable patients including those living with a learning disability or difficulty, or with dementia. They used tools to assess patients' mental capacity and understood the procedures to follow if patients were at risk of a Deprivation of Liberty if they were restricted or restrained.

Staff said their managers provided good support and felt the hospital was a friendly place to work. They had good access to professional development and most staff had completed mandatory training and appraisals. New nursing staff said the induction had been useful, although mentors did not always have time to provide adequate support. Junior doctors were satisfied with their training opportunities.

There was high level of bed occupancy and most wards had additional beds to help manage the increased demand for medical services. There were not always enough nursing staff, medical staff and therapists to support the needs of patients. The trust had carried out a staffing audit but had not completed the review to update staffing levels. There was a culture of collaborative working and staff said they worked well together in multidisciplinary teams to coordinate patient care. We observed effective handovers between staff, which showed they considered patient's individual

Summary of findings

risks and needs. However, we observed a nursing handover on Day Lewis ward, which lacked respect towards patients. Staff assessed patient's health and welfare risks and agreed plans to support their care and treatment. They monitored changes, including deterioration in health, and took necessary actions.

Patient records were clearly completed and documented patient's risk assessments and management plans. Staff did not always keep paper records in secure trolleys, to minimise access by unauthorised persons.

The divisional leads had an agreed vision and strategy for services and a clinical governance framework. They had recognised the need to improve their management of risks, and had started to use a new approach to monitoring service risks. Staff reported incidents, and understood how to use the incident reporting system. Staff carried out root cause analysis to investigate incidents and learn from them. The service had a high proportion of harm-free care. The services took part in national and local audits to check they provided care and treatment in line with good practice guidance. They developed action plans and worked with other health and social care providers to improve care pathways. For example, project teams worked to improved discharge arrangements, cancer care pathways and stroke care.

Wards were clean and the infection control team carried out regular audits to identify any areas for improvement. At the time of our inspection, the cardiac catheter laboratory had broken down and required repair by the suppliers. Other items of equipment were maintained safely under contract and staff reported maintenance staff responded promptly when requested. The equipment library also supplied aids and equipment within the agreed timeframe.

Surgery

Good



Surgery was rated as good because services were effective, caring, responsive and well led however some aspects of safety required improvement. We rated safe as requires improvement because: Staff did not consistently complete the 'Five Steps to Safer Surgery' checklist to minimise the risk of patient harm. Patient records were not stored

Summary of findings

securely but in open trolleys, presenting a risk of breaching patient confidentiality. Mandatory training targets had variations of 50-100% compliance against the trust targets.

Staffing levels of registered nurses, particularly overnight left a poor contingency for absence.

There was poor availability of therapy staff to support postoperative patients.

However, staff knew how to report incidents, and used the investigation of incidents and never events to share learning with colleagues. They were aware of their responsibilities under the Duty of Candour, adult safeguarding and used the safety thermometer data to inform patients, staff and visitors.

Patients received care and treatment based upon national guidance, standards and best practice recommendations. The surgical services were consultant led and delivered and there was good evidence of multidisciplinary team coordination to support patients. The surgical services participated in a number of national audits such as the Hip Fracture Database, where they had performed well. The trust had robust systems to monitor patient's nutrition and fluid balance. The patients told us that their pain levels were regularly assessed and they received adequate pain relief.

Staff treated patients with kindness and showed regard to their dignity and privacy. The trust's results of the Friends and Family Test showed a higher than average response rate. The surgical wards displayed 90-100% of people recommending the ward they had been a patient in. The patients described receiving good care, thoroughly explained and which they had been involved in any decisions relating to them.

The trust had developed services to support the needs of the patients', the daily single point of access multidisciplinary (MDT) meeting helped to provide a coordinated approach to complex patient discharges. The one stop breast clinic provided timely and accurate diagnosis for patients awaiting breast cancer diagnosis.

Summary of findings

The trust had taken steps to improve the Refer to Treatment targets and the majority of the surgical specialties were only just below target. Cancellation of patients' operations was better than the England average.

Although the trust had a discharge lounge, there was no obvious drive for earlier discharges and poor usage of the discharge lounge by some of the wards caused the holding of post-operative patients in recovery, prolonging theatre lists. The lack of beds could also mean the opening up of the day case unit overnight and the admittance of orthopaedic patients into other surgical wards. According to the surgical dashboard, surgery had failed to screen all emergency admissions over 75 years for dementia since April 2015 although of those screened 100% of patients were then appropriately assessed.

Staff were aware of the trust's strategy and vision; there was good engagement from staff that were passionate about improving services and providing a high quality service to patients. Most staff felt the leadership of the trust and within surgical services were visible and supportive. Staff told us they felt proud of their service, the patients' outcomes and feedback and the response rates for the NHS staff survey was higher than national average. Patients were encouraged to be engaged in changes to services, i.e. patient hip and knee pathways.

Critical care

Good



We rated critical care at this trust as good for safe, effective, caring, and well-led care. Responsiveness of the service required improvement.

There was a strong culture of reporting, investigating and learning from incidents. Patients were protected from avoidable harm and abuse and the principles of duty of candour were well understood.

Consultants were notably present on the unit and junior doctors were well supported in developing critical care skills. Nursing staff felt well supported by doctors and there was excellent communication between doctors and nurses during handovers. Physiotherapy assessments happened within 24 hours of an admission and physiotherapists were an integral part of the care team on the unit.

Summary of findings

The unit aimed to have a senior nurse shift coordinator who was supernumerary on at all times in line with national guidance. This was not always achieved when there was unscheduled staff absence. However, we saw that during these times there was a clear escalation process and patient safety remained the priority.

Medicines, including controlled drugs, were stored and managed safely with the exception of a small number of emergency medicines, which were located in the emergency trolleys. The emergency trolleys in non visible areas were not tamper-evident. This was corrected during the inspection, medicines were put in sealed boxes on the trolleys.

The unit was submitting on-going data to the Intensive Care National Audit Centre (ICNARC). Patients' predicted mortality outcomes at this critical care service were in line with, or better, than similar units, with the exception of patients admitted with pneumonia whose predicted mortality was below similar units. There were consistently low rates of unit acquired infection and audits showed consistent compliance with best practice hand hygiene standards.

Treatment and care followed current evidence based guidelines with the exceptions of the critical care outreach services which was not available 24 hours a day seven days a week and did not have follow up provision for critical care patients. The trust was working towards having a 24 hour critical care outreach team.

Staff were sufficiently skilled in delivering critical care and 59% of the nursing staff held a post-registration award in critical care in line with national standards. The clinical nurse educator oversaw the education and training development of the nursing team though was frequently required to cover routine clinical work, which distracted from this. Appraisal compliance was low on the unit at 79% of the overall staff team in December 2015.

However, the critical care outreach team staff had all been appraised within the last 12 months. Equipment was clean and well maintained but the layout of the unit was not optimal for the delivery of critical care. The unit was not compliant with Department of Health's Health Building Notes

Summary of findings

(04-02), Risk assessments had been undertaken and there was ongoing review. The unit was not secure as there was a second entrance via another ward. There was not clear signage or mechanisms to stop visitors and staff from other wards walking on and off the unit.

Patients were not routinely discharged in a timely manner and delays occurred in over 40% of all discharges. Delays led to patients staying in mixed sex and sub optimal accommodation for significant length of time. Mixed sex breaches were not being reported immediately as they occurred which was not in line with national guidance.

Patients and their relatives were involved, where possible, in decisions made about their care and treatment. Staff were sensitive when required to deliver bad news and ensured that suitably skilled and experienced staff were available to support patients and relatives at these times.

Staff were responsive and worked collaboratively to meet patients' health needs including those unrelated to their critical illness or condition. Staff made reasonable adjustments and used tools to support patients from vulnerable groups such as individuals with a learning disability.

Maternity and gynaecology

Requires improvement



Maternity and gynaecology services were rated as requiring improvement for 'safe', 'effective', 'responsive' and 'well-led' and rated as good for 'caring'.

Consultants did not consistently supervise junior registrars and were not always readily available to assist junior staff in theatre if required.

The midwife to birth ratio did not meet national guidelines. The funded midwife to birth ratio was 1:34. An assessment in July 2015, using a tool to assess how many midwives are required recommended the midwife to birth ratio should be 1:27.

Some women's maternity records lacked clarity. Within the maternity service, risk assessments were completed at the initial booking and continually evaluated throughout antenatal, perinatal and postnatal care apart from for their mental health. Risk assessments for gynaecology patients were carried out at the pre-operative assessment, around a month before their admission. Risks to

Summary of findings

patients were not consistently reassessed on admission to the ward. Medical records were not consistently stored securely on Abbotsbury ward. Gynaecology patients were infrequently reviewed by consultants; they were normally reviewed by registrars or junior doctors.

Overall attendance at mandatory training updates was below the trust's 85% target in some cases as low as 41%. There was a risk that not enough staff had attended updates to ensure they had suitable training to care for women safely.

Harmful cleaning solutions could be easily accessed on the maternity unit and medicines were not consistently stored securely in the maternity unit. Care and treatment did not consistently take account of current legislation and guidance.

Midwives did not use the 'Fresh Eyes' approach which is considered good practice and the maternal pulse was not consistently recorded before commencement of the cardiotocograph (CTG). The maternity service did not use the 'Sepsis 6' care bundle or the NHS England 'Stillbirth Bundle'. There was no current schedule for audits. Caesarean section rates were higher than England averages and breastfeeding initiation rates were consistently below the trust target, despite the unit achieving UNICEF's Baby Friendly accreditation. The trust did not meet its target of 90% of women booked by 12 weeks antenatally.

There was one maternity theatre there was a possibility that elective cases may be delayed if emergency care was required.

There were strained working relationships between most consultants, despite participation in mediation to improve the situation. Some members of staff felt there was a risk this may impact on the quality of patient care. Consultants did not often review gynaecology surgery patients and did not communicate with nurses looking after them on the ward. They failed to attend two meetings arranged for them to meet the new ward sister. However, we saw evidence that newly appointed consultants were working effectively and improvement to the perinatal mental health service was due to start in May 2016.

Summary of findings

Overall feedback from women and relatives about their care and treatment was positive. We observed women were treated with kindness, compassion and dignity throughout our visit.

A range of equipment and medicines were available to provide pain relief in labour and for patients on the gynaecological ward. Women were able to self-administer pain relief if required.

Nursing and midwifery staff were encouraged to report incidents and robust systems were in place to ensure information and learning was disseminated trust wide. Duty of Candour was well-embedded in the maternity services, and praise given to staff, who felt supported by managers. Women had access to sufficient information to support them with their pregnancy options and gynaecological diagnosis. Women had access to telephone translation services and staff told us information could be sourced in other languages if required.

There was a clear strategy, with strong public and staff engagement. We saw evidence of learning from complaints in both the maternity and gynaecology services.

Services for children and young people

Good



We found that the services for children were good for safe, effective, caring, responsive and well led. There was openness and transparency about safety, and continual learning was encouraged. Staff were supported to report incidents, including near misses. Access to the children's ward and neonatal unit was secure. Staff were clear about their responsibilities if there were concerns about a child's safety. Safeguarding procedures were understood and followed, and staff had completed the appropriate level of training in safeguarding and other mandatory training.

The trust did not follow the Royal College of Nursing guidance on safe staffing levels for the paediatric wards. Whilst the trust did mitigate the impact of this overnight through effective rostering of competent staff, the system may not be sustainable. The unit was relatively small and not fully compliant with British Association of Perinatal Medicine (2010 Standards) requirements for a local neonatal unit as there was not a totally separate tier 1 rota, and the rota covered the children's unit as

Summary of findings

well. However, there was no evidence of any negative impact of this arrangement. There were good levels of low and middle grade doctors and they were positive about the trust as a learning environment. The unit was also non compliant with the Royal College of Paediatric and Child Health Facing the Future: Standards for Acute General Paediatric Services (2015) as the unit did not have a consultant paediatrician available during the times of peak activity, seven days a week. Although a consultant was resident overnight

Care and treatment was planned and delivered in line with evidence-based guidance, standards and best practice. The individual needs of children and young people were assessed and care and treatment was planned to meet those needs. Care pathways and multidisciplinary records were used to support practice. Staff assessed patients' pain effectively and obtained consent to treatment appropriately and in line with legal guidance. A paediatric early warning system was used for early detection of any deterioration in a child's condition and an early warning system for neonates was used in the NNU.

Staff were trained and had the skills and knowledge required to undertake their role. Staff completed appropriate competence assessments. Appraisals and supervision took place and this helped staff to maintain and further develop their skills and experience. Services, including access to consultant paediatricians, were provided seven days a week. Feedback from children, young people and parents about the care and kindness received from staff was positive. All the children and families we spoke with were happy with the care and support provided by staff. Staff worked in partnership with parents, children and young people in their care.

Inpatient services were tailored to meet the needs of individual children and young people. There were suitable facilities on wards for babies, children and young people and their families. A paediatric assessment unit, open 13 hours a day, improved patient access and flow through the hospital. There were no barriers for those making a complaint. Staff listened to the feedback given to them by parents. Play therapy staff ensured children were supported during their hospital stay.

Summary of findings

There was a clear governance structure to manage quality and risk. There was strong visible clinical leadership that had brought about positive developments. Staff at all levels of the organisation were proud to work in this department. The unit had also involved a child inspector from social services in making improvements to the service. There was a strategic plan for paediatric services 2016/17 and the service was part of the ongoing Dorset wide Clinical Services Review, and the acute services Vanguard project.

End of life care

Requires improvement



Overall this core service was rated as 'requires improvement.' We rated end of life service as 'requires improvement' for safe and effective and 'inadequate' for well-led, We rated caring and responsive as good.

Leadership and governance of end of life care services needed to improve to ensure that necessary action plans were implemented, and that quality, performance and risks were effectively monitored and managed. The palliative care consultant clinical lead worked part time therefore had limited time or capacity for strategic planning or leadership of the service, within the restricted hours available to them.

The trust was developing end of life care in line with national guidelines, but progress had been slow. The results of the National Care of the Dying Audit undertaken May 2014 highlighted several areas for improvement. An action plan had been written in November 2014 prior to the receipt of the results of the audit. The results of the National Care of the Dying Audit undertaken in 2015, showed there continued to be areas for improvement. During the inspection we saw that the end of life facilitator, appointed in August 2015, was driving improvements however there had not been audit to demonstrate this.

The trust had introduced an "end of life care for the dying patient individual care plan" to replace the Liverpool Care Pathway after its national withdrawal in July 2014, and to meet the requirement for individualised care plan. In January 2016 the trust commenced a rolling programme to

Summary of findings

implement a new end of life care plan called Achieving the Five Priorities for Care of the Dying Person. This was not yet embedded in practice across all areas of the hospital.

End of life care training was provided during induction but there was no mandatory ongoing end of life care training.

There was investigation of incidents but there was a lack of detail and recording to demonstrate how end of life issues had been comprehensively investigated or how action plans would be used to drive improvements. It was not possible to extract end of life themes or issues that had arisen through the incident reporting process and there had been limited learning from incidents that related to end of life care.

Most but not all DNACPR forms we inspected were completed according to national guidelines. The trust audits had also identified areas for further improvement, to ensure that forms showed discussions with patients and families and mental capacity decisions were documented.

Patients' needs were mostly met through the way end of life care was organised and delivered. There was rapid discharge of those patients expressing a wish to die at home most of the time, there were sometimes delays, due to difficulties in accessing community care services

Patients had appropriate access to pain relief.

Anticipatory end of life care medicines were correctly prescribed and patients were provided with pain management support.

Staff treated people with compassion, kindness, dignity and respect. Feedback from patients and their families was consistently positive. We saw good examples of staff providing care that maintained respect and dignity for the individual.

There was good care for the relatives of dying patients, and sensitivity to their needs.

Outpatients and diagnostic imaging

Requires improvement



We rated outpatients and diagnostic imaging as requires improvement. We found the service to be good for caring and responsive but requires improvement for safe and well-led.

There were significant delays in the typing of clinic letters for cardiology, haematology and dermatology, with a risk that GPs were not kept

Summary of findings

informed of any changes to medicines or the results from diagnostic tests. The trust put in place an action plan for haematology after our inspection, with work already taking place in cardiology and dermatology. Patients' records were not stored securely in the oncology department and the records store for the genitourinary medicines clinic had a leaking roof.

We had concerns that some staff did not always report incidents as sometimes they did not receive feedback or learning was not shared at team meetings. Governance processes across the four divisions and the different specialties lacked standardisation, particularly for monitoring and reporting on service quality. Risk registers were not always complete. Two patient records policies were out of date and audits to monitor compliance to these policies did not take place.

Staff followed national guidance to ensure patient care followed an evidence-based approach. Some departments used clinical audit to monitor the standard of care provided, although this was not consistently used across all departments.

The service overall met referral to treatment time targets (RTT) but did not consistently achieve the two-week wait for urgent cancer referrals. Work had been completed in a number of specialties, including ophthalmology, to help them achieve the RTT targets. The trust offered a number of one-stop clinics to reduce patient visits.

Staff working in outpatients and diagnostic imaging told us they enjoyed coming to work at the trust, they were well supported by managers and felt they provided a good standard of care to patients.

Overall, there were sufficient staff to run clinics and we observed good multidisciplinary working. Staff were up-to-date with their mandatory training and felt confident in their role. Access to additional training was sometimes affected by demand for services. The majority of staff had recently completed an appraisal but staffing shortages had impacted on this for diagnostic imaging.

Staff felt involved and able to make suggestions on how the service improvements although examples of good practice were not always shared within or across divisions, Staff found the weekly newsletter

Summary of findings

from the chief executive kept them informed of changes across the trust, however, outpatient staff at Weymouth Community Hospital did not feel engaged with the trust as a whole.

Patients commented on the cleanliness of the departments they visited and we observed staff adhering to the trust's infection control policies and procedures. However, the waiting room environment at Weymouth Community Hospital required review by the trust and owner of this hospital. Medicines and exposure risks to radiation for patients and staff were safely managed in diagnostic imaging. However, some patient group directions (PGDs) for the supply or administration of medicines held in departments were not authorised or in date for use. Staff were not following trust procedures for updating of PGDs.

All patient feedback was positive for the care and treatment they received from staff. Patients told us staff treated them with kindness, understanding and staff took the time to listen to their concerns and explain their condition in a way they could understand. Services were planned to meet the needs of local people, including those with additional needs or who were vulnerable due to their condition or personal situation. Patients were involved in developing services through experience based design projects.

Dorset County Hospital

Detailed findings

Services we looked at

Urgent and emergency services; Medical care (including older people's care); Surgery; Critical care; Maternity and gynaecology; Services for children and young people; End of life care; Outpatients and diagnostic imaging

Detailed findings

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Background to Dorset County Hospital

Dorset County Hospital NHS Trust has a single site acute hospital, Dorset County Hospital, and has been a foundation trust since 2007. The trust provides acute and some community services to a population of around 250,000, living within Weymouth and Portland, West Dorset, North Dorset and Purbeck. It also provides renal services for patients throughout Dorset and South Somerset to a total population of 850,000. The geographical spread of the community means the trust also delivers satellite services in other NHS locations including local community hospitals.

Dorset County Hospital has approximately 400 beds including 32 maternity beds and eight critical care beds with seven main theatres and two day theatres and it employs around 2401 whole time equivalent staff. The trust provides full emergency department services including critical care (the hospital has trauma unit status), acute and elective (planned) surgery and medical treatments, outpatient services, services for older people; acute stroke care; cancer services; pharmacy services; comprehensive maternity services including a midwife-led birthing service, community midwifery

support, antenatal care, postnatal care and home births. The trust also has a special care baby unit and a neonatal intensive care baby unit; children's services including emergency assessment, inpatient and outpatient services; diagnostic services such as fully accredited pathology, liquid based cytology, CT scanning, MRI scanning, ultrasound, cardiac angiography and interventional radiology, a wide range of therapy services and an integrated service with social services to provide a virtual ward enabling patients to be treated in their own homes.

We inspected this hospital as part of our planned, comprehensive inspection programme. We carried out an announced inspection from 8 to 10 March 2016, and additional unannounced inspection visits between 16 and 21 March 2016.

We inspected the following core services at Dorset County Hospital: Urgent and emergency care, medical care, surgery, critical care, maternity and gynaecology, children and young people, end of life care and outpatient and diagnostic services.

Our inspection team

Chair: Dr Nick Bishop, Ex Medical Director; National Professional Advisor at CQC (retired)

Inspection Manager: Anne Davis, Care Quality Commission

Detailed findings

The team of 46 included CQC inspection managers, inspectors and assistant inspectors and a variety of specialists, including: a consultant in intensive care medicine, a consultant gynaecologist and obstetrician, a consultant surgeon, a consultant geriatrician, consultant radiologist; consultant paediatrician and neonatologist,

emergency nurse, midwife, theatre nurse, paediatric nurse, palliative and end of life care nurse and consultant; critical care nurse; board-level clinicians and managers, a governance lead; safeguarding lead, a junior doctor and one expert by experience.

How we carried out this inspection

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

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

We carried out an announced inspection visit to Dorset county hospital 8 to 10 March 2016, and additional unannounced inspection visits between 16 and 21 March 2016. We visited unannounced during the period 8-10 February 2016. During this time we also visited out patients, day case services and dialysis services provided at two other trust sites.

Before visiting, we reviewed a range of information we held and asked other organisations to share what they knew about the hospital. These included Dorset Clinical Commissioning Groups, Monitor, Health Education England, General Medical Council, Nursing and Midwifery Council, Royal College of Nursing, NHS Litigation Authority, and Dorset Healthwatch.

We held listening events at a local library and shopping centre. This enabled local people to tell us about their views and experiences of Dorset County Hospital NHS Trust.

At the inspection we conducted focus groups and spoke with a range of staff in the trust and the hospital, including nurses, midwives, care assistants, matrons, junior doctors, consultants, governors, administrative and clerical staff, porters, maintenance, catering, domestic, allied healthcare professionals and pharmacists. We also interviewed directorate and service managers and the trust senior management team.

During our inspection we spoke with approximately 100 patients and 390 staff from all areas of the hospital. We observed how people were being cared for and talked with around 33 carers and/or family members and reviewed 187 personal care or treatment records of patients.

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

Facts and data about Dorset County Hospital

Context and activity

- This organisation has one acute hospital location: Dorset County Hospital, and satellite out patient, renal services across Dorset, including Weymouth community Hospital where there is a day surgery unit.
- There are 400 inpatient beds. In 2014-2015, there were 21,457 inpatient admissions, 289,014 outpatient attendances, and 42,367 ED attendances.

- The Clinical Commissioning Group (CCG) for this trust is Dorset CCG.
- In November 2015 the trust employed 2424 Whole Time Equivalents (WTE) staff, of which 322 were medical, 704 nursing and 496 'other clinical' and 903 'other non clinical'.
- The trust has an annual turnover of £158,319,000, and in 2014/15 the deficit was (-) £710,000.

Detailed findings

- Bed occupancy overall was higher than the England average.

Safety (trust wide)

- There two never events reported in the trust and 46 serious incidents between October 2014 and September 2015.
- There were 4,130 incidents reported to the National Reporting and Learning System (NRLS) in December 2014 – November 2015. The rate of NRLS reported incidents per 100 admissions was 0.4% lower than the England average: 8.8 per 100 admissions, against an England average of 8.4 per 100 admissions.

Number of incidents -% against (England Average %)

Deaths 3 - 0.07% (0.12%)

Severe Harm 29 - 0.66% (0.34%)

Moderate Harm 60 - 1.38% (2.93%)

Low Harm 901 - 20.7% (21.92%)

No Harm 3357 - 77.1% (74.67%)

- There were 19 cases of C Diff in this trust between August 2014 and July 2015, and one case of MRSA.

Effective (trust wide)

- The HSMR for this trust for October 2014 and December 2015 was 118.02, this is higher than expected.
- The SHMI for this trust for October 2014 and December 2015 was 1.13, again higher than expected.

Caring (trust wide)

- This trust performed similarly to other trusts in the CQC 2015 in-patient survey. It had consistently better scores than the England average for both the PLACE indicators and the Friends and Family test.
The trust received 385 complaints between 2014 and 2015.

Responsive (trust wide)

- A&E four hour target was not always met; but overall above the England average. 95% target met for five months from May to July 2015 and in September 2015.

- The 92% referral to treatment standard for incomplete pathways was met for seven out of 12 months from Dec 2014 to Nov '2015.
- 16.6% of delayed transfers of care in the trust were "waiting for further NHS non-acute care" lower than the England average.
- 1560 patients were awaiting "completion of assessment" at 19% it was relatively higher than England average 18.5%.
- 26.7% (2,184 patients) of delayed transfers of care in the trust were due to "awaiting nursing home placement or availability" this was higher than the England average at 12.6%.
- There were 823 patients with delayed care due to public funding; that equates to 10% which is higher than the England average of 4.5%
- The trust was meeting cancer waiting times for patients to see a specialist within two weeks of referral and from decision to treat to first definitive treatment within 31 days. The trust also met the waiting times target for two week wait referral to first definitive treatment within 62 days was just below 85% target at 84.5.

Well led (trust wide)

As of November 2015 there were 2424.2 WTE staff working in this trust. The numbers of staff by staff type in full time equivalents are given below:

Nurses 704

Doctors 322

Other 1399

Total 2424

(NB: 'Other' includes AHPs, other clinical staff including healthcare and maternity care assistants, and non-clinical staff.)

- Staff sickness in this trust was 4.8% in the last financial year and there was a turnover rate of 6.4% in April 2015 to March 2016.

Detailed findings

- As at November 2015, the contracted WTE medical headcount was approximately 322, and the skill mix percentage for each grade of doctor was: Consultants 39%, Middle Career 14%, Registrar group 28% and Juniors 20%.
- Performed similar to the England average for the majority of indicators in the NHS Staff Survey 2014, but also achieved 2 positive findings and 1 negative findings (out of 31 indicators). The response rate was 55%

Our ratings for this hospital







Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
Medical care	Requires improvement	Good	Good	Good	Good	Good
Surgery	Requires improvement	Good	Good	Good	Good	Good
Critical care	Good	Good	Good	Requires improvement	Good	Good
Maternity and gynaecology	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Services for children and young people	Good	Good	Good	Good	Good	Good
End of life care	Requires improvement	Requires improvement	Good	Good	Inadequate	Requires improvement
Outpatients and diagnostic imaging	Requires improvement	Not rated	Good	Good	Requires improvement	Requires improvement
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

Notes

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

Urgent and emergency services

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

Information about the service

The Dorset County Hospital served a population of about 250,000 people across West Dorset, Weymouth, Portland, Dorchester and the Purbecks. The emergency department, a dedicated trauma unit, had approximately 850 attendances per week. There were 42,367 attendances in the year 2013/14; of these 18% were children.

The department was purpose built. The department consisted of a reception and waiting room for walk in patients. There was a triage room off the main waiting area as well as a separate waiting room for children. There were six 'minors' cubicles including a treatment room for children. The 'majors' area had access for ambulances to a two bedded, well equipped resuscitation room. The majors area within the department had a single two-bedded bay as well as five cubicles. There was also a five bedded observation ward.

There was a consultant in the department between 8am-8pm Monday to Friday. At weekends, there was a consultant in the department for a minimum of 6 hours. There was appropriate senior medical cover over 24 hours.

During the inspection we observed the care and treatment of patients, and looked at 51 treatment records. We spoke with approximately 25 staff, 12 patients, and 11 relatives.

Summary of findings

We rated the service in the emergency department (ED) as good for effective, caring and responsive but it required improvement for safe and well-led.

The department was visibly clean, but the fabric of the building required some maintenance, which made cleaning difficult. Equipment was available, but was not always clean and fit for purpose. It was not clear who had responsibility for cleaning or checking some equipment. There was no regular monitoring of the environment and equipment to identify risks to patients. Following the inspection, we received a cleaning rota from the trust. There was some monitoring but this was not always effective. Maintenance was slow. There was not a patient call system in all treatment rooms.

The service had identified improvements were needed in the coordination of governance processes. Risks were not always identified or adequately managed. The ED was well led clinically by senior doctors, but nursing leadership was stretched. The matron did not have sufficient time to work clinically and had a dual post as service manager which detracted from the quality assurance role, and led to fragmented nursing leadership and risks within the department not being identified.

Urgent and emergency services

The department had a culture of safety where incidents were reported. Learning was shared and changes made as a result of this. Staff adhered to infection control procedures. Medicines were mostly appropriately managed and stored.

The department had appropriate medical staffing levels that included a consultant present for 12 hours a day and senior medical cover for 24 hours per day. There was an appropriate number of suitably trained and skilled nurses in the department; this included a lead nurse for children. There was a matron and service manager in a dual role, a consultant nurse, as well as skill mix of emergency nurse practitioners, advanced nurse practitioners and children's lead nurse. There were a low number of nursing vacancies within the department. Agency staff were seldom used. However, when agency staff were used, an appropriate induction to the unit was not always provided.

The safeguarding requirements for children, young people and vulnerable adults were understood, and there were appropriate checks and monitoring in place.

The department provided effective care that followed national guidance and this was delivered to a high standard. Pain relief was offered appropriately and the effectiveness of this was checked. Multi-disciplinary work was in evidence and the department ran its services seven days a week.

Patients gave positive comments about the care they received, especially the attitude of the staff. Patients and relatives told us they were treated with compassion, dignity and respect, and staff treated them with kindness and courtesy. Patients were kept informed of treatment options and were involved in decisions about their care.

The hospital was not consistently meeting the national emergency access target of 95% of patients who required hospital admission to be transferred to a ward or discharged from ED within four hours. Patients were however, mostly assessed and treated within standard times. Overall the trust performance had been in line or better than the England average. There was good support provided for patients with a mental health condition and patients living with dementia.

The departmental strategy and vision was not recognised by all staff, although the service had involved senior staff in away days and meetings about developments in the service. The culture within the department was one of accessible leadership with mutual trust and respect, leading to the maintenance of an effective team. There was appropriate monitoring of incidents and performance by senior staff.

Urgent and emergency services

Are urgent and emergency services safe?

Requires improvement



By safe, we mean that people are protected from abuse and avoidable harm.

We rated safe as requires improvement because:

- The minor operations room that was used as a cubicle was unsuitable for patients as they could not be easily observed. There was also no system for patients to be able to call for assistance. During the inspection patients complained of being cold in this area.
- Oxygen cylinders were not always stored safely in the department.
- Effective cleaning could not be undertaken as there was damage to many wooden surfaces around doors in the department.
- There were contaminated trolley mattresses that required urgent replacement.
- There was equipment for the immobilisation of patients with suspected neck or spinal injuries that was contaminated and dirty.
- Patient records in the admissions ward were not kept securely and could be accessed by unauthorised persons if the member of staff assigned to the area was providing care behind a curtain. Patient records in the observation ward were not stored securely.

However,

- Staff understood when to report an incident, incidents were investigated appropriately and the learning shared across the department. There was evidence that changes had been made to processes and clinical practice because of incidents.
- Staff knew about their responsibilities under the duty of candour, and gave an apology and feedback to patients and relatives after an incident.
- Senior staff regularly attended mortality and morbidity meetings and shared learning from these.
- The department was visibly clean. There was an agreed cleaning rota for the department, and protocols in place for deep cleaning if there was a risk of infection.
- Patients attending the department with a suspected infection were isolated from other patients in cubicles to reduce the risk of spreading infection.

- There was a reception desk and a separate waiting area for adults and children. There were appropriate arrangements in place to maintain the security of staff and other patients such as CCTV and location alarms.
- The department had a safe system of triage that provided patients with prompt initial assessment in minor injuries.
- There was protocol in place for the rapid transfer of critically ill children from ED to a specialist unit such as Southampton or Oxford. Staff were appropriately trained in the recognition of the sick child.
- The minor injuries area was staffed primarily by emergency nurse practitioners but there was also a middle grade doctor.
- Staff received appropriate mandatory training, and used recognised tools to detect deterioration of adults and children. Staff were aware of the safeguarding of vulnerable adults and children. Children safeguarding checks were always undertaken, and processes were in place to escalate concerns to the local authority if needed.
- Medicines were generally stored and managed appropriately.
- There were an appropriate number of suitably trained and qualified nursing and medical staff in the department across 24 hours.
- There was a plan in place to deal with a major incident, and the department held appropriate equipment if required. The staff were aware of the major incident plan and had received training on its implementation.

Incidents

- Staff reported, investigated and learnt from incidents. There were root-cause analysis documents displayed for staff to read in the staff room, as well as a newsletter called the ED Echo that had a summary of incidents and action plans. Quality dashboard data showed that there was a high level of harm-free care.
- Medical, nursing and support staff were aware of their responsibilities to report incidents and we saw examples of submitted reports. However, we also saw an example of where an incident occurred which was not reported. This was where a child was not able to be transferred by ambulance to another hospital and remained in the department overnight. The paediatric registrar was not aware of this child remaining in the hospital.

Urgent and emergency services

- Staff reported incidents using a trust wide electronic system. All staff were able to describe to us what incidents should be reported. Feedback from incidents was shared with staff at handovers, team meetings and staff training days. The departmental newsletter helped to disseminate the learning from incidents and complaints.
 - Staff told us there was an open culture for reporting medicine incidents and this reflects the direction in the medicines policy.
 - Medicines incidents were reported on the trust wide electronic system. When reviewing incidents relating to medicines, three staff interviewed stated that the safety of patient was always their first concern.
 - Thorough investigations of serious incidents were carried out, and a report produced by the investigator. There was an example of an investigation report on display in the staff room to help raise staff awareness of the incident and why changes had been made.
 - Staff were aware of the requirements of the duty of candour when giving feedback about incidents to patients and relatives. The Duty of Candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) or 'certain a notifiable safety incidents' and provide reasonable support to that person. The service had a system for tracking incidents that triggered a duty of candour response.
 - Bi monthly mortality and morbidity meetings took place, as a part of the governance process. Doctors and nurses from the department attended to ensure shared learning. We saw a good example of a presentation given at one of these meetings that was thorough and open.
- Safety Thermometer**
- Patient safety thermometer information was clearly displayed in the department. No pressure ulcers, catheter-associated urinary tract infections (UTIs) or falls were reported in the ED between September 2014 and December 2015.
- Cleanliness, infection control and hygiene**
- Some of the main fabric of the department was creating an infection and control risk. Seating in the waiting room was torn and the foam was exposed, this had been escalated but we were not made aware of a plan to deal with the issue. There were chips on doorframes and broken panels in some doors, an item of equipment had some visible rust. This made effective cleaning of the department difficult.
 - We inspected some splints and foam blocks that were stored in the ambulance corridor, these were used to immobilise patients during ambulance transfers. However, we found these had not been cleaned and were contaminated with body fluids. There was not a staff member responsible for the cleaning of checking of these devices. This was escalated to the department manager during the inspection.
 - Personal protective equipment such as gloves and aprons were available for staff to use and we observed them being used, when examining patients or providing care. These were available in all areas of the department.
 - Hand sanitiser gels and hand washing facilities were available for staff, patients' and visitors' use around the department. Monthly hand hygiene audits were undertaken and the department exceeded their 95% compliance target between September 2014 and December 2015. We observed that staff washed their hands after carrying out patient care or treatment.
 - Patients with a suspected infection, diarrhoea or vomiting were located in a cubicle to prevent the spread of infection. Staff told us that when the patient left the department a deep clean of the cubicle took place before the next patient. The department met its cleaning audit target of 95% between April and October 2015.
 - We observed staff disposing of needles and other used sharp objects correctly according to the hospital's waste disposal policy. There was no build-up of waste in the department.
 - We checked six trolley mattresses in the department and found that two worn looking ones were contaminated due to a breach in the cover. This was escalated to the department manager to ensure that they were replaced. Most of the trolley mattresses in the department had recently been replaced, but there was no programme in place for checking the mattresses.
 - Toys in the children's waiting room were visibly in need of cleaning. We were unable to establish if there was a member of staff responsible for this and there was no cleaning schedule for the toys.

Urgent and emergency services

- There was a storage area within the minor operations room; this was cluttered with some equipment stored on the floor, making the floor difficult to clean.

Environment and equipment

- There was a risk to safety from the inability to properly clean damaged surfaces around the department, which had not been identified.
- The reception desk for walk in patients had a glass panel to help protect the reception staff from unruly patients and the weather when the automatic doors were opened. The reception was located inside the main external door to the department. There was space for one patient to be booked in at a time. It was not possible to hear a patient giving their personal information to the receptionist from the waiting room seating.
- The department was formed of a majors area and minors area, around a public waiting room.
- To promote the safety and welfare of children there was a separate waiting room specifically for children, equipped with a television, toys and books. There was a glazed door on the room, but this was mainly kept open to allow staff access to observe children. Staff did not always signpost parents with children to the children's waiting room. Some older children we spoke with preferred not to use the facility as they thought it was for toddlers.
- The majors area had direct access for ambulances. There was a resuscitation room with two bays, five cubicles and a two bedded bay behind the nurse's station. The minors area had six treatment cubicles, including one decorated and equipped for use by children and a dedicated eye examination cubical.
- The resuscitation room had a remote patient monitoring system. This allowed staff to see the output of monitors from outside the resuscitation room.
- There was an emergency department admission unit that had capacity for five patients. The area was not easily observable and required a member of staff to remain in the unit to ensure that patients were observed. The trust told us that a member of staff was allocated to the area as standard practice and remained in place with support in order to ensure patients were observed".
- The minor operations room was used as a cubicle. There was the potential for patients to be placed at risk

as staff could not easily observe patients in this room due to the door being recessed. Patients in this room had no means of calling for assistance. Patients complained of being cold in this area.

- There was a relative's room, furnished with sofas. Interviews of patients who attended the department with a mental health problem took place in this room. This was because the door could be opened inwards or outwards in an emergency and there was a call bell to summon assistance if required.
- There was dedicated resuscitation equipment which was checked daily against a checklist. The emergency medicines and equipment we checked were in date and ready for use. Paediatric resuscitation equipment and supplies had been provided to match the specification of the Wessex trauma network. This ensured that the equipment was standard and stored similarly so that doctors and nurses from other trusts would be familiar with it.
- The resuscitation room was well designed with easily accessible storage cupboards fitted with digital code locks. This meant that staff did not have to find the keys to get medicines in an emergency.
- Equipment was maintained, serviced and calibrated by the trust equipment library service. Equipment required for patients urgently was requested electronically from the equipment library to reduce delay.
- There was a patient shower room in the department. It was not in use during the inspection as the flooring leaked into the pharmacy department below. Staff told us that this facility had been out of use for about six months, and were not aware of when it would be fixed. The shower was being used for storage. However, on the unannounced inspection on the 21 March 2016 the flooring had been replaced and the shower was ready to be put back into use imminently.

Medicines

- Medicines were stored correctly and securely across the department. There were coded locks for secure medicine storage in the resuscitation room and other areas. The exception was the refrigerator in the resuscitation area, which was unlocked. This had been risk assessed and deemed safe, as the area was busy with the constant presence of staff.

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- In the minors area there were some ophthalmic medicines that were not held securely. This meant there was the possibility that they could be tampered with or misused.
- There were four oxygen cylinders stored appropriately in cradles. However, an extra one was also stored where there was no cradle and there was a risk that this could fall and cause an injury.
- The department received regular bulletins from pharmacy to inform them of significant events, pharmacy interventions and changes of process.
- Staff disposed of medicines correctly in pharmacy waste bins sent to pharmacy, in accordance with the trust waste management policy.
- Controlled drugs were stored securely and managed in line with the trust policy.
- Prescriptions were written electronically, with individual staff using an access card to sign into the medicine administration screen. This system flagged all patients requiring administration of medicines and helped ensure they were given to patients at the correct time. Patient allergies were documented on the electronic prescribing system, as well as venous thromboembolism prophylaxis (the assessment was held on the electronic patient system). Medicine reconciliation and additional advice was documented on the system by pharmacy.
- We observed good patient interaction in minors which included information on the administration of medicines. Nurses gave the patient time and provided them with comprehensive information about medicines.

Records

- Patient records were completed fully and clearly and were contemporaneous.
- Risk assessments were appropriately completed for patients with suspected sepsis, mental health problems, venous thromboembolism and falls.
- Patients attending the department had a set of paper records generated by the receptionist on arrival. This included different documents depending on the patient's age and presenting condition. For example, if a patient presented with a problem and was receiving chemotherapy, a neutropenic sepsis pathway

document was produced automatically. This helped ensure that staff started with the pro forma they needed, to help them ensure that they followed correct procedures.

- The records of patients that had been discharged were filed in the main office. They were filed alphabetically for each day and were retained for 10 days. This meant that any patients re-attending the department within that time would have a copy of their recent care record. Although the records were not kept in a locked space, the office was manned 24 hours a day. If required, the office could be secured.
- Patient records in the emergency department admissions ward were stored in an open rack behind the nurse's station. This was not secure and patient records could easily be accessible to unauthorised persons.
- There was a large screen that displayed the details of the rooms and cubicles in majors. However, there was patient specific information displayed on the screen, including names and working diagnoses. The display was located in the corridor opposite the nurse's station, so it would be difficult, but not impossible that this information would be seen by unauthorised persons. This concern about the confidentiality of patient's information was raised during the inspection, the trust told us this had been risk assessed.

Safeguarding

- There were clear policies and procedures in place for safeguarding. Staff showed a comprehensive understanding of differing safeguarding issues.
- There was a safeguarding hub within the hospital, which was the route of contact with the children safeguarding team.
- A safeguarding website was well populated with safeguarding information. For example, there were electronic safeguarding referrals forms and contact details for safeguarding professionals at the trust and social services.
- There was a secure safeguarding mailbox with social care, for the receipt and sending of safeguarding referral forms and a clear referral pathway for raising safeguarding concerns.

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- A named nurse and named doctor for safeguarding children and young adults and a named nurse for safeguarding adults, were available for assessment and advice and to ensure the trust fulfilled its legal obligations.
- Safeguarding checks were carried out on children attending the department; staff asked a series of questions to ensure that any safeguarding concerns could be followed up. We reviewed the care records of 20 children and found that all of them had appropriate safeguarding checks made. There were plans in place to monitor children's safeguarding checks through audit.
- Trust safeguarding procedures for Child Sexual Exploitation (CSE) linked into Dorset Social Services Multiagency procedures and the trust was represented at high risk multiagency meetings for CSE.
- The trust had undertaken an intensive campaign to ensure that staff had been appropriately trained in children's safeguarding; the target of 90% was reached by the end of September 2015 in ED. Training was also provided in safeguarding adults with 94% of staff having undertaken this.

Mandatory training

- Mandatory and statutory training covered a range of topics including fire safety, adult basic life support, safeguarding, patient moving and handling, information governance, infection control, dementia awareness and equality and diversity.
- Nursing and healthcare assistants in the medicine division (that included the ED) met the trust compliance levels for mandatory training; however, compliance levels were consistently below 85% for medical staff. Governance reports highlighted when staff groups needed to improve compliance with mandatory training, so managers could remind staff to complete it.
- When staff had completed their mandatory training, the trust's electronic staff database was updated. This database alerted managers when staff were due to attend training.
- Ward sisters accessed staff training records on the trust intranet and booked staff onto training courses. Staff we spoke with said that they were up to date with their mandatory training. Some training was provided online, which made it easier for staff to access.
- Records showed that medical staff had up to date training in life support for adults and children.

Assessing and responding to patient risk

- The department had implemented a range of measures to ensure that patients presenting with symptoms of infection were screened for sepsis and treated quickly. If there was any suspicion of sepsis a pro forma would be generated as part of the patient's care record. A new sepsis pathway had been introduced after the General Medical Council survey showed that this was not optimal; however, these developments had yet to be audited. Trust data showed that the number of patients receiving appropriate antibiotics within an hour had increased from 44% in quarter 2 (2015-16) to 51% in quarter 3.
- The triage nurse carried out the initial assessment of walk-in patients. Patients were assessed and observations recorded. Patients were then asked to return to the waiting room if, following assessment it was deemed safe for them to do so.
- We saw good examples of where walk-in patients had been triaged quickly and taken to majors. For example, a patient with uncontrolled asthma was triaged and routed to the resuscitation room for urgent care and treatment.
- There was good access to plain film x-rays for assessment, these were ordered electronically.
- We observed that there was a 'bottle neck' with the triage system during busy periods. This meant that patients did not always receive an initial clinical assessment within 15 minutes. It was not clear that there was a mechanism for recording or escalating when this occurred.
- Children were seen by a registered practitioner within 15 minutes of arrival. The initial assessment included observations and a pain score was undertaken using an appropriate paediatric early warning chart that included prompts specific to age. Although there was not a children's trained nurse on every shift, sisters had all received training in paediatric life support. This training included the recognition of the sick child.
- There was a protocol in place for the retrieval of critically ill children from the ED. Children were collected from the ED by the Southampton or Oxford retrieval team, to ensure safe transport and care to a specialist unit.
- Patients attending the department by ambulance were brought into the corridor where initial assessment and handover from ambulance staff occurred. Based on this

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assessment the coordinator decided where the patient would be accommodated. For patients with suspected life threatening conditions, the resuscitation room was used for initial nursing and medical assessment.

- Patients were appropriately screened for sepsis on entering the department, and during the initial assessment. There were care pathways in place for patients presenting with chest pain, suspected stroke or fractured neck of femur.
- There was an early warning system in use, as well as a triage outcome on the paperwork. However, both were used inconsistently, although we did not observe any impact of this. There were different early warning observation sheets for different age groups of children; the correct one was printed when the patient booked in at reception. Staff were observed escalating patients with serious or unstable conditions appropriately. Staff recorded observations using the early warning system charts. If repeated observations were required and the patient remained in the department the patient's details would be entered onto the electronic system to enable observations to be recorded.
- There was limited access to an ambulatory care service provided by the acute physicians. This was because allocated ambulatory care beds on the medical admissions ward (Ilchester) were being used for medical patients.

Nursing staffing

- The nurse coordinator was responsible for the running of the whole department during a shift. This was always an experienced senior nurse (band 7) or band 6 sister.
- There were suitable numbers of appropriately qualified and experienced nursing staff. When shifts were understaffed, this was reported and escalated. Data provided by the trust indicated there were a small proportion of shifts where the department was understaffed, for example of 705 shifts on rota, 51 were understaffed.
- There were emergency nurse practitioners on duty from 8am-10pm to provide the minor injuries service in minors. There were plans to increase working hours but there were insufficient trained staff to allow this at the time of inspection.
- Nursing handovers occurred in front of a large plasma display screen that gave a departmental overview. The

display showed patients in all locations, whether they had been referred to a speciality, the state of investigations and their destination ward. Handovers we observed were comprehensive and focused.

- There were four senior sisters (band 7) that supported and supervised teams of band 6 and 5 nurses. There was also a nurse consultant for the department who worked clinically supporting medical and nursing staff. The nurse consultant also supervised the trainee majors practitioners and the emergency nurse practitioners.
- There was a children's lead nurse for the department. There were two children's trained nurses within the staff complement. This meant that it was not possible for a children's nurse to be on duty every shift. However, staff had been trained in paediatric life support and children's safeguarding. The children's lead was also responsible for staff training around the assessment and care of sick children. All band 6 nurses that acted as coordinator were trained in paediatric life support; this ensured there was cover across all shifts. This training included the recognition of the sick child.
- There was occasional use of agency staff in the department, however there was no specific induction process that was used for staff who had not worked in the department before.
- Staff sickness and absence in the department was lower than in the rest of the hospital at 2.4 %. There was a low proportion of shifts that remained unfilled.

Medical staffing

- The department had 6.5 whole time equivalent consultants. There was a consultant in the department for a minimum of 12 hours a day from Monday to Friday. At weekends a consultant was present in the department for at least 6 hours. A consultant on-call always attended a call for a trauma patient. The department was working towards an increase in consultant presence, through recruitment of an additional consultant, as this was less than 14 hours per day. This was agreed as the required level for the unit following Clinical Services Review led by the CCG.
- The on-call consultant always attended the department within 20 minutes for a patient being brought in with trauma.
- There were an appropriate number of middle grade doctors on the rota, and there was senior medical cover (ST4) in the department across 24 hours. The

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department had a larger than average number of middle grade doctors, who were suitably experienced. This balanced a lower number of junior doctors than the England average on the rota.

- Handovers between medical staff occurred in front of the plasma display that provided an overview of the department. Medical staff were mindful to ensure that there were no patients or relatives able to overhear the information, as this area was a main thoroughfare. We observed well-structured and effective handovers between staff.
- Doctors in the department had current training in advanced life support for adults and children.
- There was a thrombolysis rota in place to ensure access to this treatment overnight and at weekends. This rota was split between stroke consultants and other trained physicians including ED consultants.
- Although the minor injuries area was staffed primarily by emergency nurse practitioners there was also a middle grade doctor.
- Locum doctors were not commonly used in the department.

Major incident awareness and training

- There was a major incident plan in place; this was available on the intranet. There were clear actions cards for staff with key predefined roles in a major incident. Training was given to staff in the implementation of the major incident plan.
- There was a remote door locking system, to prevent a potentially violent or threatening patient from entering the department. This could be activated from the reception desk. The reception desk itself was protected with a high glass screen. This also protected the reception staff from the weather, as the main door was very exposed to the elements.
- Equipment to deal with chemical or biological emergencies was held securely within the department. The department had a decontamination tent, and staff had received training and practice in using this.
- The department had continual monitoring with CCTV. Security was provided by the portering service. The porters (including the department's own porter) had been appropriately trained in de-escalation and restraint. There was also a rapid response team to deal with a security issue anywhere in the hospital.

Are urgent and emergency services effective?

(for example, treatment is effective)

Good



By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

We rated effective as good because:

- Evidence based and up to date guidance was used across the service. Local audits were undertaken to measure the department against national standards. There was appropriate monitoring of performance against national targets. The results of audits were used to improve treatment.
- The trust performed well against other units on the outcomes for patients attending with trauma. Consultants attended trauma calls promptly across 24 hours.
- Food and drinks were always available for patients that were able to eat and drink. Pain relief was given in a timely way and its effectiveness checked by staff.
- Patient outcomes were collected and monitored by staff in line with the clinical standards. Staff understood and followed critical pathways for sepsis, asthma and paracetamol overdose. There were care pathways in place for chest pain, stroke and fractured neck of femur.
- Staff were trained and supervised appropriately. There were educational opportunities available for all grades of medical and nursing staff. There were suitable arrangements in place for the supervision and appraisal of staff.
- Patients were cared for by a multidisciplinary team that assisted with assessment, diagnosis and treatment. Staff worked effectively together to provide patient care in a coordinated way.
- The department had 24 hours access to scans and X-rays seven days a week. This included the use of CT and MRI scans and endoscopy. There was also timely access to other services such as critical care, emergency surgery, and physiotherapists.

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- Staff had immediate access to patient information. There were robust systems and processes to ensure that information was kept secure, but was available to all clinical staff that needed access to them.
- Patients' consent for treatment, observation or examination was sought by staff treating them. When people lacked mental capacity to make decisions, staff understood their responsibilities around making best interest decisions. Staff were aware of the impact of the Mental Health Act (2005) and the Deprivation of Liberty Safeguards.

Evidence-based care and treatment

- Staff used policies based on National Institute of Health and Clinical Excellence (NICE) and College of Emergency Medicine (CEM) guidelines; some were available via the intranet. Posters and information for staff were displayed in discreet clinical areas to highlight changes to clinical guidance and to raise awareness. Discussions about changes to guidance and policies took place at risk and governance meetings, with information disseminated and acted upon as appropriate.
- The department submitted data to national benchmarking audits such as the college of emergency medicine and looked at results to make changes to clinical practice. Audits were undertaken in the department, such as for sepsis treatment, and action plans were developed to track improvement.
- Patients that attended the department were quickly screened for signs of sepsis. If any signs were identified (by ambulance staff or the department's reception staff) a sepsis pro forma would be generated as part of the patient's care record. This was in line with current guidance on the detection of sepsis. A new sepsis pathway had been introduced after the General Medical Council survey showed that this was not optimal; however, these developments had yet to be audited.
- Patients that were admitted with suspected stroke were triaged quickly and entered onto the stroke pathway. This meant that they were referred to acute physicians and an urgent CT scan was ordered, with the aim of getting the patient thrombolysis within an hour of presentation. This pathway was in line with NICE clinical guideline 68.
- There was a pathway for the treatment of patients with fractured neck of femur. If beds were available patients were transferred to the orthopaedic ward within an

hour. However, if beds were not available on the orthopaedic wards, rather than moving the patient to a non-orthopaedic ward, the patient stayed in the department until one became available.

- We observed that staff adhered to local policies and procedures such as infection control and the protection of patients' privacy and dignity.
- We saw the effective use of a local audit. For example, ED consultants used audit to demonstrate the effectiveness of a pathway they had developed for neutropenic sepsis. The audit showed an increase in the number of patients that received antibiotics within an hour from 70% to 73%.
- Staff had access to databases that provided information on the treatment of patients that had ingested poisonous substances. They also had access to local policies, procedures and national guidance via the trust intranet.
- The department mostly followed the guidance on standards for children and young people in emergency settings.

Pain relief

- Pain relief was given to patients; however, the use of pain scores was inconsistently recorded in the 51 patient care records we reviewed. The department had already recognised this and there was a particular focus on ensuring that staff recorded patient's pain scores.
- The A&E survey (2014) reported that the department was better than the other trusts for the speed patients received pain relief, and that staff did all that they could to help control a patient's pain.
- We observed patients being asked if they were in pain, and being given pain relief in a timely way. Staff also went back to check that the pain relief had been effective.

Nutrition and hydration

- Food and drinks were available for patients that needed them, these were provided whenever necessary, and this included provision for special diets.
- The trust scored better than the England average in the A&E survey (2014) about the availability of food and drinks for patients in the department.

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- There was a sign in the waiting room that reminded patients not to eat or drink until they had been seen by a doctor or nurse. This helped ensure the safety of patients that may have to undergo a surgical procedure or require sedation.
- There was a water chiller and cups available for patients in the department.

Patient outcomes

- The department performed well in timely care of trauma patients, with prompt consultant presence. The hospital was part of the Wessex Trauma Network, whose data showed the department to be the best performing in the area it covers.
- The department took part in national audit schemes such as the College of Emergency Medicine (CEM) audits. These audits were led by consultants and junior doctors who were encouraged to participate.
- The department performed better than other trusts in England in the 'assessing for cognitive impairment in older people audit' 2014/15.
- The department reported performance in line with other trusts in the 'initial management of the child with convulsions' and 'mental health in the ED' audits 2014/15.
- The computer system ensured that patients with certain potentially serious conditions such as chest pain or sepsis were seen by a consultant before being discharged.
- The unplanned re-attendance rate within seven days was better than the England average, between November 2013 and October 2015.
- Since an audit, a set of sepsis pathways had been introduced where the initial assessment identified any flags for sepsis. The appropriate pathway was added to the patient's record, for example, the paediatric sepsis screening tool or suspected neutropenic sepsis pro forma. Trust data showed improved performance in the administration of antibiotics within an hour.
- Junior nursing staff underwent a comprehensive competency based work training programme. This included all aspect of skills required to work in the ED.
- The band 7 nurses were responsible for a team of more junior staff for supervision and competency sign off. Junior qualified nursing staff were only allowed to undertake the role of triage nurse after they had demonstrated competence. This was not before six months to a year in post.
- A consultant nurse provided teaching and supervision to the trainee majors practitioners and the emergency nurse practitioners. Majors practitioners (MAPS) are nurses with extra training in assessment and enhanced skills, which can provide practical support for medical staff in the ED. The nurse consultant also took a lead on practice development across the department.
- Staff we spoke with had received supervision and appraisal by senior nursing staff. Trust data showed that 100% of nursing staff had an appraisal from April to December 2015.
- We saw examples of nursing staff in the department supervising and mentoring nursing students. We observed a nurse giving a student a comprehensive explanation of the patients' medical conditions, treatments and normal observational parameters.
- There were a number of new initiatives to promote staff development. For example, nurses had the opportunity to rotate from the medical admissions ward (Ilchester) to minors in ED and the Weymouth minor urgent care centre, to learn about the management of minor injuries.
- There were resources on the intranet to support nursing staff in revalidation.
- Staff on the unit had lead link roles, this meant they received extra training on an aspect of patient care and acted as a resource for other staff. Link roles were allocated in such things as infection control, domestic violence, drugs and alcohol, palliative care and stroke.
- The department had improved its results in the General Medical Council survey of junior doctors, with no red ratings in 2015.
- Medical staff had rotas planned to ensure that they were able to attend four hours of protected teaching time each week. Staff told us there was also good access to study leave for junior doctors.
- There was a children's lead nurse in the department and another nurse with paediatric training. These staff

Competent staff

- Nursing and healthcare assistant staff reported good access to professional development and they said their managers encouraged them to attend training and develop skills.

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helped train other staff in the care of children. All staff received training in safeguarding children. ED adult trained staff were given the opportunity to attend study days in children's retrieval at Southampton. There were also rotational opportunities for ED adult trained nurses to gain experience of the care of children provided by the children's ward and day unit at the hospital.

Multidisciplinary working

- Medical staff told us that there were good relationships between the ED and speciality doctors. There were also good links with therapy staff, including speech and language therapists.
- Staff had access to an alcohol and substance misuse liaison team.
- Patients attending the unit with a mental health problem could be referred to the liaison psychiatry team. This service operated between 7.30am-9pm, seven days a week.
- Ambulance staff told us that the consultants in the ED were happy to offer them clinical advice by telephone. For example, consultants would discuss with ambulance staff the decision to convey a patient to hospital or allow the patient to remain at home, with immediate care and treatment.
- There was timely access to staff from other specialities such as critical care and surgery.
- The department had good links with social services, mental health liaison and the trust discharge team.

Seven-day services

- The emergency department was open 24 hours per day, seven days a week. The service met the NHS England requirements for emergency departments, with access to investigations and reporting seven days a week.
- The department did not collect data on the time to first review by a consultant.
- There was access to therapists such as physiotherapists and occupational therapists seven days a week from 8am to 5pm.
- The department had good access to social services support, with an allocated social worker.
- The liaison psychiatry service was available between 7.30am and 9pm every day. Out of hours patients were referred to the mental health crisis team with on-call psychiatry available.

- The department had access to X-rays and scans 24 hours a day, with a staffed unit between the hours of 8am and 8pm. There was also out of hours' service provision that ensured scans and X-rays were available for patients that needed them.
- The unit had access to laboratory services seven days a week.

Access to information

- Staff told us that patient records were quickly accessible.
- Nurses handed over patient information details when they transferred patients from the ED to a ward. Paper copies of the records of care and treatment were scanned and copied to enable handover documentation to accompany the patient to a ward.
- The plasma displays in the ED provided an overview of the acuity and capacity of the department. Since it had been introduced in January 2016, all staff told us that it had helped with ensuring key information about critical patients was available to those that needed it. There were concerns about the accessibility of confidential patient information on the main plasma display screen located in the corridor opposite the nurses' station in majors.
- The trust had direct access to electronic information held by community services, including GPs. This meant that staff could access up-to-date information about patients, for example, details of their current medicines.
- Staff could request and access X-rays and radiological investigations on a secure computer system.
- Doctors and nurses had access to laboratory results via a secure computerised system. Samples were sent from the department to the lab by a vacuum tube system that went directly to the laboratory. This reduced the risk of samples being lost in transit to the laboratory.
- Records were available to clinical staff when they needed them.
- Patients that were discharged from the department were provided with information about their care and treatment. Discharge letters for GPs were completed in a timely way.

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Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We observed that staff asked patients for their consent before observations; examinations or care was carried out. This included parents and children and young people themselves if the child was assessed as able to give consent.
- Staff understood their roles and responsibilities regarding the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS). They had access to advice and had completed training on MCA and DoLS. The trust had introduced two levels of MCA training, with level 1 for all staff and volunteers and Level 2 for health professionals. Compliance with level 2 training was 79% in December 2015.
- The ED patient assessment form prompted staff to carry out mental capacity assessments if they felt patients might not have the capacity to make decisions or provide informed consent.
- In the event of a patient requiring to be restrained in the department for the safety of themselves or others, the porters acted as security staff and had certified training in the restraint of patients.

Are urgent and emergency services caring?

Good



By caring, we mean that staff involve and treat people with compassion kindness, dignity and respect.

We rated caring as good because:

- The emergency department (ED) staff were welcoming, and did all they could to provide patients with privacy when booking in. Staff treated distressed patients with kindness and compassion.
- Staff treated patients and their relatives with dignity and respect.
- Emotional support was provided for patients and their relatives in the department.
- The chaplaincy team were available over 24 hours, and were able to provide additional support for patients and

their relatives. They also supported ED staff if needed, after trauma or a death. Patients and their families told us that they chose to attend this department in favour of others that might be closer for them.

- Data showed that the patients and their family had the opportunity to talk to a doctor, and conditions and treatments were explained in a way people could understand. Staff also took into account the patient's home and family circumstances, and gave suitable information and advice when discharging patients.

Compassionate care

- We observed nurses and doctors providing care in the department. Staff demonstrated respect for the individual's personal, cultural and social needs. Staff spoke with patients in a respectful and considerate manner. Consent was sought from patients before undertaking treatment, observation or examinations. Staff took time to ensure that children and their parents were fully informed about care and treatments. The A&E survey 2014 showed that the trust was better than others for staff offering explanations about tests and results in way that people understood, as well as discussion about anxieties or fears about the patient's condition and treatment.
- We observed that dignity and respect for patients was maintained at all times during treatment or examination. Curtains were drawn around patients for all interventions and care to maintain privacy. The department was rated higher than other trusts in England for patients responding that they were treated with dignity and respect, and involved in decisions about their care and treatment (A&E survey data, 2014).
- Relatives commented that staff were caring and maintained the patient's privacy and dignity during assessment and treatment.
- Patients and their relatives we spoke with expressed that they would chose to attend this ED in favour of others that were geographically closer for them. The reason given for this was the caring and individualised care and treatment given by friendly staff. The A&E survey data from 2014 showed that the trust scored above other trusts in the numbers of patients that said they had confidence and trust in the staff treating them.
- Staff responded promptly to the needs of patients in the department, including responding to requests for pain relief. Staff introduced themselves to the patients that they would be responsible for.

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- Staff respected the confidentiality of patient's information and care records at all times.
- The NHS Friends and Family test results (December 2014 to November 2015) showed between 82% and 89% of patients would recommend the department, this was below the England average. However, the response rate for the department was very low, despite the introduction of the text message system to get patient feedback.
- A discreet butterfly laminate sign was used to communicate to staff that there was a patient that had died in cubicle. This was also used on the door of the relative's room to ensure staff were aware that there was a bereaved family using the room. Staff were reallocated to ensure continuity with the family of deceased patient if they had built a rapport with them. For example, we saw that the nurse allocated to the resuscitation room was reallocated to allow her to continue the care of a deceased patient and their family.

Understanding and involvement of patients and those close to them

- We observed that relatives of patients being treated in majors were kept informed of plans for investigations and treatments. There was proactive support available for the parents of sick children attending the department.
- Patients and relatives using the department were informed partners in their care. Medical and nursing staff described tests, investigations and treatment options in simple English and checked patients' understanding.
- The results of the A&E survey 2014 showed the trust was better than other trusts in England for taking into account a patient's home and family circumstances, and giving information on the danger signals regarding their illness on discharge. The department was also better than other trusts when patient's family members wanted to talk to a doctor.

Emotional support

- Most relatives and patients we spoke with were very happy with the service, as they were kept informed and assessed promptly.
- The department was busy when we inspected. However, the patients attending were happy with the care and

treatment they received. Some parents had travelled a distance to attend this ED in preference to one closer to their home. The reason for this they explained, was that the staff in this department were friendly and reassuring.

- The trust chaplaincy team were responsive to requests from staff to support patients in ED. They also offered to support to staff after traumatic incidents or deaths in the department.

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

Good



By responsive, we mean that services are organised so that they meet people's needs.

We rated responsive as good because:

- Although the trust had not consistently met the national emergency access target for 95% patients to be admitted, transferred or discharged within 4 hours, overall trust performance had been in line or better than the England average.
- Time to initial assessment was better than the England average.
- The department provided a separate waiting room for children. There was also a cubicle in minors equipped and decorated for children.
- The median time to treatment was generally better than the England average between October 2013 and October 2015.
- Senior staff provided a rapid assessment and treatment service.
- There were translation services available for patients whose first language was not English. Sign language interpreters could also be made available for patients that needed them. Patient information was available for patients to take away, and could be provided in other languages on request.
- The needs of patients living with dementia were assessed by staff. The ED provided assessment services for patients with a mental health problem. Reasonable adjustments were made to meet the needs of patients with a learning disability.

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- Information was available for patients or relatives that wished to raise a complaint about the department. Complaints were dealt with appropriately by the trust. Changes were made in response to complaints from patients and relatives.
- The department was fully accessible to people with physical disabilities.

However,

- The trust reported 157 black breaches between December 2014 and November 2015. This is when ambulances were not able to hand over patients within one hour. A lack of physical capacity in the hospital was the main reported reason for this.
- There was insufficient space in the waiting room for the numbers of patients attending the department.
- During busy periods the demands on the triage system became a bottle neck, leading to an increase in the time to initial assessment.

Service planning and delivery to meet the needs of local people

- The department was small, so if several ambulances arrived at the same time, patients would be required to wait in the corridor with ambulance staff.
- The majors area consisted of a two bedded bay and five cubicles, there was an appropriately equipped two bedded resuscitation room equipped for adults and children. There was a room provided for the relatives of critically ill patients in majors. The minors area consisted of five cubicles.
- The department was not particularly child friendly. There was a small separate waiting room for children. This was decorated and equipped with books and toys as well as a television and DVD player. However, it was possible to see and hear the main waiting room from the area. One of the treatment rooms in minors was also decorated and equipped for children, this was used flexibly and could also be used by adult patients.
- There was a toilet within the children's waiting room, however the signage indicated this was for female use only. We observed a father carrying his young child out of the children's waiting room in order to find a male toilet.
- The strategic direction of the service was under review at the time of the inspection because of the wider Dorset Clinical Commissioning Review. This county-wide review was set up to respond to the increase in

proportion of elderly patients with complex health needs and to improve the efficiency and quality of care. Plans for refurbishment and renovation of the ED had been put on hold until the outcome of this review.

- The ED served the community of Dorchester, Weymouth, Portland, West Dorset and the Purbecks, providing a service 24 hours a day for adults and children. It was the lead receiving unit in the area for trauma patients. The ED provided facilities for resuscitation, major injury or illness as well as minor injuries. The service was appropriately staffed by doctors and nurses with additional skills and training. The trust liaised with a local trust that provided psychiatric assessment services. This link assisted the department with patients who needed a mental health assessment, or needed to be detained under the Mental Health Act.
- There were 42,367 attendances in the year 2013/14. However, the department was originally designed to see around half this number of patients.
- There was an X-ray department that was easily accessible from the department. The main X-ray department if needed for CT scans and ultrasound was located just outside the department. This meant it was accessible quickly for urgent diagnosis of life threatening conditions, such as stroke.
- There was an accessible helicopter landing area for trauma patients conveyed to or from the department by the air ambulance service.
- A room for relatives located near the majors area was used to accommodate the relatives of critically ill patients in the resuscitation room. Staff told us that relatives using this room were regularly updated on the condition of the patient.
- The department had level access and was suitable for patients with disabilities. There were appropriate adapted toilet facilities.

Meeting people's individual needs

- Staff were aware of the needs of patients living with dementia. If dementia was suspected in a patient this would be flagged. This ensured that patients were given priority and that a small core of staff would look after the patient to increase continuity for them. In order to reduce exposure to noise, patients living with dementia would be cared for in a cubicle.
- Confused patients or those living with dementia at risk of wandering, were cared for in the trolley bays nearest

Urgent and emergency services

the nurse's station. This allowed closer observation of these patients by all staff. A member of staff would sit with a patient if they were very disorientated, distressed or frightened. We observed safe and compassionate care of a confused and unwell patient being monitored in this area. Staff asked patients some screening questions to ensure that patients living with dementia were identified. Staff had undergone training on caring for patients living with dementia.

- Patients with a learning disability were given a priority; their attendance at the department was flagged. Patient's relatives would be asked for their help in the completion of a 'this is me' document. This provided staff with information of the needs and preferences of a patient that may not be able to willing to share this with staff they do not know.
- For patients whose first language was not English, translation services were available for staff to access via telephone if needed. Staff were aware of how to access this service should a patient need it.
- There were a range of patient leaflets available, giving information and follow-up advice on different conditions and minor injuries. There was an emergency nurse practitioner responsible for keeping the patient information up-to-date.
- There were translation services available for patients whose first language was not English. All staff had access to the telephone translation service. Sign language interpreters could also be made available for patients that needed them. Patient information was available for patients to take away, and could be provided for them in other languages on request.
- There were trust chaplaincy services available 24 hours a day for patients or relatives who needed them. This included access to religious and emotional support through periods of distress. The chaplaincy service also offered patients access to multi faith support. The service also provided support to staff after trauma or the death of a child. The hospital chaplain visited the department during the inspection to check on the wellbeing of staff and patients.

Access and flow

- Although there was an electronic display in the waiting room, it did not display approximate times a patient could expect to wait, it displayed information on how to ask for help and the process for prioritising patients.

- There was an effective triage system in place for minors. However, with one triage nurse this caused delays when the department was busy.
- In addition to the main plasma display, there was a further screen in the minors area to allow all staff to be aware of the pressures on the department. This system also had flags that showed the status of patients in terms of medical input, referral to speciality, progress of investigations and the patient's destination. The system had recently been introduced; feedback from all staff was positive and it allowed them to see an overview of the department. Speciality doctors were also able to find patients they needed to see more quickly.
- The plasma screen display helped the nurse coordinator to see when capacity was being reached and escalation would be required.
- In the A&E survey, the trust scored better than the England average for the question 'how long did you have to wait before seeing a doctor or nurse'.
- The national emergency access target for 95% of patients to be admitted, transferred or discharged from ED within four hours was almost met or met through the year. The target was met for five out of seven months between May 2015 to November 2015, with a drop to 92% in October 2015.
- Overall the trust's performance between November 2014 and November 2015 was better than the England average. The four hour target was met for Q3 2015/16 but in January 2016, this dipped to 92%.
- Between October 2014 and October 2015, 167 people attending the department waited between four to 12 hours from the decision to admit to hospital. However, no patients waited over the 12 hours. This was better than the England average.
- The number of patients leaving the department without being seen was better than the England average.
- On average there were 347 ambulance journeys per month that were delayed over 30 minutes. Of these, an average of 11% were delayed more than 60 minutes.
- Ambulance time to initial assessment was better than the England average. Patients were given an initial assessment quickly by the coordinator who took the handover from ambulance staff.
- During busy periods the demand for triage meant that the time from arrival of walk-in patients to initial assessment increased.

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- The waiting room became very crowded during busy periods, with staff having to locate further seating to accommodate waiting patients. There was no mechanism for informing patients of an approximate wait time.
- The trust reported 157 black breaches between December 2014 and November 2015. A black breach occurs when handovers from ambulance arrival to the patient being offloaded to ED take longer than 60 minutes. The reason for black breaches was reported as no physical capacity in 97% of occurrences. Patients were kept safe by using effective plans developed in partnership with the ambulance service.
- During periods of high demand where ambulances were held at the hospital, the ambulance service bronze command attended the department. They coordinated ambulance staff to look after patients in the X-ray waiting area (after hours) and provide support for their staff. This allowed ambulance vehicles to be released. The ED and ambulance service worked effectively together to ensure that patients were safe during periods of escalation.
- The site management team provided a 24 hour service 7 days a week to support access and flow through the hospital. They used an electronic system to assist them in monitoring and planning patient movements and estimated discharge dates. Site managers and the hospital discharge team worked collaboratively to maintain access and flow, with senior manager involvement when necessary.
- There was a bed bureau within the main office, this took calls direct from GPs and dealt with expected patients and liaised with acute physicians. Ideally, expected patients directly attended wards to be seen by speciality doctors. This was affected by the availability of beds within the hospital however.

Learning from complaints and concerns

- In the waiting room there was a visible Patient Advice and Liaison Service notice board that displayed information, comments and concerns. This board also contained friends and family information.
- We saw evidence that improvements had been made as a result of patient feedback. For example, parents made comments that the toys in the children's waiting room were not sufficient to keep a child attending the department entertained. A range of new toys had been purchased.

- Information was available for patients or relatives that wished to raise a complaint about the department. Complaints were dealt with appropriately by the trust. Changes were made in response to complaints from patients and relatives.

Are urgent and emergency services well-led?

Requires improvement

By well-led, we mean that the leadership, management and governance of the organisation assures the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

We rated well-led as requires improvement because:

- The matron did not have sufficient time to work clinically and had a dual post as service manager. This potentially detracted from the matron quality assurance role, and led to fragmented nursing leadership and risks within the department not being identified.
- There was no evidence of matron walk around audit activity recorded.
- Governance and quality monitoring processes were in place across the department, however the quality assurance was not sufficiently robust and the department was not aware of all risks.
- There were risks and quality issues that were not identified and escalated. These did not appear on the department's risk register.
- The strategy and vision for the department was not understood by all junior staff, although the service leads had involved senior staff in away days and meetings about developments in the service. .

However,

- The staff in the department spoke highly of senior nursing and medical staff who promoted an open culture, and learning from incidents. Staff felt safe to raise concerns. Staff commented on the strong team focus that cut across all disciplines and grades.
- The leadership and staff actively looked for improvement to services from evidence of incidents, complaints and near misses.

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- Staff were highly engaged with their department and expressed their pride in the service they provided to local people. This was in line with the trusts' vision and values.
- There were governance meetings that included mortality and morbidity reviews.

Vision and strategy for this service

- The departmental vision and strategy formed part of the medical division strategy. Junior staff we spoke with were not able to describe the trust's vision for the department. The service leads had involved senior staff in away days and meetings about developments in the service. There had been plans for a redevelopment and upgrade of the department but this had been put on hold. Staff were able to tell us about the trust's organisational values.
- There was an on-going Dorset wide clinical services review being carried out,. Until this was completed strategic plans for the department were on hold.

Governance, risk management and quality measurement

- The department was not aware of all risks. Risks identified by the inspection did not appear on the risk register for the department.
- The trust's clinical governance committee, led by a clinical consultant, held bimonthly meetings and received papers from subcommittees. These included committees for clinical audit, infection prevention and control, safeguarding adults and children, learning from patients and NICE implementation.
- The clinical governance committee reported to the senior management team, responsible for operational performance, risk management and planning. The trust's finance and performance committee produced meeting reports each month, which included detailed summaries of activity against all national and local performance targets.
- The medical division's clinical governance group reported to the trust's integrated governance committee with exception reports. The divisional clinical governance committee met monthly to discuss assurance around quality and safety. Topics covered included incidents and complaints, infection control, audits, adherence to NICE guidance, workforce issues, complaints and patient feedback. The divisional leads had a good understanding of service performance and

barriers to improvement. The governance committee captured key actions for named leads to report on within a stated timeframe. They also received the department's mortality and morbidity meeting minutes and escalated any learning from these.

- The ED held monthly governance meetings, chaired by the clinical lead. These had a standard agenda, including incidents, complaints and patient feedback.
- Although there were governance arrangements in place and staff were committed to them, the coordination of quality assurance and risk management activity needed to improve .
- The ED used a clinical dashboard that reported on a range of quality indicators. This included hand hygiene and cleaning audits, patient screening and assessment, mortality, friends and family feedback, waiting times and ambulance handover times delayed over 30 minutes. The dashboard was used to look at fluctuations in the department's performance on a monthly basis, to inform governance meetings. The dashboard contained limited data for screening and assessments.
- The department maintained a risk register as part of the medical division's risk register. This indicated that senior staff were aware of risks to the department, for example overcrowding due to a lack of space. Risks identified were raised to the matron / service manager and would be added to the risk register. However, there were risks that did not appear on the risk register. For example, the infection control risks arising from immobilisation splints found contaminated with body fluids. There was also no escalation of the requirement for maintenance of the fabric of department such as damaged doors and doorframes that compromised effective cleaning.
- There was no evidence that audit activity was carried out to identify such risks. The shower in the department had been out of operation for six months due to a leaking floor covering. This meant that patients were not able to access a shower and we could not find any escalation of the lack of action on the outstanding maintenance work. The issue relating to the shower was resolved following the inspection.
- A new lead consultant came into post in October 2015. They told us they were focusing on improvements to the overall coordination of governance activities. There

Urgent and emergency services

were many examples of good governance practice undertaken, but there needed to be assurance that all governance activities were coordinated to avoid duplication of work.

Leadership of service

- The ED was in the medical division, which comprised four directorates; emergency services, general medicine, specialist medicine, and elderly care. A divisional manager and a clinical director led the division. There were four service managers and clinical directors for the division as well as clinical site managers and two matrons.
- Committed clinicians and managers led the department. The post of matron and service manager was integrated and filled by one person carrying out this dual role. This meant that some functions of the matron were not being undertaken consistently, due to the priority and pressures being focussed on managing flow through the department. The matron/service manager did not have enough time to work clinically in the department. The dual role meant that it was difficult to get a clear overall view of the department and its management. The service manager role did not allow the matron role to be performed effectively.
- The new lead consultant was keen to build on the open and transparent ethos of the department and the professionalism and commitment of the staff.
- Senior staff told us that the role of nurse consultant was working well across the department and complimented the leadership. All staff we spoke with were positive about the nurse consultant role and told us that it had helped staff development, leadership and education.
- Staff told us that senior trust managers were not visible in the department. Duty managers however, regularly attended the department.

Culture within the service

- There was a supportive and open culture within the department. Junior nursing staff told us that they felt well supported by senior medical and nursing staff. Junior doctors were supported with their training; they were given protected time for learning within the department.
- Staff we spoke with told us that they would not hesitate to report an incident of poor care or another incident of concern to a member of senior staff.

- Staff from the ambulance service praised the ED staff's professionalism, helpfulness and caring attitude.
- Doctors and nurses told us they worked well together and there was an obvious mutual respect between all staff across the department.
- The department had a culture of staff development, aiming to ensure that band 5 nurses were given support to train and develop into band 6 roles.
- Staff were aware of their responsibilities under the duty of candour requirements, and this formed part of the investigation process.
- The feedback we received from patients was overwhelmingly positive, and particularly highlighted the friendliness and professionalism of the staff. The culture within the department was centred on the needs of patients, and staff were committed to improving patient experience.

Public engagement

- The trust encouraged patients and their relatives to give feedback on their care using the NHS Friends and Family Test (FFT). The medicine division performance dashboard included monthly data on the percentage of inpatients that had completed the survey and the percentage who would recommend the service.
- The department sought friends and family feedback from patients using a text message system in an effort to increase the response rate. However, the response remained low as is normal for emergency departments.
- The service used complaints to gain feedback from patients. We saw evidence that improvements had been made as a result of patient feedback. For example, parents had commented that the toys in the children's waiting room were not sufficient to keep a child attending the department entertained. A range of new toys had been purchased to improve this facility.

Staff engagement

- Staff showed high levels of engagement with the department and the trust. There was a newsletter produced within the department for the sharing of good practice and learning from complaints and incidents.
- Staff were involved in changes and improvements within the department such as the development of the majors practitioner role and extension of roles.







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- A high proportion of staff (57%) took part in the 2015 NHS staff survey. This showed improvement on the previous year in the numbers of staff that would recommend the hospital as a place to work and receive treatment, and levels of staff motivation.

Innovation, improvement and sustainability

- The department had a proactive attitude to staff development with band 5 nurses being trained to take on roles with greater responsibility to prepare them to take them on in the future. Staff development was given a high profile for nursing staff. Staff attributed this focus in part, to the nurse consultant within the department.
- The department was working to develop and train its own majors assistant practitioners, to ensure a sustainable workforce for the future.
- The department was working to recruit and train further emergency nurse practitioners to enable them to increase the hours the service was available.
- The department was investigating a potential integration of the ED with the Weymouth minor injuries unit. This had the potential to offer patients better access to the service.
- The department was actively involved in the Wessex trauma network for sharing and developing best practice.

Medical care (including older people's care)

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

Information about the service

Dorset County Hospital (DCH) provides cardiology, gastroenterology, respiratory, medicine, oncology and stroke services. It also provides general medical services and has two wards for the care of elderly patients. There is an integrated assessment unit (IAU or Ilchester ward) and the medical services division includes a hospital@home service.

DCH is the main provider of acute hospital services to a population of around 250,000, living within Weymouth and Portland, West Dorset, North Dorset and Purbeck. It also provides renal services for patients throughout Dorset and South Somerset, a total population of about 850,000.

We inspected the IAU, the two elderly care wards (Day Lewis and Barnes), the respiratory ward (Hinton), the cardiology ward (Maud Alexander) and acute coronary care unit, Fortuneswell oncology ward, the stroke unit and Moreton gastroenterology ward. We also visited the renal unit in DCH, including the Prince of Wales renal ward and dialysis unit, and a satellite dialysis unit at another NHS trust. We visited the discharge lounge, the hospital@home service, Evershot step-down ward and endoscopy.

In total we spoke with 102 members of staff, including divisional leads, nurses at different grades, healthcare assistants, consultants, junior doctors, ward clerks and secretaries, housekeeping staff, pharmacists and therapists. We observed interactions between staff and patients, considered the environment, reviewed 26

patient records and spoke with 29 patients or their relatives. In addition, we reviewed documents relating to the management and performance of the trust and reports from other stakeholders. We attended three listening events in the community, in advance of the inspection, to hear what patients wanted to tell us about their care. We invited patients to send us their comments directly and we received 17 comments relating to medicine via email or from written feedback cards.

Medical care (including older people's care)

Summary of findings

We found that medical care (including older people's care) was good for effective, caring, responsive and well led and 'requires improvement' for safe.

Staff managed most aspects of medicine administration, storage, disposal and recording safely. However, we found that Patient Group Directions (PGDs) for medicines on the satellite renal dialysis unit were not the most recent versions. Staff had not followed trust policy for updating PGDs. Resuscitation trolleys were not tamper evident, creating a risk of incomplete equipment and medicines in an emergency.

Patients and relatives told us staff were caring and compassionate, and treated them with respect. They felt involved in their care and recommended the hospital to others based on their own experiences. Staff helped them with pain relief. Medical services sought patient views both routinely on discharge and to help improve treatment pathways. Groups of patients took part in focus groups to share their specific experiences of care.

Staff had a good understanding of how to care for vulnerable patients including those living with a learning disability or difficulty, or with dementia. They used tools to assess patients' mental capacity and understood the procedures to follow if patients were at risk of a Deprivation of Liberty if they were restricted or restrained.

Staff said their managers provided good support and felt the hospital was a friendly place to work. They had good access to professional development and most staff had completed mandatory training and appraisals. New nursing staff said the induction had been useful, although mentors did not always have time to provide adequate support. Junior doctors were satisfied with their training opportunities.

There was high level of bed occupancy and most wards had additional beds to help manage the increased demand for medical services. There were not always enough nursing staff, medical staff and therapists to support the needs of patients. The trust had carried out a staffing audit but had not completed the review to update staffing levels.

There was a culture of collaborative working and staff said they worked well together in multidisciplinary teams to coordinate patient care. We observed effective handovers between staff, which showed they considered patient's individual risks and needs. However, we observed a nursing handover on Day Lewis ward, which lacked respect towards patients. Staff assessed patient's health and welfare risks and agreed plans to support their care and treatment. They monitored changes, including deterioration in health, and took necessary actions.

Patient records were clearly completed and documented patient's risk assessments and management plans. Staff did not always keep paper records in secure trolleys, to minimise access by unauthorised persons.

The divisional leads had an agreed vision and strategy for services and a clinical governance framework. They had recognised the need to improve their management of risks, and had started to use a new approach to monitoring service risks. Staff reported incidents, and understood how to use the incident reporting system. Staff carried out root cause analysis to investigate incidents and learn from them. The service had a high proportion of harm-free care. The services took part in national and local audits to check they provided care and treatment in line with good practice guidance. They developed action plans and worked with other health and social care providers to improve care pathways. For example, project teams worked to improved discharge arrangements, cancer care pathways and stroke care.

Wards were clean and the infection control team carried out regular audits to identify any areas for improvement. At the time of our inspection, the cardiac catheter laboratory had broken down and required repair by the suppliers. Other items of equipment were maintained safely under contract and staff reported maintenance staff responded promptly when requested. The equipment library also supplied aids and equipment within the agreed timeframe.

Medical care (including older people's care)

Are medical care services safe?

Requires improvement



By safe, we mean people are protected from abuse and avoidable harm

We rated safe as 'requires improvement' because:

- Staff were not following trust procedures for updating of Patient Group Directions (PGDs). PGDs in the satellite renal dialysis unit were not updated versions and authorised for use.
- Resuscitation trolleys were not tamper evident, there was a risk of incomplete equipment or missing medicines in an emergency.
- Patient records were not always secured safely, in lockable storage equipment to ensure confidentiality. There was a risk that unauthorised people could access patient records.
- Due to capacity issues suitable rooms were not always available to isolate patients with infections. This meant there was a risk of cross infections between patients.
- There were not always enough nursing, therapy and medical staff with the right skill mix to provide safe care. Staffing levels had been reviewed, but changes to staffing levels identified as necessary from the reviews had not been fully implemented at the time of the inspection. The trust had a lower proportion of middle grade doctors than the national average, which put pressure on the medical teams. The trust was working to improve this.
- The layout of the satellite dialysis unit meant patient access to the unit was difficult. Patients had to pass through an inpatient ward for elderly patients to gain entry to the unit from the car park. If there was an infection risk on the care of the elderly ward, dialysis patients had to go outside and back in again. This meant there was a potential risk to the dialysis patients using this facility. All outpatients attended the satellite unit directly via an entrance off the main hospital car park.

However,

- Staff reported, investigated and learnt from incidents. There was a high level of harm-free care.

- Staff were aware of the Duty of Candour legislation and the service had a system for tracking incidents that triggered a Duty of Candour response.
- Systems were in place to enable staff to assess and respond safely to deterioration in patients' health. The trust used an electronic warning system to prompt staff to take the necessary action to help prevent further deterioration in patients' health. Staff completed relevant risk assessments for patients and shared information about patients' care and treatment needs at handover meetings.
- Most staff were up to date with mandatory training. Managers monitored compliance and supported staff to remain up to date with training. Although most staff were up to date with mandatory training, some staff groups showed lower levels of compliance in topics such as safeguarding children.
- Staff adhered to the bare below the elbow policy and maintained safe standards of infection prevention. The trust scored higher than the national average for cleanliness in the patient-led assessments of the care environment (PLACE), scoring 99%. The hospital's infection control team carried out audits which led to improvements in standards of hygiene.
- Pharmacy and nursing staff had improved their medicines management, using electronic prescribing and checking stock levels. They kept medicines at safe temperatures and disposed of medicines correctly.
- There were safe systems for maintaining dialysis equipment and staff reported the equipment library was responsive.
- Staff created clear, accurate patient records. They included information to help staff provide the right care for patients, and were signed and dated.
- The service had prepared major incident plans.

Incidents

- There were 24 serious incidents reported in the medical services core service in the 12 months to January 2016. The majority were slips, trips and falls and pressure ulcers. The trust reported more no-harm incidents and severe harm incidents than the England average, which indicates a positive reporting culture.
- Staff reported incidents and near misses using the trust's electronic reporting system. All staff we spoke with understood the process and when asked, most could recall recent incidents and actions taken. Staff working in the satellite renal dialysis unit at Royal

Medical care (including older people's care)

Bournemouth Hospital (RBH) knew when and how to report incidents under both the Dorset County Hospital (DCH) system and the RBH one, depending on the incident.

- There was one never event reported in the medicine division during the 12 months to January 2016. This related to a medicine incident. Never events are serious, largely preventable patient safety incidents that should not occur if staff have implemented the available preventative measures. This never event occurred in August 2015 in the stroke department and involved a patient receiving a medicine twice in one week when it had been prescribed for weekly administration. Staff undertook a root cause analysis (RCA) which identified a system error within the electronic medicine administration system. The trust alerted the system supplier who carried out an update in response to this finding, to minimise the risk of it happening again in both the trust and in other hospitals. Hospital staff also shared learning with the senior pharmacist at NHS England. The trust issued a bulletin reminding nurses to check changes to medicines against prescriptions.
- The risk management department coordinated serious incident reviews and RCAs. Incident reviewers reported their findings in 'significant risk event investigation summary reports'. These reports included a detailed chronology of events related to the incident and identified any actions required to improve safety or for further learning. They shared learning at clinical governance meetings and at sister/matron meetings. The trust board received reports on serious incidents and the action taken to improve care.
- Risk leads reviewed incidents and trends at their weekly meetings. For example, a possible trend in patients developing heel pressure ulcers led to the trial of new product and a new pressure ulcer monitoring tool which staff said was useful.
- One RCA related to a pressure ulcer on a patient's heel. The analysis identified the need for more consistent completion of wound charts and an amended safety brief to ensure staff were aware of patients' pressure area care needs. We observed that safety briefings alerted staff to patients with pressure area risks and patient records included pressure area assessments and plans.
- Ward sisters said serious risk event reviews were thorough, and the review process focused on sharing learning. They provided an example of attending a review meeting, in relation to a pressure ulcer, and the tissue viability nurse gave advice and support.
- Ward sisters discussed incidents in their monthly meetings and cascaded learning via emails, information notice boards and communication books, depending on their preferred choice.
- The renal dialysis unit shared learning from both local and national incidents, and near misses. For example, an incident at another hospital led to a change in practice to use normal saline direct from ampoules (instead of from a dressing tray) to avoid mistakes. Because of a local incident, the dialysis service required two nurses to check medicines and this had reduced medicine errors.
- Some staff reported incidents relating to staff shortages, for example when physiotherapy staff could not attend patients in a timely way. However, others also said they did not always report staff shortages as they felt it would not help bring about changes.
- Staff said the electronic system for reporting incidents had improved feedback on incidents and they received emails confirming the action taken. However, some staff said they were not aware of the feedback process. Others commented they found it took a long time to complete the reports, and they did not always find the time.
- The trust held mortality and morbidity meetings at departmental, divisional and trust level. Records of these meetings showed that consultant staff reviewed any deaths that occurred in the department and they identified and shared any lessons learnt. Minutes showed that consultants reviewed their own patients, whereas it is good practice for another consultant, from the same speciality to carry out these reviews. The trust had identified higher mortality rates on Sundays and had started a full review. Junior doctors commented they were not always included in these meetings.
- The Duty of Candour (DoC) is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person. The trust's policy on 'being open and duty of

Medical care (including older people's care)

candour' reflected the DoC legislation. RCA reports showed staff used the DoC reporting process and the trust's incident reports included the number of DoC incidents.

- The risk management team identified incidents reported by staff that triggered the DoC and then coordinated the response and investigation. There was a trust-wide system for tracking their DoC responses and in the quarter October 2015 – December 2015, 12 incidents triggered the DoC response.
- Staff we spoke with were familiar with the concepts of openness and transparency and some could give examples of how they or their colleagues had applied the DoC.

Safety thermometer

- The NHS safety thermometer is a monthly snapshot of avoidable harms, about pressure ulcers, catheter-related urinary tract infections (C-UTIs), venous thromboembolism (VTE, or blood clots) and falls. Ward staff displayed the information for falls and pressure ulcers on notice boards where patients, visitors and staff could view the results and trends. However, they did not display data on C-UTIs and VTEs which meant they did not display all aspects of the safety thermometer.
- Staff often displayed this information in terms of a safety cross, highlighting when pressure ulcers or falls had occurred during the month. The information did not include the number of 'harm free days' since the previous incident or show any monthly trends.
- The trust's February 2016 board report showed the harm free care, safety thermometer measurement, was 97.9%, which was in line with the monthly trend for the year. This data reflected the safety thermometer measurements across the trust.

Cleanliness, infection control and hygiene

- The wards we visited were visibly clean. Staff maintained cleaning schedules and usually displayed these on the wards with signed checklists. Renal dialysis machines automatically disinfected between patients, and staff checked the disinfection reports each time to make sure the procedures had been effective.
- Most commodes displayed stickers to show staff had cleaned them and they were ready for use, but we observed gaps and pointed these out to staff. The trust's

managerial ward audits focused on commode cleanliness, and reports for Barnes, Hinton, Maud Alexander and the IAU showed results of 100%. The audits highlighted areas for improvement.

- Staff used personal protective equipment (PPE) appropriately, such as gloves and aprons, and we observed good compliance with hand hygiene. There were hand sanitiser gels at the end of each bed and at the entrances to each ward or bay. Staff also adhered to the trust policy for 'bare below the elbows' to minimise the risk of spreading infections.
- The trust's infection control team carried out regular audits of hand washing. If wards scored below 90% they had to present improvement plans.
- Hand hygiene audits in October 2015 showed most wards exceeded the target of 95%. The Prince of Wales ward and DCH renal dialysis unit achieved 100% in February 2016. The improvements had been achieved following hand hygiene audits carried out in October 2015 which highlighted that volunteers had not been hand-washing consistently, resulting in a below 95% result. Staff addressed this shortfall with the volunteers and results for these areas had improved to meet the target required.
- The trust scored higher than the national average for cleanliness in the most recent patient-led assessments of the care environment (PLACE), in April 2015, scoring 99%.
- Infection control champions attended quarterly meetings to share information, learning and trends.
- Wards had single rooms where they could isolate patients to control infection risks, however there was constant pressure for these as they were also used for caring for patients requiring single rooms, for example for those receiving end of life care. The Prince of Wales renal ward had an isolation bay of three beds, but this was also an escalation bay when it was not required for infection control purposes. Senior staff had to risk assess how best to use the isolation rooms or bays.
- Staff at both the DCH and the satellite renal unit in Royal Bournemouth Hospital (RBH) used aseptic techniques when cannulating patients, to minimise the risk of infections.
- The renal service had specific policies about blood borne viruses, to protect patients from infections. Staff gave renal dialysis patients detailed guidance on hand hygiene. They also instructed patients on how to keep

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catheters clean. The care pathway for dialysis patients included monthly tests for infections such as methicillin-resistant staphylococcus aureus (MRSA) and methicillin-susceptible staphylococcus aureus (MSSA).

- In November - December 2015, there were three cases of Clostridium difficile. one in CCU, one in ITU (surgical division) and one on Maud Alexander. An MDT meeting took place to review the three cases and reinforced the importance of national guidance and the report identified delays in isolation. There was evidence that the rationale for antimicrobial prescribing was poor for one of the three cases. The trust carried a deep clean of the units, reinforced the use of hand wipes before meals and issued updated guidance on the effective management of diarrhoea.
- We saw the trust had circulated guidance on the management of diarrhoea across the trust and discussed the learning from the review at matron/sisters meetings. Most patients told us they were encouraged to wipe their hands before meals.
- There had been no hospital acquired MRSA infections in the 12 months to November 2015. The rate of MSSA was higher than the national average for 10 out of 13 months between August 2014 and 2015.
- It was hospital policy to screen 95% of patients on admission to the hospital for MRSA. Trust data showed they achieved this target in the period April 2015 to November 2015.
- Staff displayed the results of weekly cleaning audits on most wards. Examples included Hinton (respiratory) ward 98%; Prince of Wales (renal) ward 98% and 97% on Day Lewis ward. The trust also carried out managerial environmental ward audits, which included aspects of infection control and cleanliness. These alerted ward managers on areas requiring improvement such as high level dusting.
- The trust data on staff training in infection control showed compliance levels of 70% for medical staff, 85% for nursing staff and 81% for healthcare assistants. This was against a trust target of 85%. This meant not all staff were up to date with trust policy and guidance on infection prevention and control.
- The endoscopy unit was clean, with effective decontamination systems maintained by the trust's sterile services department.

Environment and equipment

- At the time of our inspection, the cardiac catheter laboratory had broken down and required repair by the suppliers. There were contingency plans for this as the equipment had broken down previously. The trust had a longer-term plan to install a new cardiac catheter laboratory, to increase overall capacity.
- Staff reported prompt responses from maintenance team when equipment required repair. Staff at the satellite renal dialysis unit reported the technician was available 24/7 and attended the unit within an hour of being called.
- DCH dialysis unit used two independent water filtration plants, on alternate days. This meant there was also a backup should one fail. Staff reported prompt and effective maintenance support.
- The trust policy on dialysis fluid quality defined how to test and maintain safe water quality standards. Water testing logs showed staff acted on any results outside an acceptable range and then rechecked equipment before using it. The service maintained its own equipment maintenance log.
- There were two different types of water system and dialysis machines in DCH, which limited the flexibility of junior staff. Staff only worked where they had the competency to use the equipment. Senior staff were competent to use both systems and could be flexible and use the equipment used on Prince of Wales ward as well as the dialysis unit.
- The layout of the satellite dialysis unit meant patient access to the unit was difficult. Patients had to pass through an inpatient ward for elderly patients to gain entry to the unit from the car park. If there was an infection risk on the care of the elderly ward, dialysis patients had to go outside and back in again. This meant there was a potential risk to the dialysis patients using this facility. All outpatients attended the satellite unit directly via an entrance off the main hospital car park.
- Staff said they had sufficient air mattresses and had good access to specialist equipment to support people at risk of developing pressure ulcers.
- Resuscitation trolleys were not tamper evident. Although this was in line with trust policy, it meant equipment or medicines could be removed from the trolley at any time and staff would have no means of

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knowing this, outside of daily checks. This may affect a later emergency if the right equipment was then not available when required. The trolleys were new and well maintained and staff checked their contents each day.

- One resuscitation trolley was shared between the Day Lewis and Barnes wards for care for the elderly which presented a risk to patient safety.
- Equipment was bar coded and tracked by the trust's equipment library. This included blood sugar testing equipment and hand held electronic devices.
- Staff reported good access to equipment for bariatric patients, from the hospital equipment library if available, or from local external contractors within four hours.
- The hospital's discharge lounge had 13 chairs, including two reclining chairs, and an ensuite toilet. It was equipped with an isolation room with a bed, if required.
- The Barnes (elderly care) ward was painted and arranged to be suitable for patients living with dementia. The entrances to bays were painted different colours, and the toilets were decorated to aid visual location.
- A therapy gym was located on the same floor as the stroke unit. Stroke patients could be given therapy within the ward area or taken to the specialist therapy room with access to appropriate equipment.

Medicines

- The satellite renal dialysis unit had copies of out of date or unauthorised patient group directions (PGDs) for medicines. It was not clear which PGDs to refer to, as there were different versions on the trust intranet. Staff had not followed trust procedures for updating of Patient Group Directions (PGDs).
- Staff managed controlled drugs (CDs) safely and maintained low stock levels. However, we found a few unwitnessed entries in the CD register. We discussed this with the ward manager during the inspection and they checked and revised procedures.
- We observed a medicine administration round observation and nurses checked the identity of patients and completed the administration procedures correctly. The trust used an electronic system for recording medicine administration, and this helped prompt timely administration and monitor any omissions. Staff

recorded any allergies to medicines on this system and on nursing records. Staff recorded the results of any additional monitoring requirements on paper charts at the end of patients' beds, such as blood glucose levels.

- Three patients on Hinton (respiratory) ward told us nurses left medicines for them to take and that staff did not check they had taken them. There was a risk that the patients had not taken the medicines as prescribed.
- Pharmacists checked prescription charts and added further advice when necessary to help nurses with the administration of medicines.
- The trust stored medicines at safe temperatures. It had set up a system for continuous monitoring of medicine storage temperatures using a trust-wide wi-fi system. This extended to the fridge in the satellite renal dialysis unit.
- Medicines were safely and securely stored in locked cupboards, patient lockers, fridges and medicine trolleys. The medicine cupboards and fridges were in locked rooms controlled by key-pad entry.
- We checked medicines and all were in date.
- Pharmacy staff checked patients own medicines and checked creams were labelled with the date of opening. They carried out audits of medicines in different wards each week and reported findings to ward leaders if there were concerns.
- The pharmacy team checked medicine stock levels to help control stored quantities.
- All appropriate oxygen cylinders were full, generally secure and in date. One cylinder was unsecured on Hinton (respiratory) ward.
- The pharmacy department managed medicine recalls. Matrons responded to medical safety alerts and highlighted them in their daily safety brief to team leaders.
- Staff disposed of medicines in the pharmacy waste bins and used sharps bins for the disposal of sharp items such as needles. The sharp bins were not overfull.
- Staff in the discharge lounge checked patients left with the correct, prescribed medicines. The staff were trained in medicine administration and they said they had good support from the pharmacy team.

Records

- Patient records were a mix of paper and electronic records. Ward staff kept the paper records in files, and each ward had hand-held electronic devices to capture vital observations, such as pain scores and VTEs.

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- Staff did not always keep paper files securely. On Prince of Wales (renal) ward, they were in locked trolleys, but in Maud Alexander (cardiology), they were stored in an open rack behind the nurses station. On other wards, they were in closed, but not locked, trolleys. In Fortuneswell (oncology) ward, they were in open trolleys. This meant there was a risk that people without correct authorisation could access patient records.
- Paper records were clearly written, and generally well organised. They included information about patients' medical history and social situation, as well risk assessments, care plans and observations. They also included entries from different disciplines, including therapists, palliative care team and dieticians where appropriate. Entries were signed and dated with almost all were completed in a timely way, with clear narrative.
- Staff reported that matrons and ward sisters carried out local audits including weekly audits of records. Their audit of the adult inpatient records had started in October 2015 in order to drive improvements. The audit results showed where staff most often omitted assessments. The assessment of safeguarding and mental capacity was the part most frequently left blank, followed by timely assessments of infection and prevention. The introduction of regular audit had improved standards of record keeping in some areas but this was not consistent.
- There was a secure access the electronic medicine administration system, with authorised staff using individual swipe cards. The system was colour coded to show when patients required their medicines and to mark when staff had given them. The prescription charts were clear and complete.
- Compliance amongst medical and nursing staff with safeguarding children level 2 was 89% and 71% respectively. The trust target for compliance with all mandatory training was 85%. Less than 85% of doctors in roles requiring safeguarding children level 3 training were up to date with this training.
- The trust's safeguarding nurse received supervision from the matron and attended regular monthly peer reviews for doctors to share learning.
- In November 2015, the trust held an information week on domestic abuse, which included a display in the hospital restaurant, presentations and training.
- Safeguarding leads received training in February 2016 on how to provide safeguarding supervision and support. The trust planned to offer staff three-monthly safeguarding supervision, however in the meantime, staff could request one to one support when necessary.

Mandatory training

- Mandatory and statutory training covered a range of topics including fire safety, adult basic life support, safeguarding, patient moving and handling, information governance, infection control, dementia awareness and equality and diversity.
- Nursing and healthcare assistant staff in the medicine division met the trust compliance levels for mandatory training, however compliance levels were consistently below 85% for medical staff. For example, 55% of medical staff were up to date with adult basic life support. Governance reports highlighted when staff groups needed to improve compliance with mandatory training, so managers could prompt staff.
- When staff completed their mandatory training this updated the trust's electronic staff data base. This data base alerted managers when staff were due to attend training updates.
- Ward sisters accessed staff training records on the trust intranet and booked staff onto training courses. Staff told us they were up to date with their mandatory training, some of which was provided online, which made access easier.
- Staff working at the satellite renal unit also complied with local mandatory training in fire safety and basic life support.

Assessing and responding to patient risk

- Staff completed risk assessments for patients in relation to malnutrition, mobility and falls risk, skin integrity and

Safeguarding

- Staff had a good understanding of safeguarding and described actions they had taken to keep a patient safe from suspected abuse.
- Staff told us they had received training in both safeguarding vulnerable adults and children. All staff and volunteers received an information leaflet about safeguarding adults in June 2015, which equated to level 1 training in safeguarding.
- Healthcare assistants had completed training in safeguarding children level 1.
- Compliance with safeguarding adults level 2 was 91% in December 2015, for registered health professionals.

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pressure ulcers. Staff recorded these assessments in the trust 'adult inpatient record' booklets and the results were summarised in the ward handover sheets. Medical staff assessed risks of VTE and patient pain levels and recorded this information in the electronic records system.

- The trust assessed all patients over the age of 75 for dementia. This enabled the staff to respond to and manage risks associated with living with dementia.
- Dialysis staff had created a specific assessment record for dialysis, which prompted staff to complete assessments in relation to a range of risks including infection control, falls, pressure ulcer development and foot problems.
- Although the emergency department had sepsis screening stickers to include in patient notes, staff did not apply always them and further work was required to embed the sepsis pathway across the trust. An audit of the sepsis pathway showed improvement in the timeliness of assessment and administration of intravenous antibiotics, following low levels of assessment between April 2015 and September 2015. Staff reported the sepsis pathway worked well, with a flagging system to alert them to take particular actions in response to test results and observations.
- Nursing staff used a safety brief at handover. The nurse in charge led the briefing, commented on any changes on the wards, any patients whose health had deteriorated, incidents, falls and pressure ulcers and any other risks to be aware of. Lead nurses then gave a more detailed patient-specific handover to the nursing and healthcare assistants directly involved in patient care.
- We observed handovers and these showed staff responded to patient risks, for example by requesting specialists in a timely way and by obtaining specific equipment and aids.
- Medical staff conducted structured morning handovers attended by senior clinicians from each medical specialty. They used these to discuss any outlier patients (those placed on the ward but under a different specialty because of bed pressures) and plan their particular medical needs.
- Medical staff used medical assessment forms with prompts, for example for assessments for patients admitted for stroke or chest pain. They reported these were well designed to promote full, safe assessments.
- On the two older persons wards (Day Lewis and Barnes), staff placed patients at a high risk of falling in beds

where they could be observed most closely from the nursing station. Where necessary, staff arranged for 1:1 support for patients, for example if they had a high risk of falling or if they needed supervision.

- The trust used an electronic early warning scoring system for monitoring deterioration in patients, which alerted staff to significant changes in a patient's observations. Staff understood the actions they should take should a patient's score increase above an agreed level. Records showed that staff had taken the appropriate actions.
- Staff in the renal dialysis units did not use the early warning scoring system as it did not meet the needs of dialysis patients. Renal staff used their professional judgement and experience to alert the critical care outreach team.
- Patients commented on the prompt response of staff when their health had deteriorated. One dialysis patient described a rapid response in an emergency that staff had managed safely.

Nursing staffing

- Ward leads displayed staffing levels in each ward, showing the actual number of nurses and healthcare assistants on duty, as well as the nurse in charge and their deputy.
- The trust had completed a review of acuity and dependency on wards in January 2016, and this was to be used to review safe staffing levels. At the time of the inspection, the nursing staffing levels were not always sufficient to meet the needs of patients. This was partly because the number of beds on some wards had increased and also because the layout of the wards meant it was difficult to organise safe staffing ratios.
- Frontline staff on all wards reported that requests to fill staffing gaps, for example to cover for unplanned leave or sickness were not always fulfilled.
- The trust monitored planned versus actual staffing for each shift on each ward. Results showed when shifts were fully filled, under filled or overfilled, or when the skills mix was altered. The data for November 2015 showed that shifts on most wards were fully filled or over filled, apart from cardiac catheter laboratory and the which showed 33% of shifts were under filled. This data did not reflect the number of requests to for additional staff, over the planned level.
- Staff said the established staffing levels on Ilchester integrated assessment unit (IAU) was based on a lower

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number of beds than were in use on the ward. Since the ward had six extra beds, which the ambulatory care service had previously used, the staffing establishment of three nurses and three healthcare assistants was not always enough to meet the needs of patients. Although the target ratio of nurses to patients was 1:9, staff said it was often 1:12. Staff had escalated this and there was a business case for additional staff. There were vacancies on this ward and the regular use of agency staff affected the skill-mix of staff.

- On all the wards we visited, the nurse in charge was often required to provide nursing cover although they were not part of the nursing establishment. This meant they had reduced time to carry out their management and leadership roles.
- For the unannounced visit, there was significant pressure on wards due to the high number of admissions and an outbreak of norovirus. This put additional pressure on staffing, with ward sisters having to book agency staff at short notice.
- Hinton (respiratory) ward received funding for 16 beds, with two nurses and two HCAs on day shifts and two nurses and one HCA on night shifts. When we visited the ward had five additional escalation beds, three of which were in cubicles, and the trust had agreed an increase to three nurses on day shifts, and an additional HCA on nights. The trust had also approved an additional day-shift HCA when patient numbers were above 19. The ward manager used regular bank and agency staff to fill vacant shifts. Sometimes the charge nurse provided additional nursing cover when they considered this necessary.
- Some wards were regularly escalated, such as Moreton and Hinton wards which showed 46% and 68% of shifts were staffed above the planned level in November 2015. Staffing levels were being adapted to meet the demands of the escalation beds. The nurse staffing review confirmed the additional establishment was required to expand the base number of beds for these wards on a continuous basis.
- There were 1.5 wte vacancies for band 5 nurses on the Day Lewis (elderly care) ward. It was noted that there were five staff nurses (out of 13 band 5 nursing staff) recruited from abroad. The trust told us three nurses had been part of the ward team for several years. There were two nurses from overseas who were on their preceptorship programme.
- On Barnes (elderly care) ward, there was a nurse and a healthcare assistant allocated to each bay. The ward had four nurses and four healthcare assistants (HCAs) each morning, and three nurses and four HCAs in the afternoon. At night, the establishment was for two nurses and three HCAs. Although this ward was equipped to support people living with dementia, the trust had not appointed a specialist dementia lead nurse to provide specialist guidance.
- Staff on the Maud Alexander (cardiology ward) also experienced pressures, exacerbated by a relatively high sickness rate. The establishment was for two nurses on the coronary care unit (CCU), with six beds, and one on the 10-bedded ward which included three telemetry (cardiac monitoring) beds. If another ward required an additional nurse, such as the cardiac catheter laboratory, there was a risk of only one nurse covering CCU. Data showed the cardiac catheter laboratory had high levels of sickness in November 2015 (at 33% of shifts for the month). This resulted in some reduced lists in line with staffing availability. The staff were aware the trust had recently reviewed the staffing model and expected the staffing level and mix to improve. The nursing establishment on Fortuneswell (oncology) ward was based on 14 beds, however following a demand for additional beds, the ward had been operating with 16 or 17 beds since Christmas 2015. When the number of patients on the ward increased to 17, this triggered the ward staff to include an additional HCA to the staffing model. However on the day we visited, this had not been possible.
- The 13-bedded Prince of Wales renal ward had opened an additional bay that was used for escalation purposes. The ward required a high level of agency nurses and the trust had approved additional staffing and recruitment was under way to fill identified vacancies.
- There were not enough trained dialysis nurses to provide renal dialysis continually within the ward setting (inpatients). To increase capacity, the service was developing competencies for junior nurses. The unit was short of one senior nurse and one registered nurse had been identified to support the training of junior staff and was not included in the roster numbers.
- Staff said it was sometimes hard to find agency staff with the right skills for specialist services, such as cardiology or respiratory care. Ward sisters said they used bank or agency staff to fill gaps in staffing when

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necessary and justified. They used a regular pool of agency or bank staff, so they were familiar the ward environment, but the numbers of suitably trained and experienced staff were limited.

- Where there were outlier patients on a ward managers said they assessed the needs of individual patients and requested additional staff as necessary. They requested additional staff to provide 1:1 support for staff with particularly high support needs.
- The satellite renal dialysis unit was a nurse-led unit and shifts were arranged with one staff member to four patients, with two nurses and two HCA on duty each shift. Staff reported the staffing levels were suitable to meet the needs of patients.
- The trust employed two acute oncology nurses, to support new admissions. The nurse specialists provided a teaching role and had access to the oncology registrar on call. They also coordinated the care of complex patients involving the relevant specialities.
- Between September 2015 and December 2015, the level of physiotherapists was consistently below target, at 45% to 90% variance. The respiratory physiotherapists did not provide a dedicated service to different departments, but worked in response to demand. They prioritised critical care patients, which meant their service to medical wards was limited.
- Trust data showed the trust was short of speech and language therapists for 17 out of 18 weeks to January 2016.

Medical staffing

- The trust had a higher proportion of junior doctors and consultants than the national average (31% compared with 22% and 40% compared with 34%, respectively). There was a significantly lower proportion of registrar-group doctors, with 24% compared with 39% overall. Medical staff recognised this put pressure on medical staffing across the trust.
- There were eight registrars in post, against an establishment of 12. Staff said this had an adverse impact on junior doctor training and their rotas were not always appropriate for their learning or for patient safety. The trust had recently added a new, temporary registrar post to the daytime rota, which had helped the situation. The trust management team was fully aware of the shortage of registrars. It was working with the local educational training board and other trusts to improve the situation.

- Medical rotas for junior doctors sometimes meant a lack of continuity of junior doctors on wards, such as the cardiology wards. There was a vacancy for one registrar in cardiology and a forthcoming vacancy for a registrar on the respiratory ward. This was a known issue and the divisional manager had supported a review of the rotas.
- There was a complex arrangement for consultant ward rounds, which meant that patients did not always receive treatment from consultants with specialist skills. For example, renal patients could be under the care of an acute medical consultant if the renal consultant was not on site at the time of their admission. Speciality wards had 'buddies' so that bed managers preferentially placed patients on buddy wards when there were bed pressures. For example, the respiratory ward buddied with orthopaedics and oncology wards. This meant consultants looked after patients outside their speciality and potentially had more patients to see.
- On Ilchester IAU, there were two full time acute medical consultants, each working one in eight days and weekends on call. There was out of hours medical staffing on the ward. Staff felt this was not enough consultant cover for the assessment unit, to enable specialists to spend time in their specialist area. When patients remained on the IAU, because there were no suitable beds on the wards, the specialist doctors came to the IAU to support patient care.
- Consultants for oncology were based at another hospital. They visited regularly throughout the week and junior doctors said access to specialist advice was readily available. Junior doctors managed the day-to-day medical care and the respiratory consultant team provided cover in the absence of oncology consultants. Haematology consultants were also employed and based on site.

Major incident awareness and training

- Staff were aware of the procedures for managing winter pressures and major incidents. The trust had contingency plans for power or water failure. For example, renal dialysis staff understood what to do if the water sterility failed.
- The trust had an emergency preparedness plan, with supporting action cards and triggers for escalation.
- The trust had reviewed arrangements for emergency planning, resilience and response and had completed a

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self-assessment as part of the national assurance process. This identified that substantial arrangements were in place but they also needed to address a minority of the new core standards.

Are medical care services effective?

Good



By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

We rated effective as 'good' because:

- Medical services followed pathways and protocols based on national guidance, such as the National Institute for Clinical Excellence (NICE) guidelines. Endoscopy services were accredited by the Joint Advisory Group for gastrointestinal endoscopy, which showed they provided effective treatment. Patients' care was planned and delivered in line with current evidence-based standards.
- Staff undertook a range of clinical audits to benchmark practices and identify areas for improvement. Where results were below expected levels, staff investigated causes and implemented improvement plans.
- The results of most national audits showed medical services provided effective treatment. In February 2016, the trust met the target for cancer treatment times for all measures except one, and to improve, the service had implemented an action plan. The results of the myocardial ischaemia national audit project (MINAP) national audit 2013/14 showed the trust's outcomes were similar to or better than the England average.
- The services provided food that patients liked and was in accordance with their specific needs. Staff monitored the quantities of food and fluid patients took, if necessary, to help them with their nutrition and hydration.
- Staff from different disciplines coordinated patient care effectively, by sharing information formally and collaborating to support patients with complex needs. They worked together to plan patients' discharge arrangements to take account of their health and social needs.

- Staff were qualified and had the skills they needed to carry out their roles effectively. They participated in annual appraisals and there was good access to professional development.
- Staff obtained patient consent for their care and treatment. They understood the Mental Capacity Act 2015 and Deprivation of Liberty Safeguards and how to apply these.

However,

- The sentinel stroke national audit (SSNAP) results had fallen in quarter 3 to below the national average, to level D. The stroke service had an action plan to promote improvement with executive team support.
- Staff did not always use a tool to assess pain effectively in patients who had difficulty communicating verbally.
- There was a backlog in writing discharge letters to GPs for cardiology patients. The trust was aware of the situation, had implemented some short-term solutions and included this on the risk register.
- There were not enough therapy staff to provide effective treatment to medical patients, particularly stroke patients.

Evidence-based care and treatment

- Medical services had pathways and protocols for a range of conditions, based on national guidance such as the National Institute for Clinical Excellence (NICE) guidelines. These were in place, for example, for heart failure, thrombolysis, management of acute upper gastrointestinal haemorrhage in adult, haemodialysis, stroke, diabetes, respiratory conditions, falls prevention, pressure ulcer prevention and sepsis. The trust monitored their policies to check they followed NICE guidance. There was a high level of compliance with only two policies requiring review.
- The trust's sepsis group had developed a sepsis screening and treatment pathway based on the National Clinical Guideline No. 6. Sepsis Management. Doctors and nurses used this tool to assess the risk of sepsis in patients and to give clear guidance on what actions to take and when.
- The trust used a scale recognised by NICE to assess the risk of pressure ulcer development. This enabled staff to categorise the risk of skin breakdown and prompted them to take the right action. The trust used skin bundles for both preventative care and treatment of pressure ulcers.

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- Staff assessed patients at risk of malnutrition or dehydration using the malnutrition screening tool developed by the British Association for Parenteral and Enteral Nutrition.
- For patients with heart failure or who had suffered a stroke the care pathways were integrated and promoted effective care and treatment from a multidisciplinary health team.
- The medical division took part in national audits to benchmark practice and find areas for improvement. These included audits of stroke care, cardiac care, diabetes, different cancers and the national confidential enquiry into patient outcome and death.
- In addition, the trust undertook a planned range of local and regional audits based on NICE guidance or guidance from other professional bodies. These included for example, audits of the management of cardiovascular risk factors in chronic kidney disease, upper gastrointestinal bleeding and the use of blood products and waiting times for patients awaiting coronary angiography. Staff also audited MRSA screening, MUST screening, patient records, antibiotic prescribing and ward organisation. Trust staff developed action plans when audits identified areas for improvement. These action plans were acted upon.
- Patients at risk of venous thromboembolism (VTE) received VTE prophylaxis in line with NICE guidance. The trust monitored this to check compliance.
- An audit in August 2015 showed consultants reviewed all acute medically unwell patients twice a day in line with NICE guidance.

Pain relief

- Staff monitored and recorded patients' pain levels on a score of 1-3 on the electronic assessment system.
- Patients we spoke with told us staff gave them pain relief when they needed it and said they felt this helped them manage effectively.
- An audit of pain management on elderly care wards in November 2015 showed staff were not sufficiently skilled in recognising and treating pain. Although physiotherapists used the Abbey pain score, to identify non-verbal signs of pain, nursing staff did not use this tool, which showed a lack of consistency in approach. This meant there was a risk that patients would not receive adequate, prompt pain relief to aid their comfort and rehabilitation.

Nutrition and hydration

- Staff assessed and recorded patients' nutrition and hydration status using a recognised tool. They completed food and fluid charts when assessments showed there was a need and noted patients' intake each day.
- Staff also monitored the quantity of fluids taken by patients who required intravenous infusions, to ensure they received the right amounts.
- Speech and language therapists assessed patients' ability to swallow safely and left clear guidance for ward staff on how to prepare their food and drink to the right consistency. Dietitians were also involved in patients' care. They provided dietary advice for patients with poor appetites or for those with diabetes and those identified as at risk according to the screening tool.
- Healthcare assistants knew the dietary need of the patients they were supporting and could explain why some patients needed foods and fluids with modified consistency.
- Patients' meals were marked up by the kitchen to show patients' specific dietary needs, such as high protein, diabetic, low fat or low fibre.
- Patients chose their meals from the menus provided the day before. They told us they found the quality and choice of food was good and the quantities were suitable. We observed patients had jugs of water available on their tables and they told us these were refreshed regularly.
- The hospital's patient-led assessments of the care environment (PLACE) audit in April 2015 showed the hospital performed above the national average for food, scoring 92% against the national average of 88%.
- The Day Lewis (elderly care ward) used coloured trays to identify those patients who needed help with their meals. However, wards did not use this system consistently across the hospital.

Patient outcomes

- The medical division took part in national audits. These included the bowel cancer audit, cardiac rhythm management, the falls and fragility fractures audit programme, the lung cancer audit, the national chronic obstructive pulmonary disease audit programme and

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the sentinel stroke national audit (SSNAP). The trust explained the actions staff had taken to improve the standard of treatment and care in response to audit results.

- The trust monitored and reported on performance data linked to patient outcomes. For example, the February 2016 performance report showed the trust had consistently achieved VTE risk assessments above the target minimum level of 95%.
- Specialist nurses collected data for national audits and they acknowledged that data collection and data quality needed to improve. There had been a delay in compiling data for some audits, such as the heart failure audit. When we inspected, the service had just appointed a heart failure specialist nurse to focus on this area. Nursing staff were not always aware of outcomes from national audits, such as those relating to heart failure.
- The trust took part in 39 national clinical audits in 2015/16. For some of these, the trust reported a coding problem, which had affected the accuracy of the audit results. For example, the trust performed below the national average for the heart failure audit in 2013/14. The only areas where the trust was similar to or above the national average was for patients receiving an echocardiogram, discharge planning and prescribing beta blockers on discharge. Patient safety coordinators reported difficulties with data entry for this audit, as they could not identify the eligible patients correctly.
- Results of the myocardial ischaemia national audit project (MINAP) national audit 2013/14 showed the trust's outcomes were similar to or better than the England average. Of 174 patients with non-ST-elevation infarction (nSTEMI), 94.3% were seen by a cardiologist or a member of the cardiology team. This was the same percentage as the national average. The audit showed 56.9% of these patients were admitted to a designated cardiac ward (against a national average of 55.6%). The trust performed significantly better than the national average for the proportion of nSTEMI patients referred for an angiogram; 94.3% against 77.9% nationally.
- The trust had audited the time nSTEMI patients waited for angiograms. The trust met this standard 80% of the time and reported there was a good reason why many of the 20% had not had this intervention, as it would not have been a safe procedure for them.
- The SSNAP aims to improve the quality of stroke care by auditing stroke services against evidence-based

standards and national and local benchmarks. Results for all trusts carrying out the audit are reported quarterly. For the most recent quarter, October 2015–December 2015, the stroke service overall performance dropped from a score of B (above the national average, which is C) to a score of D. This was because the service showed a drop in the percentage of stroke patients with 90% of their stay on the stroke unit and the percentage of high-risk transient ischaemic attack (TIA) patients assessed and treated within 24 hours. The trust also performed behind target for the percentage of stroke patients admitted directly to an acute stroke unit, within four hours.

- The stroke steering committee, chaired by the chief executive, had developed a detailed action plan to improve outcomes for stroke patients. It attributed the reduced performance in the SSNAP to the time taken to carry out a CT scan outside normal working hours and the access time to the stroke unit. This was partially related to the number of outlier patients on the ward and the overall patient flow in the hospital. The trust did not have designated acute stroke beds and there were times when there was no capacity on the stroke ward for new stroke admissions. Staff then moved patients to other wards, to accommodate acute admissions. During our inspection, the stroke ward itself also had outlier medical patients.
- In addition, the stroke steering committee's action plan explored options for earlier supported discharge for patients. The trust was part of a hub with other local hospitals to provide weekend clinics for patients with transient ischaemic attacks (TIA).
- In February 2016, the trust met the target cancer treatment times for all measures except one. This was the 62-day wait from urgent GP referral to treatment, where the trust achieved 67.5% against a target of 85%. The trust understood the reasons for this result, which were primarily due to longer waits for prostate cancer treatment at another hospital. To improve the situation, service leads worked with partners in the specialist hospitals to redesign the waiting lists.
- To improve identification and treatment of sepsis, the trust had appointed a part time sepsis and acute kidney injury (AKI) nurse for three months to raise awareness and improve sepsis treatment. The trust had set up a new assurance framework for sepsis including a new screening tool, based on NICE guidance. The trust also set up an alert system for suspected cases of sepsis.

Medical care (including older people's care)

Audit results in February 2016 showed the percentage of patients screened had increased to 83% and administration of IV antibiotics had increased to 51%. Further work was planned to roll out training to nursing, junior doctors and healthcare assistants to improve and sustain outcomes for patients.

- Results of the National Diabetes Inpatient Audit (NaDIA) in September 2013 showed the trust performed better than the England median percentage for 15 out of 21 measures. The trust performed well for measures relating to meals and staff knowledge. However, the trust scored worse than the England median for prescription errors and foot risk assessments.
- The relative risk of readmission to the hospital for all elective and non-elective procedures was lower than the England average (August 2014-July 2015). This is a positive result for patient outcomes.
- The renal service undertook annual audits of the service, across all its sites, reviewing amongst other things, mortality and transplants.
- The Joint Advisory Group for gastrointestinal endoscopy had accredited the endoscopy unit. It had audited the service's policies, procedures and checks against good practice guidelines to award it full accreditation.
- The national cancer audit surveyed patients for their views of care and treatment and highlighted strengths and weaknesses in services. The trust was in the lowest 20% of trusts nationally for three aspects of care, including involvement in treatment and given the name of the specialist nurse. It was in the top 20% for six aspects, including dignity and respect and staff commitment to providing support and pain relief.

Competent staff

- Nursing and healthcare assistant staff reported good access to professional development and they said their managers encouraged them to attend training and develop skills. For example, one nurse said they had a secondment to train as an advanced practitioner, to develop the outreach team. A healthcare assistant was proud to report her role as an end of life champion.
- In addition, some healthcare assistants had trained as patient transfer assistants to support busy wards with a high rate of patient movement.
- Specialist nurses provided support and guidance to staff in disciplines such as chest pain, heart failure and arrhythmia.

- New nursing staff completed induction training which included education on pressure ulcers management, falls prevention and nutritional assessment. They said they felt well supported and their induction training included a period when they were supernumerary to the staffing numbers. They also had mentors.
- Student nurses gave positive feedback about the mentorship programme, except that two commented their mentor was not available as often as they would like. Students found it difficult to achieve sufficient time with stroke and renal mentors for their courses.
- We observed a staff nurse training a student nurse from the dialysis unit in how to administer a medicine to prevent blood clots, using a specific technique.
- The trust had not achieved its 90% target for annual staff appraisals. In January 2016, 87% of staff had received an appraisal, however this was lower within the medicine division, at 76%. Staff we spoke with said they were up to date with their appraisals and had found them useful. The trust aimed to review and relaunch the appraisal process in 2016/17.
- Senior nurses assessed competencies of registered nurses by working alongside them and raising issues that needed addressing at the time and reviewing patient records. They discussed competency assessments in the annual appraisal process.
- Of those staff required to complete training in intravenous medicine administration, 64% were up to date.
- Nurses in the renal dialysis service had university accredited renal nursing certificates, or were working towards this.
- Oncology staff said they received good training from the Dorset Cancer Network, with support from the nurse specialist. They were encouraged to gain university qualifications and also attend courses provided by the local hospices.
- The trust had not set up formal clinical supervision for staff below band 6, and supervision arrangements varied by ward. Oncology nurses said there was a good clinical supervision programme for their department and the palliative care team offered a reflective group session each week.
- Nursing staff had received information and guidance on revalidation and felt they understood what they needed to do for revalidation.

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- Junior doctors said they received two hours of training each week, although one junior doctor reporting missing these for three weeks due to lack of cover. They said they felt comfortable seeking advice and guidance from consultants.
- The Foundation School visit in January 2015 reported a supportive culture for foundation trainees, with enthusiastic and engaged educational supervisors.
- Allied health professionals in different disciplines said they had access to support, training and professional development. They commented on their involvement in different initiatives to improve patient care.

Multidisciplinary working

- Staff told us multidisciplinary team (MDT) working across the division was well developed with staff from different disciplines supporting each other to coordinate patient care and treatment. Patient records showed that care planning for patients with complex needs included assessments by different professionals.
- Wards had 'board rounds', where staff planned further care or discharge arrangements for each patient on the ward. During weekdays these involved consultants, therapists, a social worker and the sister in charge. Board rounds took place each weekday on Ilchester integrated assessment unit and three times a week on the elderly care wards.
- There was a shortage of therapists, which meant there was a lack of flexibility for staff to cover for leave or sickness and risked delays in patient discharges. The trust was aware of the issue and this was on the risk register.
- The shortfall in speech and language therapists meant medical patients did not receive a consistent level of support and therapists could not deliver much dysphagia training.
- A shortage of physiotherapists meant they could not provide consistent ward cover and support patients with their rehabilitation and recovery. There were two trained physiotherapists and one physiotherapy assistant to cover critical care, medical wards and surgical wards. There was one physiotherapy vacancy for the team. Physiotherapy staff felt they could manage, but there was a lack of staff to provide cover across the hospital, for example to cover staff leave or sickness.
- Occupational therapists had monitored the number of requested versus delivered interventions in the 52-week period to October 2015. The results showed they were

unable to provide 265 interventions on Hinton (respiratory) ward and they missed 192, 176 and 100 interventions on Barnes (elderly care), Day Lewis (elderly care) and Fortuneswell (oncology) wards, respectively, during this period.

- All services held MDTs. The renal department held monthly MDTs, involving medical and nursing staff, dieticians, and therapists. Staff discussed incidents, mortality, audits, individual patients, service issues and equipment. Staff said the MDTs were well attending and useful in coordinating care.
- Barnes elderly care wards held two MDT meeting each week, and Day Lewis elderly care ward three. These involved the ward sister, representatives from palliative care and social services, therapists and a consultant. The service no longer received services from an older-adult psychiatry liaison nurse, which meant patients were referred to consultant psychiatrist and waited longer for psychiatric reviews.
- Oncology services held video conferences with oncology consultants in Poole and Bournemouth. There was not an oncologist on site each day, but the haematology consultant provided cover.
- Pharmacist and pharmacy technician visited wards each weekday but were not usually part of the MDT meetings.
- Staff reported the procedures for discharging patients were complicated and slow. This was particularly when they worked with social service departments outside the county to transfer patients out of Dorset.
- The discharge team worked closely with each ward to assist with patients leaving the hospital. The trust employed patient transfer assistants who liaised with staff on the busiest to help patients with the discharge process.
- Medical services had fortnightly capacity meetings with other hospitals where they had integrated treatment pathways, such as cancer pathways. These meetings provided opportunities to discuss improving the timeliness and quality of treatments pathways.

Seven-day services

- Two full time acute medical consultants covered the Ilchester IAU ward on weekdays and weekends on call. Consultants visited the ward each day and until 3pm on weekends.
- Specialist oncology doctors were based at other acute NHS hospitals. Their patients came under the care of the

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respiratory or haematology consultant and nurse specialists. Staff said there was good access to specialist advice and the oncology consultants visited the wards when they were on site for outpatient clinics.

- The endoscopy service operated weekdays, with an out of hours on call nurse-led service for gastrointestinal bleeds. The service planned to add evening and alternative Saturday sessions.
- The Moreton (gastroenterology/endocrine) ward had seven-day consultant cover, and a diabetic nurse specialist working five days a week.
- The elderly care consultant visited the Evershot (temporary step-down) ward three times a week, and the hospital at home service daily. Acute hospital at home service maintained support for patients until they were ready for discharge to the community nursing teams.
- The hospital@home service provided support for patients in the community seven days a week.
- An out of hours physiotherapy service was available at weekends but not on week days. At weekends, physiotherapists provided part time cover, and prioritised critical care and the acutely unwell patients on wards. There was trust-wide consultation to develop seven-day working for therapy teams, by reconfiguring the service and recruiting staff.
- The hospital's critical outreach team worked 8am to 8pm. Staff said they could access medical support at night via the fast bleep system.
- The trust was developing the hospital at night service, with staff training in progress to relaunch the service in June 2016.
- The renal dialysis units operated 7am until 11pm or 12pm Monday to Saturday. These were nurse-led units with medical oversight.
- A pharmacist and pharmacy technician visited wards each weekday to check patients' medicines history and review prescription charts. The pharmacy opened Monday to Friday 8.30am–5.30pm, on Saturdays 9.30am–2.30pm and on Sundays and bank holidays 10am–2pm. There was an on-call pharmacist available 24/7 for emergencies outside these times.
- The diagnostic imaging department provided a 24/7 on call service for CT and ultrasound scans. Staff carried out CT and MRI scanning 8am–8pm Monday to Friday and Saturday morning services for elective patients. There was a sonographer/radiologist on call to deliver a carotid scanning service on Saturdays and Sundays.

Access to information

- Staff said patient records were accessible. Some commented that when ward clerks were not on duty, there could be a delay in completing discharge letters to GPs and filing records off the ward.
- There was a backlog in writing discharge letters to GPs for some specialties. This was a particular issue for cardiology patients, but primarily for outpatients, where the backlog had been as much as nine weeks in October 2015. This meant the hospital did not always share patient information promptly. The trust was aware of the situation, had implemented some short-term solutions and included this on the risk register.
- Staff reported that the lack of standardisation of documentation made it difficult to record and find information quickly. There was a project group to improve documentation and the trust aimed to develop a simplified computer record system to improve access to information.
- Nurses handed over patient information details when they transferred patients to different wards. They updated handover sheets when they admitted new patients onto wards.
- The trust had direct access to electronic information held by community services, including GPs. This meant that staff could access up-to-date information about patients, for example, details of their current medicines.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff asked patients for their consent before providing care or treatment. The inpatient assessment form prompted staff to carry out mental capacity assessments if they felt patients might not have the capacity to make decisions or provide informed consent. Medical staff or occupational therapists carried out the assessments.
- Staff understood their roles and responsibilities regarding the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS). They had access to advice and had completed training on MCA and DoLS. The trust had introduced two levels of MCA training, with level 1 for all staff and volunteers and Level 2 for health professionals. Compliance with level 2 training was 79%.
- We reviewed a range of patient records on different wards and they included evidence of informed consent.

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Where appropriate, staff had completed MCAs and DoLS referrals. Ward sisters highlighted those patients with a DoLS in the ward safety brief and the handover forms made reference any DoLS due to expire or required renewal.

- A trust audit showed a high level of compliance with DoLS documentation, and any shortfalls were shared with the ward sister to rectify.

Are medical care services caring?

Good



By caring, we mean that staff involve and treat patients with compassion, kindness, dignity and respect.

We rated caring as good because:

- Patients and their relatives were positive about the caring attitude of staff, their kindness and their compassion. They said staff treated them with dignity and respect
- Patient surveys showed that staff were caring and protected people's privacy and dignity. The hospital's 'patient-led assessment of the care environment' (PLACE) audit score for privacy and dignity was 92%, above the national average of 86%. The Friends and Family results showed 96%-99% of patients recommended medical services at the hospital.
- Patients said they felt involved in their treatment, understood their treatment plans and able to make their own decisions. They also said staff helped them emotionally with their care. Renal patients were particularly complimentary about the caring attitude of staff.

However,

- We observed a nursing handover on Day Lewis ward, which lacked respect towards patients' privacy and dignity.

Compassionate care

- We received a range of positive feedback about the caring attitude of staff and their skills in communicating

with patients. People said the staff were attentive, friendly and kind. One visitor told us, "The staff are fantastic," saying their relative was "treated with compassion and kindness".

- Patients said staff aimed to maintain confidentiality and spoke to people using discretion. We observed staff closed curtains during ward rounds to give some privacy for discussions. One patient commented they had overheard confidential conversations held in the bay, as curtains could not provide enough privacy, but they recognised this was a difficult issue to resolve.
- Almost all patients said staff treated them with dignity and respect. They said staff introduced themselves and were courteous and closed curtains around patient beds before carrying out personal care.
- Patients who regularly attended for dialysis were particularly positive about the attitude, warmth and kindness of staff. Staff knew their patients well and they had clearly built up a good rapport.
- The hospital's 'patient-led assessment of the care environment' (PLACE) audit in April 2015 showed the hospital performed above the national average for privacy and dignity, scoring 92% against the national average of 86%.
- Friends and Family Test (FFT) results for the trust showed the hospital had a higher percentage response rate (38.7%) than the national rate (33.7%) for the period July 2014 to June 2015. Results by ward showed the highest response rates were from patients on the Barnes elderly care ward and the cardiology unit. The wards with the most consistently positive feedback were the cardiology unit, the stroke unit, the Prince of Wales (renal) ward and the Hinton (respiratory) ward.
- FFT results for the seven months to October 2015 showed the rate of response varied between 36% and 42% for medical inpatients. The percentage of inpatients that recommended the service was high, and varied between 96.4% and 99.6%.

Understanding and involvement of patients and those close to them

- Renal dialysis patients said they understood their options about where to have their treatment and staff always answered any queries. Some were particularly pleased they could view their tests results on line.
- The dialysis service offered a home dialysis service to a few patients who were suitable. One patient told us they received excellent guidance, support and training to

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prepare for home dialysis, in a way that built their confidence. They were complimentary about the approach taken to make sure they understood each step of the process and developed their skills gradually.

- A new dialysis patient was grateful for having had the opportunity to speak with other patients before starting their treatment. They also said they had been involved in choosing the times for their dialysis, to fit in with family commitments. Another patient said staff had helped them rearrange sessions to allow them to be at family celebrations.
- We observed a consultant ward round in the coronary care unit where staff involved patients in discussions about their care. Staff explained procedures and medicines and listened to patients' questions.
- Patients told us they were involved in their care, with one person commenting, "The doctor introduced himself and explained in detail, in layman's terms, what he was doing". They said this had helped reassure them. Another patient said they were kept informed and able to make their own decisions about their care and treatment.
- One patient said they would have liked the doctor to write things down for them, as they tended to forget things and this would have made it easier for them.
- We observed a nursing handover on Day Lewis ward where staff discussed each patient's needs at the end of their bed. However, they did not always actively include the patient in discussions about their care and treatment. This meant staff discussed issues of a personal or confidential nature between each other, in front of the patient, potentially within hearing of other patients.

Emotional support

- Dialysis patients were grateful for the emotional support provided by the renal social worker and specialist nurses. Some commented particularly on the value of having the satellite service in Bournemouth as it meant it was closer to their home and family. They also felt staff went the extra mile in supporting them when they used the holiday dialysis unit.
- We observed dialysis unit staff spoke with patients and relatives in a sensitive way, to help reassure them, particularly if they were new to the service. The renal unit also had access to psychologist.

- A counsellor visited patients on the oncology ward twice a week and staff said that chaplaincy support was excellent.
- One patient, who had been on four different wards within the past year, said that at each admission, staff had put them at ease and provided them with a safe, reassuring environment. They were particularly grateful for this as it had helped them psychologically as well as physically.
- Staff discussed patient care in a sensitive way. At handover meetings, it was evident that staff considered patients' wellbeing, including their emotional needs, when discussing their care and treatment. This included helping patients prepare for their discharge from hospital.

Are medical care services responsive?

Good



By responsive, we mean that services are organised so that they meet people's needs

We rated responsive as good because:

- The medical services leadership team planned services to meet the needs of the local population, in coordination with other health and social care services. This recognised the local geography, population and neighbouring services. For example, renal patients could access dialysis services in satellite units and patients with respiratory problems had access to the Dorset adult integrated respiratory service (DAIRS). This was a small outreach service that coordinated care between the hospital and patients' own homes.
- There were services to improve the access and flow of patients through the hospital, to promote shorter lengths of stay. For example, the hospital@home service helped reduce patients' lengths of stay and helped them receive short-term nursing care at home. The Evershot ward provided a step down ward for medically fit patients waiting for care packages before staff could discharge them.
- Ward staff and the discharge team started to consider and plan patient discharges from the date of admission. The trust worked with partners to improve the coordination of patient discharges and transfers to remove barriers to delays where possible.

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- Staff tried to resolve patients' concerns before they became complaints. They took complaints seriously and made changes in response to patient feedback. Complaints were managed in a timely way.
- Patients received information leaflets about their treatment. Dialysis patients commented on the personalised approach to care and treatment and appreciated written guidance for reference.
- Staff understood how to provide support to vulnerable people, including those living with a dementia or a learning disability or difficulty.

However,

- The average bed occupancy on medical wards was 95.8%, above the England average of 88%. This was above the 85% level, at which bed occupancy can start to affect the quality of care provided to patients. The number of patients placed on wards other than those particular to their needs, had increased, as the hospital was on red alert. This meant there was a risk their specific care and treatment could suffer.
- Bed pressures meant that bed management tended to be reactive. The average lengths of stay for medical patients were lower than the England average, but had increased in December 2015. Audit results showed 10% of patients experienced delays in their transfer of care to community hospitals. The main causes were delays in arranging social care packaging and a lack of reablement schemes.
- The ambulatory care service had ceased, to provide additional inpatient beds. Some patients might not have received the most efficient care and treatment.
- We were told patient transport was a common cause of complaint, particularly for homeward transport.
- There was no specialist liaison nurse for learning disabilities.

Service planning and delivery to meet the needs of local people

- The strategic direction of some services was open to review at the time of the inspection because of the Dorset Clinical Commissioning Review. This countywide review was set up to respond to the increase in proportion of elderly patients with complex health needs and to improve the efficiency and quality of care.
- Medical services already provided some services in partnership with neighbouring acute and community

health services. The medicine divisional service strategy (2015-2018) emphasised the importance of improving collaborative working with partners in health and social care, to develop more integrated care pathways.

- The trust had implemented some initiatives to support the needs of people locally. These included the renal home dialysis service, satellite renal dialysis units outside of Dorchester, the hospital@home service and an outreach respiratory service. The trust planned to extend its cancer services to improve services to patients in Dorchester and West Dorset.
- The trust provided a regional renal service and delivered dialysis and outpatient clinics at satellite units in Poole, Bournemouth and Yeovil. It worked in partnership with specialist transplant and surgical hospitals outside the county. It also offered home dialysis for patients assessed as suitable and trained for this service. In addition, staff supported patients to receive holiday dialysis. To meet demands for dialysis the service also contracted services from the private sector.
- The hospital@home service was set up for medically fit patients who could return home with short-term nursing care. A dedicated team of staff supported patients at home who otherwise would need to stay in hospital longer for routine nursing care. Staff assessed patients on the wards to make sure they were suitable for this service.
- The Dorset adult integrated respiratory service (DAIRS) was a small outreach service that helped patients with respiratory problems by coordinating their care between the hospital and their homes. The team provided home follow-ups and linked patients with local community services. Staff felt the service was too small to have a significant impact, particularly given the size of the geographical area covered.
- For cancer patients, the trust worked in partnership with nearby acute hospitals and planned to build a radiotherapy facility within Dorchester hospital. This was so patients could receive this treatment locally instead of travelling to Poole.
- Medical services provided a medical day unit, with four chairs for patients requiring regular treatment, such as blood transfusions.
- There were not toilet facilities in side rooms for patients on Moreton (gastroenterology) ward. Patients used the toilets in the ward bathrooms. This meant patient dignity could be compromised if they were severely unwell.

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Access and flow

- The average lengths of stay for medical patients were better than the England average, in almost all specialties. It was slightly higher for non-elective geriatric medicine and gastroenterology.
- The average bed occupancy on medical wards for the four months November 2015 to February 2016 was 95.8%. This was above the England average of 88% and the 85% level, at which bed occupancy can start to affect the quality of care provided to patients.
- The site management team provided a 24/7 service to support access and flow through the hospital, using an electronic tool. This helped them monitor and plan patient movements and estimated discharge dates. Site managers and the hospital discharge team worked collaboratively to maintain access and flow, with senior manager involvement when necessary. As well as daily (and sometimes more frequent) ward based bed meetings, the hospital held weekly discharge meetings to discuss patients with particularly complex discharge requirements. This helped improve the planning and management of patient discharges.
- The trust had set up different initiatives, with executive leadership, to improve patient flow. It had recently created a control centre, with social services' input, to develop longer-term solutions to delays in discharges.
- Site managers, matrons, the discharge team and social services attended site management meetings where they discussed patient discharge dates and matched staffing needs to wards. We observed that ward staff discussed planned and estimated discharge dates for patients and shared updated information with the site management team. Staff started to plan patient's estimated discharge date from admission.
- Bed pressures meant that bed management tended to be reactive. The trust reported a significant increase in emergency admissions in December 2015 and the average length of stay in hospital increased. They identified that 10% of patients experienced delays in their transfer of care to another provider. This issue was on the departmental risk register.
- During our inspection, the hospital was on red escalation status, due to the increased demands for its services. A trust audit showed this was due to delays in arranging social care packaging and a lack of reablement schemes. For example, 31 patients waited for social care packages and reablement, and 32 patients waited for community hospital transfers. Eleven patients waited for continuing healthcare placements. Some elderly care patients were sometimes on the ward for up to a month when they were medically fit, which put them at risk of developing further health complications. A trust senior manager estimated the hospital experienced an average of 30 delayed transfers at any one time.
- Where possible, wards had opened additional beds to increase capacity. For example, the Fortuneswell (oncology) ward had three winter pressure beds. Moreton (gastro/endocrine) ward had 25 beds, having opened two extra for winter pressures. The Prince of Wales (renal) ward opened two additional bays normally used for day case patients.
- The trust opened the Evershot (step down) ward in February 2016 to support medically fit patients with short-term rehabilitation and reablement. The ward had 10 beds for patients from surgical and orthopaedic wards, as well as medical wards, who stayed for two to three days while services organised their discharge package. This initiative created beds on specialist wards to support patient flow.
- The hospital@home service supported about 30-40 patients a week and the service helped free up beds for unwell patients on wards, creating approximately nine additional beds each day.
- The DAIRS service, although limited in size, was effective in reducing the length of admission for their patients by about five days.
- The trust used a bed management tool to monitor patient moves and aimed to move patients no more than three times during their admission. Results for the 12 months to November 2015 showed 48.7% of patients experienced no moves, 40.4% one bed move and 8.5% two bed moves. However, staff did not formally capture moves out of hours. They aimed to avoid patient moves after 10pm.
- However, patient transfers from the IAU often occurred at night, which was not in the best interests of patients, particularly those living with dementia or with a learning difficulty. For example, on one night in March 2016, there were 17 transfers from the ward between 8pm and 3am. Three patients we spoke with commented on the number of times they had moved beds. Two said they had moved at night which had been disruptive to them and other patients in the bay.

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- Hospital data showed they discharged 5.3% of patients at night between July 2015 and September 2015. This was higher than the target of 4.3%. The percentage reduced to 2.7% in the following quarter (October 2015 – December 2015) and the hospital had an action plan to improve safe discharges.
- The Ilchester (IAU) received patients directly from GPs, clinics or the emergency department. Patients admitted onto the IAU usually stayed on the ward for up to 48 hours. However, due to a shortage of suitable beds for them on inpatient wards they sometimes stayed longer. When we visited, three patients on the 31-bedded ward had been on the unit longer than 48 hours. This sometimes prevented newly admitted patients from being assessed on the IAU and meant they were transferred directly to wards. Medical staff from the IAU then monitored them as outliers on the other wards. Staff said there were often between two and seven patients to monitor in this way.
- Occasionally, when the IAU was full, staff said patients went to the emergency department instead, which was an inefficient use of beds and resources.
- The number of outliers on wards varied. Results from August 2015 to November 2015 showed the stroke unit had an increasing number of outliers, with 41 patients in November 2015, equating to 129 bed days. Hinton (renal) ward also had a high number of outliers. When we visited the Prince of Wales (renal) ward it had nine outlier patients, but this was unusual.
- To maintain flow, most wards had outlier patients, both medical and surgical. Prince of Wales renal ward had 13 beds, nine of which were occupied by medical outliers. Staff on Maude Alexander (cardiology) ward reported they usually had some outlier patients, which sometimes meant their patients were located on other wards.
- The trust had a ward 'buddy' system to link surgical and medical wards and they aimed to place outlier patients on a buddy ward when possible. Staff said this helped organise outlier allocations and improve patient care. It was not always possible to follow this process if the demand for beds was high.
- There had been one mixed sex breach in the past year, when a patient was admitted to the coronary care unit due to bed pressures. This was a mixed sex ward for acute care but this patient did not need acute care.
- Systems had been set up to improve the use of the discharge lounge, with staff from the discharge lounge actively supporting wards to transfer patients. The discharge lounge opened between 8.30am and 6pm each day and two part-time 'floating' patient transfer assistants helped the busier wards such as the IAU with discharge arrangements.
- On Day Lewis (elderly care) ward, some beds were allocated as older patient assessment beds. These were allocated beds in the two bays most easily viewed by staff from the nursing station. However, because of bed pressures when we visited, these were not collocated in one place in the ward which reduced efficiency. The unit did not have the support of a dedicated allied health professionals, such as physiotherapists and dieticians, to complete assessments promptly and make best use of this initiative.
- Staff reported other factors that hindered patient flow. For example, they attributed some delays to a lack of staff. The shortage of therapists dedicated to services meant discharges were sometimes delayed, for example, from the Fortuneswell cancer ward. Ward clerks provided a centralised service. Staff on some wards said it was difficult to manage queries and discharge paperwork efficiently on the day when they did not have an allocated ward clerk. There had been breaches in the six-week diagnostic time in endoscopy causing delays to patient treatment. A range of staffing issues had caused this and the service had taken action to clear the backlog. They achieved this through recruitment, weekend working and the use of an endoscopy agency.
- The older-adult psychiatry liaison nurse had been assigned a different role which meant patients had to wait longer for psychiatric reviews, via a referral to the consultant psychiatrist.
- Staff also commented that preparing medicines for patients to take home delayed discharged. They were aware of a project group to improve the speed of medicine dispensing.
- Staff also reported concerns with the timeliness of patient transport. Staff from various wards described the patient transport service as 'unreliable', although they were aware that managers were working to make improvements. This had a particular impact on the renal dialysis service and staff reported spending unnecessary amounts of time liaising with the transport service. They said patients often waited for long periods and the transport service affected patient wellbeing and sometimes safety. For example, a diabetic patient's

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journey home from the unit took 90 minutes, when it should have taken 30 minutes. The patient developed a very low blood sugar level which could have been harmful.

Meeting people's individual needs

- Staff in medical services provided person-centred care that reflected individual patient needs.
- Renal dialysis patients said they received a range of guidance documents to help them understand their care. These included leaflets about renal dialysis and how to minimise the risks of infections. They also provided guidance on holiday dialysis locations and contact details for patient groups. These materials were available in different formats and staff could provide them in another language or on audiotape. Staff also set up education evenings for patients and relatives.
- The dialysis services used a secure website to put patient blood test results online, so patients could view their own results remotely. Staff also trained patients suitable for home dialysis. The suitability assessment included an environmental assessment of the patient's home and the service provided and managed the necessary dialysis equipment.
- Learning disability link staff on the dialysis unit supported a patient living with a learning disability and adjusted their plan care to help them access the unit. The Day Lewis (elderly care) ward also had a learning disability champion, who was supported in their role by the trust safeguarding lead.
- Staff showed an understanding of how to care for patients living with a learning difficulty or disability. For example, we spoke with staff on the Prince of Wales (renal) ward, Moreton (respiratory) ward and Fortuneswell (oncology) ward who described how they had made adjustments to support patients living with a learning difficulty.
- The electronic patient administration system identified patients with a learning disability, to help staff prepare for their admission to the ward. Some staff spoke of the care passport and learning disability assessment form. The trust introduced the assessment form in June 2015 and a recent audit showed it was used effectively.
- However, the trust did not employ a designated learning disability liaison nurse to provide expert knowledge, liaison with families and staff training. Some staff had volunteered to be learning disability champions, to take lead in their department for improving the care for patients living with a learning disability.
- The DCH dialysis unit had a range of entertainments for patients to use during their dialysis, much of which they had bought using donations from local charities. For example, there were televisions for each dialysis chair, patients could use the free Wi-Fi and the unit offered a range of books and DVDs. In addition, the hospitals providing dialysis created accessible parking bays so patients could park close to the units.
- Patients on the elderly care wards could use the 'memory lane room' on Barnes ward, which had with a range of reminiscence items and had facilities for cooking as well as a television and DVDs. However, the room was only open to patients three days a week and activity coordinators only worked on weekdays.
- The trust had appointed dementia champions on some wards, such as the dialysis unit and in the discharge lounge. However, there was no dementia specialist nurse. Improving care for people living dementia was a trust priority, and the management planned further work. Some patients living with dementia had 'This is Me' booklets, particularly if they were admitted from a care home. One relative told us they had been pleased to complete one of these for the partner living with dementia, to help staff give care in the way they wished.
- We attended four handover meetings and observed staff had a good understanding of patient's specific needs, risks and preferences. For example, staff knew which patients had a limited knowledge of English and how to support their communication needs.
- The Fortuneswell oncology ward had a quiet room for patients and their visitors as well as a garden. Patients could seek support from the oncology helpline, which was available outside normal working hours, manned by ward staff.
- Staff recognised people's religious and cultural differences. They explained how they had respected the views of a Jehovah's Witness explaining treatment options and risks. The trust employed chaplaincy services, which provided 24/7 on call support. It also had contacts with all major faith leaders in the area.
- The trust had access to telephone, face to face and sign language interpreters. It could also offer patients written, large print, Braille and audio translations.

Medical care (including older people's care)

Learning from complaints and concerns

- In the seven months to November 2015, medical services received 151 complaints, including formal and informal complaints.
- The trust board felt they provided good quality responses to complaints and complainants rarely took their complaints to a second stage, requesting intervention from the Parliamentary and Health Service Ombudsman. The executive team recognised they should identify learning points from complaints more effectively, and addressed this.
- The trust recorded the time taken to respond to complaints and had targets to respond to simple complaints within 20 days and within 25 days for more complex ones. It aimed to change this to agreeing the response time with the complainant, rather than following set timeframes. All complainants received a personal telephone call from the relevant manager as well as a short letter. Complainants received a formal response if they wished and a meeting with a senior manager to discuss their concerns.
- Staff said they tried to resolve patients' queries and concerns before they became a cause for complaint. Ward managers for example tried to speak to each patient daily.
- One senior nurse said they had changed the rotas in response to a complaint relating to a lack of time to eat meals. They ensured healthcare assistants were available to help patients at mealtimes.
- We observed ward notice boards displayed "you said/ we did" feedback. For example, there was some negative feedback on the IAU ward about phone calls not being answered. The response given was the hospital had updated the telephone directory to ensure phone calls were directed appropriately and staff had been reminded to answer calls promptly.
- Staff discussed complaints and themes at divisional governance meetings and departmental meetings.
- Staff reported that patient transport was a consistent cause of complaint, in particular from dialysis patients.

Are medical care services well-led?

Good



By well led, we mean that the leadership, management and governance of the organisation assures the delivery of high quality person-centred care, supports learning and innovation and promotes an open and fair culture.

We rated well led as good because:

- Medical services had developed strategies with clear objectives to develop staff and services in collaboration with other stakeholders in health and social care.
- There was a governance framework for the services, although the leadership team recognised this needed improvement. Staff reported on service quality, safety and performance each month, and used this information improve services.
- Services participated in audit programmes and the clinical governance team had oversight of audit, performance, risks, quality and finance. This enabled them to provide challenge and support decision making in developing services.
- Staff used different ways to gather patient feedback, including 'experience based design' surveys to find out how people felt about their care and treatment.
- Staff said the leadership team were supportive and there was good visibility from the executive team. They said they would feel confident to raise concerns if they felt a need.
- Staff felt the trust was good at recognising staff contributions. Many of the wards displayed recognition awards for teams and individual staff.
- The division had a variety of projects to improve services. For example, there was a business case to increase dialysis capacity and to refurbish the units. The oncology service planned redesign of their unit to include radiotherapy facilities and offered a community outreach service integrated with community services.
- Service staff worked innovatively to promote health and social care services for patients in the community. Staff from the oncology team had set up a charity to encourage donations for the support of women undergoing treatment of gynaecological cancers.

Medical care (including older people's care)

However,

- Ward leaders did not always have protected time for management tasks as they also covered for staff absences.
- Wards did not have clerks each day to provide administration support.
- Risk registers did not include all risks and show evidence of mitigation and review. Services used new risk registers, to identify and mitigate service risks, but this was a new approach, not embedded in practice.

Vision and strategy for this service

- Trust leaders had published their vision which was to deliver compassionate and safe healthcare. The medical division's vision and mission, as outlined in their strategy for 2015-2018, was one where 'excellent, compassionate care is the norm'.
- The division had a relatively new management team. They had focused initially on staff training and appraisals to build staff confidence and stability and had plans to improve clinical governance arrangements.
- Their divisional strategy included specific divisional and specialty objectives. These related to service and staff developments and reflected national and local priorities. A key strand through all these was to improve collaborative working with other health and social care providers to deliver integrated services.
- Staff had been involved in developing the objectives and broadly understood the trust's vision and values. This was against a backdrop of the Dorset Clinical Commissioning Review, which was open for consultation at the time of the inspection.
- Ward managers displayed trust values in staff rooms. All staff were passionate about providing high quality compassionate and safe care.
- Some aspects of service planning appeared reactive. For example, staff did not know the plans for Evershot step down ward beyond March 2016, nor the future of the sepsis specialist service. Plans for the Yeovil dialysis unit were not agreed, yet the contract expired in March 2016. The need for inpatient beds had led to the closure of the ambulatory care service yet this service helped to reduce admissions.

Governance, risk management and quality measurement

- The trust recognised that improving governance was a priority and the governance framework was under external review at the time of the inspection.
- At divisional level, the medicine division comprised four directorates; general medicine, specialist medicine, elderly care and emergency services (not included in medical care report). A divisional manager and a divisional director led the division. There were four service managers and clinical leads for the division as well as clinical site managers and two matrons.
- The division's clinical governance committee, led by a clinical consultant, held bimonthly meetings and received papers from subcommittees. These included committees for clinical audit, infection prevention and control, safeguarding adults and children, learning from patients and NICE implementation.
- The clinical governance committee reported to the senior management team, responsible for operational performance, risk management and planning. The trust's finance and performance committee produced meeting reports each month, which included detailed summaries of activity against all national and local performance targets.
- Quality measures were included in the divisional monthly performance reports. These included narrative and data relating to key performance indicators and finance as well as brief governance summaries.
- The medical division's clinical governance group reported to the trust's integrated governance, Audit committee with exception reports. The divisional clinical governance committee met monthly to discuss assurances about quality and safety. Topics covered included incidents and complaints, infection control, audits, adherence to NICE guidance, workforce issues, complaints and patient feedback. The divisional leads had a good understanding of service performance and barriers to improvement. A range of projects were in place to promote improvement, for example to improve discharge arrangements and treatment pathways. The divisional governance committee captured key actions for named leads to report on within a stated timeframe. They also received the department's mortality and morbidity meeting minutes and escalated any learning.
- The medical directorates carried out monthly governance meetings, chaired by a clinical lead. These had a standard agenda, including incidents, complaints,

Medical care (including older people's care)

patient feedback. These meetings did not review current risks consistently, and the trust had identified this as an area for further development. Junior doctors reported a lack of involvement in clinical governance.

- The medical division had separate risk registers for each directorate and escalated red risks to the trust's risk register. These registers were relatively new and risks were not fully described. They were not consistently up to date with mitigations and actions and did not fully capture current risks. For example, the cardiac catheter laboratory was not operating when we visited, as equipment had broken. The equipment has broken down on various occasions in 2015, and each time had been out of service for 24-48 hours. This meant patients did not receive their diagnostic tests and treatments in a timely way. However, this risk had not been included on the service or divisional risk registers. The trust recognised they needed to clarify the use of risk registers.
- The divisional clinical governance team reviewed final incident investigation reports and presented them to the trust's risk management committee. Risk leads reviewed incidents at their weekly meetings and investigated incidents and near misses using the trust's significant incident process. The trust's scrutiny panel used the investigation reports to identify and share learning and recommendations.
- Medicine division's audit programme included national and local audits. The divisional clinical governance reports reported on results from audits and details of further actions required to improve outcomes for patients. Audit action plans were detailed, showing leads for each action point and deadlines for completion.
- The department's mortality and morbidity meeting minutes were structured and showed evidence of discussion and review. They were escalated to the divisional clinical governance meetings by exception.
- The trust arranged new, monthly multi professional clinical education sessions, with greater emphasis on clinical governance.

Leadership of service

- The medicine division aimed to offer strong clinical leadership and direction and improve staff stability. The division had created a new matron post, but there were still vacancies in the clinical leadership teams.

- Visibility of the executive team was generally good, with the chief executive visiting wards. The chief executive also emailed weekly news updates, which staff said were informative. Staff liked receiving updates on service developments as well as on incidents and patient feedback results. Managers also emailed staff with commendations on their performance or patient survey results, which staff appreciated. Staff consistently commented on the supportive leadership style and senior ward staff were also highly complimentary about their teams. Ward managers encouraged staff to attend training, gain skills and develop their own leadership skills. The dialysis unit staff said the matron and service manager visited daily and gave a high level of support.
- However, the ward leadership team was stretched. For example, one matron covered emergency services as well as the IAU. Ward sisters reported they often covered for staff shortages, which meant they lost the protected time for leadership tasks. They did not all have team meetings as it was hard to find the time for these.
- Ward managers developed their own styles of leadership. For example on Hinton (respiratory) ward, the nurse in charge role was rotated around all the trained nurses. This aimed to encourage all nursing staff to develop their leadership and decision-making skills and staff reported this worked well.
- Ward managers commented it was hard to arrange regular team meetings, and most had set up different ways of communicating messages to their staff. These included sending emails, using staff noticeboards to share messages and putting important memos into information folders. Team meetings had just been set up for the DCH dialysis unit, and staff reported this was useful.
- The trust offered leadership training to staff, which they accessed through the appraisal 'talent mapping' process.

Culture within the service

- Throughout the inspection, we observed a strong sense of collaboration and teamwork. Almost all staff said they liked working at the hospital, saying it was friendly and staff worked well together. They commented on the mutual support and good morale amongst staff in different teams. Descriptions they used were, "It's like a community here", "It's small enough that people know a lot of people and it inspires loyalty" and "I feel comfortable to approach people in trust headquarters".

Medical care (including older people's care)

- Staff said there was an open culture where they were prepared to ask questions. They said they felt comfortable raising concerns, although sometimes they felt there was no point if issues were not addressed, such as the process required obtaining approval for agency staff.
- Medical consultants commented they covered each other well, however that meant at times patients were not under the care of consultants with the relevant specialty. Junior doctors said they felt well supported and there was evidence of teaching on the wards.
- Staff were most proud of the quality of care they provided, their caring approach and the quality of the clinicians. Staff on the cardiology ward however commented on the lack of senior clinical cooperation.
- Sickness absence rates for the division fell during 2015 and were at 3.5% in September 2015, slightly higher than the sickness rate for the trust overall. Most months, the sickness absence rates were below the national average. Service managers monitored staff sickness each month and followed trust policy in providing support.

Public engagement

- The trust encouraged patients and their relatives to give feedback on their care using the NHS Friends and Family Test (FFT). The medicine division performance dashboard included monthly data on the percentage of inpatients who had completed the survey and the percentage who would recommend the service. This report also showed this as a trend. In addition, the service set up surveys and used complaints to gain feedback from patients.
- Wards also displayed feedback from patients, including any comments for improvement and the action they had taken in response.
- The oncology service had used an 'experience based design' tool to involve patients in improving the service. For example, they had set up focus groups where clinicians and breast cancer patients discussed ideas on how to improve patient experience. The service had used this to redesign the treatment pathway. Similarly, the hospital@home team used the same principles to survey 17 patients in July and August 2015. The audit lead reported the results in narrative and graphical format to highlight areas for improvement.
- The oncology service was the lead for patient experience within the Dorset Cancer Alliance and had

recruited a group of volunteers as patient advocates to help improve services. In June 2015, the Dorset lung cancer patient survey asked 26 patients over 30 questions about their experiences. The questions were about how they received the diagnosis and treatment and their feelings at each step of the pathway. Similarly, the upper GI cancer 'experience based design' survey in September 2015 focused on how patients and carers emotional experiences of care and treatment. The results gave a rich picture of how patients were affected by both positive and negative experiences.

- The dialysis service collected patient feedback patients on the education evenings to help design further sessions. Patient feedback had also supported the decision to increase capacity at the Dorchester unit, to offer additional twilight dialysis sessions.
- The national inpatient survey results, based on patient feedback between September 2014 and January 2015, showed patients at DCH rated their care about the same as patients at other hospitals.

Staff engagement

- Most staff said they felt included in the organisation of their service. However, they understood the trust was part of the Dorset Clinical Commissioning Review and waited to learn the outcome of this and how it affected their own service. Some had attended focus groups to develop the trust's values and staff had voted on the hospital logo.
- The trust had invited staff to share their ideas for improving services or reducing costs. The 'Bright ideas' campaign had led to a staff suggestion to cut costs.
- Staff felt the trust was good at recognising staff contributions. Many of the wards displayed recognition awards for teams and the staff, using an external scheme where patients recommend staff. There were nine such awards on display in the IAU, for example, and seven on Hinton (respiratory) ward.
- For almost all the questions in the NHS Staff Survey 2014 staff gave similar ratings to staff in other trusts. They rated one question below the national average, and that was for 'Fairness and effectiveness of procedures for reporting errors, near misses and incidents'. This had improved year on year since 2013. The trust had recently introduced a 'Risk Matters' monthly newsletter for staff.







Medical care (including older people's care)

- The trust had developed an action plan in response to the staff friends and family test for 2014/2015. Results showed a decrease in the percentage of staff who would recommend the trust as a place to work.

Innovation, improvement and sustainability

- The medicine division had a variety of project groups for service improvements. For example, there was a business case to increase dialysis capacity and to refurbish the units. The oncology service planned redesign of their unit to include radiotherapy facilities and offered a community outreach service integrated with community services.
- The trust led a project to improve both discharge procedures and discharge summary reports, to make them more timely and unified. An audit of patients discharged to care homes showed a high proportion could have been discharged to their own homes if the right support had been in place. The hospital had set up the hospital@home scheme and the temporary Evershot ward to support discharges to patient homes.
- Service staff worked innovatively to promote health and social care services for patients in the community. For example, they supported older people living alone at home with free Christmas lunches. Staff from the oncology team had set up a charity to encourage donations for the support of women undergoing treatment of gynaecological cancers.

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

Information about the service

Dorset County Hospital NHS Foundation Trust provides surgical services at Dorset County Hospital and Weymouth Community Hospital. Dorset County hospital is a major trauma unit and consequently carries out a significant amount of emergency surgery. In the period September 2014 to August 2015 19% of the surgical activity was emergency surgery, 14% was elective surgery and 66% day surgery. General surgery and trauma and orthopaedic surgery made up 60% of all surgical treatments carried out. The hospital also carried out ENT, maxillo- facial and breast surgery.

There were seven main operating theatres and two-day theatres located at Dorset County Hospital. An additional day surgery theatre is located at Weymouth Community Hospital.

We visited the surgical assessment unit and the four surgical wards, all theatre areas and the recovery area. We also visited the trust's day surgery theatre at Weymouth Community Hospital.

We spoke with 16 patients and relatives and 72 members of staff. These included nursing staff, healthcare assistants, ward clerks, junior and senior doctors, pharmacists, physiotherapists, occupational therapists, housekeeping staff, porters, volunteers and managers. We reviewed 18 care records. We observed care and treatment within the wards, departments and theatres.

Summary of findings

Surgery was rated as good because services were effective, caring, responsive and well led however some aspects of safety required improvement

We rated safe as requires improvement because:

Staff did not consistently complete the 'Five Steps to Safer Surgery' checklist to minimise the risk of patient harm. Patient records were not stored securely but in open trolleys, presenting a risk of breaching patient confidentiality. Mandatory training targets had variations of 50-100% compliance against the trust targets.

Staffing levels of registered nurses, particularly overnight left a poor contingency for absence. There was poor availability of therapy staff to support postoperative patients.

However, staff knew how to report incidents, and used the investigation of incidents and never events to share learning with colleagues. They were aware of their responsibilities under the Duty of Candour, adult safeguarding and used the safety thermometer data to inform patients, staff and visitors.

Patients received care and treatment based upon national guidance, standards and best practice recommendations. The surgical services were consultant led and delivered and there was good evidence of multidisciplinary team coordination to support patients. The surgical services participated in a

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number of national audits such as the Hip Fracture Database, where they had performed well. The trust had robust systems to monitor patient's nutrition and fluid balance. The patients told us that their pain levels were regularly assessed and they received adequate pain relief.

Staff treated patients with kindness and showed regard to their dignity and privacy. The trust's results of the Friends and Family Test showed a higher than average response rate. The surgical wards displayed 90-100% of people recommending the ward they had been a patient in. The patients described receiving good care, thoroughly explained and which they had been involved in any decisions relating to them.

The trust had developed services to support the needs of the patients', the daily single point of access multidisciplinary (MDT) meeting helped to provide a coordinated approach to complex patient discharges. The one stop breast clinic provided timely and accurate diagnosis for patients awaiting breast cancer diagnosis.

The trust had taken steps to improve the Refer to Treatment targets and the majority of the surgical specialties were only just below target. Cancellation of patients' operations was better than the England average.

Although the trust had a discharge lounge, there was no obvious drive for earlier discharges and poor usage of the discharge lounge by some of the wards caused the holding of post-operative patients in recovery, prolonging theatre lists. The lack of beds could also mean the opening up of the day case unit overnight and the admittance of orthopaedic patients into other surgical wards.

According to the surgical dashboard, surgery had failed to screen all emergency admissions over 75 years for dementia since April 2015 although of those screened 100% of patients were then appropriately assessed.

Staff were aware of the trust's strategy and vision; there was good engagement from staff that were passionate about improving services and providing a high quality service to patients. Most staff felt the leadership of the trust and within surgical services were visible and supportive. Staff told us they felt proud of their service,

the patients' outcomes and feedback and the response rates for the NHS staff survey was higher than national average Patients were encouraged to be engaged in changes to services, i.e. patient hip and knee pathways.

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Are surgery services safe?

Requires improvement



By safe, we mean that people are protected from abuse and avoidable harm.

We rated safe as requires improvement because:

- The trust electronic incident reporting system had not been adopted as per the trust's risk event policy throughout the surgical services. Some staff used a supplementary paper-based system, in addition to the incidents being recorded on the electronic system.
- Surgical teams were not fully compliant with the Five steps to Safer Surgery safety checklist, which minimises risks of patient harm.
- Patient records were stored on the wards in unsecured trolleys, presenting a risk to patient confidentiality.
- The surgical specialties had not met mandatory training targets, varying between 50-100% compliance.
- There was insufficient physiotherapy staffing for post-operative surgical patients due to the low numbers of therapists and the necessary prioritisation of ITU patients.
- The service did not always meet planned staffing levels; registered nurse numbers particularly overnight were low with a high risk that if there was sickness or absence there would not be enough registered nurses, particularly as one ward was being used for step down HDU or ITU patients.
- In general medicines management was good but some improvements were needed in storage of medicines in original packaging and consistent counter-signing of the controlled drugs register, in line with trust policy.

However,

- Most staff knew how to report incidents and to escalate appropriately. There was evidence of learning from incidents.
- Staff were aware of their responsibilities under the Duty of Candour.
- Staff used the safety thermometer data to publically share with patients, staff and visitors.
- Regularly serviced and maintained equipment was available for patients use.

- Staff were aware of safeguarding and their responsibilities.
- Staff followed infection prevention and control policies and procedures.

Incidents

- The trust reported 15 serious incidents from October 2014 to October 2015 within surgical services, of which one was a Never Event that occurred in June 2015. 'Never Events' are serious, largely preventable patient safety incidents, which should not occur if the available preventative measures have been implemented. The never event related to the application of an anaesthetic block to the wrong limb prior to the surgery. Detailed root cause analysis investigations were completed for serious incidents and never events which identified learning and any actions required to reduce the risk of similar occurrences happening. For example, following the recent never event in June 2015, lessons learned were identified as using a 'Stop Before you Block', the understanding of distractions, speaking of intention and marking of the site prior to a procedure being undertaken. An audit was to planned to ensure the implementation of the actions. The highest number of serious incidents reported were slips, trips or falls (a total of six) followed by pressure ulcers (a total of five).
- Staff reported incidents using an electronic reporting system. Most staff we spoke with knew how to report incidents using the electronic system. Staff who said they were not sure how to report incidents said they would cascade the incident to a more senior member of staff for them to report.
- The trust electronic incident reporting system was being used differently in the anaesthetic services with some staff using a supplementary paper-based system in addition to the electronic system. The trust risk event policy stated that all areas should use the electronic reporting tool, supplementary paper based steps are not mentioned as acceptable practice. While there was no evidence of a delay in reporting, if a different person enters the event into the electronic system potentially some details of cases may be lost.
- Staff who had reported incidents said they had received feedback. They could report examples of changes in practice and learning resulting from incidents. For example, in relation to patient falls, the trust had

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introduced a comprehensive falls risk assessment and staff discussed the care of patients identified as high risk of falls at the safety briefing that took place at the beginning of every new nursing shift.

- Monthly morbidity and mortality meetings were used to discuss incidents. The minutes of these meetings summarised any trends and actions taken locally. This ensured there were opportunities for shared learning from these incidents, across surgical wards and theatres. The minutes were available for staff who were unable to attend the meeting.
- Each clinical speciality had morbidity and mortality meetings in which they reviewed morbidity and mortality issues. Records from the meetings indicated clinical leads discussed the causal factors for unexpected deaths and learning was shared and acted upon.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person.
- Nursing, therapy and medical staff across the surgical services we visited were familiar with the requirements of the Duty of Candour legislation. All staff who we spoke with understood the principles of openness and transparency that the Duty of Candour encompasses. Staff were aware of the importance of investigating incidents and potential mistakes and that the Duty of Candour now made meeting the patient/family and sharing the findings of investigations a legal requirement.

Safety thermometer

- The trust monitored its safety performance through use of the safety thermometer. The safety thermometer provides a monthly snapshot audit of the prevalence of avoidable harms that occur including pressure ulcers, falls, venous thromboembolism (VTE) and catheter related urinary tract infections (UTI). Also included is the percentage of patients receiving harm free care.
- The wards displayed safety thermometer information at the entrance to the ward, so patients and staff could see the figures for the previous month.
- The safety thermometer data for surgical services showed 12 pressure ulcers (grade 2-4), three falls and four catheter related urinary tract infections (September

2014- September 2015). The prevalence rates for pressure ulcers were highest in between March 2015 and May 2015, but the results did not indicate any particular trend.

- Ward sisters explained the actions they took to minimise the risk of avoidable harms. They monitored the use of and completion of risk assessments and fluid charts. Where they found issues relating to care they raised them with staff directly. They also used the morning and evening safety brief to reinforce messages relating to patient safety.

Cleanliness, infection control and hygiene

- From August 2014 – August 2015 there had been no cases of Methicillin Resistant Staphylococcus Aureus (MRSA) and 22 cases of Clostridium difficile (C-Diff) for the trust. Surgical services only had one lapse of care for C-Diff.
- Audits of surgical site infections (SSI) within the Public Health England for knee replacement surgery report showed Dorset County Hospital having a downward trend in SSI incidents since the end of 2014 until Dec 2015. The data showed SSI rate for these cases were similar to the national average (July-September 2015).
- The clinical environments and communal areas we viewed were visibly clean and tidy. These included patient bed spaces and the individual rooms, corridors and equipment.
- The areas we visited had cleaning schedules and infection prevention measures in place, such as infection prevention and control guidance. There were hand-cleansing facilities, including hand sanitisers, at the entrance to all wards and departments and at the entrance to all patient accommodation areas. We observed staff adhered to the infection control policies, including 'bare below the elbows', hand hygiene and appropriate use of personal protective equipment, such as disposable aprons and gloves and masks and discarding them between each patient contact. There was information displayed advising visitors about hand hygiene.
- At Weymouth Day Surgery Unit, we observed patients walking into the Weymouth Day Surgery Theatre in outdoor shoes, potentially creating a risk of spreading infection. On the day we visited there was no floor cleaning taking place in-between patients to minimise any potential cross infection. The trust later told us that individual patient risk assessments were carried out

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prior to the patients walking into the theatre or being wheeled in. Consideration for the use of over shoes was given depending on the patients' risk of slipping or falling.

- Staff completed monthly hand hygiene audits. The results of these audits showed that the compliance of theatre staff with hand washing techniques varied from 93% to 100% (January 2015 to December 2015). The compliance of ward staff with hand washing techniques varied from 60% to 70% as of September 2015. Where improvements were identified by the audits, action plans were developed and implemented to address the areas. For example, all bed spaces now had alcohol hand rub available at point of care.
- During our announced inspection, one of the patient bays in the Ridgeway ward was closed, due to infection control issue. The infection control team was overseeing this area. Outside the affected ward and the bay, the ward staff had displayed clear signs alerting patients, visitors and staff entering the area to the risks.
- Staff followed the MRSA screening protocol which meant that routine Day Surgery patients were not screened for MRSA. We were informed that unplanned post-operative admissions of these patients could leave elective orthopaedic patients vulnerable to infection, as unscreened MRSA positive patients could be admitted to the same bay. Staff mitigated the risk by admitting unscreened orthopaedic patients to alternative wards to protect the elective patients from potential infection, but this left orthopaedic cases in wards unfamiliar with their care.
- Nursing and therapy staff expressed concerns about accessing staff uniform. Staff had waited for several months to get their uniform. An example was given where a newly appointed member of staff had waited for more than two months to obtain their second set of uniform. This delay could have implications in the availability of clean uniforms required to reduce the risk of cross contamination.

Environment and equipment

- Staff told us there was sufficient stock of well-maintained equipment for them to care for patients.

- Staff reported good access to equipment including beds and mattresses to support patients at risk of developing pressure ulcers, and mobility equipment. Equipment such as commodes, bedpans and urinals were readily available on the wards we visited.
- Waste management on the wards was seen to be effective and well segregated, sharps boxes were properly assembled and clear waste streams were identified for waste bins.
- Each ward and clinical area had sufficient moving and handling equipment to enable patients to be cared for safely.
- Regular equipment checks and maintenance took place. Clearly labelled equipment showed the date when the next service was due.
- Labels on equipment indicated safety testing was up to date.
- Staff completed and documented daily checks of resuscitation equipment. We reviewed the records for the checks on wards and theatre departments and found these completed and signed daily. The equipment was stored in an accessible trolley. This was not tamper evident, meaning that equipment could be removed from the trolley at any time and staff would have no means of knowing this, outside of daily checks. This may affect a later emergency if the right equipment was then not available when required.
- Staff knew how to report faulty equipment and said the equipment maintenance team attended to faulty equipment promptly. Staff said that if required, timely replacements of equipment were available. This meant they had the equipment needed to provide safe care and treatment.
- Records evidenced that there were daily anaesthetic equipment checks and weekly changes of circuits. This met the Association of Anaesthetists of Great Britain and Ireland guidelines.
- Medical engineering department staff were able to electronically track all the equipment in the hospital including their service history and date for next service. Equipment maintenance records showed servicing and maintenance of equipment was planned and monitored. Equipment therefore was available and fit for purpose.
- The trust had clear procedure for ordering equipment for bariatric patients. Ward staff told us that they had good access to bariatric equipment.

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Medicines

- The wards and theatres generally managed medicines safely. Medicines, including controlled drugs, were stored securely on the wards and in theatres.
- We found two unidentified syringes containing drawn up medicines left unattended on the counter top within the treatment room on Lulworth ward. This was a concern, as it was not clear what was in the syringes or whom they were intended for. These were disposed when brought to the attention of the ward staff.
- There were a small number of medicines found loose in strips and ampules out of packets, which is a risk, as medicine names and expiry dates are not always clear on small strips.
- The resuscitation trolley contained medicine boxes which, although secure, could be accessed and removed, which could impact in case of an emergency. The trolley was not clearly tamper evident.
- There was a trust wide central monitoring system by pharmacy that continuously monitored the temperature of medicines fridges on all the wards and theatres to ensure medicines were stored at the correct temperature as recommended by the manufacturer. The pharmacy team took actions if the fridge temperature deviated from safe levels for medicine storage.
- Nursing staff could describe the procedure to follow for the issuing of and documentation required for controlled drugs (CD). The controlled drugs register in the wards had been mostly completed and signed as per hospital policy. Two entries in the controlled drugs register were not signed as witnessed on Lulworth ward over a two month period. The pharmacy department was aware of the issue and had commenced a rolled out a robust CD monthly audit for all wards and departments. The pharmacy department was actively improving systems and processes to audit and prevent similar occurrence in the future.
- Patients' prescription charts had known allergies clearly identified to reduce the risk of being given inappropriate medicines.
- There was a good system of electronic prescribing across the trust. Staff told us the support from the pharmacy service was good. Surgical wards had ward based pharmacist who were able to dispense certain medicines on the ward and thus facilitate discharges.
- Ward sisters were aware of medicine incidents, which happened on their wards and the learning they took from these incidents.
- Medicine administration and prescription charts clearly detailed the name of the patient, the dosage route of administration and the time that medicine needed to be given and when it was actually administered. Staff recorded reasons any medicines were not administered.
- Patients told us they were usually given their medicines on time. They also said that medicines were explained to them and they were told about risks associated with taking medicines.
- Nursing staff were observed giving patient's medicines only after the correct checks had been made. Nurses were observed being protected from interruptions whilst they undertake medicine rounds. Staff had good access to information about medicines.
- Staff adhered to the trust's microbiology protocols for the administration of antibiotics.

Records

- Records were in both paper and electronic format, and all healthcare professionals made their notes in the same document. We reviewed 18 patient records. Patient records were well maintained and completed with clear dates, times and designation of the person documenting. Records were legible with comprehensive and complete assessments, with associated action plans and dates.
- Storage of patient records on wards did not fully protect patients' confidential details. Staff stored records in open topped unlocked trolleys. Patient records were therefore potentially accessible to people who did not have a professional need to look at them. However, the ward staff kept the records trolleys in clear sight to ensure sure that they were not accessible to passing or through traffic.
- Medical records of patients reviewed, demonstrated surgical consultants and junior doctors reviewed them regularly; this included surgical patients treated on wards other than surgical wards (outliers).
- Staff carrying out operations completed the operating department records of care, which included the pre-operative checklist, peri-operative care details, and recovery observations. We reviewed the records for patients through their operation journey and saw accurately completed records.

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Safeguarding

- All staff we spoke with understood safeguarding and how they should report concerns. There were clear policies and procedures in place, which included working with external agencies. Ward staff could name the adult and child safeguarding leads to whom they could go for advice and support.
- Most staff had completed mandatory training in safeguarding adults and children. In December 2015, the training compliance rates for staff within surgical division ranged between 87.5% and 100% against the trust's target of 85%.
- Safeguarding governance reporting arrangements were in place to ensure that safeguarding processes were monitored trust wide.

Mandatory training

- Mandatory training covered a range of topics including fire safety, health and safety, basic life support, safeguarding, manual handling, hand hygiene, dementia awareness, equality and diversity and information governance training. Staff received an electronic reminder when the training was due.
- The data provided by the trust showed that the compliance with mandatory training varied across the surgical services with some areas and teams demonstrating higher compliance than others. The range of staff completing their mandatory training varied between 50% to 100%, against the trust's target of 85%. The compliance of completing mandatory training was particularly low in allied health professional staff group. However, on inspection we were not shown a plan of how the target was going to be achieved.
- Staff reported they were booked to attend face to face mandatory training and could access e-learning topics at the hospital. Ward staff did not report any concerns in accessing the training.

Assessing and responding to patient risk

- Patients' treatment prescription for the prevention of thromboembolism was dependent upon their risks and recorded in patient records; the admitting doctor or practitioner recorded the VTE risk assessment on the patient's prescription chart. Staff carried out a pre-operative assessment for patients undergoing elective surgery, which included risk assessments of the patient's baseline health status. Staff also assessed

patients for their risk of developing pressure ulcers, for falls and malnutrition. They also reviewed risks relating to patients' medical history, medicines and lifestyle. The pre-operative assessment helped the staff to understand patient's health situation and decide if further investigations were needed to make sure patients were fit for surgery. However, we were told that sometimes the pre-operative assessment was carried out quite a few weeks before the surgery, which meant that all the risk assessments needed revisiting and completely rewriting following the patient's admission to the ward after their operation, rather than just updating with any changes, which was time consuming for the ward staff.

- The staff undertaking surgery used a surgical safety checklist based on the World Health Organisation (WHO) Five Steps to Safer Surgery checklist. The hospital used checklists tailored to their specific needs and adapted to include additional checks. For example, there was a specific checklist for eye surgery. We observed effective use of WHO surgical checklist in most of the theatres.
- We observed staff carrying out the Five Steps to Safer Surgery checklist with music in the background at Weymouth day surgery theatre. This background noise could be distracting to the safe checking process. A recent Five Steps to Safer Surgery checklist audit undertaken by the trust between November 2015 and February 2016 indicated 8% of distractions took place whilst the sign in and sign out were carried out and 17% during 'time out'.
- An audit of the checklist, undertaken by the trust in January 2016, showed that the five steps were not always followed, for example there was no consultant signature in 30% of records. This had been the case for the past 3 months, and the audit plans did not detail any actions to improve this.
- Staff carried out interventional radiology in line with the Ionising Radiation (Medical Exposure) Regulations 2000 - IR(ME)R. Staff used a specific WHO checklist for radiology to include the IR(ME)R procedures.
- Staff monitored patients' health during surgery, recovery and on the wards, and systems were in place to respond to any deterioration. The hospital used an electronic system to record patients' vital indicators on handheld devices. The surgical wards and recovery areas used the nationally recognised Early Warning Score (EWS), a scoring system that identified patients at risk of deterioration or needing urgent review. Analysis

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of these results indicated if a patient was deteriorating and alerted staff to take the appropriate action. This included alerting a doctor and, if necessary, the hospital's critical outreach team, to support the patient. The critical care outreach team observed the system remotely to track deteriorating patients and also liaised directly or attended the wards when necessary. Nursing and medical staff told us the system worked well.

- There were systems in place to minimise the risk of patient harm. For example, if patients were at risk of dehydration staff monitored their fluid balance and provided pressure-relieving equipment to help prevent skin damage. Every surgical ward had a safety brief at the beginning of a new nursing shift. In the safety brief, staff beginning the new shift were made aware of patients with high risks of falls, pressure ulcers, cognitive impairment and any patients who were acutely unwell. Staff also discussed any untoward incidents that happened that day, admissions, awaiting discharges, staffing concerns and any general safety issues.

Nursing and therapy staffing

- The trust had set their staffing establishments based upon the nationally defined minimum safe staffing levels for inpatient hospital wards. These include Safe Staffing: A guide to Care Contact Time (NHS England, November 2014), Direct Care Measurements (NHS England, January 2015). The recommended staffing establishments are one registered nurse for eight patients, and we were told that the trust generally adhered to this ratio.
- Nursing numbers were assessed using an acuity tool and minimum staffing levels were set. Wards displayed the safe staffing levels, including planned and actual numbers of registered and health care assistants.
- The trust displayed the actual nurse staffing hours against planned nurse staffing hours on their website, this illustrated that the longer stay surgical wards had average shortfalls of 5% registered nursing hours. The surgical divisional risk register (2015-2016) highlighted nurse workforce vacancies as a 'moderate' risk. As of March 2016, there was a 9% vacancy rate for the registered nurses across surgical wards and for theatre suites. Nursing staff turnover rate as of March 2016 was approximately 11% for surgical wards and theatres.
- Staff told us that when staffing levels were not sufficient to meet the care and treatment needs of patients they contacted the matron or nurse on call for the hospital and completed an electronic incident form.
- Staff shared their concerns over managing the high patient acuity overnight on Lulworth ward, which acted as a step down for the High Dependency Unit and intensive therapy unit. Routinely there were just two registered nurses on night duty, and a registered nurse working a twilight shift, covering 28 beds supported by two health care assistants. Thus for the majority of the night, one registered nurse would be caring for 14 patients which is in excess of the one for eight that the trust stated as the requirement for the patient acuity. During the days of the inspection, the high patient acuity was evident with 13 patients with documentation relating to Deprivation of Liberty Safeguards in place.
- The use of agency nursing was highest in the Ridgeway ward and Purbeck ward (January 2014 to November 2015) between 7% to 20% each month and over 20% for three months in the same time period. When possible regular bank and agency were used but there were occasions when other agency staff were used, which could impact on continuity and quality of care. The lowest fill rate for bank or agency registered nursing staff in the surgical wards was 92% for day shifts and 96% at night. When temporary staff were used, an induction checklist was used to ensure the staff members were familiar with their working environment.
- There was a mechanism for escalating staffing gaps to the senior nurses, who would risk assess the staffing resources and move staff accordingly. On our unannounced inspection on 17 March 2016, we observed that due to sickness of a member of registered nursing staff, Purbeck ward had only one registered nurse on the night shift along with registered nurse who could support the ward till midnight. Additionally the ward was staffed with three health care assistants. The ward had patients with high acuity such as patients living with dementia, those with high risk of falls and patients needing four hourly nursing care. Staff had escalated this situation to the matron. Whilst on site we were assured of a plan to backfill the ward by ward basing the site coordinator to ensure safe cover, however; we were told subsequently that provision was made to backfill this ward with the late arrival of an

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agency nurse. We raised this concern with the trust's executive team who later confirmed that an agency nurse released from Abbotsbury ward had supported the ward and thus mitigated any risks.

- Staff told us when patients required 1:1 care, additional staff were requested and authorised but these requests were not always filled by the bank. Staff told us that the previous day to the announced inspection there had been gaps of five shift requests which had not been filled.
- Patients told us the staff and the units were busy especially at night but the nursing staff looked after them and they did not have to wait long for help or care. The nursing handovers that we observed were good. There was a thorough discussion of each patient, which included information about his or her progress and potential concerns.
- The management team were aware about the challenges associated with the nursing staffing level in the hospital. They told us of various measures, such as open recruitment days and overseas recruitment initiatives they had put in place in an effort to decrease the vacancy factor. All ward-based staff were aware of these initiatives and were supportive of them. There was general agreement that recruitment and retention of nursing staff was seen as a priority by the trust.
- Nursing staff on the surgical wards told us that it was becoming progressively difficult to access physiotherapists to assist with patients on the wards. Physiotherapy staff told us that staffing level for therapists was generally low. There were two full time physiotherapists and one part time therapy assistant staff who was covering general surgery wards, medical wards and critical care unit. Staff told us that the caseload was frequently difficult to manage as the prioritisation of critical care patients due to the acuity of their conditions always took place. Staff told us that the surgical wards sometimes remained unattended especially if one of the therapy staff was on leave or attending a training session. However, staff told us that urgent patient referrals on surgical wards were always seen.

Surgical medical staffing

- Surgical services at the trust were consultant delivered and led.
- Medical working patterns ensured consultant, middle grade and junior doctor for all surgical specialities were

available to attend to patients when needed. This included carrying out urgent and emergency surgical work in and out of hours. The medical staff and service leads confirmed that there was always a trained surgical doctor available to see urgent patients within 30 minutes. There was also a consultant anaesthetist on call overnight and weekends to provide an additional 30 minute response.

- Nursing and theatre staff told us they could contact any consultant, out of hours or when not on-site, if they needed advice about the best care and treatment for a patient. They told us they had a good working relationship with the medical staff.
- Nursing staff told us there were sufficient consultants and doctors on the wards during the week. Junior doctors felt there were adequate numbers of junior doctors on wards out of hours and that consultants were contactable by phone if they needed any consultant support.
- On surgical wards, medical staff saw patients daily. Over the weekend, the consultants reviewed all new and acutely ill patients.
- The trust had slightly less number of consultants (44%) and more middle career medical staff who have at least three years' experience at senior house officer or higher grade in chosen specialty (19%) than the England national average of 41% and 11% respectively. The registrar group (specialist registrars 1-6) were significantly smaller in the hospital at 28% of medical staff, compared with 37% as an England national average. These results were for the ten-year period to September 2015.
- Trust data for the period April 2014 to November 2015 showed the number of locum doctors working for the trust varied over the last 20 months. In surgical services, the proportion of locum doctors working at the hospital varied between 0% to 40% over this time period with higher numbers of locum doctors used for dental surgery and orthodontist services.
- Vacancy rates for medical staff within surgical directorate varied between different specialities as at Dec 2015. Ophthalmology speciality had the highest vacancy rate of 32% followed by ENT speciality with vacancy rate of 18%. The vacancy rate for other surgical specialities varied from 0% to 6% over the same time-period.
- Theatre staffing was in line with The Association for Perioperative Practice (AfPP) recommendations.

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Major incident awareness and training

- Staff we spoke with were mostly aware of the procedure for managing major incidents, winter pressures on bed capacity and fire safety incidents.
- The trust had put emergency plans and evacuation procedures in place. The staff had received training in how to respond to major incidents although the staff told us they were not aware of any recent tests.
- Recently the implementation of an electronic bed management system took place; this was to ensure patients' needs continued to be met when there was an increased demand on beds. At the time of the inspection, due to increased numbers of patients, the general surgical wards were caring for trauma and orthopaedic patients.
- The trust followed a defined process for deferring elective activity to prioritise unscheduled emergency procedures.

Are surgery services effective?

Good



By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

We rated effective as good because:

- Patients received care and treatment based upon national guidance, standards and best practice recommendations.
- The surgical services were consultant led and delivered and there was good evidence of multidisciplinary team coordination to support patients.
- The surgical services participated in a number of local and national audits, some results were better than national average i.e. the fragility hip fractures and the elective hip replacement patient reported outcome measures (PROMS). The results from audits were used to improve processes.
- The trust had robust systems to monitor patient's nutrition and fluid balance; we observed nursing staff discussing individual patients' needs. The patients told us that their pain levels were regularly assessed and they received adequate pain relief.

- The trust supported staff to become competent and provided training specific for their roles based on their annual appraisal.

However,

- The trust performed poorly for patients having a consultant surgeon review within 12 hrs of emergency admission for laparotomy and for the patient over 70years having an older person's physician review.
- The trust was still working toward a 7-day service, this was dependant on further cover from the critical care outreach team, and there was no formal 'hospital at night' service currently. The trust was planning for the development of advanced nurse practitioners to provide the service from January 2017..There was limited access to physiotherapy out of hours and at weekends.

Evidence-based care and treatment

- The trust used relevant national guidance, standards and best practice recommendations to plan and deliver care and treatment for patients.
- Staff provided care and treatment to patients based on national guidance including that produced by the National Institute for Health and Care Excellence (NICE) and the Association of Anaesthetists of Great Britain and Ireland (AAGBI). The operating department's record of care was based on AAGBI and NICE guidance. The patient care plans for nursing care reflected Department of Health and NHS guidance.
- Staff running the pre-operative assessment clinic followed the National Institute for Health and Care Excellence (NICE) guidance CG3 Preoperative tests, to ensure patients had relevant tests performed prior to surgery, to minimise the risk of complications or harm. Theatre staff followed NICE guidance (QS49) Surgical site infection. This included steps to follow to minimise the risk of infection during surgery.
- The National Institute for Health and Care Excellence (NICE) recommends that all patients have an assessment against the risk of developing venous thromboembolism (VTE) on a regular basis. Local policies and pathways such as the pressure ulcer prevention and management policies and surgical venous thromboembolism (VTE) pathways were written in line with national guidelines and staff we spoke with

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were aware of these policies. Patient records we reviewed showed risk assessments and care plans for patients who were at risk of developing pressure ulcers and VTEs.

- However, the trust target of 95% of patients being risk assessed for VTE had not been achieved for the past 9 months, with 88% of surgical patients assessed on admission. Prophylactic measures were in line with their risk assessments.
- A review of minutes of meetings, including ward and clinical governance meetings, showed updates in NICE guidance was registered and reviewed to improve patient care. The monthly risk, governance and quality improvement forms included a section for highlighting any new NICE guidance.
- Surgical staff managed emergency laparotomy surgery in accordance with National Confidential Enquiry into Patient Outcome and Death (NCEPOD) recommendations. We found the Royal College of Surgeons standards for emergency surgery/surgery out of hours were consultant led and delivered.
- To improve patient outcomes in elective orthopaedics, evidence based enhanced recovery pathways were being used. Staff prepared patients for surgery and provided a structured post-operative recovery plan, including pain relief and early mobilisation. This involved both therapists and social workers where appropriate, to help patients with recovery and discharge arrangements. We reviewed the enhanced recovery pathway documentation for orthopaedic surgery. There was clear guidance for staff regarding the recording of pre-operative and post-operative care and treatment.
- Surgical services had an annual audit programme. This included repeated audits for known risks, audits of clinical practices, patient outcomes and compliance with trust policies such as record keeping, the surgical safety checklist and the use of tools for assessing risks such as pressure ulcers and malnutrition.
- Surgical services participated in national clinical audits, for example, the National Joint Registry. This registry collects information on all hip, knee, ankle, elbow and shoulder replacement operations, and monitors the performance of joint replacement implants.

Pain relief

- We observed nurses and doctors monitoring the pain levels of patients and recording the information. Regular

observational checks included monitoring patients' pain. The Early Warning Score (EWS) chart also utilised pain level scores to assess the patients overall condition.

- Patients we spoke with told us staff had asked about and assessed their level of pain at various stages during their stay in hospital. Medicines was given promptly to manage any pain they were experiencing. We heard discussions about reviewing pain medicines of a post-operative patient in the Ridgeway ward. Staff had good knowledge of pain management, which they recorded within patients' records, while also ensuring that the patient's needs were being discussed and pain relief provided in a timely way.
- Patient records reviewed, demonstrated that staff had completed a pain management plan and given patients written information at the pre-assessment clinic about how to manage any pain once they were home. Pain scores had been recorded and acted on appropriately by staff during the patients' stay in hospital.
- Staff could access specialist advice from the pain management team when required. The pain management team were available for advice and support; and documented their advice within the patient record.

Nutrition and hydration

- Patients spoke positively about the choice and quality of the food, saying it was appropriate for their needs post-surgery.
- Nursing staff discussed patient dietary requirements as part of their pre-operative assessment and on admission.
- As part of patient risk assessments, to identify patients at risk of malnutrition the malnutrition universal screening tool (MUST) was completed. For additional advice, a dietitian could be contacted.
- We observed staff using fluid balance charts to monitor patients' hydration status, where required. Records recorded ongoing fluid balance and staff used them to support clinical decision-making.
- Patients had access to drinks by their bedside. Care support staff checked that regular drinks were taken by patients where required.
- Some patients were being monitored for nausea and vomiting. It was recorded within their notes when they were given anti-sickness medicines.

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- Staff reported good access to dietitian support, for example post bowel surgery.
- Patients attending day surgery at Weymouth Hospital had access to snacks following their surgery.
- The catering team found it helpful to have patients' dietary information in advance and sought advice from the dietician when planning the menus. We reviewed the menus; they clearly showed patients which meals were vegetarian or high energy for example

Patient outcomes

- Surgical services participated in a number of national audits, for example, the elective surgery Patient Reported Outcome Measures (PROM) programme, national hip fracture database and national joint registry. Clinical governance meetings reviewed performance in the national audits.
- Patient Reported Outcomes Measures (PROMs) is a national tool used to measure health gain in patients following hip replacement, knee replacement, varicose vein and groin hernia surgery in England. The measures are reflective of patients' responses to questionnaires before and after surgery. The data provided by the trust demonstrated that the trust had better patient reported outcomes (PROMS) for hip replacement than the England average (April 2014-March 2015). PROMS for knee replacement and groin hernia surgery were similar to the England average and those for varicose veins were worse than the England surgery for the same period.
- The trust performed well in the 2015 Hip Fracture Audit, performing better than the England average on all comparable measures. Data provided by the trust showed that in 2015, the percentage of patients admitted to orthopaedic care within four hours after attending the hospital, following hip fracture was 72% as compared to national average of 47%. The percentage of patients who had surgery for a hip fracture on the day or day after admission was 88% as compared with national average of 72%.
- The hospital had participated in the national bowel cancer and lung cancer audits in 2014. For the bowel cancer audit, results showed the hospital was in line with the national average for most aspects of the audit and better in areas such as 'seen by clinical nurse specialist', 'CT scan reported' and 'discussed at multidisciplinary team meetings'. The lung cancer audit showed improvements were required to meet the national target of 95% of patients receiving a CT scan before a bronchoscopy.
- The trust had a mixed performance in the 2015 National Emergency Laparotomy Audit. This showed the trust performed poorly for patients having a consultant surgeon review within 12 hours of emergency admission and for an older person physician seeing patients over the age of 70. However, the trust performed very well on 'final case ascertainment' and 'consultant surgeon present in theatre'. The trust preformed within nationally acceptable levels for the remaining six outcome areas of the audit. The senior clinical leads said they were monitoring their performance against the audit criteria. They said they had identified steady improvement in the two areas of poor performance.
- The departments undertook and monitored audit programmes effectively. In 2015, surgical services had completed 27 different audits for different specialities including anaesthetics, ophthalmology, orthopaedics, breast surgery and vascular surgery. Monitoring progress against the audit plans at governance meetings showed that clinical leads discussed the outcomes of local audits, as well as national audits.
- The overall risk of readmission for both elective and non-elective patients at the trust was lower than the England average.

Competent staff

- There was an induction programme for all new staff and staff who had attended this programme felt it met their needs. New overseas staff had received a specific induction and all new staff were supernumerary on shifts until assessed as competent.
- Staff told us they did not receive formal supervision. However, in addition to informal learning opportunities within handovers, ward rounds and board rounds they were supervised clinically and also had a supportive structure within the ward. Overall, patients expressed the view that staff were skilled in their work.
- Nursing staff were aware of the need to revalidate their registration. The appraisal process was being used to support them with their revalidation process.

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- Staff told us they had regular annual appraisals. The data provided by the trust demonstrated that from April 2015 to December 2015 the overall appraisal completion rate for surgical division was 82% against the trust target of 90%.
- Staff had access to specific training to ensure they were able to meet the needs of the patients they delivered care to. For example, staff on the Ridgeway and Purbeck wards had opportunities to attend an in-house training programme and had attended a spinal study day organised by the neighbouring NHS trust. Nurses on these wards were also encouraged to attend some of the junior doctors training sessions conducted by the trust.
- Trained dementia champions were a selected number of staff within the surgical and trauma and orthopaedic wards. These staff had undertaken level 2 and level 3 dementia awareness training provided by the trust.
- Nursing staff told us they felt they had the training to ensure they had the specialist skills required to offer specialist interventions.
- Nursing staff told us that they felt they had the training to ensure they had the specialist skills required to offer specialist interventions. For example the trust had developed specific competencies for staff working in recovery units. Staff working in the recovery unit at DCH told us they had participated in a competency programme. However, although the staff rotated from DCH to Weymouth day case unit, those we spoke with at Weymouth had not yet participated in it.
- Staff commented positively about the training opportunities and education packages for professional development and we heard several examples where the trust had supported staff in undertaking training programmes from a local college or university. For example, the trust had supported a member of pharmacy staff working on a surgical ward to undertake postgraduate diplomas in pharmacy.
- In the General Medical Council (GMC) National Training Scheme Survey 2015, the trainee doctors rated their overall satisfaction with training as similar to other trusts. Trainee doctors we spoke to said they felt well supported and they felt hospital was a safe place to work.
- The therapy staff on the medical wards told us that they attended in-service training once a week and the junior physiotherapy staff also received weekly teaching related to their speciality.

Multidisciplinary working

- Throughout the inspection, we observed good multidisciplinary working between the different teams involved in a patient's care and treatment. There was clear communication between staff from different teams, such as the anaesthetist, surgical doctors, and theatre staff to ward staff.
- Staff described the multidisciplinary team as being supportive of each other. Health professionals told us they felt supported, and that their contribution to overall patient care was valued. Staff told us they worked hard as a team to ensure patient care was safe and effective.
- Daily ward rounds, involving nursing and medical staff, took place seven days a week on all surgical wards. Pharmacists and therapists visited the wards on a regular basis and they had a good understanding of individual patient needs.
- The therapy team, including physiotherapists, physiotherapy technicians and occupational therapists worked together to promote patients rehabilitation and safe discharge from hospital.
- Staff said that they could access medical staff when needed to support patients' medical needs.
- Junior doctors and nursing staff told us they worked well together within the surgical specialities. We saw evidence of this on the surgical wards and the day care unit. There were clear lines of accountability that contributed to the effective planning and delivery of patient care.
- The trust had a process to refer patients for assessment and review by dietitians and the pain management team when required.
- There was pharmacy support on all the wards we visited which helped to speed up patient discharges and timely provision of 'to take home' medicines.
- The records viewed identified family involvement at admission to encourage effective discharge.
- Multidisciplinary team meetings, also known as 'Single Point of Access' (SPOD) meetings took place on every ward when plans relating to appropriate discharge and reviews of unwell patients were discussed. Therapists, nursing staff, medical staff and social worker, attended these meetings.
- We attended the medical handover meeting in the Purbeck ward, attended by surgical consultants, junior doctors and nursing staff. The staff present made a

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constructive contribution to the meeting and focussed on identifying the patients' needs and treatment planning, completing action plans following the discussion.

- The hospital transferred patients to neighbouring hospitals for certain treatments. For example, when patients may require emergency spinal surgery, they will be referred, reviewed remotely and if appropriate transferred to a local specialist provider. There was a pathway for this, to ensure staff had made the necessary arrangements with the receiving hospital and prepared patient information with the handover checklist.

Seven-day services

- Services were currently not fully compliant with the NHS 7 day priority standard, as there was no formal 'Hospital at Night' team and the critical care outreach worked Monday – Friday 8am-8pm, without these the service could not fully adopt 7 day working.
- Consultants were on call 24 hours a day to cover surgical wards seven days a week. Nursing staff and junior doctors told us consultants were on-call out of hours and were accessible when required.
- In the anaesthetics department, there was 24-hour on-call consultant anaesthetist cover available over seven days a week. In addition to this, there was also a 24 hour on call consultant available to cover the trauma surgery list in theatre over the weekend.
- The hospital at night team was not fully established and access to medical advice at night came from junior medical staff and on call consultants. Nurses told us they followed the trust's escalation policy for out of hours medical advice and reported that the medical teams were very responsive. The trust was planning for the development of advanced nurse practitioners to provide the service from January 2017. This would release the junior medical staff cover from the rotas at night and provide better continuity.
- The pharmacy department was open seven days a week, but with limited hours on Saturday and Sunday. An on-call pharmacist was available to dispense medicines over the weekends.
- Daily ward rounds took place on surgical wards for all patients. Over the weekend, the on-call surgical consultant saw all new and deteriorating patients.

- A seven-day physiotherapy service was available, but with limited hours over the weekends, to support patient with mobilisation and recovery. This service was not available overnight for patients.
- The surgical services had access to radiology support seven days a week, with rapid access to CT scanning when indicated.
- Surgical consultants regularly reviewed surgical patients who were on non-surgical wards as outliers.

Access to information

- Staff told us they had good access to patient-related information and records whenever required. The bank and agency staff also had access to the information in care records to enable them to care for patients effectively. All areas used electronic handover sheets to ensure all staff had up-to-date information about patients on their ward.
- Nursing staff told us when transferring patients between wards or teams, staff received a handover of the patient's medical condition and on-going care information was shared appropriately in a timely way. We observed informative and effective handovers between theatre and recovery staff. This helped to ensure the transfer was safe and the patient's care continued with minimal interruption and risk.
- GPs received discharge summaries to inform them of their patient's medical condition and the treatment they had received; such as details of the surgery, and any implant used, within 48 hours following patient discharges. This ensured that GPs were aware of their patient's discharge and could offer adequate community support if required.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff ensured patients gave their consent prior to any interventions. Where there was a risk patients did not have capacity to consent, staff carried out mental capacity assessments in accordance with the Mental Capacity Act 2005 (MCA). If necessary, they carried out best interest decisions to agree treatment and care. Staff recorded patient consent in their records.
- Patients told us they had been able to make an informed decision about surgery, before signing the

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consent form. The consultants discussed the risks and benefits of surgery with them and these were included on the consent form. The consent forms we checked confirmed this.

- The staff spoken with were able to describe what was meant by mental capacity and the Deprivation of Liberty Safeguards (DoLS). Trust guidance on consent and the MCA was available for staff to refer to.
- Staff understood how to act when restriction or restraint might become a deprivation of liberty. Staff were also aware of the trust's policy if any activities, such as physical or pharmaceutical restraint, met the threshold to make an application to the local authority to temporarily deprive a patient of their liberty.

Are surgery services caring?

Good



By caring, we mean that staff involve and treat patients with compassion, kindness, dignity and respect.

We rated caring as good because

- Staff treated patients with kindness, and showed regard to their dignity and privacy. We observed their interactions with patients and found them to be polite and in the majority of cases timely.
- The trust's results of the Friends and Family Test showed a higher than average response rate with the surgical wards displaying 90-100% of people recommending the ward and service. There was direct evidence of actions resulting from patients' feedback.
- The patients described good care, which was thoroughly explained. They were involved in any decisions relating to them.
- The patients spoke positively about the support given to them by the staff, there was a chaplaincy service available should patient require additional emotional support.

Compassionate care

- Throughout our inspection, we witnessed staff treating patients with compassion, dignity and respect. We observed staff communicating with patients in a

respectful way in all situations and ensuring the maintenance of confidentiality when attending to patient care needs. We observed answering of call bells were in a timely manner on most of the occasions.

- Patients told us "the staff provide excellent care" and staff responded quickly to their needs.
- We observed compassionate care from the theatre teams, who ensured the maintenance of patients' dignity, and members of the teams made sure patients felt at ease.
- Staff in multidisciplinary meetings demonstrated knowledge, skill and a caring attitude towards patients during their discussions.
- The wards reported results of the Friends and Family Test (FFT), which asked people if they would recommend the hospital or ward. The results were publically on display for patients and their relatives to view. Overall FFT results for the hospital showed a higher average response rate than the national average (40.6% compared with 35.5%) between August 2014 and July 2015. Across surgical wards, 90% to 100% of people would recommend the ward they had visited. Generally, scores had improved over the year, but this was not a consistent trend.
- The 2014 CQC inpatient survey found the trust overall scored similar to other trusts on all key areas relating to care and dignity.

Understanding and involvement of patients and those close to them

- Patients and relatives we spoke with stated that they felt involved in their care. Patients told us the staff had explained their treatment options to them, and they were aware of what was happening with their care and felt involved in the decision-making process regarding their treatment. Relatives felt fully informed about their family member's treatment and care. There was an opportunity for patients to speak with their allocated consultant.
- Patients and their relatives commented that information was shared in a manner they understood. Patients told us the doctors had explained their diagnosis and that they were aware of what was happening with their care. None of the patients we spoke with had any concerns with regard to the way they had been spoken to, and all were complimentary about the way they were treated.

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- In theatres, staff demonstrated they understood patients' wider family context and took these into account when planning care and recovery for patients
- We observed nurses, doctors and therapists introducing themselves to patients at all times, and explaining to patients and their relatives about the care and treatment options.
- Patients and relatives were involved in their discharge planning. We saw a patient, their relative, nursing and therapy staff working together, making discharge arrangements that would meet the needs of the patient and their relative.

Emotional support

- Staff were observed being responsive to patient emotional needs during our inspection, and we saw friendly and supportive interactions from staff to patients.
- Patients spoke positively about the emotional support that staff provided. Comments included "excellent and professional service - most reassuring when feeling 'low'. Patients and carers told us they valued the support staff had given them on the day of surgery.
- Patients were given an emergency contact telephone number at discharge, should they need to speak to a member of staff about any concerns they had.
- The hospital chaplaincy had a visual presence around the hospital and were happy to meet people to offer them emotional and spiritual support.
- A wide variety of specialist nurses provided emotional and practical support for patients with specific conditions and these were accessed following assessment and care planning.

Are surgery services responsive?

Good



By responsive we mean that services are organised so they meet peoples' needs.

We rated responsive as good because

- The trust was awaiting the outcomes of the Dorset Clinical Services Review which will affect aspects of the

surgical services. Currently surgery provided at the hospital is for urgent and elective surgical with some partnership trusts commissioned to provide additional services.

- The trust is part of the recently announced Vanguard project for improving patient pathways across the acute hospitals in Dorset.
- Services had been planned to meet the needs of the local population such as Weymouth Day Surgery Unit for surgical procedures and the one stop breast clinic for timely and accurate diagnosis for patients awaiting breast cancer diagnosis. Patients' individual needs were met following assessment, including specialist needs such as patients with a learning disability or those living with dementia.
- Patients were admitted on the day of surgery following pre-operative assessment to ensure fitness for surgery. The daily single point of access multi-disciplinary team meetings, helped to provide a coordinated approach to complex patient discharges.
- The trust had taken steps to improve the Refer to Treatment targets and the majority of the surgical specialties were only just below target. Cancellation of patients' operations was better than the England average.
- Complaints were responded to locally by ward staff, there was information on the wards about the process and staff were clear of their responsibilities

However,

- Although the trust had a discharge lounge, there was no obvious drive for earlier discharges and poor usage of the discharge lounge by some of the wards caused the holding of post-operative patients in recovery prolonging theatre lists. The lack of beds could also mean the opening up of the day case unit overnight to keep patients safe and the admittance of orthopaedic patients into other surgical wards.
- According to trust data, surgery had not been achieving the required screening of emergency admissions over 75 years for dementia since April 2015, although of those screened, 100% patients were assessed appropriately.

Surgery

Service planning and delivery to meet the needs of local people

- At the time of the inspection the hospital's services, and those of other acute hospitals in Dorset, were subject to the Dorset Clinical Services Review to redesign and improve quality of care for people in the county.
- Commissioning of services across three of the NHS trusts serving Dorset, Bournemouth and Poole meant services were often planned in partnership. Some services were commissioned jointly with Poole and Dorchester NHS trusts, such as the vascular surgical network. The successful bid for Vanguard funding meant there was opportunity for closer working and planning of acute surgical pathways across the three acute trusts in Dorset
- The trust did not offer certain services, such as prostate and bladder cancer procedures. These were provided at neighbouring hospitals.
- Dorset County Hospital had seven main theatres and two day case theatres and their average usage rates were generally above 83% (August 2015-October 2015).
- One of the trust's day case theatres was located at Weymouth Community Hospital to meet the needs of the local population and average utilisation rate of this theatre was 71.66% (September 2015-November 2015).
- Theatre lists were organised to release a theatre for dedicated lists for unplanned emergency sessions. This was in line with the Confidential Enquiry into Peri Operative Death (CEPOD) recommendations to set time aside for emergencies.
- The trust offered modernised 'one stop clinic' for urgent referrals for breast surgery at Dorset County Hospital. The 'one stop clinic' involved a triple assessment offering a more thorough and accurate breast cancer diagnosis on the same day. This helped in reducing the time to diagnose breast cancer making sure any treatment that is needed can be started straight away.
- The layout of the hospital meant all areas were accessible for people in a wheelchair.
- The waiting area at Weymouth day surgery unit was very small and did not have any toileting facilities for patient relatives, although staff told us that relatives could use patient toilets if needed to. There were other toilets available outside of the day case unit that would be more appropriate for visitors use to ensure the privacy and dignity was maintained of those patients receiving treatment.

- The day surgery unit at Weymouth had recently had screens installed (the week before our visit) to segregate male and female patients. The day we visited patients were walking in front of members of the opposite sex to and from the toilets, staff were creating signage to guide them appropriately

Access and flow

- Bed occupancy in the trust was in the range of 90% to 95% for the period from January 2015 to December 2015. This was above the England average and recommended average of 85%. It is generally accepted that at 85% level, bed occupancy can start to affect the quality of care provided to patients, and the orderly running of the hospital.
- Patients were admitted for surgery through a number of routes. Including elective (planned), pre-planned day surgery, from a GP referral or via the hospitals' emergency department.
- Staff carried out a pre-operative assessment for patients undergoing elective surgery. The trust ensured that patients were fully informed about their procedures and the post-operative recovery by attending pre-operative assessment (POA). POA also ensures that patients are in optimum health and had arranged socially for their admission, discharge and post-operative care at home. Staff told us that if there had been social or long-term care needs identified at pre-operative assessment, there was no opportunity for pre admission referral to social services. This meant that patients had to wait until after their operation for social care referral, which delayed their length of stay at the hospital.
- Although the trust had a discharge lounge, there was no obvious drive for earlier discharges and poor usage of the discharge lounge by some of the wards caused the holding of post-operative patients in recovery prolonging theatre lists. Which impacted on patients as they would have no access to their visitors. The lack of beds could also mean the opening up of the day case unit overnight to keep patients safe and the admittance of orthopaedic patients into other surgical wards.
- Discharge plans commenced on admission and patients had estimated dates of discharge documented in their records. Discharge coordinators supported ward staff in planning complex discharges and carried out specialist assessments such as those for NHS funded continuing care. Single Point of Discharge (SPOD) meetings coordinated complex discharge arrangements.

Surgery

- The trust staff told us that the main cause of delays was the provision of community services, especially care home placement to meet patients' on-going needs. The trust was engaged with partner organisations in managing these delays to minimise the impact on individual patients and the service overall. Patients who had less complex need were assessed by in reach team from neighbouring community trust that supported in facilitating discharges by providing short-term care support.
- In order to support with safe and early discharge process the trust had developed an 'Acute hospital at home team' who provided nursing and therapy support for two to three weeks post discharge.
- The trust had a discharge lounge where patients could await transport or final discharge arrangements such as medicines. The discharge lounge was open Monday to Friday between 8am and 6pm. We observed that the discharge lounge team cared for patients effectively.
- There was a trust-wide operational group responsible for the coordination of capacity and bed availability. This group liaised daily with individual wards to establish the numbers of patients on the ward and how many beds were available for new admissions. They also discussed any action that was required when wards were at full capacity. Staff told us, due to the demand for trauma and orthopaedic beds it was normal practice for orthopaedic patients to be cared and treated on the general surgical wards
- At the time of our announced inspection, trauma and orthopaedic patients were outlying in general surgical wards. A trauma and orthopaedic outlier medical team was tasked with providing the medical care and treatment for trauma and orthopaedic patients on non-speciality wards. We saw this team saw trauma and orthopaedic patients on non-speciality wards. This ensured patients received the appropriate medical care and treatment.
- None of the surgical specialities had met the referral to treatment standards (RTT) for the time period between September 2014 to March 2016 although the majority were just under target, there were two specialties that were particularly challenged and there were action plans to address these. This was due to pathway delays and capacity problems and the trust had taken steps to improve these timeframes.
- The hospital's cancellation rate for operations had varied each quarter in 2014/15. However, this was

similar to England average. The number of patients who had surgery cancelled and not treated within 28 days had increased in 2015 as compared to previous year. However, the numbers during this period remained lower than the England average.

- The trust had organised a theatre scheduling event for the theatre service managers in December 2015. The aim of this event was to improve theatre schedules, reduced number of cancelled operations on the day of planned surgery, to increase number of patients admitted to the correct ward and thus to improve patient flow and experience.
- Orthopaedic wards ran a dressing clinic seven days a week. The Ridgeway clinic also ran a 24 hour telephone advice line for post-operative patients and saw these patients at clinic where necessary

Meeting people's individual needs

- Individual wards displayed their FFT scores as well as specific comments and 'you said/we did' feedback. For example, on Ridgeway ward, actions were taken in response to a comment relating to disturbances at night. Different wards chose their own style of sharing this information.
- During the patient's pre-assessment staff recorded information on patients' additional needs. This included information about any disabilities and social support needed during the patient's stay or once discharged.
- The trust should screen all emergency patients over 75 years for dementia using a recognised methodology on their admission; however, in surgery with under 50% being screened against the target of 90%. this was not routinely being achieved. Of those who were screened, 100% were then appropriately assessed. Staff had completed basic dementia awareness training. The wards we visited had a named dementia champion. The trust had developed a 'dementia care bundle' that assisted staff to meet the needs of these patients.
- The trust had introduced and adopted the use of the 'This is Me' booklet for patients living with dementia, which had been developed by the Alzheimer's Society to alert and inform staff to identify and meet the needs of these patients. On Lulworth ward we saw that patients living with dementia had this booklet and it was appropriately completed.
- Learning disability nurses employed by a neighbouring trust, provide support to staff for individual patients. The trust used a 'flagging' or 'alert' system for patients

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with a learning disability, on their admission to the hospital. Every surgical ward had a named learning disability champion. The hospital also provided support for patients with a learning disability and for staff or relatives caring for these patient groups.

- The trust provided psychiatry support for patients with mental health needs. There was also an arrangement with the local NHS mental health services to provide advice for young patients with mental health disorders. The trust was supporting carers of patients with mental health problem to stay overnight if that was beneficial to the patients and if it was appropriate.
- Interpretation services were available and staff knew how to access the service when needed. A wide range of patients' literature was displayed in clinical area covering diseases. Procedure specific- information, health advice and general information relating to health and social care services was available locally.
- The service had access to telephone, face to face and sign language interpreters. It could also offer patients written, large print, Braille and audio translations.

Learning from complaints and concerns

- Surgical staff respond to complaints in line with the trust's policy. Staff showed us that patients were given information on how to complain. Staff directed patients to 'Patient Advisory Liaison Service (PALS)' if they were unable to deal with their concerns directly and advised them to make a formal complaint.
- Staff on all ward and department areas said they would attempt to resolve issues with patients and relatives, so they did not escalate to a formal complaint.
- Literature and posters were on display advising patients and their supporters how they could raise a concern or complaint, formally or informally.
- Patients expressed confidence they could voice concerns and complaints and were confident staff would respond appropriately.
- Records of clinical governance meetings showed how learning from complaints was shared amongst clinicians.

Are surgery services well-led?

Good



By well-led we mean that the leadership , management and governance of the organisation assures the delivery of high quality person centred care, supports learning and innovation and promotes an open and fair culture.

We rated well led as good because:

- Service leads had identified priorities for improvement. The strategic vision was in part dependent on the Dorset Clinical Services Review, but also driven by the recent Vanguard project for more coordinated acute services across Dorset.
- Staff spoken to were aware of the trust's strategy and vision. The staff were passionate about improving services and providing a high quality service to patients.
- The surgical services had a governance structure in place, which monitored audit action plans, and following an external review had plans to further strengthening the structure.
- Most staff felt the leadership of the trust and within the specialty were visible and supportive. They felt proud of their service, the patients' outcomes and feedback and the response rate for the NHS staff survey was higher than national average
- Patients were encouraged to be engaged in changes to services, i.e. patient hip and knee enhanced recovery pathways.

However,

- An external review had identified areas for improvement in governance and improvements were planned.

Vision and strategy for this service

- The strategic direction of services was open to review at the time of the inspection, because of the Dorset Clinical Services review. This meant the trust did not know what services they would be providing in the future, making it difficult to develop a long-term strategy for the surgical services. The surgical services strategy and plans were discussed and presented to the executive team in December 2015 and approved where appropriate.

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- The trust was part of a recently approved Vanguard project with the aim of providing more coordinated patient pathways across the acute hospitals in Dorset. The surgical service leads identified the priorities for the service, which were to strengthen the governance processes within surgical specialities, improve the nursing establishment across the surgical services, improving business intelligence process and improving patients' journey and experience of care. Managers were able to discuss these priorities and describe the challenges the trust had in implementing it.
- Staff we spoke with were aware of the trust's strategy and described high quality patient care as key components of the trust's vision. The staff were passionate about improving services and providing a high quality service to patients.

Governance, risk management and quality measurement

- Surgical services had clinical governance arrangements in place. This included monthly divisional governance meetings where the results from clinical audits, incidents, complaints and patients' feedback were discussed and shared with staff. Minutes of divisional governance meetings showed patients' experience data was also reviewed and monitored. The minutes of these meetings were shared with the trust's executive committee.
- The surgical division had recently been part of an external review of divisional and service governance processes and had plans to strengthen the governance processes following the recommendations from the external review. Ridgeway ward was piloting a quality metrics dashboard as part of a hospital wide pilot on five wards.
- Within surgical services, each surgical speciality also had their monthly clinical governance meeting and mortality and morbidity meetings. For example; the trauma and orthopaedic speciality had a monthly clinical governance meeting where the performance and other governance related issues were discussed.
- We reviewed the minutes of clinical governance meetings of various surgical specialities. The minutes included a review of incidents, complaints, general patient safety information, infection control review, sharing from incidents and information.

- The wards we visited had regular team meetings at which performance issues, concerns and complaints were discussed. If staff could not attend ward meetings, steps were taken to communicate key messages to them.
- The service had a risk register that included all known areas of risk identified in the surgical service. These risks were documented and a record of the action being taken to reduce the level of risk was maintained. The risks were reviewed regularly in the clinical governance meetings and appropriately escalated. The higher risks were escalated to the trust's risk register where they were reviewed by the trust's executive committee. We saw evidence of this relating to a lack of patient segregation for infection prevention within the Intensive Care Unit.
- The surgical divisional risk register (2015-2016) highlighted nurse workforce vacancies as a 'moderate' risk'. As of March 2016, there was a 9% vacancy rate for the registered nurses across surgical wards and for theatre suites. Nursing staff turnover rate as of March 2016 was approximately 11% for surgical wards and theatres.

Leadership of service

- Most staff spoke positively about their line managers and departmental leads. Staff were complimentary about the leadership in surgical and orthopaedic departments, commenting on the support and guidance they received.
- Staff in all the clinical areas across the surgical services spoke highly about and had confidence in their local leaders, who included matrons, ward managers and lead consultants. Staff across surgical wards told us matrons were visible and had a regular presence on their ward. Staff told us that the interim director of nursing was approachable and helpful.
- Junior doctors felt well supported by consultants and senior colleagues. Medical staff felt supported by the medical leadership in the division and the trust.
- The student nurses told us they felt supported on the ward and received supervision training from the senior staff. They told us consultants were accessible and approachable.
- Staff told us the chief executive was visible within the trust and was approachable. All the staff spoke highly of the chief executive.

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- Staff told us the surgical service leads had a visual presence on the wards and provided good leadership.

Culture within the service

- Staff spoke positively and passionately about the care and the service they provided. Quality and patient experience were seen as a priority and everyone's responsibility. There was an open culture in raising safety concerns, and staff were encouraged to report any identified risks.
- Staff at all levels felt valued and were proud of the service, patient outcomes and feedback. They felt supported to provide high-quality care.
- Staff felt proud to work for the trust. Staff, including student nurses, doctors and housekeeping spoke passionately about their work and of being part of the team.

Public engagement

- There were examples of patients being closely involved in service development. These included patient survey feedback such as the NHS Friends and Family Test and learning from complaints, concerns and compliments received from patients.
- In orthopaedic and trauma wards, staff had encouraged patients to get involved in development of enhanced recovery pathways for hip and knee surgeries. For example, views of the patients who had undergone hip and knee surgeries were considered while writing and updating the information leaflets for hip and knee surgeries.
- There were plans to develop a 'dementia day room' on Purbeck ward. Staff on the Purbeck ward was undertaking a fund raising event along with patients for this new development. We saw information displayed on the notice board, which stated that a patient who had been treated on Purbeck ward in the past was doing a 16 miles walk to raise funds for the day room.
- Clinical governance meetings showed patient experience data was reviewed and monitored.

Staff engagement

- The trust's overall response rate for the NHS staff survey (2014) of 55% was better than the national average of 42%. The results of this survey showed that the trust's performance was better than expected for one out of 31 indicators which was 'percentage of staff having equality and diversity training in the last 12 months'. The trust







performed worse than the national average on one indicator related to 'fairness and effectiveness of procedures for reporting errors, near misses and incidents'. On the remaining indicators, the trust's performance was within expectations.

- The trust was taking initiative to engage and integrate staff across the trust by creating different opportunities. Information was sent to staff regularly by email and weekly briefing email sent by the chief executive. Staff were encouraged to look at the staff intranet.
- The trust had recently held focus groups for all staff to discuss the new trust values. Staff were also given an opportunity to vote for the trust logo. The trust was holding a bright ideas campaign where staff were encouraged to make suggestions to make financial savings.
- The trust held celebration awards (Wow awards) for staff nominated by peers. Staff we spoke with were complimentary about this process. Information about the award was published on the trust's website on the intranet. Staff were proud to tell us about nominations for these awards.

Innovation, improvement and sustainability

- Staff said the trust supported innovative and new ideas. The service was forward looking, encouraging innovations to ensure improvement and sustainability of the service. We saw many examples of innovation and good practice.
- The trust had recently recruited a physician's assistant in anaesthesia, which was a relatively unique post. The post holder worked with the anaesthetic medical staff and assisted with patient's perioperative anesthetic care in routine theatre lists.
- The anaesthetic department ran different teaching courses in the trust's clinical simulation suite. The trust's clinical staff, as well as those clinical staff from neighbouring NHS hospitals, attended.
- Surgical leads told us there were financial challenge on the service however the service leaders were working collaboratively with financial partners and had identified a range of cost improvement plans (CIP) which included procurement efficiencies and recruitment efficiencies. For example, the service had recruited ophthalmic advanced nurse practitioner who was participating in ophthalmology middle grade doctor rota.

Critical care

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

Information about the service

Critical care services at Dorset County Hospital (DCH) are made up of an Intensive Care Unit (ICU) and a High Dependency Unit (HDU) which collectively form the Critical Care Unit (CCU). Critical care at this hospital is within the surgical division. The ICU has five beds and an isolation room where patients presenting as an infection control risk could be nursed. The HDU has four beds. The CCU was funded to provide four ICU and four HDU beds. Patients requiring Level 3 care were treated on ICU and patients requiring Level 2 care were treated on ICU or HDU. Level 2 beds are for patients who require a higher level of care and more detailed observation and/or intervention. The patient may have a single failing organ system or require post-operative care. Level 3 beds are for patients who require advanced respiratory support alone or basic respiratory support together with the support of at least two organ systems. Level 3 also includes complex patients who require support for multi organ failure.

There is a critical care outreach service provided at Dorset County Hospital who advise and support in the management of patients on medical wards whose condition maybe worsening.

During our inspection of critical services we visited ITU and HDU. We spoke with three patients, two sets of relatives and 14 members of staff. The staff we spoke with included nurses, healthcare assistants, physiotherapists, junior and senior doctors, the ward clerk, the unit pharmacist and

service leads. We observed care and treatment including clinical handovers and we reviewed three care records. Before the inspection, we reviewed performance information from, and about, the hospital.

Critical care

Summary of findings

We rated critical care at this trust as good for safe, effective, caring, and well-led care. Responsiveness of the service required improvement.

There was a strong culture of reporting, investigating and learning from incidents. Patients were protected from avoidable harm and abuse and the principles of duty of candour were well understood.

Consultants were notably present on the unit and junior doctors were well supported in developing critical care skills. Nursing staff felt well supported by doctors and there was excellent communication between doctors and nurses during handovers. Physiotherapy assessments happened within 24 hours of an admission and physiotherapists were an integral part of the care team on the unit.

The unit aimed to have a senior nurse shift coordinator who was supernumerary on at all times in line with national guidance. This was not always achieved when there was unscheduled staff absence. However, we saw that during these times there was a clear escalation process and patient safety remained the priority.

Medicines, including controlled drugs, were stored and managed safely with the exception of a small number of emergency medicines, which were located in the emergency trolleys. The emergency trolleys in non visible areas were not tamper-evident. This was corrected during the inspection, medicines were put in sealed boxes on the trolleys.

The unit was submitting on-going data to the Intensive Care National Audit Centre (ICNARC). Patients' predicted mortality outcomes at this critical care service were in line with, or better, than similar units, with the exception of patients admitted with pneumonia whose predicted mortality was below similar units. There were consistently low rates of unit acquired infection and audits showed consistent compliance with best practice hand hygiene standards.

Treatment and care followed current evidence based guidelines with the exceptions of the critical care

outreach services which was not available 24 hours a day seven days a week and did not have follow up provision for critical care patients. The trust was working towards having a 24 hour critical care outreach team.

Staff were sufficiently skilled in delivering critical care and 59% of the nursing staff held a post-registration award in critical care in line with national standards. The clinical nurse educator oversaw the education and training development of the nursing team though was frequently required to cover routine clinical work, which distracted from this. Appraisal compliance was low on the unit at 79% of the overall staff team in December 2015. However, the critical care outreach team staff had all been appraised within the last 12 months.

Equipment was clean and well maintained but the layout of the unit was not optimal for the delivery of critical care. The unit was not compliant with Department of Health's Health Building Notes (04-02), Risk assessments had been undertaken and there was ongoing review. The unit was not secure as there was a second entrance via another ward. There was not clear signage or mechanisms to stop visitors and staff from other wards walking on and off the unit.

Patients were not routinely discharged in a timely manner and delays occurred in over 40% of all discharges. Delays led to patients staying in mixed sex and sub optimal accommodation for significant length of time. Mixed sex breaches were not being reported immediately as they occurred which was not in line with national guidance.

Patients and their relatives were involved, where possible, in decisions made about their care and treatment. Staff were sensitive when required to deliver bad news and ensured that suitably skilled and experienced staff were available to support patients and relatives at these times.

Staff were responsive and worked collaboratively to meet patients' health needs including those unrelated to their critical illness or condition. Staff made reasonable adjustments and used tools to support patients from vulnerable groups such as individuals with a learning disability.

Critical care

Are critical care services safe?

Good



By safe, we mean that people are protected from abuse and avoidable harm.

We have rated safe as good because:

- There was a culture of reporting, investigating and learning from incidents. Staff understood and could apply the principles of duty of candour.
- The unit showed good performance in relation to protecting patients from avoidable harm.
- Infection control practices were in line with trust policy and the unit achieved 100% monthly hand hygiene audits throughout the whole of 2015. The unit had a consistently low rate of unit-acquired infections.
- There was effective management of medicines, other than the small amount of emergency medicines stored insecurely in the emergency trolleys. This was corrected during the inspection; medicines were put in sealed boxes on the trolleys. The medicine administration room was secure and members of the public could not gain access to the room as it required key code entry. Controlled drugs were safely stored and managed.
- Records were current, clearly laid out and provided a clear record of the patient's care and treatment.
- Staff knew how to identify when patients were at risk of harm or abuse and safeguarding processes were well understood.

However,

- The unit was not secure as there was access via two entrances, one of which was through an open ward. This presented both an infection control and security risk.
- The unit did not comply with the Department of Health's Health Building Notes (HBN) 04-02 and action was not being taken to sufficiently address the risks as a result. Staff consistently told us that the layout of the ward was not optimal for the safe delivery of critical care. This had been risk assessed and was under review..
- Emergency trolleys that were not visible at all times, were not tamper-evident.

Incidents

- All staff we spoke with knew how to escalate and report incidents and told us they were encouraged to do so by their managers. Staff were aware of the need to report incidents such as patient falls, equipment errors, medicines errors and admissions and discharges to the unit between the hours of 10pm and 7am.
- Incidents were reported electronically and the system was said to be quick and straight forward to use and staff received feedback by email once the incident had been reviewed by a senior member of staff.
- We reviewed incidents for the period between January 2015 to December 2015 during which time 63 incidents were reported. All incidents reported were graded as either no or low harm. Records showed there was a culture of reporting and reviewing all incidents and ensuring that actions were taken to prevent such incidents from occurring in the future. For example, several staff told us of a medicines administration error that had occurred in 2015 and how they had changed their storage of medicines as a result.
- Consultant led multidisciplinary mortality and morbidity meetings took place monthly. Mortality and Morbidity meetings are peer reviews of the care and treatment of patients with the objective to learn from them. Consultants identified those patients from the previous month to review and identify any areas of learning. The findings of the mortality and morbidity meetings were discussed at the critical care delivery group meetings and service leads then had responsibility to ensure learning was shared across the wider critical care team. Minutes were also circulated to ensure all staff had access to the cases discussed and the learning.
- The duty of candour (DoC) is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person. Staff were aware of the principles of DoC and could recall incidents where DoC had been triggered. For example, following a medicines administration error staff had informed the patient and their relatives, offered an apology and involved them in reaching actions as a result of learning that took place. The electronic reporting system included a specific prompt relating to DoC.

Critical care

Safety thermometer

- The NHS Safety Thermometer is a national tool used for measuring and monitoring and analysing common causes of harm to patients, such as new pressure ulcers, catheter and urinary tract infections (CUTI and UTIs), falls with harm and venous thromboembolism (VTE). This information provides a means of checking performance and is used alongside other measures to direct improvement in patients' care.
- The Safety Thermometer data for this unit showed that the unit performed well in relation to protecting patients from avoidable harm. There was one catheter related urine infection (CUTI) and one pressure ulcer reported between January to December 2015. There were no patient falls reported to the patient safety thermometer in the same data period.
- The Safety Thermometer data for the unit was partially displayed. Staff updated a noticeboard daily to show how many patients on that day had pressure ulcers but they were not displaying data about CUTIs and UTIs. Staff told us they were working towards displaying the full range of safety thermometer data. This meant that patients and their relatives were not given the full range of patient safety data available so could not be aware of the overall prevalence of avoidable harm on the critical care unit. We saw information displayed advising patients that they were planning to start displaying the full range of safety thermometer data.

Cleanliness, infection control and hygiene

- The critical care unit (CRCU) could be accessed from two points. The main front entrance was secure and required visitors to ring a bell to gain access. The second entrance at the back of the unit was through another ward and was not secure. We observed visitors and staff walking freely onto the unit after walking through the adjoining ward. This meant there was no control over who could access the unit which could pose an infection control risk to vulnerable patients.
- The CRCU as a whole area and individual items of equipment was visibly clean and well maintained. We checked four empty bed spaces at different times during the inspection and found the bed spaces and equipment were clean.
- Staff adhered to the 'bare below the elbows' policy, washed their hands between patients and used

personal protective equipment (PPE), such as disposable aprons and gloves. Staff used different coloured aprons for each bed space to minimise the risks of cross infection.

- The CRCU undertook regular infection prevention and control audits which included hand hygiene. Monthly hand hygiene audit results showed that there was 100% compliance with best practice guidelines throughout 2015.
- The unit had one isolation room available. This room could be used to provide a negative pressure environment. Negative room pressure allows air to flow into the isolation room but not escape out from the room, preventing contaminated air from circulating amongst other patients in the unit. We saw that a second isolation room was in the process of being refurbished for use, which would also have negative pressure facilities.
- Adjacent bed spaces were separated by disposable curtains, which were changed after each patient.
- The CRCU had a consistently low rate of unit-acquired infections. There had been no cases of unit-acquired methicillin-resistant staphylococcus aureus in the unit between September 2014 and September 2015, and no cases of clostridium difficile or bloodstream infections during the same period.
- The CRCU also monitored and reported on ventilator acquired pneumonia (VAP). CRCU undertook a monthly audit of patients with tracheostomy tubes of which all, if not most, were ventilated.
- Staff followed clear waste and clinical specimen disposal arrangements. The unit had separate dedicated areas for clean and dirty equipment, linen and specimens, with clearly marked standard waste and clinical waste bins. Sluice facilities were contained in the dirty utility.

Environment and equipment

- The CRCU did not adhere to the guidance of the Department of Health Building Note (HBN) 04-02 for critical care units. Health building notes give 'best practice' guidance on the design and planning of new healthcare buildings and on the adaptation/extension of existing facilities. The CRCU had identified through their Business Plan (2014-17) that they were non-compliant with HBN 04-02 in a number of areas. In the HDU area there was not a wash basin in each bed space (HBN 04-02 4.3). The bed spaces in ITU and HDU

Critical care

were below the minimum recommended dimensions of 25.5 metre squared (4.14). Staff at the nursing station could not see multi-bed spaces under their control or the entry points to the ward (6.1). The non-compliances with HBN were recorded on the CRCU risk register but were graded as a low risk priority and there were no clear mitigating actions documented on the register. However, in the business plan the non-compliance across the areas were noted as being 'significant clinical risks'.

- Risk assessments had been carried out to reduce the risk of the current layout of the unit. The number of incidents recorded as a result of the layout and space issues were stated to be minimal. A further review with director and deputy director of nursing with the matron was on-going.
- There was clear signage directing visitors to either HDU or ITU. Both areas were accessed via separate entrances. The entrance to ITU was locked and had an intercom system to enable staff to verify visitors before they entered the ward. The HDU entrance was accessed via an adjoining ward. Staff said that relatives were clearly told whether their loved one were on HDU or ITU and could then follow signs to the correct area of CRCU. However, we observed relatives entering CRCU through the HDU entrance to visit their relative in the ITU area. The door separating the CRCU from adjoining ward was kept wide open and unlocked because it was said to be too disruptive to staff who were working in the adjoining coronary care ward. This meant that staff could not maintain oversight of visitors to the ward, which could pose a security risk. This risk was on the CRCU risk register and the risk assessment showed risk management measures were in place. These included staff taking a proactive approach in approaching visitors to the unit, the ability to lock the unit if there was an identified security threat, and the use of coloured tape to highlight the second entrance to the unit.
- The majority of staff we spoke with, including service leads, said that the layout of the ward was less than optimal for the delivery of critical care. Nursing staff told us that the distance between the ITU and HDU areas meant they frequently felt they could not maintain an awareness of the safety of the unit as a whole when assigned to one area.
- There were two emergency equipment trolleys in the unit. The contents of the trolleys were checked daily in line with trust policy. Neither were tamper-evident

meaning that they were open and accessible at all times. One trolley was in main ITU, which was staffed at all times. The second trolley was in an open and accessible corridor outside the HDU area. Other staff or visitors could therefore remove items from this trolley. This presented a security risk and a risk that the trolley may not be fully stocked at all times, which could have a negative effect on patient safety. Staff promptly moved the trolley to inside the HDU area (which was always staffed when in use) when this was raised by the inspection team.

- Risk assessments had been completed which supported the resuscitation trolleys being unlocked. However, the risk assessments stated there were minimal risks associated with this as the trolleys were visible to ward staff at all times but we observed this was not the case. The resuscitation officer was unaware that medicines were loose in the trolley outside the HDU but was aware this was the case with the trolley in ITU. The loose medicines were replaced with sealed boxes of emergency medicines during our inspection. The trolleys overall remained non tamper-evident.
- The CRCU had central monitors displaying live observations from the patients' own monitors, allowing remote monitoring. This meant medical and nursing staff were able to monitor patients when they were away from the patient's bed space.
- The unit had immediate access to regularly used specialist equipment, and could request other equipment not held locally. Equipment in the unit included machines capable of haemofiltration (a process where a patient's blood is passed through a machine where waste products and water are removed. Replacement fluid is then added and the blood is returned to the patient), syringe drivers and non-invasive breathing equipment. Staff told us they could get specialist bariatric equipment (equipment used in the care of obese people) through the central hospital supply if required.
- Equipment in the CRCU was regularly maintained. We reviewed a random sample of equipment and found servicing and safety testing was in date.
- Training records showed that staff were appropriately trained to safely operate equipment in the CRCU.

Medicines

- Medicines in CRCU (other than the small number of medicines kept in the resuscitation trolleys) were stored

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safely and securely. Staff used a numerical key code to gain access to the clinic room where medicines were stored. The temperature of the fridge used to store medicines was within the required limits and this was monitored on a continuous basis using an electronic Wi-Fi system.

- Controlled drugs (CDs) were stored safely and managed in accordance with legislation and policy. Keys to the CD cupboards were held by nominated nurses, identified to all staff at the beginning of each shift. All CDs were audited daily, with evidence of these checks being recorded in the CD registers.
- The unit used an electronic prescribing system supplemented by specialist paper prescription charts for complex infusions which staff told us worked well. We reviewed both the paper and electronic records and found they were accurate. Records of medicines administered were maintained. We carried out a random check of three electronic prescription records and found they were all fully completed.
- Nursing staff told us they received training about the safe administration of medicines and could only administer medicines after they had completed competency assessments.
- Antibiotics were administered in accordance with the trust's microbiology protocols which staff had access to and microbiologists provided advice on antibiotics as needed.
- The unit had a dedicated pharmacist. They were present on the ward each day during usual working hours. The pharmacist reviewed all patients' prescriptions to ensure that patients were prescribed medicines safely, and that medicines were being managed according to best practice guidance and trust policy.

Records

- Records were stored safely. They were current, clearly laid out and provided a clear history of patient care and treatment. The majority of patient records were paper records.
- Staff followed a uniform process for daily recording of both nursing, medical notes and patient observations across both the HDU and ITU. Observation charts were located at the patient bedside. Observation charts

recorded details of medically led care plans, which outlined the interventions required in the next 24 hours including multidisciplinary input such as physiotherapy or review by specialist practitioners.

- Staff documented detailed conversations with relatives on a separate record, which meant that staff could ensure they did not duplicate or give conflicting information.
- The CRCU used electronic prescribing and the pharmacist told us staff had restrictions on their log in with differing level of access. Only doctors or pharmacists had prescribing rights. Therefore other staff could not alter the medicines prescribed, including infusions, IV or oral medicines.

Safeguarding

- There were processes and guidance documents available to support staff in managing safeguarding concerns. Policies and procedures relating to safeguarding were easily accessible on the trust's intranet system.
- Staff were aware of their responsibilities with regard to safeguarding. They were able to tell us what would constitute a safeguarding concern and the process they followed to raise an alert. Staff were able to describe scenarios where they would need to raise a safeguarding alert with accuracy.
- Safeguarding adults and children was part of the mandatory training requirements for all staff at this hospital. At the time of our inspection 39 out of 41 eligible staff within critical care had completed the required minimum (level 1) safeguarding adults training. Thirty one out of 38 eligible staff had completed the required training in safeguarding children at level 2.
- There was up to date and relevant safeguarding information on staff noticeboards in the CRCU which contributed to making sure that protecting patients and their relatives from harm or abuse was given sufficient priority.

Mandatory training

- The trust had an induction programme for all newly appointed staff that included the mandatory training required. Staff could access both e-learning training modules and face to face training.
- Overall mandatory training compliance for CRCU nursing and clerical staff was 97.8% at the time of our inspection. Mandatory training for CRCU staff included

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basic life support, fire safety, infection prevention and control, information governance and moving and handling. However, overall training compliance for medical and anaesthetic staff was 85.2% which was below the trust target of 95%.

- The critical care outreach team were 100% compliant with mandatory training requirements at the time of our inspection.

Assessing and responding to patient risk

- All patients admitted to CRCU had on-going risk assessments completed. These were available in the patients' records seen, and used in the development of care plans. The risk assessments included pressure ulcer, venous thromboembolism (VTE) and falls.
- The National Institute for Clinical Excellence (NICE, 2010) recommends that all patients should be assessed for the risk of developing thrombosis (blood clots) on a regular basis. The unit's performance for completing pressure ulcer and VTE risk assessments for the months July to December 2015 was 100% compliance. Patients were prescribed prophylactic (preventive) medicines and other measures such as stockings for the prevention of thrombosis.
- Staff followed guidelines for the prevention and management of pressure injury. Patients had their pressure risk assessed using a standardised assessment tool. Pressure relieving equipment such as pressure relieving mattresses were on all the beds.
- A hospital-wide electronic national early warning system (eNEWS) was used to identify deteriorating patients, as part of the escalation process. Although the eNEWS system was not used in the CRCU, it helped identify when a patient maybe escalated for critical care review on the wards and appropriate care and support provided. eNEWS was also used when a patient was identified as ready for transfer to a medical ward from CRCU. This meant that when the patient was transferred the receiving ward already had baseline observations on their arrival.
- The critical care outreach team reviewed patients on wards who were assessed as deteriorating. The outreach nurses offered critical care advice and support to the host ward team. They liaised with critical care doctors if required to support this, and facilitated admission to the CRCU if needed.

Nursing staffing

- The CRCU staffing numbers were reviewed and agreed annually at trust level using the Association of United Kingdom University Hospital's (AUKUH) acuity and dependency tool.
- The unit leaders aimed to have a band 6 or 7 senior nurse on each shift who was supernumerary and supported staff in safely managing the unit. However, we saw that this was not always possible to achieve with the available nursing staff. We observed during our inspection that a band 5 was left as the most senior member of the nursing team and was also in charge of the direct care of a patient. The nurse in charge had escalated this to the matron who was available by telephone or pager if needed. The nurse told us they felt confident in managing the shift requirements and the matron told us that this particular nurse was very experienced and had previously worked at a more senior level.
- There was unscheduled staff sickness during our inspection which had reduced the number of nurses during that time.
- During our inspection we reviewed planned staffing and actual staffing for the CRCU, which correlated closely. Where staffing shortages were predicted senior staff would request bank and agency staff and/or rearrange shifts if appropriate. Where staffing shortages were at short notice, senior staff who would not usually be included in the staffing numbers, such as the Clinical Nurse Educator (CNE) or the nurse consultant would provide clinical support to the unit.
- The minutes of the critical care delivery group meeting November 2015 demonstrated that the trust, through their own gap analysis of the service specification, had identified a non-compliance as they did not provide a supernumerary person in charge 24/7, compared with 70% of the network who do. This was not in line with national guidance from The Faculty of Intensive Care Medicine, 2015, which specifies that there should be a clinical coordinator on duty 24 hours every day in critical care units.
- The CRCU had five level 3 (intensive care) beds and four level 2 (HDU) beds as well as one isolation room which could be used for either level 2 or 3 patients. Level 3 patients require one to one care, whereas level 2

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patients require one nurse to two patients. The duty roster was planned to provide cover for this but nursing staff told us that they flexed the nursing staff across all beds according to clinical need at the time.

- We reviewed the staffing numbers for the period between August and November 2015 and found that CRCU were funded for 36.36 (whole time equivalent) nursing posts and had used between 33.42 and 35.39 with steadily increasing numbers during that time.
- The Clinical Nurse Educator (CNE) was routinely providing clinical cover during our inspection. Service leads were aware that this was not in line with national guidance from The Faculty of Intensive Care Medicine, 2015, which states that each critical care unit will have a dedicated CNE responsible for coordinating the education, training and continued professional development of nursing staff. The CNE was not included on the unit rota but nursing staff said that the CNE spent the majority of their work time providing clinical cover to the unit. However, we saw evidence, such as training schedules and educational notice boards, which showed the CNE had been able to deliver training and development to staff on the unit.
- The critical care outreach team was made up of a nurse consultant leader, two full time nurses and one nurse who was shared between the outreach team and the CRCU. The outreach staff we spoke with told us this was sufficient to provide the current service from 8am to 8pm.
- The nursing handover took place daily at 7.30am and 7.30pm and followed a structured format. The shift leader for day and night handed over to each other in the staff office. Each patient was reviewed and any changes were clearly communicated including any new treatment and investigations. Staffing numbers were confirmed and staff allocated ensuring continuity of care and staff were able to request change of patients. The shift leader was responsible for passing on the handover information to the rest of the shift on duty.
- Several staff we spoke with told us that the unit was often very busy and there was not always sufficient nursing staff to provide adequate care to the patients. We observed that the CRCU was very busy and staff appeared to be rushing through tasks.
- Bank and agency use between May 2014 and November 2015 ranged between 3.7% and 10.7% of the total staffing. We spoke with one bank nurse who told us they

were well supported in their role. Other staff we spoke with, and shift rosters we reviewed, evidenced the use of a pool of regularly used bank and agency staff which ensured consistency of care for patients.

- Healthcare assistants worked to support the role of the registered nurses. Rosters showed that there was usually one healthcare assistant on each day working alongside an average of five to six registered nurses. The nurses allocated tasks to the healthcare assistants that were appropriate to their level of skill and experience.
- The CRCU did not have a dedicated physiotherapy team but shared one full time physiotherapy team leader, one physiotherapist and one therapy assistant with all of the medical wards except those wards which provided care for the elderly. There was one vacant physiotherapy post, which was awaiting approval to be advertised. The physiotherapy lead and nursing staff told us that there was not sufficient physiotherapy cover across the surgery division. However, the physiotherapy team prioritised critical care to ensure that all patients were reviewed by a physiotherapist within 24 hours of their admission to the unit.

Medical staffing

- Medical staffing on the CRCU met the Guidelines for the Provision of Intensive Care Services (2015) in relation to overall consultant intensivist to patient ratios. The consultant intensivist to patient ratio was one consultant to every eight patients if the unit was at full bed occupancy. This meets the guidance of no more than one consultant intensivist to more than 15 patients.
- Consultant cover was provided from 8am to 8pm weekdays and for eight hours per day at weekends. Outside of these hours, there was a nominated consultant on call who was shared across CRCU, obstetrics and theatres. The Guidelines for the Provision of Intensive Care Services (2015) defines the standard that the consultant in intensive care medicine must be immediately available by telephone 24/7 and able to attend within 30 minutes. The consultants and service leads were aware that they may not be able to meet this standard if they were required in obstetrics or theatre. We were not made aware of any contingency plan if this situation occurred. However, they told us there were unaware there had ever been a situation where they were unable to attend CRCU within 30 minutes. There were no recorded incidents of this within the year prior

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to our inspection. The service leads had risk assessed the potential impact and concluded that the level of demand across the hospital at night did not require a change in practice.

- There was a junior doctor at core trainee year one (CT1) or above on CRCU 24 hours a day, seven days per week.
- Speciality trainee doctors in year three (ST3) or above supported less experienced junior doctors including at weekends.
- All medical staff we spoke with said there was sufficient numbers of trainees and middle grade doctors to safely cover the workload on the unit. Junior doctors we spoke with said they were well supported by more experienced medical staff including consultants.

Major incident awareness and training

- Staff were aware of how to access the trust's major incident policy both in paper format and on the trust's intranet. The trust had a major incident plan, which included specific plans for critical care staff to follow. This included emergency grab bags to use in the event of a major incident.

Are critical care services effective?

Good



By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

We rated effective as good because

- Nationally recognised care bundles were followed.
- The unit participated in national audit programmes such as submission of data to the Intensive Care National Audit Centre (ICNARC). Patients' predicted mortality outcomes at this critical care service were in line with, or better, when compared with similar units with the exception of patients admitted with pneumonia.
- The unit was offering evidence based care and treatment in line with national guidance.
- Patient' nutritional needs were met and dietetic input was offered through twice weekly hospital wide 'nutritional rounds'.

- Physiotherapists prioritised critical care to ensure that all patients received a physiotherapy review within 24 hours of their admission. Rehabilitation prescriptions were provided to each patient when they were discharged from hospital.
- There was effective multidisciplinary working and we saw excellent communication between nurses and doctors in the multidisciplinary handover.
- Fifty-nine percent of the nursing team had completed a post-registration award in critical care which was in line with national guidance. Staff were sufficiently skilled to deliver critical care. Local induction arrangements were in place for new staff which included a competency framework to achieve and supernumerary time to do this.
- The critical care outreach team had all received an annual appraisal.
- This unit had seven day access to physiotherapy, pharmacy and microbiology.
- There were robust systems in place to ensure that staff had timely access to information about patients and to support effective care and treatment.

However,

- Patient's pain was not being routinely monitored or managed effectively.
- Not all staff (21%) on the CRCU had received an annual appraisal which was not in keeping with trust policy.
- The unit had a dedicated Clinical Nurse Educator (CNE) as recommended through national guidance. However, we were told, and observed, that the CNE was frequently required to cover direct patient care which reduced the time they had to organise and deliver the required training and education for nurses at this unit.
- The critical care outreach team was not a 24 hour service which was not in line with nationally agreed guidance. The trust was working towards a 24/7 outreach service.

Evidence-based care and treatment

- The CRCU's care practices followed current evidence based best practice. We observed both medical and multidisciplinary handovers during which discussions demonstrated that evidence based treatment was carried out.
- Nationally recognised care bundles were followed. A bundle is a structured way of improving the processes of care and patient outcomes: a small, straightforward set

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of evidence-based practices that, when performed collectively and reliably, have been proven to improve patient outcomes. These included care bundles to reduce the risk of ventilator acquired infections, and central line infections or complications. The trust had not had a ventilator acquired pneumonia in the last year and no central line infections in the last five years.

- There was a clinical trials/research board in the staff room which had up to date information about clinical trials and research programmes that were underway.
- The CRCU was using national best practice guidelines and research from relevant groups to ensure care and treatment was effective. Policies and practices were based on Royal College guidelines, Intensive Care Society recommendations and National Institute for Health and Care Excellence (NICE) guidance. The unit were compliant with NICE guidance, CG32, Nutritional Support in Adults.
- Records showed the unit was fully compliant with NICE 83 guidance for Rehabilitation After Critical Illness in Adults. Physiotherapists completed assessments of patients rehabilitation needs within 24 hours of admission. They ensured that a rehabilitation prescription, an extension of a discharge/transfer summary including on-going health and social care plans. In particular, the prescription ensure patients' needs, and the plans made to address these, are clear as patients move from one setting to another, were available for the patient on discharge.
- The CRCU used the nationally recognised FAST HUG care bundle (Feeding, Analgesia, Sedation, Thromboembolic prophylaxis, Head-of-bed elevation, stress Ulcer prevention, and Glucose control) as a means of identifying and checking some of the key aspects in the general care of all critically ill patients.
- Patients were safely ventilated using specialist equipment and techniques in accordance with national best practice. This included mechanical invasive ventilation to assist or replace the patient's breathing using endotracheal tubes (through the mouth or nose into the trachea) or tracheostomies (through the windpipe). The unit also used non-invasive ventilation to help patients with their breathing, using masks or similar devices. All ventilated patients were constantly reviewed and checks made were recorded hourly.

- Protocols for the management of controlled ventilation was available and followed which included acute respiratory distress algorithms and took account the predicted weight of patients.
- The Core Standards for Intensive Care Units (2013) recommend all patients are screened for delirium. Patients in a critical care setting are at high risk of psychological effects resulting primarily from the medicines used to treat patients such as sedatives. Patients were screened for delirium using the confusion assessment method for intensive care units.
- The critical care unit adhered to NICE guidance CG135 Organ donation for transplantation: improving donor identification and consent rates for deceased organ donation by promoting and participating in a programme of organ donation led nationally by NHS Blood and Transplant. A specialist team facilitated the organ donation programme and worked closely with the unit.

Pain relief

- Patient's pain and responses to pain were not routinely measured as part of their on-going observations. Only patients receiving specific pain relief, such as Patient Controlled Analgesia (PCA) or fentanyl skin patch, had a related care plan which included hourly recording of pain observations.
- We observed a patient who was evidently in a lot of pain not having their pain treated effectively. The patient had been prescribed PCA but was unable to administer the analgesia themselves at that time due to their physical condition. The patient did not have a PCA care plan or pain monitoring chart. Nursing staff implemented a PCA care plan and assessed and managed the patient's pain when this was raised by the inspection team.
- Prescription records showed regular pain control was administered which included as required pain relief.
- Staff told us they could access the specialist pain team who were responsive and provided guidance and support to manage patients' pain effectively, including daily visits to the unit. A patient whose pain had not been well controlled had been referred to the pain team and was awaiting review. However, without on-going monitoring and recording of pain assessments some patients may not be assessed as requiring further pain management. The acute pain team also managed epidurals (pain relief injections into the space surrounding the spinal cord) in CRCU.

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- Patients who were approaching readiness for discharge to a medical ward would be started on Vitalpac, which is the trust's patient clinical monitoring system. Vitalpac will alert staff if the patient's vital signs are outside expected limits. We saw where Vitalpac had been used for a patient who was awaiting transfer to a medical ward and their pain had been scored and recorded.
- Staff told us they assessed patient's pain levels by observing non-verbal signs such as facial expressions or agitation as well as listening to patients own expression of pain if they were able to verbalise. However, as this was not routinely being recorded there was no way that staff could assess whether a patient's pain was worsening or improving in response to interventions.
- Staff confirmed there were no pain score tool used in CRCU which would be appropriate for patients with a learning difficulty and those living with dementia. This could impact on the delivery of effective pain control at the right time to meet the needs of these patients.

Nutrition and hydration

- Patients' nutrition and hydration needs were being met. Staff followed the trust's standard feeding protocols to ensure ventilated patients received adequate nutritional intake. This included the target rates for feeding according to the patient's weight. Staff were advised to gradually increase the feeding rate according to tolerance. This was monitored and reviewed on the consultant round and in the twice daily handovers.
- The CRCU did not have dedicated dietetic support. However, dietetic advice and support was available through the hospitals twice-weekly nutritional rounds, which included a visit to the CRCU.
- Patients' nutritional intake was recorded and monitored, daily fluid balance charts were maintained. We reviewed three care records and found the fluid balance charts were completed fully.
- Staff provided support with food and drinks in a respectful manner. Patients who were able to feed themselves were given the time and opportunity to do so. Hot and cold drinks were available and we observed staff ensured these were placed within the patients' reach.

Patient outcomes

- The CRCU submitted data to ICNARC in order to monitor patient outcomes and compare performance to that of similar units. The most recently published report was viewed, which was for the period 1 July 2015 to 30 September 2015.
- ICNARC data showed that the predicted mortality of overall patients discharged from this unit was better than that of both all other CCU participating nationally and when compared with similar (network). This had been consistent since 2010.
- Annual ICNARC data from 2015 showed that patients admitted with sepsis, trauma and for elective and emergency surgery had a better predicted mortality than seen nationally or when compared with similar units. For patients admitted with pneumonia their predicted mortality was worse. We were not made aware of any targeted action being made by the trust to address this.
- Between 1 July and 30 September 2015 ICNARC data showed that the average length of stay in this unit was lower than other units nationally and in the network. For patients admitted with sepsis the length of stay was significantly lower with an average stay of below five days.
- In the same reporting period mortality overall was 8.5% which was 17 out of 201 patients. Of these, 82.4% had treatment withdrawn due to medical futility. Where patients predicted outcomes were discussed management plans were put in place to improve outcomes or support the withdrawal of treatment if appropriate.
- The ICNARC data for this period also showed that this unit performed better than the national and network average for early readmissions to the unit. This means that fewer patients than seen in other similar units were readmitted to this CRCU within 48 hours of their initial discharge. In the same data period this unit showed a fluctuating picture for late readmission (after 48 hours) where they were both better and worse than the national and network average at varying times in the data collection period.
- Staff told us they were proud of the positive outcomes for patients at this unit as the patient population they served had a higher than average number of elderly

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people who often presented with complex needs. Staff were aware of the significance of the data submitted and minutes showed patient outcomes were discussed at the critical care delivery group.

Competent staff

- Junior doctors told us they had good support from consultants and nursing staff. They were able to access regular training including weekly training sessions delivered by consultants. Junior doctors were able to develop their skills and gain clinical experience such as insertion of lines.
- Fifty nine percent of nursing staff had completed post-registration training in critical care nursing. This met national guidelines that a minimum of 50% of nursing staff in a critical care setting have a further qualification in critical care nursing.
- New nursing staff were supported through a supernumerary induction. There was a competency framework developed by the Clinical Nurse Educator (CNE) for new staff to complete. The supernumerary period was usually for one week with the nurses caring for less complex patients after this with support from more experienced staff. The supernumerary period could be extended depending on the individual's competence and confidence.
- The CNE had developed a training matrix for all nursing staff, kept a record of the nurses' training to date and identified any gaps in skills or training, and offered individual training to staff as needed. Staff spoke positively about the CNE role but said the CNE was too often required to cover clinical shifts. We saw an education notice board located near the staff room, which evidenced training compliance and detailed upcoming training or educational events.
- Four nursing staff we spoke with told us they had received an annual appraisal but said that appraisals were not always achieved for all staff within the annual timeframe.
- Data provided by the trust showed us that in December 2015 79% of the CRCU staff had received their annual appraisal. This was not in line with trust policy and meant that staff would not have had the opportunity to formally review their aims, objectives and development needs for the year.
- The critical care outreach team had all received an appraisal within the annual timeframe at the time of our inspection.

- Nurses we spoke to told us they were being supported by the unit leaders and the CNE in working towards the nursing revalidation requirements.

Multidisciplinary working

- We saw excellent multidisciplinary working between nursing and medical staff on the CRCU. We observed a multidisciplinary handover which was attended by nursing and medical staff at a varying range of seniority. The physiotherapist team leader also attended. All staff at the handover displayed professional courtesy and there was an obvious culture of making team agreed decisions based on a multidisciplinary approach to care and treatment.
- Pharmacy staff visited the unit daily and a designated pharmacist was allocated to the unit. Microbiologists were available to offer advice and support to the unit as needed.
- There was good support from clinicians across other directorates. This included orthopaedics and care of the elderly physicians. For patients who had undergone surgery, the surgical medical teams also reviewed their patients.
- There were good links with the end of life care team and there were two nominated end of life care champions on the unit who took the lead in ensuring staff were implementing best practice in end of life care.
- There was a multidisciplinary team approach for the planning and discussing organ donation with the patient and those close to them. The CRCU had a good relationship with the organ donation service. The specialist nurse for organ donation post was vacant at the time of our inspection. However, interim support had been organised and we saw effective discussions between the organ donation nurse and staff on the CRCU.

Seven-day services

- The service had intensivist cover on site 24 hours a day, seven days a week. Out of hours the on call intensivist was immediately available for telephone consultation and could access the hospital within 30 minutes.
- Once admitted to critical care, a consultant intensivist led the patient's care as defined by the Faculty of Intensive Care Medicine. The Consultant saw all patients

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under their care at least twice daily, which included weekends. This was in the form of a structured bedside round where management plans were discussed and reviewed with the critical care team.

- Patients were reviewed by a consultant intensivist within 12 hours of their admission to the CRCU. This met the standard outlined in the Guidelines for the Provision of Intensive Care, 2015.
- There was good access to other services seven days a week. Physiotherapy, radiology, pharmacy and microbiology were all available seven days a week; with out of hours' access available where required through the trust's on-call system. The physiotherapy team provided cover in the unit seven days a week, although at weekends this was a reduced service. They were responsive to patients' needs and assessments were completed to identify those patients requiring additional input.
- The outreach team was available from 8am to 8pm seven days a week. This meant that critical care did not meet the nationally agreed guidance that 'each hospital should be able to provide a critical care/rapid response team that is available 24/7'. Senior managers were aware of this and was working towards expanding the outreach service to be 24 hours a day seven days a week within the next three years. The trust were actioning plans to combine the hospital at night and critical care outreach function as there was deemed to be insufficient demand to have the critical care team 24/7.

Access to information

- In the ITU area patients' notes were held by the patient's bedside so all staff had access to patient information. In the HDU area patient's records were held in a locked cupboard which was accessed by staff working in that area.
- At the multidisciplinary handover the team were able to access patients' investigation results which facilitated discussion about plan of care and discharge planning.
- When a patient was discharged to another ward from the unit, all relevant notes and records required to support their on-going care were available. Where appropriate, records were printed from the electronic system and were sent with the patient to the ward. The CRCU staff also completed a detailed paper transfer form to ensure all relevant information was available to promote continuity of care.

- Test results, for example X-rays, scans and blood tests were available on the electronic system.
- During the bedside round, the nursing co coordinator completed a 'critical care daily plan sheet' for each patient. This communicated any changes in the patient's care such as weaning from ventilation, sedation hold, and any tests to ensure effective communication from the bed patient's round.
- Policies, procedures and other supporting information were available on the trust's intranet to support and guide staff's practices.
- The critical care service were in the process of developing an identified 'sharepoint' on the trust's intranet which would contain all information relevant to the critical care setting which could be accessed by all staff.
- Staff could access information on staff noticeboards in the staff room about topics such as pressure ulcer prevention, infection control practices, safeguarding and duty of candour requirements.
- The shift coordinator used a clipboard, which contained all essential information for the shift including staffing, patient care plans including daily objectives and any safety updates. This provided a useful quick guide to the unit's clinical activity for that shift.

Consent and Mental Capacity Act.

- Staff were aware of the need to seek permission where possible from patients before carrying out any care or treatment. We observed verbal consent being sought from conscious patients prior to provision of care. Patients we were able to speak with confirmed that they were asked for permission before any care or treatment was provided. There was evidence of consent being requested in patient records.
- Nursing staff we spoke with told us they would always gain a patient's consent before delivering interventions, where possible. Where patients were assessed as lacking capacity, decisions were made in their best interests ensuring that relatives were consulted with and the individual circumstances were considered.
- Staff we spoke with had an effective understanding of the Mental Capacity Act (MCA 2005) and Deprivation Liberty Safeguards (DoLS). They were aware of the impact of DoLS when providing care and treatment to patients in the CRCU environment.
- Records from critical care strategy group meetings showed that there was some uncertainty around how

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the use of DOLS were suitably applied in the critical care setting. However, the service leads were liaising with other critical care providers in the local network to share practices and ensure patients were not unlawfully deprived of their liberty.

- We saw consideration of patient's deprivation of liberty being fully explored during the multidisciplinary handover. If the team agreed that a patient's liberty was being deprived an application was made to the local authority for authorisation. There were examples where the urgent authorisation for DoLS had been implemented when patients had required emergency ventilation. The expiry dates and time taken to respond to DoLS applications were monitored and recorded as an incident when time frames were exceeded. When this occurred follow up action was taken and recorded.

Are critical care services caring?

Good



By caring, we mean that staff involve and treat patients with compassion, kindness, dignity and respect.

We rated caring as good because .

- Patients were treated with respect care and compassion by staff. Patients and relatives we spoke with confirmed that staff were kind and helpful in their approach.
- Patients and their relatives were involved, where possible, in decisions made about their care and treatment. Staff were sensitive when required to deliver bad news and ensured that suitably skilled and experienced staff were available to support patients and relatives at these times.
- Emotional support for patients, such as the development of patient's diaries, was encouraged and valued.
- Relative feedback through the Family Reported Experience Evaluation survey published in 2015 confirmed that relatives valued the compassionate care offered by nursing and medical staff.
- The multi-faith chaplaincy service could offer emotional and spiritual support if requested.

- Staff demonstrated a good awareness of the emotional needs of critical patients both during and after their admission. Staff had referred patients to local support groups for critical patients if the need for on-going emotional support was identified.

However,

- There was no psychology service at this trust so critical care patients with complex emotional needs could not be referred for formal psychological support.

Compassionate care

- Care was provided in a caring and compassionate way that offered dignity and respect to the patient. Staff took the time to talk with patients, even when they were sedated and explained what they were doing.
- Where visitors entered the unit through the main entrance they were welcomed into the department and staff conversed with visitors in a caring and compassionate manner.
- We spoke with one patient who said that though staff were very busy they made the patient feel that 'nothing was too much trouble'.
- We spoke with two sets of relatives who told us that they were happy with the care offered to their loved ones and reported that the nursing staff were 'kind' and 'helpful'.
- The unit participated in the Family Reported Experience Evaluation study between 9 June 2013 and 30 June 2014, and received the published results in April 2015. The results of this study showed that relatives found that staff were compassionate in their care of critically ill patients. The overwhelming majority of comments from relatives were positive and included 'I cannot fault the care my husband received' and 'the compassion demonstrated by the [unit] was total and carried out with great respect and humility'. No relatives commented unfavourably about staff's delivery of compassionate care.

Understanding and involvement of patients and those close to them

- Patients who were able to speak with us said they were provided with information and involved in the care and decision regarding their treatment.
- The unit had developed the use of patient diaries. The diary was a summary of events of the time when the patient was admitted critically ill, likely to have been sedated from which they had only fragmented or no

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memories at all. The diaries were also seen as an important support for a long time after their stay in the CRCU. All staff and patient's relatives were encouraged to contribute to the diary. One patient we spoke with said the diary had helped them to make sense of their experience in critical care.

- Relatives felt they were fully informed about their family member's treatment and care. They said staff checked whether they wanted to be contacted overnight with any changes in their family member's condition and their wishes regarding this were respected.
- Both patients and their relatives commented that information was discussed in a manner they understood. They said there was always a member of staff available to help them understand the explanations. Relatives said staff explained everything to the patient, even though their understanding might be limited or not known. This was particularly evident for patients suffering from delirium following sedation.
- We saw a consultant talking to some relatives in a calm and reassuring way. The relatives were given time to ask questions and provided with reassurance about the patient's current condition.
- The unit participated in organ donation programmes. We observed the multidisciplinary handover where the team planned to have sensitive discussions with relatives about the potential for organ donation. The team considered which team member was best placed to hold the discussion and how that particular family would be likely to respond and what support they may need. We also observed staff discuss a patient with a living will and their commitment to ensuring that the patient's wishes in the event of their death were met was very evident.

Emotional support

- Staff respected and demonstrated concern for patients and their relative's emotional needs on the CRCU.
- Breaking bad news was always done with a consultant intensivist and a senior nurse present. This meant that patients and their relatives were being told difficult information by staff who were suitably skilled and experienced to deliver news sensitively.
- Staff told us that they could request emotional and spiritual support through the trusts multi-faith chaplaincy service at the patient or relatives request. The chaplaincy service did not routinely visit the CRCU unless requested to do so.

- We observed a discussion in handover about a patient's presenting anxiety and staff demonstrated that they understood what measures would be helpful such as giving clear and concise information and sticking to agreed timescales for interventions to avoid further unnecessary anxiety.
- The end of life care champions on the CRCU worked collaboratively with the trust end of life care specialist in providing end of life care and support to patient families and also to staff caring for the patient.
- Staff told us of times where they had referred patients identified as requiring on-going emotional support to a regional branch of a national support group for critical care patients.
- This trust did not have a psychology service. This meant that patients requiring complex emotional support were unable to access formal psychological intervention. The Faculty of Intensive Care Medicine recommend, but do not require, that psychological input should be available to critical care patients.

Are critical care services responsive?

Requires improvement

By responsive, we mean that services are organised so that they meet people's needs

We rated responsive as requiring improvement

- Patients were not always discharged in a timely way.
- Delays in discharges meant patients ready to move to a ward were accommodated in mixed sex accommodation, and an environment not best suited to meet their needs, for significant amounts of time. Mixed sex breaches were not being identified and reported in line with national guidance.
- There was no follow up clinic available for patients post-discharge from the CCU.

.However,

- The critical care service was responsive to individual patient needs. Staff were responsive and worked collaboratively to meet patients' health needs including those unrelated to their critical illness or condition.
- Staff at the unit were responsive to emergency admissions and provision of critical care beds to accommodate unwell patients.

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- There had been no complaints about this service during the whole of 2015. Concerns from patients and relatives were responded to in a timely manner and there were clear arrangements for escalating, investigating and learning from complaints as they arose.
- Staff made reasonable adjustments and used tools to support patients from vulnerable groups such as individuals with a learning disability. There was recognition that critical care units are not, by nature of the complex equipment required, dementia friendly. However, effort was made by staff to move patients out of the CRCU once their condition had stabilised.
- There were consistently low numbers of non-clinical transfers to and from this unit.
- The CRCU was not suitable for patients who were ready for transfer home or to a medical ward. There were no facilities on the unit for those patients to shower or to make themselves drinks if there were well enough to do so.
- The relative's rooms on the CRCU did not allow for relatives to stay overnight unless they slept on small sofas. Nursing staff told us they would be flexible if relatives needed to stay due to a patient's declining presentation but this could not be guaranteed. There were no refreshments available in the relative's rooms.
- Relatives had to leave the unit to get refreshments and use the toilet which was sited off the unit. Lack of facilities for relatives had been commented on by a significant number of relatives in the Family Reported Experience Evaluation study published in 2015.

Service planning and delivery to meet the needs of local people

- Staff at the unit were responsive to emergency admissions and there was timely provision of a critical care bed.
- The trust submitted continual data to ICNARC which meant they could routinely evaluate the demographics of the people using critical care services including age range, gender, health needs before the need for critical care and any trends in rising or falling numbers of patients requiring critical care services in this region.
- At the end of 2013 there was a review of the service provision including the unit's strengths and weaknesses and compliance with the Intensive Care Society Core Standards (2013). From this review, the Dorset County Hospital NHS Foundation Trust Critical Care Clinical Business Planning 2014-17 was developed.
- The unit was aware of the limitation of the design of the unit and the impact this had on their ability to provide service including the number of isolation rooms. An additional isolation room was being provided. Other environmental issues required a greater investment to address such as lay out of bed spaces and the provision of single hand wash sinks in each bed space in order to comply with HBN 04-02.
- The service was considering how the unit could comply with the Intensive Care Society Core Standards (2013) including providing a twenty four hour seven day a week outreach service. Also, how the service could provide a follow up clinic for critical care patients. Action had already been taken to ensure compliance with NICE 83 guidance Rehabilitation after critical illness in adults.

Meeting people's individual needs

- Staff told us they felt confident to deal with people who were confused or disorientated as this was often an after effect of sedation or the patient's underlying critical illness.
- The unit had good links with the dementia team who were available to provide advice and support for patients living with dementia. As with all critical care units, the environment was not dementia friendly. A senior staff said they always tried to transfer the patient out to a more suitable environment as soon as possible.
- Staff told us that though rarely required they were able to access translation services and translation services contact information was available on the trust's internet if needed.
- Reasonable adjustments were made for patients with a learning disability. For example, the unit had provided the patient with a 'care passport' document, a document which detailed holistic aspects of the patient's individual care needs. The care passport included things that were important for staff to know about the individual, their strengths and areas that needed support with even when they were well. The unit had asked the patient's mother to support the completion of this document and planned to send a copy to the patient's GP, keep one in the patient's record, and send the patient home with their own copy. This could be used by other care staff who supported them at home. We observed staff referring to the care passport when planning care and treatment.

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- The CNE had developed a leaflet about critical services for relatives which contained useful information about all aspects of the service including what they should expect when visiting, visiting hours and parking discount information. However, we only saw one copy of this leaflet attached to a noticeboard so could not be taken by relatives for reference. There were no leaflets available in the relative's rooms. Two relatives we spoke with had not been given any written information about the service.
- The relatives rooms were small and we saw where a large family were visiting a relative and could not all be together in the relatives room at one time. Relatives had frequently commented on the environment in the Family Reported Experience Evaluation (FREE) survey, which was conducted in June 2014 and published in April 2015. Relatives frequently commented in the survey that the waiting area and relative rooms were too small. These had not changed since publication of the FREE survey report. In response to the FREE survey results the trust had refurbished the relative's rooms and waiting areas but the size of the rooms had not been addressed.

Access and flow

- The CRCU had a clear admission policy and guidance, which staff followed. All patients were admitted under a consultant. Admissions to the unit included elective admissions (post-operative patients), and emergency admissions from all other specialities within the trust, as the hospital was a designated trauma unit. Other admissions included requests and transfers in from other hospitals.
- ICNARC data between July and September 2015, showed 3% of all admissions to the unit were for patient's requiring level 1 care within the first 24 hours of their admission. This meant that patients may not have been placed within the most suitable environment to meet their needs at that time. Throughout our inspection, we observed only patients requiring level 2 and 3 care in the unit.
- Admissions were discussed with the CRCU first and the outreach team also kept the CRCU staff informed of deteriorating patients around the hospital who may require intensive care. A senior nurse told us in the event of a CRCU bed not being available; a senior staff member from the unit would support the patient in the recovery area in theatres until a bed became available. Nursing staff we spoke with said this happened rarely.
- The Royal College of Anaesthetists recommend maximum critical care bed occupancy of 80%. ICNARC data for the July to September 2015 reporting period showed that the unit was most frequently using between five and seven of the ten available (eight of which are funded) CRCU beds. This meant that there was flexibility in meeting increased demand for beds.
- The ICNARC data showed 40.8% of discharges from critical care to a ward were delayed over 12 hours. This meant patients remained on a critical ward when their needs could be best met in an alternative setting. In February 2016, there were 40 reported delayed discharges with delays ranging between 4.10 hours and 36.3 hours. Of the 40.8% delayed discharges reported between 1 July and 30 September 2015, 89.1% were then discharged to another ward within the hospital.
- The same data submission showed that 3.3% of all discharges occurred between 10pm and 8am which is not in line with national standards as defined by the Faculty of Intensive Care Medicine. Two percent of those patients discharged out of hours were transferred to another ward in the hospital.
- In the same ICNARC data period there were no non-clinical transfers in or out of this unit. This is better than the national and network average and means that patients are not moved to or from this CRCU to another for non-clinical reasons such as bed availability.
- The CRCU was a 'mixed sex' environment. The Department of Health (DoH) guidance 2010 on mixed sex accommodation acknowledges it may be difficult to eradicate this in a critical care environment. However, the guidance clearly sets out that critical care units are required to report unjustified mixed sex breaches. Once the patient no longer requires critical care they become an unjustified breach and should be reported locally and nationally. There were no mixed sex breaches reported for CRCU between September 2015 and February 2016. Given the high proportion of delayed discharges and the limited scope to segregate male and female patients on the unit it is likely that mixed sex breaches were under reported. This meant that a

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significant number of patients were being nursed in the mixed sex critical care unit, without appropriate facilities, when their needs would be best met in a specialty ward or other environment.

- The trust's local agreement was that mixed sex breaches occurred as soon as the patient was 'ward ready' but they were not reported until after 12 hours had passed. Additionally, the 'clock stopped' between 8pm and 8am as they had identified that patients were not ordinarily discharged during this time period. The DoH guidance states that mixed sex breaches should be reported as soon as they occur with no time delay. The trust's mixed sex policy also stated that mixed sex breaches were 'acceptable if patients agree to remain in ITU/HDU whilst an appropriate bed is found'. This meant that the unit was not adhering to DoH guidance and not ensuring that patients no longer requiring critical care were being care for in single sex accommodation.

Learning from complaints and concerns

- The CRCU had not received any complaints in the last 12 months. We reviewed the last complaint received and found good multidisciplinary involvement in the investigation and good communication with the complainant. Records were clear and lessons learned recorded and effectively disseminated and there was senior leadership oversight.
- We saw information about how to raise a complaint including the Patient Advice and Liaison Service (PALS) was available to the patients and their relatives.
- Staff followed the trust's complaint policy and said they reported complaints from patients or their relatives to the manager or matron.
- Relatives and patients we spoke with said they would raise any concerns directly with the nurse in charge and were confident that any concerns would be taken seriously.
- Staff told us they would always try and resolve concerns raised or patients or relatives in a timely way to offer a better outcome for the patient rather than encouraging the formal complaint route which is slower for the patient.
- The critical care delivery group reviewed any complaints received and investigated ensuring the sharing of learning across the unit.

Are critical care services well-led?

Good



By well led, we mean that the leadership, management and governance of the organisation assures the delivery of high quality person-centred care, supports learning and innovation and promotes an open and fair culture.

We rated well led as good.

- Critical services had a clear vision, strategy and objectives based on improving quality and safety that were in line with the overall trust vision.
- This critical care unit had effective governance arrangements. There were structured meetings to review all aspects of performance, quality and risks and high risks were escalated through the critical care strategic delivery group.
- Staff were familiar with and aimed to deliver their work in line with the trust's values of excellence, integrity, respect and teamwork. Staff felt connected to senior leaders including the Chief Executive Officer who communicated regularly with frontline staff.
- Frontline staff were able to describe the overall aims for the service which were in keeping with those described by the strategic leads.
- The unit undertook monthly audits which were discussed and learning was shared through the critical care delivery and strategic delivery groups.
- The unit had a locally held risk register which showed that risks were identified, mitigated and reviewed on a regular basis. However, we saw that some risks were not given sufficient priority on the risk register.
- Staff were positive about leadership arrangements and nursing leadership was visible on the unit. Junior doctors valued the strong leadership presence from the consultants on the ward. Managers recognised emerging issues and responded to them before a problem arose.
- Unit leaders displayed interest in staff wellbeing and offered the opportunity for emotional support, including formal debrief, as needed.

Critical care

Vision and strategy for this service

- Staff were familiar with the trust's values which were displayed in several places throughout the unit including on staff ID badges. The values were integrity, respect, teamwork and excellence. Staff could link their work to the trust values and staff told us their aim was to promote the values in their everyday practice.
- The service leads had produced a clinical business plan for the period 2014 – 2017, which outlined the business objectives including financial projections. The business plan stated a fully functioning critical care service was required to support the trusts vision to deliver compassionate and safe healthcare and their mission to deliver effective healthcare through professional, well motivated and committed staff; achieve high quality and safe clinical outcomes; improve the patient experience; provide value for money and learn from experiences in order to improve services.
- The vision of critical care unit was in line with the vision of the trust which was to deliver compassionate and safe healthcare.
- The objectives were to deliver the vision and a high quality, cost efficient critical care service; with a stable and contented workforce. The actions to achieve the objectives included developing knowledge and skills with outreach and training; specific investment in training nursing staff and enabling them to be released for training opportunities; addressing weaknesses in non-compliant areas identified against national guidelines; capital development plans for clinical and non-clinical areas; a rehabilitation facility for inpatient and post-discharge from critical care; a follow up service and the ability to refer to clinical psychology. Staff we spoke with could tell us what the operational aims of the service were over the next year such as developing the outreach service and improving facilities for relatives.
- The majority of staff we spoke with, including service leads, told us that the Dorset wide clinical service review was underway, which meant they did not have clarity about the strategic direction of critical care services. Staff reported that there had not been sufficient investment in the CRCU due to the lack of certainty about its future.
- Critical care services at this hospital were within the surgical division. Governance arrangements were clear and well understood by staff with a clear reporting line from front line staff to the divisional manager. The CRCU matron and the nurse consultant leader for the outreach team directly reported to the divisional manager. The clinical lead for the CRCU reported to the clinical director.
- The unit contributed to monthly local audits, which included infection control, ventilator acquired infection, central lines and early readmissions to the critical care unit. The audit results were discussed at governance meetings to ensure appropriate actions were recorded and monitored. Learnings from these audits were shared with the team as appropriate through the critical care delivery group meetings.
- The unit had a risk register, which was linked to the trust risk registers. A review of the risk register took place at the clinical care delivery group ensuring it was shared with frontline staff and any updates recorded. There were 13 risks recorded on the risk register which were reflective of the risks described by service leads and frontline staff. However, some risks such as the risks associated with the environment and non-compliance with HBM 04-02 were not given rating accurately and not given sufficient priority actions. All 13 risks were recorded as very low, low or moderate risks. Risks recorded included not meeting national guidance in relation to the limited outreach service and the staffing issues..
- The critical care delivery group meetings were held bi-monthly and happened in the evening to allow more staff to attend. Every other month there was a critical care strategic delivery group meeting which senior leaders such as the director of nursing, the divisional director and the matron attended. Meetings from these group meetings showed information being shared between operational and strategic staff involved in critical care.
- The trust collected performance data on a monthly basis which includes admissions, discharges (including out of hours), readmissions, unit acquired infections and patient outcomes. The data was reviewed through the critical care delivery and strategic group meetings. The data analysis enabled service leads to compare the performance of this service with other similar services as well as identifying trends or concerns.

Governance, risk management and quality measurement

Critical care

Leadership of service

- Critical care was part of the surgical division of the trust. The unit had a lead consultant and an experienced staff team. They communicated a strong passion and commitment in delivering a service which was patient centred.
- The nursing leadership was visible and involved in the day to day management of the unit. There were two senior sisters who reported to the matron for the surgical division. Staff were complimentary about the matron and senior nursing colleagues who they told us were very supportive and genuinely committed to provide support to staff. Nursing staff we spoke with said the matron was frequently present on the unit and would respond positively when issues were escalated.
- The consultants we spoke with had a high regard and respect for the nursing team, and the allied health professionals. Staff, including nursing staff and junior doctors, told us the consultants were highly visible on the unit and supportive towards them.
- Managers recognised emerging issues and responded to them before a problem arose. This included ensuring that skill mix in the unit was reviewed to provide safe care. For example, we observed the matron going through the projected staffing for the two weeks ahead and predicting where staffing deficits may arise and put in contingency measures such as use of bank staff or changing staff duties.

Culture within the service

- We saw a culture of recognising and valuing achievement. Several staff told us with pride about other staff achievements such as the ICNARC administrator who had been recognised for their timely data submissions.
- All staff were encouraged to contribute on issues raised and given the opportunity to talk openly with each other, and told us they felt safe in doing so. We saw where doctors asked nurses for their input on patient treatments and nurses asking doctors for their clinical advice.
- Staff were confident in raising concerns regarding patients' care such as reporting any errors and two staff told us they felt they would receive management support.

- There was good team work and support from the matrons and the clinical lead, so the morale was high with professional respect evident between team members.
- The matron and senior staff took an interest in the staff's wellbeing in the unit with opportunity for debrief. We saw where staff had been offered a formal debrief following a death in the week prior to our inspection. We also saw where individual staff were being offered additional support and referrals to occupational health if they wished following this incident.
- The unit benefitted from highly flexible staff in critical care working extra hours and ensuring the right skill mix to provide safe care.

Public engagement

- Patient and relative's feedback was obtained by the use of satisfaction surveys as well as on an ongoing basis throughout the patients admission.







Staff engagement

- Information from the trust executive and non-executive leaders was shared with the team. We saw where information from the trust board was on staff noticeboards.
- The Chief Executive Officer (CEO) for the trust wrote a weekly blog which several staff said helped them to feel connected to the wider trust.
- The CEO was invited to the critical care strategic delivery group and attends on an occasional basis. The interim director of nursing regularly attended this group. Staff we spoke with valued their involvement and observed that critical care is important to the senior managers at this hospital.

Innovation, improvement and sustainability

- The critical care business plan outlined the business objectives for critical care at this hospital between 2014 and 2017. The service leads who had written the plan had identified strengths and challenges including potential threats from competitors which were noted as minimal.
- Staff, including service leads, told us that they did not know how the Dorset wide clinical services review would affect critical care services at this trust and that this impacted on their ability to plan and coordinate future service delivery.

Maternity and gynaecology

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

Information about the service

Dorset County Hospital NHS Foundation Trust provides maternity and gynaecology services to the population of Dorset. There were 1938 births in the year from April 2014 to March 2015.

Inpatient maternity care is provided in the maternity unit which comprises nine antenatal beds, eight ensuite delivery rooms, one of which is a 'home from home room' and the pool room. There are 12 postnatal rooms, 10 of which are single rooms.. There is a bereavement room, and a two bedded bay where women can stay if their babies are in the special care baby unit. There is one dedicated maternity theatre and recovery area for women who require an assisted delivery or emergency or booked caesarean section. The trust employed integrated midwives, meaning the midwives split their time equally between providing care in the hospital and community. Community bases are in Bridport, Weymouth, Blandford and Dorchester.

Gynaecological surgical services are provided on Abbotsbury ward, a female mixed surgical speciality ward. There is an early pregnancy unit situated in the gynaecology outpatients area. Fertility services are also provided at Dorset County Hospital.

During our inspection we observed care throughout the maternity unit, maternity theatre, gynaecology theatres and on Abbotsbury ward. We spoke with three relatives, five women on Abbotsbury ward and five women on the maternity unit. We spoke with a total of 38 staff individually and a further 12 attended focus groups. Staff included

clinical leads and divisional managers. We also spoke with consultants, registrars and junior doctors, midwives, maternity support workers, nurses, care assistants and members of the housekeeping team. We reviewed a total of 15 sets of women's' records and attended two shift handovers. Before, during and after our inspection we reviewed the trust's performance information.

We attended three listening events in the community, in advance of the inspection, to hear about patients experiences of care at Dorset County Hospital.

Maternity and gynaecology

Summary of findings

Maternity and gynaecology services were rated as requiring improvement for 'safe', 'effective', 'responsive' and 'well-led' and rated as good for 'caring'.

Consultants did not consistently supervise junior registrars and were not always readily available to assist junior staff in theatre if required.

The midwife to birth ratio did not meet national guidelines. The funded midwife to birth ratio was 1:34. An assessment in July 2015, using a tool to assess how many midwives are required recommended the midwife to birth ratio should be 1:27.

Some women's maternity records lacked clarity. Within the maternity service, risk assessments were completed at the initial booking and continually evaluated throughout antenatal, perinatal and postnatal care apart from for their mental health. Risk assessments for gynaecology patients were carried out at the pre-operative assessment, around a month before their admission. Risks to patients were not consistently reassessed on admission to the ward. Medical records were not consistently stored securely on Abbotsbury ward. Gynaecology patients were infrequently reviewed by consultants; they were normally reviewed by registrars or junior doctors.

Overall attendance at mandatory training updates was below the trust's 85% target in some cases as low as 41%. There was a risk that not enough staff had attended updates to ensure they had suitable training to care for women safely.

Harmful cleaning solutions could be easily accessed on the maternity unit and medicines were not consistently stored securely in the maternity unit.

Care and treatment did not consistently take account of current legislation and guidance. Midwives did not use the 'Fresh Eyes' approach which is considered good practice and the maternal pulse was not consistently recorded before commencement of the cardiotocograph (CTG). The maternity service did not use the 'Sepsis 6' care bundle or the NHS England 'Stillbirth Bundle'. There was no current schedule for audits.

Caesarean section rates were higher than England averages and breastfeeding initiation rates were consistently below the trust target, despite the unit achieving UNICEF's Baby Friendly accreditation.

The trust did not meet its target of 90% of women booked by 12 weeks antenatally.

There was one maternity theatre there was a possibility that elective cases may be delayed if emergency care was required.

There were strained working relationships between most consultants, despite participation in mediation to improve the situation. Some members of staff felt there was a risk this may impact on the quality of patient care. Consultants did not often review gynaecology surgery patients and did not communicate with nurses looking after them on the ward. They failed to attend two meetings arranged for them to meet the new ward sister. However, we saw evidence that newly appointed consultants were working effectively and improvement to the perinatal mental health service was due to start in May 2016.

Overall feedback from women and relatives about their care and treatment was positive. We observed women were treated with kindness, compassion and dignity throughout our visit.

A range of equipment and medicines were available to provide pain relief in labour and for patients on the gynaecological ward. Women were able to self-administer pain relief if required.

Nursing and midwifery staff were encouraged to report incidents and robust systems were in place to ensure information and learning was disseminated trust wide. Duty of Candour was well-embedded in the maternity services, and praise given to staff, who felt supported by managers. Women had access to sufficient information to support them with their pregnancy options and gynaecological diagnosis. Women had access to telephone translation services and staff told us information could be sourced in other languages if required.

Maternity and gynaecology

There was a clear strategy, with strong public and staff engagement. We saw evidence of learning from complaints in both the maternity and gynaecology services.

Are maternity and gynaecology services safe?

Requires improvement



By safe we mean people are protected from abuse and avoidable harm.

We rated safe as 'requires improvement' because:

- Consultants were scheduled to be on the labour ward; however, they were not always readily available or proactive in assisting junior colleagues to assess women or carry out procedures with higher risk factors.
- Potential risks were not consistently managed. Women did not have ongoing mental health checks throughout pregnancy, the maternal pulse was not consistently recorded on commencing a CTG trace for foetal wellbeing, and there was an inconsistent approach to the review of CTG traces.
- The midwife to birth ratio did not meet national guidelines. The midwife to birth ratio was 1:34. The England average was 1:28 and an assessment completed on behalf of the trust indicated it should be 1:27. The trust had a recruitment plan in place and was working to address this.
- Risk assessments for gynaecology patients were carried out at the pre-operative assessment, around a month before their admission and risks to patients were not consistently reassessed before admission to the ward.
- Some notes in the maternity unit lacked clarity, were not fully completed or safely and securely filed. Records were not securely stored on Abbotsbury ward..
- Gynaecology patients were infrequently reviewed by consultants; they were normally reviewed by registrars or junior doctors.
- The door to the housekeeping store in the maternity unit did not have a lock and was left open so visiting children could easily access cleaning solutions.
- Overall attendance at mandatory and statutory training updates was below the trust's target of 85%. Training attendance for some subjects was as low as 41%. There was a risk that not enough staff had attended updates to ensure they had suitable training to care for women safely.
- Although medicines were mostly managed safely some patient group directions were out of date..

Maternity and gynaecology

- Higher than recommended levels of Entonox had been identified in the maternity unit, while this had been monitored and some action taken the issue still existed.

However,

- Incidents were reported, robustly investigated and learned from.
- Staff across the services had a good understanding of the Duty of Candour legislation and it was a well embedded practice in the maternity unit.
- All of the areas we visited were visibly clean. We observed staff adhered to the trust's infection control policies and protective equipment was readily available.
- Staff knew where emergency equipment was located and all equipment was appropriately checked.
- Controlled drugs were correctly stored, fridge temperatures were checked and staff responded to our concerns about insecure medicines used in an emergency situation by relocating them to secure areas.

Incidents

- There were four serious incidents during the period October 2014 to September 2015. These incidents had been investigated and action taken to prevent them happening again. For example, in response to an incident where midwives were not informed when a woman was due to be telephoned back, telephone conversation record sheets were introduced. This was to ensure the advice given to women calling the maternity unit was recorded along with the time of their call.
- Staff reported incidents on the hospital's electronic system. The incident reports for maternity were reviewed and actioned by the maternity risk manager with support from the trust wide risk management team. If there were concerns that a midwife's practice was less than optimal, discussion took place with the Supervisors of Midwives. One of the consultants investigated incidents which involved medical staff and kept the Head of Midwifery (HoM) informed.
- The maternity unit held debrief sessions as soon as possible after a serious or unusual incident. When urgent changes of practice needed to take place this was recorded in a handover book and a 'safety notice' read out to all staff at the start of the next shifts. Staff received feedback about incidents in the monthly maternity newsletter and individually if necessary.

- Learning from incidents was included on training days, for example, awareness of the risk of respiratory arrest occurring with use of a fentanyl patient controlled analgesia (PCA) pump was added to the next training day after an incident occurred.
- Quarterly mortality and morbidity meetings for maternity took place. Cases were also discussed at monthly maternity forums which were attended by obstetricians, midwives and paediatricians.
- Senior ward staff on Abbotsbury ward told us incidents were discussed at the daily safety briefing. Investigations and learning from incidents were included in the monthly ward meetings, in a monthly newsletter and in a ward communication folder. Nurses confirmed they received information via email about the outcome of any incident they had reported and incidents were regularly discussed to ensure learning took place.
- Nurses told us about a change to practice as a result of incident reporting. Previously, when medicine was given to women to commence the termination of pregnancy, there had been occasions when the surgery had been cancelled after the woman had taken the medicine. To ensure this did not happen again, doctors were contacted an hour and a half before planned surgery to ensure the operation would go ahead, before the medicine was given.
- The Duty of Candour (DoC) is a regulatory duty that relates to openness and transparency. It requires providers of health services to notify patients (or other relevant people) of certain notifiable safety incidents and then provide reasonable support to that person. All grades of staff we spoke with were aware of the principles of Duty of Candour. There was a trust-wide system for tracking their DoC responses. The risk management team identified incidents reported by staff that triggered the DoC and then coordinated the response and investigation. Records of investigations for serious incidents showed members of staff had identified that the duty of candour legislation was applied.

Safety thermometer

- The NHS Safety Thermometer is a local improvement tool for measuring, monitoring and analysing harm to patients and 'harm-free' care. Harm includes new pressure ulcers, catheter-related urinary tract infections, venous thromboembolism and falls.

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- One hundred percent of woman in the maternity unit were assessed for venous thromboembolism (VTE) between September 2015 and February 2016. Their 'best practice noticeboard' encouraged staff to 'make VTE assessment part of your daily examinations'. Ninety eight to 99% of women admitted to the gynaecology service were assessed for the risk of VTE during the same time period.
- The results of the safety thermometer were on display on Abbotsbury ward. However, the results were for the ward as a whole and gynaecology care was not specifically identified
- The maternity unit had commenced the maternity safety thermometer in December 2015. There were plans to display the information to ensure all staff and visitors were aware of how the unit had performed.

Cleanliness, infection control and hygiene

- All areas we visited were visibly clean. Staff followed the trust bare below the elbow policy and were seen washing their hands and used hand sanitiser appropriately. Women told us they saw staff washing their hands, particularly before examining their abdomen.
- Hand hygiene audits, to monitor compliance with the trust policy, had identified lack of compliance on Abbotsbury ward. The audit for November 2015 showed only four out of nine staff observed washed their hands correctly. Senior ward staff developed an action plan to ensure all ward staff met the standards of hand hygiene. The audit results for January 2016 showed 100% of staff washed their hands properly.
- Personal protective equipment was available and staff were seen changing gloves and aprons in- between patients to prevent the risk of cross infection.
- Maternity and housekeeping staff were clear about whose role it was to clean which pieces of equipment. Cleaning checklists were displayed in the delivery rooms and a system of pinning the curtain up signalled the room and equipment in it had been cleaned.
- Cleaning instructions were on display to ensure a consistent approach. For example, information was available to aid staff to clean the birthing pool effectively to prevent the spread of infection. Monthly cleaning audits were conducted by the housekeeping supervisor who shared the results with the housekeeping team.
- There were no reported incidents of Methicillin resistant Staphylococcus aureus (MRSA) or Clostridium difficile (C Diff) infections between April 2015 and February 2016.

Environment and equipment

- All of the wards and clinical areas we visited had portable resuscitation trolleys. The trolleys contained medicines to be used in the event of a cardiac arrest. We saw daily check sheets which documented all trolleys had been checked to ensure equipment was available and in date. Staff knew where emergency equipment was located including 'grab boxes' which contained everything needed for specific emergencies, for example hypoglycaemia.
- There was one operating theatre in the maternity unit. Protocols were in place to ensure a second theatre was available and suitably staffed in the event of an emergency.
- In the delivery suite there was an emergency trolley which contained equipment which was used in the event of a post-partum haemorrhage (PPH). PPH is often defined as the loss of more than 500 ml or 1,000 ml of blood within the first 24 hours following childbirth. We saw the trolley had been checked to ensure it contained sufficient quantities of the correct medicines and equipment.
- Within Abbotsbury ward and the maternity unit equipment used to support the delivery of care, for example hoists and portable monitoring equipment, was stored appropriately. The equipment was clean and fit for purpose. All equipment displayed a sticker which gave information detailing when it had been serviced and tested. All equipment reviewed had been checked within the last 12 months.
- A range of equipment to aid labour was available in the maternity unit. This included one birthing pool and two upright inflatable birth stools, used to support women in their chosen position for delivery of their baby.
- On three occasions during our announced visit to the maternity unit we found the room to the housekeeping store room open. Children who came to visit could easily access harmful cleaning tablets and solutions. We raised this with the matron present who told us a door lock had been ordered. We found the door closed during our unannounced inspection. We were told a lock was due to be fitted imminently.
- Higher than the recommended levels of Entonox had been identified in the maternity unit. A potential cause

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was given as midwives not using extractor fans when women were using Entonox. Testing in October 2015 showed that four out of the 10 Entonox monitoring tubes showed a level higher than the recommended 100ppm. An immediate safety notice was circulated reminding the staff to turn on the fans and move any items obstructing the vent. Retesting in January 2016 reported that under controlled conditions, levels remained higher than the recommended 100ppm level of Entonox. The fans were cleaned and the Entonox ports checked to ensure that they were not leaking. In February 2016 a survey of rooms' airflows indicated that the air change rate was 5.86 but should be 15. Once aware of the situation the trust took action however the issue still existed. Discussions were underway with the estates department to ensure the necessary modifications to the labour rooms were completed

Medicines

- In most areas medicines were stored correctly within locked cupboards and resuscitation trolleys. However, we found adrenaline and Vitamin K stored on the resuscitaires, (a mobile device used to resuscitate babies), in publically accessible areas and ampoules of local anaesthetic insecurely stored in the delivery rooms. The trust's policy stated medicines could be kept unlocked if they were required in an emergency, for example for resuscitation. A risk assessment had been carried out and this determined the risk was low. The risk assessment had identified the use of pod lockers to secure some medication in the delivery rooms. The HoM informed us that a business case was required to be submitted to purchase the pods..However, during our inspection the HoM removed all the unsecure medicines and informed staff of its new location.
- There were weekly audits to assess the safe and secure storage of medicines. In July 2015 the epidural room, which contained medicines, was not secure. A lock was fitted and the room made secure.
- Medicines were organised to minimise errors. Intravenous fluids were stored in their labelled containers. We checked all of the fluids and found them to be in date.
- The trust stored medicines at safe temperatures. A system had been set up for continuous monitoring of medicine storage temperatures using a trust-wide wi-fi system.

- We found the neonatal resuscitation trolley had a key pad lock to ensure the medicines were not accessible to unauthorised personnel. However, we found the trolley was unlocked. We raised this with a matron who immediately locked the trolley. We found the trolley locked when we arrived for our unannounced inspection.
- Three patient group directions (PGDs) (agreements for the supply of medicines by non prescribers) in fertility services went out of date in November 2015, when nurses stopped supplying the medicines by PGD. Nurses told us there was no impact on women as consultants could sign prescriptions. We were told a PGD review was being presented at the next PGD meeting for women's services.
- Patients were permitted to take medicine home to self-administer for inducing miscarriage. Risk assessments were in place to ensure women were safe to administer the medication at home. However, in one set of womens records we found no evidence that the assessments had been used and there was no information about whether the woman had decided to take the medicine. There was a very small potential risk of inappropriate use or supply to other individuals.

Records

- We reviewed fifteen sets of medical records, two of which were not completed correctly. For example records were not always clear, contemporaneous, clearly dated or signed with an identifiable name. In one set of notes an entry had been signed but the person had not printed their name. An interventional procedure had been performed on a baby and it was unclear who had performed the procedure.
- One woman's file contained the notes of two pregnancies and there was no clear division between the two. We found loose sheets in another set of women's records and loose sheets at the bottom of the notes tray. There was a risk that information may be missing or not communicated effectively if women's records were not organised correctly.
- In the maternity unit records were stored securely in notes trolleys or cupboards. On Abbotsbury ward notes were stored in open trolleys behind the nurses station which was situated in the middle of the ward. The trolleys were not lockable and there was a risk patient records could be easily accessed by unauthorised personnel.

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- Midwives completed the baby's health record book, "the red book" which was issued to women antenatally by their health visitor. Midwives had access to books on the maternity unit if a woman delivered their baby before contact with the health visitor.

Safeguarding

- All of the staff we spoke with were clear about their roles and responsibilities and the processes and practices that were in place to keep women safeguarded from abuse. Information provided by the trust showed 86% of nursing and midwifery staff in the family services division had completed level 2 safeguarding adults training, and 95% of required staff had completed level 3 safeguarding children training. Eighty one per cent of medical staff had completed level 2 safeguarding adults training and 82% level 2 safeguarding children training.
- Doctors received training for the care of women who had undergone female genital mutilation (FGM). This included the need for appropriate referral to the police and children's services. The management of women or girls who were pregnant and had undergone FGM was covered in the safeguarding policy. Procedures were in place which ensured the safeguarding midwife was informed and further referrals made to the Department of Health.
- Trust safeguarding procedure for child sexual exploitation (CSE) linked into Dorset Social Services Multiagency Procedures and the trust was represented at high risk multiagency meetings for CSE.
- A named nurse and named doctor for safeguarding children and young adults were available for assessment and advice and to ensure the trust fulfilled its legal obligations.
- We observed effective communication between staff when a woman who had safeguarding concerns was admitted to the maternity unit. Information was shared appropriately and the notes discreetly labelled which ensured all staff were aware.
- The trust's 2015 Safeguarding Children Report suggested the minutes of safeguarding meetings were not always included in maternity notes. The report stated that the safeguarding midwife required administrative support to complete this task. The HoM told us there was now administrative support for the safeguarding midwife for the period of the annual audit. This was to ensure all relevant safeguarding information was available to all staff.

Mandatory training

- For the maternity service, attendance at mandatory training updates did not consistently meet the trust target of 85%. Figures for 2015 to 2016 showed that staff attendance for various training days such as neonatal resuscitation, equality and diversity, safe blood transfusion and conflict resolution were between 41% and 86%. There was a risk that not enough staff had attended updates to ensure they had suitable training to care for women safely.
- Midwives' mandatory training included annual practical obstetric multi-disciplinary training (PROMPT), and CTG interpretation using a simulator. Trust data showed 82% of staff had attended PROMPT training and 47% of staff had carried out training on the CTG simulator.
- Staff on Abbotsbury Ward had access to e-learning and dedicated training time twice a week.

Assessing and responding to patient risk

- Midwives in the delivery unit did not use the 'fresh eyes' approach for foetal monitoring. The process of 'fresh eyes' is considered good practice and involves a different midwife who regularly checking the CTG trace. This is to ensure any concerns with the foetal heart trace had not been missed by the midwife responsible for the woman's care. Midwives told us they reviewed the trace themselves hourly during labour and asked a band 7 midwife to review only if they recognised concerns. If the band 7 midwife had concerns, they called the registrar. One woman's partner confirmed this happened during their partner's labour.
- We saw one set of notes which contained a 'suspicious' trace, which meant there was a concern about foetal wellbeing, however there was no evidence in the notes that a 'fresh eyes' approach had been taken by another midwife. The registrar was called to review the trace, however the notes did not reflect a formal assessment had taken place by either the registrar or the midwife.
- There was no consistent approach used for the review of the trace for foetal well-being. We saw midwives used three different methods and only one of these was compliant with the National Institute for Health and Care Excellence (NICE) guidance.
- The maternal pulse was not consistently recorded at the start of the CTG. Three of the records we reviewed did

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not show any record of the maternal pulse when the CTG had commenced. Maternal pulse should be taken and recorded to ensure the trace recorded is that of the fetus and not the mother.

- Some, but not all midwives, used stickers as a prompt to review every aspect of the CTG trace this meant there was a risk the deteriorating condition of a baby in labour may not be picked up.
- Women did not consistently have their mental health assessed throughout pregnancy. Midwives assessed women's mental health at their initial booking appointment. Senior staff told us women who required support with their mental health needs were referred to the safeguarding midwife. Care plans were devised and kept securely. On admission the women were identified and the care plan accessed. However, we reviewed six women's maternity notes and found they did not contain any evidence that the women had ever been asked about depression or anxiety during the remainder of their pregnancy. Three of the women had a history of mental health illness, one of which had a history of postnatal depression. There was no plan of care documented for the current pregnancy.
- All the records we reviewed on Abbotsbury Ward contained relevant risk assessments; however they were not consistently up to date. The assessments were carried out during the pre-operative assessment appointment around a month to six weeks before admission to hospital. We reviewed five patients records, three of which did not have further risk assessments completed on admission to the surgical assessment lounge. For example, one patient's risk assessments were completed in mid January 2016, they were admitted to the surgical assessment lounge on 5 March and no further assessments had been completed by the time of our visit on 9 March. Nurses told us any changes in assessments would have been documented by staff in the surgical assessment lounge.
- Midwives did not use the Modified Early Obstetric Warning Score (MEOWS) for all women. This was a system that enabled midwives to record observations and gave protocols for staff to follow if the observations deviated from the woman's norm. Staff were aware of the circumstances in which a chart should be used, according to their trust guidelines. For example, they were used for women after a postpartum haemorrhage (PPH) greater than or equal to 1,000mls and also after caesarean sections.
- Nursing staff on Abbotsbury ward used an electronic early warning scoring system (EWS). The electronic scoring system enabled nurses to assess patient's observations and provided protocols to follow if the observations varied from the patient's norm.
- We observed the five steps to safer surgery were completed for gynecology day surgery procedures and for a procedure in maternity. This is a nationally recognised system of checks designed to prevent avoidable harm and mistakes during surgical procedures. These checks include a team brief at the beginning of each theatre list, a team debrief at the end and the World Health Organisation (WHO) surgical safety checklist (a tool for the relevant clinical teams to improve the safety of surgery by reducing deaths and complications). Compliance of the WHO surgical safety checklist was audited. For 2015, 76.5% check lists had been signed by a consultant. The target was 100%. No information was available on compliance in the midwifery theatre.
- There were clear instructions on how to evacuate a woman from the birthing pool in an emergency using a sling. All staff we asked were clear about the required actions, although there was no record of any formal training. To further manage any possible risk, women with a body mass index (BMI) greater than 35 were not permitted in the pool. Women with a BMI between 30 and 35 were allowed in the pool for early labour only.
- Women who required high dependency care in the maternity unit were cared for in the room nearest the midwives' desk.. Midwives did not have any additional training to look after these women, although they stated they felt competent to care for the women. Staff from other areas of the hospital were called to undertake tests, such as electrocardiograms (ECGs), when the midwife needed assistance. Very sick women were transferred to the hospital's main high dependency beds or the intensive care unit.
- If a woman considered to be at risk requested a home birth a risk assessment was completed by the Supervisor of Midwives and a plan put in place to mitigate the risks. We were told of one woman who was informed of the risks and supported in her choice to stay at home. The midwives kept the ambulance service and consultant updated so that they could act quickly if necessary.

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- A second midwife attended homebirths when birth was imminent and there was always a midwife in attendance who was trained in advanced newborn life support.
- One hundred percent of woman were assessed, on admission for venous thromboembolism (VTE) between September 2015 and February 2016. Further assessments were conducted at every hospital admission which included postnatal care and the labour ward. The maternity unit's 'best practice noticeboard' encouraged staff to 'make VTE assessment part of your daily examinations'. Between 97.6 to 99% of women admitted to the gynaecology service were assessed for the risk of VTE during the same time period.
- Nurses told us the distance between gynaecology theatres and Abbotsbury ward was approximately 290 metres. We observed women were accompanied by registered nurses and the porters carried 'phones to call for help if the patient's condition became unstable.
- Midwives were acting as scrub nurses, surgical first assistants and recovery staff for caesarean sections. Midwives told us they had received further training which enabled them to perform these roles. Midwives told us this impacted on the availability of midwives in the maternity unit. Maternity support workers often helped as 'runners' in theatre. Senior staff told us there were plans to recruit surgical scrub nurses to commence employment on 1 May 2016 and a review of midwives who acted as surgical assistants would take place. Recovery nurses were due to take over the care of women in the immediate post operative period from 1 May 2016.
- Matrons were called to assist clinically on most days they worked. This was in addition to the one shift a week they were rostered to work clinically. One matron told us, "it's why some things don't always get completed." One coordinator told us, when midwives had been moved to the area of the unit in need and more staff were still required, they called the matron or the HoM before contacting a midwife who worked in the community to help in the unit. However, senior managers told us the matron and HoM only worked clinically if all other options for staffing had been considered. Some midwives told us they were frequently called to assist in the maternity unit when on call or working in the community. Some specialist midwives told us they often had to complete their additional roles in their own time if they had been called into the unit to help. Overnight, three band 5 or 6 midwives and one band 7 midwife were available on call.

Midwifery and nursing staffing

- The trust employed 51 whole time equivalent (WTE) Band 5 or 6 midwives, plus 15.6 WTE Band 7 midwives, two matrons and 19.7 WTE maternity support workers (MSWs).
- The midwife to birth ratio did not meet national guidelines. The funded midwife to birth ratio was 1:34. The Royal College of Obstetrics and Gynaecology guidance (Safer Childbirth: Minimum standards for the Organisation and Delivery of Care in Labour, October 2007) states there should on average be a midwife to birth ratio of 1:28. The England average was 1:28. There was a staffing assessment in July 2015. The assessment tool used, provided a comprehensive assessment of the staffing needed to provide the care required by a woman in the maternity services. The results showed that acuity had increased, mainly due to the increased levels of maternal obesity and other risk factors. The findings recommend the actual ratio should be 1:27.
- Three midwives and one maternity support worker had been recently recruited. A further two midwives and three support workers were planned to be recruited in April 2017 to ensure the staffing establishment met the recommendations of the staffing review.
- Planned numbers of staff on the maternity unit were seven midwives and two MSWs from 7.30am to 2.30pm and from 8pm to 8am and eight midwives and two MSWs between 1.30pm to 8.30pm. Some midwives worked from 7.30am to 8.30pm by choice.
- On the day of our unannounced inspection the early shift was one midwife short and the late shift was three midwives short due to cancelled bank shifts and sickness. Midwives working in the community were called in and the HoM escalated the situation to the divisional manager
- Records showed between April 2015 and February 2016 100% of women received one-to-one care in labour. One woman said, "I felt safe. I had all five hours with one-to-one care." Women told us calls bells were answered without delay.
- The maternity unit coordinator was not supernumerary as recommended by 'Safe midwifery staffing for maternity settings' (NICE Guidelines NG4). Midwives told

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us the co-ordinator was rarely supernumerary and were often required to support women in labour until further help arrived. This presented a risk as it meant they were unable to give their full attention to supervising the unit.

- During times of unplanned sickness the HoM was called upon to help clinically usually three or four times a month, in addition to one night or two day time shifts they were rostered to work clinically. They told us this had an impact on their strategic role and timely completion of management duties. For example they told us responding to letters could be “challenging sometimes”.
- Handovers in the maternity unit were systematic, professional, respectful and thorough and were conducted in private. Important facts such as allergies were made clear to staff.
- Staff on Abbotsbury ward conducted a whole ward handover to ensure all staff were aware of the needs of all of the patients on the ward. Handover documentation contained information about the patient’s condition and if any patient had been identified as at risk, for example from falls, or pressure ulcers.
- Senior staff told us the staffing ratio on Abbotsbury ward was one registered nurse to eight or nine patients. They used an acuity tool to ensure sufficient staff were available to meet the needs of the patients. Senior staff told us they had a significant amount of junior staff.
- Staff on Abbotsbury Ward worked a two shift pattern 7.30am to 8.30pm or 8pm to 8am. They reported being short of staff since additional beds were opened to meet hospital demand. The ward employed agency and bank staff when additional nurses were required. Between September 2015 and February 2016, 58 shifts had been covered by agency and bank staff.
- Senior nurses from other wards often came to work on Abbotsbury ward during shifts when there was a high proportion of junior nurses. Senior staff told us this was to ensure junior staff were supported and there were sufficient senior members of staff to meet the needs of the patients.
- There were 2.78 WTE Band 5 vacancies on Abbotsbury Ward and the sister planned to ensure one of those recruited was a trained gynaecology specialist nurse.

Medical staffing

- Nine consultant obstetrician/gynaecologists, four middle grade doctors and seven junior doctors cared for women in the maternity and gynaecology services. There were no locum doctors.
- The planned consultant presence on the ward met the Royal College of Obstetricians and Gynaecologists Good Practice Guidelines 2010 of 60 hours per week. Consultants were rostered to cover the labour ward with no other commitments between 8.30am and 5.30pm. However we witnessed presence could be interpreted as just being in the unit. We observed one consultant was based in the unit but he was not dressed for theatre to ensure he could promptly assist in an emergency if required. The medical director told us it may not have been made clear to consultants they should be dressed and ready to attend in theatre if required.
- Nurses told us consultants did not regularly review gynaecology patients. Women were seen by registrars or junior doctors. Nurses said registrars appeared to discuss any women of concern with consultants over the phone. The clinical director agreed there had been ad hoc presence on Abbotsbury Ward but told us there had been recent agreement that the consultant on call in the afternoons would try and review the new admissions, although they acknowledged many of the other women would have been discharged by that time.
- Between 8.30am and 5pm there was one junior doctor who covered the maternity unit and another available for the gynaecological patients. Between 5pm and 8.30pm the junior doctor based on the maternity unit covered gynaecological emergencies as well. On the two days a week there were elective caesarean sections, there were two junior doctors instead of one.
- Two nights a week there was a resident on call consultant based on the maternity unit. A junior doctor worked the same nights. On the other five nights, a registrar was based on the maternity unit.
- Midwives and registrars agreed that consultants always attended the unit when they called them in from home.
- A dedicated anaesthetist was available between 8am and 5.30pm. Overnight, cover was provided by one of two anaesthetic registrars who covered the whole hospital. Midwives told us a consultant anaesthetist would always attend if called.

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- Results of the General Medical Council's National Trainee Scheme Survey for 2015 showed satisfaction with local teaching in maternity and obstetrics was significantly below the national score and overall trainees gave negative comments about receiving feedback during their placements. One consultant told us after the results were published, meetings were held with the trainees and an action plan drawn up to address trainees' concerns.
- In the maternity unit we saw two medical handovers. Each was systematic, professional, respectful and thorough and was conducted in private.

Major incident awareness and training

- Midwives and nurses did not recall participating in any major incident training, however a registrar did.
- The maternity department did not participate in a recent trust training exercise but the HoM received texts during training exercises and could explain what would happen.

Are maternity and gynaecology services effective?

Requires improvement



By effective we mean that people's needs are assessed and care and treatment is delivered in line with legislation, standards and evidence based guidance.

We rated 'effective' as 'requires improvement' because:

- Care and treatment did not consistently take account of current guidelines and legislation. We saw that around 15% of maternity guidelines were overdue for review.
- There was no midwife-led birth centre as recommended by 'Maternity Matters' 2007, the Birthplace study 2011 and the National Maternity Review of 2016.
- There was no comprehensive assessment of babies' tongue ties prior to surgery. The GROW software package (an individualised growth chart designed to more accurately detect foetal growth problems which are associated with stillbirth) was not in use. The NHS England 'stillbirth bundle' was not used, although its component parts were being developed. The 'Sepsis 6' care bundle was not used in the maternity unit.
- Rates of caesarean section were higher than England averages. Breastfeeding initiation rates were

- consistently below the trust's own target, despite the unit achieving UNICEF's Baby Friendly accreditation. A high percentage of women gave up breastfeeding soon after leaving hospital. Between 3.5 and 5% of newborn screening tests needed repeating. This meant those babies had to be retested and there may have been a delay in the diagnosis of any underlying conditions.
- Seven of the nine consultants performed a caesarean section just once a month, which might impact on their competence. Not all consultants adequately supervised junior registrars. There was little communication from the consultants to the nurses looking after the gynaecology patients and their attendance was described as "variable".
 - Women who were at risk of miscarriage were only offered scans between Mondays and Fridays. Women were required to attend the emergency department or were referred to a neighbouring trust out of hours.

However,

- Staff in the maternity unit attended thorough practical obstetric multi-professional training (PROMPT) and had access to a training simulator to test their knowledge of CTG traces.
- Rates of primary postpartum haemorrhage (PPH) and third and fourth degree tears were within target.
- Staff had an understanding of informed consent, mental capacity and the Deprivation of Liberty Safeguards (DoLS).
- Women who were suspected of having an ectopic pregnancy could be scanned by an on call radiologist out of hours. There was 24/7 access to an urgent abdominal scan in the maternity unit.
- A range of equipment and medicines were available to provide pain relief in labour and for patients on the gynaecological ward. Women were able to self-administer pain relief if required.
- Women in the maternity unit and on Abbotsbury Ward had access to food and drinks to meet their needs.

Evidence-based care and treatment

- Care and treatment did not consistently take account of current legislation and nationally recognised evidence based guidance.
- Some women did not have their mental health assessed throughout pregnancy, as recommended by NICE's 'Antenatal and Postnatal Mental Health' guidance.

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- We observed consultants did not consistently supervise junior registrars in line with Royal College of Obstetricians and Gynaecologists (RCOG) good practice guideline number 8. During our inspection we observed one registrar telephoned the consultant to inform them about the lack of progress of the delivery. The consultant did not attend because they felt the registrar was competent. Another registrar confirmed that some consultants “will help if needed but won’t get involved if the registrar is managing”.
- Midwives did not routinely follow NICE guidance. For example a record of the maternal pulse rate at the start of CTG monitoring was not consistently taken and CTG stickers used were not in line with NICE guidance on intrapartum care.
- There was no midwife led birth unit provided, contrary to ‘Maternity Matters’ 2007, Birthplace study 2011 and the 2016 National Maternity Review. However there were plans to make part of the unit a separate midwifery led unit and a business case had been submitted.
- Guidance for the remedy of a tongue tie was not clear. The guidance did not detail what assessments the baby required to determine whether or not the tongue-tie should be cut. We reviewed one woman’s notes whose baby had had their tongue tie cut. There was no evidence in the woman’s or baby’s notes that they had consented to the procedure for their baby or whether an assessment had taken place.
- The trust did not follow the stillbirth care bundle developed by NHS England. However, the HoM said they were progressing with its component parts and all stillbirths were reviewed by the organisation UK Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBBRACE).
- The GROW software package (which comprises an individualised growth chart designed to more accurately detect foetal growth problems which are associated with stillbirth) had not been fully rolled out. However, this was a recommendation from the RCOG since 2002.
- The guideline for maternal sepsis did not follow the modified ‘Sepsis 6’ care bundle as recommended by RCOG green top guideline 64b (2012). However guidance from the Health Protection Agency about viral rashes in pregnancy was discussed at the maternity forum and information disseminated to staff via a newsletter.
- Policies and guidelines were not consistently reviewed. We found approximately 15% of maternity guidelines were overdue for review. For example, the hyperemesis

guideline was due for review in March 2015. Minutes from governance meetings indicated that reviews were the responsibility was the individuals, but clear information triggers for reviews or the monitoring if timeliness of review.

- Eighty three per cent of women who delivered their babies between 24 and 35 weeks were given at least one dose of antenatal steroids, slightly lower than the National Neonatal Audit Programme standard of 85%.
- There were audits of the medical management of miscarriage and the service to women with an ectopic pregnancy. The maternity unit audited surgical site infections using the national audit tool and took necessary actions.

Pain relief

- Overall, patients on Abbotsbury Ward reported they received pain relief in a timely manner. For example one patient told us, “They ask if I have any pain and they give me painkillers if I say yes.” Another patient told us, “They are always very prompt with my pain medicine”.
- Women on Abbotsbury ward had access to a variety of pain relieving medicine which included patient controlled analgesic (PCA). Women had pre-operative and on-going assessments for pain during their stay.
- Gynaecology patients’ pain was assessed as part of an audit into pain management of day surgery cases in March 2015. The audit found women’s pain was slightly better controlled than other patients’ pain in the recovery area. However, on the ward, moderate to severe pain was observed in 25% of patients on the whole and was slightly higher in gynaecological patients, at 26.8 %. Gynaecology patients had access to support from the pain team for pain relief between Monday to Friday if required. A consultant or registrar offered further support for pain relief out of hours. Women in labour were offered a choice of a transcutaneous electrical nerve stimulation (TENS) machine, Entonox, pethidine and epidural pain relief. A birthing pools was available to aid pain relief and the majority of midwives were trained in aromatherapy for labour.
- A dedicated anaesthetist was available between 8am and 5.30pm to ensure women had prompt access to epidural pain relief. The Royal College of Anaesthetists suggests that over 80% of women who requested an epidural should be seen by an anaesthetist within 30 minutes. Attendance rates were audited quarterly and

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showed that 86% of women were seen within the 30 minute time frame. Overnight, an experienced anaesthetist was on call with primary responsibility for maternity. Further anaesthetic cover was provided by an anaesthetist based in critical care. A non resident on call consultant anaesthetist was also available. Midwives told us if the anaesthetists were busy the on call consultant would always attend if called.

Nutrition and hydration

- The maternity unit had been awarded the UNICEF's Baby Friendly accreditation. This meant staff had fully implemented breastfeeding standards which had been externally assessed by UNICEF.
- However, in the 11 months between April 2015 and February 2016, breastfeeding initiation rates were between 71.2% and 81.4%, below the trust's target of 85%. The England average for April to June 2015 was 73.8%. Initiation rates for women having their first baby were over the 80% target for just six out of the 11 months.
- Trust figures showed between July and September 2015, 9% of women gave up breastfeeding before they left hospital, and 24% of the remaining women gave up breastfeeding before they were discharged to the care of health visitors, usually around day 10 to 14 after birth. The HoM told us there was a minimum of one breastfeeding support worker on every shift in the unit, however none of the infant feeding team worked in the community. The lack of breastfeeding support in the community appeared to be impacting on the numbers of women breastfeeding beyond two weeks.
- Patients on Abbotsbury Ward had their nutritional status assessed using the Malnutrition Universal Screening Tool (MUST). Nurses made a referral to dietitians if a patient required further support with their nutrition.
- Women in the maternity unit had access to meals including a hot breakfast trolley and snacks were provided overnight.
- Total caesarean section rates (elective and emergencies) were consistently higher than the England average of 25.5%. Between May and November 2015 rates were between 28.25% and 34.1%. The maternity risk manager and a consultant reviewed all emergency caesareans on a daily basis, in recognition of the higher than average rates. In January 2016 the caesarean section rate increased to 30.43%. In response, the previous six months' cases of caesarean sections were audited. Maternity staff told us one newly appointed consultant had taken responsibility for identifying and addressing the reasons for the high rate of caesareans in order to increase the numbers of women delivering vaginally.
- There had been 7 stillbirths between April 2014 and March 2015
- Smoking in pregnancy rates were higher than the England average. A smoking cessation midwife was funded by Public Health Dorset. There was a continuous monthly audit, but the results showing how many women had given up as a direct result of the intervention were not available during our inspection.
- The trust's target of neonatal blood spot screening tests needing repeating was 2%, but 5% of tests required repeating because of inadequate samples. This caused a delay in screening because some babies required a retest, however there was no evidence that any harm had occurred by the delays. As a result midwives were required to complete an e-learning package after which the rate of retests reduced to 3.5%. The tests were being continually monitored to ensure the rate of re test reduced to a new target of 0.5% or below.
- The target of less than 4% of births resulting in a third or fourth degree perineal tear was consistently met between April 2015 and February 2016, with just 0.0% to 2.6% of women being affected.
- Rates of primary postpartum haemorrhage (PPH) measured as blood loss greater than 1,000mls within 24 hours of birth, were between 6.4% and 13.7% for the period April 2015 to February 2016. On most months the rate was around 9%. The trust did not set a target for PPH, but the England averages between 2012 and 2014 were around 13.8%.
- Homebirth rates were higher than the England average of around 2%. In May 2015, prior to the start of the homebirth team, the rate was 4.6%. By February 2016 the rate was 5.3%. The team aimed for a 9% homebirth rate.

Patient outcomes

- Outcomes for women and babies were monitored monthly using the maternity dashboard.
- Between July 2014 and June 2015 the elective caesarean section rate was slightly lower than the England average and the emergency caesarean section rate was 2.2% higher at 17.4%.

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- There was only one unplanned admission of a mother to the intensive care unit between April 2015 and February 2016 and rates of unplanned admissions to the special care baby unit were between 3.5% and 5.8% during the same period, which were within expected limits.

Competent staff

- Midwives, medical staff and MSWs attended annual practical obstetric multi-professional training (PROMPT). This included management of sepsis, post-partum haemorrhage, shoulder dystocia and cord prolapse as well as interpretation of CTGs. Management of situations in a homebirth environment were also included. Midwives and medical staff also tested their knowledge of CTG interpretation by using a training simulator.
- All midwives were assigned a Supervisor of Midwives (SoM). The regulation of midwives includes an additional layer of investigative and supervisory responsibilities provided by a supervisor of midwives. The supervisor of midwives is someone who has been qualified for at least three years and has undergone further training to enable them to fulfil the role. The supervisor of midwives provides advice and support, audits midwives' record keeping and investigates any areas of concern relating to practice. The proportion of Supervisors of Midwives to midwives was 1:24, which was higher than the recommended ratio of 1:15, however the SoMs achieved 97% of reviews.
- Women had access to specialist gynaecology nurses on Abbotsbury Ward. The ward employed two specialist nurses and ensured one of them was always available. A third nurse was attending further training as a specialist nurse. One health care assistant had a special interest in gynaecology. Senior staff told us further training was being delivered to all staff to ensure they had an understanding of the care gynaecology patients required.
- The trust target for completion of appraisals was 90%. Figures sent to us by the trust showed 92.31% of all medical obstetrics and gynaecology staff had an appraisal while only 79% of midwives had received an appraisal.
- The same two consultant obstetricians always performed the twice weekly elective caesarean sections. The clinical director estimated this meant the other

seven consultants performed caesarean sections just once a month or less. This meant some consultants may not perform sufficient caesarean sections to ensure their knowledge and skills are kept up to date.

- One member of staff had received further training and had advanced skills to enable them to perform procedures to remedy a tongue-tie. The member of staff provided further training to five other midwives to enable them to remedy the most simple tongue ties. Complex cases were referred to the member of staff who had advanced skills.
- There were specialist midwives trained to meet a variety of complex needs. For example antenatal screening and diabetes.

Multidisciplinary working

- There was multidisciplinary working between the maternity and paediatric service as required.
- Abbotsbury Ward nurses described good working relationships with physiotherapists and occupational therapists.
- There was little communication between the consultants and the nurses on Abbotsbury ward. Consultants told us they did not normally seek out a nurse to do the ward round with as the nurses were busy and the ones they approached were often not gynaecology trained. Senior nursing staff told us they had tried to arrange meetings with the consultants to address this, however they had been unsuccessful..
- If staff on Abbotsbury Ward did not feel confident to look after a woman miscarrying before 20 weeks of pregnancy or terminating a pregnancy due to an abnormality, they contacted the maternity unit and women were cared for there in the bereavement room.

Seven-day services

- The acute pain team was available to women on Abbotsbury Ward between Mondays and Fridays.
- The early pregnancy unit was open between 8am and 2pm on Mondays and Tuesdays, 8am and 3.30pm on Wednesdays and 8am to 1pm on Thursdays and Fridays. When the unit was closed staff on Abbotsbury ward gave telephone advice.
- Women at risk of miscarriage were only offered scans between Monday to Friday. Women were required to attend the emergency department or were referred to a neighbouring trust out of hours. Women with a suspected ectopic pregnancy could be scanned by an

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on call radiologist out of hours. One midwife who worked at night was a trained sonographer. There was also an on call sonographer and all the registrars could scan if required.

- Consultants were contactable via telephone out of hours. Staff on Abbotsbury ward told us their attendance at hospital if required was “variable”. Registrars led weekend ward rounds.
- Midwives were unsure whether a physiotherapist was available to them seven days a week, although women were seen at their local community hospital if they preferred.
- Two midwives were participating in the Wessex wide Labour Line commencing in April 2016. The aim of which was to provide a telephone triage service.

Access to information

- Pregnant women carried their own records. These were used by all clinicians involved with the woman’s care during the pregnancy.
- On Abbotsbury Ward observations and test results were recorded on the electronic recording system. Staff told us they were easy to use and gave them up to date information about the patient’s condition.
- Maternity support workers telephoned the community midwives to inform them which women had been discharged and required visiting.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Throughout our visit staff we spoke with were clear about their roles and responsibilities regarding the Mental Capacity Act (2005). They were clear about processes to follow if they thought a patient lacked capacity to make decisions about their care.
- Medical staff told us the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (DoLS) was covered during their mandatory training.
- The trust target for attendance at Mental Capacity Act and DoLS training was 85%. We saw from records that 61% of midwives had attended training. This meant some staff had not attended updates to ensure their knowledge was up to date.
- All of the patients on Abbotsbury Ward told us they were asked for their consent prior to any medical intervention. One woman told us, “They explain everything and ask if it’s okay before they do it”.

- Staff told us they identified any concerns about gynaecological patients’ mental capacity at their pre-operative assessment appointment. This was communicated to ward staff to follow up prior to the patient’s admission. Ward nursing documentation contained a checklist which prompted staff to check about the patient’s ability to provide consent.
- During our inspection, one woman refused to have a blood test. We observed the midwife explained why it was advisable but did not pressure the woman and respected her wishes.

Are maternity and gynaecology services caring?

Good

By caring we mean that staff involve and treat people with compassion, kindness, dignity and respect.

We rated ‘caring’ as ‘good’ because:

- Midwives and nurses were described as “caring” and one woman described midwives as “reassuring and supportive”. We saw that women were treated with compassion and their privacy and dignity was respected.
- Staff helped people and those close to them to cope emotionally with their care and treatment. Women and their families who had undergone a bereavement had access to counselling facilities.
- One gynaecology nurse ran a support group for women with gynaecology cancer and bereavement midwives set up a support group for bereaved women and personally delivered the results of post mortems.

However,

- Friends and Family Test results showed variable satisfaction with care throughout the maternity unit. Sometimes 100% of the women who responded were satisfied, but generally women rated the service less favourably than the England average.

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Compassionate care

- Overall patients were positive about the care they received on Abbotsbury ward. For example one patient said “They are brilliant, they are so kind to me.” Another patient told us, “The nurses are busy but very caring”.
- We observed throughout our visit that women were treated with respect and dignity. Curtains were drawn around patients on Abbotsbury Ward when personal care was delivered. Signs displayed on the doors of the maternity unit asked staff to knock and wait before entering.
- Overall women described their maternity care as “brilliant” and said their concerns were listened to. One woman told us staff in the maternity day assessment unit were “reassuring and supportive”. However, one woman’s relative told us several obstetricians “seem not to care” and were “very matter of fact.”
- We witnessed a midwife talking to a distressed woman. The midwife spoke in a caring and reassuring way and acknowledged the woman’s distress.
- Women rated the trust about the same as other trusts in the CQC’s 2015 Survey of Women’s Experiences of Maternity Services, apart from one question where the trust scored better than average; more women than average reported they had confidence and trust in the staff caring for them in labour and at the birth.
- However, Friends and Family survey results for maternity services were mixed and generally not as good as England averages. For the year December 2014 to November 2015 antenatal care was only equal to or better than the England average on two occasions, with results in February to March and July 2015 of 81% and 84% respectively recommending antenatal care compared with the England average of 95%. Postnatal care varied and was sometimes recommended by much higher or lower percentages of women to the England average of 93%, with a low of 88% in February 2015 and a high of 98% in April 2015.

Understanding and involvement of patients and those close to them

- Midwives asked to look after women in the hospital who they knew from the community. The integration of midwives provided a higher chance that women would be looked after in labour and postnatally by a midwife they had already met.

- We saw from women’s records that discussions had taken place with regards to choices in pregnancy care for example one consultant described how they discussed the risks and benefits of staying on anti-depressants with pregnant women. Information was given to enable women to make informed decisions about where they would like to deliver their baby.
- The HoM told us they always ensured the women and their partners were told of the ultimate risks to the woman and baby if they requested a birth at home when they were considered ‘high-risk’. This allowed women to make fully informed decisions

Emotional support

- A gynaecology nurse specialist and a former patient ran the monthly ‘GO Girls Support Group’, which supported women with a gynecological cancer, their families and friends.
- Antenatal screening midwives provided ongoing emotional support and information to women who were told their baby had an abnormality.
- Women were able to access further support and counselling from the midwives in the early pregnancy unit if they chose a termination because of foetal abnormality.
- Staff arranged for the local registrar to attend the bereavement room to save parents having to attend the register office after a baby’s death.
- One of two specialist bereavement midwives made home visits following a stillbirth or neonatal death. They made follow up visits to tell the parents post-mortem results in person and offered to provide antenatal care for women in any subsequent pregnancy. They also set up the monthly ‘Forget Me Not’ bereavement support group in a local children’s centre. They set up and closely monitored private social media page for women who had lost a baby during pregnancy or after birth.
- All women were offered the opportunity to talk about their birth experience and if they wished to, discuss events in more detail with a midwife.

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Are maternity and gynaecology services responsive?

Requires improvement



By responsive we mean that services are organised so that they meet people's needs.

We rated responsive as 'requires improvement' because:

- The trust only met its target of 90% of women booked by 12 weeks once in the 11 month period between April 2015 and February 2016. NICE guidance suggests women have access to antenatal care ideally before 10 weeks of pregnancy.
- Elective caesarean sections were delayed, often for several hours and this was not monitored by the trust.
- There was no perinatal mental health service, however work had taken place resulting in a start date for a clinic in May 2016.
- There was no midwifery led unit to enable women to have the choice of midwife led care at this hospital.

However,

- Women had access to sufficient information to support them with their pregnancy options and gynaecological diagnosis. Women had access to telephone translation services and staff told us information could be sourced in other languages if required.
- Women could have their ultrasound scans and see specialists at the same visit as their consultant appointment and registrars could perform scans if a woman arrived at the unit without an appointment and required one. Scans were also available in Bridport and Blandford.
- Eighty percent of gynaecology patients waited less than six weeks for a diagnostic test in November 2015 and 100% had their test within six weeks in December 2015. There were no cancelled operations during these months.
- Some rooms in the maternity unit could be used as either delivery or postnatal rooms, giving some flexibility to meet changing needs. Reclining chairs meant partners could stay overnight in single rooms.
- Maternity services were designed to meet women's individual needs. There were specially designed services

for 'Young Mums' and a healthy living clinic for women with a high BMI. Women were supported to deliver their babies at home and a weekend postnatal clinic was available to support women.

- Information was displayed which enabled women to make complaints. Complaints were taken seriously and investigated. Improvements were made to the quality of care as a result of complaints and concerns.

Service planning and delivery to meet the needs of local people

- There was no perinatal mental health service; women were seen by general psychiatrists if necessary. However there were plans to develop the service from May 2016. Plans included access to a perinatal psychiatrist, an obstetrician and midwife with special interests in mental health and a community psychiatric nurse.
- In 2007, the Department of Health recommended women should have a choice to deliver in a midwifery led unit close to an obstetric unit, there was no midwife led birth unit provided at the hospital. This recommendation was made again in 2016 National Maternity Review. There were plans to make part of the unit a separate midwifery led unit.
- Some rooms in the maternity unit were interchangeable from postnatal to delivery rooms or vice versa. This gave flexibility to meet the frequently changing needs in the unit.
- There was a three bedded day assessment unit (DAU) with plans to extend it to accommodate seven beds and a chair.
- In response to a higher than the England average rate of births for women and girls under 20 (4.6% compared with the England average of 3.7%), specialist midwives for 'Young Mums' were recruited for a year's trial of specialist services. These included breastfeeding and smoking cessation education specifically designed for teenagers in Weymouth and Portland. Specially designed group antenatal classes for pregnant teenagers ran in Bridport. Midwives held one-to-one sessions at the end of classes to listen to the baby's heartbeat, if requested. The 'Young Mums' were offered separate tours of the maternity unit.
- Midwives felt the integrated service they provided meant women were seen by one of a team of three midwives antenatally and had a much higher chance than in other units of being cared for in labour and

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postnatally by one of the midwives they already knew. One woman told us she saw noticeably fewer different midwives in pregnancy this time compared with three years previously.

- Discussions were taking place to develop a seven day early pregnancy service within the Dorset wide acute services Vanguard project.

Access and flow

- Women did not consistently have prompt access to maternity services. The trust maternity dashboard for April 2015 to February 2016 set a target of 90% of women booked by 12 weeks. This was only met once in the 11 month period between April 2015 and February 2016. The lowest was 79% in January 2016. The HoM informed us this had been exacerbated by having to reallocate community midwives to work at the maternity unit. The planned increase in the number of midwives would help to address this. A new booking system was also being piloted with the aim of ensuring a home visit took place at approximately 16 weeks for all women and all women would be seen between 9-10 weeks for a preliminary booking.
- The consultant on call for women in labour was also one of the surgeons for the elective caesarean sections. One consultant told us this resulted in around 20% of elective caesarean sections being delayed. We observed three women who waited over six hours for their elective caesarean section. The trust did not monitor the delays but would ensure the procedure took place on the scheduled day.
- Bed occupancy in the maternity unit was consistently below the England averages between October 2013 and September 2015.
- Women in early labour were assessed in delivery rooms and if there were not enough beds in the DAU, women were seen in the antenatal rooms.
- Women were often able to stay in the same room they delivered their baby in until discharge. If the room was required for another woman they were moved to the postnatal area.
- Induction of labour was restricted to two women having their first baby per evening and two other women per morning.
- Midwives ran a weekend postnatal 'drop in' clinic between 10am and 4pm. Women were able to attend until four weeks after the birth of their baby. This meant that well women did not have to stay at home waiting for the midwife to visit them.
- Women were able to attend the hospital and have a scan at the same time as their hospital appointment. One woman described attending the hospital every two weeks and seeing the consultant, diabetic specialist midwife and diabetic specialist nurse and having a scan within the same visit.
- In the CQC's 2013 Survey of Women's Experiences of Maternity Services, the trust scored slightly better than the England average for the question, 'If you used the call bell how long did it usually take before you got the help you needed?'
- Eighty percent of gynaecology patients waited less than six weeks for a diagnostic test in November 2015 and 100% had their test within six weeks in December 2015.
- Between October and December 2015, 100% of women were offered a colposcopy appointment within two weeks of a smear test result and 100% of women were offered an appointment within six weeks of a borderline or low grade Human papilloma virus (HPV) result.
- Women with hyperemesis were treated as inpatients on Abbotsbury Ward. Staff told us they could "stay as long as needed".
- The staff on Abbotsbury Ward told us they tried to ensure all gynaecology patients were cared for together in one area of the ward. However on the second day of our inspection we found gynaecology patients were in different areas of the ward. Staff told us this was due to the hospital shortage of beds. Staff told us one of the patients had settled in their area and it was preferable for them to stay settled rather than move.
- The clinical director told us operations were usually cancelled due to staff sickness. There were no cancelled operations in the family services division in November or December 2015. From information sent to us by the trust we saw that 82 operations were cancelled between September 2015 and February 2016. Reasons included Patient social/work reasons (19 patients), patient unexpected illness (10 patients) and ran out of theatre time (four patients).
- Staff on Abbotsbury Ward used enhanced recovery pathways to facilitate a shortened length of stay in hospital.

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- In the period April 2015 to February 2016, the unit had closed to admissions for four hours once in November 2015 and overnight once in February 2016. One member of staff was allocated to answer the 'phones and liaise with other hospitals. Women were assessed and directed to appropriate nearby hospitals.

Meeting people's individual needs

- A Health and Wellbeing Clinic was provided for women with a body mass index greater than 35. A dietician advised on how to maintain a healthy weight in pregnancy. Postnatally women had access to six weeks free membership of a national slimming club.
- The Cygnet homebirth team had five midwives and had been developed to support women who chose to give birth at home. A named midwife was allocated to any woman who asked for care outside of the homebirth guidelines. The midwives ran a monthly meeting of those who were interested in homebirth and those that had a homebirth.
- The HoM was proud the maternity service supported women who wished to deliver their baby outside of suggested guidelines. For example, one woman was supported to deliver twins at home. To facilitate as safe a birth as possible the HoM met with the woman and her partner several times and sought advice from other specialists. An on call rota of experienced midwives was created purely for the woman. The service provided three experienced midwives during the woman's labour and continued to support the woman when she refused to transfer to the hospital against their advice. Another woman whose baby had been diagnosed with abnormalities was supported to deliver her baby safely at home as she wished.
- One consultant was working with GPs to ensure diabetic women were referred to them before trying to conceive in order to keep them and their baby in the best health.
- Additional equipment was available to ensure bariatric women were safely and comfortably accommodated. We saw a delivery room had been prepared with a chair and bed suitable for a bariatric woman due to arrive.
- Women whose babies were considered not likely to survive long after birth were given the option to talk through whether or not they wanted a paediatrician to attempt resuscitation at birth.
- A 'cooling cot' was available if women wished to keep their stillborn baby in the room with them. A mobile 'cuddle cot' was available if parents wanted to take the baby home.
- Antenatal education was no longer available across the area but was centrally provided in Dorchester. One woman told us the distance to the class meant she could not attend. However classes were introduced for women who lived at a local army base.
- There were specialist midwives trained to meet a variety of complex needs. For example, mental health, smoking cessation and bereavement. Food was available to meet a variety of special dietary and religious requirements. A fridge was provided in the bereavement room so that women and their relatives were able to eat and drink without having to leave the room.
- Face to face and telephone translation services were available if required. Staff told us they could access a range of written information in other languages and Braille if required.
- Staff on Abbotsbury Ward displayed a 'Learning Disability Assessment and Reasonable Adjustment Record' to prompt them to offer personalised care to women with a learning disability.
- Women miscarrying or having a medical termination of pregnancy were accommodated in Abbotsbury Ward, in a side room away from the main ward area, whenever possible. They could be monitored remotely by CCTV with their consent, so they did not have to be disturbed.

Learning from complaints and concerns

- Between April 2015 and February 2016 there were five formal complaints about the maternity service. Formal complaints were tracked by the patient engagement team. Verbal complaints were not recorded however all complaints were discussed at regular meetings. The HoM or matrons emailed the woman or relative to acknowledge their complaints. Once the complaint had been investigated the HoM or matron offered to meet with the complainant to discuss the results of their investigations. Staff meetings were held to discuss complaints and learning points were published in the maternity newsletter. We saw from complaints logs that staff were spoken with if their actions or attitude had resulted in a complaint.

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- The antenatal screening coordinator and one of the matrons had attended further training in the consent process for post-mortems. This was in response to concerns about the availability and experience of some paediatricians to discuss the process.
- Staff on Abbotsbury Ward recently started a complaints folder. Staff were to be sent information which confirmed actions and learning points resulting from complaints.

Are maternity and gynaecology services well-led?

Requires improvement



By well-led we mean that the leadership, management and governance of the organisation assures the delivery of high quality, person-centred care, supports learning and innovation and promotes an open and fair culture.

We rated 'well-led' as 'requires improvement' because:

- Consultants did not all work well as a team, working relationships were strained and potentially risked impacting on patient care.
- The 2015 GMC's National Trainee Scheme Survey reported trainee doctors were dissatisfied with their obstetrics and gynaecology placements due to a lack of learning and feedback.
- The maternity risk register was not an effective tool to manage risks, which were often miscalculated.
- There was no robust lone worker system in place for midwives in the community, midwives had to use their own mobile phones.
- Midwives and support workers often covered vacant shifts and worked after their shifts finished. This and the frequent need for managers to help with clinical work was unsustainable.

However,

- The head of midwifery (HoM) provided positive leadership. We found the HoM and matrons acted quickly to make improvements.
- Midwives felt well supported and there was a culture where poor practice was supportively challenged and praise given for good practice.

- There was a clear strategy and plans for the maternity services. The trust was part of the ongoing Dorset wide clinical service review and the Developing One Dorset vanguard to integrate acute care.
- There was a clear statement of the trust values driven by quality and safety
- Staff on Abbotsbury Ward were positive about their relationship with managers.
- There was strong staff and public engagement within the maternity service.

Vision and strategy for this service

- There was a clear strategy for the maternity unit. The key areas for focus were reducing the caesarean section rate, increasing the normal birth rate and the development of the midwifery led unit and the perinatal mental health clinic. Staff were aware of the strategy for the maternity service. The trust was part of the Dorset wide clinical services review. Alongside the review three Dorset acute hospital trusts were working together to integrate acute care as part of the Developing One Dorset vanguard project.
- Staff were aware of the trust's values: integrity, respect, teamwork and excellence and had chosen a lanyard to reflect which value was most important to them.
- The matron told us the strategy for Abbotsbury Ward was to maintain some stability of management staffing. Staff were aware of the aims of the strategy. Medical staff told us the gynaecology service was being developed and aimed to expand and improve outcomes for women in for example, pelvic floor trauma. There were also plans to increase pre-conception counselling and information to women by producing leaflets to display in GP surgeries and holding meetings with GPs.

Governance, risk management and quality measurement

- Maternity and gynaecology services were within the family services division governance structure
- The head of midwifery (HoM) and interim director of nursing (DoN) met regularly and the HoM raised midwifery issues at board level if necessary. The HoM encouraged staff to report risks due to low staffing levels.
- There was a weekly multi-professional maternity forum meeting, and the maternity dashboard was used to monitor quality. Managers discussed the maternity dashboard, new guidelines, risk register and root cause

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analysis (RCA) investigations at the monthly family services clinical governance meeting. The minutes of the meeting were discussed at the trust's clinical governance meeting. Managers described "supportive challenge" of root cause analysis at scrutiny panel which the head of risk, DoN and chief executive attended.

- Staff on Abbotsbury Ward were clear about individual patient risk but not ward risk, however there were no risks relating to gynaecology patients on the relevant risk registers.
- Staff concerns were reflected in the risk register for maternity and the matrons and HoM were aware of the risks. However the analysis of risks was not consistently robust. For example, scoring used to measure the impact of the risk was often miscalculated or underestimated. Some scores had been added up wrongly. Consequences, action plans and mitigation were not immediately apparent as they were written in paragraphs rather than within the allocated boxes. For example failure to complete observations on mother and baby had been identified as a moderate risk. This had been placed on the register in November 2015. There had been no review of the risk documented and there was no information to support action plans had been developed to mitigate this risk. The HoM told us the risk register was in the process of redevelopment and some of the calculations and narrative may have gone awry.
- In response to the variable friends and family test results the maternity service completed a 'you said we did' action plan. We saw information that showed any negative comments had been investigated and information and learning shared with the midwifery team.
- The HoM acknowledged that there was little audit activity to provide quality assurance.
- An external review had been commissioned on the service. The report from the external review had not been published at the time of our inspection.

Leadership of service

- There was a clinical lead for women's health who reported to the family services divisional director. The head of midwifery (HoM) reported to the divisional manager for family services. The lead for obstetrics and gynaecology was relatively new to the post.
- One of the consultants told us the HoM was "inspirational". Midwives told us they felt cared for and

recognised for good practice. The HoM told us they were proud of their team and frequently gave staff positive feedback. One registrar confirmed the HoM also gave positive written feedback to medical staff.

- Midwives told us they saw their managers as approachable and supportive and acknowledged they "pulled their weight".
- Senior midwives and managers in the maternity unit acted quickly to make improvements. We fed back to senior staff that midwives felt unable to challenge medical decisions. After our inspection a flow-chart was produced to support staff in questioning decisions and prompt doctors to ensure all options for clinical care were considered. During our unannounced inspection staff told us the flowchart had been used and senior managers planned to present it at the clinical governance meeting to ensure all medical staff were encouraged to use the document.
- Staff on Abbotsbury Ward were positive about their relationships with immediate managers, despite a recent frequent change of managers. The ward sister had been in post eight weeks and staff hoped for a period of stability.
- The consultants' managers described all but one consultant working in "relative isolation to the rest of the trust".
- There was a long standing divide between many of the consultant obstetricians/gynaecologists. Their managers told us they were aware of what they described as "strained interpersonal relationships" and the events which led to the breakdown in relations between the consultants. The managers had taken appropriate steps to investigate the initial concerns, however consultants did not feel that the executive team had taken the necessary action when they were informed and so a referral was made to the General Medical Council (GMC). However, the divisional director and divisional manager did feel listened to and supported by the chief executive.
- The 2015 GMC's National Trainee Scheme Survey reported trainee doctors were dissatisfied with their obstetrics and gynaecology placements due to a lack of learning and feedback.

Culture within the service

- Mediation had been arranged to try and improve the poor relationships between consultants, however nurses told us that the situation had not improved and

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had become “untenable”. We were told the consultants had remained professional in front of patients and other staff. Indeed some staff we spoke with were unaware of the difficulties between the consultants, however some nurses told us they felt patients and staff had been affected.

- Midwives and obstetricians reported good working relationships. One registrar described the midwives as “friendly”. Consultants told us they had a “great relationship” with midwifery staff. Midwives agreed but did acknowledge that they didn’t always feel comfortable challenging medical decisions they were unsure about or didn’t agree with.
- We observed staff interacting with each other and their immediate managers on Abbotsbury Ward. They treated each other with respect and were able to speak freely with managers.
- Midwives felt supported on return to work from sick leave; they told us they were initially allocated non-clinical work if that was more appropriate.
- Midwives were proud of working in what they described as a friendly, woman-focussed unit with a stable and flexible workforce. They felt there was good team-working even when they felt stressed. They told us supervisors of midwives challenged poor practice but there was no culture of blame.
- All midwives told us they would report poor practice and thought they would be supported in the process. Most doctors we asked they felt able to ‘whistle-blow’ and their concerns would be taken seriously. One told us they had used the whistleblowing policy and appropriate action had been taken. However, two were supported by divisional managers but had lost faith the executive team would take action as they felt their concerns had not been dealt with by them on previous occasions.
- Midwives’ lone working was risk assessed, with visits to known high risk families in pairs. However midwives told us they had to use their own ‘phones when they worked in the community and there was no lone worker safety device or use of a control centre to check on midwives.
- The 2015 GMC’s National Trainee Scheme Survey reported trainee doctors were dissatisfied with their obstetrics and gynaecology placements due to a lack of learning and feedback.

Public engagement

- The local national childbirth trust (NCT) group were involved in planning the midwife led birth unit and a member of the NCT was invited to the weekly maternity forum.
- Midwives made follow up visits to women requesting care outside of guidelines and brought their feedback to the maternity forum.
- Young mums with babies were encouraged to get involved in the Bridport teenage antenatal classes to offer peer support.
- Midwives organised the monthly ‘Forget Me Not’ bereavement support group in a local children’s centre. They also set up and closely monitored a private social media page for women who had lost a baby during pregnancy or after birth.
- The two bereavement midwives won the local radio station’s ‘The Services Award 2015’; they were nominated by someone they had cared for.
- Twenty midwives were nominated by women or their relatives for a ‘WOW! Award’ for outstanding service.
- One midwife won the GEM Awards (Going The Extra Mile) after being nominated by a woman she cared for.

Staff engagement

- Midwives told us their ideas were welcomed by managers. They could contribute to the monthly newsletter if they wished.
- The maternity managers gave positive feedback to staff if they noted good practice when reviewing incidents. Staff were emailed so they could keep the feedback to use for revalidation to renew their registration on the Nursing and Midwifery Register.
- The HoM nominated the infant feeding lead for the RCM Support Worker of The Year Awards.
- There were monthly meetings on Abbotsbury Ward and a ward newsletter staff were encouraged to contribute to. Staff were asked how they could encourage nurses to work on the ward to fill the vacancies.
- The safeguarding midwife was nominated and won the Community Midwife of the Year Award for going “above and beyond her role”.

Innovation, improvement and sustainability







- One of the maternity service’s goals was for a member of the Cygnet homebirth team to be available to assess low-risk women who were not booked for a homebirth

Maternity and gynaecology

but were in early labour at home. This would save women attending the unit to be assessed and if appropriate, they would be offered a homebirth at that point.

- The trust participated in providing information to women via a Smartphone 'App' to be available from April 2016. This showed women information about and photographs of the maternity unit so they could compare it with others.
- One of the gynaecology nurse specialists and a former patient ran the monthly 'GO Girls Support Group' and social media pages, supporting women with a gynecological cancer, their families and friends.
- The maternity unit relied on midwives and managers who worked extra hours due to gaps in staffing. This could not be sustained long term; the head of midwifery was waiting to hear the outcome of the business case for more midwives and maternity support workers.

Services for children and young people

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

Information about the service

Dorset County Hospital NHS Foundation Trust provides services for children and young people living in West Dorset.

The hospital provides care for young people up to the age of 18 years with complex and chronic illnesses, many of whom require investigative or daycare treatment. The in-patient services provide care for children and young people up to their eighteenth birthday for those with medical, surgical, ear nose and throat, ophthalmology, dermatology and orthopaedic conditions.

The service has one general ward, an assessment unit, and a child health unit in a separate building where most of the outpatient services are provided. Children and young people are also cared for in other areas of the hospital depending upon their needs. In addition, there is a local neonatal unit for premature and sick babies.

The general children's ward has 17 cots/beds arranged in a mixture of cubicles and bays. There are four beds in the paediatric assessment unit. The ward facilities allow parents to stay with their child overnight. The ward also has a schoolroom with teaching staff so children can continue their education during their hospital stays. There is a special play area for children and their younger siblings.

The assessment unit is located on the general ward. It allows rapid access for GP referrals for children and young people, to gain urgent advice from paediatricians, without having to attend the hospital's emergency department.

The neonatal unit provides care and treatment for babies who were born prematurely or who need medical care. The neonatal unit has 14 cots with a 'hot room' for intensive care (up to 48 hours) and two isolation cubicles. The service admits single babies from 27 weeks gestation and twins from 28 weeks gestation.

Children are also cared for in other areas of the hospital for example for surgery and the emergency department.

A community paediatric service provides support within the local area and a service for pre-school and school children with special needs.

We spoke with 10 parents and eight children and young people. We also spoke with 15 staff members, including nurses, consultants, medical staff, managers and support staff during our inspection. We inspected all paediatric areas as well as areas in which related facilities were shared with adult services. We observed care and examined 14 care records and other documents in all inspected areas. We also reviewed other documents from stakeholders, and reviewed performance data about the trust.

Services for children and young people

Summary of findings

We found that the services for children were good for safe, effective, caring, responsive and well led.

There was openness and transparency about safety, and continual learning was encouraged. Staff were supported to report incidents, including near misses. Access to the children's ward and neonatal unit was secure. Staff were clear about their responsibilities if there were concerns about a child's safety. Safeguarding procedures were understood and followed, and staff had completed the appropriate level of training in safeguarding and other mandatory training.

The trust did not follow the Royal College of Nursing guidance on safe staffing levels for the paediatric wards. Whilst the trust did mitigate the impact of this overnight through effective rostering of competent staff, the system may not be sustainable. The unit was relatively small and not fully compliant with British Association of Perinatal Medicine (2010 Standards) requirements for a local neonatal unit as there was not a totally separate tier 1 rota, and the rota covered the children's unit as well. However, there was no evidence of any negative impact of this arrangement. There were good levels of low and middle grade doctors and they were positive about the trust as a learning environment. The unit was also non compliant with the Royal College of Paediatric and Child Health Facing the Future: Standards for Acute General Paediatric Services (2015) as the unit did not have a consultant paediatrician available during the times of peak activity, seven days a week. Although a consultant was resident over night

Care and treatment was planned and delivered in line with evidence-based guidance, standards and best practice. The individual needs of children and young people were assessed and care and treatment was planned to meet those needs. Care pathways and multidisciplinary records were used to support practice. Staff assessed patients' pain effectively and obtained consent to treatment appropriately and in line with legal guidance. A paediatric early warning system was used for early detection of any deterioration in a child's condition and an early warning system for neonates was used in the NNU.

Staff were trained and had the skills and knowledge required to undertake their role. Staff completed appropriate competence assessments. Appraisals and supervision took place and this helped staff to maintain and further develop their skills and experience. Services, including access to consultant paediatricians, were provided seven days a week.

Feedback from children, young people and parents about the care and kindness received from staff was positive. All the children and families we spoke with were happy with the care and support provided by staff. Staff worked in partnership with parents, children and young people in their care.

Inpatient services were tailored to meet the needs of individual children and young people. There were suitable facilities on wards for babies, children and young people and their families. A paediatric assessment unit, open 13 hours a day, improved patient access and flow through the hospital. There were no barriers for those making a complaint. Staff listened to the feedback given to them by parents. Play therapy staff ensured children were supported during their hospital stay.

There was a clear governance structure to manage quality and risk. There was strong visible clinical leadership that had brought about positive developments. Staff at all levels of the organisation were proud to work in this department. The unit had also involved a child inspector from social services in making improvements to the service.

There was a strategic plan for paediatric services 2016/17 and the service was part of the ongoing Dorset wide Clinical Services Review, and the acute services Vanguard project.

Services for children and young people

Are services for children and young people safe?

Good



By safe, we mean that people are protected from abuse and avoidable harm.

We rated safe as 'good' because

- Staff followed processes and procedures to learn from incidents. There was openness and transparency about safety. Staff were supported to report incidents, including near misses. There were no serious incidents reported for the period October 2014 to December 2015.
- A paediatric early warning system was used for early detection of any deterioration in a child's or baby's condition.
- The environment and equipment were well maintained. Age-appropriate specialist and emergency equipment was available and maintained.
- Access to the children's ward and neonatal unit was secure.
- There was an established system for the safe management of medicines.
- Staff were clear about their responsibilities if there were concerns about a child's safety. They understood and followed trust safeguarding procedures. Staff had completed the appropriate level of safeguarding training and other mandatory training.
- There was a flagging alert system to identify Looked After Children within the trust.
- Staff knew about their responsibilities if a major incident was declared.

However,

- Whilst there were good levels of medical cover on the neonatal unit during the day, the unit was not compliant with British Association of Perinatal Medicine (2010 Standards) requirements for a local neonatal unit at night. There was not a dedicated medical doctor for the neonatal unit between 9pm and 8am. The medical doctor who covered paediatric ward also covered the neonatal unit. This meant, in some instances, there was only one doctor covering both the neonatal unit and the paediatric ward.

- Medical staffing on the children's wards was well managed with good fill rates for posts and the consultants worked flexible to provide cover. However, the unit was non compliant with the Royal College of Paediatrics and Child Health guidelines for acute general paediatric services as the unit did not have consultant paediatrician available during the times of peak activity, seven days a week.
- The trust did not follow the Royal College of Nursing guidance on safe staffing levels for the paediatric wards. Whilst the trust did mitigate the impact of this overnight through effective rostering of sufficiently qualified and experienced staff, the system may not be sustainable.
- The staffing levels and beds numbers on the children's ward were monitored and managed by the Matron who took a flexible approach to try to ensure staffing levels were safe. There was no formal tool to assess the acuity of patients and the required staffing levels for paediatrics.
- Income of the outpatient areas such as the fracture clinic, children were seen with adults. No suitable arrangements had been made to separate children from adults.

Incidents

- Staff were open and transparent about reporting incidents. Systems were in place to make sure that incidents were reported and investigated. All staff told us that they would report incidents without hesitation and knew which incidents to report. Staff received training on incident reporting at induction and through periodic updates. Staff leading investigations such as the ward sister and deputy sister, received training in root cause analysis.
- The matron reviewed and graded reported incidents, with the support of the trust wide risk management team and investigated them where necessary. Staff told us they received feedback on incidents they reported this included emails, discussion of recent incidents at daily safety briefing and team meetings. Information on recent incidents were also placed in the nursing communication book for all to read and sign.
- For the children's services there were no serious incidents reported under the Strategic Executive Information System (STEIS) or never events (serious,

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largely preventable patient safety incidents that should not occur if the available preventative measures had been implemented) for the period October 2014 to December 2015.

- Between April 2015 and December 2015, 70 incidents were reported across the children's services. Of these 66% were graded as no harm, near miss or harm was prevented. Where harm may have occurred they were all graded as low harm. Information provided by the trust indicated that all incidents were reviewed.
- Children's services held multi-disciplinary paediatric mortality and morbidity meetings and minutes showed cases were discussed and learning points and actions taken were recorded.
- Information posters on Duty of Candour (DoC) were displayed in the neonatal unit (NNU) and in staff areas of the paediatric unit. Staff had also been provided with guidance. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person.
- The trust's policy on 'being open and duty of candour' reflected the DoC legislation. RCA reports showed staff used the DoC reporting process and the trust's incident reports included the number of DoC incidents.
- The risk management team identified incidents reported by staff that triggered the DoC and then coordinated the response and investigation. There was a trust-wide system for tracking their DoC responses and in the quarter October 2015 – December 2015, 12 incidents triggered the DoC response.
- All staff we spoke with understood the principles of openness and transparency; nurses told us that the ward sister talked to parents if anything went wrong.

Safety thermometer

- The trust submitted data to the national tool for children monitoring patients with an early warning score completed, triggered and not escalated, extravasation, patients in pain at the point of survey, any pressure ulcer and any moisture lesion. Information was used by the trust as a way of monitoring harm free care.

Cleanliness, infection control and hygiene

- There had been no cases of meticillin resistant staphylococcus aureus (MRSA) bacteraemia or Clostridium difficile in the child health service including the neonatal unit (NNU) during 2015.
- All areas visited were visibly clean and kept tidy. There were cleaning guidelines in place. Records reviewed showed the ward and the NNU were checked for cleanliness daily. The matron made weekly-unannounced checks of all areas to monitor the general state of cleanliness. Staff used ward cleaning schedules and we observed cleaning of areas after patients were discharged and to ensure the areas were clean and ready for use.
- Staff received infection control and prevention training as part of their mandatory training programme. All staff in the NNU had completed their mandatory training in infection control and prevention. Ninety-five percent of ward staff had completed the training.
- The infection control team regularly carried out environmental cleaning audits and the paediatric ward consistently scored over 97% and the NNU 99%. The infection prevention control team was available for advice, if required.
- We observed staff adhere to the infection control policies, including 'bare below the elbows', hand hygiene and appropriate use of personal protective equipment, such as disposable aprons and gloves. Signs reminded staff and visitors to use hand sanitiser to clean their hands on entering the ward.
- Hand hygiene observation audits were undertaken monthly. Monthly overall scores for NNU for the period May 2015 to January 2016 were between 98-100%. The paediatric wards scored on average 96% for the time period May 2015 to January 2016.
- Extra care was taken for children and young people with suppressed immune systems, including cohorting and appropriate use of isolation facilities. There were a sufficient number of side rooms across the unit to isolate patients who were at risk of spreading infections. There were signs outside isolation rooms reminding staff of transmission risks.
- There were designated areas on the NNU for used/dirty equipment, which was then cleaned ready for use. The paediatric ward had a storage area for clean equipment. An environmental audit (November 2015) identified

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various areas of improvement including lack of storage space in the sluice. During our inspection, we found action had been taken as a result of this audit. We found the storage area clean and tidy.

- Families commented positively on the cleanliness of the units and staff attention to hand hygiene.

Environment and equipment

- The equipment and the environment was suitable for the age-range of the child. Whilst there was no dedicated theatre recovery area for children, suitable arrangements were in place to ensure children were separated from adults.
- We observed a child being taken into recovery area after their surgery and saw mobile screens were used to provide them with some protection from hostile sights and sounds through the use of mobile screens.
- Certain clinics, such as the fracture clinic, children were seen with adults. Whilst this was not ideal, no suitable arrangements had been made to separate children from adults. Where possible children were seen for outpatients appointments at the children's centre, which had a more suitable waiting environment for them. All outpatient waiting areas we visited provided toys and activities should children attend, where the layout allowed, this area was away from the main waiting area.
- There was an established system to safely monitor who entered and left the children's unit. The reception staff monitored who entered and exited the ward through a camera link. Entry was through one central door and visitors and other staff rang a bell to gain access. They then reported to this desk where they were guided to their destination. Exiting the ward was only possible when the reception staff pressed the exit button.
- There was a written sign on the door to the children's ward informing parents and carers to ensure that no patients tried to exit the area as they went into the unit and not to let anyone else in with them. The same applied as the parent or carer left the unit.
- The NNU was a secure unit with entry by call bell system. This was secure out of hours.
- The paediatric unit and the NNU were well-equipped. An equipment officer oversaw the ordering of equipment and making sure equipment was charged, quality tested and ready for use. There was a schedule of maintenance for specialist equipment. For example,

the weighing scales machines had been recently serviced. The equipment library tracked equipment through a central electronic system. The checking and electrical testing of equipment was centralised and ensured no electrical safety testing of equipment was out-of-date. We checked six items and all had been safety tested

- Emergency equipment was readily available and stocked. Daily checks took place and were documented.
- There was a designated high dependency area for children, with the correct paediatric equipment, maintained under contract and checked daily.

Medicines

- Medicines were stored securely in locked cupboards, medicine fridges and controlled drug cabinets in treatment rooms secured by keypad locks. There was a central electronic system to monitor the fridges where medicines were stored, to help ensure they were kept at optimal temperatures.
- Allergies, heights and weights were recorded on prescription charts, these were all complete on the 10 records we reviewed. This helped ensure safe administration of medicines.
- Nurses checked medicine packs when medicine was dispensed on the ward to take home.
- Nurses shared information with parents to ensure they understood the reason for the medicines being given to their child.
- Staff provided training and assessment for parents to administer intravenous antibiotics, supported by guidelines for parents and young adults on home intravenous antibiotic therapy.
- There were 17 incidents relating to medicines. Each of these incidents was investigated and results were shared with staff meetings.
- Information on medicine alerts and medicine errors were placed in the nursing communication book for all to read and sign.
- Nursing staff received regular training on medicine management to support safe use of medicines.

Records

- Records reviewed showed daily reviews of patients by consultants and clear documented management plans.
- We found records were not always stored securely. This was because on the children's ward they were kept on a

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trolley that was not locked. These concerns were raised at the time and action taken. At the unannounced inspection, we followed up on these concerns and found the records were being stored securely. Records in the NNU were safely managed.

- There was a flagging alert system to identify Looked After Children (LAC) within the trust. As such, patterns for significant events could be established. The local authority informed the trust of children with a protection plan or case conference in West Dorset. This information was shared with emergency department on a daily basis, Monday to Friday.

Safeguarding

- There were clear policies and procedures in place for safeguarding. Staff showed a comprehensive understanding of differing safeguarding issues for example, child abuse and female genital mutilation.
- There was a safeguarding hub within the hospital, which was the route of contact with the team. A safeguarding website was well populated with safeguarding information. For example, there were electronic safeguarding referrals forms and contact details for safeguarding professionals at the trust and social services.
- There was a secure safeguarding mailbox with social care, for the receipt and sending of safeguarding referral forms and a clear referral pathway for raising safeguarding children concerns.
- A named nurse and named doctor for safeguarding children and young adults were available for assessment and advice and to ensure the trust fulfilled its legal obligations. There was a clear policy and procedures for safeguarding children and young people, with guidance on what to do and who to contact if there were any concerns.
- In January 2016, 100% of all paediatric staff were trained to level 2 and 98% were trained to level 3 in safeguarding children. All paediatric consultants had attended level 3 training, which meant they were trained to recognise and take the correct actions if a child was considered at risk of harm. In the NNU, 98% staff had completed level 3 training.
- Trust safeguarding procedure for Child Sexual Exploitation (CSE) linked into Dorset Social Services Multiagency procedures and the trust was represented at high risk multiagency meetings for CSE.

- Safeguarding was considered within all assessments. Staff completed a safeguarding checklist for patients on admission to the assessment unit or the ward. They also checked if children were subject to a child protection plan. Safeguarding questions were recorded in paediatric and NNU records. Staff used safeguarding children proformas to document details of safeguarding concerns. In-house training on the use of proformas was provided and the documentation was audited. A guidance document had been developed to support correct completion.
- The matron with overall responsibility for safeguarding (hospital named nurse) received supervision from the designated lead nurse. However, the doctor did not routinely receive supervision. The safeguarding nurse (band 7) received supervision from the matron and used doctors for support. They also attended peer review for doctors for shared learning.
- The trust followed the statutory guidance 'Working Together to Safeguard Children'. (2015) and Facing the Future (RCPCH, 2015) Standard 10. This stated that all children and young people, children's social care, police and health teams had access to a paediatrician with child protection experience and skills (of at least Level 3 safeguarding competencies) to provide immediate advice and subsequent assessment, if necessary, for children and young people under 18 years of age where there were child protection concerns. The requirement was for advice, clinical assessment and the timely provision of an appropriate medical opinion, supported with a written report.
- There were clear pathways for staff to follow when children did not attend appointment. There was also a separate pathway to follow if parents of young children cancelled appointment. Staff we spoke with were aware of these pathways.

Mandatory training

- The trust had a 90% target for compliance with mandatory training. Trust data received during the inspection showed compliance rates of 90–100% for nursing staff across the range of training, including blood awareness, complaints and claims, risk management, infection control, basic life support, health and safety, fire safety, and moving and handling.
- Trust data showed paediatric junior doctors at 78% compliance for internal trust provided training days.

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- The trust had promoted education on 'Spotting the Sick Child' to all staff

Assessing and responding to patient risk

- Staff used the paediatric early warning systems (PEWS) to identify and escalate deterioration in a child's condition. PEWS observation charts for children of different ages clearly identified when observations were outside the normal range and the actions to take for different scores. We reviewed three sets of notes and found appropriate actions were undertaken.
- Staff on NNU used an early warning system for identification and escalation of a deteriorating neonate. Staff told us they understood what actions to take in the case of a suddenly ill or collapsed child or infant. We reviewed three sets of notes and found appropriate actions were undertaken.
- Staff maintained observation charts, paediatric early warning systems (PEWS) and fluid charts were used. High dependency observation charts were completed for higher risk patients. Recording of information was done electronically allowing for closer monitoring of patients. Staff reported that this helped them monitor care more effectively.
- There were always appropriately trained staff on the ward and the neonatal unit who had received training on advanced child and neonatal life support.
- There were clear protocols and transfer arrangements for children who needed to be ventilated or required transfer for treatment. There was an area on the children's ward referred to as an observation area. Children who required more intensive care would be transferred either to Adult ITU or HDU for stabilisation or transferred to another hospital using the paediatric critical care network.
- In the trust, adult critical care unit a multidisciplinary approach taken and staff were supported through discussions with, and guidance from, regional children's intensive care unit and the involvement of paediatric specialists at Dorset County Hospital. All children who required airway support were discussed with the clinicians from the regional unit and a collaborative decision would be made whether to keep the child at DCH or to transfer the patient to the specialised children's intensive care unit.

- There was a system for recording waiting time within the assessment unit. There was a process in place to ensure no patient waited for more than four hours. Children with an acute medical condition were seen by a tier 2 doctor within 4 hours and a consultant within 14 hours.
- We saw the five steps to safer surgery checklists were completed for children and young people having surgery

Nursing staffing

- The Royal College of Nursing (2013) guidelines for children's wards state there should be a minimum of 70:30 registered to unregistered staff. The guidance recommends a higher proportion of registered nurses in areas such as children's intensive care or specialist wards. It is recommended that there should be a minimum of two registered children's nurses at all times in all inpatient and day care areas and at least one nurse for each shift, in each clinical area, trained in advanced or European paediatric life support.
- There were at least two registered children's nurses on duty at all times in the inpatient and day case areas. The weekday staffing was five trained children nurses and three healthcare assistants from Monday to Friday. At night, there were three trained children nurses and one health care assistant seven days a week. At weekends, there were three trained children nurses and two healthcare assistants.
- The paediatric assessment unit (PAU) was open during the day and staffed by a nurse and a health care assistant from the ward. The higher observation bay referred to as the 'high dependency area' was staffed from the ward team. If this was used, the number of beds on the ward was reduced to ensure safe staff ratios were maintained.
- There was no formal tool to assess the acuity of patients and the required staffing levels for paediatrics. The nurse staffing did not always comply with The Royal College of Nursing (2013) guidelines in terms of numbers or ratios of nurse to healthcare assistants with current ratios of 60:40. The matron was aware of this and ensured that if there were sicker children, the ward was safely staffed with registered nurses.
- The ward was not designed with designated areas for different age groups. The zones on the ward and the age demographic changed on a daily basis. Staffing levels were not specifically calculated taking account of a

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child's age. The trust had acknowledged in January 2015 that at night they did not meet the standard nurse to children ratio. Additional staffing had been agreed as part of a business plan.

- There was a senior sister in a supervisory capacity during the daytime. There was usually a band 6 nurse on every day shift and night shift. We inspected the staffing rota for four weeks and found three instances when there were no band 6 nurses on duty at night. In those three instances, the matron assessed the risk and mitigated this by rostering sufficiently qualified and experienced band 5 nurses to be on duty. The matron told us the ideal situation would be a band 6 at every shift, but it was difficult to recruit and there was a shortage of band 6 children nurses.
- There was a team of community nurses based on the ward who provided a service 8:30am to 4:30pm five days a week with a 24hour on call rota to cover end of life care.
- The NNU was staffed in line with guidance with three qualified nurses including at least two with a qualification in the speciality and a support worker on duty at all times. The local neonatal network reported the unit was compliant with the British Association of Perinatal Medicine (2010 Standards) for nursing staffing 86% of the time. This was an acceptable level of compliance.

Medical staffing

- Trust wide data on medical staffing skill mix showed a lower proportion of consultant and middle-career doctors and higher proportion of registrar-level doctors than the national average. There were 11% junior doctors compared with the 7% England average.
- On NNU there was a separate medical cover in the daytime, using advanced neonatal nurse practitioners (ANNPs) working along with junior doctors. ANNP can diagnose and initiate treatment plans for sick babies and can deliver complex high level interventions on their own. There were two ANNPs on the medical rota covering three and 1.5 long shifts per week respectively working alongside the doctors. Consultant cover was provided on a shared rota with the children's ward. The neonatal lead consultant carried out a weekly ward round.
- However, the unit was not compliant with British Association of Perinatal Medicine (2010 Standards) requirements for a local neonatal unit as there was a

shared medical cover overnight (between 9pm and 8am) between the neonatal unit and paediatric ward. That meant if there was an emergency on the paediatric ward, the neonatal unit could be left with no medical doctor cover. This could place sick babies on the neonatal unit at risk of harm if their condition deteriorated suddenly, although there was no evidence that patient safety had been impacted on by the current arrangements.

- Eight consultants, five registrar trainees, and a full rota of junior doctors covered the children's unit in line with the Royal College of Paediatrics and Child Health (RCPCH's) standard for 'small and remote' units. Two junior doctors covered the PAU and ward, with a senior registrar or consultant available. At night the medical cover was shared between the paediatric unit and the neonatal unit.
- The unit was also non compliant with Facing the Future-Standards for acute general paediatric services (RCPCH, Revised 2015) as the unit did not have consultant paediatrician present and readily available during the times of peak activity, seven days a week. However, while the consultants provided an on call service in the evening they did not provide a resident service overnight.
- The junior doctors told us they were well supported by consultants and registrars, including out of hours. Their rotas were structured in a manner that allowed them to access training sessions. Junior doctors felt well supported by senior clinical staff.
- Surgical junior doctors supported paediatric surgical patients, with paediatrician support as needed. The duty consultant was the named paediatrician for surgical patients. In an emergency, general surgical cases were seen by a paediatrician then reviewed by a surgical doctor.
- Children requiring admission as an emergency, who needed surgical review, were admitted by the children's service and then reviewed by a general surgical middle grade doctor. A paediatrician admitted children under the age of five. There was a one in six model for anaesthetic cover with daily ward rounds for surgery and paediatrics. The one in six model provided for emergency cover for children. There was a lead intensivist for children with 20 -30 children admitted to the adult ITU per year.

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- We observed an afternoon medical handover on the paediatric unit, which was attended by a consultant, two registrars and a senior house officer. There was appropriate information sharing and decision making.

Major incident awareness and training

- The service had a major incident plan. Emergency plans and procedures clearly identified what measures would be required to meet the needs of paediatric patients. Staff were aware of the actions required.

Are services for children and young people effective?

Good



By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

We rated effective as good.

- Care and treatment was planned and delivered in line with evidence-based and national guidance.
- The individual needs of children and young people were assessed and care and treatment was planned to meet those needs. Care pathways and multidisciplinary records were used to support practice.
- Children's pain was adequately assessed and they received pain relief in a timely way.
- Consent to treatment was obtained taking into account a young person's ability to give consent
- Outcomes of care and treatment were positive and met expectations, when monitored using national and local audits.
- Staff were trained and had the skills and knowledge required to undertake their role. Appraisals and supervision took place and this helped staff to maintain and further develop their skills and experience.
- Services were provided seven days a week, including access to consultant paediatricians.
- Multidisciplinary working was very strong within the service.
- Young people with chronic conditions were transferred appropriately to adult services with the right arrangements in place.

Evidence-based care and treatment

- The service was providing evidence-based care and treatment. Trust policies and guidelines had been developed to account national policies and guidance. These included the National Institute for Health and Care Excellence (NICE) guidelines and the Royal College of Paediatrics and Child Health. Policies were available to all staff via the trust intranet system and staff demonstrated they knew how to access them. NICE quality standards and guidance were discussed at monthly ward meetings and monthly governance meetings. For example, the nursing communication book contained the latest NICE guidance.
- The neonatal unit used evidence care pathways for monitoring and treating specific conditions for example, neonatal jaundice.
- We saw evidence of guidelines being used. For example, there were guidelines on treatment of diabetes for young children that followed the NICE guidelines published in August 2015.
- Clinical pathways were in place for the most common reasons children presented to hospital, including head injury, abdominal pain and fever. These clinical pathways gave clear and consistent guidance about how to treat these conditions.
- Clinical guidelines were available on the intranet. For example, there were paediatric sepsis guidelines introduced in August 2015 based on paediatric sepsis 6 guidelines. Staff were aware of actions to take for patients suspected for potential sepsis.

Pain relief

- Acute pain management guidelines were available to staff. Medicine records showed clear prescribing of pain relief and the time, route and dose of the medicine administered.
- An acute pain team was available to support the children's service.
- Nursing documentation we reviewed contained paediatric pain assessment charts. Staff reviewed pain relief for its effectiveness and reviewed treatment if necessary.
- There was guidance in care plans about pain management for children where it was appropriate, for example after surgery. We observed that pain relief was discussed with patients and/or their parents. Parents received an information leaflet about pain relief at

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home after surgery. We spoke with a parent whose child was being discharged and they told us they felt well equipped to provide appropriate pain relief and had the phone number of the ward to contact in case they had any concerns.

Nutrition and hydration

- Meal times were protected and parents were supported in feeding the children..
- There was a two-week rolling menu with a range of choices suitable for children. Religious, cultural and special dietary needs were accommodated. We spoke with a parent who told us how they had been offered appropriate dairy-free food for their child.
- Staff supported mothers to provide breast milk for their babies and the service was working to increase the number of mothers giving breast milk after the child was discharged. There was a breast feeding group to support mothers of babies on the neonatal unit. A mother was positive about the support from attending the breast feeding group.
- Paediatric dietitians provided nutritional support, advice and education to children and parents about diet and enteral feeding.
- The service was performing well to ensure babies on the neonatal unit received breast milk. Mothers told us they received support to breast feed when they visited the neonatal unit.
- There were arrangements in place that if needed, babies had access to any specialist feed required.
- During the inspection, breast milk was stored in an unlocked milk kitchen and the fridge was unlocked. This meant milk was accessible to anyone in the unit. However, this was highlighted to the trust as potentially unsafe and the trust ensured the kitchen and the fridge was locked at all times. We checked this again during our unannounced inspection and found both milk kitchen and the fridge locked.

Patient outcomes

- The department participated in the national paediatric diabetes audit, the national neonatal audit programme, the epilepsy audit and the cystic fibrosis audit.
- According to the 2013/14 National Paediatric Diabetes Audit, proportionately more children with diabetes had their diabetes under control (HbA1c < 58 mmol/mol) than the England average. The mean HbA1c level was better than the England average.

- In response to the issues raised by the diabetic peer review June 2014 (post the National Diabetes Audit 2013/2014) and a 'safe diabetes focus group' for children, the trust had made changes. The review had highlighted that the provision of paediatric diabetes education had not been undertaken in a co-ordinated manner because there had been problems in the recruitment and retention of ward nurses. The review also highlighted lack of access for dietetic support on the ward and appointment times for patients. Since the review, the recruitment and retention of nurses had improved and the ward had instituted paediatric diabetes education for all clinical ward staff. Furthermore, the department had also increased the dietetic support on the ward. In the 2014 National Neonatal Audit Programme (NNAP), the service was meeting all the standards.
- The service compared favourably with other units in Wessex and the UK in the Epilepsy 12 (Royal College of Paediatric and Child Health) national audit in November 2014. Although the trust was partially compliant overall there were significant improvements in two standards over the year and 95% patient/carer satisfaction. The trust was a negative outlier in two standards of access to epilepsy specialist nurse and an appropriate first clinical assessment. The trust had implemented access to epilepsy specialist nurse and improved assessment to appropriate first clinical assessment.
- The service participated in and had taken actions to address the findings of Cystic Fibrosis Trust peer review June 2014. Improvements that were made included all children with cystic fibrosis should be seen at least twice a year by a neighbouring hospital multidisciplinary team, and an increase in physiotherapy and dietetic time to meet the standards of care. The service was rated "compliant" for models of care.
- The trust provided multiple readmission data for epilepsy for patients between 1-17 years. Because of low numbers, there was no data for asthma and diabetes. There were also no data provided for patients under one year because of low numbers. The multiple readmission rate from July 2014 to June 2015 (1-17 years) relating to epilepsy was worse than the England average.
- There were emergency readmissions within two days of discharge after elective surgery admissions among patients under one age range and in the 1-17 age group between June 2014 and May 2015. However, no treatment specialty reported six or more readmissions.

Services for children and young people

- The non-elective paediatric emergency readmission rate within two days was similar than the England average for the under one age range and for the 1-17 age range.

Competent staff

- All staff had specialist knowledge and skills to treat children with their presenting conditions. There was a commitment to training and education within the service and staff told they were supported to access training. Staff were encouraged to keep up-to-date with their continuing professional development.
- All nursing staff within the unit had been trained in paediatric life support and consultants had also been trained in advanced paediatric life support.
- On the neonatal unit 96% of nursing staff had a qualification in the specialty and all nursing staff were trained in neonatal life support
- There was a trust wide electronic staff training record. Managers were informed of training completed and alerted when staff required updates.
- Staff we spoke with were positive about the quality of supervision. Protected time was given for this and staff gave examples of how they benefited from supervision. A member of staff told us how they were provided with strategies to handle verbal complaints from parents.
- Staff on the wards told us they did not receive safeguarding children supervision or group supervision. It is good practice to ensure staff support, supervision is available as part of staff development.
- Staff told us they had received an appraisal during the last year. The figures provided by the trust showed a compliance rate of 88% for the children and young people's services. Staff learning needs were identified through the appraisal process and through supervision meetings. The matron had identified training programmers that the team would benefit from over the coming year.
- Junior doctor skills were monitored and they were compliant with expected competencies. The monitoring was undertaken by the clinical tutor. The junior doctors had access to training sessions.
- Surgeons and anaesthetists had appropriate training and competence to provide routine and emergency surgical care of children.

Multidisciplinary working

- There was a range of multidisciplinary staff providing care and treatment to patients on the paediatric unit and the NNU, including paediatric physiotherapists, pharmacists, dietitian, play specialists and a school teacher.
- Staff worked professionally and cooperatively across different disciplines to ensure care was co-ordinated to meet the needs of children and young people. Staff reported good multidisciplinary team working with meetings to discuss children and young people's care and treatment. During our unannounced inspection, we observed a doctor, nurse and a healthcare assistant discuss a recent admission with a parent. They explained to the parent and the child what care would be provided over their stay in the hospital.
- During the inspection we observed effective multidisciplinary working and handovers on the wards and the NNU.
- There was regular access to paediatric physiotherapy and speech and language therapy (SALT) on wards with occupational therapy provided on request.
- The neonatal unit and the ward had access to specialist pharmacist advice
- Physiotherapy service was provided weekly on the neonatal unit. If a baby required additional service such as swallowing or feeding assessment, this was also available. All babies with low birth weight had access to dietetic service.
- Play specialists helped children to understand their condition and medical treatment. They provided support and helped prepare children for potentially stressful experiences such as medical or surgical procedures. They were available between 9am and 5pm, Monday to Friday.
- Administrative staff covering tasks such as preparing and dispatching letters, preparing discharge reports, answering telephone calls and arranging appointments, assisted the clinical teams on the paediatric ward and the neonatal unit.
- There was a policy for the transition of children to adult services. This addressed the medical, psychological and educational or vocational needs of the young person and the needs of their parents or carers.
- Most young people transferring to adult services were following a 'Ready Steady Go' transition pathway where young people and their family were initially introduced

Services for children and young people

to the concept of transition. They were then helped with the process of preparing, planning and moving from children's to adult services. Staff helped children develop their confidence, this included helping them understand their condition and supporting young people to have a considerable degree of autonomy over their own care. Transition was well established for the sub-specialty of diabetes, asthma and cystic fibrosis. For example, there were transition arrangements in place to transition children to the regional adult cystic fibrosis clinic based at a neighbouring hospital.

- There was a speech and language therapy, physiotherapy and occupational therapy sessions for younger children. They met every week at the children's centre and provided a holistic care to children who needed it. It brought staff from a multidisciplinary group including the nursing, speech and language therapy, physiotherapy and occupational therapy. There was positive feedback from parents for this service.

Seven-day services

- Paediatric consultant job plans covered weekends. This was in line with RCPCH recommendations and current evidence on patient outcomes.
- The unit had access to physiotherapy and dietetic services as and when required.
- There was 24 hour medical cover with medical presence over the weekend seven days a week on the units. There was access to radiology support at weekends and an on-call pharmacy outside normal working hours.
- Play specialists were available between 9am and 5pm, Monday to Friday.

Access to information

- Records were multidisciplinary and standardised. There were assessment and care record documents for specific care pathways, such as head injury, orthopaedic and trauma, children's traction, ear nose and throat (ENT) and surgical emergency.
- The care records for paediatric and for neonatal unit included relevant assessments of care needs and risk assessments. Care plans were patient centred and personalised.
- Staff were focused on ensuring that patients and their parents understood care and treatment and were involved in making decisions.
- The wards used joint multidisciplinary records that supported good communication across the team.

- Staff reported good access to laboratory test results and diagnostics through electronic systems.
- Staff told us they had access to notes when they needed it. Notes were placed with the nurses in clinics.
- GPs were sent timely discharge summaries and letters, to ensure they had sufficient information to support children and young people when at home.

Consent

- The consent process was clearly described within the range of information leaflets available to parents and young people. Staff we spoke with were aware of Gillick competency and Fraser guidelines. These help assess whether a child, 16 years or younger, has the maturity to make their own decisions and to understand the implications of those decisions.
- Staff assessed a young person's ability to give consent depending on their maturity and their ability to understand. If a young person lacked the capacity to consent, consent would be sort from their parent or legal guardian.
- Staff used an assessment checklist to confirm if consent had been obtained using the principles of the Mental Capacity Act 2005 (MCA) for children between 16 and 17. Staff told us they obtained consent from children, young people and their parents or carers before starting care or treatment.
- We reviewed six consent forms for surgical procedures and found they were fully completed and signed, and included information about risks and benefits of the procedure.
- We observed staff discussing the treatment and care options available to children, young people and their parents.

Services for children and young people

Are services for children and young people caring?

Good



By caring, we mean that staff involve and treat patients with compassion, kindness, dignity and respect.

We rated caring as good.

- Feedback from children, young people and parents about the care and kindness received from staff was consistently positive. People reported they were always treated with dignity and respect.
- There were very good relationships between staff and those using services. Staff worked in partnership with parents, children and young people in their care.
- Parents and families were fully informed and involved in their care. Children, young people and their parents were positive about the emotional support provided to them.

Compassionate care

- Children, young people and their parents we met were all positive about the service, spoke highly of the care they received and said the staff were friendly and supportive. One parent commented about staff on the ward, "I can only sing their praises" and another that "the staff are very attentive."
- We observed good interactions between staff, children, young people and their families. We saw these interactions were caring and compassionate. Staff were skilled in talking with and caring for children and young people. One parent commented that one nurse was especially good at engaging with their child.
- Children and young people were treated with dignity and respect at all times and the parents we spoke with confirmed this.
- Care from nursing and medical staff was delivered with kindness and patience. The atmosphere was calm and professional without losing warmth.
- Results of the Friends and Family Tests (FFT) were displayed in the paediatric assessment unit where the public could see them. The response rates were low

(20%), but out of those who responded a high percentage (over 95%) would recommend the service. Kingfisher ward had been using electronic tablets to encourage children and parents to give feedback.

- The trust did not participate in the 'voice of the child' audit.
- There was a nursery nurse who provided play and distraction for children who came for dental procedures. The nursery nurse provided compassionate care by distracting children away from the impending procedure. Parents and carers welcomed their intervention.

Understanding and involvement of patients and those close to them

- We observed staff explaining to parents, children and young people in a way they could understand using age appropriate communication. One parent whose child had used Kingfisher ward over many years told us that nurses kept them well-informed and now mainly spoke directly to their child to explain treatment.
- Parents told us staff kept them well-informed throughout their child's treatment. Both parents and children were involved in care planning and the 10 care plans we inspected, eight had documented evidence confirming this.
- Parents were allowed in the anaesthetic room and in the recovery area once the child had regained consciousness. One parent we spoke with told us how reassuring it was for her daughter to see her present as she opened her eyes.
- Parents were encouraged to be involved in the care of their babies and children as much as they felt able to. Parents were encouraged to visit and spend time with their children by staff. There were open visiting times in place on the children's ward.
- Parents were aware of the named nurse caring for their baby, child or young person.
- Play therapy staff supported children to understand their care and reduce anxiety. A play therapist described how they used age-appropriate techniques for distracting children during medical procedures using finger-puppets with young children and picture books with older children, for example. We observed excellent interactions between patients, consultants, nurses and parents.

Services for children and young people

- In diagnostic imaging, children watched a DVD of their choice, whilst nursing staff inserted a cannula prior to receiving treatment, to provide distraction.
- The National Children's and Young People's Inpatient and Day care Survey (2014) highlighted the trust performed better than other trust in planning of the child's care. Parents and carers said staff agreed a plan for their child's care with them.

Emotional support

- The parents we spoke with told us they had received good emotional support from nursing and medical staff for themselves and their child.
- Staff had actively developed a holistic family centred palliative care and bereavement support service.
- Families were facilitated to spend time with their deceased child as they needed and staff supported them in memory making. Staff provided ongoing support after death, through phone contact and visiting families at home.
- Staff training included aspects of breaking bad news and emotional support. Families were encouraged to attend workshops and teaching sessions and share their stories. There was a parent support group.
- Staff shared an example of a family that had been provided with the support from the chaplaincy department.
- Children, young people and their parents were positive about the emotional support provided by specialist nurses and play therapist staff.
- We observed staff providing emotional support to children, young people and their parents. Staff responded to children's individual concerns in a positive and reassuring way. One parent was very positive about the way a play therapist had distracted and reassured their son as he went into surgery.
- One woman on the neonatal unit was very complimentary about the emotional support she had received from staff especially as her partner had been unable to visit the ward due to sickness.
- Staff on the neonatal unit (NNU) were observed to be compassionate and welcoming to parents, who were made to feel at ease at a very stressful time.

Are services for children and young people responsive?

Good



By responsive, we mean that services are organised so that they meet people's needs

We rated responsive as good.

- Services were tailored to meet the needs of individual children and young people. They were delivered in a flexible way
- A paediatric assessment unit that operated from 8am to 9pm every day improved patient access and flow through the hospital.
- There were good facilities on the wards for babies, children and young people and their families. There was also a purpose-built child health centre that catered the needs of children.
- The provision for palliative care and end of life was very good. The unit was a purpose-built design that provided privacy and dignity for parents and families whose children needed palliative and end-of-life care.
- Parents had access to information leaflets on diabetes, epilepsy and minor ailments. There were also leaflets for parents on what to look out for children suspected for having meningitis.
- There were no barriers for those patients or families to make a complaint. Staff listened to the feedback given to them by parents.

However,

- Outpatient clinics were not always planned to meet the specific needs of children. For example, adults and children were seen and treated in the same area for conditions such as bone fractures.

Service planning and delivery to meet the needs of local people

- The paediatric wards and the neonatal unit were designed to meet the needs of babies, children and young people and their families.
- The general children's ward has 17 cots/beds arranged in a mixture of cubicles and bays.

Services for children and young people

- The paediatric unit provided a 'child-friendly' setting. Parents and children contributed to the design of the unit. For example, there was a playroom and a school room and access to a sensory room. There were a variety of toys and play equipment.
- The neonatal unit had 14 cots with a 'hot room' for intensive care (up to 48 hours) and two isolation cubicles. The service admits single babies from 27 weeks gestation and twins from 28 weeks gestation.
- A community paediatric service provides medical support within the local area and a medical service for pre-school and school children with special needs.
- A four bedded paediatric assessment unit was operational from 8am to 9pm every day. This improved patient flow. It was felt having a facility whereby patients could be observed for longer than four hours allowed the paediatric team to reduce their admission rate to inpatient areas.
- After a review of day surgery facilities and an anaesthetic review it was identified that paediatric day surgery required re-location with a preference from clinical staff for this to be co-located next to Kingfisher ward to ensure paediatric services were cohesive. The preferred area next to Kingfisher was not available due to other clinical use so the move was delayed. There had been no explanation to staff on the reasons for this hold-up. This has generated a level of frustration within the service. At the time of the inspection the paediatric day unit was planned to be accommodated the following month. This will improve the joint working of the two teams and the care of children.
- There was a purpose built child health clinic where most outpatient services were provided. It had 10 consulting rooms and associated facilities. Children were seen in some outpatient clinics in the main hospital for specialities such as fracture clinics and eye clinics. For example, a child coming to the clinic because they needed their plaster removed would likely share the treatment room with an adult. However, play therapist staff told us they were informed of children visits and they were given opportunity to help distract children during the clinical interventions.
- Children and adults attended the same x-ray department. However, arrangements were made to x-ray children and young adults in an appropriate and friendly manner. For example, staff explained the purpose of the x-ray machine and engaged patients on what it did.
- Where possible children were seen for outpatients appointments at the children's centre, which had a more suitable waiting environment for them. All outpatient waiting areas we visited provided toys and activities should children attend, where the layout allowed, this area was away from the main waiting area.
- Some outpatient clinics were not planned to meet the specific needs of children. For example, children attending fracture clinics, attended with other adult patients.
- For neonates, children and young people receiving palliative care, the trust had designed a special unit called the Gully's Place Suite. This was a purpose-designed space located at the far end of children's unit. The aim of this suite was to provide privacy and dignity for children that required palliative and end-of-life care and their families.
- All areas were wheelchair accessible
- The National Children's and Young People's Inpatient and Day care Survey (2014) indicated that the children services at the trust matched those provided at other sites. The trust performed better in certain areas including parents and carers saying the wards had appropriate equipment or adaptations their child needed and there were enough appropriate toys for their child to play with on the ward.
- In the NNU, parents had access to a dedicated parent kitchen and a family room with TV and sofa chairs. Within the children's ward there was a temporary closure of the parent sitting room for planned building work and so parents were found space elsewhere when needed.

Access and flow

- GPs could refer children direct to the assessment unit, and following triage children were then admitted or they could return home. GPs had access to an advice line run by senior registrars Monday to Friday. The service was provided by the paediatric assessment unit. GPs could phone the unit for information or advice about a child. Ambulance staff told us they were always informed when patients needed to be taken to the assessment unit.
- The community nursing service was available Monday to Friday 9am to 5pm. On-call care was provided by the team for children at the end of life.

Services for children and young people

- Staff in the assessment unit told us they prioritised care and treatment for people with the most urgent needs. One parent we spoke with on the assessment unit was relieved they had not been required to go through the emergency department.
- Ambulance staff told us they were always informed when patients needed to be taken to the assessment unit.
- The unit was operational between 8am and 9pm Monday to Friday. Outside these hours paediatric patients were seen in the accident and emergency by a consultant and where appropriate they were transferred to the ward. Once on the ward, there were arrangements in place to ensure the patient accessed appropriate medical care.
- Children with long term conditions who had previously accessed the children's ward via ED or a GP referral had direct access to the children's unit and did not have to go to A&E. Direct access to the ward was available given to children that need it 24/7.
- Parents, children and young people had access to free wi-fi and access to TV/DVD player. There were an appropriate range of selection for children and young people to access.
- For neonates, children and young people receiving palliative care, the trust had designed a special unit called the Gully's Place Suite. The unit was a purpose-built design that provided privacy and dignity for parents and their families who required palliative and end of life care. Gully's Place was used when there had been a sudden death of a child or young person in the community, in the emergency department or on the children's unit. The suite was also used as a transition to home area for children with complex health needs.
- There was a liaison nurse with a child adolescent mental health service (CAMHS) background who provided emotional support for children and families managing long term health conditions. The assessments acute mental health issue was managed through the on-call CAMHS service provided by another trust.
- Play therapist organised daily play services in the playroom and at bedside. They provided play to help children with fear and anxiety by supporting them through frightening and unfamiliar experiences. Play therapists also helped children cope with pain. They were available on the wards and when required in clinic areas.
- There was a special bike group in place for children with learning disability to instill them with greater confidence. There was positive feedback from parents for this service.
- There was a specific health promotion initiative for children with autism and Asperger's syndrome. This brought a community of parents and carers of children with autism and Asperger's syndrome together to share tips, vent frustration and get general support. A parent who attended these events told us that it was a support to meet and share with parents going through similar experiences.
- One of the paediatric community nurses was trained in using Makaton and another worked in a local school for children with special education needs so was well-known to children and families that used both the school and the hospital.
- Parents had access to information leaflets on diabetes, epilepsy and minor ailments. There were also leaflets for parents on what to look out for children suspected for having meningitis.

Meeting people's individual needs

- Young people were given choice of attendance on adult or paediatric wards allowing them a choice of where to receive their care.
- Parents were encouraged to stay with their child on the paediatric wards and there were no restrictions to visiting. One parent for each child was welcome to stay overnight and beds or reclining chairs were provided next to their child. In the neonatal unit there were four parent rooms for parents to stay overnight. Two of those were en-suite.
- There was a school room in operation staffed by a school teacher Monday to Friday from 9am to 12 noon and from 12.30pm to 2.30pm. This enabled children to receive education during their hospital stay. There was also a special play area for children and their younger siblings.
- There was a teenagers room with a TV, video and computer games, books and magazines available for young people.
- Parents gave examples of how food was served in appetising ways. For example, the layout of peas and carrots on a plate was done in the shape of a smiley face.

Services for children and young people

Learning from complaints and concerns

- There was guidance about how to raise concerns or complaints in all the patient and parent information leaflets. Children and young people were also encouraged to share comments and feedback.
- Children were provided with an electronic device to share their concerns. There were also child-friendly information on how to complain and raise concerns.
- Staff were encouraged to respond to and resolve concerns raised by parents at an early stage before the issue raised became a complaint. During our inspection, we observed how staff handled a very challenging situation that could have become a complaint.
- Any learning from complaints was discussed at monthly ward meetings. For example the importance of keeping parents well-informed throughout their child's treatment was discussed after a complaint about poor communication.
- Complaints were monitored monthly. At the time of our inspection there were no current complaints about children services.
- Parents told us they were happy to escalate any concerns and that staff, especially the matron, were very responsive.

Are services for children and young people well-led?

Good



By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

We rated well-led as good because:

- There was a strategic plan for paediatric services 2016/17 and the service was part of the ongoing Dorset wide Clinical Services Review and the acute services vanguard project.
- There was a clear governance structure that included audits, external review, and clear reporting structure to manage quality and risk.
- A strong visible clinical leadership that had brought about positive developments and improvement.

- Staff at all levels were proud to work in the department with a commitment to creating an open culture of learning, reflection and improvement.
- There were positive working relationships between nursing, medical and allied healthcare professionals, built on mutual respect and cohesive team working.
- Children and parents were listened to and engagement had resulted in changes to the service.

However,

- There was no separate quality dashboard for children and young people's services.

Vision and strategy for this service

- There was a strategic plan for paediatric services 2016/17. The trust was part of an ongoing clinical services review led by the Clinical Commissioning Group (CCG) and the Developing One Dorset Vanguard to integrate acute care, which has identified work streams.
- The leadership team had considered various options that would emerge and were confident that whilst there could be a potential threat to their status as a unit, they could still provide a quality service to the people of West Dorset. They would be part of the multi-service joint venture with other two acute hospitals to deliver the vision of high quality care and treatment to children in Dorset.

Governance, risk management and quality measurement

- Child health was part of the children's services directorate part of the family services division. A clinical director was the overall lead of the service. The clinical director was responsible for cascading information upwards to the senior management team and downwards to the clinicians and other staff on the front line. There was a named paediatric surgeon. There was also a non-executive director for children's services on the trust board.
- There was clear governance structure to manage quality and risk. There was a clinical governance committee for both neonatal and for paediatrics that met monthly to discuss clinical governance issues.
- Members of the clinical governance meeting had responsibility for reviewing local guidelines to ensure there were reflective of current national guidance. This was reflected in three sets of minutes reviewed.

Services for children and young people

- The Board received annual reports on safeguarding. The last report was received in February 2016. The Board also commissioned an audit (October 2015) on how the trust performed against the clinical standard for review of patients within 14 hours of admission. The audit highlighted that the compliance in paediatrics to this standard was 92%.
- Reports from the division relating to financial performance, workforce and an overall divisional report were presented to the board and contained information on a rolling monthly basis or a yearly summary. Where overspends were identified, a commentary was added to the report indicating the action taken. Quality and safety were not included in the financial report.
- However, there was no single document, such as a dashboard, which gave an overview of the quality of the service provided by the department. Children's services were included in the family services clinical dashboard along with maternity and gynaecology services.
- The risk register for the department was discussed at the monthly paediatric and neonatal clinical governance meeting which was supported by the four sets of minutes reviewed. Senior staff were aware of the risks identified on the risk register and had plans in place to mitigate these risks. For example, there was an out of date ventilator on the Kingfisher ward. The risk was assessed and a new machine had been purchased. However, certain other risks identified during this inspection such as the lack of Band 6 nurses for certain shifts and shared medical cover between the paediatric ward and the neonatal unit had not been placed on the risk register.
- At service level there were a range of quality initiatives such as audits and parent satisfaction questionnaires. The results of these were shared with nursing staff through their monthly meetings and discussed at the monthly paediatric and neonatal clinical governance meeting.
- An executive director carried out monthly patient safety walkabouts. Actions were identified and progress reported. For example, cleanliness for the unit had been identified and improved as a result of these walkabouts. During the inspection, powdered milk was left in the relatives lounge. This was a risk to babies as the milk could be contaminated. Immediate action was taken to rectify the situation.

Leadership of service

- A clinical director was the overall lead of the service and provided medical leadership to the unit.
- There was nursing leadership across paediatrics with a lead nurse paediatrics (Matron). In April 2015, the paediatric ward appointed a supervisory sister with extensive clinical experience. This post has had a positive impact both in developing and supporting staff. Through joint working, improvements in care and service delivery had been achieved over the last 18 months.
- The matron had plans to ensure all senior nursing staff were part of the ward leadership development programme. This programme had not yet begun.

Culture within the service

- The service had made a commitment to creating an open culture of learning, reflection and improvement. This included listening to and empowering and involving children, young people and their families.
- Staff at all levels felt valued and were proud of the service, the patient outcomes achieved and parent feedback. They were aware of the values of the trust of integrity, respect, teamwork and excellence. They felt supported to provide high-quality care.
- There were very positive working relationships and cohesive team working between nursing and medical and allied healthcare professionals, built on mutual respect. All had clear roles and accountabilities and were focused on working towards high-quality patient care.
- We found a culture of multidisciplinary learning and development and positive team work across the service.

Public engagement

- The trust's results for the 2014 CQC children's survey were about the same as other trusts for all questions except 'did you think there were appropriate things for your child to play with on the ward?' where the trust scored better than other trusts.
- Staff sought patients' views on ideas for improvements through regular surveys of children, young people and parents. For example, parents told us that the timings of the evening meal had been changed as a result of feedback from parents.

Services for children and young people

- There were regular parent meetings and surveys on the NNU and staff made changes to facilities for parents as a result. For example, visits from family members were encouraged.
- The paediatric assessment unit had developed a patient information leaflet about the service it provided. Parents whose children had been treated on the wards had designed the leaflets.
- Families were actively involved in the development of paediatric palliative care and bereavement support services at the hospital, for example through attendance at family workshops and feedback on their experiences.

Staff engagement







- Staff on the children's ward attended monthly ward meetings and minutes were circulated via email.

- Staff were encouraged to look at the intranet to keep up-to-date with hospital policies.

Innovation, improvement and sustainability

- The unit had recently (February 2016) involved the services of young inspectors and young researchers as part of the local council initiative. The aim of the project was to bring together young people with a range of life experiences, skills and abilities to work in small teams. Young people were trained to carry out inspections of a variety of different services they used. They also gave their views on how specific services were working together in the area. This initiative was very much welcomed by staff.

End of life care

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

Information about the service

End of life care at Dorset County Hospital is provided on all general wards supported by a consultant-led palliative care team. The team included specialist palliative care nurses and an end of life care (EOLC) nurse specialist. Between April 2014 and March 2015 there were 761 in-hospital deaths. For all in-hospital deaths October 2014 to March 2015, 52% of patients were on an EOLC pathway. July 2014 – March 2015 there were 341 referrals to the specialist palliative care team, 15% were non-cancer patients and 85% cancer patients. Between April –October 2015 there were 284 referrals, 75% cancer and 25% non-cancer patients. Non-cancer patients had illnesses such as heart failure and other heart conditions, dementia, renal failure and respiratory disease. The team offers short term or long-term support to patients or provides advice and support to ward staff caring for patients at the end of life.

During our inspection we visited seven wards, the emergency department and critical care unit where end of life care was provided, the bereavement centre, the chapel and the mortuary. We spoke with five patients, five relatives and 24 staff, including staff nurses, health care assistants, ward sisters, members of the specialist palliative care team, porters, chaplaincy, mortuary and the bereavement staff.

We observed interactions between staff and patients, and their relatives. We looked at 36 ‘Do Not Attempt Cardio Pulmonary Resuscitation’ (DNACPR) orders and 20 medical and nursing care records. Before our inspection, we reviewed performance information from and about the hospital.

Summary of findings

Overall this core service was rated as ‘requires improvement.’ We rated end of life service as ‘requires improvement’ for safe and effective and ‘inadequate’ for well-led, We rated caring and responsive as good.

Leadership and governance of end of life care services needed to improve to ensure that necessary action plans were implemented, and that quality, performance and risks were effectively monitored and managed. The palliative care consultant clinical lead worked part time therefore had limited time or capacity for strategic planning or leadership of the service, within the restricted hours available to them.

The trust was developing end of life care in line with national guidelines, but progress had been slow. The results of the National Care of the Dying Audit undertaken May 2014 highlighted several areas for improvement. An action plan had been written in November 2014 prior to the receipt of the results of the audit. The results of the National Care of the Dying Audit undertaken in 2015, showed there continued to be areas for improvement. During the inspection we saw that the end of life facilitator, appointed in August 2015, was driving improvements however there had not been audit to demonstrate this.

The trust had introduced an “end of life care for the dying patient individual care plan” to replace the Liverpool Care Pathway after its national withdrawal in July 2014, and to meet the requirement for

End of life care

individualised care plan. In January 2016 the trust commenced a rolling programme to implement a new end of life care plan called Achieving the Five Priorities for Care of the Dying Person. This was not yet embedded in practice across all areas of the hospital.

End of life care training was provided during induction but there was no mandatory ongoing end of life care training.

There was investigation of incidents but there was a lack of detail and recording to demonstrate how end of life issues had been comprehensively investigated or how action plans would be used to drive improvements. It was not possible to extract end of life themes or issues that had arisen through the incident reporting process and there had been limited learning from incidents that related to end of life care.

Most but not all DNACPR forms we inspected were completed according to national guidelines. The trust audits had also identified areas for further improvement, to ensure that forms showed discussions with patients and families and mental capacity decisions were documented.

Patients' needs were mostly met through the way end of life care was organised and delivered. There was rapid discharge of those patients expressing a wish to die at home most of the time, there were sometimes delays, due to difficulties in accessing community care services

Patients had appropriate access to pain relief. Anticipatory end of life care medicines were correctly prescribed and patients were provided with pain management support.

Staff treated people with compassion, kindness, dignity and respect. Feedback from patients and their families was consistently positive. We saw good examples of staff providing care that maintained respect and dignity for the individual. There was good care for the relatives of dying patients, and sensitivity to their needs.

Are end of life care services safe?

Requires improvement



By safe, we mean people are protected from abuse* and avoidable harm

We rated safe as 'requires improvement' because:

- Palliative care consultant staffing was not in line with national guidelines.
- Some specialist palliative care team staff were not up to date with all aspects of trust wide mandatory training.
- The specialist palliative care team understood their responsibilities to raise concerns and report incidents. However, details of end of life care incidents, across the trust were not available and therefore risks and learning outcomes were not identified.
- There were systems in place to prevent and protect people from infection. However, there were no clear understanding of infection control procedures for cleaning the mortuary trolley, and these were not fully implemented.
- The trust monitored duty of candour through their online incident reporting system. We were given examples of these from the clinical leads. However, not all the specialist palliative care team had a clear understanding of duty of candour.

However,

- Medicines were stored and managed safely for end of life patients. Records were complete and accessible and enabled information to be accessed to support patients' welfare.
- There was access to syringe driver equipment and they were in line with national standards.
- Safeguarding vulnerable adults was given sufficient priority and staff were able to identify safeguarding concerns as they arose.

Incidents

- Incidents were reported through the trust's electronic reporting system. All of the specialist palliative care team we spoke with were familiar with the process for

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reporting incidents, near misses and accidents using the trust's electronic reporting system. Mortuary staff and porters stated they were encouraged to report incidents particularly for end of life care patients.

- The clinical leads for palliative care, we spoke with told us that the electronic reporting system did not allow specific incidents relating to end of life care to be identified. However, the trust wide risk team had acknowledged this and were in the process of amending it.
- We reviewed incidents that had occurred in the mortuary; these demonstrated that investigations and root cause analysis took place and that action plans were developed to reduce the risk of a similar incident reoccurring. We were given an example of an incident that related to a deceased bariatric patient and the size of the fridge in the mortuary. This incident resulted in face to face training and written instructions for ward staff, porters and mortician staff to ensure patients were placed in the correct fridges for their size.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person. The trust monitored duty of candour through their online incident reporting system. The specialist palliative care team had a variable understanding of the duty of candour and it was not known to all staff; some staff could describe the principles of the regulation and knew of the policy.

Cleanliness, infection control and hygiene

- The trolley for transferring deceased patients to the mortuary was stored outside the mortuary. It was visibly dirty, and it was unclear among staff whose responsibility it was to maintain it. When this was highlighted the trust reacted proactively by creating a cleaning schedule.
- On the unannounced inspection the mortuary trolley appeared visibly clean and a cleaning schedule was in place. However, the cleaning schedule showed the mortuary trolley had only been cleaned fifty percent of the times after it had been used.
- We observed staff adhered to the 'bare below the elbow' policy, bare below the elbow means clinical staff were

not wearing long sleeves, jewellery on wrists or fingers and no false nails. Staff, washed their hands between patients and used personal protective equipment, such as disposable aprons and gloves as appropriate.

Environment and Equipment

- There was enough space in the mortuary, the facilities were clean and were well maintained. However, the bariatric fridges had been highlighted as not always fit for purpose; contingency plans had been put in place.
- Syringe driver equipment met the requirements of the Medicines and Healthcare Regulatory Agency (MHRA). Patients were protected from harm when a syringe driver was used to administer a continuous infusion of medicine, because the syringe drivers used were tamperproof and had the recommended alarm features.

Medicines

- We observed medicine rounds on Fortuneswell and Moreton ward. Staff carried out appropriate checks to ensure medicines were given to the correct patients. Staff wore tabards to indicate they should not be disturbed and followed the trust's Medicines Management Policy November 2015.
- We reviewed the storage and administration of controlled drugs in the hospital. They were stored appropriately and medicine records were accurately completed. Emergency medicines were available for use and were checked regularly. The trust guidance on the administration and the destruction of unused controlled drugs was followed.
- There was appropriate access to syringe drivers, used to administer regular continuous analgesia (pain relief). These were available through the medical equipment library. An electronic prescribing process was used for medicines given by syringe driver. Data showed that 145 staff across the trust had attended training to ensure that they were competent to use this device.

Records

- The specialist palliative care team wrote in the patient records. Decision process and discussions with relatives were clearly documented. Staff also wrote details of fast track progress and continuing care referrals.
- There was a managed phased implementation of Achieving the Five Priorities for Care of the Dying Person, care plan across the trust.

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- We reviewed the medical and nursing notes for six patients who were receiving end of life care. Notes were accurate, complete, legible and up to date.
- There was a clear recording process in place for the movement of the deceased through the mortuary from point of arrival until the funeral directors collected the deceased.
- We reviewed 36 “Do Not Attempt Cardio Pulmonary Resuscitation” (DNACPR) forms throughout the ward areas. All were reviewed and signed by a consultant within 72 hours. These were kept at the front of a patient’s notes, allowing easy access in an emergency.

Safeguarding

- There was a trust policy which described the processes to safeguard vulnerable adults, children and young people.
- Safeguarding training was mandatory, all staff from the specialist palliative care and end of life care team had undertaken safeguarding adults level 2 and safeguarding children level 2 training. Staff were knowledgeable about their roles and responsibilities regarding the safeguarding of vulnerable adults and children.

Mandatory training

- The specialist palliative care team and the end of life care facilitator said they had completed their mandatory training. However, data provided by the trust showed that two out of the team of six staff had not completed fire safety, basic life support, and infection control training.
- The hospital did not classify end of life care training as a mandatory subject as recommended by the National Care of the Dying Audit 2013/14. End of life care training was provided for trained nurses during preceptorship, as part of the care certificate for healthcare assistants and in the education programme for doctors. However there was no mandatory ongoing end of life care training for staff.

Assessing and responding to patient risk

- The National Early Warning system (NEWS) had been established for use with all patients to identify those who are clinically deteriorating and require urgent intervention, which may prevent cardiopulmonary arrest. Nursing staff used an early warning system, based on the National Early Warning Score, to record

routine observations. Where patient’s physiological observations were deteriorating but full escalation of treatment was not in the patient’s best interest treatment options were discussed and a treatment escalation plan completed for the patient. The treatment escalation plan outlined the level of intervention required should the patient’s condition worsen.

- Physiological observations were not routinely undertaken for patients who were at the end of life, so as to keep them comfortable and undisturbed
- The results from the National Care of the Dying Audit 2013/14 showed 33% of patients were recognised by the multi-disciplinary team as dying; the England average was 61%. Results of National Care of the Dying Audit undertaken 2015 showed 82% of patients were recognised as at end of life, just below the national average 83%.
- The end of life care facilitator (in post since August 2015) was improving identification and recognition of the patient who was dying, through daily visits to wards to review patients, informal face to face training, and attendance at multidisciplinary team meetings. All staff we spoke with knew how to refer patients to the SPCT. However, there was limited audit data to support this as the end of life database had been commenced in January 2016.
- There were daily morning handover meetings within the specialist palliative care team where they discussed all new patients. Work was prioritised and patient visits were planned at these morning meetings.
- Advice and support from the specialist palliative care team concerning deteriorating patients was available on all wards by telephone or by visit request. Staff on the wards were clear that the specialist palliative care team responded quickly to requests for advice and support.

Nursing staffing

- The specialist palliative care team included three part time palliative care clinical nurse specialists which were two whole time equivalent (WTE) posts, they reported to the lead nurse for cancer services. They provided cover five days a week.
- The team had appointed an end of life care facilitator. Staff told us they had already made a substantial impact on the ward in terms of advice on identifying and caring

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for end of life patients and helping with discharging patients for those who wished to die at home. However at the time of our visit there was limited audit data to support this improvement.

- There were no dedicated 'end of life' beds at the hospital. Patients who required end of life care were nursed on general medical and surgical wards. Nursing staff we spoke with told us they would give priority to the care of those patients in the last hours or days of life.
- The clinical leads informed us that there had been ward champions for end of life care but their numbers had decreased and the champion role was under review. The champions continued to have meetings every two months. We spoke with the end of life champions on the intensive care unit and they were extremely passionate about end of life provision and had developed their own local initiatives.

Medical staffing

- The medical team comprised one part time palliative care consultant delivering four sessions a week with each session lasting four hours. A part time associate specialist consultant delivered two sessions a week. Two further consultants from the local hospice provided cover for holidays and sickness. As the trust had 356 beds medical staffing was not in line with the Association for Palliative Medicine of Great Britain and Ireland recommendations or the National Council for Palliative Care guidelines, which states that there should be a minimum of one consultant per 250 beds.
- The consultants for specialist palliative care divided their working week between the hospital and the local hospice. This enabled a link between the two services and provided "joined up care" between the hospital and the community.

Major incident awareness and training

- Mortuary staff and the specialist palliative care team were aware of the major incident plan and actions to take in event of a major incident.
- There were 33 spaces in the mortuary; a contingency plan was in place with the local undertakers in the event that the mortuary became full.
- The chaplaincy services were on call for any major incidents.

Are end of life care services effective?

Requires improvement



By effective, we mean that people's care, treatment, and support achieved good outcomes, promoted a good quality of life, and was based on the best available evidence.

We rated effective as "requires improvement" because:

- The trust participated in the National Care of the Dying Audit in May 2014 and in 2015. The trust performed worse than the England average in most areas for both audits. The service had been slow to start actions and make changes to improve end of life care for patients.
- The proportion of patients dying in the trust who were referred to the palliative care team was lower than the national average (especially those with non-cancer diagnoses). These patients may therefore have been denied the benefits of such care.
- There was very limited monitoring of people's outcomes of care and treatment. We found evidence that the service had recently commenced auditing outcomes of people's care and treatment. However, no results were available at the time of our visit.
- The trust had responded to best practice guidance and the withdrawal of the Liverpool Care Pathway. The service had implemented an "end of life care for the dying patient individual care plan" and was in the process of replacing this with the Achieving the Five Priorities for Care of the Dying Person, care plan. However, this had not yet been rolled out across all wards and had not been audited
- The trust did not provide face to face specialist palliative care services, seven days per week, to support the care of dying patients and their families or carers.
- Staff had an awareness of the Mental Capacity Act 2005 but not all 'Do not attempt cardiopulmonary resuscitation' forms were supported by mental capacity assessments when stated that patients lacked capacity.

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However,

- At inspection, review of records showed that patients identified as having end of life care needs were assessed, reviewed and their symptoms managed effectively.
- There was positive multidisciplinary working between specialist palliative team members, ward teams and the local hospice.
- Medicines were prescribed for end of life patients in anticipation of symptoms to ensure patient comfort. Patient's nutrition and hydration needs were effectively managed.
- Ward staff reported good access to the specialist palliative care team and found they were helpful, and supportive.

Evidence-based care and treatment

- July 2014 – March 2015 there were 341 referrals to the specialist palliative care team, 15% were non-cancer patients and 85% cancer patients. Between April –October 2015 there were 284 referrals, 75% cancer patients and 25% non-cancer patients.
- The specialist palliative care team told us that following the national withdrawal of the Liverpool Care Pathway in July 2014, the trust had produced “end of life care for the dying patient individual care plan”. This met the requirements for individualised care planning.
- The service developed an end of life care strategy November 2014. This was based on national guidance such as the with National Institute for Health and Care Excellence (NICE) qualities standard 13, which defines clinical best practice in end of life care for adults, and the Department Health National End of life care strategy.
- A new end of life care plan was introduced in January 2016, ‘achieving the five priorities for care of the dying person,’ This document guides delivery of the priorities of care for patients recognised to be in their last few days or hours of life, for whom no potential reversibility was possible or appropriate, and followed best practice. At the time of inspection, the document had been rolled out to eight out of the 14 wards at the hospital and there was a programme to incorporate it across the remaining wards within the next few months. Following full implementation an audit was scheduled to take place in June 2016.

- Patient needs were assessed and care and treatment delivered in line with National Institute for Health and Care Excellence (NICE) quality standards. For example, clinical staff followed guidance relating to falls assessment and prevention, pressure ulcers, nutrition support and recognising and responding to acute illness. Staff discussed patient care of dying adults in the last days of life as per NICE guidelines 31 December 2015.
- The specialist palliative care team told us the Wessex Palliative Care Handbook of clinical guidelines (2014) was a good reference for guidance in end of life and palliative care delivery. All staff had access to this handbook along with trust end of life care policies these included, for example anticipatory medications, DNACPR, how to look after patients and relatives when once they had died.

Pain relief

- Pain was monitored using an assessment tool. Pain scoring was completed for patients every time their observations were recorded. For patients on the end of life care framework this was assessed every two hours.
- Patients we spoke with on Fortuneswell ward told us that there was “no problem at all” in getting pain relief night or day. Another patient on Hinton ward said “nothing is too much trouble and pain relief comes quickly”.
- The hospital used syringe drivers for end of life patients who required a continuous infusion to control their pain.
- Results from the National Care of the Dying Audit 2014 demonstrated the trust was in line with the England average for achieving the organisational key performance indicator 5: Clinical protocols for the prescription of medications for the five key symptoms at the end of life.
- The trust had procedures in place for prescribing anticipatory medicines, medicines prescribed for the key symptoms in the dying phase (i.e. pain, agitation, excessive respiratory secretions, nausea, vomiting and breathlessness). We reviewed six medical and nursing case notes of those patients identified as being in the last hours or days of life and anticipatory medicines were prescribed appropriately.
- Patients were prescribed appropriate medicines for symptom and pain management.

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Nutrition and hydration

- Patients were assessed using the Malnutrition Universal Screening Tool (MUST) which identified nutritional risks.
- Nutrition and hydration was included in the achieving the five priorities for care of the dying person the care plan and in all end of life care provided. Symptoms such as nausea were managed and this was documented in the patient records we reviewed.
- There was access to a specialist assessment from a speech and language therapist (for swallowing difficulties) and a dietician.

Patient outcomes

- Patients had timely access to the specialist palliative care team (SPCT). Data provided by the trust for November 2015, showed that 84% of patients had been seen within 24 hours of a referral being made to the SPCT. We reviewed six medical and nursing records of patients in the last days of life and saw where the patient had been seen within 24 hours of a referral to the SPCT.
- The National Gold Standards Framework 2012 is a systematic, evidence based approach to optimising care for all patients approaching the end of life. Three wards were preparing for accreditation against the Gold Standards Framework; however, we found little progress had been made within the last year. The trust acknowledged further work was required and funding had been provided by the local clinical commissioning group to assist with this.
- The trust had taken part in the National Care of the Dying Audit May 2014 and only achieved four out of the seven organisational key performance indicators (KPI). The trust was worse than the England average on all but one of the clinical indicators in the same audit. The trust scored significantly lower than the England average for; KPI 1: Multi-disciplinary recognition that the patient is dying, KPI 4: Assessment of the spiritual needs of the patient and their nominated relatives or friends; KPI 5: Medication prescribed for the 5 key symptoms that may develop during the dying phase and KPI 7: A review of the patient's nutritional requirements.
- In February 2015 the end of life care team developed an action plan to address all the issues highlighted in the

National Care of the Dying Audit in May 2014. It included 15 key actions and targets: The data provided to us showed slow progress had been made in achieving these targets.

- The trust participated a further National Care of the Dying Audit conducted in 2015 and achieved just one out of the eight organisational key performance indicators (KPI). This was a lay member on the trust board in place with a responsibility for end of life care. The trust had not sought views of bereaved relatives or friends, did not have seven day face to face access to specialist palliative care seven days a week, did not have an end of life care facilitator, and did not provide communication skills training for the last hours or days of life.
- A part of the audit 49 cases were reviewed and the service was below the national average against the five clinical indicators:

- 82% were recognised as at end of life, just below the national average 83%.

- 65% against a national average of 75%, had documented evidence within the last episode of care that health professional recognition that imminent death had been discussed with a nominated person(s) important to the patient.

- 54% against a national average of 66%, had documented evidence that the patient was given an opportunity to have concerns listened to.

- 20% against a national average of 84% had documented evidence that the needs of the person(s) important to the patient were asked about.

- 27% against a national average of 84% documented evidence in the last 24 hours of life of a holistic assessment of the patient's needs regarding an individual plan of care.

- At the time of the inspection these results had not been published and therefore the trust would not have an action plan, however, the audit was undertaken in July to August 2015 and it also reviewed deaths that had occurred in May 2015.
- Some actions, taken since August 2015, had started to address shortcomings. The trust had appointed an end of life care facilitator to meet one of the audit organisational KPIs.
- The recent introduction and use of the 'achieving the five priorities for care of the dying person' care plan had

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started to address the clinical issues identified. During our inspection, March 2016, we noted that all the records reviewed had written clear evidence that patient concerns were listened to, there was holistic care planning against patient needs. We saw evidence of family involvement in care planning and their needs listened to.

- However, the impact of end of life care facilitator and the implementation of the care plan across the hospital had not yet been audited; this was planned for 2016.
- A clinical audit programme for 2016 was in progress, this programme included an end of life care outcome measurement tool, opioid prescribing, and preferred place of death. An opioid prescribing audit had been completed in 2015 and an action plan had been put in place. The outcome measurement tool and preferred place of death had commenced in January 2016.

Competent staff

- End of life and palliative care training was delivered at both medical and nursing induction days, including input from the chaplaincy services.
- Porters received training around palliative and end of life care via the mortuary staff and end of life facilitator. Training included an orientation to the mortuary, health and safety training, manual handling and training on the administration duties required when registering a body in the mortuary. Porters we spoke with during our inspection confirmed they had received this training.
- The trust participated in the National Care of the Dying Audit in May 2014. The results showed the trust was identified as better than the national average in relation to continuing education and training in palliative and end of life care.
- The SPCT took part in study days organised by other teams, for example a half day for renal nurses working in dialysis and plans for an end of life care session within the dementia champions training day.
- However, the trust recognised training in end of life required further support and the newly appointed end of life care facilitator was leading on training and education. A recent training needs assessment identified training in communication skills in end of life care was a priority.
- The chaplain held listening skills training once a month attended by trust staff.

- 100% mortuary and bereavement staff and 75% of palliative care nurses had an appraisal; the remaining nurse had a date booked. The trusts performance target was 90%.
- The specialist palliative team all received one to one supervision once a month and found these supervision sessions beneficial.

Multidisciplinary working

- We attended the weekly hospital palliative care multidisciplinary meeting. Medical staff, nurses and social services attended this meeting. All palliative and end of life, cancer and non cancer, patients were reviewed in relation to their care, the appropriateness of medicines and achievement of preferred place of care. Patients who were discharged or had died were also discussed, including ongoing support to their families.
- The end of life care facilitator attended multidisciplinary ward meetings to ensure end of life treatment and care was considered if a patient was entering their last year of life.
- All staff we spoke with were positive about multidisciplinary working. We observed ward meetings between specialist palliative care staff, ward based nurses and medical staff, which were professional, effective and ensured high quality care.
- Medical consultants we spoke with said the palliative care team were good at networking throughout the hospital and always responded quickly to requests for advice on patient care and treatment.
- The end of life care facilitator told us there was good engagement from the medical staff over the new documentation.
- The chaplaincy services were represented on the trust end of life care committee and were a core member of the palliative care multi-disciplinary team.

Seven-day services

- The National Care of the Dying Audit for Hospitals (NCDAH) 2013/14 recommends hospitals should provide face-to-face specialist palliative care service from at least 9am to 5pm, seven days per week, to support the care of dying patients and their families, carers or advocates.

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- Specialist palliative care services, doctors and nurses, were available five days a week from 9am to 5pm. One of the specialist palliative care nurses told us they attended the hospital on a Saturday, but this was not a formal arrangement.
- The consultants and specialist palliative care nurses provided out of hours telephone advice through an on-call rota. The specialist palliative care nurses told us they would contact the hospice if they needed further advice or support.
- Mortuary services were available 8.30am to 4.30pm seven days a week with on-call cover out of hours.
- Chaplaincy services were available within normal working hours and on Sunday mornings. These hours were divided between two chaplains who also provided an on-call chaplaincy service.

Access to information

- Staff had access to hospital policies and guidance specific to palliative and end of life care via the trust intranet. Staff found this resource valuable and easy to access.
- The specialist palliative care team had access to the electronic record system which the local hospice used. This meant if a patient within the hospital required inpatient care at the hospice a referral could be made quickly and simply.
- When a palliative care patient was discharged home the GP, district nurse and care agency were informed. On Fortuneswell and Hinton ward we were told that if a palliative care patient died staff would telephone the GP practice.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We observed staff explaining procedures, giving patients opportunities to ask questions, and seeking consent from patients before providing care or treatment. Verbal consent to treatment was recorded in all the patient records we reviewed.
- Staff were clear about their roles and responsibilities regarding the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (DoLS). Staff had received Mental Capacity Act training and various resources were available on the trust intranet, if staff needed more support.
- We reviewed 36 'Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR) or 'allow a natural death'

forms. Twenty nine of the DNACPR forms had been fully completed to a good standard and discussions held were recorded in the nursing and medical notes. For the other seven forms, the medical notes did not show, if a discussion had taken place with the patient or relatives or the patient's mental capacity assessed.

- The trust carried out regular audits of DNACPR forms and the audit in February 2016 looked at 61 forms. The results of the audit reflected what we found on inspection, 24% of discussions with patients were not documented; however 88% of decisions had been signed by a consultant within 48hrs.

Are end of life care services caring?

Good



By caring, we mean that staff involved and treated people with compassion, kindness, dignity and respect.

We rated caring as 'good' because:

- Compassionate and person centred end of life care was provided to patients on wards by medical and nursing staff and by the specialist palliative care team. Medical and nursing staff showed sensitivity when communicating with patients and relatives.
- The specialist palliative care team spoke with care and compassion at their handover meetings and considered the dignity of end of life patients. They were sensitive to people's needs in a holistic way.
- Feedback from patients and their relatives was consistently positive about the care they had received. All family members, including pets, were supported to visit or stay at the hospital.
- All staff we spoke with valued and respected the needs of both, the patients and their families. There was good access to the multi-faith chaplaincy service for patients and their families. Patients' emotional, social and religious needs were considered and were reflected in how their care was delivered.

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- The bereavement and mortuary staff were caring, understanding and responded sympathetically to patients and relative's needs. There was a special viewing room where relatives could spend time with their loved ones.

Compassionate care

- The trust participated in the National Care of the Dying Audit in May 2014. The results identified the trust was worse than the national average in relation to the provision of care that promoted patient privacy, dignity and respect, up to and including after the death of the patient. On the inspection, we observed that care was provided that promoted patient privacy, dignity and respect; ward staff always accompanied the deceased with the porters to the mortuary to maintain the patient's dignity and respect
- Feedback from patients and their relatives was consistently positive about the way staff treated them. End of life patients on Hinton ward stated "consideration is the word I would use about care patients receive from staff here at the hospital, they make you feel you matter" another patient stated "the care here cannot be faulted, from the cleaner upwards they are just fantastic 'they can't do enough for you'".
- We found the care and treatment of EOLC patients within all departments was flexible, empathetic and compassionate. Staff developed trusting relationships with patients and their relatives. Family members were encouraged to visit, this included children and family pets.
- Throughout our inspection we witnessed patients being treated with compassion, dignity and respect. We observed staff communicating with patients in a respectful way in all situations. Staff ensured confidentiality was maintained when attending to care needs.
- Patients and relatives we spoke with reported that the care, they and their relatives received was excellent and stated that staff were very sensitive and attentive to their needs.
- One patient told us "the staff were always smiling and are very caring and excellent" and staff responded quickly to their needs. We saw evidence of good relationships with specialist palliative care nurses, a high level of trust and appreciation of support provided.
- The bereavement officer and mortuary staff demonstrated sensitivity and caring behaviour. For

example, if relatives were unable to attend the registrars the bereavement staff would personally take the death certificate to the registrars. The bereavement officer would attend the funerals for those patients who do not have any next of kin.

- Chaplaincy services told us they had arranged weddings for patients who were receiving end of life care.
- Staff recognised and respected the emotional needs of relatives. We saw in the emergency department staff would be alerted to an end of life or deceased patient through the use of a poster of a butterfly.

Understanding and involvement of patients and those close to them

- There was evidence of health professional's discussions with both the patient and their relatives/friends regarding their recognition that the patient was dying and communication about the plan of care documented in patients' notes.
- Families felt they were well informed about the condition of their relatives. They found the information helpful and reassured them that their loved ones would be supported throughout their dying days. One relative told us that staff communicated to them in a sensitive and unhurried way.
- One relative confirmed they had open access visiting and a camp bed was available for them to use to stay overnight.
- Specialist palliative care nurses and the end of life care nurse specialist, involved relatives and, where possible, patients in the planning and delivery of care. Conversations involving families and friends, updating them with patient progress and decisions such as preferred place of care, were routinely taking place and recorded in patients' notes.
- The bereavement officer met with relatives after a death and talked through aspects of next steps and provided information to relatives.
- We found that patients at end of life were identified effectively and there were early discussions about their preferences for care. We observed initial discussions regarding advance care planning decisions in the clinical documentation.

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Emotional support

- The bereavement office staff saw offering emotional support to relatives as part of their role. We were given examples where staff had met with bereaved relatives and assisted with the funeral arrangements.
- Nursing staff reported good access to the chaplaincy department. They knew the members of the chaplaincy team by name and said that the chaplains would frequently visit. During our inspection we observed the chaplain offering emotional and comfort support to a patient's relatives.
- Chaplains told us they visited the wards to support patients and relatives. They also had a list of people and volunteers from different faiths whom they could call on to ensure that a patient's religious wishes were met.
- We attended a weekly hospital palliative care multidisciplinary meeting. The emotional impact on family and staff caring for a dying patient was considered for all patients.
- All the specialist palliative care nurses were trained to Level 2 in psychological support for patients and carers.

Are end of life care services responsive?

Good



By responsive, we mean that services were organised so that they met people's needs.

We rated responsive as "good" because:

- People's individual needs were met through the way end of life care was organised and delivered.
- The hospital delivered patient centred care in a timely way. Most patients were reviewed by the specialist palliative care team within 24 hours of a consultant referral. Ward staff found the specialist palliative team to be helpful, supportive and responsive to the needs of patients.
- There was open access for relatives visiting patients who were dying.
- Peoples cultural and spiritual needs were met and there were facilities to meet multi faith needs of people. The bereavement services were well organised and responsive to people's needs.

- The trust operated a rapid discharge home to die pathway which served to discharge a dying patient who expressed wanting to die at home within 24 hours. . Although we did not see any audits to evidence this.

However,

- There was limited data to suggest those patients in the last days or hours of life were in their preferred place of care.
- Learning from complaints was not shared at team meetings.

Service planning and delivery to meet the needs of local people

- The hospital did not have dedicated end of life beds. Patients identified as being in the last days or hours of life were mainly nursed on general medical and surgical wards. Nursing staff, we spoke with told us those patients recognised as being in the last hours or days of life were, where possible, nursed in a side room to protect their privacy and dignity.
- There were no palliative care beds within the trust, but the team had established links with the local hospice and community palliative care services. This was to ensure smooth access to both inpatient hospice beds and community services and further specialist support services.
- The 'achieving the five priorities for care of the dying person' care plan began when the patient was recognised to be likely in their last days or hours of life. Advanced care planning was included in this document. We reviewed six documents and saw the patients preferred place of care/death had been written.
- Information about the numbers of referral and re referrals of all patients and those with non-malignant disease were collected monthly, this showed an increasing number of non cancer patients referred to the service.
- The service was working with the CCG to secure funds to support the planned implementation of the Gold Standard Framework on three wards, as this had not yet been achieved.

Meeting people's individual needs

- The needs and preferences of patients and their relatives were central to the planning and delivery of care at this hospital. The hospital was flexible, provided

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choice and ensured continuity of care. Staff gave us an example of a patient being cared for at the end of their life, on the coronary care unit, who expressed a wish to remain on that ward.

- In January 2016 the trust started auditing the number of patients who had identified a preferred place of care, this was 80% in January 2016 and 78% in February 2016. The percentage who had identified a preferred place of care and achieved it was 100% in January and 76% February, 2016.
- Translation and interpreter services were available and staff knew how to access this when needed. These services included telephone, face to face, sign language interpretation, written large print, Braille and audio translations.
- The trust had electronic flagging on the patient administration system so that patients with a learning disability could be identified. Whenever a patient with a learning disability was admitted an automatic alert was emailed to the matrons so that they could ensure reasonable adjustments were made.
- Relatives told us they could visit the ward at any time when their loved ones were approaching the end of life. Relatives were supported with refreshments and free car parking permits.
- Staff we spoke with told us that when a patient was at the end of their life they tried to allocate a nurse to sit with the patient to read or play music.
- The chaplaincy offered a responsive service and was part of the specialist palliative team. Out-of-hours services were also available through an on-call system and chaplains visited wards across the hospital to link up with people
- The spiritual needs of patients were identified in the achieving the five priorities for care of the dying person and the advance care planning documentation. This meant patients and their relatives could access chaplaincy services in a timely manner. The chaplain told us that when patients or relatives had requested faith leaders from other religious denominations, this would be arranged by the chaplaincy service.
- The multi-faith chapel, for patients, relatives and staff was clean. There was a Muslim prayer room with adequate washing facilities available.
- There was a mortuary viewing area, which was well maintained and dignified. The public entrance to the mortuary viewing area was through the bereavement

room. A Monday to Friday and out of hour's service were provided. Out of hours involved the mortuary staff or the bereavement officer assisting the families with the viewing process.

- The bereavement services, worked alongside mortuary services, chaplaincy, the coroner's office and the registrars to ensure arrangements were in place after death. They provided information to relatives and booklets around services available at the hospital, and for coordinating arrangements to view the deceased's body.
- The bereavement officer would meet with bereaved families to arrange collection of the patient's death certificate in addition to arranging a viewing at the mortuary if required. Where post mortem arrangements were in place this would be explained to the family.
- Advance care planning is a process of discussing and/or formally documenting wishes for future care. It enables health and care professionals to understand how patients want to be cared for if they become too ill to make decisions or speak for them. We found the advance care plan; 'Planning for my Future Care', designed by Dorset clinical commissioning group for use, in the community and in hospital, was not implemented across all services with patients in the last year of life. Although there was good quality information and guidance available for staff, it was not used. We were informed that patients were given the advance care plan but during the inspection none of these were seen.
- When patients were admitted and considered to be in the last year of life, they were asked by staff if they wanted to have an advance care plan; if they opted for this a note was placed on the patient administration system. This enabled staff to recognise patient's wishes throughout their care whilst they were in hospital and if they returned to hospital. Staff we spoke with were unaware of this practice.

Access and flow

- The National Framework for NHS Continuing Healthcare and NHS Funded Nursing Care was published in 2007, and revised in 2012. This framework sets out that patients with a rapidly deteriorating condition should be 'fast tracked' to receive NHS funded care in a place of their choice at the end of their life. From January 2016, the trust began collecting data on the number of end of life patients who were discharged with fast track in

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place, as well as the numbers of patients who expressed a wish to die out of hospital for whom this was not achieved. 14% who expressed a wish to die elsewhere died in hospital in February 2016.

- The trust operated a rapid discharge home to die (RDHD) pathway for patients who were thought to be in their last days of life and had requested to die at home. The pathway included a comprehensive list of actions, which ensured that a patient could be discharged home in a safe and timely manner, and included liaison with primary care, voluntary sector services and relatives. The pathway aimed to discharge patients' home within 24 hours. We encountered two patients that were unable to be discharged to die at home due to delays in arranging care packages. Despite these limitations the staff worked hard to respond positively to meet the needs of patients at end of life.
- We did not see any audits to monitor if patients were discharged within 24 hours when requested.

Learning from complaints and concerns

- Data provided by the trust showed that there had been two written complaints and seven verbal complaints related to end of life care services within the last year. We were given information about the complaints, which the trust dealt with promptly and resolved satisfactorily with the family members concerned. There were no themes, and we did not see any learning or changes as a result of complaints.
- We saw Patient Advice and Liaison Service (PALS) leaflets available around the hospital.
- Staff in the bereavement office told us that they try to resolve any concerns from relatives in a timely way to avoid escalation to a formal complaint.
- Learning from complaints was not however, shared at team meetings. The trust CEO recently introduced a bulletin to share learning from incidents and complaints across the trust.

Are end of life care services well-led?

Inadequate



By well-led, we mean that the leadership, management and governance of the organisation assured the delivery of high-quality person-centred care, supported learning and innovation, and promoted an open and fair culture.

We rated well led as “inadequate ” because:

- The leadership and governance processes for end of life care services had not been sufficient to ensure that necessary action plans were implemented, and that quality, performance and risks were effectively monitored and managed.
- Service leads articulated a vision and the priorities for end of life care services across the trust, but there had been slow progress in delivering these. An end of life strategy was drafted in November 2014. There had been limited progress against the work streams to implement the strategy
- There were insufficient evidence of audits of quality and performance of end of life care services.
- Risks, and issues were not always identified and managed appropriately or in a timely way and were not monitored via risk registers.
- There was a limited approach to obtaining the views of people who use services and other stakeholders. There was no mechanism to ensure feedback was captured and actioned in a timely way.
- The clinical lead worked part time therefore had limited time or capacity for strategic planning or leadership of the service. There was intermittent board level leadership for end of life care, and the board were not sighted on issues relating to the service or implementation of improvements.
- Priorities for improvement focused on achieving the Gold Standard Framework standards, but progress had been slow.

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However,

- Staff were motivated to provide good end of life care and the service was effective and supportive to staff, patients and relatives.
- The development and improvements in end of life services across the trust had been strengthened with the appointment of an end of life care facilitator.

Vision and strategy for this service

- The clinical service lead, the part time consultant had produced an end of life care strategy in November 2014 which outlined its vision and aims for 2014 to 2016.
- The trust end of life strategy document did not contain detail of how the recommendations would be met through specific initiatives and service developments. The service had identified four task and finish groups to ensure end of life care was delivered in accordance with this strategy. These included education / communication skills training; implementing priorities for care of the dying patient; a patient and carer feedback group and a Gold Standards Framework group.
- The four task and finish groups were chaired by two of the specialist palliative care team, one by the deputy director of nursing and one by the patient & public experience lead. The purpose of these groups was to promote and drive the end of life care agenda, as well as provide a clear link to the board. We were informed that meetings were held and we asked for minutes but were told no minutes or action plans were recorded.
- The operational policy for the hospital based specialist palliative care team, produced in May 2014 outlined its main aim was to work alongside the team caring for patients in hospital and to improve the quality of patients last year of life.
- The trust's strategic plan for 2014 to 2019 did not include end of life care. However the operational plan and vision for the trust was to further expand the quantity and range of services delivered closer to home and to develop integrated care pathway models in five key clinical areas; urgent care, child health, end of life care, frail elderly, and long term conditions.

- Service leads and the specialist palliative team articulated a vision and the priorities for end of life care services across the trust. One of those was to ensure all patients at end of life patients were offered holistic assessment and care planning.

Governance, risk management and quality measurement

- There were limited audit systems to monitor the quality of the service for example, the National Care of the Dying Audit Hospitals (NCDAH) 2013/14 recommended all hospitals should undertake local audit of care of the dying, including the assessment of the views of bereaved relatives, at least annually. A clinical audit programme had been commenced in January 2016 but audits were not effectively embedded in order to demonstrate that actions or new initiatives were improving end of life care. For example, this programme did not include views of bereaved relatives.
- End of life care fell under the medical division. However, end of life care was not documented on the medical division organisational structure provided by the trust,
- The end of life committee reported and sent minutes of meetings to the clinical governance committee. The clinical governance committee reported to the quality committee and they reported to the board. We saw no evidence of reports to the board on end of life care.
- There was no separate risk register for end of life care. The business unit and division organised risk registers. There were no end of life care risks on the registers, clinical leads informed us that any issues or risks related to end of life were escalated to the clinical governance committee. The minutes of the medicine clinical governance group in August 2015 showed that issues relating to end of life care were discussed
- The end of life care committee met in January 2016. We saw from minutes that the committee discussed the end of life strategy with several objectives agreed which included a database for palliative care caseload and fast track patients for discharge home.
- An End of Life project plan dated February 2015 detailed key performance metrics and indicators, but there was

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no evidence of monitoring of these in 2015. The trust started measuring performance against some of these in January 2016 therefore there was minimal data available at the time of the inspection.

Leadership of service

- The medical director was the named trust board representative for end of life care, supported by the deputy director of nursing and the specialist palliative care team. The medical director was sponsor of the end of life care project but did not attend or chair any end of life care meetings.
- In July 2015 the end of life care committee had identified the need for further clinical engagement to drive the end of life care agenda forward. This was discussed at the senior management team meeting and the chief executive agreed to chair the committee for a period of time to assist with this.
- The consultant in palliative care championed end of life and palliative care and led the service clinically. However, due to the hours they worked this meant that there was limited capacity to plan care services within the restricted hours available to them.
- All staff demonstrated a good awareness of developments of the service. However, the specialist palliative care team told us they were not able to contribute as effectively as they would like with service development, due to time constraints, as they had to prioritise direct patient
- The service was developing in several areas under the leadership of a newly appointed end of life care facilitator.
- Staff we spoke with felt their line managers and senior managers were approachable and supportive.

Culture within the service

- Staff across the trust wanted to provide good care to patients and support relatives whose loved ones were at the end of life. They worked well individually and collectively across the trust to make the patient journey the best they could. They were proud of the work they did and we saw the staff were committed to provide quality care.

- The specialist palliative team were supportive of each other and aware of the emotional stress of working in end of life care. The handover meeting was a time for checking on team wellbeing.
- Staff told us the end of life care facilitator had made a positive contribution in supporting staff on the medical wards in care of patients in the dying phase of their illness. We observed the end of life care facilitator having supportive, yet directive, discussion about end of life patient care; which contributed positively to the overall care the patient received.

Public engagement

- The bereavement coordinator gave out information packs to families when they came in to collect death certificates. It contained a bereavement questionnaire; however the coordinator had only received two responses so far.

Staff engagement

- There were systems in place that ensured staff were consulted by the leadership team about the way the services were run. For example, a healthcare assistant had developed the last offices checklist and had been asked to support training on wards.
- The trust recognised the hard work and contribution of their staff and publicly said thank you through their 'WOW' awards. Nominations for these awards were received either from staff working at the trust or, from the public.







Innovation, improvement and sustainability

- The clinical lead met quarterly with the Dorset Specialist Palliative Care Group. Membership included palliative care leads and consultants from surrounding trusts, with representation from local commissioning groups and county councils. The purpose of this group was to standardise care across Dorset.
- The trust had the aspiration to move towards Gold Standards Framework accreditation. Senior members of the department told us that the trust was assured of funding to sustain and improve the service and local commissioning groups were working with them to ensure a high quality of service for end of life care.

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- The trust was participating in Commissioning for Quality and Innovation (CQUIN) initiative related to end of life care. This was the care record of key information for cancer, palliative and end of life care patients.

Outpatients and diagnostic imaging

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

Information about the service

Dorset County Hospital NHS Foundation Trust provides outpatient and diagnostic imaging at Dorset County Hospital and, through agreement with the local community trust, at three community hospitals: Weymouth, Blandford and Bridport; with diagnostic imaging clinics also held at Portland and Sherborne. Some additional clinics are also held at Royal Bournemouth Hospital, Poole Hospital and local health centres, with some specialities offering outpatients appointments in the patients' own home.

The site at Dorset County Hospital has five main outpatients areas, medical, surgical, ear nose and throat/ oral surgery, ophthalmology, orthopaedics and haematology/oncology. There are also separate outpatient areas for physiotherapy, cardiology and orthodontics.

The diagnostic imaging service provides X-ray, computerised tomography (CT) and magnetic resonance imaging (MRI) scanning, ultrasound, mammography, dental fluoroscopy, interventional radiology and nuclear medicine at Dorset Community Hospital. At the community hospitals, plain film X-ray and ultrasound are offered.

The outpatients and diagnostic imaging service is not a standalone service, but is provided across specialties. Each speciality is part of a directorate that is managed within one of four divisions, medicine; surgery; family services; clinical and scientific. The different specialities run outpatients and diagnostic clinics as part of the service they offer to patients.

For the period July 2014-June 2015, the trust saw 311,624 adult patients in outpatients, with on average 725 different

clinics held each week, across nearly 100 specialities. The busiest three specialities at Dorset County Hospital were trauma and orthopaedics, ophthalmology and orthodontics. The majority of outpatient clinics are held Monday to Friday between 9am-5pm, with evening and weekend appointments in diagnostic imaging.

During our inspection, we visited all the main outpatients areas and diagnostic imaging at Dorset County Hospital and visited outpatients at Weymouth Community Hospital. We observed and spoke with patients and staff working in the following clinical specialities:- ophthalmology, haematology and oncology, physiotherapy, diagnostic imaging, genitourinary medicine, gynaecology, orthodontics, dermatology, respiratory, orthopaedics, urology and ear, nose and throat. We also visited the pathology department, cardiology investigation unit and patient access team.

We spoke with 24 patients, four carers and reviewed 24 comment cards with written feedback from patients who attended appointments prior to the inspection. We spoke with approximately 100 staff, including nurses, healthcare assistants, medical staff, physiotherapists, radiographers, administrators, reception staff, medical secretaries, porters and divisional managers. We observed care being provided, reviewed 43 patient records and analysed data provided by the trust both before and after the inspection.

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Summary of findings

We rated outpatients and diagnostic imaging as "requires improvement". We found the service to be good for caring and responsive but "requires improvement" for safe and well-led.

There were significant delays in the typing of clinic letters for cardiology, haematology and dermatology, with a risk that GPs were not kept informed of any changes to medicines or the results from diagnostic tests. The trust put in place an action plan for haematology after our inspection, with work already taking place in cardiology and dermatology. Patients' records were not stored securely in the oncology department and the records store for the genitourinary medicines clinic had a leaking roof.

We had concerns that some staff did not always report incidents as sometimes they did not receive feedback or learning was not shared at team meetings. Governance processes across the four divisions and the different specialties lacked standardisation, particularly for monitoring and reporting on service quality. Risk registers were not always complete. Two patient records policies were out of date and audits to monitor compliance to these policies did not take place.

Staff followed national guidance to ensure patient care followed an evidence-based approach. Some departments used clinical audit to monitor the standard of care provided, although this was not consistently used across all departments.

The service overall met referral to treatment time targets (RTT) but did not consistently achieve the two-week wait for urgent cancer referrals. Work had been completed in a number of specialties, including ophthalmology, to help them achieve the RTT targets. The trust offered a number of one-stop clinics to reduce patient visits.

Staff working in outpatients and diagnostic imaging told us they enjoyed coming to work at the trust, they were well supported by managers and felt they provided a good standard of care to patients. Overall, there were sufficient staff to run clinics and we observed good multidisciplinary working. Staff were up-to-date with their mandatory training and felt confident in their role.

Access to additional training was sometimes affected by demand for services. The majority of staff had recently completed an appraisal but staffing shortages had impacted on this for diagnostic imaging.

Staff felt involved and able to make suggestions on how the service improvements although examples of good practice were not always shared within or across divisions, Staff found the weekly newsletter from the chief executive kept them informed of changes across the trust, however, outpatient staff at Weymouth Community Hospital did not feel engaged with the trust as a whole.

Patients commented on the cleanliness of the departments they visited and we observed staff adhering to the trust's infection control policies and procedures. However, the waiting room environment at Weymouth Community Hospital required review by the trust and owner of this hospital,. Medicines and exposure risks to radiation for patients and staff were safely managed in diagnostic imaging. However, some patient group directions (PGDs) for the supply or administration of medicines held in departments were not authorised or in date for use. Staff were not following trust procedures for updating of PGDs.

All patient feedback was positive for the care and treatment they received from staff. Patients told us staff treated them with kindness, understanding and staff took the time to listen to their concerns and explain their condition in a way they could understand. Services were planned to meet the needs of local people, including those with additional needs or who were vulnerable due to their condition or personal situation. Patients were involved in developing services through experience based design projects.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services safe?

Requires improvement



By safe, we mean people are protected from abuse and avoidable harm.

We rated safe as requires improvement because:

- Staff were not reporting all incidents which occurred and where these were reported some staff told us they did not always receive feedback. There was therefore a risk to staff and patients' safety as improvements could not be made when things had gone wrong and learning was not shared wider.
- There were significant delays in the typing of clinic letters for cardiology, haematology and dermatology, so a risk that GPs were not kept informed of any changes to medicines or the results from diagnostic tests.
- Patients' records were not stored securely in the oncology department and there were potential risks to patient confidentiality and care and treatment. Notes for the genitourinary medicine clinic were at risk of damage as stored in a room with a leaking roof.
- Staff were not following trust procedure when patient group directions were updated, it was not clear that PGDs held in outpatient departments were in date and authorised for use. There was therefore a potential risk to staff and patient safety, with staff not working within current guidelines.
- There were instances where some safety systems to keep patients and staff safe were not being followed, including equipment not stored safely or serviced at regular intervals.
- Staff shortages and increased demand for the diagnostic imaging services had impacted on timely reporting of imaging results for the assessment of patients.

However:

- The majority of clinical areas were clean and tidy, with positive feedback from patients about the standards of cleanliness and hygiene. Staff followed trust's infection control procedures to reduce the risk of the spread of infection.

- Medicines were stored safely and securely in most departments, including nuclear medicine.
- Staff knew where to access resuscitation equipment and had access to equipment for bariatric patients
- Overall, there were enough staff, with the right level of skills for the different outpatient clinics. In departments where there were vacancies, managers had taken action to help manage this and continue to provide a service for patients.
- Staff were up-to-date with the mandatory training. Staff were confident in describing the different types of abuse and knew how to raise a safeguarding alert. Staff in the genitourinary medicine clinic worked well with external agencies, as they sometimes had to support patients who had suffered domestic or sexual abuse.
- A number of departments used the World Health Organisation surgical safety checklist to ensure patient safety, whilst having minor procedures in outpatients. There were systems in place to respond to patients who became unwell.
- In diagnostic imaging, appropriate steps were being taken to minimise the exposure risk to radiation to patients and staff following the recent radiation protection adviser report.

Incidents

- There was a culture across outpatients and diagnostic imaging of not reporting incidents. Staff had received training on the electronic reporting system, felt competent to use it and to raise concerns. However, staff told us of incidents which they had not reported because previously when they had raised concerns they had not always received feedback nor had learning always been shared at team meetings. They felt discouraged from using the system. There was no assurance that staff always reported safety concerns or they were acted upon.
- There were exceptions to this in urology, genitourinary medicine (GUM) and pathology where incidents were reported, investigated by a senior member of staff and action to be taken shared with staff. In diagnostic imaging, incidents were discussed at team meetings but not always recorded on the electronic reporting system. A newsletter was used across the main outpatients teams to highlight key messages to staff, which included the importance of reporting incidents.
- It was difficult to correlate the number of incidents which had occurred in outpatients and diagnostic

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imaging with the number reported to National Reporting and Learning System,. Initially, the trust provided no data on incidents in diagnostic imaging, due to an error with the data which was submitted, this was later provided. There was limited assurance that the figures reported were accurate and we had concerns around the quality of the incident data management systems.

- The radiation protection adviser (RPA) report for January 2016 showed 18 incidents (relating to ionising and non-ionising radiation) had been reported during 2015 on the electronic reporting system. Feedback forms had been completed for seven incidents, four were still under investigation and for the remaining seven incidents no feedback form had been completed as per trust guidance. One incident had reached threshold for reporting under the requirements of Ionising Radiation (Medical Exposure) Regulations 2000 (IR(ME)R), this had been reported appropriately to the Care Quality Commission and action taken with the introduction of a double checking process at each stage of the patient's pathway.
- There had been two serious incidents between January-December 2015, in ophthalmology and dermatology. Both of these had been investigated and changes made to practice, such as introduction of new guidelines and review of the booking process for appointments, these changes had been shared with staff.
- The Duty of Candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person. The trust's policy on 'being open and duty of candour' reflected the Duty of Candour legislation. The risk management team identified incidents reported by staff that triggered the Duty of Candour and then coordinated the response and investigation. There was a trust-wide system for tracking their Duty of Candour responses and in the quarter October 2015 – December 2015, 12 incidents triggered the Duty of Candour response.
- Staff with responsibility to investigate incidents were receiving additional training which included applying Duty of Candour. This had started in October 2015, with the aim of all staff receiving training by October 2016. As

of March 2016, 20% of relevant staff had completed this training. Frontline staff were required to read the trust Duty of Candour policy and sign to confirm they had done so.

- Reports for the two serious incidents and the IR(ME)R reportable incident showed that the patient had been kept informed of the investigations taking place and had been offered an apology.
- Staff at Weymouth Community Hospital were not aware of Duty of Candour and told us they had not received any training or information, however, they did access the trust intranet during our visit to find out more information. Information provided by the trust showed that information had been shared with staff at this site around Duty of Candour, through the outpatients newsletter.

Cleanliness, infection control and hygiene

- Overall, the clinical areas we visited were visibly clean and tidy. However, we did not see this standard of cleanliness in the physiotherapy department at Weymouth Community Hospital where there was evidence of poor infection control practices.
- In this department, six of the seven examination couches we checked had a layer of dust on them and were therefore not clean and ready for use. However, information provided after the inspection confirmed these couches were not in use and consideration was being given as to where to store these or ensure they were cleaned to the same standard as other equipment in the area. We asked to see the cleaning checklist but staff told us they did not keep a written checklist for the cleaning of equipment. Information provided by the trust after the inspection showed cleaning rotas were kept in the department. The couch in the physiotherapy gym was clean. The physiotherapy suite at Dorset County Hospital had carpet on the floor. There was a potential cleanliness and infection risk as any spillages would be difficult to remove. To manage this we were told the carpet was deep cleaned every six months, with the last deep clean in January 2016.
- In the orthopaedic clinic waiting area there were a number of chairs in the waiting room that were ripped which may pose an infection control risk as they could not be cleaned properly. Information provided after the inspection confirmed replacement chairs had been ordered.

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- At both hospitals, cleaning schedules were in use in outpatient clinic rooms showing staff what should be cleaned and with what cleaning material. The schedules we checked were complete and up-to-date. Written and verbal feedback from patients was positive about the standard of cleanliness in outpatients.
- In the GUM clinics, there were robust infection control procedures which staff followed whilst carrying out tests to reduce the risk of cross contamination of samples.
- We observed staff adhering to trust infection control procedures, such as cleaning their hands, before and after contact with patients and using personal protective equipment such as gloves and aprons. Staff also followed bare below the elbow trust's policy. Hand sanitizer points were visible at the entrance to all departments we visited, to encourage patients and visitors to clean their hands and reduce the spread of infection.
- Data provided by the trust for April-December 2015 showed monthly hand hygiene audits had been completed in all outpatient and diagnostic imaging areas. Year to date performance showed 90% compliance with the trust target of 95%, for outpatients at Weymouth Community Hospital, all other departments were compliant. An action plan had been developed and there had been 100% compliance for January 2016 at Weymouth Community Hospital.
- We saw examples of good practice for infection control and hygiene. In diagnostic imaging, plastic sheaths were used on ear supports and bite blocks. These were changed between patients. A new system had been introduced for the cleaning of ultrasound probes, staff told us this system was more effective and reduced the risk of infections being passed between patients. In the ear, nose and throat clinic, there was a robust process in place for the sterilisation of laryngoscopes.
- There were arrangements in place to protect patient from the risk of acquiring a healthcare associated infection. Staff in outpatients and diagnostic imaging told us if a patient was known to have an infectious disease, they would try to see them at the end of the clinic. The area and any equipment were then thoroughly cleaned to minimise the infection risk to staff and patients.

Environment and equipment

- The environment and equipment was well maintained in 11 out of the 15 clinical areas we visited, therefore, practices to keep patients and staff safe were not always being followed.
- For example, in diagnostic imaging, we found five unlocked doors, for areas where only staff should have access. This included the rubbish store and the cleaning cupboard, which contained cleaning products which should be locked and may pose risks to patients. We brought this to the attention of the team leader at the time. The cupboard was also untidy with items stored on the floor and draining board, meaning the space could not be fully used for its intended purpose. In the clean store, there were some items stored on the floor due to limited storage space in the department, this made it difficult for the floor to be cleaned properly. Lack of storage space in the therapy departments was also raised by staff attending once of the focus groups. In other areas we visited substances hazardous to health were stored securely.
- In the physiotherapy suite at Dorset County Hospital, we saw two damaged staff chairs, which staff were using as there was no funding for replacements. One of the chairs had screws that could be felt in the seat padding and the other did not stay in a fixed height position.
- Staff followed the trust's policy for the disposal of clinical waste. Sharp boxes we checked were labelled, stored appropriately and removed when the fill line was reached. In the orthopaedic clinic, we observed the lock to the cupboard in the sluice was broken and staff had taken appropriate action and safely stored substance hazardous to health to safeguard patients and the public.
- Porters raised concerns that they could not move the new beds purchased by the trust using the 'bed puller'. This piece of equipment allowed one member of staff to move a bed rather than two. Staff were concerned that there would be delays in collecting patients for appointments as two members of staff would be needed. The trust confirmed there were only two staff on duty in the morning. Staff did not know what action the hospital was taking to address their concern and we did not see the risk listed on any of the four division risk registers.
- We had concerns that equipment testing did not follow trust's policy as we found five pieces of electrical

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equipment, which had not been safety tested portable appliance testing since January 2015. Trust policy advised equipment should be tested on an annual basis. One piece of equipment in ophthalmology was out of date for its annual service, due 2015. We made senior staff aware of this who provided written evidence after the inspection, confirming the piece of equipment had been removed from use, and a service had been arranged.

- There was suitable equipment in physiotherapy and diagnostic imaging for the assessment and treatment of bariatric patients. Adjustable patient chairs were used in the fracture clinic to provide a safe and accessible service to patients.
- Resuscitation equipment such as oxygen and adult masks were available in all departments we visited. There were inconsistencies in the management of resuscitation equipment. At Weymouth Community Hospital, senior staff told us staff checked the equipment weekly, however, this was not recorded. In one department there was no paediatric mask available, although children attended these clinics. We brought this to the attention of the manager of the department and they took action to address this.
- At Weymouth Community Hospital, the resuscitation trolley was kept in the minor injury unit and staff said they would shout or ring for help. All staff we spoke with knew where the nearest resuscitation trolley was kept for the area where they worked
- In diagnostic imaging, there was signage to alert patients to potential radiation hazards in relevant areas. Personal protective equipment such as lead aprons were readily available for staff to use and these items were regularly checked for damage. Radiography staff told us and we saw signed documentation to confirm they had read local rules and adhered to these within their working day.
- In ophthalmology, a second pair of goggles was on order, to enable staff or carers to stay and support a patient, whilst a laser procedure was taking place.

Medicines

- Patient group directions (PGDs) were in use in five outpatient departments. A PGD provides a legal framework that allows some registered health professionals to supply and/ or administer a specified medicine(s) to a pre-defined group of patients, without

them having to see a doctor. A PGD is used in situations that offer an advantage to patient care, without compromising patient safety. Staff were not following trust procedure for updating PGDs.

- In ophthalmology, there was confusion with the number of PGDs currently in use. At our initial visit, we were told by staff and reviewed two patient group directions (PGD) for tropicamide and oxybuprocaine. Staff using these two PGDs had signed them and been assessed as competent. Review with the trust pharmacy team found five ophthalmology PGDs were in use, four of which were authorised for staff to use; this was confirmed by data submitted by the trust. The intranet version of the oxybuprocaine PGD had no date for review, which is part of the authorisation process, although the department copy stated October 2016, which was confirmed by information submitted by the trust during review of the report. Some aspects of the copies of the tropicamide and oxybuprocaine PGDs held in the department had not been completed, the author and sponsors had not signed and dated the new version of the PGDs and the PGD lead had not been completed for the oxybuprocaine PGD. There were inconsistencies in the information held at trust and department level, with a potential risk to staff working from the PGD.
- In the departments we visited, medicines were not always stored safely and securely, although all items we checked were in date. We found some medicines for the ear nose and throat clinic stored in the same cupboard as food items and sample bottles, which was not in line with best practice and the trust's medicines management policy.
- The central pharmacy team, monitored fridge temperatures remotely by Wi-Fi, including at Weymouth Community Hospital, to ensure medicines were stored at the correct temperature. If they noted any errors they visited the department concerned and if necessary medicines were disposed of.
- Nursing staff ensured prescription pads (FP10s) were locked away when clinics were not taking place. There were systems in place for daily auditing of the log numbers of prescriptions issued, which staff recorded in departmental registers. Those we looked at were up-to-date and complete.
- In the GUM clinic, there were seven nurses who were non-medical prescribers, all had completed the relevant prescribing course. Medicines management processes were particularly robust in this department.

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- In diagnostic imaging, we saw appropriate systems were in place for the safe use, storage and disposal of nuclear medicines, as part of the Medicines (Administration of Radioactive Substances) regulations 1978. This included inspections by the counter terrorism unit and the environment agency.

Records

- We had concerns relating to the safe storage and completeness of patients' records in six out of the 13 clinical departments we visited. There were also no daily audits on missing patients' notes.
- In the haematology and oncology outpatients area, we saw patients' records stored on open trolleys in the corridor. This meant the records were easily accessible to the public and breaching patients' confidentiality.
- In the same department, there were around 30 records that had been prepared for haematology clinics, which had been left on worktops unsecure due to a lack of storage space and delays in typing notes from the haematology clinic. Due to the typing delay there was an associated information governance risk as patients' notes were not being stored securely for forthcoming clinics as the space was taken with notes waiting to be typed. Oncology patient notes were stored in cupboards with locking facilities, however, these were unlocked with the key in the lock. Staff told us these records needed to be accessible to emergency department staff if needed. The trust told us they had purchased a new storage unit and three lockable trolleys for the department, due for delivery the end of April.
- We had significant concerns about the turnaround time for clinic letters to be typed and sent to GPs across the trust but in particular for haematology, cardiology and dermatology. This was a risk to patients' care and treatment as GP's were not kept informed of any new diagnosis or changes to treatments. The dictation system used enabled consultants to flag any urgent letters; staff endeavoured to type these the same or next day.
- In the GUM department, there was a robust system to ensure records and patients' confidentiality was maintained. All patients' records contained a unique identification number. However, we observed records were at risk of being damaged as following a leak in the roof, staff had used plastic sheeting to protect the records and this was not sustainable long term. This risk was not on the family services division risk register. The trust advised after the inspection that the roof had been repaired.
- The administration staff were responsible for preparing patient records for clinics, including locating, collating the referral information and ensuring the paperwork was securely stored in the correct order. We found in seven out of 11 sets of records at Weymouth Community Hospital, there were loose sheets, containing clinical reviews and test results. There was the risk of patient's records being mislaid or filed in other patients' notes. Some records were not labelled appropriately with patients' identification stickers.
- We saw some patient records files which were very large. A staff member told us that one set of records weighed 13kgs, which posed a moving and handling risk.
- Data provided by the trust showed they did not audit missing notes for each clinic on a daily basis. Staff we spoke with told us there were issues with patient notes not always being available for appointments but they did not know if this data was captured and audited. If a patient's notes were not available a temporary set was created, which contained the last clinic letter and referral letter where possible.
- The trust 'Health records management policy' stated that a monthly audit should be completed by the health records department of a random selection of clinics to audit the number of missing notes. The results should be discussed at the health records department governance meetings. The next review date for the policy was December 2013, therefore there was no assurance that the policy still followed trust or national guidance.
- The trust submitted data showing monthly data captured for just one speciality for each month between July-December 2015. There was no audit report with the audit results so it was not possible to identify the outcome. The results implied that 100% compliance had been achieved for each clinic, a total of 331 sets of notes. However, the notes for 32 patients were recorded as missing but on their way. The audit results did not show if these notes arrived in time for the patient's appointment.
- The trust 'Policy on Health records standards' required annual baselines record keeping audits to be completed for all professional groups. This policy was due for

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review in 2013 A trust wide audit was completed in 2014, which showed an overall improvement in compliance by 2% from 2013. A further audit was planned for 2015 but no data was submitted. The trust policy also required each division to complete an annual clinical patient's record audit. We requested the most recent audit for each division. No data was submitted. Evidence was submitted during the factual accuracy stage to show review of these policies had taken place in February 2016 and ratified in March 2016.

- Some departments also completed their own records audits such as orthodontics. An audit completed in November 2015, showed overall good compliance with record keeping standards.

Safeguarding

- There were trust wide safeguarding children and adults policies. Staff in all the departments we visited knew how to access these policies and the process they should follow if they needed to raise a safeguarding concern. We saw information in staff areas reminding staff about the importance of raising a safeguarding concern and how to do this. Four staff confidently described the signs that may identify a patient had been abused and the different types of abuse.
- Staff working in diagnostic imaging followed a non-accidental injury policy and procedure when performing scans on children who may have a non-accidental injury. This included working closely with the child protection teams and also ensuring staff knew how to access support and counselling, due to the upsetting nature of this work.
- Due to the staffing structure used within outpatients, with staff being employed across all four divisions, it was not possible to achieve an accurate breakdown of compliance with safeguarding training for this core service type. The trust wide training figures for safeguarding adults were level 1 98% and level 2 91%. For safeguarding children the figures were level 1 97%, level 2 84% and level 3 93%.
- The majority of staff we spoke to told us they had completed their safeguarding adults and children training. However, at Weymouth hospital, staff told us and evidence provided by the trust showed it had been difficult to allocate a session for staff who needed to update their child protection training although staff told us they did have a date booked within the next month for their training. Two staff working in administrative

roles at the main hospital told us they had not completed their safeguarding training, however they did know how to find the relevant information if they had a concern.

- The radiology service was compliant with the trust target for safeguarding adults and children training.
- In GUM, staff had established links with external organisations and charities to raise alerts or make referrals for patients they saw. There was a pathway in place for staff to follow should a patient attend who had been assaulted. Staff in this department were aware of the Dorset wide Female Genital Mutilation policy and knew how to refer if they had a concern about a patient. There were also posters developed and training provided to staff to raise their awareness on recognising signs of young people at risk of abuse and child sexual exploitation.
- Following a safeguarding investigation, a robust action plan had been implemented which included an extra module in the staff's induction programme on safeguarding.
- Nursing staff working in gynaecology outpatient clinics at Weymouth Community Hospital told us they had not received additional training on recognising signs to indicate female genital mutilation.

Mandatory training

- Mandatory training for staff included equality and diversity, information governance, manual handling and basic life support. Training modules were a mix of online e-learning or practical sessions. Each department we visited had a lead for mandatory training who reminded staff when they needed to update their training. Staff completed their mandatory training as part of their induction and then updated courses at set intervals.
- Staff told us they had completed their mandatory training and we saw training matrixes for four departments which were complete or staff had been allocated a date to attend training.
- The trust target for compliance with statutory and mandatory training was 85%. Compliance with mandatory training was reported at division level with feedback given at the trust clinical governance meetings.

Assessing and responding to patient risk

- Staff working in outpatients and diagnostic imaging completed adult basic life support training as part of

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their induction training and updated this on a yearly basis, to enable them to respond quickly if a patient collapsed. Staff told us they would also alert a doctor, if there was one working in the clinic, or would arrange for the patient to be transferred to the emergency department. Staff knew how to call the 'crash team' at Dorset County Hospital. Staff at Weymouth Community Hospital called 999 as there was no emergency team onsite.

- Staff in outpatients told us they had not been trained to observe and calculate early warning scores for patients but felt confident to raise the alarm and seek support. There were emergency call bells in the outpatients and diagnostic imaging rooms at Dorset County Hospital. At Weymouth Community Hospital, staff carried 'panic alarms' and used these to raise the alarm if a patient became unwell.
- We saw in rooms used for treatments and procedures there was access to oxygen and where appropriate suction machines. In dermatology, an alarm sounded if a patient was about to receive too greater dose of ultraviolet radiation.
- In diagnostic imaging, there were systems and processes in place to help respond to potential risks to patients. Staff found it very helpful that the RPA was based on-site should they need advice. There were radiation protection supervisors (RPS) for each clinical area and staff knew who these were. The supervisors ensured exposure risks to radiation were kept to a minimum for staff and patients. The duty radiologist name was on the board in reception so all staff knew who to contact if support was needed.
- Senior radiographers reviewed all requests received for diagnostic tests to ensure they were made by staff competent to do so, this was in keeping with IR(ME)R requirements.
- We saw do not enter signs and warning lights outside rooms used where radiation exposure took place. The name of the RPS was written on the sign as well, in the event of an incident.
- We did not see any signs in the main waiting areas advising women who were or may be pregnant to always inform a member of staff prior to having a test performed. However, there were signs in the changing cubicles and there were robust checking procedures prior to a member of staff performing a test. We checked

five sets of records in dental X-ray for female patients of child bearing age, for four out of five, the patient had signed the pregnancy declaration form. Pregnancy tests were available if needed.

- Diagnostic imaging staff used the 'Red dot policy' to highlight any abnormal findings on the images, to staff working in the emergency department, to bring staff attention to the issue to aid in the diagnosis.
- There was a consistently high number of unreported MRI and CT scans at the end of each month, averaging 192, although figures had decreased each month. The department used short-term reporting initiatives to help reduce the delays. This impacted on timely access to test results and any treatment they may need.
- In diagnostic imaging an adapted version of the World Health Organisation (WHO) Surgical Safety Checklist was used when carrying out non-surgical interventional radiology. The department had just started to audit compliance with the WHO checklist, provisional results indicated good compliance. The WHO surgical safety checklist was also used in ophthalmology and dermatology for patient injections. The results were not currently audited to review staff compliance and patient safety.

Nursing and non-medical staffing

- Staff we spoke with told us there were normally enough staff with the appropriate level of skills to cover the different outpatient and diagnostic imaging clinics. This was supported by data showing the actual number of nurses on duty met or was safely managed compared to the planned number for clinics held between August-November 2015.
- Team leaders planned the number of nursing staffing needed based on the number of clinics running each day and the number of patients in each clinic. Staff told us although planned staff numbers were met, they struggled sometime to support patients, chaperone and complete the administrative aspects of the clinics. In outpatients, there is no national acuity tool to help plan the number of nursing staff needed.
- Staff in three departments described different initiatives that they had used during periods of understaffing to keep services safe. In all services, staff prioritised urgent patients. In diagnostic imaging there was regular use of agency staff for sonography, a national shortages of trained sonographers was affecting recruitment to the two vacant posts. More senior radiography staff covered

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clinical shifts but this had impacted on their time to complete administrative aspects of their role. This had affected services as timetabled sessions had been reduced in interventional radiology due to radiology nurse staffing vacancies

- In physiotherapy, four band 5 staff had been recruited and followed a one year accelerated development programme due to a national shortage of band 6 staff. This allowed staff to work at Band 6 level after a year, if they achieved all their set competencies. This helped the department to meet the vacancies it had at this grade.
- In oncology, the outpatients chemotherapy service held at the community hospitals had stopped, to ensure the service at the main hospital was safely staffed.
- There remained the need for an additional plaster technician in orthopaedics, as there were only two in post, who supported both inpatients and outpatients. It was difficult to fully cover the service if staff were sick or on annual leave. Bank staff provided cover for three days a week. Weymouth Community Hospital minor injuries unit staff had been trained to fit plaster casts to reduce demand on Dorset County Hospital services.
- Agency and locum staff use was kept to a minimum but there were trust and local induction procedures in place when they were used.

Medical staffing

- No consultants we spoke with raised any concerns about medical staffing for the departments they worked for. The outpatients clinics were consultant led and often consultant run. Medical staffing was based on the number of clinics being held.
- Locum radiologists were used to cover the breast clinic due to a vacant post.
- There were comprehensive on call arrangements in diagnostic imaging to ensure a radiologist could always be contacted. There was an on call ophthalmologist who saw patients out of hours in the emergency department.

Major incident awareness and training

- Business continuity plans were available on the trust wide shared drive system, which all staff could access. There was a member of the senior management team on duty each day responsible operationally for any

major incident affecting the hospital. Junior staff did not know of their individual responsibilities within a major incident but would access the shared drive to find out more information or speak with their manager.

- Staff working at Weymouth Community Hospital, did not know if there was a local contingency plan in the event of a major incident at the hospital, although they did know who to speak to in an emergency.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

We report on effectiveness for outpatients and diagnostic imaging services. However, we are not currently confident that, overall, CQC is able to collect enough evidence to give a rating for effectiveness in the outpatients and diagnostic imaging services.

- There were significant delays with typing and sending of clinic letters to GPs which was placing patients at risk of not receiving effective care and treatment. This was a particular problem in cardiology, dermatology and haematology.
- Staffing shortages in diagnostic imaging had resulted in nearly a third of radiography staff not having a recent appraisal.
- There was good use of clinical audit but little information gathered on patient reported outcomes to enable monitoring and changes to practice and treatments.

However:

- Care and treatment for patients was planned using current evidence based guidance, standards and best practice. This was particularly evident for genitourinary medicine. A number of diagnostic services had national accreditation demonstrating the standard of their work.
- Multidisciplinary working was a particular strength for this core service with teams working well together

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within the trust and with other external services. There were many one-stop clinics to reduce the number of appointments and enable patients to receive treatment more promptly.

- Staff overall felt competent to do their role and felt supported to complete additional training.
- Patients received sufficient information prior to giving consent, which was documented correctly in the patient record. Staff were mindful of considering patients capacity to give consent and making best interest decisions when appropriate.

Evidence-based care and treatment

- Overall, the majority of staff in outpatients and diagnostic imaging told us they followed relevant national guidelines such as National Institute for Health and Care Excellence (NICE) guidance to ensure patients received effective care and treatment. Department and divisional minutes showed that new or updates to guidance such as NICE were monitored and acted on where relevant.
- In genitourinary medicine (GUM), staff adhered to NICE guidelines, such as PH33 and PH34, for HIV testing, chlamydia and sexually transmitted infection testing.
- In diagnostic imaging, a new software system had been introduced to enable consultant radiologists to share unexpected or abnormal findings with the referrer by email and establish an audit trail to show this information had been sent and received. This was introduced in response to standards from the National Patient Safety Agency and guidance from the Royal College of Radiologists.
- Work was taking place in diagnostic imaging to ensure local diagnostic reference levels were set to ensure patients did not receive a greater dose of radiation than necessary. This was in response to the radiation protection adviser report from November 2015 and a requirement of the Ionising Radiation (Medical Exposure) Regulations 2000 (IR(ME)R). The DRL's were last reviewed in 2010.
- A member of staff in diagnostic imaging commented that keeping compliant with NICE guidance had impacted on demand for their service, as more patients were being referred for diagnostic tests.
- We saw evidence of completed audits in ophthalmology and diagnostic imaging auditing local practice against NICE and other national guidance; if not compliant the audit lead identified actions and shared them with staff.

- The genitourinary medicine (GUM) service had a comprehensive quality outcome indicators report which assessed the quality of the service against a number of standards from the British HIV association, National Chlamydia Screening Programme and British Association for Sexual Health and HIV. In the most recent report for 2015, the department had met the majority of the 24 indicators measured.
- In physiotherapy a number of protocols were used to provide evidence based care for patients, such as those receiving acupuncture.
- Nursing staff in some general outpatient teams were unable to identify how the care they gave to patients was guided by evidence or best practice such as recommended in guidelines produced by NICE, although staff were following local policies for their departments.

Pain relief

- Patients undergoing procedures in outpatients were given advice on pain management prior to the procedure.
- Staff in the fracture clinic described the factors they would consider when assessing a patient's pain. The plaster technicians were aware that pain might indicate complications such as immobilisation devices not fitting properly or the possibility of infection occurring.

Patient outcomes

- There was little evidence other than in physiotherapy and GUM, that departments collected, monitored and acted upon information on patient reported outcomes (PROMs) for outpatients appointments. Staffing shortages in the physiotherapy department meant they had not analysed recent PROMs data, however, data submitted showed they had completed this previously.
- In the GUM clinic, a clinical audit reviewing the introduction of a new patient pathway for patients aged 16-17 years, found this identified a higher percentage of patients at risk of self-harm, and mental health issues than the previous care pathway. Therefore, staff would continue with using the new pathway.
- In ophthalmology medical staff had logged a number of incidents due to some patients having complications post cataract surgery performed by a different provider. The trust were carrying out an internal review and monitoring the situation.

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- Nine of the departments we visited completed local clinical audits such as ophthalmology and orthodontics. We saw results from these were discussed at team meetings and changes to practice shared with staff. The trust audit department identified that although a number of audits for ophthalmology were completed, they did not have a copy of the report in their department for governance purposes.
- The pathology service had Clinical Pathology Accreditation (CPA), which demonstrated the quality and competence of the service to provide accurate diagnostic results as part of a patients care and treatment. They completed a monthly scorecard aligned with standards from the CPA. The neurophysiology and audiology service had accreditation to the Improving Quality in Physiological Services accreditation scheme, which again recognised the standard of the service they provided.

Competent staff

- Patients told us they felt staff were competent to provide the care they needed. This was confirmed by most staff who told us they felt supported to maintain and further develop their professional skills and experience.
- Nursing staff told us they were aware of their responsibilities around revalidation and were being supported by their manager. This included ensuring staff personal files were up-to-date and contained information on all trainings they had attended.
- Consultant staff told us they were up-to-date with their appraisal and knew when their revalidation was due.
- The majority of the 13 specialities we visited held regular multi-disciplinary team meetings (MDT). These were used to share learning from cases and offer peer review. Staff told us and we saw minutes were taken at these meetings. These were then emailed to staff. Departments included staff working at community sites in their training events.
- We saw completed competencies for health care assistants undertaking cannulation and wound dressings.
- Departments had local induction procedures in addition to the trust wide induction programme, this include a period of shadowing and supervision for new starters,

even if they were not new to their role. There was limited use of agency staff across the departments we visited. Shifts were filled with current or bank staff who had the necessary training.

- Staff in the oncology service told us it was difficult to release staff for training due to the demand for their service and difficulties finding suitably trained staff to cover.
- Outpatients nurses told us they did not receive any clinical supervision. There was no opportunity for them to discuss complex or difficult cases or share learning with their colleagues. However, information provided by the trust showed monthly reflective meetings were due to be held for staff from March 2016 for staff who permanently worked at that site.
- Appraisal data was not available for outpatients and diagnostic imaging as it was reported by division, with many staff working across inpatients and outpatients. Staff we spoke with verbally told us they had received a recent appraisal, although in diagnostic imaging staffing shortages meant some radiography staff had not completed a recent appraisal. Twenty six out of 90 staff had not received an appraisal in the last year. Senior staff were aware of this and planned to address this once the department was fully staffed in July 2016. There had also been an impact on senior staff being able to attend their radiation protection supervisor training. This was also identified in the RPA report from January 2016.
- However, this department offered student placements and there were robust systems in place for students support, including staff who were trained to act as assessors or could sign off competencies. This information was displayed so students knew who to approach.
- Staff administering radiation had received appropriate training for their role. The department was compliant with the requirements of Medicines (Administration of Radioactive Substances) Regulations (MARS) in relation to the administration of radioactive medicinal substances.

Multidisciplinary working

- We observed, saw evidence in patients' records and staff told us that there was effective multi-disciplinary (MDT) working within teams and with other teams, both internally and externally.

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- One-stop clinics, such as the symptomatic breast clinic, neck lump clinic and age related macular degeneration clinic were held to enable patients to access a number of services on the same day, reducing the number of appointments and providing quicker access to a diagnosis and treatment. All these clinics involved medical staff working with nursing or allied health professionals. The neck lump clinic was cross speciality involving ear, nose and throat, diagnostic imaging and pathology.
- The lung function and cardiology service held joint MDT meetings to discuss patients who required care from both services. The GUM service held MDT meetings with schools, the police and local safeguarding team as many of their patients were vulnerable and required input from multiple services.
- The dermatology service held video conferences with colleagues in Poole and Bournemouth to discuss complex cases.
- In diagnostic imaging, staff obtained previous scan results for patients where possible, to avoid unnecessary exposure to radiation. The trust used an electronic request and results system which was available nationally, so they could access results from tests performed at other hospitals.

Seven-day services

- Outpatient clinics were held Monday to Friday between 9am-5.30pm. There were no regular clinics held at weekends to help address increasing demand for services. The outpatient redesign programme was reviewing clinic utilisation and efficiency.
- The GUM clinic offered evening appointments until 7.30pm, three days a week. They had trialled weekend clinics but there had been a poor uptake, so instead they developed pathways for patients needing urgent treatment for GP's and emergency department staff.
- The diagnostic imaging service provided a consultant on-call service seven days per week for CT and ultrasound. There was also an emergency out-of-hours X-ray service and CT scanning for urgent patients, including those with suspected stroke. The standard CT and MRI service ran from 8am to 8pm, with additional MRI clinics held on Saturdays to help meet demand for appointments. CT radiographers provided an out of hours on-call service, seven days a week. There were occasional evening and weekend clinics for mammography and ultrasound.
- In phlebotomy, an on-call service was provided with a member of staff on-site throughout the night.
- In physiotherapy staffing vacancies made it difficult to sometimes cover the current clinics provided during the week.
- At Weymouth Community Hospital, the outpatients area was used in the evenings and weekends, by the GP out-of-hours service.

Access to information

- There were significant delays in turnaround time for clinic letters to be typed and sent to GPs across the trust but in particular for haematology, cardiology and dermatology. This resulted in GP's contacting administrative staff with questions about changes to medicines.
- Staff told us the backlog had been present in haematology for five years. At the time of our inspection in March, letters were being typed from clinics dated 20th January 2016. This was a delay of seven weeks, staff told us the trust target for was for letters to be typed within 24-48 hours of the patients appointment. However, written information from trust implied a two week turnaround time was acceptable. Staff and consultants had raised concerns but the action taken by the trust had not had a sustained effect, additional ad hoc staff had been employed to help with the backlog since 2012. The trust recognised that further work was needed to reduce the backlog.
- During our inspection, staff were typing cardiology letters from five weeks ago. Data provided by the trust for February 2016 showed dermatology were nine weeks behind. The trust had tried to address the delays, particularly within the medicines division, however, haematology was managed by a different division, so the delays for this service had not been responded to by the trust until our inspection.
- Administrative staff were behind on other aspects of their work as they had to spend additional time typing letters to try and get on top of the backlog. Staff told us, short term fixes were often used, which reduced the backlog, this then increased again, and data for cardiology supported this. There was no flexibility should staff leave or be off sick.
- Since the inspection the trust submitted an action plan in response to the issues in haematology, based in the Fortuneswell Unit. Additional administration staff were

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helping to type letters and the delay had reduced to five weeks. Senior managers were looking at the cost of introducing voice recognition software to enable letters to be typed as they were dictated.

- No staff raised any concerns around accessing test results or current turnaround time for results, which were available electronically.
- Reporting times for diagnostic imaging were monitored against five key performance indicators (KPI), including the number of unreported exams. Data for August-November 2015 showed the only KPI met for all four months was reports were sent to GPS within 14 days. The target for reporting of CT and MRI scans within 14 days was not met, nor the reporting of minor injury unit X-rays within 48 hours. There was a service level agreement in place with another provider for the reporting of plain film X-rays to help address any delays. The company internally audited their reports and sent a copy of the audit to the department.
- Physiotherapy staff raised concerns that they sometimes had incomplete information for out of area referrals. They were reliant on the patient bringing their discharge letter with them.
- At the GUM clinics, there was a robust system for sharing test results with patients to minimise the risks of data breaches.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff described and we saw in patient records that consent had been sought and documented prior to procedures or diagnostic tests being performed. Consent was either gained verbally and recorded or for more complex procedures a consent form was completed. We checked two consent forms and these had been filled in correctly, including the risks and benefits of the planned procedure. Patients told us they felt fully informed prior to giving consent.
- A nurse told us they had stopped a procedure going ahead as the patient had signed the incorrect consent form. This incident had resulted in a change in procedure within the department concerned.
- In diagnostic imaging, pregnant women completed a specific consent form, prior to an MRI scan being performed.

- The genitourinary medicine clinic recorded consent at each visit. Also, they had developed a proforma used with patients under the age of 18, which included the patient's mental capacity assessment and ability to consent for contraception and intercourse.
- The orthodontic department had completed a documentation and consent audit in November 2015. This had shown amber compliance (between 30-50% non-compliance) for a number of areas around consent, including documenting that information leaflets had been given to patients at the time of consent and ensuring it was recorded in the notes that the patient had been given a copy of the consent form. A further audit was planned for September 2016.
- Clinical staff told us they completed Mental Capacity Act training as part of their induction. As staff worked across all four divisions it was not possible to provide cumulative data on training figures for outpatients and diagnostic imaging. However, we saw in minutes from divisional meetings compliance rates for mandatory training were monitored and action taken if the trust target of 85% was not met. The trust wide training figures for safeguarding adults MCA and DoLS Level 2 was 78%.
- Staff could describe when they may need to consider a patient's ability to give informed consent but had used this training infrequently. Staff knew who to speak to if they needed advice. A member of staff described using the capacity assessment form as part of the consent process for a patient living with dementia.

Are outpatient and diagnostic imaging services caring?

Good



By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

We rated caring as good because:

- All feedback from patients, both verbal and through patient comment cards collected during the inspection was positive about the care they had received from staff. Patients felt staff took the time to listen to their concerns, provided clear explanations about their care

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and treatment and during their appointment provided care of a high standard. This included treating patients with dignity and respect, and maintaining privacy and confidentiality.

- Patients felt they were treated as individuals and they and those close to them were involved in making decisions about their care. Staff considered patients emotional needs, not just their clinical needs. Family members and carers were also offered support. There were a number of support groups for patients providing additional support and enabling patients to manage their own health and wellbeing as much as possible.

Compassionate care

- All patients we spoke with were very happy with the quality of care they had received. Staff had spoken to them in a kind manner and treated them with dignity and respect. Staff enabled strong, supportive relationships with patients and their relatives. Patients told us 'staff always do their best', 'I am always treated with respect and upmost care'.
- Staff ensured confidentiality and privacy by knocking and waiting for a response before entering the consultation or treatment room. We saw doors or curtains were kept closed during consultations or whilst staff were providing care.
- The layout of the majority of reception areas meant conversations between patients and the reception staff could at times be overheard but we observed that reception staff spoke to patients discreetly in an effort to maintain confidentiality. There were no signs seen asking patients to stand back from the desk until it was their turn, to help maintain confidentiality.
- In the physiotherapy suite at Dorset hospital, conversations between staff and patients could also be overheard but again staff tried to maintain confidentiality where possible. There was a side room for more difficult or sensitive discussions with patients.
- Chaperone signs were seen in some but not all waiting areas. However, where appropriate staff were observed asking patients if they would like a chaperone during their consultation. Staff told us this was documented in the patients' notes, including if they declined a chaperone, however we did not see this in the notes we reviewed. Outpatients staff at Weymouth commented that medical staff asked for a chaperone if a patient needed an intimate examination.

- Friends and Family test data was collected by the trust, with some departments such as the fracture clinic, ophthalmology and dermatology displaying the results for their speciality in their waiting areas. Results showed the majority of patients would recommend the trust to friends or family if they needed care or treatment. Data collected across all of outpatients for April 2015-January 2016 showed an average of 92% of patients would recommend the trust, with an average response rate of 28%. Outpatients staff at Weymouth Community Hospital were not aware that Friends and Family test data was collected. They told us they had not seen any results, although the trust produced a monthly newsletter for staff which included Friends and Family test results and was shared across all sites.

Understanding and involvement of patients and those close to them

- We observed staff introducing themselves prior to starting the consultation and taking the time listen to any concerns the patient or carer had before going ahead with the consultation or assessment. Staff took the time to explain any diagnostic tests the patient needed and the reasons for these.
- Patients and carers told us all staff had given clear explanations, in sufficient detail for each stage of their care and treatment. They were in general also given written information to support the discussions that had taken place, however, two patients specifically commented no written information was given and they would have found this helpful. In some clinics, such as respiratory the specialist nurse provided patients with a contact card, so they could call the department if they had any concerns or questions after their appointment.
- Comments from patients included 'I feel well informed', 'the service was wonderful and I feel reassured after my assessment'.
- The majority of patients we spoke with either had their next appointment date when they left the clinic or knew this would be sent to them. Patients told us test results were sent to their GP who contacted them if necessary or results were discussed at their next appointment.

Emotional support

- Staff in busy clinics still took the time to offer emotional support to patients when needed. Staff were seen to show empathy and compassion to patients. In oncology outpatients, staff acknowledged the need to keep clinics

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flowing but balanced this with the patients' need for emotional support when they had received difficult news. Volunteers also helped staff by taking the time to speak with patients.

- A number of specialities, such as ophthalmology and gynaecology cancer offered support groups for patients or held open days so patients could seek additional advice and meet other patients with the same condition.
- In the GUM clinic a holistic approach was taken, with the patients' physical, social and psychological needs all considered, along with their medical needs.
- The diabetes service linked with a local charity group to offer a cycling group to encourage patients to start regular exercise to help with their wellbeing but also so patients could seek support and advice from each other.
- We observed and spoke with staff at the call centre responsible for rebooking patient appointments. They were courteous and polite when speaking with patients. Staff completed customer care training as part of their induction to help them support patients who became angry or frustrated.

Are outpatient and diagnostic imaging services responsive?

Good



By responsive, we mean that services are organised so that they meet people's needs.

We rated responsive as good because:

- Services were planned and delivered to meet the needs of the local population. Outpatient clinics and diagnostic imaging were available at community clinics as well as at the main hospital. Patients were offered a choice of appointment times, with patients finding it easy to make appointments. Once they arrived for their appointment patients told us the service they received was efficient.
- There were appropriate facilities available for patients attending appointments, including those with additional needs. Staff were mindful of how they could support patients with learning difficulties or those living with dementia and provided examples of good practice.

- Staff worked hard to keep clinics flowing, as waiting areas were not designed to meet the current demand for services.
- There were initiatives in place to keep did not attend and appointment cancellations to a minimum. These were effective and the trust achieved or performed better than national targets for these areas. The patients' access team worked hard to ensure clinic profiles were correct and patients were booked to the appropriate clinic at the correct time.

However:

- Although the trust overall met the 18 week referral to treatment time target, there were some therapy services where the wait for a first appointment was 16 weeks. The trust also did not consistently achieve the national cancer targets for patients seeing a specialist within two weeks of an urgent GP referral, nor patients receiving their first definite treatment within 62 days of GP referral.
- The environment and facilities in the waiting room at Weymouth Community Hospital needed improvement to ensure they met the needs of all patients attending outpatient clinics.
- Patients did not receive copies of clinic letters sent to their GP, to ensure they were kept informed about all aspects of their care and treatment.
- Sharing of learning from complaints with staff, was not consistent across all departments we visited.

Service planning and delivery to meet the needs of local people

- Each speciality was responsible for planning and running its outpatients service, with oversight from directorate and divisional leads. Speciality managers we spoke with identified the key needs for people accessing their service and how these were currently being achieved and managed. Managers had development plans so their service could continue to meet the needs of the local population served by the trust.
- Most outpatient clinics were held at Dorset County Hospital, with clinics also held at four community hospitals to provide a more accessible service for patients who did not live in Dorchester. Patients told us they valued these local clinics, particularly as car parking was difficult at the main hospital site.
- All outpatient areas we visited were working to maximum capacity for the size of the waiting area and the number of clinic rooms available, within the times

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when clinics were held. This was Monday to Friday, other than for diagnostic imaging, which offered appointments out of hours and at weekends. The dermatology department was considered to have 'outgrown its estate' and was included on the divisional risk register. At Weymouth Community Hospital, outpatient nursing staff told us there was not always a separate room available if they needed to provide support to a patient who had received bad news.

- Waiting areas at Dorset County Hospital, were appropriate, containing seating of different heights and some chairs with arms, for patients with mobility needs. Televisions were provided and patients and carers had access to free Wi-Fi. One patient told us the ophthalmology environment was much improved since the trust had redecorated. Each waiting area contained a water fountain and information was provided for patients on where they could get refreshments.
- In oncology outpatients, staff gave patients pagers so they could leave the waiting room for a break and not miss their appointment. Where possible children were seen for outpatients appointments at the children's centre, which had a more suitable waiting environment for them. All outpatient waiting areas we visited provided toys and activities should children attend, where the layout allowed, this area was away from the main waiting area.
- We had concerns at Weymouth Community Hospital as patients waited in corridors, on wooden chairs with no arms which made it difficult for patients with limited mobility to get in to or out of the chairs. No patient information was displayed in the out patients area. There was no canteen at the hospital for patients to use if they were there for a longer visit. However, there was a shop selling snacks and a fridge was located in an adjacent building where sandwiches and salads could be purchased. The hospital was owned by a different provider and we were told by a senior manager that discussions were taking place with them about improving the environment.
- Signage at Dorset County Hospital was not always visible, which made it difficult to locate the different outpatient areas. On some signs some of the letters were missing. Signs for the ophthalmology department were not in a more visible format, such as black text on a yellow background, to assist patients with a visual impairment.

- The trust offered 61 telephone clinics across a range of specialities including, diabetes, dietetics and urology. These helped to reduce the number of hospital appointments for patients, which was beneficial to both patients and the trust.
- At Weymouth Community Hospital a drop-in clinic was held in diagnostic imaging for patients referred by their GP who needed an x-ray. This provided patients with greater flexibility when they could attend for their appointment.
- In oncology, plans were in progress for a new onsite radiotherapy service at Dorset County Hospital, to prevent patients having to travel to Poole for their treatment. The plans also included a new outpatients area to increase capacity. The trust hoped the first stage of the work would be complete by the summer next year.

Access and flow

- The trust had a robust patient access policy and procedures manual which provided staff with clear guidance on booking of appointments and referenced national guidance on referral to treatment times.
- Between December 2014-November 2015 the trust achieved the national referral to treatment time (RTT) standard that 92% of patients on an incomplete pathway should start consultant-led treatment within 18 weeks of referral, for seven out of 12 months. It went below this target between April-August 2015 but performed better than the target for September-November 2015. The incomplete pathway looks at the number of patients who are still waiting to receive treatment at the end of each month.
- Data was available by medical speciality so departments struggling to meet the target could be identified and action taken.
- RTT data was reported on at division level for surgery, medicine and family services division as part of the divisional dashboard. Incomplete pathways that breached the 18 week wait resulted in a fine for the trust. Biweekly meetings were held with the patient access team and a representative from each division to highlight any patients which were due to breach. Action points were sent round after each meeting. Key performance indicators (KPI) were reviewed at these meetings which included, grading delays for letters, patients cancelled who had no further appointment booked and a review of choose and book referrals.

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- Physiotherapy staff raised concerns around the waiting time for new appointments. This was 14 weeks at Dorset County Hospital and 16 weeks at Weymouth Community Hospital. Staff triaged referrals so more urgent patients were seen but told us that increased demand for their service, particularly their specialist services such as hydrotherapy and musculoskeletal, combined with a shortage of staff had increased the waiting times. A review was taking place of the service to look at the skill mix of staff and working hours..
- Across the trust the percentage of patients waiting more than the national target of six weeks for a diagnostic test had been below (better than) the England Average of 2% since October 2014.
- Between April 2015-February 2016 the percentage of patients seen within two weeks of GP referral for suspected cancer ranged from 78% to 99%, with an average of 93%. The trust did not consistently achieve the England average of 95%, or the trust target of 93%. This had impacted on the trust achieving the target of 85% of patients waiting less than 62 days from urgent GP referral to first definitive treatment. However, over the same time period the trust had performed better than the England average of 98% and the trust target of 96%, for the percentage of patients waiting less than 31 days from diagnosis to first definitive treatment, with an average of 99%. Performance to these targets was discussed at the cancer speciality meetings, with additional clinics held where possible.
- New patients could book appointments using the Choose and Book system for those clinical specialities that used this system. A consultant or clinician reviewed all new appointment letters to ensure the patient had been allocated to the most appropriate clinic. Some consultants reviewed referrals online to improve the speed for the patient receiving their appointment letter. The trust target was for a new appointment letter to be sent to the patient within 10 days of the referral being received. No performance data was available on whether this target was met.
- We observed and spoke with staff at the call centre responsible for rebooking patient appointments. The service ran Monday to Friday, during office hours, there were no plans to run the service at weekends. The manager could monitor the number of abandoned calls, total calls and longest time a caller had been waiting. This went red after approximately a minute; if other staff were available they would answer calls. KPI data was being developed for this team.
- Patients told us that the availability of appointments was good and appointments were provided at times that met their needs. Patients were complimentary about the efficiency of the service as a whole.
- The orthodontic service structured their clinics to ensure appointments were available in school holidays, as they regularly saw teenagers. This minimised the impact on their schooling, as they often attended the service for a number of years.
- There were rapid access clinics for patients with chest pain and transient ischaemic attack. Hot clinics were provided for patients needing prompt medical care but who did not need admission to hospital and to avoid patients attending the emergency department.
- The follow-up to new ratio across the trust was in keeping with the national average of 2.5:1. A low ratio meant greater availability of appointments for new patients, with fewer follow-up appointments for patients where clinically possible.
- All outpatient waiting areas had boards advising patients of any delays to the clinics which were running. We observed in four departments these boards being updated and where there were significant delays, staff took the time to speak with patients to keep them informed. Reception staff also advised patients of delays when they arrived.
- The trust told us that data was not captured on the number of patients seen within 30 minutes of their appointment time. However, this information was contained within the division dashboards for surgery and medicine. The target was 90%, both divisions were below this target between April 2015-February 2016, averaging 80%, however, the percentage of patients for whom the time seen was recorded on the appointment system was low at 12%. There needed to be an increase in compliance with this to make the data more meaningful.
- Two patients and the outpatients nursing staff from both hospitals raised concerns about patients using hospital transport arriving late for appointments or being collected more than an hour after their appointment had finished. Hospital transport was provided by a different organisation. Staff were not aware of any local audits so this information could be

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shared with the provider. Information from the trust identified an action plan was in place and staff had reported some incidents where transported had been delayed. .

- We were concerned that nursing staff told us there had been two instances where patients were left alone in a waiting area as staff had gone home, prior to hospital transport arriving. Staff told us these had not been reported as incidents. Patients should be taken to a ward but this did not always happen.
- The 'did not attend' (DNA) rate across the trust between July 2014 to June 2015 was low at 6%. This was better than the national average of 7% over the same period. Text message reminders were sent to patients to help minimise DNA rates and enabled contact with those patients with no fixed address. Also, in diagnostic imaging, ultrasound patients were called two days prior to their appointment to encourage attendance. This had reduced their DNA rate from 4.6% to 2.6%. Some departments such as orthodontics audited their DNA rate, but staff were not aware of these audits in every department we visited, such as in orthopaedics, oncology or at Weymouth Community Hospital.
- The patient access team had within the last month introduced sending follow-up appointment letters to patients via email. Patient consent was sought and a standard operating procedure was in place to ensure risks around information governance were managed appropriately. The team planned to audit the uptake of this service once it had been running for a number of months.
- The trust wide cancellation rate, between August-November 2015, for appointments more than six weeks away was low at 2%, with 0.6% of appointments cancelled within six weeks of the appointment date. This generally was due to the clinician becoming unavailable at short notice. Staff were required to give six weeks' notice for booking of annual leave, teams managing clinic cancellations felt this was adhered to.
- The trust had introduced partial booking for a number of specialities including ophthalmology. If a patient required an appointment more than six weeks in advance they were added to the outpatient waiting list. Patients were advised of this as they left their appointment, or were sent a letter if they were a new patient. As clinics were released patients were added from the list to the clinics. This helped reduce the number of appointment cancellations and provided a

more efficient service for patients. We saw that patients were prioritised on the outpatient waiting list and comments could be included if the patient needed to see a particular doctor. If patients could not be booked close to their required appointment date, staff from the clinic management team escalated this to senior managers and action was taken.

- An outpatient redesign programme had started in January 2016. This was reviewing outpatient clinic utilisation, consistency of appointment booking across specialities and management of DNA's or cancelled appointments to improve access to appointments for patients.

Meeting people's individual needs

- Staff in outpatients and diagnostic imaging recognised the need for supporting people with complex or additional needs and made adjustments wherever possible. Information was provided on the trust website about support for patients with additional needs and new patients were asked to contact the hospital prior to their appointment if they needed any extra help.
- Staff could access an interpreter through the language line facility, this enabled them to support patients for whom English was not their first language. Staff told us this system worked well. It was also possible to book an interpreter. Staff in outpatients at Weymouth and in oncology outpatients told us family members sometimes provided interpretation. This was not in keeping with trust policy, which advised friends or family should only be used when the patient had declined an independent interpreter and specifically requested an adult carer or friend to interpret.
- All written information, including pre-appointment information, was provided in English. Leaflets did not include information on how to access the information in other formats, such as large print or braille, other than in the GUM clinic. However, this information was available in other formats on request. The patient access team could also print patient letters in large print if notified by a member of staff. This was then added as a flag on the patient appointment system. A sign language interpreter could also be arranged for patients who had a hearing impairment.
- Patients were not routinely asked if they would like a copy of the clinic letter sent to their GP for them to refer to after their appointment or so they could share this with other services as needed. The exceptions to this

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were the orthodontic and genitourinary (GUM) clinics. In the GUM clinic, staff asked patients as part of their registration if they would like a copy of their clinic letter. We reviewed 21 sets of notes in the main surgery and medicines outpatients, 18 of these did not copy the letter to the patient.

- There was a dementia champion for each outpatient area, staff had all completed Level 2 dementia awareness training and three out of five had completed Level 3, a requirement for the role. The other staff had yet to have a date identified for this training.
- In ophthalmology and diagnostic imaging, family members or carers of patients living with dementia were provided with appropriate personal safety equipment so they could stay with the patient during treatments, such as laser or X-rays, to offer reassurance and support.
- The layout of the departments we visited meant all areas were accessible for people in a wheelchair or with limited mobility. In physiotherapy and diagnostic imaging there was specific equipment to enable bariatric patients to access these services and receive care and treatment.
- In diagnostic imaging, children watched a video of their choice during nuclear medicine scans to improve compliance during the scan
- The patient access team booked a double appointment slot for patients identified as having a learning disability, to provide additional time for the appointment. A flag was added on the patient appointment system to make staff aware of this need. Where possible patients were seen at the beginning or end of a clinic. Patients and their carers could attend for a preview visit so the environment was more familiar at the actual appointment. Staff also described how they adapted their approach when seeing patients with a learning disability to improve communication and engagement.
- The genitourinary medicine clinic ran clinics at the local prison and in community settings, to increase the number of people who could access their services. They also offered screening and support services at events for lesbian, gay, bisexual and transgender people to encourage people to access their service in a non-threatening environment. The GUM service worked jointly with the local child and adolescent mental health service, to support young people with learning

difficulties, as they were more vulnerable to harm and needing psychology support. A psychologist was available to patients at the GUM clinics providing valuable support and health advice.

Learning from complaints and concerns

- The hospital had an up-to-date complaints policy, with a clear process to follow to investigate, report and learn from a complaint. There were 105 complaints received for outpatients and diagnostic imaging between January-December 2015. Twenty-one of these were for ophthalmology, 15 for orthopaedics and nine for urology. The remainder were spread across other departments. In response to some complaints in ophthalmology a partial booking system was introduced to reduce the number of cancelled and rebooked appointments.
- The trust target for responding to complaints was 20 days for formal complaints and 25 days or more for complaints categorised as complex, the response time was discussed and agreed with the complainant. Divisions reported on and monitored the number of overdue responses each month as part of their divisional dashboard data.
- Learning and action from complaints was documented at trust and division level. Some frontline staff told us they did not regularly receive feedback from learning from complaints at team meetings. Staff felt this was because there were few complaints for their service or staff on duty dealt with them informally at the time, without them escalating to a formal complaint. Although, we saw from minutes and talking with staff that this did occur in the dermatology, fracture and pathology departments.
- Information for patients on how to leave feedback or make a complaint was provided in waiting areas. Patients told us they would speak to a member of staff if they had concerns but none of them had made a complaint as their care had been good. We saw in a number of departments, thank you cards from patients displayed, this included for staff in the patient access team, who were not a visible service to patients.

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Are outpatient and diagnostic imaging services well-led?

Requires improvement



By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation and promotes an open and fair culture.

We rated well-led as requires improvement because:

- Governance, risk and quality monitoring were not fully embedded across each speciality or division. There were inconsistencies in the way information was recorded and reported. There were areas of good practice for monitoring and using data on service quality but this was not consistent and good practice had not been shared across departments or divisions. Senior managers acknowledged improvements were needed and had started to address this.
- Risks registers were in use at local, directorate and division level but these were not always complete and some risks remained in place after a couple of years, with little progress, even if risks had been escalated. Some risks we identified during the inspection were not on the risk register.
- There were no systematic processes to oversee overall quality and the identification and management of risks and learning across outpatients services.
- Staff, particularly at Weymouth Community Hospital, felt there was lack of visibility of senior managers and members of the executive team to outpatients and diagnostic imaging. Staff at Weymouth felt disengaged and concerns about the outpatients department were not always recognised or understood.

However:

- There was a clear vision for each division and those specialities we visited. We saw at division level, strategies were in place to help achieve their vision, with mitigating actions for any risks.
- Staff were positive about the leadership of the teams they worked for. They had confidence in their managers and felt well supported by them. They described a

positive culture and enjoyed coming to work at the hospital. They felt the team working was a real strength and enabled their service to offer a good standard of care to patients..

- The trust had started to use experience based design in some specialties to seek the views and work collaboratively with patients and staff to make improvements to services. We saw examples of changes departments had made to improve the overall patient experience.
- Staff were positive about how they could develop and improve their service and felt able to contribute their ideas.

Vision and strategy for this service

- The trust launched new values of integrity, teamwork, respect and excellence in February 2016. Some staff we spoke with were aware of these new values and they were displayed in staff rooms as a reminder for staff.
- As outpatients and diagnostic imaging services were integrated within the division for their speciality, there was no specific vision for the entire outpatients service. However, An outpatients transformation programme had started in January 2016, with the vision of aim of achieving 'a successful outpatients service that meets the needs of patients, GPs and staff, and supports the delivery of referral to treatment times'. A member of the senior management team was overseeing the project, with local leads for each speciality involved in the project, this included ophthalmology, gastroenterology and dietetics. Key metrics had been set up, along with a reporting structure so progress with the programme could be monitored. More junior staff we spoke with were not aware of the transformation programme or what it hoped to achieve, however, the final details for the project had only recently been confirmed.
- Diagnostic imaging, orthodontics and orthopaedics had their local vision displayed in their waiting room for patients and visitors to read. In other departments, managers told us what the vision was for their service and how they hoped to achieve this, for example, 'to have the best ophthalmology service in the south west', 'to provide excellent care and treatment to patients' attending orthopaedics.
- Each division had a vision and associated strategy for achieving this vision for the forthcoming financial year, which included the outpatients services they provided. The strategy clearly identified both the financial and

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clinical risks and how these could be mitigated against. Each strategy was written based on the service provided for patients, but the focus did not always come across as person-centred care, more achievement of targets.

Governance, risk management and quality measurement

- Management of governance, risk and quality was not to the same standard across each speciality in outpatients and diagnostic imaging, nor each division. The trust had commissioned an external review of its governance processes which was presented to the board of directors meeting in March 2016. This recommended the need for a continued development of governance but with a particular focus on the reporting of service quality. There needed to be the development, reporting on and use of this information to help monitor and develop services. The information also needed to be standardised across each service.
- A service dashboard was in use in ophthalmology, to monitor key service quality indicators such as referral to treatment times (RTT), number of complaints and friends and family test responses against the trust targets. The trust planned to introduce this in other specialities.
- Divisional dashboards were in use, but the clinical and scientific division dashboard was in a different format to the other three divisions and did not contain the same information on service quality. This division included therapy service and diagnostic imaging, who reported on waiting times for appointments at service level. A quick comparison on outpatient performance and quality, such as RTT times, was not possible across all four divisions. Although this division contained a number of discrete specialities, the relevant components contained within the other divisional dashboards had not been used. The outpatient transformation programme intended to improve the quality and reporting of data.
- We saw examples of good practice for reporting of risk, governance and quality at speciality clinical governance meetings in diagnostic imaging, orthodontics, and pathology. The minutes from the clinical governance meetings for the genitourinary medicine (GUM) clinic were particularly robust. However, agendas and minutes from divisional business and clinical governance meetings, which included discussions on their outpatient services, were not all to the same format, for ease of reporting to senior management and the trust board. Each division seemed to be working in silo, with no evidence of sharing of good practice between divisions or consideration of the overall quality of the whole outpatients service.
- We reviewed the risk registers for eight outpatients specialities, two directorates and for each division. Risks for outpatients which were rated as high had been added to the directorate and if necessary the division risk register, for additional monitoring. All risk registers were the same format but some of the detail around the individual risks had not been completed, such as the risk rating, progress made to date. It was therefore not possible to see how the risk was being managed. A number of outpatients risks had been on the risk registers since 2014, with little progress made. This was particularly the case for ophthalmology. There had been a specific action plan for this department, with reporting to the sub-trust board committee due to the level of concern. The service and directorate had worked hard at addressing a number of the risks such as capacity for the service and frequent cancellation of appointments. The delay in typing patient letters in haematology and lack of storage for patient notes in oncology were not on the relevant divisional risk registers.
- Standard operating procedures (SOPs) were not in use across all outpatient services, which caused a potential risk for new, agency and locum staff. This was highlighted in the radiation protection adviser report for diagnostic imaging, although the department was taking action to address the concerns raised in the report; and also on the head and neck directorate risk register for ophthalmology. However, we saw SOPs in place for staff to follow in patient access, pathology and orthopaedics.
- There were additional concerns around governance as we reviewed two records policies, both were out of date, dated 2013, with adherence to these policies not being monitored as stated in the policy. The trust were not adhering to their own governance systems to monitor quality and standards nor policies kept up-to-date.
- The World Health Organisation surgical safety checklist was completed but not audited in each department using it. Also, staff did not always report incidents as they did not receive feedback or feel action had been

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taken into the concerns they had raised. This included staff not reporting delays with patient transport, therefore, this quality and performance information was not audited or shared with the provider of this service.

- Staff did not know some of the data quality information which were collected across the trust such as did not attend rates, Friends and Family test results. The information was not routinely shared with them.

Leadership of service

- There was a lead for radiology and outpatient leads within specialties and divisions. Staff in outpatients and diagnostic imaging were positive about their departmental managers, telling us they were approachable and visible and they could speak to them about any concerns they had. Those with a managerial role told us they felt well supported by their immediate manager but further support from within the directorate or division they worked within was not always forthcoming.
- A reoccurring comment from staff interviews and focus groups was the lack of visibility of divisional senior managers or trust executive team within outpatient and diagnostic imaging, particularly at Weymouth Community Hospital. The action plan for the 2015 staff survey identified the need for senior staff to be more visible across the trust, with some additional visits having taken place. Outpatients staff felt their role or the challenges their service faced were not fully understood as the focus was on inpatient services. Equally, some staff felt the success and achievements of their services were missed.
- Staff appreciated receiving the weekly email newsletter from the chief executive and staff at Weymouth Community Hospital told us this helped them to feel connected with the trust. However, team leaders told us it was not always possible for them to attend meetings at the Dorchester site as travelling time was not considered when lunchtime meetings were held and they had clinical commitments as well.
- The pathology service nominated members of staff to enrol on the trust management training scheme to encourage staff development and develop leadership skills within their service.
- Physiotherapy staff found it difficult to express concerns about delays in appointments due to having no service manager for the last two years, although there was a head of therapies in place over this time period. They

felt the service lacked overall strategic leadership, although day-to-day concerns were managed. However, evidence from the trust showed how staff were supported over this period, whilst a review of therapy services was also taking place.

- Three team leaders raised concerns that increased demand for their service and staff vacancies had reduced their administration time. They had covered shifts to minimise the impact on patient care and treatment and support the staff in their team.
- The trust offered leadership training to staff, which they accessed through the appraisal 'talent mapping' process.

Culture within the service

- The majority of staff we spoke with felt respected and valued. Staff commented how everyone worked well together and supported each other. Staff told us they were proud of the services they worked for and when they had 'challenging days' the teamwork was a real strength.
- Specific comments included 'staff are committed and work above and beyond', 'we all help each other' and 'we give a high standard of care, with the resources we have'.
- Staff told us the trust were already making changes across services but the speed of change had increased due to the inspection, they felt this was a positive as ultimately it benefited the patients.
- In diagnostic imaging, staff valued the support from the chaplaincy service, who offered a debrief session for staff involved in upsetting and difficult cases.
- There was a process in place to support staff working in the patient access team, who were verbally abused by patients during calls. Staff also completed customer care training to help them manage patients who became angry or frustrated.
- Outpatients staff at Weymouth Community Hospital felt disconnected from the wider trust and felt their service was not always considered. However, they enjoyed working at the hospital and all supported each other.
- Moral was low amongst staff in the physiotherapy service due to lack of local leadership, inability to provide the service they wished to offer patients and a recent review of all therapy services. Service leads were mindful of the impact on staff wellbeing and knew this needed to monitor this.

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- Data for January-December 2015, for staff vacancies, turnover and sickness rates for nursing staff and additional clinical services staff only working in outpatients and diagnostic imaging was low overall. In areas where there were higher rates, action had been taken as documented throughout this report.

Public engagement

- Some but not all services were using questionnaires to seek patients' feedback and develop their service in addition to the Friends and Family test data collected. Staff seemed unsure how patients' feedback was being captured and reported on, although the trust provided evidence how this was shared through newsletters..
- Multiple services within the trust used The oncology and diagnostic imaging services had both used experience-based design methodology to collect the thoughts, feeling and experiences of patients, their carers and staff along with ideas for service development. Changes made included the use of buzzers in chemotherapy so patients could leave the department until it was their turn, improved communication between trusts for patients having radiotherapy and the need to ensure patients were fully informed about their condition and their planned pathway. In diagnostic imaging two new reception staff were employed to ensure someone was there to welcome patients in the evenings and at weekends. A member of the senior management team told us the trust planned to introduce this approach across more services.
- At Weymouth Community Hospital, no information was displayed on the WOW awards recognition scheme should a member of the public wish to nominate a member of staff.

Staff engagement

- We saw minutes from and staff told us they had team meetings where they felt they had chance to raise concerns. These were multi-disciplinary for some services such as orthodontics and ophthalmology but this approach was not consistent to ensure all staff involved in a service met together. Teams often met as staff groups rather than by service speciality.
- The trust recognised the hard work off staff through long service awards, WOW awards and Going the extra mile (GEM) awards. A number of teams and staff within

outpatients and diagnostic imaging had been nominated for and won awards. Certificates were on display in departments and information was on the trust website.

- There was a 'bright ideas' project where staff could submit ideas for improving services across the trust. None of the staff we spoke with commented on this project and therefore greater publicity and engagement was needed, as staff were keen to make the trust an excellent place to work.
- For almost all the questions in the NHS Staff Survey 2014 staff gave similar ratings to staff in other trusts. They rated one question below the national average, and that was for 'Fairness and effectiveness of procedures for reporting errors, near misses and incidents'. This finding was consistent with comments from staff about feedback when they reported an incident. The trust used a had recently introduced a 'Risky Matters' monthly newsletter to communicate with for staff about learning from incidents.
- Trust-wide results for the staff friends and family test, for July-September 2015, showed 59% would recommend the trust to friends and family as a place to work, with a response rate of 11%. The trust was slightly below national figures with 63% of staff recommending their trust as a place to work and a national response rate of 12%. The trust results had been consistent over the last year.
- The most recent trust wide staff Friends and Family test results for July-September 2015, showed 80% of all staff would to recommend the trust as a place to receive care or treatment, which was in keeping with the national average of 79%, but below the trust target of 85%.

Innovation, improvement and sustainability

- Across the teams we visited, there were plans either in place or in development showing how teams planned to improve and develop their service to improve the care provided to patients.
- This included the introduction of a new training programme for assistant practitioners in diagnostic imaging and the development of nurse practitioner roles in ophthalmology and ear, nose and throat (ENT), to increase the number of patients which could be seen.
- The ENT and orthopaedics departments were considering how to introduce virtual clinics, to reduce the number of appointments patients had to attend for,

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with consultants reviewing results and the patient then being contacted with the outcome. At present, all patients attended the fracture clinics for follow up although all patients may not require a follow up.

- The orthopaedic clinics were trialling new product which would benefit patients and replace use of back slab as same plaster could be used throughout their treatment.
- Cost improvement programmes had been developed by each divisional team, with consideration given to the impact on patient care and treatment. The introduction of the patient access team sending follow-up letters by email was recognised as a cost saving.
- The trust aspired to taking more service into the community and worked with other providers and services to consider how they could integrate care. The diagnostic and imaging service were part of the Dorset Acute Care Vanguard project, with the intention of achieving a Dorset wide imaging service, which had accreditation by the Imaging Services Accreditation Scheme.

Outstanding practice and areas for improvement

Outstanding practice

- The hospital@home service provided a valuable service supporting medically fit patients to have earlier discharges to their homes. This service was provided 24/7 and helped improve access and flow in the hospital as well improve outcomes for patients.
- The support for renal dialysis patients was outstanding, with individualised care for patients to receive home dialysis and holiday dialysis when appropriate and safe.
- The genitourinary medicine service was a well-led, patient focused service that had identified the needs of the patient groups it served, many of whom were vulnerable. There was excellent multi-disciplinary working with external agencies and robust clinical standards in place, which they service audited themselves against, always looking for how they could improve the service. Outpatient clinics and advice sessions were held, where possible, at venues that encouraged attendance from patients who had the greatest need for the service but could not or found it challenging to attend a hospital.
- The two bereavement midwives made home visits following a stillbirth or neonatal death. They made follow up visits to tell the parents post-mortem results in person and offered to provide antenatal care for women in any subsequent pregnancy. They also set up the monthly 'Forget Me Not' bereavement support group in a local children's centre. They set up and closely monitored a private social media page for women who had lost a baby during pregnancy or after birth.
- A gynaecology specialist nurse ran the 'Go Girls Support Group' along with a former patient, to provide support for women diagnosed with a gynaecological cancer.
- Midwives ran specially designed antenatal, breastfeeding and smoking cessation sessions for 'Young Mums'. They were also offered separate tours of the maternity unit.
- There were several examples of patient involvement in the codesign and improvement of services and excellent use of experience based design (EBD) methodology.

Areas for improvement

Action the hospital MUST take to improve

The hospital MUST ensure:

- All equipment is clean and fit for purpose and ready for use in the emergency department.
- A clear process must be implemented to demonstrate the mortuary trolley has been cleaned, with appropriate dates and times recorded.
- The five steps to safer surgery checklist is appropriately completed.
- The management and administration of medicines always follows trust policy.
- Patients in the minor operations room (used as a majors cubicle) in the emergency department have a reliable system in place to be able to call for help from staff.
- There are sufficient therapy staff available to provide effective treatment of patients.
- The numbers of nursing on duty are based on the numbers planned by the trust all times of the day and night to support safe care.
- Sufficient palliative care consultant staffing provision in line with national guidance and to improve capacity for clinical leadership of the service
- The number of midwives is increased according to trust plans and in line with national guidance, to support safe care for women.
- Staff attend and complete mandatory training updates.
- Turnaround times for typing of clinic letters are consistently met, monitored and action taken when targets are not met across all specialities within the trust.

Outstanding practice and areas for improvement

- All patient records must be stored securely to maintain patient confidentiality Risk registers at local, directorate and divisional level are kept up-to-date, include all factors that may adversely affect patient safety. And progress with actions is monitored.
- There is implementation of clear and measurable action plans for improving end of life care for patients. There is monitoring and improvement in service targets and key performance indicators, as measured in the National Care of the Dying Audits.
- Care and treatment in all services consistently takes account of current guidelines and legislation and that adherence is audited.
- Consultants supervise junior registrars in line with RCOG guidance.
- Continued to development of governance processes across all specialties and divisions, with a standardised approach to recording and reporting. Ensure the information is used to develop and improve service quality.
- Regular monitoring of the environment and equipment within the emergency department, and action taken to reduce risks to patients.
- Mixed sex breaches in critical care must be reported within national guidance and immediately that the breach occurs.
- A recognised pain assessment tool is used in critical care to assist in the monitoring and managing pain for patients.
- Pain score appropriate tools are used for non-verbal patients across the hospital.
- Discharge letters are sent to GPs in a timely way and patients are given a copy.
- Standards of cleanliness are maintained in all outpatient areas.
- Patient outcome data is recorded and analysed to identify improvements to clinical outcomes for patients.
- Staff working in outpatients always follow the trust interpretation policy for patients who are non-English speaking.
- Nurse staffing on the children's unit is reviewed in line with The Royal College of Nursing (2013) guidelines in terms of numbers or ratios of nurse to healthcare assistants.
- Compliance with Facing the Future-Standards for acute general paediatric services (RCPCH, Revised 2015) requirements for consultant paediatrician present and readily available during the times of peak activity, seven days a week.
- Review of medical staffing in line with British Association of Perinatal Medicine (2010 Standards) requirements for sufficient medical staff on the neonatal unit at all times, including overnight (9pm to 8am).
- Increased compliance with recording of key metrics in outpatient services, such as the time the patient is seen, to enable data analysis to be more meaningful when used to monitor service quality.
- Daily recording of data on missing notes for outpatient clinics, which is audited and actions taken.
- Face-to-face specialist palliative care service, 7 days per week, to support the care of dying patients and their families.
- The critical care unit access is secure to maintain infection prevention and control and the safety of vulnerable patients on the unit.

Action the hospital SHOULD take to improve

The hospital should ensure:

- All staff report incidents, feedback is given to the member of staff reporting the incident and learning is shared with staff and across teams when relevant
- The trust electronic incident reporting system is fully implemented throughout the surgical specialty
- Management and specialist staff have the time to undertake their roles
- Resuscitation trolleys are tamper evident.
- Staff follow trust procedures when patient group directions are updated, so it is clear they are authorised for use.
- Increased compliance with recording of key metrics in outpatient services, such as the time the patient is seen, to enable data analysis to be more meaningful when used to monitor service quality.
- Daily recording of data on missing notes for outpatient clinics, which is audited and actions taken.
- Face-to-face specialist palliative care service, 7 days per week, to support the care of dying patients and their families.
- The critical care unit access is secure to maintain infection prevention and control and the safety of vulnerable patients on the unit.

Outstanding practice and areas for improvement

- The development of critical care 'follow up' clinics, in line with national guidance, in consultation with stakeholders and commissioners.
- All maternity guidelines are reviewed to ensure they are up to date
- Pregnant women's mental health is assessed throughout pregnancy using a tool as recommended by NICE 'Antenatal and Postnatal Mental Health' guidance.
- The use of a NICE recommended CTG evaluation tool which should be entered into the woman's notes every time the trace is reviewed.
- The use of a software package, with an individualised growth chart designed to more accurately detect foetal growth problems which are associated with stillbirth.
- The development of a midwifery led birthing unit, in line with National Maternity review recommendations.
- The use of the modified 'Sepsis 6 care bundle' in the maternity units.
- The use of the Stillbirth Care Bundle developed by NHS England to ensure that all known measures are taken to reduce the chances of stillbirth.
- Improved rates of dementia screening to ensure that all emergency admissions over 75yrs are screened and then appropriately assessed.
- A robust system to support lone workers in the community.
- Identify and develop a quality dashboard to monitor the quality of the services.
- Governance arrangements provide sufficient overview of the quality and risks across outpatient services.
- Implementation of nursing staffing acuity tool in child health.
- Supervision for staff involved in children's safeguarding.
- The arrangements for children attending appointments in general outpatient clinics are reviewed
- All staff caring for dying patients undertake mandatory training in end of life care, so that they have the necessary knowledge and skill to deliver end of life care in line with the 'achieving the five priorities for care of the dying person'.
- Cleaning between cases in day surgery is sufficient and there are effective arrangements to prevent cross infection.
- Nursing handover on Day Lewis ward are arranged to respect patients' privacy and dignity.
- There are arrangements for more timely discharges earlier in the day (before lunchtime) and more effective use of the discharge lounge by all ward teams.
- The emergency department environment is reviewed to make it more child friendly.

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

Diagnostic and screening procedures
Maternity and midwifery services
Surgical procedures
Treatment of disease, disorder or injury

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulation 12(1)(2)(b)(c)(g)(i)

How the regulation was not being met:

- Nationally recognised best practice guidance was not always followed in obstetrics and gynaecology.
- Medicines were not always managed safely and in line with current regulation.
- Five steps to safer surgery checklist was not always fully completed
- Consultants did not always supervise junior registrars in line with Royal College of Obstetricians and Gynaecologists guidance.
- There were delays in clinic letters being typed and sent to GPs in a number of specialities, including cardiology, haematology and dermatology. Delays ranged from five to nine weeks. There was a clinical risk to patients as GPs were not aware of changes to treatment.

Regulated activity

Diagnostic and screening procedures
Treatment of disease, disorder or injury

Regulation

Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises

Regulation 15 (1)(a)(b)(c)(e)

How the regulation was not being met:

- Suitable arrangements were not in place in relation to infection control procedures and maintenance of the mortuary trolley.
- Patients in the minor operations room in the emergency department had no means of calling for assistance.

This section is primarily information for the provider

Requirement notices

- Equipment in the emergency department was damaged, in some incidences had not been cleaned.
- There was damage to the fabric of the environment of the emergency department.
- There was not a patient call bell system in all treatment areas used as cubicles in the emergency department

Regulated activity

Diagnostic and screening procedures
Maternity and midwifery services
Surgical procedures
Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulation 17 (1)(2)(a)(b)(c)

How the regulation was not being met:

- Patients' records were not complete and contemporaneous due to delays in clinic letters being typed. Information relating to decisions on care and treatment was not always available.
- There was a secondary information governance risk as patient records were not stored securely in all areas of the hospital.
- Governance processes to assess and monitor and improve service quality were not consistently used and embedded across departments, directorates and divisions.
- Insufficient systems to assess, monitor and improve the quality of the EOLC services provided.
- There was not systematic monitoring of all equipment and the environment in the emergency department, to identify and manage risks to patients.
- Risk registers were not all kept updated to reflect all factors that might adversely affect patient safety, with actions to mitigate risks.

Regulated activity

Diagnostic and screening procedures
Surgical procedures

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

Regulation 18 (1) (2)(a)

This section is primarily information for the provider

Requirement notices

Treatment of disease, disorder or injury

How the regulation was not being met:

- There was insufficient medical cover, at consultant level, for end of life care services across the hospital.
- There were not always enough nursing, midwifery, therapy and medical staff with the right skill mix to provide safe care. Staffing levels had been reviewed, but changes to staffing levels identified as necessary from the reviews had not been fully implemented at the time of the inspection.
- There was low compliance with mandatory training updates in some staff groups.