

North Bristol NHS Trust

# Southmead Hospital

## Quality Report

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

### Ratings

#### Overall rating for this hospital

Requires improvement



Urgent and emergency services

Good



Medical care (including older people's care)

Requires improvement



Surgery

Requires improvement



Critical care

Good



Maternity and gynaecology

Good



End of life care

Requires improvement



Outpatients and diagnostic imaging

Requires improvement



# Summary of findings

## Letter from the Chief Inspector of Hospitals

We carried out this focused inspection of the North Bristol NHS Trust to follow up on the areas that were rated as inadequate and requires improvement in our inspection in November 2014. Because we rated children's services as good in November 2014 we did not inspect them. All services had been rated as good for caring in November 2014 so we did not reinspect this area, although we observed how people were cared for during the inspection.

The announced part of the inspection was carried out on 8, 9 and 10 December 2015 and the unannounced part of the inspection was carried out on 16 December 2015.

Overall we saw improvements had been made at this hospital, although the rating remained requires improvement.

Our key findings were as follows:

### Safety:

- Although we rated safety as requires improvement at Southmead Hospital, improvements had been made.
- There were significant improvements within safety in urgent and emergency care services, with patients now receiving timely assessment on arrival.
- Systems for investigating incidents were embedded in most areas. However, improvements were required in end of life care as not all incidents had been reported, for example, those from mortuary and bereavement services.
- There had been a review of nursing and midwifery staffing in all areas of the hospital and numbers had increased in urgent and emergency care, medical services, critical care, surgical services and maternity services.
- In places this increase in numbers had been through the recruitment of staff requiring development and in most places, notably urgent and emergency care and critical care, training and development support had been put in place. However, in the theatre department, improvements were required in ensuring that new staff were developed sufficiently to support the flow of patients through theatre lists.
- Wards and departments were visibly clean, and equipment had 'I am clean stickers' on them. Staff were observed to observe the 'bare below the elbows' policy in the trust. Handwashing facilities were readily available at the entrance to each ward and alcohol hand sanitising gel was available. Staff were seen to be using the personal protective equipment (gloves and aprons) in all areas.
- The hospital did, however, have higher than expected levels of *Clostridium difficile* infections and MRSA infections reported.
- Following a *Pseudomonas aeruginosa* colonisation in the critical care department, the trust reviewed the cleaning regimen and replaced all of the tap faucets in the department. A full investigation was undertaken and actions identified to prevent further incidents occurring.
- A new electronic records system had been implemented in the month prior to our inspection. Although training and support had been put in place for staff, some were hesitant and found the system difficult to navigate. The new system involved more steps for emergency department staff to complete when a patient attended the department and this was having an effect on the time taken with each patient.
- In most areas of the hospital, paper records were stored securely. However, in the theatre department and outpatients areas, some were stored in rooms which were not secured.
- Improvements had been made in medicines management. However, some controlled drugs cabinets were not of sufficient size to accommodate all medications and in surgical services it was not clear if the temperatures of medicines fridges had been checked or actioned if outside of range.

### Effective:

- We rated the overall effectiveness of services in the hospital as requires improvement. However, improvements had been made in urgent and emergency care services, which we rated as good.

# Summary of findings

- Across the hospital there was involvement in audit and benchmarking both internally and externally. There were clear links to improvement in care within most areas. However, within end of life care the results of audit and monitoring had not yet enabled objective improvements in quality.
- Improvements had been made in supporting staff within their roles, through the appointment of nurse education practitioners and education programmes in the emergency department and in critical care. Further support was required in the theatre department for newer staff.
- Staff appraisals were undertaken across the hospital, but improvements were required within medical services.
- In urgent and emergency care and surgical services assessments of patient need were clearly undertaken and recorded within patient records. However, within medical and end of life care services assessments were not always complete or recording the full range of patient needs. Within medical services this was due to omissions in the completion of the electronic patient record via the new electronic recording system.
- Within medical services there were omissions in the assessment and documentation of patient capacity to consent to care and treatment. Within end of life care staff completing do not attempt resuscitation documentation were not always recording in line with the Mental Capacity Act 2005 Code of Practice.
- Throughout the hospital we saw patients receiving timely pain relief.
- Patients' nutrition and hydration was well managed in all areas, including the emergency department where housekeeping staff provided regular hot drinks rounds.

## Responsive:

- Although there was a trust wide focus on patient flow within the hospital and improvements had been made this still required improvement. Bed occupancy within the hospital was consistently high at 96% and within critical care was above 80%. Research has shown that bed occupancy of both 85% (and above 70% within critical care services) could start to affect the quality of care provided to patients.
- The four hour standard, within the emergency department, to admit or discharge patients to the hospital had been achieved for a three month period between June and August 2015. However this had deteriorated from September 2015 and in November 2015 only 82% of patients met this standard.
- There was a high level of delayed transfers of care which was frequently above 100 patients per day and at the time of the inspection was 114. However, there had been significant work undertaken since the inspection in November 2014 to facilitate patient discharges. This included the implementation of an integrated discharge lounge in October 2015. There was a focus on embedding discharge pathways and gaining pace in discharge activity.
- Within surgical services there was not timely access for patients to treatment and operations. There were long waiting times, delays and cancellations ongoing. Action to address this was not always timely or effective and had resulted in a high number of complaints. The trust performed worse than the England average for most national standards, this included the Admitted Adjusted Referral to Treatment time (where the time from referral to treatment should be less than 18 weeks). The trust was also not meeting standards for referral to treatment pathways within outpatient services.
- The number of cancelled operations was worse (higher) than the England average and the percentage of patient not treated within 28 days of a cancelled operation was above (worse than) the England average.
- This had an impact on the critical care unit which had a high number of delayed discharges from the unit and the length of stay for patients was higher than the NHS national average. This was not optimal for patient social and psychological wellbeing.
- Within maternity services, 'flow midwives' had been introduced to provide an overarching approach to flow within the service. This enabled midwives to focus on providing direct patient care. Although bed occupancy remained high within maternity services (excluding the central delivery suite) this had improved flow within the service.
- The needs of patients with complex needs were well understood within all areas of the hospital. Patients with dementia received care and treatment that was sympathetic and knowledgeable. The work undertaken by the dementia care team within medical services was seen as outstanding. There were 100 dementia champions within the trust (including the director of facilities) and a focus on environmental changes to support patients.

# Summary of findings

- Useful information was provided to patients and visitors and communication aids including interpreters was readily available.
- Complaints were dealt with in line with trust policy. It was easy for people to complain or raise a concern and they were taken seriously when they did so. Improvements were made to the quality of care as a result of complaints and concerns.

## Well Led:

- Improvements had been made in leadership across the hospital. In urgent and emergency care and medical services we rated the well led domain as good. However, we rated the well led domain in surgical and end of life services as requires improvement.
- There was strong clinical leadership within urgent and emergency care services which had led to improvements in safety, effectiveness and some improvements in the responsiveness of the emergency department. The vision and values were clear and focused on safety and quality. Governance arrangements had been strengthened since our inspection in November 2014 and risks and quality were regularly monitored and escalated when necessary.
- The medical directorate had gone through a period of consolidation by embedding governance and having a greater focus on learning change and improvement.
- There was a culture of candour openness and honesty within the hospital. However, within the theatre department staff did not always raise concerns or report incidents because they were not always taken seriously or treated with respect when they did.
- Governance arrangements in the theatre department required improvement and did not identify when important safety checks were not carried out.
- Improvements in leadership for the specialist palliative care team had occurred since the last inspection. Governance and performance management arrangements within end of life care across the trust did not always operate effectively. Risk registers were not in place for end of life care and risks did not appear on the hospital or trust risk register. Quality issues and priorities were understood but the actions required to ensure change were not yet fully embedded.
- In most areas of the hospital staff felt supported. However, within the end of life care formal substantive leaders were absent for chaplaincy and bereavement services, although temporary leadership arrangements were in place for staff in bereavement services. In the theatre department staff did not feel that leaders were visible or provided the guidance they needed.

## We saw several areas of outstanding practice including:

- As the major trauma centre for the Severn region the department was required to report all treatment results of major trauma patients to the national trauma audit and research network (TARN). Results for 2015 showed that the emergency department at Southmead hospital had the best survival rate of any trauma centre in England and Wales.
- Frontline staff and managers were passionate about providing a high quality service for patients with a continual drive to improve the delivery of care.
- Managers were strong and committed to the patients and also to their staff and each other.
- There was an outstanding example of responsiveness with the work of the dementia care team and the availability of 100 dementia champions in the trust including the Head of Facilities who was focussing on environmental changes.
- In the pre-admission clinic they had a pharmacist working full time who reviewed elective patients. They made sure their VTE assessment was completed. They reviewed patients' medications, wrote them up on the medication chart and gave advice to patients about their medication (what needed to be stopped prior to admission). The purpose for this was to reduce the amount of operations cancelled due to medication issues.

# Summary of findings

- The bereavement midwife visited women in the CDS and also followed women up at home at any time, even beyond the normal time limit for postnatal midwifery care. Family support was also offered for subsequent pregnancies
- The trust had developed some good training for staff in caring for patients living with dementia. Staff explained how they were able to offer extra time to this group of patients to ensure they were well cared for and made to feel relaxed and calm in an unfamiliar environment. Staff in the pre-operative assessment clinic were able to assess patient's cognition and report back to GPs if it was below expected levels.
- The specialist palliative care team was one of several in the country to join acute medicine unit board rounds to ensure patients' needs were identified to access end of life care. We saw evidence that the specialist palliative care team had worked with the acute medical unit with complex end of life patients to improve patient outcomes.

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

Importantly, the trust must:

- Improve patient flow within the hospital and ensure that there is a robust hospital-wide system of bed management so as to: significantly reduce delays in patient flow through the emergency department; reduce occupancy to recommended levels within medical services; and, ensure that there is capacity within the hospital so that patients can be admitted to and discharged from critical care at the optimal time for their health and well-being.
- The medical directorate must improve access and flow in order to reduce occupancy to recommended levels.
- Records must be fully completed and provide detailed information for staff regarding the care and treatment needs of patients.
- Ensure there is capacity in the hospital so that patients can be admitted to and discharged from critical care at the optimal time for their health and wellbeing. This includes a robust hospital-wide system of bed management
- Take action to improve the safe storage of medical notes
- Ensure patient information remains confidential through appropriate storage of records in the outpatient clinics and theatre departments to prevent unauthorised people from having access to them.

In addition the trust should:

- Check equipment in the emergency department resuscitation room to ensure that it is ready to use.
- Review patient group directives in the emergency department to ensure they reflect current best practice.
- Ensure that psychiatric patients attending the emergency department at night have timely access to appropriate treatment.
- Ensure that the emergency department computer system is easy for staff to use and can provide information needed to manage current and future performance.
- Integrate new emergency department triggers for escalation action into the hospital full capacity protocol.
- Chemicals and substances that are hazardous to health (COSHH) should be secured and not accessible to patients and visitors to the medical wards.
- Opening dates or in used expiry dates should be added to medicines where appropriate.
- Controlled drugs cabinets should be of an adequate size for the required controlled drugs.
- Medicines refrigerator temperatures within surgical services should be monitored, recorded and actions taken in accordance with trust procedures.
- Equipment and medicines required in an emergency should be tamper evident.
- Make sure any changes to practice should be shared with bank and agency staff who work a number of shifts so they are up to date.
- Make sure auditing of safety checks of anaesthetic machines takes place to make sure they are being done.

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- Make sure cleaning of all theatre equipment takes place and provide evidence to support this.
- Increase staff locker capacity in theatres to prevent storage of personal bags in the theatre room and to improve infection control practices in theatres.
- Review the cleaning of laryngoscope handles to make sure they are in line with the current guidance.
- Review the orange bags being used, as they were prone to leaking onto the cages used to transport clean linen in theatre.
- Look at ways of making theatre management more visible to staff and improving staff morale.
- The trust should improve the facilities for patients in interventional radiology if this is to be used as the escalation ward.
- Continue to work on improving the WHO safe checklist score to meet their target.
- Use the information from themes of complaints to make changes to practice to reduce the number of complaints received.
- Ensure mandatory training is given suitable priority so that compliance rates across the hospital meet trust targets.
- The system for checking resuscitation equipment should be consistent across the directorate.
- Staff should ensure patient notes have clear records of assessments and best interest decisions for patients who lack the mental capacity to make their own decisions.
- The security of confidential patient records should be reviewed to ensure they are safe from removal or the sight of unauthorised people.
- Continue to support new staff in critical care to attain a post-registration award in critical care to ensure a minimum of 50% of nursing staff hold such a qualification.
- Continue the recruitment programme in the critical care unit to ensure the recommended numbers of safe staffing, including supernumerary coordinators, are achieved at all times.
- Ensure store rooms in critical care are kept locked at all times when unattended.
- Ensure care records are available in a timely manner to allow useful mortality and morbidity reviews to take place.
- Review the critical care response to deteriorating patients within the hospital, and follow-up of patients discharged from critical care.
- Monitor the numbers of elective surgery that are cancelled as a result of no critical care beds being available.
- Consider instructions for cleaning baths between uses are readily available for staff use.
- Make available antibacterial hand disinfectant at the entrance from Quantock Ward to the Central Delivery Suite.
- Consider how they are to progress towards meeting the Royal College of Obstetricians and Gynaecologists guidance for dedicated consultant hours on the delivery suite
- Consider auditing the completion and submission of HSA4 forms in accordance with the legal requirements for termination of pregnancies.
- Ensure sufficient staff within the recovery area in the maternity theatre department to meet the Association of Anaesthetists of Great Britain and Ireland guidance which states that no fewer than two staff (of whom at least one must be a registered practitioner) should be present when there is a patient in the post anaesthetic recovery area who does not fulfil the requirement for discharge to the ward.
- Ensure that risk registers include risks associated with care for end of life.
- Ensure that care plans for end of life care and associated supporting documentation including resuscitation information demonstrate complete and consistent recording to provide staff with full detail regarding the patients' assessed care needs.
- Ensure that patient records for patients at end of life care demonstrate complete and consistent recording including the relevant consent and decision making assessment requirements for specific decision making in relation to the Mental Capacity Act 2005 and resuscitation decisions.

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

# Summary of findings

## Our judgements about each of the main services

### Service

#### Urgent and emergency services

### Rating

Good



### Why have we given this rating?

Overall we rated the emergency department as good because:

- There had been significant improvements in safety and effectiveness since our last comprehensive inspection in November 2014. There had also been improvements in patient access and flow.
- Openness and transparency about safety was encouraged. Adverse impacts on patients following safety incidents had reduced significantly in the last year and patient safety remained a priority.
- Risks to people who used the department were assessed, monitored and managed on a day-to-day basis.
- Initial clinical assessment of patients took place in a timely fashion. However, the lack of a rapid assessment and treatment system meant that there were often delays in seeing a doctor for patient arriving by ambulance.
- Nurse staffing levels had been increased and all staff had high levels of skills and experience
- Care and treatment followed national guidance and best practice evidence from professional bodies such as the Royal College of Emergency Medicine, the National Institute for Health and Care Excellence (NICE) and the Resuscitation Council UK. However, there was a lack of awareness of national standards for the treatment of broken hips.
- Results of national audits showed that patient outcomes were similar to, or better than most hospitals England. Audit results from the national trauma and research network showed that survival rates following major trauma were the best in England and Wales.
- Changes had been made to working practices in order to reduce delays but the department was not consistently meeting the 95% standard to admit or discharge patients within four



# Summary of findings

hours. There had been a noticeable decline since September 2015 and by November 2015 the standard was only being met for 82% of patients.

- Delays for patients who needed admission to a ward were a particular concern. During October and November 2015 19% of patients waited between four and twelve hours to be admitted.
- The total time patients spent in the department compared badly to other hospitals. In September and October the average (median time) that all patients spent in the department was three hours. The England average was two hours.
- The needs of people with complex needs were well understood and addressed appropriately. People with dementia received care and treatment that was sympathetic and knowledgeable.
- There was strong leadership in the emergency department which had resulted in improvements in quality and had led to improving staff morale. Governance and performance were proactively reviewed and reflected best practice. Lessons learned and changes in practice were communicated to staff via monthly governance meetings and newsletters.

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

### Requires improvement



We have judged the medical care services overall as requiring improvement, although there were some areas of good practice and one of outstanding practice since the last inspection.

- Patient safety required improvement overall but some areas were good.
- There were inconsistencies in the systems for checking resuscitation trolleys to ensure equipment was fit-for-purpose.
- The storage of medicines had improved. Medicines were stored in secure cupboards in all areas and were well managed. However, records of medicines administration were not always accurately maintained.
- The completion of records did not consistently reflect the care needs of patients. Recording of



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assessments on some wards was not consistent and we were unable to see that assessments for some patients had been done in a timely manner.

- The tracking system for patients requiring medical examination had improved and this meant that medical staff could assess and prioritise patients effectively.
- Since our inspection in November 2014 there had been a review of staffing, skill mix and acuity of patients. There were safer nursing staff levels in the medicine directorate. Although some of the mandatory training compliance was below trust targets.
- Effectiveness of medicine services required improvement to demonstrate patient care was delivered in accordance with best practice.
- Participation in national audits had improved and the directorate had carried out a more comprehensive range of local audits to monitor performance. Continued pace was required and managers were keen to develop further action plans for national and local audit to demonstrate the effectiveness of care with actions taken and lessons learned to improve care.
- Patients were well supported with nutrition, hydration and pain.
- Staff had the skills, knowledge and experience to deliver effective care and treatment through training. However, completion of appraisals was below trust target and required improvement.
- The responsiveness of medical services required improvement, although some aspects were good and one was outstanding.
- There had been improvements to patient flow; however, patient flow remained a challenge in the directorate with medically fit patients across the directorate awaiting social care packages to support their discharge from hospital.
- The trust was participating in the 'Enhanced Care Project' to improve the way enhanced

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care was given to patients and had implemented certain aspects of the project in advance of the completion date as there had been overwhelming evidence of its efficacy.

- There was an outstanding example of responsiveness with the work of the dementia care team and the availability of 100 dementia champions in the trust including the Head of Facilities who was focussing on environmental changes.
- We have judged the leadership of the service as good with some areas requiring improvement.
- The directorate was facing a period of consolidation following the move to the new building in 2014. Governance structures were embedding and managers were focussed on ensuring that audits, incidents, complaints and other key information were used to demonstrate learning, change and improvement.
- Good local leadership was provided throughout the directorate and frontline staff and managers were passionate about providing a high quality service for patients with a continual drive to improve the delivery of care.
- Most staff were positive about working for the trust and showed commitment to their patients, their responsibilities and to one another. There was a strong camaraderie within teams with flexibility provided where possible.
- Innovative practice across the directorate still required development. There had been an improvement since our previous inspection with a programme of local audit and an innovation programme had been introduced to improve the way enhanced care was given to patients.

## Surgery

### Requires improvement



We rated surgery as requires improvement because:

- Patient records were not being stored securely on the wards and in theatres, so there was a risk of access by unauthorized people.

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- Not all staff in theatres was reporting incidents; for example, staffing shortages, because they felt there was no improvement or response from their managers.
- National guidelines were not followed in theatres for infection control procedures and the cleanliness of some equipment.
- Evidence did not demonstrate that essential daily safety checks on equipment in the theatre department had consistently taken place.
- There was a high turnover of staff in the theatre department and the sickness rate was higher than the trust's target. The theatre department had recruited a large number of predominantly Band 5 (junior) staff but they required training to obtain the skills and knowledge to meet the clinical standards and needs of this department. Some surgical wards were also experiencing higher levels of sickness and staff vacancies. The trust was working to address this shortfall.
- The hospital had a mixed performance in a number of national audits, including the Patient Reported Outcome Measures (PROMs) for April 2014 to March 2015, which is based on patients reporting to the hospital on their outcome following surgery for groin hernias, hip replacements, knee replacements, and varicose veins. The trust also had mixed performance in a national hip fracture audit.
- Patients relative risk of readmission rates after surgery (due to corrective measures being needed or infections) were variable between elective (planned) and emergency surgery. From June 2014 to May 2015 (in relation to how many procedures were performed) this was worse than the England average. The average length of stay for surgical patients within the hospital was also worse than the England average. It is recognised as sub-optimal for patients to remain in hospital for longer than necessary and a barrier to other patients being admitted.
- Access to surgical services for patients required improvement. The trust-wide Admitted Adjusted Referral to Treatment (NHS England consultant-led referral to treatment time standards of within 18 weeks) performance was

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worse than England average between September 2014 and August 2015. The number of operations cancelled as a percentage of elective operations was higher (worse than) the England average between April 2013 and April 2015.

- Due to pressure for their beds and the demand for their services, the trust had to use the interventional radiology day unit to house patients overnight. There were limited facilities for patients, including toilets, and there was only one shower that was away from the unit, and this was a staff shower. This meant staff had to escort patients to the shower and were away from the unit. This put pressure on the unit when fitting in their planned patients for procedures.
- From September 2014 to October 2015, the surgery directorate had the most complaints in the trust. Which they felt was due to cancelled operations.
- Theatre staff felt the leadership in theatres was not good, they felt unsupported by them and they were not visible.
- However:
- At the last inspection, issues were identified with the Sterile Services Department (SSD). At this inspection, we heard from theatre staff and surgeons about the significant improvements made resulting in less anxiety and complaints from staff and fewer operations being cancelled due to issues in the sterile equipment trays.
- The pre-admission clinic had a pharmacist in attendance to review patients' medications, write up their medication for admissions and liaise with their GP if required. This was to reduce the number of cancelled operations due to medication issues with patients. This was outstanding practice.
- All staff were 'bare below the elbow' and this was also an improvement since the last inspection.

## Critical care

Good



We have judged the critical care unit to be good for safety, and as requiring improvement for responsiveness. Because this inspection was focused on the areas that required improvement

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following our inspection in November 2014, we did not inspect against the caring, effective and well-led domains. The overall rating for the service is good because:

- The most pressing issue for the safety of the unit in November 2014 was the low numbers of nursing staffing, and the lack of skill and experience of the nursing staff group. During this inspection we found the unit had increased staffing numbers, improved its skill mix and supported staff development in achieving a post-registration qualification in critical care. Although there were still some gaps in staffing, for example supernumerary cover, detailed recruitment plans had been agreed and a full establishment of staff was expected to be in place by the end of March 2016.
- The critical care unit was designed to accommodate patients in single rooms, called 'cubicles'. Our November 2014 inspection reported challenges with this design because patients were not visible at all times. A new standard operating procedure had been introduced to help staff adapt their practice. This had helped to improve observations of patients most of the time, but a challenge remained at times; for example, when staff were taking rest breaks.
- Incident reporting, learning and improvements to practice following incidents had improved, with daily safety conversations being introduced.
- There was an improving picture in relation to the incidence of patient harm. In November 2014 we found an unusually high incidence of falls, pressure ulcers and patients removing their own medical devices. The unit had responded to this with increased staffing and education, and a reduction of 50% was expected to be achieved by the end of the year. However, the majority of the mandatory training topics, including falls training, were below the trust's target for 85% of staff to have completed their training.
- Our previous inspection in November 2014 found the responsiveness of the unit required improvement. This was because the poor flow of patients through the hospital affecting the ability

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of critical care to respond effectively. During this inspection we found there were still a very high number of delayed discharges, despite the unit working hard to identify patients who could be discharged in the early morning. Bed occupancy also remained high, affecting access for patients requiring intensive care.

- The length of stay for patients remained much higher than the NHS national average and was not optimal for patient social and psychological wellbeing.
- There was no critical care outreach team (a recommendation of the Core Standards for Intensive Care Units (2013)) to provide a response to deteriorating patients elsewhere in the hospital, or to follow-up patients who had been discharged from the critical care unit.

## Maternity and gynaecology

Good



This follow up inspection reviewed only the safety and responsiveness domains. Both were judged to be good because:

- There was a positive culture around incident reporting and staff were encouraged to report concerns. Learning from incidents was shared with staff on a daily basis. Practice development midwives ensured learning points were embedded in the formal education programme and changes to practice were fed into the ongoing audit program.
- The maternity unit appeared clean and hygienic, benefitting from a dedicated domestic team.
- Systems were in place to identify vulnerable women or children. Staff were confident in using the referral system and felt supported by the specialist safeguarding midwives.
- Staff reported access to mandatory training was good. Practice development midwives monitored attendance at and organised training sessions.
- There were numerous systems in place to assess risk to both women and babies enabling staff to respond quickly and effectively when conditions changed.

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- Midwifery staffing levels had increased since our last visit meaning women and babies were being looked after in a safer environment. Recruitment was ongoing to ensure improved levels were maintained.
- There was 74 hours of dedicated consultant cover on the central delivery suite each week. This was below the Royal College of Obstetricians and Gynaecologists' Safer Childbirth recommendations but was kept under regular review as the issue was on the risk register.
- Checks on adult and baby emergency resuscitation equipment were inconsistent. With some confusion amongst staff about what needed to be checked and when. This was pointed out to staff at the time and daily and monthly check sheets were immediately created.
- Routine antenatal care was generally carried out in community settings near to where people lived. A range of specialist and multidisciplinary ante natal clinics were held at Southmead Hospital and in specific community settings to ensure women got the specialist care, advice and support needed.
- During our last inspection we found that fathers had limited opportunity to stay with their partners overnight. At this inspection we were told funding had been secured for 14 reclining chairs. They had been ordered but were yet to arrive.
- Elective caesarean section lists had been increased from three funded sessions per week to five funded sessions per week. This had improved the flow of women through the service.
- The early pregnancy assessment centre took into account women's preferences. When attending, women often experienced long waiting times. They were asked if they wanted an appointment system introduced. Feedback identified women preferred to wait and be seen on the same day even if it meant a long wait.



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- Routine dating and growth ultrasound scans took place at Southmead Hospital. Scanning at Cossham Birthing centre and other community settings was being considered to relieve pressure of the main unit.
- Bed occupancy for maternity services (excluding Central Delivery Suite) was 83.3% in the first quarter of 2015. This continued to be significantly higher than the England average for maternity services.
- Staff completed incident reports if there were delays in transfer to or from the Central Delivery Suite (CDS) because there were no postnatal beds available once a woman had given birth. This also meant that at times, women remained on CDS longer than needed because of the lack of available postnatal beds.
- 'Flow midwives' had been introduced, on a six month pilot. Their role was to have an overarching approach to patient flow issues and deal with the associated problems thus freeing up midwives on duty to continue with direct patient care. Staff told us they had found improvements in flow since their introduction.
- There was access to translation and interpretation services. Information leaflets were available in the unit and on the trust website in a number of languages and could be produced in alternative formats if required.
- Complaints were dealt with in line with trust policy. Women were often invited to the unit to discuss their concerns or outcomes of complaint investigations. Staff said changes in practice required as a result of complaint were communicated to staff via emails, newsletters and/or safety briefings.

## End of life care

### Requires improvement



We rated end of life care as requires improvement because:

- Some incidents were not reported at the time they occurred and there were issues in end of life care that were not being formally monitored. For example, incidents relating to the adherence to the policy on the management of a deceased adult patient or last offices policy by ward staff. Mortuary staff who dealt with the incident did

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not always report incidents. The number of incidents that occurred when bereaved relatives tried to pick up death certificates were not being monitored.

- The risks associated with anticipated events and emergency situations were not fully recognised, assessed or managed for end of life care. All relevant parties were not fully aware of their role in a major incident and the response plans had not been tested and reviewed regularly with all relevant staff. For example mortuary and specialist palliative care team staff had not been involved in major incident exercises.
- Patients identified as being at the end of their life or receiving end of life care were sometimes at risk of not receiving all relevant care or treatment. This was because care assessments did not always record the full range of patient's needs.
- Patients end of life care and treatment was planned and most was delivered in line with current evidence-based guidance, standards, best practice and legislation. However, staff completing the do not attempt resuscitation documentation were not recording in line with the Mental Capacity Act 2005 code of Practice. The spiritual and emotional aspects of care were sometimes overlooked in assessments.
- Seven day services were not available for face to face end of life care from the specialist palliative care team. We saw evidence that patients received care from a range of different staff, teams or services, which was coordinated.
- The arrangements for governance and performance management of all end of life care in the trust did not always operate effectively. There was not a risk register in place for end of life care. There were risks identified during our inspection, which were known about. We did not see these recorded on a local or trust wide corporate risk register.

## However:

- Patients receiving end of life care and those close to them were treated with dignity and respect and were involved in their care.

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Feedback from patients and those close to them was positive about the way staff supported and cared for them. We saw patients were treated with dignity, respect and kindness during interactions with staff.

- Patients had assessments which included consideration of clinical needs, health, physical health nutrition and hydration needs.
- Pain was managed well as was nutrition and hydration.
- End of life care took account of the local population when planning services.
- Reasonable adjustments were made and action was taken to remove barriers when patients found it hard to use or access services. There was openness and transparency in how complaints were dealt with. Complaints and concerns were taken seriously, responded to in a timely way and listened to.
- Access to care was managed to take account of patient's needs, including those with urgent needs. Discharge from hospital and to patients preferred place of care was achieved in many cases. The specialist palliative care team had worked to ensure they and others in the trust had access to information needed to support patients who received end of life care.
- The trust supported the director of nursing and the specialist palliative care team to promote high quality person-centred end of life care. The specialist palliative care team had a clear statement of vision and values and end of life care was driven by the desire for quality and safety this included plans for a seven day service. The strategy was credible and strategic objectives had been identified recently as part of commissioning for quality and innovation and were supported by quantifiable and measurable outcomes. Despite the recent work of the specialist palliative care team and the director of nursing the strategy and vision for good end of life care had not yet been fully implemented throughout the trust.

# Summary of findings

- Staff in the specialist palliative care team we spoke with felt they were respected, valued and supported. Staff we spoke with valued the specialist palliative care team.

## Outpatients and diagnostic imaging

### Requires improvement



We judged the safety and responsiveness of the outpatients and diagnostic imaging service as requires improvement because:

- There were areas in outpatients where patients' medical notes were left unattended and records were stored insecurely.
- There were a high number (between 10 and 20%) of patient notes 'missing' in outpatient clinics. This posed a risk to patient safety. No data was collected on the number of patient appointments which were cancelled as a result.
- Patients did not always receive timely access to treatment. The trust were found to be breaching the standards for referral to treatment pathways

However,

- . We found there were systems in place for all reported incidents to be investigated, staff were clear on the process for reporting and felt able to report appropriately.
- The cleaning of the outpatient and diagnostic areas was of a high standard, staff reported a responsive cleaning team to the needs of the services they provided.
- There were processes in place to assess and respond to patients risk and staff were trained to recognise and act upon abuse or suspicions of abuse in vulnerable people.
- We found the outpatient services and opening times were flexible to meet the needs of the general population.
- The staff were very knowledgeable in responding to the needs of patients living with dementia in the outpatient setting, enabling them time to adjust to a different environment and ensuring the patients received a tailored service.

# Southmead Hospital

## Detailed findings

### Services we looked at

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

# Detailed findings

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## Background to Southmead Hospital

North Bristol NHS Trust is an acute trust located in Bristol that provides acute hospital and community services to a population of about 900,000 people in Bristol, South Gloucestershire and North Somerset. The trust is not a foundation trust. It also provides specialist services such as neurosciences, renal, trauma and plastics/burns to people from across the South West and in some instances nationally or internationally.

The trust has five main locations that are registered with the Care Quality Commission. It provides healthcare from Southmead Hospital, Cossham Hospital, Frenchay hospital site, Riverside and Eastgate House. The main hospital at Frenchay closed in May 2014 when the new hospital at Southmead was opened, however the Head Injury Treatment Unit remains on the Frenchay site providing outpatient services. The trust also provides community healthcare for children and young people including mental health services across Bristol and South Gloucestershire. There are 996 beds on the Southmead Hospital site.

The trust was under significant financial pressure. The trust had a deficit of £19.8m for the 2014-2015 financial

year. The city of Bristol is ranked 79 out of 326 local authorities in the Indices of Multiple Deprivation. South Gloucestershire is less deprived with a rank score of 272 out of 326. Life expectancy for both men and woman in Bristol is slightly worse than the England average. However, it is better than the average for men and woman in South Gloucestershire. According to the last census 16% of Bristol's population was non-white (Bristol Unitary Authority). Black was the highest represented race, closely followed by Asian. Five per cent of the population of South Gloucestershire were from black and ethnic minority groups.

We carried out this focused inspection of the trust to follow up on the areas that were rated as inadequate and requires improvement in our inspection in November 2014. The inspection team inspected the following core services at the Southmead site • Accident and Emergency • Medical Care (including older people's care) • Surgery • Critical care • Maternity Services • End of life care • Outpatients • Maternity Services • We also inspected community mental health services for children and young people.

## Our inspection team

Our inspection team was led by:

**Chair:** Louise Stead, Chief Operating Officer and Director of Nursing, Royal Surrey County Hospital NHS Foundation Trust.

# Detailed findings

**Head of Hospital Inspections:** Mary Cridge, Head of Hospitals Inspection, Care Quality Commission

The team included CQC inspection managers, inspectors and a variety of specialists including: A board governance director, a director of nursing, a divisional director of medicine, a specialist accident and emergency nurse, a

specialist nurse in medicine, a specialist theatre nurse, a consultant surgeon, a junior doctor with experience in critical care and anaesthesia, a specialist critical care nurse, a consultant gynaecologist, a head of midwifery, a director of nursing for end of life care, a divisional general manager and head of nursing.

## How we carried out this inspection

We carried out the announced part of our inspection between 8 and 10 December 2015 and returned to visit some wards and departments unannounced on 16 December 2015.

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

Prior to the inspection we obtained feedback and overviews of the trust performance from Bristol and South Gloucestershire Clinical Commissioning Groups and the Trust Development Authority.

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

## Facts and data about Southmead Hospital

Southmead Hospital has 996 beds and is staffed by approximately 8,405 members of staff. They provide care to around 900,000 people across Bristol, South Gloucestershire and North Somerset.

In 2014/15, the trust had 69,782 inpatient admissions and 82,481 attendances at the emergency department. There were 416,356 outpatient attendances. It had revenue of £552.9million, the full cost was £572.7million therefore there was a financial deficit of £19.8million.

Since the second quarter of 2013/14 the bed occupancy at the trust has been above the national average (85.9%). It is generally accepted that bed occupancy over 85% is the level at which it can start to affect the quality of care provided to patients and the orderly running of the hospital. During the period from June 2014 to May 2015, the hospital's bed occupancy rate was on average 97%.

North Bristol NHS Trust has seen a number of changes to their executive team in the past three years with interim posts for Director of Nursing and Chief Executive during 2012/13. The chief executive started in September 2013, and the appointment of a substantive director of nursing in December 2013, (she had been on secondment to the trust since 2012). The Director of Operations has been appointed since our comprehensive inspection in

November 2014. The non-executive membership was more stable, with the chair on his second term as chair having been a non-executive director previously. There were three new non-executive directors who had been in post since shortly after our inspection in November 2014.

### CQC Inspection History

North Bristol NHS Trust has had a total of 14 inspections since registration. Five of these have been at the old Southmead Hospital site. In May 2011 a themed inspection was undertaken specifically looking dignity and nutrition. The required outcomes were met, but some areas for improvement were identified. In September 2011 a routine inspection found minor concerns relating to: safeguarding people who use services from abuse; staffing; and informing CQC of notifiable issues. In March 2012 a themed inspection was undertaken specifically looking at terminations of pregnancy and the trust was found to be meeting the required standards. In January 2013 a further routine inspection identified concerns relating to the management of medical records; this was followed up in July 2013 and was found to be meeting the required standards.



# Detailed findings

Three inspections have been undertaken at Frenchay Hospital. In March 2011 a route inspection was

Undertaken in which all 16 of the essential standards were inspected, the standard relating to records was not met. However, a follow up in September 2012 judged that the required standard had then been met. In May 2012 a responsive inspection following concerns was undertaken, three standards were inspected and all were found to be met.

There have been two inspections of the Riverside Unit the most recent of which took place in December 2013 and all four standards inspected were met.

A comprehensive inspection of the trust was undertaken in November 2014 where we rated the trust overall as requires improvement. Significant concerns were found in urgent and emergency care services and a warning notice was served on the trust. We followed up these concerns in May 2015; however, the warning notice had not been met at this time. We worked with the trust and partner organisations to ensure that action was taken to improve the service. A further focused inspection was carried out in October 2015 to follow up on the concerns raised in urgent and emergency care services and the trust was found to have met the warning notice.

## Our ratings for this hospital






Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
<b>Urgent and emergency services</b>	Good	Good	N/A	Requires improvement	Good	Good
<b>Medical care</b>	Requires improvement	Requires improvement	N/A	Requires improvement	Good	Requires improvement
<b>Surgery</b>	Requires improvement	Requires improvement	N/A	Requires improvement	Requires improvement	Requires improvement
<b>Critical care</b>	Good	N/A	N/A	Requires improvement	N/A	Good
<b>Maternity and gynaecology</b>	Good	N/A	N/A	Good	N/A	Good
<b>End of life care</b>	Requires improvement	Requires improvement	N/A	Good	Requires improvement	Requires improvement
<b>Outpatients and diagnostic imaging</b>	Requires improvement	N/A	N/A	Requires improvement	N/A	Requires improvement
<b>Overall</b>	Requires improvement	Requires improvement	N/A	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	Good	
Effective	Good	
Responsive	Requires improvement	
Well-led	Good	
Overall	Good	

## Information about the service

The emergency department (part of the emergency zone) at Southmead Hospital is open twenty-four hours a day, seven days a week. It treats people with serious and life threatening emergencies and those with minor injuries which need prompt treatment such as lacerations and suspected broken bones. As the major trauma centre for the Severn region it has a helipad to enable air ambulances to land.

The department has a six-bay resuscitation area. One resuscitation bay contains equipment for children although children requiring an ambulance are taken to the specialist children's department at the Bristol Royal Children's Hospital. There is a major treatment area with 11 cubicles and three rooms with doors. Less seriously ill or injured patients are seen in the minor treatment area which has eight rooms. There are three rooms equipped to treat children who also have their own waiting room. The former seated assessment area had been converted to an observation unit and stepdown area for major treatment patients. There is a dedicated imaging suite providing plain X-ray, CT and ultrasound. The emergency department last year (ending June 2015) saw approximately 85,000 patients. Almost 9,000 of these were children.

This was a follow-up inspection to review the requirements that we had identified following our comprehensive inspection in November 2014. We visited between 8 and 10 December 2015 and undertook an unannounced inspection during the evening of 16 December 2015. During this inspection we observed care and treatment of patients, looked at 18 treatment records and reviewed

performance information about the department. We spoke with approximately 30 members of staff including nurses, consultants, doctors, receptionists, managers, support staff and ambulance crews.

# Urgent and emergency services

## Summary of findings

Overall we rated the emergency department as good because:

- There had been significant improvements in safety and effectiveness since our last comprehensive inspection in November 2014. There had also been improvements in patient access and flow.
- Openness and transparency about safety was encouraged. Adverse impacts on patients following safety incidents had reduced significantly in the last year and patient safety remained a priority.
- Risks to people who used the department were assessed, monitored and managed on a day-to-day basis. Initial clinical assessment of patients took place in a timely fashion. However, the lack of a rapid assessment and treatment system meant that there were often delays in seeing a doctor for patients arriving by ambulance.
- Nurse staffing levels had been increased and all staff had high levels of skills and experience.
- Care and treatment followed national guidance and best practice evidence from professional bodies such as the Royal College of Emergency Medicine, the National Institute for Health and Care Excellence (NICE) and the Resuscitation Council UK. However, there was a lack of awareness of national standards for the treatment of broken hips.
- Results of national audits showed that patient outcomes were similar to, or better than most hospitals in England. Audit results from the national trauma and research network showed that survival rates following major trauma were the best in England and Wales.
- The needs of people with complex needs were well understood and addressed appropriately. People with dementia received care and treatment that was sympathetic and knowledgeable.
- There was strong leadership in the emergency department which had resulted in improvements in quality and had led to improving staff morale.
- Governance and performance were proactively reviewed and reflected best practice. Lessons learned and changes in practice were communicated to staff via monthly governance meetings and newsletters.

However:

- Changes had been made to working practices in order to reduce delays but the department was not consistently meeting the 95% standard to admit or discharge patients within four hours. There had been a noticeable decline since September 2015 and by November 2015 the standard was only being met for 82% of patients.
- Delays for patients who needed admission to a ward were a particular concern. During October and November 2015 19% of patients waited between four and twelve hours to be admitted. The total time patients spent in the department compared badly to other hospitals. In September and October the average (median time) that all patients spent in the department was three hours. The England average was two hours.

# Urgent and emergency services

## Are urgent and emergency services safe?

Good



We rated safety in emergency and urgent care services as good because:

- Safety had improved since our inspections in November 2014 and May 2015.
- Openness and transparency about safety was encouraged. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. They were fully supported when they did so.
- Adverse impacts on patients following safety incidents had reduced significantly in the last year.
- When something did go wrong, there was an appropriate and thorough investigation that involved all relevant staff. Lessons were learned and communicated widely to support improvement. Safeguarding of vulnerable adults and children was well understood and implemented.
- Risks to people who used the department were assessed, monitored and managed on a day-to-day basis. These include signs of deteriorating health, medical emergencies or behaviour that challenged. Initial assessment of patients took place in a timely fashion although the assessment of ambulance patients was sometime superficial.
- The hospital did not use a rapid assessment and treatment system. This sometimes meant delays in seeing a doctor for patients who arrived by ambulance.
- The risk register reflected concerns reported to us by staff.
- Staffing levels and skill mix were planned, implemented and reviewed. There were sufficient doctors and nurses to treat and care for the patients that attended the department. Any temporary staff shortages were responded to quickly and adequately and there were effective handovers at each shift change. The majority of staff had received up-to-date training.
- The department was well designed and well-equipped although not all equipment was checked to ensure that it was ready for use.
- Facilities for children complied with national standards.
- There were insufficient bathroom facilities in the observation unit.

- Plans were in place to respond to major emergencies. All relevant parties understood their role and the plans were tested and reviewed.

## Incidents

- There had been two reported serious incidents in the emergency department in the year ending November 2015. This was less than during our previous inspections and neither was related to delays in treatment within the emergency department. The incidents had been investigated in an open, honest and thorough way. All contributing factors were taken into account and measures were identified to help prevent a repeat of similar incidents. Learning points from these incidents were clearly described in governance meeting minutes
- Incidents and accidents were reported using a trust wide electronic system. All staff had access to this and knew which incidents required reporting. In May 2015 we had reviewed incidents from 1 February 2015 to 20 May 2015 and found that of a total of 418 incidents 115 (28%) were regarded as being of moderate impact and 23 (6%) were regarded as major or catastrophic.
- By October 2015, we found that of the 433 incidents between May 2015 and September 2015 11% were regarded as being of moderate impact and 2% were regarded as major. None were catastrophic.
- In October and November 2015, 193 incidents were reported. Three (0.02%) had a moderate patient impact, none had a major impact but one (0.005%) was catastrophic. This incident was shared with another department so there was a joint investigation and appropriate action was taken as a result.
- Mortality and morbidity discussions were incorporated into monthly governance meetings.

## Duty of Candour

- Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, is a new regulation which was introduced in November 2014. This Regulation requires the trust to be open and transparent with a patient when things go wrong in relation to their care and the patient suffers harm or could suffer harm which falls into defined thresholds.
- All staff that we spoke with understood the principles of openness and transparency that are encompassed by the duty of candour. We were told that the incident reporting system automatically alerts staff when an incident is subject to the duty of candour. Senior staff

# Urgent and emergency services

demonstrated detailed knowledge of the practical application of this new responsibility. They described discussions that had taken place with the patients concerned and their families and it was clear that they had fulfilled the requirements of the legislation.

## Cleanliness, infection control and hygiene

- The department appeared clean and tidy. Hand washing facilities were readily available and we observed staff wash their hands and use hand gel before and after patient contact. This helped to prevent the spread of infection.
- Hand hygiene audits took place monthly and consistently showed compliance of between 98% and 100%. The “bare below the elbow” policy was adhered to.
- We observed staff treating a patient who was suspected of having a contagious infection. Isolation techniques were used in accordance with trust policies and procedures. This included the appropriate use of gloves and disposable aprons.
- Staff were aware of the actions necessary to look after someone with, or who may have been involved in, the recent Ebola outbreak. There were notices in the entrance asking people to inform the receptionists if they had recently travelled to the affected countries

## Environment and equipment

- There was a dedicated ambulance entrance, which was located near to the major treatment and resuscitation areas.
- The helipad was situated close to the emergency department and there was good access. There was a helicopter landing policy to ensure the safe arrival and departure of patients and staff. We observed this in operation and it proved to be a safe and efficient procedure.
- There was a large u-shaped resuscitation area, which was well laid out to provide good lines of sight of all patients. There were designated bays for trauma, children and stroke treatment.
- There was an adjacent imaging suite providing plain x-ray, computerised tomography (CT) and ultrasound.
- We checked a range of specialist equipment, including resuscitation equipment. It was clean, well maintained and ready for use.

- There were well stocked resuscitation trolleys in all parts of the department. However, these were not always checked to make sure that they were ready to use. For the week beginning the 6 November 2015 the checks had only been carried out on three out of seven days. There were similar omissions for the week beginning 30 November 2015.
- The fridge used to store blood products was secure and alarmed to ensure the correct temperature was maintained.
- The area previously known as the seated assessment area was being used as a “step down” area for major treatment patients and as an observation unit. It had space for 16 patients, some of whom spent 18 hours in the unit. However, there was only one toilet and no bathroom which was not sufficient to meet the hygiene needs of 16 patients.
- There was a designated room for seeing patients who required a mental health assessment. This was comfortably and safely furnished, had safety alarms and two doors to allow for easy access and exit.

## Medicines

- Medicines were stored correctly in locked cupboards or fridges. Controlled drugs and fridge temperatures were regularly checked by staff working in the department and seen to be within required parameters.
- Unused drugs were disposed of in accordance with hospital policy.
- We observed staff administer intravenous fluids safely and correctly. They accurately completed details on the medication chart.
- Allergies were clearly documented on medication charts and antibiotics were prescribed according to local protocols.
- Nurses used patient group directives (PGD) in order to administer a number of different medicines such as painkillers and some antibiotics. We found that the majority of PGDs had not been recently reviewed and may not have complied with up-to-date practice. Nurses told us that a more up-to-date version was available on the computer system but this could not be found during our inspection.

## Records

- A new computerised patient record system had been introduced three weeks before our inspection. Although all staff had received training and support for the use of

# Urgent and emergency services

the system many of them told us that it took longer to record patient information than previously. We observed the difficulties experienced when trying to find the records of patients who had previously attended the department.

- Doctors, triage nurses and emergency nurse practitioners recorded clinical details directly into the computer system. Nursing records and risk assessments were paper based and were kept in files together with a front sheet produced by the computer. Unique patient identifiers had been completed on all patient documents. Patient records were stored in wall-mounted racks or storage trays and were supervised at all times.
- The nursing records we looked at were clear, complete and easy to follow. There was space to record appropriate assessment, including assessment of risks such as pressure ulcers, infection, allergies and falls. Clinical observations, pain scores, nursing care, advice and medication were all accurately recorded.
- The nurse in charge of the department checked a minimum of five nursing records each day to ensure that they were properly completed. If there were any deficits these were analysed and members of staff were given support to improve record keeping.

## Safeguarding

- Staff that we spoke with were aware of their responsibilities to protect vulnerable adults and children. They understood the safeguarding procedures that were in place and how to report concerns. There were clearly documented procedures for responding to patients who had suffered from domestic violence, female genital mutilation (FGM) and human trafficking. The latter had been successfully put into practice in the month before our inspection. The “at risk” register was checked for all children up to and including the age of seventeen.
- All clinical records for children contained a risk assessment tool aimed at quickly identifying any concerns regarding child welfare. These were completed correctly in the records that we reviewed.
- At the time of our inspection 70% of nursing staff had completed training in adult safeguarding and 79% had completed appropriate children’s safeguarding training. This was less than the hospital target of 90%. The

emergency department matron explained that some training had been cancelled in the previous year due to pressure of work in the department. She showed us evidence that extra training had been arranged and that all nursing staff would have attended by the end of February 2016.

- Of the doctors in the department, 90% had attended appropriate types of children’s safeguarding training.

## Mandatory training

- Mandatory training included essential topics such as fire training, health and safety, infection control and manual handling. The training had been designed for the specific needs of staff working in an emergency department. For example, manual handling focussed on lifting patients out of a car and moving them within the confined space of a CT scanner. Fire training included teaching staff how to evacuate patients from the resuscitation room.
- We saw training records up to August 2015 which showed good uptake of this annual training. Rates of attendance varied from 83% for information governance to 96% for manual handling. The hospital’s target for mandatory training was 90%.

## Assessing and responding to patient risk

- Patients arriving by ambulance as a priority (blue light) call were taken immediately to the resuscitation area. Such calls were phoned through in advance so that an appropriate team could be alerted and prepared for the arrival of the patient. We observed staff responding calmly and effectively when this occurred.
- During our previous inspections in November 2014 and May 2015 we had found that the initial clinical assessment of patients did not happen quickly enough. Since then additional nursing staff had been employed to assess patients when they first arrived in the department. Figures supplied to us by the hospital showed that in October and November 2015, on average, patients were assessed within four minutes. This is better than the standard of 15 minute set by the Royal College of Emergency Medicine (RCEM).
- During this inspection we frequently monitored the initial assessment of patients and found that no-one waited longer than 3 minutes. Figures supplied by the hospital showed that the average wait was four minutes between June and October 2015.



# Urgent and emergency services

- Patients arriving by ambulance were assessed by an experienced nurse in the “crossroads” area adjacent to the ambulance entrance. This was aimed at assessing the severity of illness or injury and prioritising the speed and type of treatment required. This is often known as triage. Although the nurse could see the patient, they rarely spoke to them or directly assessed them to check that information given to them by the ambulance crew was correct.
- Patients who walked into the department, or who were brought by families or friends, reported to the reception desk. Once initial details had been recorded patients were asked to sit in the waiting room while they waited to be assessed by a nurse. During our previous inspections we had found long delays before these patients were clinically assessed. There were no delays during this inspection.
- Senior staff had analysed when delays were most likely to occur and had ensured that a nurse was based at the reception desk from 11am to 10pm to help assess patients as they arrived. Although, this assessment was undocumented we found it to be effective. For example, a patient describing symptoms of a severe allergic reaction was taken to a treatment area rather than staying in the waiting room.
- This extra nurse was also able to observe patients in the waiting room to ensure that their condition did not deteriorate while they were waiting to see a doctor. The chairs in the waiting room had been arranged so that all patients could be observed.
- We observed the more formal initial assessment of two patients (with their consent) and found it to be thorough and effective. The nurse had completed special training in triage and had been assessed as competent before undertaking the role. There were two triage nurses at busy times.
- The department did not routinely use a rapid assessment and treatment system. This is a method of rapid patient assessment by senior clinical staff where diagnostic and treatment decisions are made and care decisions prioritised. We were told that this was only implemented if the department was particularly busy. The department’s internal professional standards stated that patients arriving by ambulance should be seen by a doctor or nurse practitioner within one hour of arrival. We observed many occasions when this was exceeded. However, no harm came to any of the patients who experienced delays.
- Patient early warning scores (EWS) were not routinely used in the department. Senior staff told us that they used other methods of identifying the deteriorating patient. For example, they used an emergency care safety checklist that required all patients to have vital signs measured at least hourly. Training of staff regarding recognition and management of a deteriorating patient was also a priority. Although these arrangements are unusual we did not find any risk to patients during our inspection. There were no serious incidents in the last year related to sub-optimal care of a deteriorating patient. We observed the EWS being used to prioritise patient care during handovers to ward staff.

## Nursing staffing

- The emergency department matron used an acuity tool to calculate the number of nurses required, by monitoring the number of patients that normally attended and the seriousness of their illnesses or injuries. In addition, nurse to patient ratios were checked against the draft guidance issued by the National Institute of Health and Clinical Excellence (NICE).
- We looked at nurse staffing for the month prior to our inspection and found the department employed enough nurses to satisfy the draft NICE guidance. Very few agency nurses were used and a senior nurse told us that most of the agency nurses worked regularly in the department and were familiar with local working practices.
- A band 7 sister was present in the department on every shift in line with the draft NICE guidelines.
- There was at least one registered children’s nurse on duty at all times.
- We observed a handover between nurses on the day and night shifts. This was well-structured, comprehensive and used as an opportunity for teaching and for safety briefings.

## Medical staffing

- The department employed 12 whole-time equivalent consultant doctors. Their rota ensured a consultant presence in the department for 24 hours a day, seven days a week. This was in line with the requirements of a major trauma centre. One of the consultants had completed further training in the treatment of children in emergency settings.



# Urgent and emergency services

- Junior doctors spoke positively about working in the emergency department. They told us that the consultants were supportive and always accessible. In-house teaching was well-organised and comprehensive. Doctors told us their rota was well-organised and provided them with valuable experience balanced with sufficient rest days.
- There were no locum doctors in the department during our inspection or in the previous month. Senior staff told us any doctors that they had needed to use on a temporary basis had previous experience in the department and were familiar with local working practices.
- We saw consultants working clinically in the department. They led the treatment of the sickest patients, advised more junior doctors and ensured a structured clinical handover of patient's treatment when shifts changed.
- Handovers between different teams of doctors was well-structured and detailed.

## Major incident awareness and training

- The hospital had a major incident plan, which was up-to-date and detailed. This provided clinical guidance and support to staff on treating patients of all age groups and included information on the triaging and management of patients suffering a range of injuries. These included injuries caused by burns, blasts or chemical contamination.
- Staff in the department were well-briefed and prepared for a major incident and could describe the processes and triggers for escalation. Similarly they described the arrangements to deal with casualties contaminated with chemical, biological or radiological material (HAZMAT). Decontamination facilities following a HAZMAT incident were spacious and effective. Major incident training had taken place in the last year.
- Equipment and documentation was kept in a locked room. The key was kept in a locked cupboard in the resuscitation room but was accessible within one minute.
- We observed security staff supporting nursing staff in the department. They were calm, polite and reassuring. They told us that they had been trained in conflict resolution and the safe restraint of violent people and spoke knowledgeably about the techniques to use. Staff told us that they responded quickly when called.

## Are urgent and emergency services effective?

(for example, treatment is effective)

Good



We rated the effectiveness of the service as good because:

- The emergency department had good governance arrangements and took part in both national and local audits.
- Policies and procedures were developed in conjunction with national guidance and best practice evidence from professional bodies such as the Royal College of Emergency Medicine, the National Institute for Health and Care Excellence (NICE) and the Resuscitation Council UK. However, we observed that treatment for patients with broken hips did not always follow best practice.
- Results of national audits showed that patient outcomes were similar to, or better than most hospitals England. Audit results from the national trauma and research network showed that survival rates following major trauma were the best in England and Wales. Local audits were undertaken in order to assess the effectiveness of treatment delivered in the emergency department.
- Pain relief was offered appropriately in most cases.
- Patients were offered food and drink although there was no hot meal service in the observation unit.
- Staff were, without exception, experienced and competent. They had undertaken appropriate specialist training and professional development was seen as a priority throughout the department. Multi-disciplinary working was in evidence so that the needs of each patient were prioritised.

## Evidence-based care and treatment

- The emergency department used a combination of National Institute for Health and Care Excellence (NICE) and Royal College of Emergency Medicine (RCEM) guidelines to determine the treatment that was provided. Guidance was regularly discussed at

# Urgent and emergency services

governance meetings, disseminated and acted upon as appropriate. For example, the triggers for escalating the department to “red alert” status had recently been revised.

- A range of clinical care pathways and proformas had been developed in accordance with national guidelines. These included treatment of major trauma, sepsis, asthma and fractured neck of femur (broken hips) and also assessment of older people and people with mental health problems. At monthly governance meetings any changes to guidance and the impact that it would have on practice was discussed.
- Staff in the department undertook audits to monitor the compliance with these guidelines. Audits currently in progress included management of low risk chest pain and treatment of transient ischaemic attacks.
- Although the ambulance service did not bring children to the department it did satisfy the requirements of the national “Standards for children and young people in Emergency Care settings”. There were sufficient staff with specialist children’s training and non-specialist staff spent time at the Bristol Children’s Hospital to gain valuable experience.

## Pain relief

- Patient records showed that a pain score was always calculated and recorded. Appropriate pain relief was given and the effects monitored.
- We observed that nurses administered rapid pain relief when they assessed patients who had walked into the department and those who had arrived by ambulance.
- During our inspection we observed timely pain relief administered to children. The results of the pain relief were monitored and additional treatment given if necessary.

## Nutrition and hydration

- Following the assessment of a patient, intravenous fluids were prescribed, administered and recorded when clinically indicated.
- We observed volunteers making frequent rounds of the department with a refreshment trolley. They offered drinks and snacks to patients and those close to them. The volunteers checked with the nurse in charge of each area to ensure that patients were able to eat and drink. However, nurses were not always present when refreshments were given and so records of hydration and nutrition were not always up-to-date.

- There was not a regular meal service for patients in the observation unit even though some patients stayed there for up to 18 hours.

## Patient outcomes

- The department took part in national audits in order to compare patient outcomes with other hospitals in England.
- The Royal College of Emergency Medicine (RCEM) had carried out two national audits since the department opened in 2014. One looked at treatment of mental health problems and the examined the assessment of cognitive impairment in older people. The results of the mental health audit were not as good as many other hospitals. However, in the last year improvements in the mental health liaison team had enhanced outcomes for this group of patients. Results for cognitive impairment assessments were similar to most other hospitals in England.
- The standards of treatment for people attending the emergency department with mental health problems in Southmead Hospital during the 2014/15 audit were as good or better than other departments in England. Three of 11 aspects investigated were not as good. These were the assessment of drug and alcohol dependency, assessment by a mental health practitioner and the speed of that assessment. Since the national audit improvements have been made in the mental health liaison service and, at the time of our inspection, 95% of patients were assessed by a mental health practitioner within an hour of referral.
- Results for the assessment of cognitive impairment in older people were similar to most other departments in England.
- As the major trauma centre for the Severn region the department is required to report all treatment results of major trauma patients to the national trauma audit and research network (TARN). Results for 2015 show that the emergency department at Southmead hospital has the best survival rate of any trauma unit in England and Wales.
- During our previous inspection we had noted that the treatment of feverish children required improvement. Since then improvements to the training and experience of staff have taken place. By November 2015 outcomes were as good as the majority of other departments in England.

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- There was an active internal audit programme. This included topics such as management of patients with low risk chest pain, management of pain in children, diagnosis and treatment of pulmonary embolus and CT scanning in head injuries.
- There had been a re-audit of the diagnosis and treatment of patients with a fractured neck of femur (broken hip). Results (published in November 2015) were compared to the national audit that had taken place in 2012/13. They showed that pain relief had improved since the last audit and that severe pain was treated more quickly than most hospitals in England. X-rays were performed more quickly than in many hospitals. However, only 62% of patients were admitted to a ward within four hours. The RCEM standard is 98%.
- We observed the treatment of a patient with a broken hip. Although the initial assessment was good, it took two hours for the patient to be seen by a doctor. This delayed the pain relief for the moderate pain that had been described on arrival. We spoke with two experienced nurses and neither were aware of the RCEM standard that states 98% of patients with moderate pain should be given pain relief within 60 minutes of arrival.
- The rate of unplanned re-attendances within seven days is often used as an indicator of good patient outcomes. At Southmead hospital it had varied between 3.3% and 5.8% since September 2014. This was significantly better than the national average of 7.5%.

## Competent staff

- Nurses were required to have gained experience in an acute setting before joining the emergency department. For example, band 5 nurses had to have worked on a surgical or medical ward for at least a year. This meant that they had consolidated the knowledge gained during their training and were skilled in prioritising patient care.
- There was a week long structured orientation programme for new staff, followed by two weeks of supervised practice. During this time there were formal assessments of skills such as ECG (echo-cardiogram) recording, application of neck collars and emergency blood tests.
- Nurses' education requirements were identified during annual appraisal and were fed into a structured education programme. This was organised and carried

out by the nursing education team that had been re-instated since our last inspection. Two members of the team were also honorary lecturers at a local university.

- All nursing staff were encouraged to research and develop areas of interest and act as a source of advice and training for the team. Examples included bereavement, infection control, tissue viability, sepsis and support for homeless people.
- There were specific training and competency assessments for triage. A year's emergency department experience had to be completed before commencing the training. A one-day theoretical course was undertaken and then supervised practice with 25 patients. In addition triage records were monitored to ensure that the nurse remained competent.
- Nurses and nursing assistants were allocated to teams, with every band seven sister leading a team and responsible for staff supervision and appraisal. Annual performance appraisal

compliance was approximately 95%, which was above the 85% trust target.

- There was a structured nursing competency framework and nurses were not considered for more senior posts until they had acquired sufficient skills and experience. For example, band 6 nurses had to have a minimum of two years emergency department experience and a wide range of proven competencies in areas such as resuscitation, major trauma, triage, suturing and application of plaster casts. They had to have undertaken formal education in emergency nursing. In addition they had to have implemented and led new areas of practice such as tissue viability of dementia care.
- There was a published, structured programme of weekly teaching for junior medical staff, who were expected to attend a minimum of 70% of sessions. Junior medical staff told us they were well supported by consultants. We observed ad hoc teaching taking place when unusual clinical situations arose.
- Hospital records showed that, only 11 of 39 doctors had had their professional registration revalidated. The reasons for this were unclear.

## Multidisciplinary working

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- There was good team working with care being delivered in a coordinated way, with support from specialist teams and services.
- There was a dedicated diagnostic imaging department in the emergency department. This consisted of two CT scanners, four plain x-ray rooms and ultrasound facilities.
- There were service level agreements detailing the turnaround times for both diagnostic imaging and pathology services. These were adhered to and monitored.
- There was a trust-wide mental health liaison service which supported the emergency department. Staff numbers had been increased in the last year and senior emergency department staff described the quality of the service as “excellent”. The service operated from 8am to 9pm, seven days a week and 95% of patients were seen within an hour of referral. This included patients who presented with alcohol or substance abuse. Further staff were being recruited with the aim of providing a 24 hour service.
- If patients had a severe mental health illness, or required treatment at night, they were treated by the crisis mental health team provided by another NHS trust. The response from this team was slow and, on all three mornings of our inspection, there was at least one patient who had waited all night to see a mental health practitioner. In the year ending October 2015 a third of patients needing mental health assessment spent more than four hours in the emergency department.
- There was a complex assessment and liaison service (CALS) which was aimed at developing a treatment and rehabilitation plan to avoid admission or shorten length of stay. The service was staffed by consultant physicians, advanced nurse practitioners, occupational therapists and physiotherapists. We observed the pro-active approach adopted by this team. They took trouble to identify patient who would benefit from their service before a formal referral had taken place.

## Seven-day services

- The department had access to radiology support 24 hours each day, with rapid access to CT scanning when indicated. There was always a senior radiology doctor available within in the hospital.
- CALS was available seven days a week. However the rapid emergency assessment care team (a team of allied health professionals and nurses who assessed and

facilitated discharge for vulnerable patients, such as elderly people living alone) only operated from Monday to Friday. Clinical staff told us that few people were discharged at weekends leading to a shortage of empty beds on a Monday.

- There was an on-call pharmacy service outside of normal working hours.
- Emergency department consultants provided cover 24 hours per day, 7 days per week, either directly within the department or on-call.

## Access to information

- Information needed to deliver effective care and treatment was well organised and accessible. Treatment protocols and clinical guidelines were computer based and we observed staff referring to them when necessary.
- A new operational computer system had been introduced three weeks before our inspection. It was designed to show how long people had been waiting and what investigations and treatment they had received. However, despite well-planned training, many staff found the system difficult to use. For example, it took 15 clicks of the computer mouse to enter the decision to admit time. There were similar difficulties in entering the time that a patient was referred to a specialist doctor. As a result, these times were rarely entered on to the computer which made it difficult to monitor the reasons for patient delays.
- The computer system would alert staff when vulnerable children or adults arrived in the department.
- Discharge letters were clear and comprehensive and, once completed, were sent to GPs on a daily basis. However, entering the discharge diagnosis onto the computer system was time consuming and doctors often delayed doing this if there were seriously ill patients who needed to be treated. This sometimes delayed the completion of the discharge letters.
- Senior staff told us that they had informed the suppliers of the computer system of the difficulties they were experiencing. However, they had been told that it could take several months for the difficulties to be resolved.

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

- We observed that consent was obtained for any procedures undertaken by the staff. This included both written and verbal consent.

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- Consent forms were available for people with parental responsibility to consent on behalf of children.
- The staff we spoke with had sound knowledge about consent and mental capacity.
- Where patients lacked the capacity to make decisions for themselves, such as those who were unconscious, we observed staff making decisions which were considered to be in the best interest of the patient. We found that any decisions made were appropriately recorded within the medical records

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

**Requires improvement**



We rated the responsiveness of emergency and urgent services as requires improvement because:

- Although significant improvements had been made in privacy and dignity and in patient flow, further improvements were required to ensure that the service was responsive to people's needs.
- Bed occupancy in the hospital was high (96%) and this often led to delays in admitting patients to a ward. Of patients waiting to be admitted to the hospital 20% waited between four and twelve hours to be admitted in October 2015 and 18% in November 2015. The total time patients spent in the department compared poorly to other hospitals. In September 2015 and October 2015 the average (median time) that all patients spent in the department was three hours. The England average was two hours.
- In the summer months, the department had met the four hour standard to admit or discharge 95% patients within four hours. However, there had been a steady decline since September 2015 and by November 2015 only 82% of patients met this standard. Ambulance crews experienced delays before they could handover their patients. Between October 2015 and the first week in November 2015 an average of two patients a week waited longer than an hour before that could be handed over to emergency department staff. During the same time an average of three ambulance patients every day waited between 30 and 60 minutes.

- Changes had been made to working practices in order to reduce delays. More nurses had been employed so that delays in initial assessment were minimal and delays in ambulance handovers were much reduced. Patients who had been referred by their GPs for medical treatment, were now treated in the adjacent acute admissions unit and the seated assessment area had been converted to an observation unit. These measures had reduced the severe crowding that had been a feature of the department since it opened.
- There was a full capacity protocol that defined the action to be taken throughout the hospital when long delays occurred in the emergency department. Senior clinical staff had recognised that the escalation triggers which informed the protocol were no longer effective. They had developed new triggers but it was not clear when they would be incorporated into the full capacity protocol.
- The needs of people with complex needs were well understood and addressed appropriately. People with dementia received care and treatment that was sympathetic and knowledgeable.
- It was easy for people to complain or raise a concern and they were taken seriously when they did so. 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

- Staff in the department had planned and implemented a number of changes to improve the service they provide.
- The former seated assessment area was now used as an observation unit and step-down area for major treatment patients. This helped to reduce the severe crowding that previously occurred.
- More nurses had been employed to ensure that all patients were clinically assessed within 15 minutes of arrival.
- Urgent patients referred to specialist medical doctors by their GPs were now assessed and treated in the acute assessment unit rather than emergency department. This reduced the pressure on emergency department resources and helped to ensure that emergency patients were treated in a timely fashion.
- The waiting room was large with sufficient seating for the people using the department. These had been re-arranged so that staff could easily observe waiting



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patients. There were refreshment facilities, televisions and a free-phone service for local taxis. There was a small children's play area for children who had accompanied adult patients.

## Meeting people's individual needs

- Staff that we spoke with demonstrated a good understanding of the requirements of patients with complex needs. There were assessment tools for frailty and confusion that helped to identify immediate treatment needs.
- The majority of staff had undertaken training in the specific needs of people with dementia and learning disabilities and the involvement of families was encouraged. The appointment of a trust-wide learning disabilities team had improved awareness and staff felt able to contact them for advice.
- We observed the treatment of two people with learning disabilities. Both were cared for in a quiet part of the department so that their exposure to the unfamiliar and confusing environment of an emergency department was kept to a minimum. Their particular needs were carefully discussed with them and their carers. Specialist advice was sought quickly.
- Patients with a known dementia had a blue forget-me-not symbol attached to their records. This prompted all staff to spend extra time explaining what was happening and checking understanding. They tried to treat patients with dementia in a quieter part of the department if possible.
- Staff showed us some "Twiddlemuffs" that were used to reduce restlessness and agitation in people with dementia. These are knitted woollen muffs with items such as ribbons, large buttons or textured fabrics attached to the inside that patients with dementia can twiddle in their hands whilst waiting in the department. The "Twiddlemuffs" provided a source of visual, tactile and sensory stimulation at the same time as keeping hands snug and warm. Staff told us that they had noticed a marked reduction in the agitation that can often result when people with dementia are in unfamiliar surroundings.
- In addition, there was a mobile computer with audio-visual programmes aimed at distracting and soothing patients with dementia. Patients could listen to radio programmes and songs from the 1940s and '50s, play familiar games or watch people reminiscing about life in the first half of the twentieth century.

- Privacy and dignity was much improved in the corridor known as the crossroads area. At our last comprehensive inspection large numbers of patients (up to 21) were being cared for in cold and drafty conditions. During this inspection ambulance patients spent no more than five minutes in crossroads before being taken to a treatment area. Seated patients still waited in the area but privacy was less of a problem as they were clothed and able to move if necessary.
- Privacy was still a problem in the observation unit as single-sex accommodation was limited to four side rooms. We saw regular incident reports from staff regarding this.
- Translators could be accessed via the telephone translation system provided by the hospital.

## Access and flow

- Emergency departments in England are expected to ensure that 95% of their patients are admitted, transferred or discharged within four hours. Although the department had been meeting this standard in the summer months (June, July and August 2015), there had been a steady decline since September 2015. In November 2015 only 82% of patients had been admitted or discharged within four hours.
- During our inspection there were very few delays for patients waiting for an initial clinical assessment. No more than five minutes for ambulance patients and eight minutes for walk-in patients. The average (median) wait for initial assessment from January to October 2015 was four minutes. This was in line with the RCEM standard that states that initial clinical assessment should take place within 15 minutes.
- The ambulance service records any delays in patient handover of more than one hour (known as black breaches). During our inspection in November 2014 this happened several times a day, with an average of 55 black breaches each week. Since March 2015 there had been a marked improvement. Although there were more black breaches than many other hospitals the number had reduced to an average of four per week in September and October 2015.
- Despite this improvement ambulance crews still had to wait too long to hand over their patients. Between October 2015 and the first week in November 2015 there were an average of 15 patients a day who waited between 15 mins and 30 minutes. There were an

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average of three patients a day when the delay was between 30 and 60 minutes. Ambulance crews that we spoke with stated that delays were always worse on a Monday.

- Records from the emergency department daily debrief meeting confirmed that delays on a Monday were frequently worse than the rest of the week with ambulances often waiting up to an hour before they could handover their patients. The reason for this poor patient flow was a consistent lack of empty beds in the hospital. It was common for 12 or more emergency department patients to be waiting for a bed by mid-afternoon on a Monday. This was equivalent to three quarters of the space in the major treatment area, leaving little space for new patients.
- The lack of rapid assessment and treatment system led to delays in some ambulance patients seeing a doctor. The hospital did not routinely monitor these delays but we looked at an example of patient attendance data in the week before the new computer system was used (3 November and 4 November 2015) and found that 32% of ambulance patients waited longer than an hour to be seen by a doctor or nurse practitioner. Delays to see a senior doctor were often longer than this.
- The average total amount of time that patients spent in the department during September and October 2015 was three hours. This is compared poorly to the England average of two hours. In November 2015 11.6% of patients spent more than six hours in the department.
- Occasionally there was a lack of co-ordination between treatment areas. We observed two occasions when the resuscitation area was full with no space available if a “blue light” ambulance arrived. On each occasion there was at least one patient whose condition had been stabilised and who was waiting to be admitted to a ward or for a specialist opinion. No thought had been given to moving them to another, less busy, area of the department where their needs could safely be met.
- It was common during our inspection for patients to experience delays for a specialist opinion. The hospital’s internal professional standards stated that specialist doctors should see a patient within one hour of referral but we often observed delays that were longer than this. The new computer system did not record when patients had been referred to specialists and so it was not possible to assess the frequency or length of these delays. We observed staff telephoning specialists to remind them about their referrals and then updating patients on the situation.
- Although the most common delays were for surgical or medical opinions the longest followed psychiatric referrals out-of-hours. This has been recognised as risk to patients and has been included in the risk register.
- Bed occupancy in the hospital was high (96%) and this often led to delays in admitting patients to a ward. Of the patients waiting to be admitted to hospital, 20% waited between four and twelve hours to be admitted in October 2015 and 18% in November 2015. No patients waited more than 12 hours.
- The combination of delays meant that there were occasions when the department was full or severely crowded. The hospital recognised that crowding in the emergency department was a serious risk when there was a high demand for services. A full capacity protocol & emergency department escalation policy had been developed to mitigate this risk by ensuring that patient flow throughout the hospital was managed. The protocol was based on the principle that the wider hospital took shared ownership of the risks associated with crowding and supported the emergency department to deliver the four-hour target.
- The full capacity protocol described and rated the escalation status of the emergency department, ranging from green (normal functioning) to black (normal care is not possible and the department is deemed “dangerous”). A series of actions were in place for each escalation status. When the escalation status was declared black senior hospital managers would consider declaring an internal major incident. This would result, amongst other actions, in planned surgical operations being cancelled and ambulance being diverted to other hospitals.
- The nurse in charge of the department monitored the triggers that decided the escalation status every two hours and recorded the results. These were reviewed by the emergency department management team every morning during the daily debrief meeting.
- For most of our inspection the escalation policy placed the emergency department on “red alert” (“regularly unable to function as normal and verging on unsafe for periods of time”) However, although there were some



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delays to patient flow, we did not find any risks to patient safety or delays in the initial assessment of patients. There was room in parts of the department for more patients.

- Senior clinical staff had recognised that, following changes in the organisation of the department, the escalation triggers were “ineffective”. New triggers had been developed in conjunction with the hospital operations director. These needed to be incorporated into the full capacity protocol before they could be implemented. Staff that we spoke with were unsure when this would be.
- An internal major incident had been declared on 1 November 2015. The reason given for this was a lack of empty beds in the hospital combined with more patients than expected attending the emergency department. We attended the weekly hospital flow meeting where senior hospital staff discussed the action plan aimed at preventing this happening in the future.

## Learning from complaints and concerns

- Complaints were handled in line with the trust policy. If a patient or relative wanted to make an informal complaint they were directed to the nurse in charge of the department. If the concern was not able to be resolved locally, patients were referred to the Advice and Complaints team that would formally log their complaint and attempt to resolve their issue within a set period of time. Information describing how to raise concerns or complaints was displayed on noticeboards throughout the department and was included in patient information leaflets.
- Formal complaints were investigated by senior emergency department staff. Replies were sent to the complainant in an agreed timeframe. The department employed a complaints officer who ensured that all complaints were investigated quickly and appropriately. Of the complaints received 95% had a response within two weeks. Replies that we saw were detailed and courteous.
- We saw that learning from complaints was discussed at the emergency department governance meetings and at nursing staff meetings. For example, the criteria for requesting ankle x-rays had been revised. Learning points from complaints were displayed on a noticeboard in the staff room under the heading “Things to remember”.

## Are urgent and emergency services well-led?

Good



We rated the leadership of the service as good because:

- There was strong clinical leadership of the emergency department, although there was a vacancy for a senior non-clinical manager. The lead consultant and matron had made significant improvements in safety and effectiveness in the last year. There had also been improvements in responsiveness.
- There was a clear statement of vision and values, driven by quality and safety. These values were shared by the staff that we spoke with.
- Changes made in the organisation of the department were not yet fully embedded and had not yet been translated into formal strategy due to temporary shortages in the leadership team.
- The service was transparent, collaborative and open with stakeholders regarding performance.
- Governance arrangements were robust with risks and quality being regularly monitored and escalated if needed. The department’s staff were positive, engaged and optimistic. They described the department as having a strong open culture with mutual trust and respect across the staff team.

## Vision and strategy for this service

- The leadership team told us that their strategy was for the emergency department to be as safe and effective as possible. They felt that recent changes in the organisation of urgent and emergency services was helping them to achieve this.
- Staff that we spoke with identified with these strategic aims and thought that progress had been made in resolving past difficulties. One member of staff told us that “There is light at the end of the tunnel”.

## Governance, risk management and quality measurement

- There were effective processes in place to identify, understand, monitor and address current and future challenges to high quality care and treatment.
- The department maintained a risk register, which defined the severity and likelihood of risks in the

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department causing harm to patients or staff. It documented the measures to be taken to reduce the risk. The risks described reflected the concerns described by staff in the department. However, many staff told us that delays in admitting patients to wards were always severe on a Monday. Reduced patient flow on Mondays was predictable and regularly caused long delays in the handover of ambulance patients. Senior staff were aware of this problem but it had not been entered on to the risk register.

- The risk register was reviewed at least monthly by the leadership team and severe risks were escalated to the board when necessary.
- An effective governance system was in place with the production of detailed information about the department's performance. This was discussed at regular governance meetings and used to demonstrate effectiveness and progress.
- The senior staff we spoke with were clear about the challenges the department faced and they were committed to improving the patients' journey and experience. There were daily and weekly meetings to review performance and results were shared with other services and with senior hospital managers.
- Where national audits had demonstrated a weakness in clinical practice the senior clinical team ensured that action plans were developed and re-audit programmes undertaken to ensure improvements to patient outcomes. For example, the training and experience of staff looking after children had been improved.
- Monthly governance meetings were held and all staff were encouraged to attend. We saw from minutes that complaints, incidents, audits and quality improvement projects were discussed and acted upon.
- Staff told us they were clear about their roles and felt fully supported by their clinical leads and senior managers

## Leadership of service

- Leadership of the department would normally be shared between the lead consultant, departmental matron and a non-clinical manager. The latter was vacant at the time of our inspection and the responsibilities of the post were shared between other staff in the department.
- Despite this, the two clinical leads had made great progress in solving the problems described in our

previous reports. They were highly visible in the clinical environment and had established an effective governance framework to support the delivery of high quality care.

- However, nursing staff told us that they would like to see more of the emergency department matron. For the last year she had also taken on the responsibility of nursing leadership in the adjacent acute admissions unit. This meant that there was less time than previously to develop nursing practice in the emergency department. Although this was a temporary arrangement it was unclear when it would change.
- Senior medical staff also said that they missed the presence of a full-time matron. For example, they wanted to update the departmental strategy but felt that they could not do this without the input of the matron. There was no time for this to happen.
- The leadership team demonstrated the skills, knowledge, integrity and experience needed for their roles. Staff told us that they trusted them and knew that they would be listened to if they raised concerns. They told us that there was a "no blame" culture that made it easier to admit mistakes and to learn from them.
- Debrief sessions were held by senior clinicians after difficult clinical situations.

## Culture within the service

- Staff told us that they felt respected and valued by their colleagues and the leadership team within the emergency department.
- There was a strong sense of teamwork which encouraged candour, openness and honesty. Staff told us that the support they received from their colleagues in the department helped them to cope with the pressures that had been experienced in the last eighteen months. There was cautious optimism that recent improvements would be maintained.
- We found that there was a cohesive focus on improving the experience of people who used the service.

## Public engagement

- Up-to-date details of the results of the NHS friends and family test were displayed on noticeboards within the department. The most recent response rate (November 2015) was good at 20.2%. Of those who responded, 96% said that they would recommend the department.

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- The emergency department matron kept copies of patient feedback and letters of comment or complaint. She told us that the ratio of compliments to complaints was three to one.






## Staff engagement

- Whenever letters of thanks were received they were displayed on the notice board in the staff room. If individuals were named a personal letter of thanks was sent to them by their line manager. Staff that we spoke with said that they appreciated this and that it made them feel special.
- Emergency department staff had organised a special Christmas float, pulled by a large tractor that took part in Christmas celebration in the city of Bristol. It raised money to improve patient services in the emergency department. Each year staff chose which part of the service should benefit. Last Christmas (2014) £6,000 was raised to improve the environment in the mental health assessment room.

## Innovation, improvement and sustainability

- Several improvements had been made in the last year such as the creation of the observation unit, improvements in staff training and increased levels of safety and privacy for patients. This had improved the overall patient experience. However, these changes were not yet fully embedded. For example, patients waiting for transport were often seated in the crossroads area when there was ample space in the waiting room and a nurse to ensure patient safety. This led to crowding in the crossroads area and an uncomfortable experience for the patients.
- Although the newly created observation unit and step-down area had reduced pressure in the major treatment area, processes to transfer patients there were not fully developed. There were a number of occasions when the major treatment area and/or the resuscitation area were full but there were up to eight empty spaces in the observation unit.

# Medical care (including older people's care)

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

## Information about the service

North Bristol NHS Trust provided inpatient medical services. Wards are located at gates and at each gate there are two 32-bedded wards (beds 1 – 32 and 33 – 64). Each ward has 24 single rooms and two four-bedded rooms.

We visited the following day care areas within the Brunel building: medical day care, renal day case and endoscopy. We visited inpatient wards within the Brunel building: Acute Medical Unit and Medical Short Stay, 7a (stroke), 8a (flexible capacity beds), 8b (renal), 9a (stroke rehab), 9b (flexible capacity beds), 27a cardiology, including coronary care unit), 27b (respiratory including the high dependency unit, infectious disease (including an isolation suite) and haematology), 28a and 28b (care of the elderly), 32a (complex assessment unit), 32b (gastroenterology, haematology and infectious diseases, Elgar House (rehabilitation). There were approximately 474 medical beds.

A service reconfiguration had taken place in July 2015 to change the way the acute medicine department worked resulting in the creation of the Acute Medicine Unit (AMU) where triage was managed and medical admissions assessed.

During our inspection we spoke with over 50 members of staff, including nurses, consultants, doctors, administration staff, support staff and housekeeping staff. We spoke with 12 patients and 5 relatives. We observed how people were being cared for, handover meetings and looked at care and treatment records and also other documents provided by the trust.

We made our announced visit on 8, 9 and 10 December and an unannounced visit during the evening of 16 December 2015.

# Medical care (including older people's care)

## Summary of findings

We have judged the medical care services overall as requiring improvement, although there were some areas of good practice and one of outstanding practice since the last inspection.

- Patient safety required improvement overall but some areas were good.
- There were inconsistencies in the systems for checking resuscitation trolleys to ensure equipment was fit-for-purpose.
- The storage of medicines had improved. Medicines were stored in secure cupboards in all areas and were well managed. However, records of medicines administration were not always accurately maintained.
- The completion of records did not consistently reflect the care needs of patients. Recording of assessments on some wards was not consistent and we were unable to see that assessments for some patients had been done in a timely manner.
- The tracking system for patients requiring medical examination had improved and this meant that medical staff could assess and prioritise patients effectively.
- Since our inspection in November 2014 there had been a review of staffing, skill mix and acuity of patients. There were safer nursing staff levels in the medicine directorate. Although some of the mandatory training compliance was below trust targets.
- Effectiveness of medicine services required improvement to demonstrate patient care was delivered in accordance with best practice.
- Participation in national audits had improved and the directorate had carried out a more comprehensive range of local audits to monitor performance. Continued pace was required and managers were keen to develop further action plans for national and local audit to demonstrate the effectiveness of care with actions taken and lessons learned to improve care.
- Patients were well supported with nutrition, hydration and pain.
- Staff had the skills, knowledge and experience to deliver effective care and treatment through training. However, completion of appraisals was below trust target and required improvement.
- The responsiveness of medical services required improvement, although some aspects were good and one was outstanding.
- There had been improvements to patient flow; however, patient flow remained a challenge in the directorate with medically fit patients across the directorate awaiting social care packages to support their discharge from hospital.
- The trust was participating in the 'Enhanced Care Project' to improve the way enhanced care was given to patients and had implemented certain aspects of the project in advance of the completion date as there had been overwhelming evidence of its efficacy.
- There was an outstanding example of responsiveness with the work of the dementia care team and the availability of 100 dementia champions in the trust including the Head of Facilities who was focussing on environmental changes.
- We have judged the leadership of the service as good with some areas requiring improvement.
- The directorate was facing a period of consolidation following the move to the new building in 2014. Governance structures were embedding and managers were focussed on ensuring that audits, incidents, complaints and other key information were used to demonstrate learning, change and improvement.
- Good local leadership was provided throughout the directorate and frontline staff and managers were passionate about providing a high quality service for patients with a continual drive to improve the delivery of care.

# Medical care (including older people's care)

- Most staff were positive about working for the trust and showed commitment to their patients, their responsibilities and to one another. There was a strong camaraderie within teams with flexibility provided where possible.
- Innovative practice across the directorate still required development. There had been an improvement since our previous inspection with a programme of local audit and an innovation programme had been introduced to improve the way enhanced care was given to patients.

## Are medical care services safe?

Requires improvement



Although there had been substantial improvements we have judged the overall safety of medical services as requiring improvement because:

- The completion of records did not consistently reflect the care needs of patients. There was a clear and well-followed process for responding to acutely ill patients and an experienced and skilled staff team to provide them. Recording of assessments on some wards was not consistent and we were unable to see that assessments for some patients had been done in a timely manner.
- Records of medicines administration were not always maintained to accurately reflect when they were administered.

However:

- Since our inspection in November 2014 there had been a review of staffing, skill mix and acuity of patients. There had been a reduced turnover of staff and the vacancy situation had improved. There were safer nursing staff levels in the medicine directorate. Staff were updating their mandatory training, but were not meeting trust targets in a number of the training modules.
- Staff were open and honest about incidents. There had been 31 serious incidents requiring investigation between August 2014 and July 2015 and we saw learning from these.
- The wards and day case areas were seen to be visibly clean, tidy and well maintained, and infection protocols were followed. There was a good range of safe and well maintained equipment. Staff were checking resuscitation trolleys to ensure equipment was fit-for-purpose. However, there were inconsistencies in the systems applied with some wards using a daily check and others a monthly one.
- The storage of medicines had improved with all wards having secure cupboards. Medicines were mostly well managed and administered safely.
- The tracking system for patients requiring medical examination had improved and this meant that medical staff could assess and prioritise patients effectively.



# Medical care (including older people's care)

## Incidents

- Staff were open, transparent and honest about reporting incidents and systems were in place to make sure that incidents were reported and investigated appropriately. All staff told us that they would have no hesitation in reporting incidents and were clear on how they would report them.
- Once reported incidents were reviewed by the appropriate clinical manager and where necessary investigated. Most staff told us they were able to get feedback on incidents they reported.
- We saw the incident reporting policy which set out the additional processes for reporting and managing incidents and the serious incident reporting policy and procedure which set out how the trust reported, investigated and managed any serious incident. The key features included which incidents would be graded as serious incidents, duty of candour for incidents which caused severe harm or death, the root cause analysis investigation process and the roles and responsibilities of staff involved in the process
- From data provided by the trust for the period between August 2014 and July 2015 we saw there had been 31 serious incidents reported under the Strategic Executive Information System (STEIS) requiring investigation. This was the largest number reported for any core service. None of these were never events (serious, largely preventable patient safety incidents that should not occur if the available preventative measures had been implemented). However, we were subsequently advised of a never event in November 2015 involving the wrong route administration of oral / enteral treatment. A dose of prescribed medication which was to be administered orally was drawn up in an incorrect syringe and given intravenously. The error was recognised immediately and reported to the patient and a formal investigation was undertaken and escalated to the director of nursing. The patient underwent close observation for 24 hours where no adverse effects were noted. Immediate messages about the administration of oral/ enteral treatment were presented to clinical governance and distributed from the pharmacy department to all other departments. Supplies of oral medication syringes were restocked and available across the trust and were kept separately from other syringes. Trained staff were required to sign a form to demonstrate their understanding of compliance of oral administration policy.
- A root cause analysis had commenced and was to be presented to the clinical risk team on 20 January 2016 and to the risk committee on 5 February 2016. The submission deadline to commissioners was 12 February 2016.
- Slips, trips and falls were the most prevalent type of serious incident accounting for over half of the incidents (19). Pressure ulcers meeting serious incident criteria were the second most prevalent (6) and two were HCAI / infection control incidents.
- From the report of the National Reporting and Learning System (NRLS) of incidents from October 2014 to September 2015 we saw that the medical service was the core service with the highest number of incidents reported (4,066 which represented 44.5% of the trust wide total). There had been a downward trend in the number of incidents reported. The trust explained that this might be in part due to delays in reporting to NRLS. There were five incidents resulting in death and 27 resulting in severe harm. There was a downward trend in the number and proportion of incidents resulting in moderate harm. The majority of incidents reported (2,608, 64%) resulted in no harm. The most commonly reported incident category was patient accidents which accounted for 40% (1,676). This category accounted for three of the five deaths during this period. The second most commonly reported category was medication incidents 15% (616). The other two incidents resulting in death were one relating to the type of treatment or procedure and the other to access, admission, transfer or discharge.
- The timeliness of incident reporting had improved over the reporting period. Since April 2015 most incidents had been reported within 60 days each month. In September most incidents were reported within 30 days.
- Data demonstrated that although there had been a slight improvement in the number of falls since our inspection in November 2014 the risk remained. The directorate were continuing to embed the improvements implemented during our last inspection. The medical assessment of patients at risk of falls was improving and included a review of medication, cognition and blood pressure. A flow chart outlining the

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process following a serious fall was in place and the rate of risk assessments was continually monitored through the falls group. Falls sensors had been purchased and were used on wards with a high number of falls and there continued to be an emphasis on the safe transfer for toileting using new hoists and alerts for the safe use of shower chairs. Staff were aware of the falls prevention policy and matrons continued to carry out walkarounds to observe how the intentional rounding programme (which was a formal checklist used by staff to check patients every hour, for basic care needs such as toileting and hydration) was being performed. There were magnetic signs on patient doors to highlight patients at risk of falls and we saw a falls care plan used that prompted cohorting patients to provide "line of sight" care to prevent falls and prompts for identifying confusion and supervision for toileting. Falls prevention training was available to all nursing staff as part of the mandatory training programme and there was a 79% compliance level for staff in the medical directorate.

- We were told about an incident on ward 8b where adjustments were not made to insulin levels following the removal of a peritoneal dialysis catheter and resulted in a hypoglycaemic episode. The patient had become unresponsive and the crash team were called. The patient sustained no lasting harm. A senior nurse went through the events with one of our specialist advisers and was planning to complete an incident form.

## Duty of candour

- Staff demonstrated an understanding of duty of candour responsibilities. Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, is a new regulation which was introduced in November 2014. This Regulation requires the trust to be open and transparent with a patient when things go wrong in relation to their care and the patient suffers harm or could suffer harm which falls into defined thresholds.
- Training for duty of candour was provided to the directorate governance group by the patient safety manager. The incident reporting system had a section for duty of candour which automatically became active if patient harm was reported as moderate, major or catastrophic. Root cause analysis incidents also had a duty of candour checklist included in the document

template with an action to discuss the incident outcome with the patient and / or their relatives. Actions and target dates were monitored by the clinical risk committee and through the reporting system.

- All duty of candour data was monitored through the patient safety team to identify compliance and directorate managers received regular reports of the duty of candour compliance for all relevant incidents. The clinical risk and patient safety web site had a page dedicated to guidance, a checklist and letter templates on the duty of candour.

## Safety thermometer

- As required, the trust reported data on avoidable patient harm to the NHS Health and Social Care Information Centre each month. This was nationally collected data providing a snapshot of avoidable patient harms on one specific day each month. This included hospital-acquired (new) pressure ulcers (the two more serious categories: grade three and four) and patient falls with harm. The report also included catheter and urinary tract infections (UTIs) and incidence of venous thromboembolism (VTE). Within this snapshot view, the prevalence rate of pressure ulcers had fallen since February 2015 with 94 pressure ulcers reported to the patient safety thermometer between July 2014 and July 2015. There had been a downward trend in the prevalence rate of falls with 37 falls reported over the same period. There were 26 catheter-associated urinary tract infections during the period July 2014 to July 2015. The prevalence had been variable with no obvious trends.
- Most wards had a multidisciplinary daily safety briefing prior to the board round to highlight safety issues such as patients at risk of falls or pressure ulcers. All staff on the ward were encouraged to attend.

## Cleanliness, infection control and hygiene

- At the time of our inspection the wards and day case areas were seen to be visibly clean, tidy and well maintained. This included patient bed spaces, corridors, staff areas and equipment used both regularly and occasionally. Patient bed spaces were visibly clean in both the easy and hard to reach areas such as beneath beds. Bed linen was in good condition, visibly clean and free from stains or damage to the material. Storage



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cupboards were well organised with most equipment on shelving units to prevent dust and dirt gathering around and beneath objects. We regularly saw the cleaners on wards during our visit.

- There were monthly trust-wide audits to measure compliance with the trust hand hygiene policy. Compliance in medicine averaged 95.5% with results ranging from the lowest at 91.7% to 100% compliance. Senior nurses told us there was clearer guidance and consistency in hand hygiene audit procedure. Details of hand hygiene audits were displayed on notice boards in ward and day case areas.
- We observed doctors and nursing staff washing their hands and using anti-bacterial gel in line with infection prevention and control guidelines. Visitors were asked to use alcohol gel when arriving on the wards and this was freely available and clearly visible at the entrance to wards and day case areas. Staff were bare below the elbow and used personal protective equipment (PPE). However, we saw staff wearing different colour aprons on some wards. This inconsistency meant that staff working in different wards might not be aware of the colour coding.
- Compliance for infection prevention and control training was at 82% for the directorate.
- Disposable items of equipment were disposed of appropriately, either in clinical waste bins or sharp instrument containers. Nursing staff said these were emptied regularly and none of the bins or containers we saw were unacceptably full.
- Cleaning schedules for nursing staff, domestics and estates were visible in most wards and details of cleaning audits were displayed on notice boards in ward areas and day case areas. Domestic cleaning schedules included daily tasks such as toilets, sinks, bins, replenishment of consumables, beverage areas and kitchens. Environmental cleaning schedules for rooms included patients' rooms and common areas. Most areas were clean, however, of the five commodes we checked there were two that were dirty with dried faeces. We reported this to nursing staff who agreed to arrange cleaning as soon as possible.
- Equipment was stored in rooms or designated areas on wards and most had "I am clean" stickers on equipment such as scales, dressing trolleys, hoists, walkers, chairs, BP machines, ECGs and in some areas stickers had been placed on work surfaces.

- Three patients told us about excellent levels of cleaning in ward areas and one patient commented that the "cleaner was marvellous ... everything is so clean".
- The trust carried out daily updates for methicillin-resistant *Staphylococcus aureus* (MRSA) and *Clostridium difficile* (C.diff) and demonstrated how they were performing against trajectory. Data showed the last infection for acquired MRSA bacteraemia was recorded on 1 September 2015 with a total of two cases against a trajectory of zero; for C.diff the last infection was recorded on 11 November 2015 with 41 cases against a trajectory of 43; for methicillin-sensitive *Staphylococcus aureus* (MSSA) the date of last infection was 22 November 2015 with 19 cases against a trajectory of 18; and for *E.coli* the date of last infection was 19 November 2015 with 26 cases against a trajectory of 60. The trust norovirus risk rating was rated as WHITE during the week of our inspection.

## Environment and equipment

- Equipment was clean and functional and was labelled with the last service date, and some equipment had decontamination status labels that identified when equipment was cleaned.
- There was safe provision of resuscitation equipment. We inspected 11 resuscitation trolleys and saw they were mostly centrally located, clean and that defibrillators had been serviced. However, there was confusion about the regularity of checking with some wards operating a daily system and others a monthly system. There was a form to complete to show the check was completed. On wards where monthly checks were completed we were advised that the contents did not expire within one month and remained in date. We saw two trolleys that did not have covers and one trolley on 27b was tucked away in a narrow area with a desk opposite and a cannulation trolley between the exit. This meant that the equipment was not located in the most easily accessible location for staff in an emergency. We spoke to the senior nurse about its accessibility and he agreed to look at its location. We saw a health care assistant (HCA) checking the resuscitation trolley on ward 8a following its use to ensure there was adequate equipment. During our visit an emergency bell was heard and staff response was immediate. It transpired that it was a false alarm as the patient had pulled the cord by accident. We also saw a trolley being restocked and resealed following use on one ward.

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- Equipment store rooms were locked. This meant that equipment such as syringes and dressing packs were stored safely and securely to prevent theft, damage or misuse.
- When we visited endoscopy staff told us the problems encountered with the sterilisers during our previous inspection in November 2014 had been resolved. The water problems and regular replacement of filters had been resolved and scopes were no longer out of action and patient procedures were not delayed or cancelled. Machines were supported by engineers who urgently responded to any problems.
- On the medical day care unit the team were testing new sharps bins and giving feedback about a number of different designs. Fridges had recently been installed containing the unit's own blood bank which were undergoing a trial period to ensure their efficiency before becoming fully operational.
- We found most utility rooms were unlocked. This meant that cleaning products were not stored securely and could be accessed by patients, relatives and members of the public. Some staff kitchen doors had been wedged open and were accessible to patients.
- Elgar House had been reopened following refurbishment three weeks prior to our inspection. Colour coded door panels had been introduced to assist patients with dementia to navigate around the ward and to find their bed area and bathroom.
- Automated guided vehicles were used to transport stocks and supplies to predetermined stations located in wards. They were programmed to navigate to pre-set routes communicating with lifts and doors en-route. They were fitted with sensors to detect obstacles, including people who might be in their path.
- There was a fully automatic pneumatic tube system linking the building to the pathology laboratory and the pharmacy department. The tubes carried samples to pathology for testing and prescriptions and were found in each ward.
- Televisions were being provided in all patient rooms at the time of our inspection.
- Staff on the medical day care told us about previous problems with flooding from areas above the unit. Investigations had identified a problem with the plumbing and the pipe work was being replaced as part of a rolling maintenance programme.
- There was an active arts programme in the trust and a two-day arts festival had highlighted the role that creativity played in health and well-being.
- The service participated in the campaign called "Green Impact" which was a national award scheme to create a healthy, resilient and sustainable healthcare service for Bristol. Staff were encouraged to take simple actions such as becoming an energy champion, having a flu jab or remembering to turn lights off and close doors behind them. Once the actions were completed staff would receive a Green Impact award at a ceremony at the end of the year. Information was available to help staff to reduce their impact on the environment and stay healthy at the same time.
- We spoke to several visitors who praised the introduction of the new motorised buggy which they had flagged down to give them a lift through the atrium. They had mobility problems and struggled to walk long distances to visit their relative or to attend as a day case.

## Medicines

- Staff had access to the trust medicines management policy which defined the policies and procedures to be followed for the management of medicines and included obtaining, recording, handling, using, safe keeping, dispensing, safe administration and disposal of medicines. Staff were knowledgeable about the policies and told us how medicines were ordered, recorded and stored.
- We looked at medicines audits, incidents and complaints, storage security, medicines records and supply and waste processes. Medicines, including those requiring cool storage, were stored appropriately. During our inspection we found that medicines were stored securely and were only accessible by staff.
- There was a ward based pharmacy service and we saw pharmacists checking that patients were taking correct medication and that records were up to date.
- Medicines trolleys had been introduced to wards during the week of our last inspection. Staff told us that they had continued to facilitate the secure transportation and efficient administration of medicines across the wards.
- Medicines were stored safely in locked cupboards. Purple syringes for oral / enteral were kept separately from other syringes and first line emergency medicines and equipment were stored in tamper evident trolleys.

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- Second line emergency medicines and spare first line medicines were stored in tamper evident containers; however, the containers could be removed from the ward on the Acute Medicine Unit (AMU).
- Controlled drugs were stored in separate locked cupboards. However, the cupboards were of inadequate size for the range of medicines held by ward 8b and Elgar 2.
- We found IV fluids and haemodialysis fluids were stored securely in locked rooms. However, on ward 8b some fluids were stored in low level cupboards under worktops which meant that to access the bottom shelf staff had to crawl or sit on the floor. Staff had asked for the cupboards to be wall mounted. The date of opening or "in use" expiry dates were not written on liquid medicines in Elgar 2.
- Refrigerators were locked and temperatures checked. However, temperatures were not recorded in accordance with trust policies which required daily checks and on 27b records indicated the temperature had been outside the recommended temperature range and actions were not taken.
- We reviewed the prescription and medicine administration records for 11 patients on five wards. We looked at signatures and dates; legibility, documentation of allergies; documentation when medications were omitted or not administered; prescription of antibiotics; VTE prophylaxis if indicated. There were some errors including illegible signatures that were not backed up with a printed name making it difficult to decipher the name; no documentation or explanation when antibiotics were omitted; no record of the time medicines were administered and patients' weights were not regularly recorded. This meant that prescription and medicine administration records were not always accurate.

## Records

- There were three sets of records: bedside, medical notes and records on the new electronic system which had been introduced three weeks prior to our visit.
- We carried out a detailed review of patient notes including: the name and grade of the nurse or doctor reviewing the patient; signature and date; whether patients were seen on post take ward rounds within 12 hours of admission; the documentation of diagnosis and management plan; the completion of nursing assessments and risk assessments; pressure ulcer risk

assessment; nutritional risk assessment; falls risk assessment; care plan including all identified care needs; evidence of daily ward round including a review with senior clinicians; patient observations recorded and early warning scores calculated and escalated; evidence of review of antibiotics; and the ceiling of care considered. Of the 27 records checked we found inconsistencies in 10 records. For example, some records had missing documentation or incomplete documentation; some medical entries were illegible and there were overdue risk assessments. Staff told us they were still getting used to the new electronic system and did not feel particularly confident about using the system and this unfamiliarity had contributed to some of the omissions and inconsistencies. They were optimistic that in time they would become fully competent.

- Most DNACPR (do not attempt cardio-pulmonary resuscitation) forms had been appropriately filled out. However, of the seven we looked at there were two where it was not clear if the patients had the mental capacity or whether there had been any discussions with the patient.
- Whilst most patient records were stored securely there were three examples where notes were left unattended outside of single patient rooms. They were left for around five minutes in most instances; however, we observed notes left unattended for 30 minutes. We alerted the ward manager and handed them the notes. Notes had also been left at nurse's station and on computer screens clearly showing the patients details. This meant that notes were open to be tampered with, removed or read by unauthorised people. The ward manager was informed.

## Safeguarding

- Staff we spoke with were knowledgeable about the trust safeguarding policy and processes and were clear about their responsibilities. They were able to explain their role and what actions they would take should they have safeguarding concerns about a patient. Staff were trained to recognise and respond in order to safeguard patients. Records indicated that staff were trained to level 2 in safeguarding. The current compliance level in medicine was 90%.

## Mandatory training

# Medical care (including older people's care)

- The trust provided a programme of mandatory training for staff which included infection control, blood transfusion, resuscitation, information governance, safeguarding, moving and handling, equality and diversity, fire training, food hygiene and hand hygiene. Mandatory training for falls was also provided by a bespoke training nurse and a medical consultant specialising in falls.
- Training was provided in a self-service format through a managed learning environment where records were monitored to review attendance and expiry dates, thereby ensuring compliance with mandatory training. Compliance was improving in all areas and managers received messages about the drive for continual improvement via monthly e-mails and directorate meetings.
- Training was provided through a mixture of e-learning and face-to-face modules. Specific training for nurses was provided for gastrointestinal endoscopy via an e-learning programme. Staff told us that training was delivered to meet their needs and that interests were encouraged and accommodated where possible. However, some staff told us that they were unable to attend other training due to capacity and time restraints and there was little time to share learning with colleagues.
- Overall there was an increase in compliance to meet the trust target for mandatory training. There was 85% compliance in the top seven areas, however, compliance was not met for fire safety (84.5%), information governance (75%) and equality and diversity (69%). This meant that most staff were up-to-date with their skills and knowledge to enable them to care for patients appropriately.
- Staff did not have specific training on control and restraint. However, many specialists were available to the wards to offer advice on managing specific patients. These included safeguarding, dementia care and mental health liaison.

## Assessing and responding to patient risk

- Risk assessments were completed and evaluated. These included assessments for pressure ulcers, nutrition and mobility. There were clear processes in place to deal with deteriorating patients. Early warning scores (EWS) were in place on wards. Each chart recorded the necessary observations such as pulse, temperature and respirations. Staff were able to articulate and were

knowledgeable in responding to any changes in the observations which necessitated the need to escalate the patient to be seen by medical staff. However, recording of assessments on some wards was not consistent and we were unable to see that assessments for some patients had been done in a timely manner.

- A new early warning scores system was being introduced for the prompt escalation of treatment for clinically deteriorating patients replacing the existing EWS. It was more sensitive and triggered more easily. Ward based training with the link nurse was being rolled out and cascaded to staff in the week following our visit.

## Nursing staffing

- There were safer nursing staff levels in the medicine directorate. Since our inspection in November 2014 there had been a review of staffing, skill mix and acuity of patients.
- There had been a reduced turnover of staff. Actions taken to address turnover included ward drop-ins by HR to seek feedback from new starters, greater focus on the completion and return of exit questionnaires and plans to ensure that new starters were well supported and mentored.
- The vacancy position had improved during the past 12 months but remained an ongoing focus for the directorate. The latest data available showed the vacancy factor at 10.6% for August with further improvement anticipated for the remainder of the year. At the time of our inspection there were 2.4 vacancies for registered nurses with 7.2 for health care assistants.
- Data showed deficits in nursing against the planned establishment in some wards. There was a greater than 10% deficit on wards 7a, 9b and 27b.
- There had been a significant financial investment in nursing and the plan was to build safe and effective teams. There was proactive management of the workforce with a recruit to turnover policy in place. New staff remained supernumerary during their induction period.
- Bank and agency use remained high showing averages of 12% for bank staff and 6% for agency, due to unfilled vacancies and use of temporary staff to fill gaps, and for patients requiring one-to-one care.
- The development of a nursing workforce strategy was already in progress and included the refocussing of the matron role to ensure optimum value and the optimisation of the supervisory ward manager roles to

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ensure capability and effectiveness of post-holders. The development of a nurse rotation programme for newly qualified nursing staff had been introduced in September 2015.

- There was an ongoing programme of continuous recruitment in line with the trust wide recruitment strategy. This included rolling advertisements for generic vacancies and focused advertising for specialist areas. All matrons and ward sisters were engaged in continuous recruitment and a number of staff had recently returned from a recruitment drive in Spain and a cardiology / respiratory open day was scheduled for early 2016.
- There was rapid assessment of acuity. The 'safe care' acuity tool which worked on the Association of UK University Hospitals (AUKUH) dependency tool was introduced on all wards in March 2015. The tool had five levels of acuity and dependency: 0 for patients requiring hospitalisation where their needs were met by the provision of normal ward care; 1A for acutely ill patients requiring intervention or those who were unstable with a greater potential to deteriorate; 1B for patients who were in a stable condition but were dependent on nursing care to meet most or all of the activities of daily living; 2 for patients to be managed within clearly identified, designated beds, resources with the required expertise and staffing level or may require transfer to a dedicated Level 2 facility/unit; 3 for patients needing advanced respiratory support and/or therapeutic support of multiple organs.
- Patients were assessed twice a day and the data recorded by the clinical ward nursing teams. This tool was used in conjunction with the number of available hours recorded on the e-rostering system. The nursing ratio average for each medical ward was based on a 1:8 registered nursing ratio and 1:8 health care assistants. Where specialties with a higher acuity of patients had been identified including the requirement for 'specialling' and 1:1 care then additional staff were utilised. Planned nurse to patient ratios on the coronary care unit and Medical HDU were 1:2 registered.
- The nursing workforce ward early warning trigger tool had flagged as a risk. Wards were RAG (red, amber, green) rated with those scoring above 12 recorded as red. From data available for August 2015 there were four wards that had not completed the tool. These areas were being reviewed by the heads of nursing and matrons to ensure any concerns were reviewed and

monthly submission occurred. No wards had flagged over 12, and the two areas which flagged in the previous month demonstrated an improvement based on vacancies being filled and an improvement in the percentage of unfilled shifts. The head of nursing was reviewing a dashboard which would assist the triangulation of the quality data with staffing and the trigger tool.

- One ward (8b) had remained in the amber range for the past 6 months. The head of nursing and matron were working closely with the ward sister to review and manage the triggers causing this to ensure that there was a more rapid and sustained improvement. Other wards (8a and 27b) scored 11 and 10 respectively. The main drivers were staff vacancies and sickness absence, mainly long term sickness leading to unfilled shifts.
- A new behavioural healthcare assistant role had been established in July 2015 providing one-to-one support for patients with cognitive or behavioural difficulties. Psychology graduates had been recruited into the role. They were trained as a healthcare assistant and were able to fulfil personal care duties. A two week training period was completed in the classroom followed by six days shadowing on the ward to complete the ward induction and orientation.
- Ward sisters met bi-monthly to share learning and ideas. Directorates took it in turns to lead and organise the meetings, and to decide the theme for the meeting and book guest speakers.

## Medical staffing

- There was a total of 245 whole time equivalent doctors providing cover in the directorate.
- The proportion of consultants was smaller than the England average. The proportion of junior doctors was similar to the England average. Data showed there were 29% compared to the average of 34% for consultants; 2% compared to 6% for middle career (at least three years at senior house officer or a higher grade within their chosen specialty); 46% compared to the average of 39% for registrar group (specialist registrar); and 23% compared to 22% for junior foundation year 1-2.
- Senior clinicians told us teams were very adaptive and worked well together. Communication had led to better engagement and they cited the example of the arrangements to cover for the proposed junior doctor strike when the teams had been engaged and cooperative in providing cover.



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- The creation of hybrid posts had provided a mixture of high quality medical posts with better job satisfaction.

## Major incident awareness and training

- There was a trust major incident plan which outlined the decisions and actions to be taken to respond to and recover from a range of consequences caused by a significant disruptive event. The staff we spoke to were aware of the trust major incident plan and how to access this on the trust intranet system. Staff had also participated in desk-top major incident simulation exercises.
- There was also an escalation plan for occasions when the hospital did not have enough patient beds. Ward procedure rooms were used as inpatient rooms and we saw the procedure room escalation policy for staff to refer to. Staff on most wards told us that this happened on a regular basis

## Are medical care services effective?

Requires improvement



We have judged the effectiveness of services as requiring improvement, because:

- Not all staff had been given their annual appraisal and this was not meeting trust targets. There was, however, a good standard of competence among the staff teams.
- A new IT platform had recently been introduced providing a real-time electronic patient record system across the trust. There were some omissions in the completion of the electronic patient record. Staff were not completely familiar with the new system and although this might have contributed to the discrepancies we could not be assured that assessments had been completed for all patients. There were also some omissions in the assessment and documentation of patient's capacity. This meant that assessments were not always completed or in a timely manner.

However:

- Participation in national audits continued and the directorate had carried out a more comprehensive range of local audits to monitor performance and

maintain standards and were monitored by the monthly governance meetings. Managers were keen to develop further action plans for national and local audit with areas of focus being identified by the directorate.

- Patient needs in relation to pain, nutrition and hydration were well managed.
- There was a good multidisciplinary approach to assessing and planning care and treatment for patients.
- Patients were at the centre of the directorate's services and the overarching priority for staff.

## Evidence-based care and treatment

- Policies and guidelines had been developed in line with national policy. These included the National Institute for Health and Care Excellence (NICE) guidelines. Policies were available to all staff via the trust intranet system and staff demonstrated they knew how to access them.
- Endoscopy services were awarded Joint Advisory Group on Gastrointestinal Endoscopy (JAG) accreditation in December 2014. The service met the accreditation standards framework such as policies, practices and procedures.
- An 'intentional rounding' programme was in use, which was a formal checklist used by staff to check patients every hour, for basic care needs such as toileting and hydration, had embedded across the directorate. Staff felt this promoted hourly patient contact and patients in single rooms told us they felt reassured by these regular contacts.

## Pain relief

- Pain relief on wards was well managed. Patients prescribed pain relief to be given 'when required' were able to request this when they needed it. Patients told us they were asked by staff if they were in any pain and medicines were provided in line with the patients' prescriptions.
- We saw nurses ask patients if they were in pain, identify the location and deliver pain relief medication where necessary.

## Nutrition and hydration

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- Patients were screened using a tool based on the the malnutrition universal screening tool (MUST) to identify those who were malnourished or at risk of becoming malnourished. The tool had been adapted within the trust to provide a more rapid response to potential risk.
- The trust had a proposed target of patients assessed within 48 hours. The trust had missed the target with 85.6% of patients being screened against a target of 90%. Despite a daily follow-up of all unassessed patients and an improvement in the three months prior to June 2015, performance had deteriorated. The trust had reviewed the data in a 24 hour period to ensure its accuracy and concluded that as some patients were being discharged from the acute medical unit before the malnutrition screening assessment was completed but had been included in the data set, the information was inaccurate. Managers would be looking at processes to ensure more accurate recording.
- A care support plan included information about nutritional care and fluid needs and how they were to be met.
- There were protected meal times on medical wards to provide an environment conducive to people enjoying their meals and being able to safely consume their food and drinks. Cold snacks were available for patients in addition to the regular meals.
- All staff and volunteers received regular training on nutritional care and management. We observed caring interaction between a patient and their family, and a nurse about their nutritional needs.
- Menu planning advice included design and structure; content and capacity; nutritional analysis; guidance on common dietary categories; terms and coding to support patients from nutritionally vulnerable to nutritionally well. It also covered texture modification, cultural and therapeutic diets.
- We observed three organised meal services on wards 6b, 7a and 27b. They were well organised and efficient with good team working. Catering assistants served the food from a trolley and health care assistants delivered the food to patients. All staff were wearing blue aprons and washed their hands or used hand gel. Cold items such as sandwiches and salads were individually plated and covered in cling film on a separate trolley next to the heated trolley. Food was delivered politely, tables were cleared to make way for the plate and assistance was provided to remove the lid from the plate. Food was well presented and portions appeared adequate and

were adjusted for one patient who was particularly hungry. Meals were delivered methodically from one end of the ward to the other. For any new patients who had not ordered a meal the health care assistant rang the central kitchen and then fetched the meal taking a 10 minute round journey to the kitchen. Food remained hot during transit. Meal times were protected and we saw a health care assistant who was asked to do another task explaining that she was unable to help. This was respected. A member of staff checked that a meal had been delivered to all patients on the ward. We noticed that two patients had been missed on 7a. We informed staff who arranged for meals to be delivered straight away.

- Patients requiring assistance were generally left until last although their meals were delivered and then remained on tables awaiting assistance. We saw clear instructions for altered texture foods for patients with swallowing difficulties. We observed a patient being assisted with a pureed meal where the food was piped in a shape as closely as possible to its original solid shape. The patient was positioned well and the member of staff interacted with the patient throughout. However, we observed staff assisting two other patients on 7a where there was no interaction and one member of staff was looking out of the window.
- One patient told us the food was "OK and always hot." However, another patient told us there was "no way of keeping food hot if I'm not ready to eat."
- We audited whether patients had a drink within their reach on most of the wards we visited. Of the 18 patients we visited we found 14 who had drinks within reach.

## Patient outcomes

- A number of regular audits were carried out by the directorate to monitor performance and maintain standards and were monitored by the monthly governance meetings.
- Managers were keen to develop further action plan for national and local audit with areas of focus being identified by the directorate.
- We saw an action plan for all national healthcare quality improvement programmes, including the National Clinical Audit and Patient Outcomes Programme (NCAPOP) participated in the medicine directorate. The audit was listed against the specialty involved and showed the report date; approved action date and the

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action plan status and included the national lung cancer audit, cardiac rhythm management audit, national audit of dementia and the national insulin pump organisational audit.

- The overall trust score for the Sentinel Stroke National Audit Programme (SSNAP) between July 2014 and June 2015 was a 'D'; the score relates to 'A' being the best and 'E' being the worst. This was the same score from the previous year's audit. However, it was noted that the trust scored 'A' for team-centred scanning indicators for all four quarters during the same period.
- The trust participated in the National Heart Failure Audit and the Myocardial Ischaemia National Audit Project (MINAP) for 2014/2015. The audit collects data on patients with an unscheduled admission to hospital who were discharged with a primary diagnosis of heart failure. MINAP provides comparative data to help clinicians and managers to monitor and improve the quality and outcomes of their local services. Data had not been published for 2014/2015. From the data available for 2013/2014 the trust performed better in the National Heart Failure Audit than the national average for patients receiving an echocardiogram (an echocardiogram creates images of the heart used in the diagnosis and management of patients with suspected or known heart diseases); but worse for six of the seven indicators relating to discharge. There were mixed results in the MINAP audit with referrals for an angiography showing 95.9% against an England average of 77.9% and admission to a cardiac ward showing 21.7% against an average of 55.6%.
- There was a local audit programme for medicine. We saw a log of audits completed during the year to date which included the management of diabetic ketoacidosis, assessment of inpatient hip fracture management, adherence to target oxygen saturation on care of the elderly wards and a review of intravenous antibiotics and the appropriate use of cultures to guide therapy.
- The antibiotic point prevalence study was carried out on one day in March 2015. All wards and Elgar were audited. There were 150 patients receiving a total of 193 antibiotics. Results showed an improvement in antibiotic prescribing from September 2014 in all areas apart from the approval of restricted antibiotics. There were nine prescriptions for piperacillin/tazobactam and one for IV ciprofloxacin that were not approved by microbiology. The three most commonly prescribed antibiotics were: amoxicillin (225), clarithromycin (125), and piperacillin/tazobactam (0.5%). Prescriptions for agents that were considered high risk for c.diff were low: amoxiclav (6%), quinolones (3%) and cephalosporins (0.5%).
- A number of local audits were still active and included medical iron deficiency anaemia, anticoagulation reversal in neck of femur fracture patients and generic multi-disciplinary clinical record keeping standards.
- Action plans were in place following participation in audits to address areas requiring improvement. Regular reviews were undertaken to monitor progress.
- The trust received mortality data with reports received each month within the integrated board report. The trust has demonstrated adjusted mortality data that was consistently better than the national benchmark. The most recent published information for the 12 months from July 2014 to June 2015 indicated a Hospitals Standardised Mortality Ratio (HSMR) indicator of 94 within confidence intervals of 89.3 and 98.5 for the 12 months. The latest available published Summary Hospital Level Mortality (SHML) related to the period January 2014 to December 2014 and confirmed a SHML of 94 within confidence intervals of 89.5 and 97.9. The board also monitored the monthly raw mortality information as an early indicator of any issues developing as this was available before the adjusted data. This rate had also been consistently low and falling over recent years. HSMR by day of admission was less than 100 for all days of the week with no evident increase for admission on weekend days. The trust quality surveillance group reviewed the data on adjusted mortality at individual service level which was available from the Dr Foster data base. Further investigation was commissioned if required although currently there were no services with mortality statistics that would be considered as outliers.

## Competent staff

- There was a commitment to training and education within the service. Staff told us they were encouraged and supported with training and that there was good teamwork.
- There was a trust wide electronic staff record where all training attended was documented. Managers were informed on a monthly basis of training completed and alerted to those staff requiring updates.



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- Staff told us that they received regular access to supervision and received regular face-to-face feedback.
- The latest data from August 2015 showed medical appraisal completion was at 71.4% with non-medical appraisals at 68.1%. The situation had improved month on month during the last year but managers were driving improvement through monthly reminder emails to staff and by targeting areas whose progress was the slowest and requiring them to provide sight of their appraisal schedules.

## Multidisciplinary working

- We saw evidence that staff worked professionally and cooperatively across different disciplines to ensure care was co-ordinated to meet the needs of patients. Staff reported an increase in multidisciplinary team working with daily meetings to discuss patient's care and treatment.
- We observed a weekly multidisciplinary team meeting where three patients were reviewed. The discussions were comprehensive and detailed and included discharge planning.
- Staff felt the open plan offices had contributed to improvement in communication between staff groups.

## Seven-day services

- There was 24 hour medical cover seven days a week on the wards.
- The pharmacy was open on Monday to Friday from 9am to 7pm, and on Saturday and Sunday from 10am to 2pm with an on-call pharmacy service outside of normal working hours. There was access to radiology support at weekends.
- There was a six day service for physiotherapy with some Saturday working to facilitate patient discharge. There was an out of hours on call service for urgent patients, for example patients requiring urgent respiratory physiotherapy. Other allied health professionals (AHPs) told us that a seven day service would be considered when funding was available.
- Medical day care areas were open on Monday to Friday from 8 am to 8pm and on Saturday and Sunday from 9am to 1pm. To meet the increasing demand endoscopy clinics were available during two evenings until 8.30pm and on some Saturdays.

## Access to information

- A new IT platform had recently been introduced providing a real-time electronic patient record system across the trust
- The director of operations had led the implementation of the system with support from the IT team. The major change had caused some uncertainty and disruption and a number of measures had been put in place to provide additional support and assurance during the transition process. Of staff, 80% were trained prior to the go-live day which consisted of classroom and on-line training. A go-live handbook was available prior to implementation and included background information, frequently asked questions, troubleshooting advice and details of how to get support.
- Staff champions had volunteered across the service and floor walkers and trainers were available during the implementation to help with basic problems and identify specific issues in order to direct support accordingly. They were gradually being phased out during the week of our inspection. In addition to the support from the IT team there was a designated page on the home page of the intranet and a self-service platform was available to staff to resolve their difficulties. New standard operating procedures had been devised describing procedures to be followed to complete a task.
- Data had been migrated from the old system to the new system in the six week period prior to implementation and administration staff had, and were continuing to experience problems with a number of glitches with backroom functions.
- The implementation of the new system and the stabilisation period would be reviewed at the next operational board meeting on 17 December 2015. Staff reported a variance in views about the training with some positive feedback about the technical advice and support provided by floor walkers and the IT team. However, others reported that the IT team had not been able to help with the clinical application element of the new system, for example, how to use it to support patient care. They were some ongoing technical issues such as the slowness of the system and difficulties completing some screens.
- We reviewed patient notes on the screens and found some were out of date and some where there was no evidence that nursing assessments had been completed from ward admission. We raised this with a senior staff nurse who was going to escalate this to the ward sister.

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We also raised this with the executive team at the end of the inspection who explained that a practice development nurse, who was the safety lead for the new system, had been auditing the records since its introduction. They were confident that nursing assessments had been completed but might not have been saved in the correct place and was concerned that we might have incorrectly interpreted a red flag on the screen as an assessment not being done when it was an indicator of risk. We were assured that there would be ongoing auditing of records to ensure completion and training would be available for staff to support them during the early stages of implementation. However, during our review of the screens a number of staff had demonstrated the functions of the system and had not been able to find the assessments. We could not, therefore, be assured that assessments had been completed for all patients.

- Notice boards at entrances to wards or day case areas showed information for patients, for example, a patient safety newsletter and a cleaning analysis. Information for staff was also displayed on notice boards showing information about staff training, safety briefing audits leadership development programme and protocols, and a flavour of friends and family responses
- Staff told us about a "15 steps idea" they were developing to look at what a visitor to the ward noticed and needed within their first 15 steps on the ward. All staff were passionate about this idea and were working on an action plan to present the best impression as soon as visitors entered the ward.

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

- Patients gave their consent when they were mentally and physically able.
- Staff had a good understanding and guidance to follow in relation to mental capacity assessments. There were patient mental capacity assessment forms which led on to considerations of how decisions were then made in the patient's best interests. The forms followed the provisions of the Mental Capacity Act (2005) in that they recognised a patient's mental capacity to make decisions could be temporary and related to the decision in question and not all future decisions.
- Compliance for mental capacity and Deprivation of Liberty Safeguard (DoLS) training was 86% in the medicine directorate and was just above the trust target of 85%.
- Staff were aware of the policy regarding risk assessment, forms assessing and requesting one-to-one support and the DoLS process. Most senior nurses felt competent to raise consent issues and to complete the relevant documentation and were aware of the policy from initiation to best interest assessment, the revisiting and lifting of DoLS where appropriate. A review of consent forms in patient notes showed that most forms had been correctly completed by an appropriate member of the medical team. However, we reviewed notes where there was no evidence of a DoLS assessment, monitoring or documentation, for example there was no risk assessment, a dementia booklet had not been completed or a care plan in place. We also saw a mental capacity assessment completed by a consultant seven days after it was recommended by a learning disability liaison nurse. This meant that assessments were not always completed or in a timely manner.
- Concerns had been expressed by staff prior to our visit that DoLS were not put in place and that staff were not equipped with the correct training or skills to deal with physically aggressive patients. Bank staff were not told prior to their shift that they were required to provide one-to-one care for confused and aggressive patients. We asked the trust to respond to the concerns. The trust confirmed that there had been a number of challenging patients within the three months prior to our visit. The trust was reviewing restraint/de-escalation training and policy in line with Department of Health Guidance Positive and Proactive Care: reducing the need for restrictive interventions (2014). The need was identified following known incidents and concerns raised by staff. The wards included within the concerns raised had been reviewed and did require some additional support and training in DoLS and the de-escalation of challenging situations.
- Internal audits of compliance with DoLS were undertaken by the safeguarding team. The results indicated a lower than desirable level of compliance across all wards. In order to address this within the directorate a number of actions were taken. These included dedicated training for Elgar staff on the application of the Mental Capacity Act 2005 (MCA) and DoLS, development of training in restraint &

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de-escalation, communication with and support for bank and temporary staff and the development of a plan for caring for patients whose capacity was impaired and were under deprivation of liberty safeguard in the context of minimal restraint, which could be adapted to meet individual needs.

- The changes had been discussed at the ward managers' meeting on 26 November 2015 and the issues had been followed up within the directorate's leadership and flow meetings which took place twice a day. These meetings were attended by sisters and senior staff nurses from each ward and it was expected that messages were cascaded to all staff within the wards.
- The Mental Capacity Act 2005 Code of Practice was available to staff in the wards and was available on the trust internet. All registered nurses are encouraged to read it. The trust adult safeguarding lead provided ongoing training for security staff around Mental Capacity Act 2005 and DoLS and the role of restraint in the context of their role.

## Are medical care services responsive?

Requires improvement



Although some aspects within the control of the directorate were good, we have judged the responsiveness of services as requiring improvement because:

- Although there had been improvements to patient flow the directorate was running at capacity with little room for flexibility.
- Bed occupancy remained high and there were medically fit patients across the directorate awaiting social care packages and too many patients were delayed in their discharge from wards.
- Managers acknowledged that patient flow was the biggest challenge and were focussed on sustaining improvements and continued to work with the site team and colleagues across the health and social care system on initiatives such as discharge to assess.

However:

- The trust was participating in the 'Enhanced Care Project' to improve the way enhanced care was given to patients and had implemented certain aspects of the project in advance of the completion date as there had been overwhelming evidence of its efficacy.
- Complaints were dealt with, as required, mostly by the Advice and Complaints Team. There was no evidence to suggest this was not being done well and to the satisfaction of the complainants.
- There was an outstanding example of responsiveness with the work of the dementia care team and the availability of 100 dementia champions in the trust including the Head of Facilities who was focussing on environmental changes.

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

- The trust took part in a daily regional teleconference between the trust, the local authority, the clinical commissioning group (CCG), the local ambulance trust, another NHS trust in the area and local community services including rehabilitation centres and nursing homes. They aimed to support health and social care teams to deliver safer patient care and discussed the availability of beds, the flow of patient treatment and what could be changed to support discharge. This was an outstanding example of all relevant organisations working in partnership to deliver efficient and safe patient care.
- There were daily system meetings with the CCG to identify issues with capacity and flow.
- We observed trust bed management meetings where immediate decisions were made to manage the bed capacity across the trust, including the discussion of medical outliers to ensure they were in the optimum location for care.
- The design of the directorate allowed for 70% of the bed capacity to be single rooms. Nursing staff reported that patients slept better in single rooms and felt more rested. Some elderly patients struggled but it was anticipated that the problems would reduce with the installation of TVs and clocks in the rooms. We spoke to eight patients in single rooms and most confirmed they were happier in a single room and enjoyed the peace and quiet. However, one patient felt the room was stuffy

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and felt isolated and did "not see staff very often."

Another patient, who had a fear of heights, found the floor to ceiling windows overlooking the atrium "very scary."

- The design enabled disruptive patients to be nursed away from other patients. However, it was not always possible to segregate patients with challenging behaviour or safe to do so for their supervision. All clinical areas were supported by a matron and had support from the corporate safeguarding team who were available to offer guidance on the best way to manage situations with specific patients. All staff told us they were encouraged to support other patients who might find the situation with a confused patient frightening.
- The trust was participating in the 'Enhanced Care Project' led by the Trust Development Authority. The project was designed to improve the way enhanced care was given to patients and was running for a period of 90 days. The trust was currently in the final 30 days of the project. The directorate had chosen to implement certain aspects of the project in advance of the completion date as there was overwhelming evidence of its efficacy. These included the risk assessment of patients which determined their supervision requirement and the activity log which indicated how much supervision and when supervision was required. Nurses who were substantive and those who were on the bank were allocated to the enhanced care shifts.
- The Enhanced Care Project defined how a nurse was relieved where the patient was challenging to provide some respite to the individual. The role of the nurse providing enhanced care was also being defined within the project.
- In the case of patients whose behaviour challenged the staff and made caring for a patient difficult, advice was sought from an appropriate specialist such as mental health liaison, safeguarding and dementia care. This ensured that the right approach was used and minimised the risk to staff, and provided the best possible care for an individual patient. If a patient was awaiting a mental health bed or had a confirmed mental illness in addition to their medical condition a registered mental health nurse would be employed to support the care of the patient and to minimise the risk of a violent incident.

- The trust used a red card/yellow card approach to patients who had mental capacity but who would not comply with their treatment and who behaved inappropriately towards staff.

## Access and flow

- During our inspection the trust's bed occupancy was 92%. The Dr Foster Hospital Guide 2012 identified that occupancy rates above 85% could start to affect the quality of care given to patients and the running of the hospital more generally. Data from April 2014 to April 2015 showed bed occupancy at an average of 94.5% with the lowest being 84.8% and the highest 99.7%. This meant that the directorate was running at near capacity with little room for flexibility.
- There was a designated medical outlier team led by the clinical director and two juniors. Daily bed reports highlighted the number of outliers. There were 25 and 21 patient outliers on the two days of our announced inspection and 32 during our evening unannounced visit. The outlier team told us that they averaged between 15 and 20 medical outlier patients each day.
- During our visit we were told there were two medical outliers on one of the gynaecology wards. Managers agreed that the wrong patients had been sent to the ward and the aim was to ensure that this would not be repeated in the future. There were operating guidelines for such patients who were on a surgical pathway and there had been occasions when this had not been followed.
- The number of delayed transfers of care had frequently peaked above 100 each day in recent months. During our visit the number reached 114. Data for the period April 2015 to September 2015 was provided showing reasons for the delayed transfer of care. Various factors were assessed and included the completion of assessments, public funding, awaiting further non-acute care, awaiting residential / nursing home placement or availability, awaiting a care package at home, awaiting community equipment and adaptations, patient or family choice, disputes and housing issues. The trust's performance was compared to England averages and performed better in most categories. However, the trust was consistently worse in the completion of assessments and those awaiting a care package in their own home. The delays extended the length of stay,

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compounded the ability to promptly medically review and process patients, and also encroached on elective capacity and adversely affected referral to treatment time.

- Significant work had been undertaken to facilitate patient discharges. An integrated discharge service went live on 31 October 2015 and discharge to assess pathways had also been introduced. Staff were aware of the three discharges to assess pathways and the challenges faced by external factors such as health and social care at home, or availability and suitability of long term care in a care setting or care home. The pathways were very new to the directorate and were variable in success and required work to increase their effectiveness. Managers acknowledged they needed some pace and told us it was a challenge to track activity and to gain accurate and timely data due to the multiple recording systems. They felt things were moving in the right direction with the aim to align systems to improve accuracy in the near future.
- A discharge lounge had opened in March 2015 and was based in a temporary location. There were two bed spaces and 18 chairs and data showed that between 20 and 25 patients were accommodated per day. It was open from 8am to 7.30pm. Staff consisted of nurses, healthcare assistants and a porter. A dedicated pharmacist would be in post from January 2016. Ward staff gave a handover to staff in the discharge lounge and if patients deteriorated ward doctors or the clinical site team were contacted. With effect from 17 August 2015 all patient transport was mandated via the discharge lounge which had improved its use by wards and specialties. A toilet was available in the corridor outside of the lounge and patients requiring assistance were wheeled to the toilet in a wheelchair. Snacks and drinks were available for patients during their stay in the lounge including sandwiches, biscuits, yoghurts, fresh fruit cheese and biscuits, hot beverages, squashes and fruit juices. Staff felt they were making a real difference to the discharge experience and one patient told us his discharge experience had been "much better compared to the last time."
- The management of bed capacity and the appropriate placement of patients continued to be a challenging process. The trust capacity and flow policy had been introduced to achieve effective and standardised management of all in-patient capacity within the trust and to establish a common understanding of the concepts for a safe and appropriate experience for the patient.
- A dedicated team managed patient flow in the trust. There were daily meetings at 8am with the general manager, the head of nursing and the site team to assess and review patient flow. The general manager looked at the corporate position as well as the directorate position and escalated issues with general manager colleagues in other directorates. At 10am and 2pm there were leadership and flow meetings attended by all matrons to discuss and debate the flow across the trust. There was a standard agenda to look at the expected target of 62 discharges per day, sharing of risk, staffing levels and acuity, and identifying of two patients per ward who were suitable as outliers. A corporate bed meeting was held at 12.30pm to review and manage the outliers. A weekly patient flow meeting was held every Tuesday afternoon to discuss the previous week's performance and the trust projections for the coming week. At 11am there was a system-wide capacity and flow conference call with the relevant CCG. Senior nurses were keen to ensure that the wider team were aware of the patient flow issues and to feedback issues and challenges raised from the flow meetings.
- The site team consisted of a GP support team who responded to GP calls between 6pm and 7pm. They handed over to the hub which consisted of a lead clinical site manager and a support clinical site manager, who were mainly nurses or midwives and an on-call manager. The team managed the hospital and were responsible for patient flow, staffing issues, directorate support and walk through the wards. The clinical site managers worked two shifts from 7am to 7.30pm and from 7pm to 7.30am. One band 7 nurse and three others (band 6 or 7) worked until 7.30pm with a twilight band 7 nurse working until 10.30pm. From 7.30pm there was a band 7 nurse and a band 6 nurse, who remained in the control room, together with a twilight nurse. Three site night nurse practitioners worked across the site and were available seven days a week. The hospital at night team consisted of 13 medical staff with a twilight nurse and the site night nurse practitioners. At weekends during the day nurse



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practitioners worked from 8am to 8.30pm. The site nurse practitioners were managed by the clinical site manager and were the first response to deteriorating patients.

- There had been intensive training for managers in capacity modelling to improve bed utilisation. Modelling was based on 32 patients per ward; however, on some wards the procedure room was used as a patient room and increased the total number to 33. Some staff expressed concern about the consistency of decisions made by the site team and felt decisions varied depending on the site manager on call.
- There were 39,568 admissions during the period January to December 2014 with 52% as emergency admissions, 3% elective admissions and 45% day cases. Data was further broken down into specialities with 42% for general medicine, 15% for gastroenterology, 12% for clinical haematology and 32% for other.
- Between September 2014 and August 2015 2% of patients had three or more ward moves. This represented a reduction from 4% during period September 2013 and August 2014. We spoke to one patient who had been moved five times during their six week stay. The patient told us that the reasons for the move had been clearly explained to her and she was quite happy with the explanation that the space was "needed by another patient who needed close observation." We observed a team meeting where patient moves were discussed.
- The average length of stay was lower than the England average for elective care but higher than the average for non-elective care.
- The trust consistently met the referral to treatment time for the 18 week target for admitted patients during the period July 2014 to July 2015. Operational standards required that 90% of admitted patients should start consultant-led treatment within 18 weeks of referral. The results in medical specialties ranged from 93% to 100%.
- The directorate's performance report identified areas not meeting targets, the reasons for the failure, management actions, the proposed action impact and the impact date. These included gastroenterology, respiratory, cancer, diabetic medicine and endocrinology, epilepsy and cardiology. An improvement plan was in place to address the challenges in these specialties which included

recruitment to fill the gaps. There had been a significant improvement in echocardiogram diagnostic performance with targets met for the preceding four months.

- The medical day care unit was a nurse led unit for patients who required urgent treatment such as IV antibiotics but were fit enough to avoid admission. Patients were referred via their GP, the acute medical unit and the emergency department. The medical day care managed their own patient flow but were mindful of the challenges faced by the remainder of the directorate and communicated with colleagues at patient flow meetings.

## Meeting people's individual needs

- Patients were treated as individuals with treatment and care being offered in a flexible way and tailored to meet their individual needs.
- We observed call bells being answered swiftly on all wards and staff in day care areas told us they tried as much as possible to prevent patients making repeated visits to the hospital. To this end appointments were arranged to coincide with other appointments.
- We saw a number of clinical pathways and protocols including an ambulatory pathway for minimally symptomatic patients with newly diagnosed type 1 diabetes who presented out of hours, community deep vein thrombosis care pathways for rivaroxaban and warfarin and very low risk GI bleed ambulatory care protocol.
- There was a learning disabilities liaison nurse to facilitate the care of patients with learning disabilities.
- Dementia was recognised as one of five priorities for the trust. It was estimated that there were 250 patients with dementia at any time in the trust. Standards for care of people with dementia had been developed both locally and nationally as part of the dementia improvement programme. The dementia care team remit was to ensure that these standards were incorporated into routine care so that people with dementia had a safe admission and discharge and as good a patient experience as possible. The current team consisted of three members, a clinical lead (0.5 whole time equivalent (WTE)), a dementia matron (one WTE) who had been in post throughout the year and a dementia

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trainer (one WTE) who joined the team in May 2015. Up until January 2015 an administrator and auditor had been in post but had not replaced. The managerial lead was the head of patient experience.

- The team had a strategy directing their work which was updated on an annual basis. It listed the standards and drivers of care for people with cognitive impairment and dementias which included: National Audit of Dementia standards; NICE quality standard one and NICE quality standard 30, acute hospital Commissioning for Quality and Innovation (CQUINS for dementia 2014/2015 and 2015/2016, enhancing the healing environment, dementia friendly hospital environments and the triangle of care including a guide to best practice for dementia care. The team reported to the overarching safeguarding committee through the adult safeguarding group.
  - Work to improve compliance with standards had been ongoing through the year. The main area of work was to produce and launch a care bundle, containing a care plan for people with dementia and cognitive impairment. The care bundle addressed many of the standards required for appropriate care of people with cognitive impairment and had been prioritised as an area of development in the past year. The complete care bundle contained a care plan, a scored functional assessment for completion by the carer or family, "This is me" document for completion with information about the person by their family or carer and an invitation to the memory café for the carer. The care bundle was started on admission when the person was noted to be confused or had a known diagnosis of dementia and continued through the admission as more information was known about the patient. It provided examples of how the environment of care could be personalised, communication and care maximised, independence promoted and the involvement of carers considered and promoted good care through ensuring that personalised care responses were given to all patients with cognitive decline.
  - The trust would be participating in the national audit for dementia in early 2016 using information from care provided during the latter months of 2015. The team told us the lack of a dementia auditor was impacting on the measurement of the national audit standards.
- Infrastructure and policies and resources were in place to comply with the standards but there was no measured review of their achievement until the next national audit in spring 2016.
- Refurbishment of wards 1 to 4 at Elgar House had taken place during the past year with Elgar 1 recently re-opened to join Elgar 2. Opportunities were taken to improve the environment using principles of colour to assist with way finding and identification of bed areas and bathroom, and improved signage. The team explained that further opportunities were limited due to resource constraints. However, they were exploring with specialist providers whether two small areas on the wards could be converted into a more homely environment for patients to sit with their families. The outdoor areas on the wards would be addressed in the next year to improve patient experience particularly during the summer months. An additional project was running in conjunction with Fresh Arts looking at improving the entry areas and corridors outside the wards. The plan was to add murals and vinyl overlays to the walls and cupboards to make a more welcoming area and to assist with directing patients and carers to the reception area. The project was externally funded and an artist had been appointed to complete the project.
  - Opportunities to affect the environment had been fewer in the main Brunel building. The installation of clocks throughout the building was in progress and nearing completion, alongside the installation of a grabber bar on each bedroom door to hold important documents relating to the person's care and wishes. We found some clocks resting on shelves with tape to hold them against the wall. Staff told us they were waiting for the maintenance department to fix them to the wall. Signage on all internal bathroom doors was awaited. An environmental audit had been completed by the dementia administrator prior to her departure from the team but had not been written up. However, the team told us that findings suggested the need for improvement of the environment to make it as suitable as possible for people with dementia. For example, the provision of lighting in the bays and internally facing rooms; the use of more definitive colours to aid identification of rooms; and the provision of seating at regular intervals to help people walking in ward spaces outside their bedroom to see where to sit down.
  - The Fresh Arts project was leading an externally funded project to provide resource cupboards and resources for



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the complex care wards. There had been some work towards providing activity areas in the reception area between gates 28a and 28b. This would need to be externally funded and would fit in with the falls improvement programme, dementia care and the Fresh Arts project.

- Training had been delivered, focussing specifically on patients' particular needs to establish good communication with patients who might have dementia and cognitive impairment and an understanding of the pathways to manage this. Level 1 training was included as part of the mandatory training programme with further levels available. Good links had been made with the emergency department with several dementia champions appointed who were actively changing patterns of working to improve the care of people with cognitive decline. A new care sheet had been introduced where a "forget-me-not" symbol indicated that cognitive decline had been noted, a cognitive assessment was being completed for all patients over the age of 65 and a sticker with a forget me not was being added onto the wristband of patients being admitted. This helped other health workers to recognise the need to make reasonable adjustments when dealing with a patient. Staff told us this was recognised and acted upon appropriately.
- The team had developed relationships with external organisations and were involved with the strategic dementia care planning group in both Bristol and South Gloucestershire, with the dementia forum, the dementia roadshows in south Gloucestershire, Bristol dementia action alliance, frailty work meetings and with the equivalent team at United Hospitals Bristol. The team also had close working relationships with other hospitals both locally and nationally through visits and had hosted visits to share ideas about dementia friendly environments and to provide mutual support.
- The need to support care of people with dementia had been added to every job description and work to include dementia standards in all new policies or policy review was ongoing.
- There was no recurring non-pay budget for the team and the team were concerned that when the charitable funds were exhausted there would be no funding to continue the memory café and dementia champion conferences or support minor improvements. There were 100 dementia champions in the trust including the Head of Facilities who was focussing on environmental changes.
- The occupational therapy team were leading the integration of meaningful activity into ward life through one-to-one involvement and social engagement.
- There was a gradual re-equipment of wards which included TVs. Reminiscence machines had recently been distributed with hand held versions available and awaiting distribution.
- There were plans to create activity boxes for each gate and a meaningful activity area at 28a with possible ideas including a hospital cinema and craft area. Work was underway with external organisations and donors to support the plans.
- As part of the UK Disability History Month (started on 22 November) the trust had or were planning to hold a number of events, including a disabled staff meeting, a deaf charter seminar external exhibitors and an autism seminar. A new deaf champion had also been introduced to look at the issues impacting on deaf people.
- The largest population by ethnic minority group were mixed, African and black with the three most spoken languages being English, Polish and Somalian. Translation services were able to meet the needs of the three largest minority groups.
- The spiritual needs of patients were met through the care provided by staff and specifically the specialist service of the chaplaincy team within the trust, who also supported staff in this aspect of care. The trust's specialist spiritual and pastoral care was provided by a team of substantive, bank and honorary chaplains and volunteers who were trained to support the spiritual and pastoral needs of patients, relatives and staff of all faiths and none. Team members were Muslim and Buddhist and links were maintained with community faith representatives from the Jewish (orthodox and progressive), Sikh, Hindu, Pagan and Jehovah's Witness traditions. In partnership with the other NHS Trusts in Bristol, 24/7 emergency spiritual and pastoral care was maintained city-wide.
- Hospital information indicated that requests for spiritual and pastoral care mirrored the local population with one third of people supported not professing any specific religion and belief. Census information for the population served by trust (893,571) indicated that 60%

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of people were Christian and 32% did not profess any particular faith allegiance. Of other faiths, 2% were Muslim and the remaining 1% were people who followed Hinduism, Buddhism, Sikhism and Judaism.

- A backlog of typing had been addressed and actively managed with the appointment of additional administrative posts and the formation of an administration improvement group to ensure pace and sustainability.

## Learning from complaints and concerns

- Patients knew how to make a complaint if they needed to and also felt they could raise concerns with the clinical staff they met. Most patients and relatives told us if any issues arose they would talk to the senior nurse available. The route to complaints was publicised in all wards through leaflets and via the trust website. Patients, carers and relatives were able to complain via the dedicated web links, by letter, email, comment cards, telephone or in person to any member of staff or directly to a member of the advice and complaints team (ACT). The trust policy directed all staff to own and to try and resolve all issues and concerns raised (escalating as necessary) to ensure quick resolution before the matter deteriorated into a formal complaint.
- Staff were aware of complaints that had been made and any learning that had resulted. The staff we spoke to were all aware of the complaints system within the trust and the service provided by the complaints team. They were able to explain what they would do when concerns were raised by patients. Staff told us that they would always try to resolve any concerns as soon as they were raised, but should the patient or their family remain unhappy, they would be directed to the ward manager or the trust complaints process.
- All complaints that could not be immediately resolved at the point of receipt were passed to the advice and complaints team where they were triaged and logged. Where possible, with the complainants' agreement, early resolution might be possible. Where issues would take longer to respond a timescale of between 35 to 55 days was agreed depending on the complexity. Complaint or concern details and an action plan were passed to the directorate complaint coordinators to allow for investigation and preparation of a draft response. Once all areas had responded a letter was prepared for sign-off by the Chief Executive or the Complaints Manager.

- A basic timeframe of 35 working days was used for complaints or concerns. Following the opening of the new Brunel Building in 2014 and a number of legacy issues, response times were poor particularly from the central clinical directorates. In January 2015 options for a recovery plan were discussed and this was formalised in April 2015 with the aim of exceeding 90% compliance by August 2015. The overall response metrics for 2014/15 were: within timescale 31.9% and greater than 20 days overdue 54%. At the end of July 2015 compliance rates had improved to: within timescale 79% and greater than 20 days overdue 9.7%. Improvement continued and the stand alone results for July 2015 were: within timescale 93.7% and greater than 20 days overdue 1.4%. However, managers noted that the directorate struggled with the timely response to complaints.
- Prior to the inspection the trust provided details of the complaints in the preceding 12 months. We saw details of the outcomes, actions taken and lessons learned. Complaint subjects ranged from communication, clinical treatment to delays in transfer and discharge.
- Minutes of the directorate's clinical governance meetings showed complaints and compliments were on the rolling agenda.

## Are medical care services well-led?

Good



We have judged the leadership of the service as good because:

- There had been progress in many areas across the directorate since the inspection in November 2014.
- The directorate was facing a period consolidation following the move to the new building in 2014. Governance structures were embedding and managers were focussed on ensuring that audits, incidents, complaints and other key information were used to demonstrate learning, change and improvement.
- Good local leadership was provided throughout the directorate and frontline staff and managers were passionate about providing a high quality service for patients with a continual drive to improve the delivery of care.

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- Most staff were positive about working for the trust and showed commitment to their patients, their responsibilities and to one another. There was a strong camaraderie within teams with flexibility provided where possible.
- Innovative practice across the directorate still required development. There had been an improvement since our previous inspection with a programme of local audit and an innovation programme had been introduced to improve the way enhanced care was given to patients

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

- There was an integrated business plan for the medicine directorate and a neurosciences business plan for 2015-2016. It was aligned with the trust vision of being the provider of choice for patients needing their expertise and delivering innovative care with excellent clinical outcomes in the most appropriate clinical setting.
- The directorate's key objectives related to the ongoing development of a safety and quality strategy with a particular emphasis on increasing the consistency and reliability of care pathways; improvement of patient flow, especially for complex patients needing support to leave hospital; and building capacity and capability across the directorate.
- The key elements of the workforce plan included the reduction in the use of agency staff and potential further investment in, or changes to the nursing pool, a continued focus on recruitment 'hotspots' and recruiting to establishment plus turnover.
- Staff and managers felt the service was taking shape and was entering a period of consolidation.

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

- A clear structure for clinical governance was developing in the directorate with regular reporting to the monthly clinical governance group, which looked at areas relating to the improvement of the quality and safety of care delivered to patients. Agenda items included an overview of serious incidents and root cause analysis, overdue discharge concerns, safety briefings including lessons learnt and quality improvement initiatives, and the risk register. The group also considered other trust

priority quality topics including falls, the quality strategy and infection control, patient experience with feedback from the patient user group, clinical audit activity and cost effectiveness.

- We saw minutes from these meetings which showed that issues affecting the service were discussed and actions taken. Recommendations were made through the group to look at the ways in which the structures for healthcare delivery could be adjusted to provide a sustainable level of improvement. In addition, the group had regard for national and local clinical priorities in the steering focus for quality improvement and patient safety.
- The group had an advisory and steering function with authority for signatory matters relating to clinical governance performed by other aspects of the organisational structure; for example, the senior management team for sign-off on serious untoward investigations, the clinical effectiveness committee for sign-off on new clinical guidelines.
- Further shared learning that was identified at the monthly clinical governance meeting was undertaken at the monthly care quality management team meeting. A subcommittee of this group, the clinical risk subcommittee, had been set up to review the directorate risk register in detail and provide feedback to the main medical directorate clinical governance group.
- We saw the register of active risks with the issue, threat or hazard identified, the consequences and risk rating and an action plan and controls.
- We also saw minutes of the safety governance meetings where individual root cause analysis were presented with lessons learnt.
- Regular auditing took place with evidence of improvement. The local audit programme showed 23 active audits with 18 completed during the past year.
- Performance data and quality management information were collated and examined to look for trends, identify areas of good practice, or question any poor results. Performance and outcome data was reported and monitored via the service performance dashboard.
- Clinical policies and guidelines were available for all staff via the trust intranet system.

## **Leadership of service**

- The senior leadership of the directorate had the skills, knowledge and integrity to lead the service. The managers were an experienced and strong team with a

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commitment to the patients, and also to their staff and each other. They were visible and available to staff and we received positive feedback from staff who had a high regard and respect for their managers. Most staff we spoke with felt supported by their managers.

- The senior leadership team told us that they were proud of their teams and recognised that staff worked hard within their roles. One manager told us they were most proud of the “safe, high quality care given by happy staff” who “always did the right thing for the patient.”
- Service leads felt the previous ‘siege mentality’ where everyone felt anxious about the future with little trust in the leadership of the trust, had been replaced by a quality focus with an ability to change and act.
- Work was ongoing to strengthen the clinical leaders especially at ward manager and consultant specialty lead level, and focussed around role clarification with supportive development models. The ward manager role was pivotal to drive changes around patient flow and discharge planning.
- Matrons were visible and approachable and often visited the wards and departments. Ward sisters worked in a supervisory capacity.
- Recruitment and retention was focussed around better advertising, ensuring the terms and conditions of employment offered were at least as competitive as neighbouring trusts or healthcare providers. The trust were exploring new roles and staff rotations in challenged areas, and would be using new staff focus groups to inform direction and emphasis and a ‘how was it for you’ methodology. Recruitment and headhunting agencies in some challenged areas of nursing and cardiac physiology had been used and this approach would be continued alongside conventional recruitment approaches where appropriate.

## Culture within the service

- The culture in the directorate encouraged candour, openness and honesty. Most staff we met said they felt supported within their teams to challenge and raise concerns and anxieties. They were confident they would be heard. A matron gave an example where she had approached the chief executive directly about an issue and she had been very supportive.

- Managers and staff told us there was less uncertainty across the directorate and they had more realistic expectations about the future direction of the service. They felt more confident in systems with more standardisation across the directorate.
- Staff sickness levels were slightly above the trusts 4% target for the past 12 months. Episodes of short term and long term sickness had been audited and all managers had attended sickness training. An analysis had been undertaken of ‘days of the week’ absence for nursing and had been shared with ward sisters for action. Hot spot areas had been identified on wards 8a, 27a, 28b and 32a. Managers had been advised to publicise absence levels in their areas to their staff. A plan had been developed to manage short-notice, out of hour’s absence on wards.

## Public and staff engagement

- We saw there were systems in place to engage with the public to ensure regular feedback on service provision for analysis, action and learning. In addition to the Friends and Family Test patients were encouraged to make comments by email, letter or twitter.
- We saw a wide range of patient leaflets displayed at the entrance to ward areas including chaperone policy, falls prevention in hospital, patient admission, transfer and discharge, getting the right medicines when you move between care settings and the yellow and red card policy (procedure for the care of individuals who were violent or abusive).
- The trust annual public meeting was held in September 2015 and members of the public, and staff heard presentations about the work the trust had done in the last year.
- Systems were also in place to engage with staff. The staff attitude survey had been sent to all staff at the beginning of October 2015 and ran for nine weeks until 27 November. Staff told us they had received either a paper survey or an electronic version by email. The survey was being managed externally and results were expected in early 2016.
- A bi-monthly magazine ‘Insight’ was published which highlighted key issues about what had been happening at the trust, news and sharing of letters of thanks received from patients and their families. Staff were encouraged to tweet or email reasons for being proud to work at the trust. Notices called “top toilet tips” were fixed to the inside of toilet doors. We saw evidence of

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notices about the new early warning system and the recent never event involving the wrong route administration of oral / enteral treatment. A weekly bulletin and newsletter were also available.

- The trust identified one of their key priorities as the improvement of staff engagement. The engagement and involvement of staff was essential when communicating, planning and implementing proposed workforce changes. The trust aimed to improve communication with, and involvement of staff, and confirmed this would be a consistent feature of all future plans.
- Staff confirmed that executive and non-executive walkarounds had occurred involving discussions with both staff and patients and they were aware of the exceptional healthcare awards and top achieving wards.
- Staff on a number of wards were caring for complex and challenging patients which could be emotionally draining. There was a good network of support through the provision of therapy sessions for staff during day and night shifts. Staff also reported support received following long-term absence from their role to assist their gradual return to work. Another member of staff told us that the move to the directorate had “changed my life for the better.” However, one member of staff was concerned that there had been no debrief after a difficult patient arrest.
- Staff were proactive in looking at cost saving initiatives and told us they were constantly looking at ways of working smarter and researching the cost of supplies and suppliers.
- Staff were aware of the trust whistleblowing policy and the arrangements for reporting poor practice without fear of reprisal and felt confident about using this process if required.






- Car parking was an issue with some staff reporting they had to arrive an hour before the start of their shift to guarantee an off-street parking space. This increased an already long 12 hour shift.
- Despite the uncertainties most staff were prepared for change and would continue to drive for high-quality care. However, staff morale was adversely affected by continued and additional change which might have an adverse impact on recruitment and retention. Workload was high and relentless and although the teams felt they worked well together they were concerned the pace was not sustainable.

## **Innovation, improvement and sustainability**

- Staff were clear that their focus was on improving the quality of care for patients. They felt there was scope and a willingness amongst the team to develop services and felt encouraged to share ideas.
- An innovation programme had been introduced to improve the way enhanced care was given to patients. On 24 November 2015 the programme had reached 60 days of the 90 days programme. Four pilot wards had held workshops and focus groups to share skills and plan ways to use one resource as effectively as possible. As a result the trust had standardised the process for assessing risk to gauge the need for patients to be ‘specialised’. A daily review document had been developed to track the decision making process and help decide if the patient needed to continue with the special or could they be ‘cohorted’ or stepped down altogether. One of the pilot wards had developed a series of flash cards to be given to the staff undertaking the care in order to help them improve the care and tailor it to the individual. The tools used to document the patient’s behaviour had been enhanced to provide more data to inform the decision about the level of supervision required, and was also used to assess progress.



# Surgery

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

## Information about the service

Surgery services at North Bristol NHS Trust are provided at Southmead Hospital. The surgical services previously undertaken at the old Southmead Hospital and Frenchay Hospital moved to this new purpose-built hospital in May 2014.

There are 29 theatres in the theatre complex managed by the Core Clinical Services. There are 2 theatres on Level 1 providing local anaesthetic based plastic surgery. On Level 2, there are 11 theatres providing a combination of elective and non-elective services and on Level 3, there are 14 theatres providing a full elective service of both day case and inpatient surgery. The operating theatre department design incorporates 'medirooms' which are used instead of traditional anaesthetic rooms and a recovery room. The medirooms were individual rooms adjoining each theatre department. There were 72 medirooms between the two floors. Patients were admitted directly into these rooms before surgery at the pre-admission end of the theatre suites and then recovered in medirooms at the recovery end of the theatre suite. Day case patients could be discharged directly from the medirooms. There were no anaesthetic rooms and patients were anaesthetised inside the operating room. The Cotswold theatre complex contains two theatres in the traditional operating model i.e. including anaesthetic rooms providing a full elective and non-elective gynaecology service (these are reported on in the maternity and gynaecology report).

In the ward areas there were 24 single rooms with en-suite facilities and two four-bed bays.

Surgery at Southmead Hospital includes the following specialities: trauma and orthopaedics, neurosurgery, plastics, burns, general surgery, including breast,

gastrointestinal, urology and vascular. The trust is the south-west lead for plastics, neurosciences, major trauma and for renal transplant and treatment. The majority of data in this report relates to the

surgery directorate (unless stated otherwise) which includes; burns, plastics, vascular, general, urology, colorectal and upper gastrointestinal.

On this inspection, we visited the surgery services on 8, 9 and 10 December 2015. We visited all the surgery wards, interventional radiology, pre-admission clinic, main theatres and the medirooms. We spoke with staff, including nurses and healthcare assistants, theatre managers, and staff from anaesthetics and recovery. We met the surgery and orthopaedic directorate management teams, the theatres management team, senior managers, matrons, ward sisters, consultants, and junior doctors. We also talked with pharmacy staff, housekeeping staff, and physiotherapists. The total number of staff we spoke with was 86. We met with eight patients and we reviewed 11 sets of patients' notes. We observed care and looked at records and data.

The trust as a whole had approximately 43,611 admissions between July 2014 and June 2015. Of these, 28% were emergency, 23% were elective and 49% were day cases

# Surgery

## Summary of findings

We rated surgery as requires improvement because:

- Patient records were not being stored securely on the wards and in theatres, so there was a risk of access by unauthorised people.
- Not all staff in theatres were reporting incidents; for example, staffing shortages, because they felt there was no improvement or response from their managers.
- National guidelines were not followed in theatres for infection control procedures and the cleanliness of some equipment.
- Evidence did not demonstrate that essential daily safety checks on equipment in the theatre department had consistently taken place.
- There was a high turnover of staff in the theatre department and the sickness rate was higher than the trust's target. The theatre department had recruited a large number of predominantly Band 5 (junior) staff but they required training to obtain the skills and knowledge to meet the clinical standards and needs of this department. Some surgical wards were also experiencing higher levels of sickness and staff vacancies. The trust was working to address this shortfall.
- The hospital had a mixed performance in a number of national audits, including the Patient Reported Outcome Measures (PROMs) for April 2014 to March 2015, which is based on patients reporting to the hospital on their outcome following surgery for groin hernias, hip replacements, knee replacements, and varicose veins. The trust also had mixed performance in a national hip fracture audit.
- Patients relative risk of readmission rates after surgery (due to corrective measures being needed or infections) were variable between elective (planned) and emergency surgery. From June 2014 to May 2015 (in relation to how many procedures were performed) this was worse than the England average. The average length of stay for surgical patients within the hospital was also worse than the

England average. It is recognised as sub-optimal for patients to remain in hospital for longer than necessary and a barrier to other patients being admitted.

- Access to surgical services for patients required improvement. The trust-wide Admitted Adjusted Referral to Treatment (NHS England consultant-led referral to treatment time standards of within 18 weeks) performance was worse than England average between September 2014 and August 2015. The number of operations cancelled as a percentage of elective operations was higher (worse than) the England average between April 2013 and April 2015.
- Due to pressure for their beds and the demand for their services, the trust had to use the interventional radiology day unit to house patients overnight. There were limited facilities for patients, including toilets, and there was only one shower that was away from the unit, and this was a staff shower. This meant staff had to escort patients to the shower and were away from the unit. This put pressure on the unit when fitting in their planned patients for procedures.
- From September 2014 to October 2015, the surgery directorate had the most complaints in the trust. Which they felt was due to cancelled operations.
- Theatre staff felt the leadership in theatres was not good, they felt unsupported by them and they were not visible.

However:

- At the last inspection, issues were identified with the Sterile Services Department (SSD). At this inspection, we heard from theatre staff and surgeons about the significant improvements made resulting in less anxiety and complaints from staff and fewer operations being cancelled due to issues in the sterile equipment trays.
- The pre-admission clinic had a pharmacist in attendance to review patients' medications, write up their medication for admissions and liaise with their GP if required. This was to reduce the number of cancelled operations due to medication issues with patients. This was outstanding practice.



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All staff were 'bare below the elbow' and this was also an improvement since the last inspection.

## Are surgery services safe?

Requires improvement



We rated the safety of surgery services as requires improvement because:

- Confidential patient medical records were left unsecured at times, potentially allowing unauthorised people access to them.
- Not all staff in theatres were reporting incidents, for example staffing shortages, as they felt there was no improvement and no feedback from their managers.
- There were some areas of cleanliness that required improvement in theatres; evidence of the cleaning of all equipment was not available. We found areas where infection control procedures needed to be reviewed, as there was the potential of cross-infection. The cleaning of certain equipment did not follow national guidelines.
- There was no evidence which demonstrated that important daily checks on some equipment in the theatre department had taken place or that it was safe to use and in working order. There was a high turnover of staff in the theatre department and the sickness rate was higher than the trust's target. The trust had recruited a large number of predominantly band 5 (junior) staff within the department but they required training to obtain the skills and knowledge to meet the clinical standards and needs of this department. Experienced staff felt this was putting undue pressure on them.
- Surgical wards also had higher levels of sickness and staff vacancies. The trust was working to address this shortfall.

However:

- The issues identified at the last inspection in relation to the Sterile Services Department (SSD) had been addressed and improvements made.
- At the last inspection we found medication was not always stored securely. We found at this inspection medication was being stored securely both on the wards and in the theatre department.
- The trust had reduced the overall number of surgical site infection rates for knee replacement and hip replacement surgery since the last inspection.

## Incidents

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- Staff knew how to report incidents using the trusts system. Some staff in theatres were not reporting all incidents when they were short staffed as they felt no improvements were made.
- The trust had reported three Never Events in surgery services between October 2014 and September 2015. A Never Event is a serious, wholly preventable patient safety incident that has the potential to cause serious patient harm or death. All were investigated and actions put in place to prevent reoccurrence.
- All Never Events were discussed at team meetings and then at directorate governance meetings and at the trust risk management committee
- To inform staff across the trust about safety incidents and Never Events a monthly safety newsletter was sent via email to all staff. However, we spoke to an agency staff who had been working at the trust for over seven months in theatres who told us they were not aware of any Never Events as they did not get trust e-mails and were not aware of changes made following these. We saw notices on the back of staff toilet doors about never events and serious incidents.
- We spoke with two members of senior staff whose roles were to look at risk management. They told us about the shared learning from one of the Never Events that took place in theatres. This related to a retained product following surgery. Changes to practice in the way equipment and items were recorded during surgery had occurred. Following this Never Event, the trust requested an external peer review by the Association for Perioperative Practice (AFPP). They were awaiting the report at the time of our inspection.
- Areas for improvement that the two staff from risk management were working on included cross-directorate working so that learning was shared and changes made to improve and embed practice and patient safety. They also wanted to improve the culture of all staff reporting 'near misses' so that these were also used as learning to prevent recurrence.
- The surgery directorate reported 18 serious and moderate harm incidents to the Strategic Executive Information System (STEIS) between October 2014 and September 2015. These included five pressure ulcers and five slips, trips, and falls. We saw the trust discussed these in governance meetings and managers shared learning with staff in ward or unit meetings.
- The surgical site infection (SSI) rate for 2014/2015 for hips replacement operations was 0.8% out of a total of

600 operations and this was equal to five infections. For knees replacement operations, it was 0.2% out of a total of 565 operations and this was equal to one infection. Both of these figures were an improvement from the previous year.

- Mortality and morbidity meetings occurred within surgical specialities either monthly or every two months. Meeting minutes for urology, breast surgery, general surgery, plastic and burns, vascular and anaesthetics, showed discussion of individual cases and opportunity for teaching and learning for those staff present.

## Duty of Candour

- Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, is a new regulation which was introduced in November 2014. This Regulation requires the trust to be open and transparent with a patient when things go wrong in relation to their care and the patient suffers harm or could suffer harm which falls into defined thresholds.
- All staff that we spoke with understood the principles of openness and transparency that are encompassed by the duty of candour.

## Safety thermometer

- As required, the hospital reported data on avoidable patient harm to the NHS Health and Social Care Information Centre each month. This was nationally collected data providing a snapshot of avoidable patient harms on one specific day each month. This included hospital-acquired (new) pressure ulcers (the two more serious categories: grade three and four) and patient falls with harm. The report also included catheter and urinary tract infections (UTIs) and incidence of venous thromboembolism (VTE). This information was on display in all the surgical wards. The data collected from September 2014 to October 2015 for the surgery directorate showed there were 59 pressure ulcers. The prevalence of pressure ulcers had fallen since February 2015. There were 18 catheter-associated UTIs reported over a 13-month period. They also had eight falls with harm reported in this timescale.
- Grade 2 pressure ulcers were flagged to the tissue viability nurse service (TVN). Each identified pressure ulcer initiated an incident report and two qualified nurses were required to validate this. Photographs of

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the pressure ulcers were taken. Senior ward staff told us these measures had reduced the numbers of pressure ulcers. Pressure ulcers were discussed on the wards at each handover.

- In all the patients' records we examined each patient had a VTE assessment in place. For patients attending the pre-admission clinic these were completed at this appointment.
- Each ward had an online document that contained information from their safety thermometer. We saw one of the surgical ward's online document.

## Cleanliness, infection control and hygiene

- We observed staff washing their hands and using hand gel between patients. All staff we saw on the wards, in theatres and in the units we visited were 'bare below the elbow', in line with trust policy. This had improved since our last inspection where we found this was not always the case.
- The surgery directorate had hand hygiene audit results of 100% for April and August 2015. Theatres which is managed by Core Clinical Directorate had audit results of 100% for April 2015 and 98.3% for August 2015.
- Not all equipment was clean or had the green 'I am clean' labels with a date was not stuck on. For example, we observed visible dust and no "I am clean" sticker on a microscope on level three of the theatre department.
- The decontamination of laryngoscope handles was not in line with national guidance, which recommend these handles were either single use and disposed of or were sterilised in the sterile stores department (SSD) to prevent the risk of cross-infection. A senior member of staff told us they had a standard operating procedure in place for staff to read in their resource file in each theatre on how to clean these handles. They told us they had obtained cleaning instructions from the company who made this equipment and that the trust's risk management committee had ratified the standard operating procedure. This was different to national guidance.
- The porters in theatre told us about a potential infection control risk. They had to transport 'orange bags' (these were bags of clinical waste that contain blood and body fluids,) to be disposed of in cages. They found that the bags were splitting as the material was thin and some of the clinical waste was spilling onto the cages. These cages were also used to transport clean linen to the theatre suite. We saw one of the cages and there were stains where the orange clinical bags had leaked. Staff told they had reported this to their line manager and were waiting for feedback.
- We observed that some surgeons and anaesthetic staff were taking their bags into theatre. Staff told us this was due to a lack of lockers for staff to store their belongings and this practice was occurring on a daily basis. This was a breach of infection control standards and could potentially place patients at risk of cross-infection. Staff told us management were aware of this.
- For staff working on the plastics ward they had to change into 'scrubs' when they arrived on duty and change back into their own clothes when leaving to maintain high standards of infection control and to prevent the risks of cross-infection.
- Staff from the burns section of the ward never crossed into the plastics end and vice versa, to prevent cross-infection.
- When caring for a patient with an infection the staff on the burns ward were dedicated to this patient for the whole shift and stayed in the side room with them. This is in keeping with best practice guidance for the care of patients with burns. They had guidance for wearing personal protective equipment (PPE), including covering dressings. They did not provide care for any other patients. This was to prevent the risks of cross-infection between patients. The infection control team and microbiologist visited the ward daily to review patients and to support the staff. There was a checklist of daily tasks around the caring for the infected patient, which we saw were completed. There were separate domestics for each end of the wards to prevent the risks of cross-infection. The side rooms with the infected patients were cleaned last and there was guidance for this for the domestics to follow, and separate equipment to use. This was evidence of good infection control procedures.
- The whole trust reported two cases of Methicillin resistant *Staphylococcus aureus* (MRSA) bacteraemia (blood stream infection) between September 2014 and August 2015. For the whole trust, they reported, 34 cases of *Clostridium difficile* (C-diff) from April 2015 to November 2015. This was above their target. All cases were investigated to look at the causes and to look at actions to help prevent further cases.
- The trust audited screening for MRSA in elective and non-elective patients. The results for November 2015

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showed 70% of all elective patients had been screened. For non-elective patients it was 39%. Prior to November 2015 the trust had been running from 78% to 95%. For patients who attended the pre-admission clinic (elective patients) in November 2015 it was 99.2%. The trust's target was 95% for elective patients and for non-elective it was 90%.

## Environment and equipment

- In May 2014 the Brunel building at Southmead hospital opened and this was where two hospitals (the 'old' Southmead and Frenchay) merged into this building.
- Staff on the wards told us that whilst single rooms had many benefits, for example maintaining patients' privacy and dignity they also brought other challenges. For example, some patients felt very lonely as they did not get to see many people, it was difficult to see where other staff were if help was needed and it was harder for the nursing staff to monitor patients, especially those at risk of falls.
- Staff in theatres told us that none of the doors leading directly into the theatres from their main corridor had a window in them. This meant that staff often opened the doors when an operation was in progress. This was an infection control risk, and a significant dignity and privacy breach. A warning light was outside some of the designated theatres that used x-ray or a laser. The trust was aware of this and staff told us a business plan was subsequently submitted to have windows fitted but this had been put on hold, due to financial constraints.
- There were two types of resuscitation trolleys in place, one was a red trolley, which was tamper evident, and sealed and other one was white that could be opened and items removed. There was potential for items to be taken from this trolley. Staff checked trolleys daily and signed to say this had been completed. Defibrillator machines were also tested daily and signed by the member of staff.
- At our unannounced inspection we observed the portering staff on both theatre suites (levels two and three) were now located in the recovery area whilst waiting for jobs to be assigned to them. They were allocated one of the desks that looked directly into some of the medirooms where patients were recovering following surgery. Staff told us they had feedback from a number of patients who felt uncomfortable with the porters sat observing them. Some of the staff felt this was not the right place to have them waiting for jobs, as they could be noisy when patients were recovering. We spoke with some of the porters who also felt this was not the best location for them due to being able to see into the medirooms. They also felt they obstructed the use of two of the sinks (one was for handwashing) and they felt the lights were very bright above their heads and this gave some of them headaches. They told us this had been reported to the management of theatres, but no changes had been made at the time of our inspection.
- At the last inspection we found issues with the Sterile Services Department (SSD) equipment. Operations were being cancelled due to missing equipment, 'wet sets' (this means they were not able to guarantee they were sterile) and broken equipment. At this inspection, staff told us improvements had been made but felt there was still room for more improvement. The relationship between SSD and theatres was much better and staff were visiting each other's work places to increase the awareness of how both departments operated. The trust told us SSD was revalidated by their regulatory body The British Standards Institute in August 2015 and it passed. The trust was monitoring their performance each month. In August 2015, SSD processed 12,279 sets, of these 178 were classed as non-conformance (this was where an issue was identified with a set). Fifty percent of the non-conformance was due to missing instruments and torn wrapping. This was an improvement from the last inspection.
- We saw that SSD clean equipment was being stored in the main corridor that runs along the front of the theatre suite on level three. Staff told us there was not enough storage for all of their equipment. None of the storage containers were closed. Patients did not have access to this corridor as it was a staff corridor but there was potential for the packaging of this equipment to become damaged and therefore this would not be able to be used.
- We observed in some of the offices used by doctors and their secretaries along this corridor there was limited space, with patients' notes not having dedicated storage areas. We also saw two seminar rooms filled with operating theatre packs from SSD, which suggested there was an issue with storage.
- We found in two theatres on level two (emergency theatres) that the recording of the daily safety checks of anaesthetic machines undertaken by theatre members of staff (not anaesthetists) prior to the start of operating

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lists had gaps of over a month in them. These checks were essential for patient safety. The Association of Anaesthetists of Great Britain and Ireland (AAGBI) issued guidelines in June 2012 on how to do these checks and the importance of them. We were not able to find any evidence that a senior member of staff was checking the records to make sure these safety checks were undertaken.

- We observed the final instrument and swab count in one of the theatres. However, this took place after the wound had been dressed (these should take place prior or during the closing of the wound). This was reported to the band 7 nurse who was in charge of theatres to follow up. We were told the scrub nurse was new and still learning.
- Specialist equipment was available for bariatric patients, for example, extensions to operating tables and hover mats to assist with transferring of patients. Beds and other equipment were also available and staff told us they requested this in advance of elective patients.

## Medicines

- Medication practices were safe.
- As part of the pre-assessment clinic process a pharmacist reviewed all elective patients. They checked patients' medications, wrote up their medication on the medication chart and liaised with the patient's GP if required. They gave patients details about what medication to take pre-operatively and if they needed to stop any. They also made sure the venous thromboembolism (VTE) assessment had been completed. Once the patient was admitted for surgery the admitting doctor would review the medication chart and sign all the prescriptions. The ward pharmacist reviewed the medication chart once the patient was on the ward. We observed the pharmacist contacting a patient's GP as they were prescribed the wrong dose of one of their medications. The patient's GP addressed this. The purpose of having a pharmacist at the pre-admission clinic was to prevent operations being cancelled due to medication issues.
- We saw good recording of patient allergies on their medication administration records on all the wards we visited.
- We examined 11 medication administration records (MARs). We saw the ward pharmacist had reconciled patients' MARs. This was done to reduce medication errors.
- Medicines were stored safely.
- We found medication was stored securely in cupboards and trolleys on the wards, medirooms and in theatres. At the last inspection, we found this had not been the case.
- Medication fridges were locked and temperatures recorded on the wards and in the medirooms. Information for staff on actions to be taken if adverse temperatures were recorded was available. We also checked the records for four medication fridges within theatres to see if they were monitoring the temperature. We found no recordings of the daily temperatures from 6 November 2015 to 9 December 2015. Therefore, there was no evidence that the medication was being stored at the correct manufacturer's recommended temperature.
- Intravenous (IV) fluids on the wards were stored securely.
- Emergency drugs on some of the wards and units were stored on the floor next to resuscitation trolleys. These were in tamper evident cases for security with the date of expiry of the medication recorded on outside.
- In the medirooms, we checked the Controlled Drug (CD) register and the balance correlated with the drugs in the cupboard. In the admission area daily checks were made of controlled drugs by two registered nurses. In the recovery area, twice-daily checks were made and these checks were recorded in the back of the CD registers.
- The pharmacy weekly audits on the urology ward showed 100% compliance regarding storage and security around medication.
- Junior medical staff we spoke with felt well supported by pharmacy staff both on the wards and by the fortnightly five minutes pharmacy update.
- Changes to the pharmacy service had reduced the need for the medication administration records to leave the ward and be taken to pharmacy.
- The prescribing of the times to administer medicines were not recorded on the medication administration records. Reliance was placed on the assumption that the six options started with a morning dose and finished with a midnight dose. This could have potentially meant

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patients did not receive their correct medication. A new in-patient medication administration record was being piloted at the time of our inspection but it had not been implemented.

- The renal ward controlled medication safe was of an inadequate size for the range of medicines held by the ward.

## Records

- Patient records were not stored in a way that protected confidentiality and prevented unauthorised access. We found care plans left unattended on the vascular ward, as they were left outside patient rooms on trolleys and were therefore accessible. Lockable trolleys were in place for safe storage of records but staff said it would not be practicable for all the professionals who needed access. Records observed behind reception areas were unattended and unsecured. The records trolley was left behind reception when not in use on ward rounds. However, staff were present during our inspection in this area.
- In the medirooms patients' records were stored in a cupboard next to the coordinator's board. This cupboard was kept closed during our time on the ward but was not locked. Patients and their visitors were present in the corridor as it was close to where the medirooms were. However staff were present during the time we were in this department. This was also the same during our unannounced inspection.
- At the last inspection we also found patient records were not always being stored securely in the reception area of the emergency theatre during weekends.
- A new electronic record system was introduced three weeks prior to our inspection. Staff were supported by 'floor walkers' who were on hand for staff to ring or visit them to help them use the new system. Computer champions on the ward were also able to provide support to their colleagues. On line training was provided for nursing staff for this new system. Medical staff were not all using this new system at the time of our inspection.
- There was a set format of documentation used on all wards for patients undergoing surgery. This included core plans of care for particular surgical procedures that staff personalised for each patient. Staff were able to

write individual plans of care if a patient's needs were not covered by a core care plan, this enabled plans to be individualised as required. We saw this in place for one patient.

- We reviewed the records of 11 patients and found all risk assessments and care plans for their assessed needs were in place. Some patients' nursing records were computer-based and we found access to these was restricted. We saw medical and nursing entries in notes were clear, dated and signed.
- Risk assessments had been completed for falls where necessary. We saw in one of the risk assessments the action was to provide one to one care from a member of staff, which we observed to be in place.
- Elective patients seen pre-operatively had their care planning documentation for surgery started by the nurses in the clinic. We also saw details of this assessment recorded in the patient's medical records if they had any tests undertaken; for example, blood tests.
- For patients on the enhanced recovery pathways a set format for care planning and risk assessment documentation was also used and this was started in the pre-admission clinic. We saw these completed post-operatively.

## Safeguarding

- Staff were up-to-date with their safeguarding training, which enabled them to recognise and respond to concerns about the safety of a vulnerable person. The training records for the surgery directorate for safeguarding vulnerable adults showed 89% of staff in this directorate were compliant with the training. That was above the trust target of 85%. The theatre department was part of the core clinical services directorate and as a whole, the training compliance level was 75% for staff completing this training, below the trust target. For child protection training the surgery directorate was at 92% and core clinical services directorate was at 90% of staff having completed this at the level appropriate to their role and interaction with children. This was above the trust target of 85%.
- Staff we spoke with were clear about reporting safeguarding. They understood their responsibilities and the trust processes for reporting any suspected abuse.

## Mandatory training



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- Staff training was meeting trust targets in some subjects, but not in others. The trust had 22 subjects that they considered to be mandatory training.
- The surgery directorate was meeting the trust target of 85% for mandatory training completion in fire, health and safety, manual handling, information governance, equality and diversity, infection control, food hygiene, waste management, resuscitation and safeguarding adults and children. Areas where this directorate were not meeting trust standards included dementia, falls and conflict resolution.
- The theatre department was part of the core clinical services directorate and they were meeting the trust's target of 85% of staff trained in health and safety, infection prevention and control, information governance, Mental Capacity Act & Deprivation of Liberty Safeguards, and adult safeguarding. The remaining 17 subjects where less than 85% of staff had completed training were blood transfusion, conflict resolution, dementia, equality and diversity, falls, fire safety, food safety, patient handling, resuscitation, safeguarding children and venous thromboembolism (VTE). Staff told us one of the major factors affecting compliance was the number of vacancies they had on the wards and in theatres and not being able to be released for training.
- Staff told us they received e-mail prompts when their mandatory training was due and attendance at mandatory training was discussed at their appraisals.
- Mandatory training was delivered by a mix of taught sessions (for example, resuscitation), and online learning (for example, information governance). Staff were able to access the online learning resources from any computer within the wards and theatres.

## Assessing and responding to patient risk

- Risks to patients who were undergoing surgical procedures were assessed and their safety monitored and maintained.
- The hospital had a policy for monitoring acutely-ill patients. The hospital used the early warning score (EWS) system for the monitoring of adult patients on wards. This used a system of raising alerts through numerical scoring of patient observations. The system was in use on wards and in recovery rooms. We looked at 11 sets of patients' notes in all the surgical wards and theatres. We saw the EWS forms completed and used in the records we reviewed. Staff told us they knew what to do if the score was elevated, for example to obtain medical advice. Patients with an EWS of four or above were escalated. Target response times were set by trust for when a doctor was required to respond. If there had been no response within 20 minutes, the staff would escalate to a registrar or consultant.
- A new patient observation chart was being introduced following our inspection. Training was planned for staff, which would be done at specific times on each ward to ensure night staff, and all shifts were covered so that all staff had access to the training.
- When a patient was discharged from the critical care unit to a ward, the critical care unit doctor followed them up next day. Communication between some of the surgical wards and critical care unit medical staff was good and staff told us they were able to speak to staff on the critical care unit if a patient who had been discharged from the unit became unwell. This was an informal arrangement as the trust had no outreach team (this is where staff from critical care unit visit a patient on the ward if their condition deteriorated and needed additional medical support).
- At night, the initial point of contact for medical assistance for patients was through the site management team unless it was an emergency when staff would ring doctors immediately.
- The hospital was using the five steps to safer surgery, which included the World Health Organisation (WHO) surgical safety checklist (this is a tool for clinical teams to improve the safety of surgery by reducing deaths and complications) in all surgical procedures. As recommended by the NHS National Patient Safety Agency (NPSA) the tool had been adapted for more specific use in areas such as ophthalmology and interventional radiology. The hospital adopted the use of the checklist as part of the introduction of the NPSA 'Five Steps to Safer Surgery 2010' guidance.
- We observed in theatres part of the WHO checklist being completed and all staff in the theatre were present.
- We saw monthly audits for compliance with the WHO surgical safety checklist in theatres and it was 98%. This was an improvement from the last inspection but still just below the trust target of 100%.
- Interventional radiology had their own WHO safety checklist. Staff told this was both paper-based and computerised. The audit results for compliance were 43% in August 2015 and this improved to 84% in

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October 2015. The trust said the low compliance figures were because of the recording of the data on the computer systems and not that the process had not been followed.

- In theatres pressure relieving equipment was available and this included gel mats and specialist moulds for heads for neurology surgery. Operating table mattresses were renewed yearly to maintain the integrity of the pressure-relieving foam to reduce the risks of patients developing pressure ulcers during their operations.
- Patients were assessed pre-operatively. There were 105 pre-assessment clinic slots per week and of these, they had 10 sessions of 'one stop clinics' per day. These were where patients saw the consultant and were assessed for surgery at the same time. These were used for patients who had a long way to travel so they only needed one visit to the hospital. The pre-assessment clinics saw all elective patients except for neurosurgery as they had their own pre-admission assessment clinic. Patients were able to undergo a number of tests, including blood tests and electrocardiograms (ECGs). They were also able to undertake cardiopulmonary exercise testing (CPEX). This test was used to measure a patient's fitness and how their heart and lungs would cope with surgery. Staff told us this helped with the planning of any critical care beds that may be required post-operation.

## Nursing staffing

- There were vacancies for nursing staff in some of the surgical wards. Ongoing recruitment was taking place and bank and agency staff were used to fill any gaps in the rotas. At times some of the wards worked under their numbers when they were not able to fill their vacancies. Theatres had recruited a high number of staff to fill their vacancies but these staff required training to meet the demands of the department.
- Theatre management told us they were using the Association of Perioperative Practice (AFPP) model for staffing and this had been introduced since our last inspection. This was guidance about how many staff should be in each theatre to make sure patients and staff were safe.
- Senior managers in the theatre department told us and showed us records that they had reduced the turnover of staff from 38% to 16%. This had been through the recruitment of 100 new staff and managers acknowledged that they had a high number of experienced staff who had left the department.
- We were given a copy of the theatre newsletter dated October 2015. In this they welcomed, from April 2015 to October 2015, 58 new members of staff. Forty-eight members of staff left within this timescale.
- Staff in theatres told us they had high numbers of staff sickness and they felt some of this was due to undue stress and 12-hour shifts in some theatre departments. From April to September 2015 Core Clinical Services Directorate (theatres was part of this directorate) had sickness percentage of 5.65% for trained nursing staff and for untrained it was 7.20%. The trust as a whole for this time frame was 4.39% therefore they were above the trust target.
- When theatre staff worked over their finishing time it was documented as overtime and recorded on a shift verification sheet. We were shown these sheets and staff told us they were paid for their extra hours they had worked. A senior manager in the theatre department was not aware of this process.
- Agency staff were employed within the theatre department. On level two they had six agency staff working across all areas (anaesthetics, scrub, medirooms and recovery). Again, these staff had worked in these areas before to maintain consistency. On our unannounced inspection, we visited the theatre suite on level three and the staff told us they had four agency nurses working on shift due to staff sickness. The department knew these staff as they worked there many times.
- The vascular ward had a period of recruitment over the months prior to our inspection and was slightly over their trained nurse establishment by 2.5 whole time equivalents (WTE) but they had 1.8 whole time equivalent health care assistant (HCA) vacancies. However, three trained nurses were due to take maternity leave next year and one trained nurse had resigned. They had one new trained nurse starting shortly, therefore all maternity leave was mostly covered.
- On the urology ward they had a number of staff leaving, this will mean they will be four trained nurses and two HCAs under-establishment but they were recruiting and staff had requested to transfer from other wards.

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- On the colorectal ward they had five staff vacancies and they were recruiting for these at the time our inspection.
- At the flow meeting for colorectal, vascular, urology, burns and plastics wards on one of the days of our inspection they discussed staffing levels. The colorectal ward was short by two health care assistants and the other wards reported they were short staffed on some of the shifts throughout the day and night. One of the wards required an extra member of staff to provide one to one care for a patient with complex needs.
- Ward staff were able to work extra shifts on the bank to cover vacancies.
- Staff were encouraged to complete incident forms to validate the need for more staff.
- The wards carried out safe staffing tool assessments every day, which looked at the acuity of patients on the wards. The trust told us they worked to one trained nurse to eight patients and one health care assistant to eight patients. Senior staff on the wards were able to access the outcomes from this on a monthly overview to review patients' needs on the wards. Staff on wards stated they did not use this as a tool generally but were aware of it and would use it to support requests for additional staff if necessary. The safe staffing tool used on urology showed when the ward was short of staff, for example on 8 December 2015 when they were 2.7 hours short, which was identified as being due to a receptionist being on leave with clinical staff covering.
- Agency staff could be used but required permission from the head of nursing for each department.
- Patient handover meetings took place at the start of each shift on the wards and these included a safety briefing. At the pre-admission clinic, they also had safety briefings at the start of each day. This was to make sure all staff were up to date with the latest information.
- The pre-admission clinic was fully staffed.
- Interventional radiology had their full complement of staff. They used bank staff to cover sickness and when the unit was opened as the escalation ward. Their sickness rate was 6.5%, which was higher than the trust target of 3.8%. Senior staff told us this was due to long-term sickness.
- The turnover of staff for radiology nursing staff as a whole, which included interventional radiology, was 9.5% and this had been reducing from 10.9%. This meant continuity of care for patients with the same staff staying in post.

- A matron told us about the procedures they had in place to monitor staff sickness. On one of the surgical wards the sickness rate of some members of staff was affecting the safe running of the ward. Disciplinary procedures were in place where needed.

## Surgical staffing

- Surgical staffing numbers meant patients had access to consultant-led care and there was sufficient doctors to meet their needs. The hospital trust had a medical staffing skill mix similar to the England average. Around 43% of medical staff were consultant grade (England average 41%). Middle grade staff levels were 5%, below the England average of 11%. However, the numbers of registrar posts at the trust was above the England average of 37% at 40%. For junior doctors the trust was the same as the England average at 12%.
- The theatre lists we observed were consultant-led.
- We observed a handover between the surgical teams where they discussed the emergency admissions from the previous 24 hours and their treatment. Consultants and other doctors of all grades were present. They all discussed any surgery that was going to be cancelled due to capacity issues. These meetings took place every day in the morning.
- Nursing staff said they felt well supported by the medical teams. Although some of the wards did not have doctors based there, they usually came quickly when requested and did spend most of their time on the wards on weekdays.
- We saw in some patients' notes that they saw a doctor most weekdays but not always the consultant. Patients told us they saw doctors and were able to ask questions about their treatment.
- The trust sent us a copy of the rota for out of hours doctor cover. Consultants were on call out of hours, weekends and bank holidays.

## Major incident awareness and training

- Staff told us there was a trust-wide major incident policy and they knew where to obtain information relating to their role in a major incident. Staff in theatres told us how they would move patients to clear the emergency theatres ready for possible transfers of patients from the major incident. They also told us that senior staff would be contacted at home so they could come to the hospital to direct their own staff groups.

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## Are surgery services effective?

Requires improvement



We have judged the effectiveness of surgery services as requires improvement because:

- Outcomes for patients who used services were below expectations compared with similar services. Participation in external audits and benchmarking was taking place but results of monitoring were not always used effectively to improve quality.
- The average length of stay for surgical patients within the hospital was worse than the England average.
- Patient readmission rates after surgery between December 2013 and November 2014 (due to corrective measures being needed or infections) were worse than the England average for elective (planned) and emergency surgery.
- Not all staff had the right skills, knowledge and experience to do their job.

However;

- The trust used enhanced recovery pathways in a number of surgical specialities, including colorectal, urology and plastics. They audited these to see if they were meeting the targets for discharge. The audit for plastic surgery showed the vast majority of patients were discharged at the correct time.
- When patients received care from a range of different staff and teams this was coordinated. All relevant staff were involved in assessing, planning and delivering patients' care and treatment. Staff worked collaboratively to understand and meet the range and complexity of patients' needs.

### Evidence-based care and treatment

- Policies and guidelines were readily available on the trust intranet. These were seen to be up-to-date and meeting national guidance. Care pathways complied with National Institute for Health and Care Excellence (NICE) guidelines.
- The trust had enhanced recovery programmes in place for a number of specialities, for example in urology, plastic and colorectal surgery. Enhanced recovery is a modern, evidence-based approach that helps patients recover more quickly after having major surgery. The

trust had an enhanced recovery team of five nurses. Their role was to support ward staff and patient using the enhanced recovery pathways. Once patients were discharged they received follow up telephone calls for a set number of days. The purpose of this was to enable patients to be discharged on the set day as directed in the pathway but they still had contact with the hospital.

- The enhanced recovery team of nurses undertook auditing of the enhanced pathways. For example, they were monitoring the length of stay of some enhanced recovery patients undergoing plastic surgery in October 2015; one out of five patients who stayed longer than the five days. In November 2015, there were two out of the six patients who stayed longer than the five days. The nurses told us they reviewed the notes to find out the reason why the patients stayed longer than the five days post-operation.
- The pre-admission clinic staff told us they encouraged patients to be as healthy as possible prior to surgery, for example to stop smoking. At the time of our inspection the pre-admission clinics held an event of the month (each month they had a different area of health promotion on which they concentrated) was to refer all patients who smoked with their permission to a smoking cessation programme.
- Patients were assessed for risks of venous thromboembolism (VTE) prior to surgery, in line with the NICE guidance. There was evidence in patient records of the use of prophylaxis injections or tablets (proactive prevention) for VTE. VTE assessments were recorded on the medication administration records and were clear and evidence-based, ensuring best practice in assessment and prevention. We saw these had been completed as per the trust's protocol

### Pain relief

- Patients' pain was assessed and managed effectively. Patients told us their pain was well controlled and that nurses asked them if they wanted any pain relief medication.
- We saw a number of patients post-operation, one of who had an epidural in place to manage their pain. A member of staff told us about the information they monitored and recorded for patients with epidurals. For example, if the patient was hallucinating which can be a known effect of the medication.

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- Staff told us they routinely asked patients if they were in pain. We saw on patients' medication administration records that they were given pain relief at regular intervals.
- The trust had a pain scale tools in place and one that could be used for patients who were not able to communicate their pain levels. Patients had a choice of faces from happy to sad to indicate their level of pain. We saw these completed in patients records. There was also information about the acute pain analgesic ladder, which provided staff with details about which analgesia to use based on their score.
- The trust had an acute pain team that worked from 8am to 7pm on Monday to Friday. Staff on the wards or medirooms could refer patients to them. Outside these hours, it was the on-call anaesthetist. The team also provided training for staff on pain control and the use of machines, for example epidurals.

## Nutrition and hydration

- Patients had their nutrition and hydration needs assessed and actions were put in place to manage these needs.
- Patients were screened using the malnutrition universal screening tool (MUST) to identify those who were malnourished or at risk of becoming malnourished. This is a validated national nutritional screening tool and was designed to identify adults at risk of malnutrition and to categorise them as being at low, medium or high risk. We saw this had been completed at pre admission clinic for a number of elective patients.
- Patients were told when they needed to stop eating and drinking prior to their admission to hospital. This was dependant on their time of admission. Some patients were offered a special carbohydrate drink prior to their operation to help with their post operation recovery, for example colorectal patients.
- For patients on the enhanced recovery pathways they were given supplement drinks prior to their operation and post-operatively to aid their recovery.
- We observed some patients had intravenous fluids post operation to maintain their fluid levels.
- We saw the management of patients' fluid balance was good. Fluid charts were in place and those we reviewed for patients who had undergone major surgery were very detailed and had totals for input and output. These also included measurements from any drains or other equipment they had in place.

- Patients told us they were offered medication to prevent their nausea and vomiting post operatively.

## Patient outcomes

- The hospital had mixed performance in the Patient Reported Outcome Measures (PROMs) for April 2014 to March 2015. These patients reported to the hospital on their outcome following surgery for groin hernias, hip replacements, knee replacements, and varicose veins. The trust performed better than the England average for both groin hernia indicators and worse than the England average for all the indicators relating to hip replacement and knee replacement. For varicose veins, the trust had not provided any data.
- Hip fracture performance for the year 2014 to 2015 was varied. In some, they were better than England average; for example, surgery on the day of admission was 85% compared to the England average of 72.1%. However, data for patients developing pressure ulcers was 5.9% compared to the England average of 2.8%. The average length of stay was 23.4 days, compared to 20.3 days for the England average. In one other measure for pre-operative assessment by a geriatrician, the hospital performance had improved over the previous year and was better than the England average.
- The trust performed well in national cancer audits. In the lung cancer audit the trust was better than the England average for discussing patients at a multidisciplinary level. In the bowel cancer audit, the trust was better than the England average for discussing patients at a multidisciplinary level, being seen by a clinical nurse specialist, and receiving a relevant scan. The trust was also above the England average of 94% for having well completed data in the bowel cancer audit.
- The trust provided data for the first patient report of the National Emergency Laparotomy Audit (NELA) dated October 2015. The audit results were rated green, amber or red based on 11 measures. This trust was rated as 'green' for only three of these measures, seven were 'amber' and one was 'red'. The 'red' rating was for review of patients older than 70 years by specialists in Medicine for Care of the Older Person (MCOP). This meant they only scored between 0-49% for patients over 70 years assessed by MCOP.



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- Patient readmission rates after surgery between December 2013 and November 2014 (due to corrective measures being needed or infections) were worse than the England average for elective (planned) and emergency surgery.
    - Urology had the highest elective surgery relative risk of readmission rate.
    - The average length of stay for surgical patients within the hospital was above the England average. It is recognised as sub-optimal for patients to remain in hospital for longer than necessary and a barrier to other patients being admitted. Data for between July 2014 and June 2015 showed that the trust had a higher than England average length of stay for elective surgery at 3.7 days (the England average was 3.3 days). There were longer than England average stays in elective trauma and orthopaedic surgery at 4.5 days (the England average was 3.4 days).
    - The trust also had a higher than England average length of stay for emergency surgery at 6.2 days (the England average was 5.2 days). There were shorter than England average length of stays for emergency neurosurgery at 11.2 days (the England average was 13.4 days) and the length of stay for emergency general surgery was the same as the England average.
  - The Trust's Anaesthetic Department had signed up to the Anaesthesia Clinical Services Accreditation scheme (ACSA). The Department were making progress towards achieving Level 1 accreditation for this voluntary quality improvement program.
  - The pre-admission clinic took part in both local and national audits. This included The Balanced Anaesthesia Study which tested the depths of general anaesthesia and its effect on patient outcomes after major surgery. This was ongoing at the time of our inspection. An anaesthetist was running another local audit taking place about uncontrolled hypertension and atrial fibrillation (AF - an abnormal heart rhythm characterised by rapid and irregular beating). Again this was also ongoing at the time of our inspection.
- Competent staff**
- Not all staff had the skills, knowledge and experience to deliver effective care and treatment to patients.
  - Staff in the theatre department told us they had the correct staffing levels but a high proportion of these staff were new and inexperienced. For staff that were experienced this increased their workload, as they had to mentor new members of staff. We were shown records of recruitment of new staff to support their staffing figures.
- Scrub support practitioners (band 4) were asked to scrub for certain operations under the direct supervision of a trained nurse and theatre managers had informed staff they were to be counted as trained staff. However, under direct supervision meant that the theatre nurse could not leave the theatre to carry out other tasks as they were monitoring the scrub practitioner. There was not always the right skill mix of staff so they could not always get ready for the next case, which affected the running of the list.
  - An education plan had been set up in theatres to support and develop staff. This covered all areas in theatres, for example scrub, anaesthetics and recovery. One member of staff told us they had just completed the document and another member of staff told us they had just started this.
  - Some staff in the medirooms told us they felt well supported by their mentors and met with them regularly every two months and more frequently if needed.
  - On the colorectal, vascular, urology, plastics and burns wards, they had 17 new staff. A practice educator was appointed to support them during their induction period. This was to help develop their skills and knowledge in the area in which they would be working.
  - Medical revalidation was launched in 2012 to strengthen the way that doctors are regulated, with the aim of improving the quality of care provided to patients, improving patient safety and increasing public trust and confidence in the medical system. The consultant appraisal rates were 80% for the surgery directorate.
  - The appraisal rate for the core clinical service directorate that oversees theatres for qualified nursing staff was 65% as of October 2015. For the surgery directorate for the same period for qualified nursing staff was 69%. Staff told us their appraisal was in line with their incremental pay date and they were sent reminders when they were due.
  - An administration assistant told us about how they monitored appraisals on one of the surgical wards, including their due dates. All appraisals needed to be completed prior to staff pay incremental dates, and they also had to have completed their mandatory training.
- Multidisciplinary working**



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- We observed collaborative working from staff contributing to patient care. All staff told us about the importance of working as a team when caring for patients. Some therapy staff told us they also attended ward rounds with the doctors to discuss patients' ongoing progress.
- We saw multidisciplinary teamwork in theatre in relation to the use of the World Health Organisation surgical safety checklist. Each member of the team had a recognised role.
- There was multidisciplinary input involved with all patient care. Patient records demonstrated input from therapists, including dietitians, physiotherapists, and occupational therapists, as well as from the pharmacist team and the medical team.
- There was evidence of a strong multidisciplinary approach from national cancer audits. In the 2014 bowel cancer audit there was 99.6% compliance for multidisciplinary discussion in the 276 cases reviewed. This was above the England average of 99%. In the 2014 lung cancer audit, there was 98.6% compliance for a multidisciplinary discussion in the 210 cases reviewed. This was above the England average of 95.6%.
- We spoke with a member of staff who helped with the discharges of patients from some of the surgical wards. On the colorectal ward, they only had two delayed discharges and they were medically fit but waiting for social care support. This member of staff told us they followed the progress up frequently.
- The enhanced recovery team of nurses told us that as part of the enhanced recovery pathway they start planning the discharge of patients' pre operatively so the patient had a date in mind of when they would be leaving hospital.

## Seven-day services

- Staff on the wards told us there were doctor-led ward rounds most days in the morning where all patients were reviewed.
- There was onsite consultant cover from Monday to Friday 8am to 6pm and an on-call system was in place outside of these hours. The plastics and burns ward had daily consultant input, including out of hours.
- There was physiotherapy cover at the weekends. A physiotherapist saw all patients on the enhanced pathway (for elective hip and knee operations) and patients, who the nursing staff had not been able to mobilise, at weekends.

- There was access to an emergency theatre at all times, including weekends and out of hours.
- Interventional radiology provided an out of hours service in the evening, weekends and bank holidays.
- Pharmacy was open at the weekends from 10am to 2pm. An out of hours on call system was in place.
- The acute pain team worked 12-hour shifts up to 7pm weekdays only and out of hours provision was the on call anaesthetist.
- The palliative care team was only accessible weekdays.
- The learning disability specialist nurse team were not available out of hours, weekends or bank holidays.
- The mental health team were available out of hours but staff reported it could be problematic to get a prompt response.
- X-ray, scanning and diagnostic testing was available 24 hours a day, seven days a week. Urgent blood tests were available out of hours.

## Access to information

- Staff had access to all the information they needed to deliver effective care and treatment to patients.
- Ward clerks told us they requested patients' notes from the hospital record system and these were received within a good timescale. There were some instances where notes were not in place in theatres and staff told us they completed an incident form.
- We observed handovers between recovery and the ward staff. Staff in recovery told us they needed to make sure they handed over all relevant information. For example, the last time the patient had pain relief and how the operation and recovery went.
- Nursing staff told us when a patient was transferred to their ward from the critical care unit records were maintained of their stay. These were stored in the patient's notes. Staff also said they received a verbal handover.
- Junior doctors told us they completed the discharge summaries as soon as possible to prevent the patient from having their discharge delayed and they were promptly sent to GPs.

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

- Processes were in place to make sure staff acted within the legal framework to safeguard patients.
- The trust had four consent forms in place. We found the consent forms for people who had capacity to make

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decisions were fully completed and signed by the doctor and patient, and risks were documented. One consent form was for patients who did not have the capacity to sign or understand the operation or procedure they required. At the last inspection, we found these were not being used correctly. However, we found that these forms were now being used correctly at this inspection.

- We saw in the record of one patient, whose first language was not English, that their consent form was signed by a translator and by them. We saw evidence that the operation was explained to them via the interpreter, including any potential risks. This was documented on the consent form.
- All patients we spoke with told us they had signed a consent form and the doctors had explained the operation and risks to them.
- Staff on the surgical wards were knowledgeable about processes and the importance of Deprivation of Liberty Safeguards. Staff on one of the wards gave us an example of the last referral, which took place in September 2015, and the subsequent best interest meeting. Senior staff told us they were confident all staff knew about the processes involved in making a referral and ensuring patients' legal rights were respected.
- Training figures for the surgery directorate for Mental Capacity Act 2005 and Deprivation of Liberty Safeguards was 81%, just under the trust target of 85%. For theatres, as part of the core clinical services directorate, it was 75%. Staff told us they had training on the Mental Capacity Act and they knew how to act in a patient's best interest if they lacked capacity to make a specific decision about their care. Managers told us they reminded staff about completing mandatory training and they were working hard to release staff to do this. However, at times this depended on how busy their wards and departments were.

## Are surgery services responsive?

Requires improvement



We rated the responsiveness of surgery services as requires improvement because:

- Access to patients and patient flow required improvement.

- Some patients were not able to access services for treatment and operations when they need do. There were long waiting times, delays and cancellations. Action to address this was not always timely or effective and had resulted in a high number of complaints.
- The trust performed worse than the England average in most of the national standards they provided data for. This included the trust-wide Admitted Adjusted Referral to Treatment (NHS England consultant-led referral to treatment time standards of within 18 weeks) performance, which was worse than the England average between September 2014 and August 2015.
- The number of cancelled operations as a percentage of elective operations was higher (worse than) the England average between since our last inspection. The percentage of patients not treated within 28 days of a cancelled operation was above (worse than) the England average since our last inspection.
- Due to pressure for their beds and the demand for their services, some patients had to use facilities and premises not appropriate for the services being provided.

However:

- The trust had devised a number of leaflets for patients to provide them with detailed information for example, 'preparing for your surgery'.
- Patients had access to other specialist teams to meet their individual needs, for example, mental health team.

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

- The trust worked with commissioners to plan for, and meet, the needs of the local population. There were regular meetings and an open relationship between them and other stakeholders. The surgery directorate management team told us when they planned services they looked at a number of areas, including what they were already providing and how changes and improvements to services could be made. For example, how many operations could be performed balanced against demand and contracts.
- The orthopaedic directorate management team had devised a plan to address the backlog of spinal surgery and those patients who have waited over 52 weeks. This plan was ongoing at the time of our inspection.

## Access and flow

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- The trust performed worse than the England average in most of the national standards they provided data for.
- The trust-wide Admitted Adjusted Referral to Treatment (NHS England consultant-led referral to treatment time standards of within 18 weeks) performance was worse than the England average between September 2014 and August 2015. The data published per surgical speciality by NHS England showed five out of the six surgical specialities were not meeting the referral to treatment time of 18 weeks. This had also not improved since our last inspection.
- The number of operations cancelled as a percentage of elective operations was higher (worse than) the England average between April 2013 to April 2015. However, this had improved since our last inspection.
- The highest number of operations cancelled was in quarter two of 2014/15 (July to September 2014) where the hospital cancelled 264 elective operations (operations meeting the NHS cancellation criteria).
- In quarter one of 2015/16 (April to June 2015) the trust cancelled 171 operations.
- The trust's proportion of cancelled operations that were not rebooked within 28 days timescale was consistently worse than the England average from quarter 1 of 2013/2014 (April to June) to quarter 1 of 2015/2016 (April to June).
- At the last inspection we found the bed occupancy levels were very high and this had affected the number of elective operations that had been cancelled. The spinal surgery list had been closed due to the numbers of patients waiting over 52 weeks for their operations. A plan had been devised to address this and was ongoing at the time of this inspection. Patients were also being cared for on wards that were not appropriate for their needs and these included medical patients on surgical wards. We found this had improved at this inspection.
- At this inspection bed occupancy levels remained high. For example, between April 2015 and June 2015, it was 95.9% and the England average was 88.4%.
- The introduction of the surgical admissions unit since our last inspection had improved the service. This was where patients came directly from the emergency department to this ward. They also had some additional beds on the gynaecology ward to transfer elective female patients when the surgical wards were full. A discharge lounge was also in place and this was used by surgical wards for patients who were able to sit in a chair and wait for their discharge letter, medication or transport. This was to help to free up beds quicker.
- We attended a flow meeting for the colorectal, plastics, burns, vascular and urology wards. These took place each morning and a senior nurse from each ward attended along with the matrons, a member of staff from the site management team and other senior staff from the directorate. They discussed staffing levels, patient admissions from the day before, discharges and surgical admissions due in that day. The purpose of this was to ascertain where they could place new admissions following their elective surgery, emergency admissions and how each ward was managing with their staffing levels.
- All but one of the wards mentioned above were using their procedure rooms to accommodate patients due to the increased demands on beds in the hospital. We spoke with a patient who was in a procedure room. They told us the room was comfortable but often if the door was closed they were missed from drinks and food rounds. They were independent and able to walk around unaided, as there was no toilet or washing facilities in these rooms.
- During our unannounced inspection staff in the theatre suite on level two (emergency surgery and elective surgery) told us they had had a very busy day due to emergency surgery and with the pressure of finding beds for emergency patients. Staff were able to show us the records they had to demonstrate this.
- In the level three theatre suite (all elective surgery), the nurse in charge told us they only had two patients who were waiting for inpatient beds and they were being cared for in recovery. The hospital site team (who managed bed allocations) were aware of these patients.
- We spoke with four consultants who told us they had delays starting their theatre lists at the last inspection due to issues with the equipment from the Sterile Services Department (SSD). They said this was now improving.
- To help improve theatre utilisation theatre senior staff were meeting with senior surgical staff to look at the scheduling of operations.
- We found at this inspection some patients were still being cared for on inappropriate wards/units. The interventional radiology suite, where they had day cases, was being used as the escalation ward when the

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hospital was extremely busy and had no beds. Staff told us they had to request beds from the bed store as they used trolleys for their patients. There were separate toilet facilities for male and female patients. When this was being used to keep patients overnight there were times where they breached single gender accommodation rules (this was where males and females were in the same bay/area).

- There were no washing facilities for patients. The only shower was down the corridor and it was a staff shower, again this breached single gender accommodation rules. Staff also had to accompany patients to the shower, which meant they were off the unit. This unit was staffed by bank staff at night as interventional radiology staff had worked during the day. When this was used, it affected the patients coming in for procedures.
- Staff on the surgical wards told us they did not have as many medical patients on their wards now and they had no problems getting them reviewed by the medical doctors. On one of the surgical wards we visited, they had two medical patients but they were not fit for discharge. We visited other surgical wards and found one ward also had two medical patients who required
- The recovery medirooms reported nine occasions in the 12 months prior to our inspection where patients had to stay in recovery overnight before returning to the ward. This was due to bed pressures within the wider hospital. Staff told us they had a procedure in place to follow when this took place.

## Meeting patients individual needs

- Patients had their individual needs assessed and met by staff.
- Patients with mental health needs could be referred to the psychiatric team or psychiatric specialist nurse and who responded quickly during the day with advice and support.
- Staff on one of the surgical wards told us how they communicated with a patient living with autistic spectrum disorder (ASD) who had been admitted and undergone surgery. They used references to objects; for example, by pointing at the object to help the patient understand what they were communicating. Staff said they were supported by specialist learning disability

nurses who gave them advice on how to communicate with the patient and how not to cause them any further anxiety. This patient had one to one support to meet their complex needs.

- On the colorectal ward, they were caring for a patient whose first language was not English. Staff told us they had used a translator. We saw in their notes they had received treatment at this hospital in the past. Staff told us they were able to communicate with this patient by pointing to objects and they could understand some English. We saw in their medical records that they brought in a friend (this was the patients choice) to act as an interpreter when they were seen at outpatients. Staff said they had access to translators and interpretation systems on the telephone.
- A specialist nurse had introduced an enhanced recovery pathway and booked patients to come back in following their discharge for removal of their catheter. This was previously carried out in the ward procedure room but this had been turned into an additional side room so it was often in use. The specialist nurse often found an available room in outpatients to use to enable the enhanced recovery pathway to continue. A business plan was being prepared to enable the ward to change a bathroom into a treatment room for this purpose.
- On the colorectal ward, they were trialling a new breakfast tray system to help encourage patients to eat and drink. This included having their own teapot and milk and having access to a wider variety of breakfast items, for example, yoghurts.
- The trust had devised a number of information leaflets for patients. These included 'preparing for your surgery', which had details about what to expect pre- and post-operatively. For patients on the enhanced recovery pathways they also had leaflets about the surgery, what to expect each day and a progression diary for patients to fill in.

## Learning from complaints and concerns

- Information was available to patients on how to make a complaint. Each ward had a leaflet available at the main nurses' station, which explained how to raise a concern, complaint or compliment. The leaflet detailed the process for patients to follow and what to do if they were unhappy with the outcome.

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- At the last inspection the surgery directorate had a high number of unresolved complaints. A plan had been put in place for extra staff to help and this had now decreased.
- At this inspection the surgery directorate management team told us they had a high number of complaints in trauma and orthopaedics, which they felt was due to cancelled operations and the backlog of spinal surgery.
- From September 2014 to August 2015 trauma and orthopaedics had 12.9% of trust complaints and general surgery had 7.9%. The surgery directorate management team told us they had six outstanding complaints in October 2015. They were working hard to address this. They said they audit complaints to find out themes and look at ways of improving their service.
- The overall number of complaints had reduced slightly at this inspection compared to the inspection in November 2014.
- None of the patients we spoke with told us they had made, or were planning to make, a complaint about their care and treatment. They all said they knew how to make a complaint.

## Are surgery services well-led?

Requires improvement



We have judged well led for surgery services as requires improvement because:

- Some staff within theatres did not always raise concerns or report incidents as they were not always taken seriously or treated with respect when they do.
- Staff satisfaction was mixed in theatres. The majority of staff told us they felt “valued”, “respected” and “trusted” by their line and wider hospital management teams. However, this was not the case for staff in the theatre department.
- Improving the culture and staff satisfaction was not always seen as a high priority in theatres. Staff do not always feel actively engaged or empowered. Staff in theatres felt morale was worse at this inspection than the one in November 2014.

- Governance arrangements in the theatre department were not robust enough to identify when important safety checks of some anaesthetic machines were not carried out in some theatres. Therefore, they were not able to demonstrate these were safe to use.

However:

- Staff satisfaction was not the same for the surgery directorate (wards) where staff felt supported and listened to. Staff had no concerns about the management or leadership at local level and divisional level.
- The trust had a number of ways to encourage staff engagement for example, team meetings, weekly bulletins and toilet tips to help keep staff up to date with development.
- The views of patients and members of the public were used to make changes. We say the ‘you said, we did’ initiative on notice boards outside of the wards where it was documented what the issue was and the changes made.

## Vision and strategy for this service

- The senior management for the surgical directorate had a three-year journey of improvements they wanted to make to the services they provided. For the immediate future, they were concentrating on merging some of the surgical teams and the recovery of 52-week spinal surgery delays. In the longer term the aim was to meet the demand for their services and to look at becoming centre of excellence in a number of specialities.
- The core clinical services directorate (theatres) said their immediate plans were to look at improving theatre utilisation to meet demand for operations.
- Staff we spoke with were aware of the trust’s visions and one was to deliver exceptional healthcare to all of their patients.

## Governance, risk management and quality measurement

- An effective governance framework was in place to monitor performance and risks and to make sure the executive board were aware of these via the trust wide governance reporting. However, some governance arrangements within the theatre department had not



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identified shortfalls where some daily safety checks on anaesthetic equipment in some of the theatres had not taken place. Therefore, they were not able to demonstrate that this equipment was safe.

- Theatres monitored their performance weekly and this included number of emergency and elective operations that took place, late finishes and early starts. This was to see how they were performing and where they could look at improving.
- Minutes of the monthly surgery governance meetings demonstrated that issues were discussed. For example, any serious incident that had been investigated.
- Minutes of the vascular governance meetings showed that doctors and nurses attended. They looked at a number of areas, for example any serious incidents and the learning from these, as well as complaints.
- We spoke with staff from the risk management department who told us each directorate had their own risk register. These were kept under review and discussed at directorate meetings. For example, on the surgery directorate it had about meeting elective surgery targets and staffing recruitment.
- The surgery directorate had their own business plan, which included where they were now and their plans for the future, which included a plan on how to meet demand for their services and national standards.
- Interventional radiology had its own governance systems that fed into its management structures. Serious risks were identified on their risk register and shared with the executive team when required.

## Leadership of service

- The leadership within the surgery directorate reflected the visions and values of the trust, which promoted good quality care. However, feedback from staff felt this was not the same for theatres.
- The majority of feedback we received from staff in theatres said there was very little leadership or guidance from the theatres management team that oversaw the running of this department despite new senior staff coming into post. They felt they were not visible, especially on level two. Staff told us the band 7 staff were meant to work 70% of their time in clinical practice but they were rarely seen in theatres.
- Staff on the wards, units and in the clinic told us they had very good leadership from their immediate line managers. All staff said they felt well supported and could speak to them about any concerns they had.

- Matrons were visible on the wards and staff said they felt supported by them and would speak to them if they had any concerns.

## Culture within the service

- Staff on the wards were all enthusiastic about working for the trust and how they were treated.
- Some staff in theatres told us they did not always report incident or concerns as they felt they were not listened too and actions taken.
- The majority of staff told us they felt “valued”, “respected” and “trusted” by their line and wider hospital management teams. However, this was not the case for staff in the theatre department. At the last inspection staff in the theatre department felt there was a lack of appreciation of their work. Some staff felt morale was worse at this inspection than the one in November 2014.
- The senior management for the surgical directorate told us they were aware that morale was low in theatres due to the numbers of staff leaving and the ongoing recruitment process. The core clinical services directorate who oversaw the running and management of theatres were also aware there were issues within theatre with morale. They said they were addressing the recruitment issues but were aware it would take time to train up the new staff.
- To recognise members of staff as individuals or as a team who had gone ‘over and beyond’ for patient care were they were nominated for trust awards. These were peer selected. We met two ward sisters who had been nominated for inspirational leaders awards.
- Senior managers told us staff were able to give their views via the “you said, we did” initiative. Staff we asked about this were not aware of it.

## Public engagement

- Patients were encouraged to give their views on the services provided to help improvement and with the planning and shaping of future services.
- Patients were able to feed back their views on the ward via the Friends and Family Test. They were asked whether they would recommend the ward to their friends and family.



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- The trust operated a “you said, we did” scheme where patients were able to give their comments about the service and the trust responded with what they had done. We saw examples of these displayed outside the ward areas.
- We saw the results of feedback from patients; this included those on the enhanced recovery pathways where they were sent questionnaires following their hospital admission.

## Staff engagement




- Staff were encouraged to give their views on the services provided to help improvement and with planning and shaping future services. However, some staff in the theatre department felt these were not listened to.
- Some staff told us they had recently taken part in a staff survey about the trust and this had run for a number of weeks and ended in November 2015.
- A bi-monthly magazine ‘Insight’ was published which highlighted key issues about what had been happening at the trust, news and sharing of letters of thanks received from patients and their families. Staff were encouraged to tweet or email reasons for being proud to work at the trust.
- We observed notices called “top toilet tips” were fixed to the inside of toilet doors. We saw two of these notices were about the new early warning system and the recent near event involving the wrong route administration of oral / enteral treatment.

- A weekly bulletin and newsletter were also available for staff to read.
- Staff were encouraged to share their views at their team meetings and staff told us these took place regularly. Theatres gave us a timetable of their staff meetings for the next few months. As part of their improvement plan theatres were planning to devise a staff committee to meet with management at set times. The date for completion of this was March 2016.

## Innovation, improvement and sustainability

- There was a theatre scheduling programme being implemented to improve the use of all the operating theatres and how they could increase capacity.
- Theatres had devised an improvement plan that included staff development, leadership and governance to improve the services they were providing. This was ongoing at the time of our inspection and not all actions had completion dates.
- The surgery directorate management team told us they had to make efficiency savings but they had to balance these to make sure they benefitted both the patients and trust.
- The trust was using a robotic machine in urology surgery to improve the surgical outcomes for patients, including a reduction in the length of stay and blood loss.
- The trust was also proposing to set up a ‘Biobank’ to help with research into urological cancers.

# Critical care

Safe	Good 
Responsive	Requires improvement 
Overall	Good 

## Information about the service

The Southmead Hospital critical care unit is at Gate 37 of the newly built Brunel building. The unit comprises of four separate patient areas called 'pods'. Each pod can accommodate 12 patients, all in individual cubicles. At the time of our visit, the unit was providing accommodation for a maximum of 40 patients. Four of the cubicles were not yet open for their intended purpose (to provide isolation) because of issues with ventilation, but were available as 'normal' cubicles. Two cubicles were being reserved for simulation training. The remaining six cubicles were not being opened until the unit had enough skilled and experienced staff (nursing and allied health professionals) to provide safe care to all 46 patients.

The critical care unit in the Brunel building started admitting patients in mid-May 2014. The first patients were transferred from the trust's previous critical care units in the old Southmead and Frenchay Hospitals.

In the year April 2014 to March 2015 the unit had 1,692 admissions.

When we visited the critical care unit it was established to care for up to 22 intensive care patients (described as 'level three') and 18 high-dependency patients (level two). This number could be flexible to accommodate more acutely unwell patients.

During this inspection we visited the critical care unit on Tuesday 8, Wednesday 9 and Thursday 10 December 2015. We spoke with a full range of staff, including consultants, doctors, trainee doctors and nurses from different grades. We met the unit's head of nursing and the lead consultant for critical care. We spoke with physiotherapists, the lead pharmacist for the critical care unit, the domestic staff and one of the unit's dietitians. We met with patients who were able to talk with us, and their friends and relatives. We also observed care and looked at records and data.

## Summary of findings

We have judged the critical care unit to be good for safety, and as requiring improvement for responsiveness. Because this inspection was focused on the areas that required improvement following our inspection in November 2014, we did not inspect against the caring, effective and well-led domains.

- The most pressing issue for the safety of the unit in November 2014 was the low numbers of nursing staffing, and the lack of skill and experience of the nursing staff group. During this inspection we found the unit had increased staffing numbers, improved its skill mix and supported staff development in achieving a post-registration qualification in critical care. Although there were still some gaps in staffing, for example supernumerary cover, detailed recruitment plans had been agreed and a full establishment of staff was expected to be in place by the end of March 2016.
- The critical care unit was designed to accommodate patients in single rooms, called 'cubicles'. Our November 2014 inspection reported challenges with this design because patients were not visible at all times. A new standard operating procedure had been introduced to help staff adapt their practice. This had helped to improve observations of patients most of the time, but a challenge remained at times; for example, when staff were taking rest breaks.
- Incident reporting, learning and improvements to practice following incidents had improved, with daily safety conversations being introduced.
- There was an improving picture in relation to the incidence of patient harm. In November 2014 we found an unusually high incidence of falls, pressure ulcers and patients removing their own medical

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devices. The unit had responded to this with increased staffing and education, and a reduction of 50% was expected to be achieved by the end of the year. However, the majority of the mandatory training topics, including falls training, were below the trust's target for 85% of staff to have completed their training.

- Our previous inspection in November 2014 found the responsiveness of the unit required improvement. This was because the poor flow of patients through the hospital affecting the ability of critical care to respond effectively. During this inspection we found there were still a very high number of delayed discharges, despite the unit working hard to identify patients who could be discharged in the early morning. Bed occupancy also remained high, affecting access for patients requiring intensive care.
- The length of stay for patients remained much higher than the NHS national average and was not optimal for patient social and psychological wellbeing.
- There was no critical care outreach team (a recommendation of the Core Standards for Intensive Care Units (2013)) to provide a response to deteriorating patients elsewhere in the hospital, or to follow-up patients who had been discharged from the critical care unit.

## Are critical care services safe?

Good



We have judged the safety of the unit to be good because:

- Most of the areas of concern from our November 2014 inspection had been addressed, and good progress was being made overall to ensure the safety of patients.
- Staff had become more accustomed with the new environment and the skill mix and numbers of nursing staff had improved. Recruitment was still ongoing to ensure sufficient staffing numbers were employed, including supernumerary pod leaders. This was on track to deliver the full establishment by the end of the financial year.
- The incidence of patient harm (including pressure ulcers, falls and patients removing their own medical devices) was falling, supported by education and increased staffing numbers. However, the unit recognised there was still some work to do to improve this further; for example, ensuring staff completed their mandatory training.
- New standard operating procedures had been introduced to help staff adapt their practice for single cubicle working. This helped to ensure patients had the appropriate safe level of observation almost all of the time, although there were times (for example, during rest breaks) where this was not always working.
- Staff were open and honest in their reporting of incidents and learning opportunities were identified and discussed with staff.
- Patient records were completed well and the risks for deteriorating patients were well managed on the unit.
- Medicines were safely managed, but storage rooms were not kept secure at all times.
- The unit was visibly clean and staff followed infection prevention and control procedures, including hand washing and using personal protective equipment.

### Incidents

- Staff were open and honest about incidents they reported. During our previous inspection in November 2014 we found that staff may not have been reporting all the incidents that occurred. This was partly because some staff were not sufficiently experienced to recognise a reportable incident and they did not always

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have time to complete incident forms. During this inspection we reviewed the critical care unit (CCU) incident reports within the trust-wide incident reporting system from June to September 2015. We saw an increased attention to incident reporting, with incidents being reported including medication errors, pressure ulcers, patient falls, patients removing medical devices (for example, tubes and intravenous lines), cleaning delays and staff shortages. The bed pressures, delayed admissions and out of hours discharges were still not, however, being routinely reported as incidents.

- Staff were receiving feedback from incidents that had been reported. Our previous inspection found that staff were not always receiving feedback from incidents; however, we found this had since improved. As well as the individual member of staff being provided feedback, all reported incidents were printed and discussed at handover. Each pod had a patient safety folder where records were stored so staff could access the information at all times. Additionally, 'toilet tips' posters were being used to share trust-wide learning. These were displayed in staff toilets, as well as other relevant areas. For example, a recent near event in another area of the trust related to medication and there was a poster on the drugs' cupboard. A weekly critical care unit medical 'grand round' also discussed learning from incidents. The meeting gave the medical staff an opportunity to discuss recent incidents while investigations were still ongoing, enabling early reflection and identification of things that could be improved.
- Patient mortality and morbidity was reviewed and discussed at unit level on a monthly basis. Minutes of the meetings were recorded and distributed. Any actions or learning points arising were allocated to a member of the team to take forward. However, there was still an issue with patient notes not being available in a number of cases. The problem had been escalated to the trust risk register and an improvement in record availability had been achieved, but there were still some cases in need of review because notes had not been available when needed.
- There had been four reported serious incidents in the critical care unit between August 2014 and July 2015. The serious incidents were unrelated and all of them

had been investigated fully with staff involvement, and learning points had been recognised. Action plans had been completed and learning had been shared with staff. No further similar incidents had occurred.

- The unit's three-strand approach to patient safety was having a positive impact. The three-strand approach included learning when things go wrong, preventing incidents and a positive incident management system (PIMS). Staff were not only being encouraged to report incidents where something had gone wrong, but also to report examples of where things had gone well. This was then reviewed and shared as good practice. Additionally, learning opportunities from other hospitals was actively sought. For example, the unit's standard operating procedure for staff rest breaks had been written after an incident at another hospital.

## Duty of candour

- Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, is a new regulation which was introduced in November 2014. This Regulation requires the trust to be open and transparent with a patient when things go wrong in relation to their care and the patient suffers harm or could suffer harm which falls into defined thresholds.
- Staff on the unit were complying with their duty to be open and honest when things went wrong. Staff were aware of their duty to inform patients and/or their relatives when something had gone wrong, and to provide an apology and explanation. We saw evidence of the regulation being met in incident reporting and investigation reports

## Safety thermometer

- The unit had experienced a high level of falls, but this was improving. The high number of falls had been recognised and escalated to the trust risk register. At our inspection in November 2014 we found the unit had developed an action plan and recognised a number of areas of concern that we had also observed or noted from evidence. These included: of 203 nursing staff, 120 were still to complete falls training; of the 22 consultants, only three had completed falls training; the new cubicle environment, coupled with the ratio of new nursing staff was presenting problems with patient visibility; outdated assessment documentation was being used; and the critical care unit was not using the trust-wide post-falls action plan.

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- We reviewed some of these concerns as part of this inspection and found that 143 staff were still to complete their mandatory falls training (45%). However, staffing ratios had improved, assessment documentation was up to date and risk assessments were being completed as a matter of course. Additionally, a new standard operating procedure for single cubicle working had been produced.
- In the period July 2014 to July 2015 there had been no falls with harm reported through the safety thermometer. However, this only captures data from one day a month. Unit managers told us they had seen a big reduction in the number of falls and internal monitoring showed they were on target to have reduced the overall number of falls on the unit by 50% this year, when compared with last year. We found this was supported by the reduced number of incident reports and improved safety thermometer performance.
- The incidence of pressure ulcers was decreasing. At our last inspection in November 2014 we found there had been an increasing trend in lower category (less harmful) pressure ulcers, although the number of higher category (more harmful) pressure ulcers was decreasing. The rising trend had been escalated to the trust risk register and an action plan produced. The identified problems included: a lack of specialist pressure-relieving mattresses; low levels of staff training; and inconsistent documentation in relation to skin integrity. At this inspection we found pressure-relieving mattresses were more readily available, although we were told that at weekends there was occasionally a shortage. The tissue viability nurses had delivered a training package for staff to complete and skin care bundles were being regularly used and reviewed. The number of incident reports relating to pressure ulcers had decreased, and the patient safety thermometer showed an overall general decrease in the prevalence rate.
- The numbers of patients unsafely removing medical devices was decreasing. During our inspection in November 2014 we found there had been a high number of patients removing medical devices (tubes, tracheostomies, venous catheters and intravenous lines). This situation had been escalated to the risk register and various actions were being put in place or tested. During this inspection we noted a reduction in the numbers of reported incidents. We found that increased staffing numbers and a new standard

operating procedure for single cubicle working had improved the observation of patients, which, along with increased staff awareness, had significantly improved this situation. We were told by unit managers that internal monitoring showed they were on target to reduce the overall numbers by 50% when comparing this year to last. Staff we spoke with agreed that incidences of patients removing medical devices had reduced. We also saw this to be the case with the number of incident reports being fewer.

- Patient safety information, including the safety thermometer, was accessible to staff and visitors. The data was displayed in the waiting room, the three 'quiet rooms' and each pod office in an easy to understand format.

## Cleanliness, infection control and hygiene

- Data from the Intensive Care National Audit and Research Centre (ICNARC) covering the period July 2014 to June 2015 showed there were some healthcare-associated infections acquired on the unit. ICNARC data reported unit-acquired methicillin-resistant *Staphylococcus aureus* (MRSA) varied between 0.5% (October to December 2014) and 3% (April to September 2014) of admissions, with 2015 results being around 1% of admissions. This was very slightly higher than the national average of about 0.5% of admissions. There had been no cases of *Clostridium difficile* (C. diff) between January 2014 and September 2014. Between October and December 2014 the C. diff rate was about 0.25%, just below the national average of 0.5%. Between January and June 2015 this had increased to about 0.75%.
- Internal hand-hygiene audits showed good compliance with trust policy. During our inspection in November 2014 we found that hand-hygiene audit results were poor, with compliance ranging between 63% and 84%. During this inspection we reviewed the audit results for each pod for the period April to September 2015 and results ranged from 90% to 100% compliance, with the vast majority being over 95. All staff during our inspection were 'bare below the elbow' and observed good hand hygiene procedures before and after patient contact. Staff also wore appropriate personal protective equipment, for example gloves and aprons, when caring for patients.

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- There had been an outbreak of *Pseudomonas aeruginosa* (PSEAE) between June and July 2015, which was investigated and well-managed. In a four-week period 23 patients had tested positive to PSEAE. The trust responded promptly with a serious incident investigation and the establishment of a dedicated team to oversee the processes needed to resolve the issues. All of the water outlets (taps and sinks) in the unit were tested, and those that tested positive were taken out of use until a full cleaning regimen had been completed and the units tested negative for PSEAE. All patients were treated successfully with antibiotics and no further incidents had occurred since July 2015. A strict cleaning regimen was still being used and a business case for replacement taps throughout the unit had been approved, although work had not yet started. We reviewed the cleaning records and saw the cleaning regimen was being strictly adhered to.
- The unit was visibly clean and free from dust. We saw regular cleaning taking place throughout the unit and found all the equipment and surfaces we checked were visibly clean. Once equipment had been cleaned it had a green 'I am clean' sticker attached with the date it was cleaned. We saw these to be in use throughout the unit.
- The unit was able to provide standard isolation facilities in the event of a patient having an infection; but, this was not the case for more complex isolation needs. All of the cubicles in the unit were single-occupancy with doors, allowing most infections to be appropriately managed. However, the four dedicated respiratory isolation rooms remained unusable for that purpose because of ongoing issues with the ventilation systems. There was uncertainty about when this would be resolved.

## Environment and equipment

- The unit was built to a high specification. Each patient had a large bed space and separation from other patients, limiting the risk of the transmission of infections. There was a policy of keeping all doors and blinds open when the patient was not receiving intimate care. This was in order to improve the visibility of patients for staff. Each cubicle had an electric bed with a pressure-relieving mattress. There were high-backed chairs in each cubicle for patient use, where appropriate. Each cubicle had a toilet and sink for patient use with a moveable screen to provide privacy. Cubicles also had hand-wash sinks for staff use. Each had soap and paper towels.
- Equipment alarms were audible. In November 2014 we found there was a risk that equipment alarms in the cubicles could not be heard on the unit when a door was closed. Since that inspection engineers had attended and turned the equipment alarms to maximum volume. Additionally, monitors in the central area of the pod had audible alarms linked to the monitors in the patients' cubicles.
- Patient hoist equipment was of a high standard. The unit had been fitted with ceiling-mounted electric hoisting equipment in each cubicle. These were suitable for use with bariatric patients. Nurses and physiotherapy staff told us of the improvements for both patients and staff in terms of safe manual handling since the installation of this system. The unit also had access to beds to accommodate bariatric patients when required.
- The unit had sufficient ventilators for patients requiring mechanical invasive or non-invasive ventilation. The ventilators and other essential equipment were checked by nursing staff at each handover session. The ventilators were all registered with the biomedical engineering team and records showed they had been serviced, as required, in the last 12 months.
- The unit had appropriate emergency equipment. Each pod had a defibrillator and tamper-evident resuscitation trolley with the specified equipment. Each pod also had a difficult airway trolley for emergency airway management equipment. Each resuscitation trolley was checked once a day by the nursing staff and the difficult airways trolleys were checked by the doctors. Checklists were provided for staff to sign when the checks had taken place, and these had been completed daily as required. On one occasion we found the resuscitation trolley in Pod C not to be sealed and without defibrillator pads. We discussed this with staff at the time and found it had been recently used and was in the process of being restocked and checked. The missing item was replaced immediately. We also noted that the checklist being used for the trolley was different to the checklist in other pods. This was raised with staff who advised an old version had been accidentally printed. The correct version was immediately printed and placed with the trolley. We checked two of the four resuscitation trolleys and found all the contents were



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present. However, one of the arterial lines had blank packaging so no size, description or expiry date were displayed. This was immediately replaced by staff and disposed of.

- Equipment had been serviced and maintained in accordance with the manufacturers' guidance. We were provided with a list of just over 900 pieces of equipment on the trust's medical equipment list used in the critical care unit. The list showed the serial number of the piece and its description. At the time of our inspection all the equipment was recorded as having had planned maintenance servicing. The list showed when the equipment service was next due, the intervals between services and the risk rating (the importance) of the equipment.

## Medicines

- The hospital used a specific prescription and medication administration record chart for patients in the critical care unit, which helped the safe administration of medicines. Medicine interventions by a pharmacist were recorded on the prescription charts to help guide staff in the safe administration of medicines. We looked at nine prescription and medicine administration records and noted all were legible and completed in full, with one exception where a delayed or omitted administration did not have a reason recorded. Allergies had been recorded in all cases.
- Medicines, including those requiring cool storage, were mostly stored appropriately and records showed they were kept at the correct temperature, and so would be fit for use. Controlled drugs were stored and managed appropriately. Emergency medicines were available for use and there was evidence these were regularly checked. On one occasion we found the main store rooms unlocked, unattended and unobserved for a period of ten minutes. This meant feeding solutions and fluids used for haemofiltration were accessible and tamperable. We also found three feeding solutions were out of date but had not been removed from the stock. We immediately informed the head of nursing for the critical care unit who removed the out of date stock and ensured the store rooms were secured. We were told the store rooms had been left unlocked because it was easier for the materials management staff to complete a large restock. However, they recognised this was not good practice and immediately changed the way they managed this to ensure the security of all medicines.

- There was a pharmacy top-up service for ward stock and other medicines were ordered on an individual basis. A specialist pharmacist visited the unit every weekday and attended daily ward rounds to provide support with prescribing and use of medicines. Patients had access to medicines when they needed them and the visit of the pharmacist helped to ensure medicines were used safely. However, we were told when the specialist pharmacist was not available a more basic supply service was provided to the unit.

## Records

- Those patient records we reviewed were generally completed well. This included nursing, medical and allied health professional notes. Each patient had standard daily, hourly or periodical observations, as required. These were well recorded. There was documentation around the insertion of medical devices and when they were due for changing. Dates and times of any investigations were recorded. The daily checklists, including the resuscitation checks (airways, breathing, circulation, disability and exposure) were recorded, as well as equipment and IV fluids. On one record we found a neurological review had been completed, but this had not been signed so it was not possible to ascertain who had completed this review.
- Standard care plans were used and were well completed. This included line management, skin care bundles, catheters and ventilator care bundles. Risk assessments were being completed and appropriate care plans started to reduce any identified risks.
- It was not possible to monitor the time taken to admit a patient into the critical care unit because the decision making time was rarely recorded. We were told there was a plan to introduce an electronic bed management system into the critical care unit in the next six months. This system was already in use in the hospital, but further work was needed to make it suitable for the critical care unit environment. Once implemented, this would accurately record the time the decision was made to admit a patient to the critical care unit, what time a bed became available and what time the patient was actually admitted.

## Safeguarding

- Most staff had been trained and understood how to recognise and respond in order to safeguard vulnerable people. Mandatory safeguarding training was delivered

# Critical care

and most staff were up to date with their knowledge. The trust required at least 85% of staff to be up to date with training at all times. This made an allowance for staff on long-term sick leave or maternity leave. The critical care unit had exceeded the 85% target for adult safeguarding (87%), but was slightly below the target for safeguarding children (82%). The unit had recruited a large number of nurses, with approximately six new starters a month since the beginning of the year, which had impacted on the ability of all staff to complete this training within the last 12 months.

- Staff knew who to contact within the hospital for both adult and child safeguarding concerns. Staff were clear about their responsibilities to report abuse, as well as how to do so using the trust's intranet guidance and reporting tools.
- Deprivation of Liberty Safeguards (DoLS) considerations were discussed daily and staff were aware of their responsibilities. Following concerns about DoLS processes at our previous inspection in November 2014, the unit had introduced a new flowchart to help staff make decisions about the need to apply for a DoLS authorisation. As part of the daily 'safety huddle', DoLS was discussed to ensure it had been considered for all appropriate patients. Staff were aware of the DoLS processes, and the need to apply for an authorisation to deprive someone of their liberty.

## Mandatory training

- Staff training was meeting trust targets in some subjects, but not in others. Training in health and safety, infection prevention and control, information governance, Mental Capacity Act 2005 and Deprivation of Liberty Safeguards, and adult safeguarding were the only five subjects among 22 where over 85% of staff were compliant. The remaining 17 subjects where less than 85% of staff had completed training were blood transfusion, conflict resolution, dementia, equality and diversity, falls, fire safety, food safety, patient handling, resuscitation, safeguarding children and venous thromboembolism (VTE). One of the major factors affecting compliance was the number of new staff who had joined the department over the last year, meaning it had been difficult to release experienced staff to complete update training. Because the unit had had a large number of patient

falls, but completion of the mandatory training was low (only 55% of the 321 staff required to complete the training were up to date), there was an increased focus on this training at the time of our inspection.

- Mandatory training was delivered by a mix of taught sessions (for example, resuscitation), and online learning (for example, information governance). Staff were able to access the online learning resources from any computer within the unit, including those in the cubicles.

## Assessing and responding to patient risk

- There was no critical care outreach team, or equivalent function, to respond to deteriorating patients throughout the hospital. The critical care unit did not provide a response function to deteriorating patients on the wards, instead only becoming involved when a patient was considered by the specialty team to require admission to the critical care unit. Although several business cases had been written and supported by all the directorates, funding had not been agreed and therefore the project remained unsupported by the trust. Critical care outreach is a recommendation of the Core Standards for Intensive Care Units (2013).
- Risk assessments were being used to assess and manage risk to patients. Of the patient care records we reviewed we found risk assessments were in place for falls, venous thromboembolism (VTE) and pressure ulcers. In response to the risk assessments, care plans had been written to minimise any risk to patients.

## Nursing staffing

- Nursing staffing levels were, generally, meeting the required numbers to care for patients safely. Since our last inspection in November 2015 the skills and experience of the nursing team had improved, with just under 20% of the total nursing staff not having had at least 12 months' critical care experience. The physical numbers of permanent staff had also increased, and was continuing to do so. To fill gaps in the full time establishment, some bank and agency nurses were being used. However, this number was decreasing month-on-month as new nurses started in the department. In August 2015 13.8% of the staffing group had been agency, reducing to 12.3% in October 2015. At the time of our visit the safe levels of staffing recommended by the Core Standards for Intensive Care

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Units (2013) were mostly being met. The recommendations are for one nurse to care for one level three patient, and for one nurse to care for two level two patients. There were occasions, however, when these standards were not being met, for example when one nurse went on a rest break and left one nurse caring for two level three patients.

- The number of supernumerary nurses was not meeting recommended standards. The Core Standards for Intensive Care Units (2013) recommend every critical care unit has one supernumerary nurse providing coordination for the whole unit. Additionally, it recommends a further one supernumerary nurse for every additional ten beds. Although the unit had one supernumerary nurse on duty at all times, there were not always sufficient nurses to provide the additional supernumerary cover required. The head of nursing for the unit explained they were still working towards achieving this standard, with nursing recruitment ongoing into March 2016. The current establishment allowed an additional two supernumerary nurses (each one covering two pods) most of the time, but occasionally these nurses had to care for patients to ensure safe levels of staffing were being achieved for the numbers of patients in the unit.
- A new education team had been established in the critical care unit to provide additional learning support to the nursing staff. This team was made up of three band 7 nurses and one band six nurse. The initial focus was to support new staff with their development, allowing them to gain relevant experience in the critical care environment and to monitor their competency levels.

## Medical staffing

- The critical care unit was consultant-led. There were two consultant-led ward rounds each day, one in the morning and one in the evening, including weekends. Both were formally documented, including handover information for the oncoming shift. There was input to the ward rounds from unit-based staff, including trainee doctors and the lead nurse for the pod. Other allied healthcare professionals were asked to attend when required. The consultant cover followed the recommendations of the Core Standards for Intensive Care Units (2013). All of the consultants were intensivists (consultants trained in advanced critical care) and Fellows of the Faculty of Intensive Care Medicine.

- There was full coverage from consultants. Critical care unit consultants were on duty seven days a week, with on-call cover being provided overnight. When consultants were on-call, their cover was dedicated to the critical care unit and not extended elsewhere in the hospital. In daytime hours, the consultant covering the critical care unit did not have other clinical commitments.
- Trainee doctor provision ensured safe care for patients. At our inspection in November 2014 we found there were occasions overnight where a pod may be left without doctor cover if the more experienced doctor was needed to assist in another pod. This time we were told the cover was planned to ensure two supernumerary doctors with advanced airway skills overnight, in addition to the one doctor per pod. This level was not being achieved all the time, but there was always at least one supernumerary doctor with advanced airway skills, which ensured there was a doctor available at all times for every pod. There had been no locum doctors employed in the unit in the last three months.
- Working arrangements with other departments ensured patients were kept safe. The unit had a formal arrangement with the theatre anaesthetics team to ensure that if the critical care unit doctor with advanced airway skills was not available (for example, they were admitting a patient from another area of the hospital) that an anaesthetist would immediately attend the department on request.

## Major incident awareness and training

- The trust had major incident plans and procedures. There was a flowchart to follow in the event of an internal critical incident or event, or external major incident alert. This described the duties of various staff in the hospital and external to it, such as the ambulance service and NHS England's local area team. Action cards were immediately available to guide staff in the event of a significant incident.
- Business continuity plans had been recently updated. The plan to ensure 'business as usual' was maintained during significant incidents had recently been updated to reflect the new hospital site.
- There had been major incident simulation exercises. The hospital had arranged some desk-top exercises to simulate major incidents and critical care staff had been represented at these.

# Critical care

## Are critical care services responsive?

Requires improvement



We judged the responsiveness of the unit to require improvement because:

- The poor flow of patients through the hospital continued to affect the ability of critical care to respond effectively. Too many patients experienced delayed discharges, despite the unit's best efforts to identify patients ready for discharge in the early morning. High bed occupancy levels affected patients requiring intensive care.
- The length of stay for patients was higher than the NHS national average and not optimal for patient social and psychological wellbeing.
- There was no critical care outreach team, or equivalent, to respond to deteriorating patients elsewhere in the hospital, or to follow-up patients discharged from critical care.
- Patients and visitors were well-supported on the unit, with useful information leaflets and communication aids, including interpreters, being available

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

- A new patient and visitor information leaflet had been introduced. At our inspection in November 2014 we highlighted the lack of an information leaflet being available for visitors and patients. This time we found a new national leaflet had been introduced, including a wealth of information about what to expect, including behaviour changes, treatments, support for friends, relatives and children, what the different staff groups do, how recovery is planned for and effects a critical illness can have on the body. An additional insert with unit-specific information, including visiting times and phone numbers, was also included.
- The unit did not provide an outreach facility. The Core Standards for Intensive Care Units (2013) recommend every critical care unit should have an outreach team to provide support to deteriorating patients in the wider hospital, as well as to provide follow-up to patients who had been discharged from the unit. Although the hospital at night team was tasked with following-up

discharges overnight, this had no critical care input. Additionally, there was no formal outreach support from the critical care unit to the hospital wards for deteriorating patients in the form of education, response and/or advice.

- Accommodation was available for visitors to stay overnight, and visitors had access to food and drink. The unit had overnight accommodation for visitors, which was available on first-come-first-served basis and reviewed daily. A list of nearby bed and breakfast accommodation was also available for anyone who was unable to secure the unit's accommodation.

### Meeting people's individual needs

- Patients were treated as individuals. Staff told us they had used translation services for both patients and relatives when English was not spoken or not easily understood. Resources were also available for communication with patients in British Sign Language. There were communication boards for patients with tracheostomies to write messages or point at symbols and images, and tablet devices had been ordered to provide even more communication options.
- The unit had link nurses for a number of different patient needs. For example, nurses in the unit with special interests in dementia, learning disability and infection control had been recognised and given the opportunity to develop their knowledge in these areas. The link nurses then provided support and training to other nurses in the unit to ensure these patients were well-supported. Additionally, dementia and learning disability specialist teams within the hospital offered support when these patients were on the unit.

### Access and flow

- There was no system-based process for bed management. The critical care unit's bed-state was not communicated electronically, because there was no system for them to do this. Clinical site managers were required to attend handover meetings in the early morning to understand the situation facing the unit that day. Work was ongoing to install an electronic management system, but this was not expected to be operational for another six months. This meant timely information was not available throughout the day as the

# Critical care

situation changed with emergency admissions, and record keeping of decision making times and admission and discharge times were not accurately captured in all cases.

- The discharge of patients from the unit was sometimes not done at the optimal time. Following our previous inspection in November 2014 we reported that between May and June 2014 the unit performed worse than the national average for out of hours' discharges. Slightly less than 15% of all discharges had taken place at night (against a national average of around 8%). During this inspection we found the position had improved, reducing to about 13% in the period October to December 2014, 7% between January and March 2015, and 10% between April and June 2015. However, with the exception of the second quarter of 2015, this remained above the national average.
- There was a high level of delayed discharge. Nationally the number of patients experiencing a discharge delay of more than four hours remains high, at about 65%. However, for this unit over 80% of all discharges between April 2014 and June 2015 were delayed by more than four hours from the time the patient was ready to leave the unit. Although patients remained well cared for in the critical care unit when they were medically fit to be discharged elsewhere, the unit was not the best place for them and could mean that another patient was unable to be admitted. The unit was doing everything it could to identify patients for discharge at the earliest opportunity, with the majority being confirmed with the clinical site management team by 8.15am each day. However, bed availability and prioritisation throughout the hospital often meant that delays in discharge occurred outside of the unit's control. We were told by staff that the majority of discharges took place between eight and 12 hours from the time the decision was made, and that although the critical care unit was a priority for beds when they became available they often lost these to other areas of the hospital.
- The length of stay for patients was above the national average for all types of admission to the unit. This included elective and emergency surgical patients, ventilated patients and those admitted with severe sepsis. Staff told us this was mainly because of delays in discharge when waiting for a bed for the patient on a ward.

- Occupancy levels on the unit were high. The unit was a major trauma centre in the South West of England and one of the biggest receivers of patients transferred from other units for clinical reasons, such as neurological or renal patients. The Royal College of Anaesthetists recommend a critical care unit should run at about 70% occupancy, and state that an occupancy level of 80% or more is likely to result in non-clinical transfers and failure to admit in a timely manner, with associated morbidity and mortality risks. The unit's reported occupancy rates were consistently higher than 80%. For 13 of the 17 months between June 2014 and October 2015, the unit reported being at 100% occupancy (June, August and September 2014, November 2014 to June 2015 and August to October 2015).
- It was not possible to establish how many elective operations had been cancelled as a result of a critical care unit bed not being available. Although staff told us there were only a few occasions where surgery had been cancelled as a result of a critical care unit bed not being available, the trust did not collect this data separately from other beds in other areas of the hospital.
- There had been no transfers out of the unit for non-clinical reasons (for example, because no beds were available) during the period April 2014 to June 2015.

## Learning from complaints and concerns



- Complaints were investigated and reviewed. There were very few complaints made to the critical care unit in relation to care and treatment. We reviewed the four complaints that had been received in the last 12 months, the investigation into them and the responses made. The responses were in clear non-medical language. Apologies were made when appropriate. The complaints were investigated on the unit and action plans were produced and circulated. The actions were appropriate to demonstrate the staff had learned from what went wrong in these situations. Preventative measures were being implemented to prevent reoccurrences. We saw discussion of the incidents recorded in department meeting minutes and lessons learned being shared with the wider staffing group.
- The unit had the trust's Concerns, Complaints and Compliments leaflet on prominent display in the reception area. This described how to correspond with the trust, which could be by letter, email, telephone or

## Critical care

fax, or in person, and who could complain. It included information about the Patient Advice and Liaison Service (PALS). The process for raising complaints and confidentiality expectations were also described.



# Maternity and gynaecology

Safe	Good	
Responsive	Good	
Overall	Good	

## Information about the service

Maternity and gynaecology services for North Bristol NHS Trust were located on the Southmead Hospital site.

Although most services had moved to the new Brunel building, maternity and gynaecology services remained in older buildings adjacent to the main hospital. The trust provided services to the local community in Bristol, North Somerset and South Gloucestershire.

General gynaecology services were provided as well as early pregnancy, antenatal, labour and postnatal care. The unit comprised of a 19 bed gynaecology ward (Cotswold); Quantock Day Assessment Unit, with seven couches; a 14 bed antenatal ward (Quantock); Central Delivery Suite comprising of ten birthing rooms (one of which had a birthing pool and one the bereavement suite, and two high dependency rooms); and a 35 bed postnatal ward (Percy Phillips Ward) containing transitional care beds. In addition there was a midwife led birthing unit comprising of four birthing rooms, two with birthing pools and a seven bed postnatal ward (Mendip Ward). The theatre suite, adjacent to Cotswold Ward and the Central Delivery Suite comprised of four operating theatres; two for gynaecology and two dedicated obstetric theatres. Antenatal clinics were run Monday to Friday in the antenatal clinic, which was a self-contained separate building adjacent to the main unit. The clinic also held obstetric and specialist clinics run by obstetricians and other specialist staff. Clinics were also held in various settings across the local community including Cossham Birth Centre, health centres and community clinics. Community midwives reported good communication between the community services and inpatient services. This was a focused inspection to follow up the findings of the comprehensive inspection visit conducted in November 2014 where the maternity and gynaecology services were found to require improvement in the safe and responsive domains. As the caring, effective and well led domains were judged to be good at that time, they were not included within this focused inspection.

Between January and December 2014, there were 6,049 births across the whole of the trust. During the inspection we spoke with 67 members of staff, one relative, two patients, and reviewed five sets of records.

# Maternity and gynaecology

## Summary of findings

Overall we found improvements had been made and safety and responsiveness were good because:

- There was a positive culture around incident reporting and staff were encouraged to report concerns. Learning from incidents was shared with staff on a daily basis. Practice development midwives ensured learning points were embedded in the formal education programme and changes to practice were fed into the ongoing audit program. The maternity unit was clean and hygienic, benefitting from a dedicated domestic team.
- Systems were in place to identify vulnerable women or children. Staff were confident in using the referral system and felt supported by the specialist safeguarding midwives.
- Staff reported access to mandatory training was good. Practice development midwives monitored attendance at and organised training sessions.
- There were numerous systems in place to assess risk to both women and babies enabling staff to respond quickly and effectively when conditions changed.
- Midwifery staffing levels had increased since our last visit meaning women and babies were being looked after in a safer environment. Recruitment was ongoing to ensure improved levels were maintained. There was 74 hours of dedicated consultant cover on the central delivery suite each week. This was below the Royal College of Obstetricians and Gynaecologists' Safer Childbirth recommendations but was kept under regular review as the issue was on the risk register.
- Checks on adult and baby emergency resuscitation equipment were inconsistent. With some confusion amongst staff about what needed to be checked and when. This was pointed out to staff at the time and daily and monthly check sheets were immediately created.
- Routine antenatal care was generally carried out in community settings near to where people lived. A

range of specialist and multidisciplinary ante natal clinics were held at Southmead Hospital and in specific community settings to ensure women got the specialist care, advice and support needed.

- During our last inspection we found that fathers had limited opportunity to stay with their partners overnight. At this inspection we were told funding had been secured for 14 reclining chairs. They had been ordered but were yet to arrive. Elective caesarean section lists had been increased from three funded sessions per week to five funded sessions per week. This had improved the flow of women through the service.
- The early pregnancy assessment centre took into account women's preferences. When attending, women often experienced long waiting times. They were asked if they wanted an appointment system introduced. Feedback identified women preferred to wait and be seen on the same day even if it meant a long wait.
- Routine dating and growth ultrasound scans took place at Southmead Hospital. Scanning at Cossham Birthing centre and other community settings was being considered to relieve pressure of the main unit.
- Bed occupancy for maternity services (excluding Central Delivery Suite) was 83.3% in the first quarter of 2015. This continued to be significantly higher than the England average for maternity services. Staff completed incident reports if there were delays in transfer to or from the Central Delivery Suite (CDS) because there were no postnatal beds available once a woman had given birth. This also meant that at times, women remained on CDS longer than needed because of the lack of available postnatal beds.
- 'Flow midwives' had been introduced, on a six month pilot. Their role was to have an overarching approach to patient flow issues and deal with the associated problems thus freeing up midwives on duty to continue with direct patient care. Staff told us they had found improvements in flow since their introduction.

# Maternity and gynaecology

- There was access to translation and interpretation services. Information leaflets were available in the unit and on the trust website in a number of languages and could be produced in alternative formats if required.
- Complaints were dealt with in line with trust policy. Women were often invited to the unit to discuss their concerns or outcomes of complaint investigations. Staff said changes in practice required as a result of complaint were communicated to staff via emails, newsletters and/or safety briefings.

## Are maternity and gynaecology services safe?

Good



The service was assessed as good because:

- There was a positive culture around incident reporting and staff were encouraged to report concerns. Learning from incidents was shared with staff on a daily basis. Practice development midwives ensured learning points were embedded in the formal education programme. The maternity unit was clean and hygienic benefitting from a dedicated domestic team.
- Entry and exit from the unit was controlled by use of a swipe card for staff. Security staff were on duty seven days a week. Out of hours access was via the central delivery suite only.
- Systems were in place to identify vulnerable women or children. Staff were confident in using the referral system and felt supported by the specialist safeguarding midwives.
- Staff reported access to mandatory training was good. Practice development midwives monitored attendance at and organised training sessions.
- There were numerous systems in place to assess risk to both women and babies enabling staff to respond quickly and effectively when conditions changed.
- Midwifery staffing levels had increased since our last visit meaning women and babies were being looked after in a safer environment. Recruitment was ongoing to ensure improved levels were maintained. There was 74 hours of dedicated consultant cover on the central delivery suite each week. This was below the Royal College of Obstetricians and Gynaecologists' Safer Childbirth recommendations but was kept under regular review as the issue was on the risk register.

However:

- Checks on adult and baby emergency resuscitation equipment were inconsistent. With some confusion amongst staff about what needed to be checked and when. This was pointed out to staff at the time and daily and monthly check sheets were immediately created.

## Incidents

# Maternity and gynaecology

- All staff reported incidents using the trusts electronic incident reporting system. We saw this was easily accessible through the trusts intranet site. Staff confirmed there was a positive culture around incident reporting with feedback given to those who reported incidents.
- There had been three serious incidents reported between August 2014 and July 2015. They had been investigated using the trusts policy and outcomes of investigations shared with relevant staff.
- All incidents were reviewed by the risk midwife who presented a risk report to the monthly maternity risk forum. This forum fed up through a variety of clinical governance groups was ultimately reported to the trusts governance and risk committees.
- Learning from incidents was shared through daily safety briefings, regular newsletters, intranet updates and local team meetings.
- The service had a list of maternity specific incidents that required reporting, such as post-partum haemorrhages and third and fourth degree tears. To ensure a link with practice development and continual learning, the practice development midwife sat on both the risk and post-partum haemorrhage forums to ensure learning from incidents was identified and disseminated through the formal education program. For example as a result of incidents reported relating to a lack of appropriate bladder care in labour, additional training had been rolled out along with the development of stickers to record the voiding of urine. Use of the stickers was then added to the audit program to ensure continued compliance with improved practice.
- Post-partum haemorrhage (PPH) monthly average rates for more than 2000 millilitres were 2.2% between April and November 2015. The monthly average for the previous year was 1.6%. The trust target was 0.8%. The monthly average rates of PPH above 1500 millilitres was 5.7% between April and November 2015. The monthly average for the previous year was 3.8%. The trust target was 1.8%. The monthly average rates of PPH above 1000 millilitres was 12.7% between April and November 2015. The monthly average for the previous year was 9.1%. The trust target was 4.6%.
- Third and fourth degree tear rates as a percentage of vaginal births, between April and November 2015 were 5.5%. The average for the previous year was 5.6%. The trust target was 3.3%.

## Duty of Candour

- Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, is a new regulation which was introduced in November 2014. This Regulation requires the trust to be open and transparent with a patient when things go wrong in relation to their care and the patient suffers harm or could suffer harm which falls into defined thresholds.
- All staff we spoke with understood the term duty of candour and told us how they involved next of kin when discussing outcomes of complaints or incidents. Senior staff described the process of complaint and incident investigation and showed us documentation that prompted staff completing it to consider 'duty of candour'.

## Safety thermometer

- Incidences of new venous thromboembolisms (VTE), urinary catheter and urinary tract infections were reported using the Safety Thermometer system (a local improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care). The rates for these were consistently better than the England average. Results were on display boards, throughout the maternity and gynaecology unit, for staff and members of the public to see.

## Cleanliness, infection control and hygiene

- There were three cases of Clostridium difficile infection trust wide in September 2015. This was lower than the trust target. There was one case of methicillin resistant Staphylococcus aureus (MRSA) trust wide, in August 2015 and one in September 2015. One of the cases was identified in the maternity unit. Learning from this had been shared across the trust.
- All areas we visited were visibly clean. However the two bathrooms on Percy Phillips ward did not have any instruction regarding how to ensure the baths were clean between uses. This was raised at the previous inspection. We spoke with a member of the cleaning staff who explained they undertook a thorough clean of baths daily and where possible twice a day. Midwifery care assistants told us they undertook 'ad hoc' cleaning should the find a bath dirty or if a patient raised a concern.
- The unit was pleased they still had their dedicated cleaning and portering team meaning there was

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consistency in the standard of cleaning and support services. Cleaning rotas and cleaning audits were displayed for staff and members of the public to see. There were a number of toys for family members within the family room on Percy Phillips room. A cleaning rota had been developed which was to be carried out by volunteers and overseen by the award manager, however this had yet to commence.

- Antibacterial hand disinfectant was available at all entrances within the unit apart from the entrance from Quantock Ward to the Central Delivery Suite (CDS). Although there was one at the entrance to the Quantock day Assessment Unit it was not clear it could be used when entering the CDS. We saw one couple with a staff member enter the CDS from Quantock Ward and none of them used the hand disinfectant.
- Staff were seen to be 'bare below the elbows' in accordance with trust policy. We saw staff washing their hands before and after carrying out patient care. Notices were displayed advising how to wash hands correctly. Hand hygiene audits were undertaken and showed compliance between 97% and 100%. However it was noted no data had been submitted to the trust wide annual audit 2015 for the Quantock day assessment unit.
- Disposable aprons and gloves were readily available and we saw staff using them appropriately. We saw "I am clean" stickers on some equipment to indicate it was ready for use.

## Environment and equipment

- Entry and exit from the maternity unit and Cotswold ward was controlled by a swipe card for staff members. Security staff were on duty seven days a week, from 07.30am - 8.00pm, to monitor access and greet patients and visitors to the maternity wards and departments. There was CCTV monitoring of the maternity unit area. Doors to the unit were locked after 8pm and access was via the CDS receptionist who was present 24 hours a day.
- There was an abduction policy accessible to all staff. It detailed actions to be taken if a baby was abducted. Babies in the unit were not tagged and parents were advised to keep them in their site at all times when they left their bedspace.
- The antenatal clinic, now seeing over 6,000 patients a year in a building designed for managing 4,000 patients

a year, remained cramped. However during a tour of the building we saw that staff used space creatively and were always looking for new ways to provide space for the range of clinics ongoing.

- The gynaecology theatre had a dedicated recovery area. The two bedded recovery room used for the two obstetric theatres remained cramped when to accommodating three women.
- Emergency resuscitation equipment was available for both mothers and babies. However, checking of emergency equipment was inconsistent. On the antenatal ward, the adult emergency trolley had not been checked daily and there was more than one checklist which made it unclear how often which bits had to be checked. On the birthing unit the baby resuscitation equipment had been checked as required but the adult resuscitation trolley had no checks recorded for December 2015 at all. On the gynaecology ward checks of the emergency resuscitation equipment were also found to be inconsistent with several dates in November and December not signed to say the equipment had been checked. On the postnatal ward the resuscitation trollies for both mothers and babies had been checked as required. Staff we spoke to were not all clear about how often the equipment should be checked. We raised this as a concern at the time which staff immediately resolved with the creation of daily and monthly 'check sheets' to be signed.
- Within the midwifery led birth unit, an adult resuscitation trolley and a neonatal resuscitaire (trolleys used for the resuscitation of babies at birth) were stored in a small office. Access to this equipment in the event of an emergency would have been difficult given the layout and other equipment in the room. We raised our concerns at the time of the inspection and the emergency equipment was quickly moved to a more accessible location.

## Medicines

- We saw medicines were kept securely stored in locked cupboards.
- During the last comprehensive inspection in November 2014 inspection we saw some unsealed and unattended boxes of emergency drugs on Quantock Day Assessment Unit and on Percy Phillips Ward. During this inspection we saw all emergency drug boxes were sealed in such a way as to be tamper evident and stored appropriately.



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- When medicines needed to be stored at low temperatures they were stored in specific medicines fridges. Temperatures were checked and recorded daily.
- Nitrous oxide, used for pain relief, was piped into the delivery rooms. Air for use on resuscitaires was provided via portable cylinders. The supply was checked during checking of the trolleys.
- Common medicines required by women when discharged home were securely stored on the wards. Staff recorded when these were dispensed.

## Records

- Women carried their own pregnancy related care notes in the form of a hand held record. These were started at the time a woman booked her pregnancy and saw the community midwife. They were completed at every visit made by a woman during her pregnancy.
- Previous medical records were retrieved during the antenatal period to enable staff to review a woman's past medical history and any previous pregnancies. The notes were held securely in the antenatal clinic. The notes were accessible during office hours, Monday to Friday. Once a woman had reached 36 weeks of pregnancy, the notes were placed in metal trolleys and kept on the central delivery suite meaning they were accessible out of hours. This situation still meant that if a woman presented in an emergency, before 36 weeks of pregnancy and out of hours, staff had to retrieve her notes from the ante natal clinic situated in a separate building adjacent to the main maternity building.
- Women were given child health records for their babies when discharged.
- All midwives had an annual supervisory review which included an audit of their record keeping. Additionally one percent of all records were audited annually by a person nominated by the maternity audit team.
- We reviewed five sets of care records and found them to be complete and detailed. Entries were legible and signatures identifiable.

## Safeguarding

- All staff were required to have safeguarding training as part of the trust's mandatory training programme. Attendance continued to be good and above the trust's target of 80%.
- Systems were in place to identify vulnerable women or children. Midwives completed a Request for Help form that was submitted to the child protection midwives

using a central email inbox. Instructions about what to do if there was thought to be immediate risk of harm were included on the form. Midwives said the response to these forms was quick and they felt supported by the system in place.

- The maternity unit had a teenage pregnancy specialist midwife, a drug and alcohol specialist midwife and trained safeguarding midwives. They visited the unit, including gynaecology, daily identifying women who needed support and providing advice to staff.
- All cases of female genital mutilation (FGM) continued to be referred to the local authority safeguarding team during the pregnancy.
- There were trust wide guidelines for the care of women with FGM, mental health problems, teenagers, substance misuse and alcohol dependency and prisoners from the nearby HMP Eastwood Park female prison.

## Mandatory training

- Staff told us access to mandatory training remained above the trust target of 80% in all areas (for example across the womens and childrens directorate compliance of 85% was reported for moving and handling and 82% for fire safety training) with the exception of equality and diversity training which showed an overall directorate compliance rate of 37%. Staff continued to request to attend on set days but if they had not booked the required training by the mid-point of the year training days were allocated to them to ensure attendance. Any staff who failed to attend were followed up by their manager and supervisor of midwives.
- There were practice development midwives who monitored attendance and organised training sessions. Staff had high praise for the practice development midwives and felt they were approachable and provided bespoke training for them.
- In addition to the trust core mandatory training there was specific mandatory training for staff working in obstetrics. Medical staff, midwives and maternity care assistants attended annual obstetric emergency skills training known as PROMPT (an evidence based multi professional training package for obstetric emergencies) as well as neonatal resuscitation training.

## Assessing and responding to patient risk



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- Staff undertook risk assessments which were updated during the pregnancy or hospital admission. These included social and medical assessments to identify the appropriate level of care during pregnancy. Risk assessments such as those for pressure ulcers and venous thromboembolisms were completed and updated as women's conditions altered (for example following surgery).
- Staff completed the Early Warning Score forms on the gynaecology ward. On the maternity unit staff completed the Modified Early Obstetric warning Score system to record observations. Both these systems are designed to allow staff to identify the ill and deteriorating patient. For care in labour the scoring method was incorporated into the partogram, a chart designed to monitor progress in labour. If required, staff also recorded observations on a baby onto Neonatal Early Warning Score forms. The forms all indicated actions for staff to take if a woman or baby's condition deteriorated.
- Pregnant women with clinical complications or those 12 days past their due date had their labour medically induced under consultant led care. Staff told us and incident reports showed that inductions continued to be postponed on a regular basis due to lack of capacity/bed space in the unit and not as a result of insufficient staff numbers. Not only was postponing an induction disappointing for a family but could lead to complications if an induction had been advised due to clinical risk. Midwives told us they triaged women waiting for an induction to ensure those most at risk were managed most quickly.
- On the Central Delivery Suite, staff practised 'fresh eyes' every two hours, ensuring the fetal heart was reviewed by someone other than the midwife looking after the woman during her labour. This meant concerns with the fetal heart were less likely to be overlooked. Staff used stickers to record the key markers within fetal heart traces to allow prompt and early escalation of concerns. In the notes we reviewed, we saw these had been used regularly (at least every 30 minutes) during labour.
- Emergency trolleys and boxes containing equipment required in an obstetric emergency were available and accessible to staff in all areas.
- Each birthing room with a pool was equipped with evacuation equipment for use in the event of an emergency. Staff told us they practised evacuation procedures regularly.
- There were two designated high dependency rooms on the central delivery suite staffed, when there were women assessed as having high dependency needs when in labour, by midwives who had received additional training. This meant women with complex care needs could be cared for on the CDS. However should a woman require ventilatory support, transfer to the intensive care unit within the Brunel building occurred.
- We saw a staff handover on Central Delivery Suite where every patient was discussed in detail. Handovers took place on all the other wards at shift change times.
- The post-partum haemorrhage rate was higher than the regional average. Post-partum haemorrhage (PPH) monthly average rates for more than 2000 millilitres were 2.2% between April and November 2015. The monthly average for the previous year was 1.6%. The trust target was 0.8%. The monthly average rates of PPH above 1500 millilitres was 5.7% between April and November 2015. The monthly average for the previous year was 3.8%. The trust target was 1.8%. The monthly average rates of PPH above 1000 millilitres was 12.7% between April and November 2015. The monthly average for the previous year was 9.1%. The trust target was 4.6%. This was recognised and multidisciplinary monthly meetings were held to review all post-partum haemorrhages. As a result new guidelines had been produced and were due to be ratified on 11 December 2015.
- High risk caesarean sections were carried out in the main Brunel operating theatres in order to allow staff access to interventional radiology and a critical care bed if required post operatively.
- The gynaecology ward (Cotswold) had developed an admissions criteria tool to be used for non-gynaecology patients being transferred to the ward. Staff on the ward told us they could not always easily access the appropriate medical team to review these patients and this sometimes took considerable time away from patient care. Staff said these patients were often difficult to discharge as they had complex needs. Staff also said it was difficult to get physiotherapists and occupational therapists to visit the patients and felt this increased the risk of, for example, falls. We were also told that medical patients were sometimes transferred at night. The Head

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of Midwifery described the work she was involved in trust-wide to ensure the most appropriate non-gynaecology patients were admitted to the ward and received the care and support required.

- In the event of emergency gynaecological surgery (such as an ectopic pregnancy), space was made within existing day lists. However there was a system in place to allow prompt transfer to the Brunel building if emergency surgery was required out of hours. In extreme emergencies, arrangements were in place for staff to attend to open the gynaecological theatre out of hours to prevent the need for transfer.

## Midwifery staffing

- The established midwife to birth ratio was 1:28 across all areas, when there was no midwife sickness or unexpected leave. This is about the same as the England average. At the time of the inspection the ratio was 1:33 taking into account sickness leave.
- According to the data the trust provided women were receiving one to one care in labour is 93.2% of the time. The trust believed this should read 100% of the time as they were confident that was what they were now providing. Senior staff told us the data collection would be reviewed as it was felt the lower percentage was as a result of incorrect data completion at the time of deliver, particularly with regards women who had experienced an elective caesarean section.
- Staff continued to complete the Birthrate Plus intrapartum acuity tool to demonstrate how many staff were required. This meant that in addition to the ten midwives that had started at the time of the last inspection another ten had been recruited. Staff told us that the increase in the number of midwives had made a big difference to their workload and ability to provide safe care. Staff said it was still busy and were pleased a rolling recruitment process was in place. Staff told us that one month adverts were placed for maternity care assistants and the next month an advert was placed for midwives. Staff felt this would help to maintain staff numbers when staff retired or moved onto other jobs.
- The overall establishment figure had been calculated in 2012. Senior staff told us there were plans to undertake this again during 2016 to ensure staff numbers met the acuity and numbers of women receiving care.
- Community midwives continued to carry a caseload of one midwife to approximately 100 women. A homebirth service was provided. The midwife on call for home

births was not given any other duties to ensure their availability to support women in labour. There remained a second on call midwife for home births who also attended.

- Staff sickness rates had reduced since staffing levels had improved. The overall rate for the directorate was 4.8% and within the maternity unit 3.7%, a fall from a high of 8.1%. The unit had focused on improving sickness rates and had commenced a staff wellbeing service which allowed staff to be referred to access mindfulness and relaxation. This service was funded for one day per week. Staffing levels on Central Delivery Suite (CDS) were one senior midwife, acting as co-ordinator, eight midwives and two maternity care assistants. There were an extra two midwives and one maternity care assistant on duty for elective caesarean section lists which were also staffed with nursing staff from theatres. We saw figures displayed that showed the expected number of staff and the actual number of staff on duty were the same.
- Staff on the wards told us they no longer had to leave their wards to provide cover on CDS as often as they had in the past.
- Some staff told us it was still very busy as the workload continued to rise. Some staff were concerned that there was not enough support for recently qualified midwives, however two recently qualified midwives we spoke with told us they felt very well supported by the whole team.
- At the last inspection we saw there were only three funded elective caesarean section lists a week, although, the unit had identified the need for five lists a week and were undertaking them though they were not funded or fully staffed. During this inspection we found there were now five funded caesarean section lists a week. This had taken pressure off the CDS who were previously providing staff from the established numbers to cover the extra two lists. This meant women labouring on CDS were at less risk as the established staffing levels were maintained consistently. However, at times there were not sufficient staff within the recovery area to meet the Association of Anaesthetists of Great Britain and Ireland guidance which states that no fewer than two staff (of whom at least one must be a registered practitioner) should be present when there is a patient in the post anaesthetic recovery area who does not fulfil the requirement for discharge to the ward.
- At the last inspection it was identified that on occasions Quantock Day Assessment Unit, which could have all

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seven couches full, was left with one midwife when the second midwife had to leave the unit to accompany a woman to the antenatal clinic or to CDS. Staff told us when the unit was full and a midwife had to leave the unit a midwife from Quantock Ward provided cover to ensure unit always had two midwives present. However at night there was only one midwife covering the assessment unit. As a result there were occasions when the unit was left with only a maternity care assistant whilst a transfer to the CDS occurred.

## Medical staffing

- The unit continued to have consultants with a range of skills and interests. With some working only on gynaecology and some only in obstetrics. Job plans had been amended to allow for personal development and best use of clinical skills.
- The obstetric and gynaecology on call rotas remained separate ensuring sufficient medical cover for both specialities out of hours.
- As with midwifery staffing the additional funding of two elective caesarean section lists meant medical staff no longer had to be drawn from the Central Delivery Suite (CDS) to cover unfunded lists.
- The consultant obstetricians continued to work a 'hot week' meaning they were present of the CDS each weekday between 8am and 5 pm. The consultant on call then took over. At weekends consultants were on CDS between 8am and 2pm. This provided 74 hours a week dedicated consultant cover. Whilst this remained below the Royal College of Obstetricians and Gynaecologists' Safer Childbirth (2007) recommendations of 168 hours of consultant presence there were also experienced registrars in post. The issue remained on the risk register and was under regular review.
- We saw that since the last inspection antenatal inpatients were reviewed daily by medical staff.
- Medical staff described good access to training and good support from colleagues. Junior medical staff told us that all medical staff were approachable.

## Major incident awareness and training

- Staff were aware of the processes to follow in the event of a major incident. The trust wide major incident policy remained available to all staff on the trusts' intranet.

## Are maternity and gynaecology services responsive?

Good



The service was assessed as good because:

- Routine antenatal care was generally carried out in community settings near to where people lived. A range of specialist and multidisciplinary ante natal clinics were held at Southmead Hospital and in specific community settings to ensure women got the specialist care, advice and support needed.
- During our last inspection we found that fathers had limited opportunity to stay with their partners overnight. At this inspection we were told that funding had been secured for 14 reclining chairs. They had been ordered but were yet to arrive. Elective caesarean section lists had been increased from three funded sessions per week to five funded sessions per week. This had improved the flow of women through the service.
- Women had been asked if they wanted an appointment system introduced for the early pregnancy assessment centre to avoid long waits. Feedback was that women preferred to wait and be seen on the same day even if it meant a long wait.
- Routine dating and growth ultrasound scans took place at Southmead Hospital. Scanning at Cossham Birthing centre and other community settings was being considered to relieve pressure of the main unit.
- Bed occupancy for maternity services (excluding Central Delivery Suite) was 83.3% in the first quarter of 2015. This continued to be much higher than the England average for maternity services. Staff completed incident reports if there were delays in transfer to or from the Central Delivery Suite (CDS) because there were no postnatal beds available once a woman had given birth. This also meant that women could remain on CDS longer than needed because of the lack of available postnatal beds.
- 'Flow midwives' had been introduced, on a six month pilot. Their role was to have an overarching approach to patient flow issues and deal with the associated problems thus freeing up midwives on duty to continue with direct patient care. Staff told us they had found improvements in flow since their introduction.

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- There was access to translation and interpretation services. Information leaflets were available in the unit and on the trust website in a number of languages and could be produced in alternative formats if required.
- Complaints were dealt with in line with trust policy. Women were often invited to the unit to discuss their concerns or outcomes of complaint investigations. Staff said changes in practice required as a result of complaint were communicated to staff via emails, newsletters and/or safety briefings.

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

- Most routine antenatal care continued to be provided by community midwives based in health centres or community clinics. Antenatal clinics were held at Southmead Hospital antenatal clinic Monday to Friday, with some additional consultant clinic held at a variety of locations around Bristol. This meant not all women had to attend the main antenatal clinic at Southmead Hospital for each appointment.
- Multidisciplinary clinics were held where specialist staff came together to see women for example diabetes clinics, foetal medicine clinics and teenage pregnancy clinics. Teenage pregnancy clinics were also held at the local mother and bay school to ensure education continued during the antenatal period.
- Preferred place of birth was discussed with women and reviewed throughout their pregnancy. Choices were explained and information leaflets provided. Information was also available on the trusts website. Low risk women were offered the choice of the free standing midwife led birthing unit at Cossham or the alongside midwife led birthing unit based at Southmead maternity unit, where they could be transferred to the Central Delivery Suite quickly if required.
- Women were encouraged to book for their pregnancy to access early medical and midwifery care. The trust had a target of 90% of women booked for antenatal care by the time they were 12 weeks and six days pregnant. The average for April to November 2015 was 90.5%.
- A bereavement midwife with specialist skills had been introduced since the last inspection. They were able to provide advice and support to families and staff as required.
- The service held clinics held for women who had undergone female genital mutilation were supported by a safeguarding midwife.

- A home birth service was run by the community midwives. The rate of 1% between April and November 2015 remained unchanged from the previous year. Midwives still felt this was because midwife led care was available at the two birthing units provided by the trust. There were times when capacity was exceeded and not enough were staff available to provide safe care. At these times the maternity unit 'closed' in accordance with the trust policy. This has happened 62 times between 1 January 2014 to 12 October 2015. During this time the home birth service had not been suspended due to the protected working status of the home birth midwife.
- At the previous inspection it was reported that there no opportunities for fathers to stay overnight with their partners unless a still birth had occurred. During this inspection we were told funding had been secured for reclining chairs and 14 had been ordered though were yet to arrive.
- Termination of pregnancy were performed by another provider who used the surgical facilities and nursing staff at the trust. Staff we spoke with were clear as to who was responsible for the patient and which organisation was responsible for the submission of legal documents following the terminations. However, these were not subject to audit by the gynaecology service.
- Colposcopy services continued to be provided as a 'one stop shop'. This meant women were able to see the doctor, have treatment and be discharged on the same day. The service was regularly audited.

## Access and flow

- Parking at Southmead Hospital remained an issue; both the amount available and the cost. There was a multi-storey car park under construction which was due to be completed in May 2016. We were told the trust was looking to provide four parking spaces close to the maternity unit for women who were in labour.
- The early Pregnancy Assessment Centre was open five days a week from 08.30am to 5pm. It was run by an advanced nurse practitioner with sonographer support and medical cover from the gynaecology ward. Due to it being a 'walk in' service the numbers of women seen each day varied. This meant on some days there could a long wait for a scan. Women were asked if the service should provide an appointment service which meant

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they may not be seen the same day or stay with a walk in service. The results showed women preferred to keep the walk in service and were prepared to wait to be seen on the same day.

- Out of hours early pregnancy services continued to be a cross city approach with a neighbouring trust providing the service for three out of four weeks and Southmead one week in four. Staff told us they were planning to increase the seven day service in the future but had no firm timescales for when this may happen.
- Routine dating and growth ultrasound scanning clinics took place five days a week and were staffed by midwife sonographers. Staff told us scanning at Cossham Birthing centre of other community clinics was being considered to relieve the pressure at Southmead Hospital.
- Women were booked for their pregnancy by community midwives. A risk assessment was carried out to advise if a midwife led home birth or a birthing centre birth was appropriate or if consultant led care was required. Women who required consultant led care attended Southmead Hospital and those women who could have a midwife led birth could be seen nearer to their home at a surgery or community clinic.
- The Quantock day Assessment Unit saw women who were not in established labour but had some concerns. This meant women could be seen and either discharged home, admitted antenatally or triaged to be admitted to the birthing unit or Central Delivery Suite (CDS). This continued to reduce unnecessary admissions to the CDS.
- Bed occupancy for maternity services (excluding CDS) was 83.3% in the first quarter of 2015. This continued to be significantly higher than the England average for maternity services. Staff completed incident reports if there were delays in transfer to or from the CDS because there were no postnatal beds available once a woman had given birth. This also meant that women could remain on CDS longer than needed because of the lack of available postnatal beds.
- Increasing the number of funded elective caesarean section lists from three to five since September 2015 had improved the flow of women through the service.
- 'Flow midwives' had been employed on a six month pilot to provide support throughout the unit. The role was designed to have an overarching approach to patient flow issues and deal with problems associated thus freeing up midwives on duty to continue with direct

patient care. They provided a seven day a week, 7am to 3pm presence. They attended the daily handover on CDS so were aware of what was happening on the unit and looked at staffing levels across the whole unit to see if any staff needed to be redeployed. They visited each ward and for example let the postnatal ward know how many planned beds would be need that day and ensured that women who needed bloods taking on the day of discharge had that done as early as possible so they could have the results earlier in the day to prevent a delayed discharge. The flow midwives were also due to meet with the community midwives to explore the possibility of some of them, once trained, carrying out some baby checks the day a woman and her baby were discharged. At present these were conducted by paediatricians or a few specially trained midwives. This could result in a wait of several hours for a check to occur before they could be discharged home. Most staff reported they had seen a benefit from having the flow midwives in place.

- The wards stocked regularly dispensed medicines in packs, ready to take home. This helped to facilitate quicker discharges for women instead of having to wait for the medicines to be dispensed from pharmacy.
- Staff had access to the Emergency Staffing Escalation policy when there was increased need. This showed how cover could be provided from the community midwives or from Cossham Birthing Centre and could ultimately lead to a temporary closure to maintain safety.

## Meeting people's individual needs

- Women with reduced fetal movements were seen on Quantock Day Assessment Unit. In the event of no foetal heartbeat being detected bad news was still discussed behind a curtain. This did not always provide privacy and whilst the staff handled the situations sensitively it was not felt to be ideal. If a spare single room could be used on Quantock ward staff did so, but this was not always possible.
- Information about the maternity services was available on the trusts website. This could be translated into a number of languages. There was information also available via the Maternity Voices and Birth Centre Bristol websites.
- Information leaflets about a variety of subjects were available on the trusts website in a variety of languages spoken by the local population.



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- Translation and interpretation services remained available via a telephone interpretation system. There was information about how to access the service readily available throughout the unit.
- Specialist antenatal clinics were ongoing. They included epilepsy, diabetes, substance misuse, female genital mutilation, teenage pregnancy, mental health support and midwife led vaginal birth after caesarean section (VBAC) clinics.
- Women who had experienced a third or fourth degree perineal tear were followed up by telephone three months afterwards. If any further intervention was needed they were seen by the gynaecology services. Physiotherapy was provided in the community if required.
- The teenage pregnancy midwife continued to provide support in a variety of settings including schools, the home and other community settings.
- The service employed a bereavement midwife who was available to support both women and their families, as well as staff from the maternity unit. There was a cold cot facility on the maple suite to allow bereaved parents to remain with their baby. The bereavement midwife






visited women in the CDS and was also able to follow up women at home at any time, even beyond the normal time limit for postnatal midwifery care. Family support was also offered for subsequent pregnancies

## Learning from complaints and concerns

- Women and their families were encouraged to provide feedback on their experiences. Staff said they tried to deal with complaints and concerns when they were raised.
- Complaints were dealt with in line with trust policy. Women were invited to the unit to discuss their concerns or outcomes of complaint investigations.
- Women had been asked whether they would like to have an appointment system introduced for the Early Pregnancy Assessment Unit due to the number of complaints about the waiting times. However the outcome was that women preferred to wait and be seen on the day they presented even if it meant a long wait. As a result, the walk in service continued in accordance with women's wishes.
- Staff said that any changes in practice that were required as a result of a complaint were communicated to staff via emails, newsletters and/or safety briefings.



# End of life care

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

## Information about the service

End of life care at North Bristol NHS Trust, Southmead, is provided by a wide range of trust staff on all wards. The staff provide end of life care as part of their day-to-day work. The staff include, nurses and doctors, staff from the chaplaincy department, mortuary staff, ward housekeepers, porters, administrative staff allied health practitioners, pharmacists and others. They are supported by a specialist palliative care team which is a trust-wide service based on the Southmead site. There is no dedicated ward for end of life care. The chaplaincy and spiritual support, mortuary services and specialist palliative care team work together to provide specialist end of life care and advice and education to patients, relatives and staff involved in end of life care.

The trust provides hospital and community services to a local population of around 900,000 people in Bristol, North Somerset and South Gloucestershire. When the Macmillan Specialist Palliative Care Inpatient Unit closed the specialist palliative care team moved to the new Southmead site in May 2014. End of life care and specialist palliative care has been provided in the 996 bed hospital since then. There are approximately 8,189 staff of which 2,409 were nurses. From April 2014 to March 2015 there were 806 cancer related referrals and 520 non-cancer related referrals to the specialist palliative care team. There was an increase in referrals overall from 1,247 patients for year end March 2014 to 1,326 for year end March 2015.

The specialist palliative care team consisted of three consultant doctors (2.65 WTE consultants), 5.5 whole time equivalent clinical nurse specialists, plus a part time end of life care facilitator. The wider team consisted of administrative support, chaplaincy staff, occupational

therapists, psychologist and pharmacist, bereavement officers and mortuary staff. The team provided complex symptom management, specialist advice and education to patients, those close to them and the trust. They also provided support with complex discharges of patients to their preferred place of care.

Palliative and end of life care encompasses all care given to patients who are approaching the end of their life and following death. It includes nursing care, specialist palliative care, bereavement support, and mortuary services. The definition of end of life includes patients who are approaching the end of life when they are likely to die within the next twelve months; patients whose death is imminent; those with advanced, progressive and incurable conditions, general frailty and co-existing conditions that mean a patient is expected to die within the next twelve months; existing conditions if they are at risk of dying from a sudden acute crisis in their condition; and life threatening acute conditions caused by sudden catastrophic events.

Day to day end of life care was carried out seven days a week and throughout a 24 hour period. The specialist palliative care team were available for face to face contact on Monday to Friday between 8.30am and 5pm. Out of hours on call was provided by a local hospice with a specialist registrar as first on call response and a consultant was available if needed.

During the inspection we visited 5 wards, intensive care, the acute medical unit, the emergency department, the chaplaincy and the mortuary. We reviewed nine sets of medical records (two from the emergency department, one record of a patient recently deceased and six records of patients who had been admitted to the hospital for several days). During this inspection we were unable to speak directly with patients at end of their life and those close to

# End of life care

them. We were able to observe care directly and review patients and relatives comments. We observed several episodes of care on wards both for end of life and for other patients.

The visit was focussed inspection. The trust had previously been rated as requires improvement (with caring being rated as good). We used a range of information sources including the inspection report from November 2014.

## Summary of findings

We rated end of life care as requires improvement because:

- Some incidents were not reported at the time they occurred and there were issues in end of life care that were not being formally monitored. For example, incidents relating to the adherence to the policy on the management of a deceased adult patient or last offices policy by ward staff. Mortuary staff who dealt with the incident did not always report incidents. The number of incidents that occurred when bereaved relatives tried to pick up death certificates were not being monitored.
- The risks associated with anticipated events and emergency situations were not fully recognised, assessed or managed for end of life care. All relevant parties were not fully aware of their role in a major incident and the response plans had not been tested and reviewed regularly with all relevant staff. For example mortuary and specialist palliative care team staff had not been involved in major incident exercises.
- Patients identified as being at the end of their life or receiving end of life care were sometimes at risk of not receiving all relevant care or treatment. This was because care assessments did not always record the full range of patient's needs.
- Patients end of life care and treatment was planned and most was delivered in line with current evidence-based guidance, standards, best practice and legislation. However, staff completing the do not attempt resuscitation documentation were not recording in line with the Mental Capacity Act 2005 code of Practice. The spiritual and emotional aspects of care were sometimes overlooked in assessments.
- Seven day services were not available for face to face end of life care from the specialist palliative care team. We saw evidence that patients received care from a range of different staff, teams or services, which was coordinated.
- The arrangements for governance and performance management of all end of life care in the trust did not

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always operate effectively. There was not a risk register in place for end of life care. There were risks identified during our inspection, which were known about. We did not see these recorded on a local or trust wide corporate risk register.

However:

- Patients receiving end of life care and those close to them were treated with dignity and respect and were involved in their care. Feedback from patients and those close to them was positive about the way staff supported and cared for them. We saw patients were treated with dignity, respect and kindness during interactions with staff.
- Patients had assessments which included consideration of clinical needs, health, physical health nutrition and hydration needs.
- Pain was managed well as was nutrition and hydration.
- End of life care took account of the local population when planning services.
- Reasonable adjustments were made and action was taken to remove barriers when patients found it hard to use or access services. There was openness and transparency in how complaints were dealt with. Complaints and concerns were taken seriously, responded to in a timely way and listened to.
- Access to care was managed to take account of patient's needs, including those with urgent needs. Discharge from hospital and to patients preferred place of care was achieved in many cases. The specialist palliative care team had worked to ensure they and others in the trust had access to information needed to support patients who received end of life care.
- The trust supported the director of nursing and the specialist palliative care team to promote high quality person-centred end of life care. The specialist palliative care team had a clear statement of vision and values and end of life care was driven by the desire for quality and safety this included plans for a seven day service. The strategy was credible and strategic objectives had been identified recently as

part of commissioning for quality and innovation and were supported by quantifiable and measurable outcomes. Despite the recent work of the specialist palliative care team and the director of nursing the strategy and vision for good end of life care had not yet been fully implemented throughout the trust.

- Staff in the specialist palliative care team we spoke with felt they were respected, valued and supported. Staff we spoke with valued the specialist palliative care team.

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## Are end of life care services safe?

Requires improvement



We rated end of life care for North Bristol NHS Trust, Southmead as requires improvement for safety because:

- Some incidents were not reported at the time they occurred and there were issues in end of life care that were not being formally monitored. For example, incidents relating to the adherence to the policy on the management of a deceased adult patient or last offices policy by ward staff. Mortuary staff who dealt with the incident did not always report incidents. The number of incidents that occurred when bereaved relatives tried to pick up death certificates were not being monitored.
- The risks associated with anticipated events and emergency situations were not fully recognised, assessed or managed for end of life care. All relevant parties were not fully aware of their role in a major incident and the response plans had not been tested and reviewed regularly with all relevant staff. For example mortuary and specialist palliative care team staff had not been involved in major incident exercises.
- The trust wide approach to assessment and the managing of risk to patients at end of life was sometimes focused on just clinical risk and did not always take a holistic view of patient's needs. Patients identified as end of life or receiving end of life care were at risk of not receiving all care or treatment because care assessments did not consider the full range of patients' needs.
- Written evidence of assessments in some patient records we sampled contained person-centred information. However some documentation was incomplete. For instance absence of complete care plans for patients receiving end of life care, treatment escalation plans incomplete and 'do not attempt resuscitation information' was incomplete. Sign off by consultants was not always recorded for reviewing resuscitation decisions. Patient's spiritual and emotional information was also incomplete.

However:

- Learning was gained from incidents formally reported across the trust in end of life care.

- When incidents were reported after something had gone wrong, patients had received a sincere and timely apology and were told about any actions taken to improve processes to prevent the same happening again.
- Staff recognised and responded appropriately to changes in risks to patients who were at end of life. We saw good evidence of re-assessment at end of life for patients whose condition was deteriorating or improving. These included signs of deteriorating health, medical emergencies or behaviour that challenged.
- Medicines for end of life were managed safely.
- Staffing levels and skill mix was planned, implemented and reviewed to support patient safety at end of life. Most staff shortages were responded to quickly and adequately.

### Incidents

- Staff we spoke with understood their responsibilities to record safety incidents, concerns and near misses, and staff knew how to report them. There were 52 incidents reported from 3 June 2015 to 30 September 2015. The incidents were reported from several departments for example medicine, surgery, maternity and the emergency department. There were 30 in relation to end of life care for adults. There were no serious incidents reported.
- Some incidents we were told about during our inspection had not been reported. They also did not appear on a list of incidents reported that we saw. For example, mortuary staff had recently received patients where ward staff had not followed the trust management of a deceased adult patient policy. We were told the incidents had been dealt with by raising immediate concerns with the ward involved at the time but there was no record of this kept. The trust supplied information that there were six incidents reported by mortuary staff in the last year but we were unable to identify them from records supplied by trust.
- We saw evidence that learning was gained from incident formally reporting across the trust in end of life care. When incidents were reported after something had gone wrong, patients had received a sincere and timely apology and were told about any actions taken to improve processes to prevent the same happening again.
- We were told about relatives who had become frustrated when they tried to collect death certificates

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which were not ready from bereavement officers. We were told by bereavement officers that patient's relatives had expressed anger and frustration when given incorrect information by ward staff about opening hours of the bereavement office or when death certificates would be ready for collection. Bereavement officers told us they experienced increased stress in their role from relatives receiving a poor service. This had not been reported as an incident. There was no audit undertaken of this process. This was under review as part of the bereavement service review process lead by head of patient experience.

- We also saw evidence that patients' property was not labelled by ward staff consistently or correctly. The bereavement office did not have dedicated secure storage for patient's property. Bereavement officers told us they were unable to report the multiple incidents fully due to their workload. Both mortuary staff and bereavement officers told us that wards did not always follow trust management of a deceased adult patient policy. This was being dealt with by mortuary staff who were maintaining a local record to share with wards and the mortuary management.
- During the inspection in November 2014 the specialist palliative care team were supporting ward staff by resolving ward end of life medication errors at the time. They and ward staff were unable to report all of the errors such as missed doses so it was possible that some learning was lost across the trust. However, their concern for any safety issue for the patient and on the spot education for ward staff became prime importance. We were told following these incidents they worked with the principle pharmacist in reviewing medicines governance. We saw evidence of audits undertaken which showed that medication errors were no longer happening and that other incidents were being reported.

## Duty of Candour

- Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, is a new regulation which was introduced in November 2014. This Regulation requires the trust to be open and transparent with a patient when things go wrong in relation to their care and the patient suffers harm or could suffer harm which falls into defined thresholds.
- The trust had a duty of candour policy in place. The specialist palliative care team were able to demonstrate

an understanding of this and senior nurses were able to describe how the duty of candour was part of their working practices. We saw evidence of that ward staff understood duty of candour process. Patients who were affected when something went wrong were told, informed of actions taken and apologies were given.

## Environment and equipment

- Staff told us there was a good supply of syringe drivers readily available for use.
- The National Patient Safety Agency (an agency established to improve patient safety in hospitals) recommended in 2011 that all Graseby syringe drivers (a device for delivering medicines continuously under the skin) should be withdrawn by the end 2015. The provider was using the recommended replacement syringe drivers which had been introduced at the trust. The equipment was appropriately maintained. We saw evidence of the syringe drivers annual service to be up to date. The specialist palliative care team ensured a comprehensive policy and guidelines on the use of syringe drivers was in place for staff to access.
- We visited the mortuary and saw it was clean and tidy. An audit of cleaning for mortuary in September 2015 showed 99.5% score.
- If the mortuary refrigerator temperatures were out of range an alarm was triggered and on call staff were called. There had been no breaches of fridge temperatures in the last year. The mortuary had a health and safety inspection in November 2015 but the report was not available to them.

## Medicines

- We saw evidence that arrangements for managing medicines for patients at the end of their life were effective in all wards and departments.
- The percentage of patients with one or more missed doses of medication across the trust increased during 2014/15. However there was improvement since March 2015.
- Prescribing for patients receiving end of life care was part of the general day to day activities of the hospital. Information about prescribing for patients at the end of their life was available on all wards we visited. Guidance and advice from the specialist palliative care team was available for complex situations.

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- We saw evidence that medications were appropriately prescribed for a range of issues at end of life. For example anticipatory or just in case prescribing to help manage symptoms such as anxiety or pain.
- Several members of the specialist palliative care team were either independent nurse prescribers or were developing the skills to be able to prescribe medicines to undertake a prescribing course. This was to support ward staff manage medications administration on the ward for end of life care.

## Records

- Six of the nine patient records we reviewed had inconsistent or incomplete recording of information. While most important information was available in the narrative of the record it wasn't immediately accessible and when it was, it was not always clear. This could lead to confusion or delay in treating patients.
- In 2014 a new unified do not attempt cardio pulmonary resuscitation record was implemented. An audit to assess the correct completion of these forms was conducted in April 2014, this showed some forms were not being completed in line with trust policy. For example, 35% of forms had not been countersigned by a GP or hospital consultant, as was the trust's policy. An action plan had been produced to include regular audit of the forms, to begin in September 2014. During this inspection we reviewed nine patient records and saw similar issues with patient records. For example unified do not attempt cardio pulmonary resuscitation records were incomplete or incorrectly completed.
- We also saw inconsistencies in recording of patients' wishes and mental capacity assessments for decisions at end of life. For example, we were unable to identify recording of the accepted format for mental capacity assessments in patient records. This included assessments of whether the patient could or could not retain, recall, weigh up or communicate the information about the decision presented to them, lengthy delays between decisions being signed off by junior doctors and the decision being reviewed by a consultant and decisions not being reviewed due to forms being incorrectly completed.
- We spoke with the resuscitation team manager and shared our findings which they said they were similar to that found in the recent audits. The most important concern they said they had noted was inconsistent consultant sign off of resuscitation forms.

## Safeguarding

- Staff we spoke with understood their responsibilities to adhere to safeguarding policies and procedures. The specialist palliative care team had completed safeguarding training as part of their mandatory training programme.
- Staff were trained to recognise and act upon abuse or concerns regarding abuse of vulnerable patients. Staff we spoke with were able to confirm the process for referring a patient to the safeguarding team.
- Volunteers who worked in the trust providing visiting services for those receiving end of life care had received disclosure and barring checks to support the safety of those who could be vulnerable.

## Mandatory training

- Trust wide staff received mandatory training in safety systems, processes and practices. This provided a basis for good specialist care. Across the trust staff demonstrated good average levels of training achievement in areas such as dementia (81%), mental capacity (80%), safeguarding (80%) although equality and diversity was at (69%). The specialist palliative care team were up to date with mandatory training.
- The end of life care strategy group met quarterly to discuss and act on clinical governance issues. Issues for concern included that ward staff lacked all of the skills to deliver 'optimal end of life care'. We saw evidence that end of life care was to be part of mandatory training for 2016.

## Assessing and responding to patient risk

- Patients who received end of life care in the hospital were assessed regularly by ward staff. We saw entries in patient records of nutrition assessments and referrals to dieticians, early warning scores, regular observation and decisions made to increase or decrease support at end of life responding to patient clinical need. There were also entries from the specialist palliative care team and others reviewing patients and taking the decision to increase or decrease nursing and medical interventions as the patient's clinical condition dictated.
- We observed one patient with a life limiting illness who needed one to one nursing care to ensure they were safe when mobilising. They had the support they needed in place following risk assessments being carried out.



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- We saw patient records where mouth care had been considered and changes to medication had occurred as a result which resulted in greater comfort for patients receiving end of life care.

## Nursing staffing

- The specialist palliative care team had safe levels of staff, although they were still building the team following recent recruitment. The specialist palliative care team had a nurse lead and a mix of band six and seven clinical nurses. Due to difficulty to recruit experienced palliative care nurses, two nurses were being developed within the team. The nurse staffing in the specialist palliative care team was 5.5 whole time equivalent clinical nurse specialists and an end of life care facilitator employed on a 0.5 whole time equivalent basis.
- The trust had 40 end of life care link nurses to support wards staff to deliver end of life care according to policy and other standards. Most wards excluding the maternity and gynaecological ward had an end of life link nurse. End of life link nurses worked day and night shifts to support delivery of optimal care day or night.
- From analysis of the trust information supplied the nursing workforce ward early warning trigger tool had shown an elevated level of risk for some wards in July 2015. They had since improved and did not show as a risk in August 2015. When we inspected some wards had reduced staffing and senior staff nurses told us they felt that staffing was close to the limit of what was safe. However, they did not feel that end of life care was affected as much as it had been previously. This had been noted in the inspection in November 2014. All wards we visited during the announced inspection were staffed at the planned staffing level. During the unannounced inspection ward 27b had one less staff than planned on early, day and late shifts. The ward senior and team felt they were running the ward safely.
- Arrangements for using bank, agency and locum staff kept patients safe at all times. Actions were taken to ensure that patients at end of life who needed one to one support had it.

## Medical staffing

- There were safe numbers of doctors for end of life care within the specialist palliative care team and across the trust. The specialist palliative care team had three consultant doctors (2.65 WTE consultants). The

specialist palliative care team were available for face to face contact on Monday to Friday between 8.30am and 5pm. Out of hours on call was provided by a local hospice with a specialist registrar as first on call response. A consultant was available if needed through a second on call contact.

- The proportion of consultants and junior doctors to support end of life care as part of their role for the trust was similar throughout the trust to the England average with total 867 whole time equivalent staff. The proportion of medical staff within the trust was 40% consultant, 5% middle career doctors (3 years experience as senior house officer and above), 43% were registrars and 13% junior doctors.

## Major incident awareness and training

- Not all risks to the service were anticipated and planned for in advance and major incident training was incomplete. Some arrangements for alerting staff and responding to emergencies and major incidents were informal. Mortuary staff described occasionally being contacted by telephone to 'stand by' for a major incident, although further information was not given when they were told to 'stand down'. They assumed the call they had was about a major incident that was being dealt with but felt that it could have been a training incident. The mortuary staff we spoke with had not been involved in any formal major incident training, nor had bereavement officers or chaplaincy. Mortuary staff told us they would contact the mortuary manager if the mortuary was close to maximum capacity.
- The trust had responded since the last CQC inspection report November 2014 and had ensured there were an additional 24 temporary mortuary fridge spaces. We were told that further temporary capacity was available at short notice. The checking of the backup equipment was not recorded in a fridge temperature log book. There were no risks identified related to end of life care on a local or corporate risk register; for example, what might need to happen if the supplier of the temporary fridge space was not contactable.
- The specialist palliative care team had not been involved in any practical major incident training but knew how to contribute to urgent discharge planning where appropriate and necessary for those patients at end of life.
- We were told the mortuary manager who was based with pathology services visited the site daily. They

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described what generally happened in a major incident outside of the hospital and felt it was unlikely that the mortuary would be needed as provision would be made at the site of the incident.

## Are end of life care services effective?

Requires improvement



The effectiveness of the end of life care service for Southmead Hospital required improvement because:

- Patients identified at end of life or receiving end of life care were at risk of not receiving all care or treatment. This was because care assessments did not record the full range of patient's needs. Patients' end of life care and treatment was planned and most was delivered in line with current evidence-based guidance, standards, best practice and legislation.
- Staff completing the do not attempt resuscitation documentation were not recording in line with the Mental Capacity Act 2005 Code of Practice. The spiritual and emotional aspects of care were sometimes overlooked in assessments but, patients had assessments which included consideration of clinical needs, health, physical health nutrition and hydration needs.
- Care was monitored to support consistency of practice and outcomes for patients through participation in voluntary external audits and internal benchmarking. The results of monitoring had not yet enabled objective improvements in quality in all areas. For example, there was no audit in relation to the length of time death certificates were signed, the do not attempt resuscitation decision making documentation audit had identified several issues that were still ongoing and audit of overall recording for end of life recording at ward level required improvement.
- Seven day services were not available for face to face end of life care from the specialist palliative care team. We saw evidence that patients received care from a range of different staff, teams or services, which was coordinated. Staff worked collaboratively to understand the range and complexity of patients' needs. Multi-disciplinary teams included the necessary staff, who met frequently enough to provide effective care.

- We saw evidence of discharge and transition planning and the specialist palliative care team working with wards to ensure particularly complex discharges happened. There were delays for some discharges due to not being able to access some care. Poor co-ordination occurred if patients moved wards just before discharge was planned to take place.

However:

- Staff in the palliative care team were qualified and had the skills they needed to carry out their roles effectively and in line with best practice. The end of life learning needs of trust staff were not all identified and while some training was in place to meet these learning needs attendance was limited.
- The specialist palliative care team staff were supported to deliver effective care and treatment, including through meaningful and timely supervision and appraisal.
- Staff could access end of life care information they needed to assess, plan and provide care to patients in a timely way. Staff were not always able to search for basic patient related information, they told us the recent move to a new electronic system to manage and share care records and information had led to difficulty in accessing information a timely way.
- Pain was managed well as was nutrition and hydration.

## Evidence-based care and treatment

- The evidence we saw from records suggested that not everyone had their needs assessed and their care planned and delivered in line with evidence-based guidance, standards and best practice. Some do not attempt cardio pulmonary resuscitation forms were incomplete, some care planning was incomplete, some symptom observation charts were incorrectly completed or incomplete. The director of nursing and end of life leads described that there was still work to be embedded. We saw evidence for this in recording in patient records and time taken for review of 'resuscitation paperwork'. Staff we spoke with including doctors described who had overall responsibility for each patients care at end of life.
- The Liverpool Care Pathway was discontinued after the national review in 2013 review. The specialist palliative care team designed and piloted the 'Personalised Plan for Care', an individualised approach to supporting dying patients. Following the review of the new tool and

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proposals from the Leadership Alliance for the Care of Dying People (2014), the Specialist Palliative Care Team developed an improved care plan, Caring for Patients at End of Life with clinical guidelines to support the delivery of high quality end of life care within NBT. The care plan was initially piloted on wards where more than 80% of deaths occurred and then across the trust in the spring of 2015. The director of nursing, the trust board representative for end of life care, described ongoing support and education needed for ward staff from the palliative care link nurses. This was to help the new paperwork being used by ward staff to be able to record care for patients at end of life.

- The trust and the specialist palliative care team were working towards the implementation of the 'ambitions for palliative and end of life care: a national framework for local action 2015-2020. Actions already taken included the implementation of individualised care plans to enable caring for the patient as an individual. There was still work to be completed in order that this consistently happened. Fair access to end of life care at ward level was being delivered and there were still issues around discharge which were beyond the specialist palliative care teams' control. For example, access to care provision in community. While we did not see any patient who was not being made comfortable or where their well-being was not being maximised, the ward patient record did not always provide objective evidence of this.
- Members of the specialist palliative care team had written the advance care planning policy; which included support with lasting power of attorney for health and welfare, advance decision to refuse treatment and in-patient will writing. They acknowledged in their annual report March 2015 that further work needed to be undertaken regarding the implementation of the policy.
- The specialist palliative care team were proactive in seeking patients who may need their support and worked closely with the acute medical unit where new admissions would be seen.
- The specialist palliative care team were involved in several audits including the National Care of the Dying in Hospitals Audit and the information was being used to inform current care, training needs analysis for 2016 and better patient outcomes.

## Pain relief

- We saw that patients' needs had been assessed and pain was managed well using recommended pain score tools.
- We saw appropriate medication including pain relief had been prescribed and given. A range of pain medications were prescribed. Ward staff and specialist palliative care team members had reviewed these and just in case medications were prescribed appropriately.
- The specialist palliative care team worked daily with the acute medical unit enabled the team to work with patients to manage pain early.

## Facilities

- Following the move to the new hospital in May 2014 the specialist palliative care team had initially been situated far away from the patients and staff they supported. The team had since moved to office space which was located centrally in the new building. This meant they were close to wards and other departments so that they could be contacted in person as needed. The location also enabled them to have the frequent confidential discussions needed in end of life care.

## Nutrition and hydration

- In the most recent national care of the dying audit the trust was scored better than the national average for hydration and slightly below the national average for nutrition. We saw examples of good practice on the wards. For example, one patient had been referred to the dieticians a day earlier than usual by a nurse for a patient at end of life. We also saw use of assessment tools to provide objective evidence of trends for patients eating and drinking.
- We observed patients had drinks available within easy reach and that they were supported to get food and drink.

## Patient outcomes

- The trust conducted several audits about the outcomes of patient's care and treatment. The information was being used to support further improvements in the service. The trust did not participate in the gold standards framework accreditation scheme.
- The trust was participating in the 2015 National Care of the Dying Audit. The most recent audit 2014 showed that the trust had performed better than the England average for five of the ten clinical key performance indicators and the trust achieved four of the seven

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organisational key performance indicators. What was good about end of life care from the national care of the dying audit 2014 was that doctors and nurses spoke with patients and those close to them about dying and communicated well about plans for last days and hours. While still above the national average the trust was close to it for reviewing interventions during dying, reviewing patient's fluid intake needs and carrying out assessments in last the 24 hours of someone's life. We saw evidence of this during our inspection. Where the trust did worse than the national average in the 2014 audit was multidisciplinary working recognising patients were dying, prescribing of just in case medication for key symptoms, reviewing patient's food intake needs and reviewing the care provided after death. We saw evidence that this had improved with specialist palliative care teams work with the acute medical unit. Although the assessment of patients and those closest to them spiritual needs was still in need of improvement.

- Where the trust did less well in 2014 was in access to specialist support in last days and hours of life this was still the case for the weekend and out of hours. The provision for continuing education and audit and clinical provision/protocols promoting privacy, dignity and respect had improved.
- The trust had the third highest referral and retrieval rate for the south west for organ donation and recovery. Their referral rate was over three times higher than the next trust and the recovery rate was over twice that of the next highest trust.

## Competent staff

- The specialist palliative care team had the skills, knowledge and experience to deliver effective care and treatment.
- The specialist palliative care team were in date with appraisals and were being supervised adequately. They were using two band 7 posts to develop two band 6 nurses to work in the team.
- In a report for September 2014 the end of life strategy group had identified that across the trust ward staff lacked all the skills to deliver optimal end of life care. The risk had escalated from being a moderate risk to a significant risk of the trust not reaching objectives in this area. We were told the end of life care strategy group had secured agreement with the trust board to

implement some end of life care training as a part of mandatory training starting in January 2016. Figures for attendance on a trust three day palliative care course were low.

- The end of life care strategy group met quarterly to discuss and act on clinical governance issues. Issues for concern included that ward staff did not have all of the skills to deliver 'optimal end of life care'. We saw evidence that end of life care was to be part of mandatory training for 2016. The plans for mandatory and other end of life training were in place for 2016. We saw evidence of low trust staff attendance at some end of life training where 12 staff had attended out of 25 booked. The mortuary technicians had contributed to the day which included a session on: end of life - psychological and spiritual support for patients and their families. Areas covered included last offices and providing an overview of preparation and how the deceased should be presented, the checks done in the mortuary, familiarisation with mortuary facility, opportunity for open questions during which topics such as faith issues, the role of Funeral Directors and protocols for viewing were discussed.

## Multidisciplinary working

- Staff worked together to deliver effective care and treatment. Staff were involved from different teams in assessing, planning and delivering patient's care and treatment. We observed the specialist palliative care team working in their own multi-disciplinary team meeting. Then the team worked with the acute medical unit in the multi-disciplinary meeting to identify patients who might be or who were at end of life. We saw evidence of the specialist palliative care team working with the acute medical unit to discharge or transfer patients with complex end of life care needs. The specialist palliative care team worked closely with occupational therapists who specialised in end of life discharge planning. Care at end of life was being coordinated on several levels, for example, the specialist palliative care team worked with the acute medical team to identify patients at end of life and rapid access to occupational therapy assessment was in place. There were 148 referrals to occupational therapy for end of life. The team recorded 783 patient contacts for occupational therapy for end of life care of which 345

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were face to face. Several contacts with the same person in a day could only be recorded as one event. The specialist palliative care team were well prepared to provide care at end of life.

- There was a clear pathway for transfer of care from hospital to community services, through the trust discharge planning team. The specialist palliative care team showed us work that involved several teams for complex discharge planning.
- Ward staff were able to refer to the specialist palliative care team through an electronic system.
- We saw evidence of effective communication between the specialist palliative care team and other services within the hospital.

## Seven-day services

- The Royal College of Physicians (2014) recommended that hospitals should provide a face-to-face specialist palliative care service between at least 9am to 5pm, seven days a week, to support the care of dying patients and their families or carers. The service the trust provided was Monday to Friday only. We saw evidence that the specialist palliative care team worked well with the acute medical and emergency departments to deliver effective care and treatment between Monday and Friday.
- Staff had access to a telephone support out of hours service and 24 hour advice line which was provided by the local hospice. All staff we spoke with were aware of this out of hours service. The lack of seven day working was identified as a risk to the service but was not on their risk register, action plans were being developed to address this issue.
- The specialist palliative care team had identified the need to provide a seven day face to face service in order to provide a specialist palliative care service including end of life care. We saw evidence of the plans to expand to provide cover for seven days but there was no business case yet submitted.

## Access to information

- Staff we spoke with had all the information they needed to deliver effective care and treatment to patients at end of life most of the time. Some difficulties had been encountered searching the new electronic patient

information system. Information for end of life care was available on electronic white boards on wards, there were also end of life care resource boxes with prescribing information available.

- When patients at end of life moved between teams and services staff told us that the information needed for their ongoing care was shared appropriately, in a timely way and in line with relevant protocols when records were complete. Difficulties were encountered when patients moved wards before discharge.
- The specialist palliative care team had amended the electronic discharge summary so that information about a patient's poor prognosis was communicated to their general practitioner on discharge.

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

- We saw evidence that had patients consent to care and treatment was sought before carrying out treatment. We also saw evidence that patient's relatives observed trust staff gaining consent before carrying out procedures.
- Patient records did not always demonstrate that staff fully understood how to record the relevant consent and decision making requirements for specific decision making around the Mental Capacity Act 2005 and resuscitation decisions. We did not always see clear evidence that account had been taken of a patient's ability or lack of ability to make specific decisions. When there was evidence it was sometimes recorded in areas of notes that were not immediately obvious or in a format that was not clear.
- Some records showed that the patient's next of kin had been involved in making decisions when their relative lacked mental capacity to make decisions for themselves.
- Not all do not attempt cardio-pulmonary resuscitation forms, had been signed by a senior clinician or been reviewed in the appropriate time or provided objective evidence of why a patient lacked capacity. We looked at the care records for two patients receiving end of life care who lacked capacity to make decisions about their care. It was unclear how decisions had been made for these patients.
- The trust carried out audits to ensure the process for seeking consent for decisions at end of life was



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monitored and that trust staff followed relevant national guidance. The audit demonstrated that there was significant learning needed but progress had been made.

- We saw evidence of training planned to improve how ward doctors and nurses recorded details of how they had reached decisions with patients or relatives using recent audit outcomes.

## Are end of life care services responsive?

Good



The service was responsive to patients' needs. We rated this as requires improvement because:

- End of life care took account of the local population account when planning services. For example, there was provision for patients with a learning disability and dementia nursing in the trust. The needs of different patients were taken into account when planning and delivering services; for example, on the grounds of disability, race, religion or belief. Religious texts were available in a range of languages and facilities took account of several faiths.
- Reasonable adjustments were made and action was taken to remove barriers when patients found it hard to use or access services. For example, ensuring that multiple outpatient appointments for patients receiving end of life care occurred on a single day.
- While there was no mechanism to report incidents and identify issues or complaints relating specifically to end of life care, it was easy for patients to complain or raise a concern in general and they were treated compassionately when they did. There was openness and transparency in how complaints were dealt with. Complaints and concerns were taken seriously, responded to in a timely way and listened to.
- Access to care was managed to take account of patient's needs, including those with urgent needs. Discharge from hospital and to a patient's preferred place of care was achieved in many cases although some delays were evident and some people did not achieve their preferred place of care. The specialist palliative care team had worked to ensure they and others in the trust had access to information needed to support patients who received end of life care..

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

- The specialist palliative care team were working to plan and deliver services to meet the needs of patients and those close to them through a number of commissioned goals. On behalf of the end of life strategy group, the palliative care team led on achievement of the 2014/5 end of life commissioning for quality and innovation. To achieve additional funds the team provided evidence of two outcomes. For outcome one, patients with poor outcomes anticipated were helped to understand their condition so that they could make informed choices about their future care and treatment. The team introduced treatment escalation decision forms for use on the medical admissions unit, they also amended the electronic discharge summary so that information about a patient's poor prognosis was communicated to their GP on discharge. For outcome two, patient's and carer views were sought to inform future service developments. The team used the VOICES questionnaire to gather feedback from bereaved relatives in Bristol, South Gloucestershire and North Somerset. The team demonstrated significant improvement from initial audit after introduction of these measures.
- End of life care was provided to meet the needs of the population served. There were a variety of texts in different languages in the chapel, there were ritual washing facilities and there was quiet space for reflection regardless of faith. End of life care and transfer to the community was flexible and choice of care was achieved often.
- There were no designated beds for patients receiving palliative or end of life care. The specialist palliative care team had moved from a setting where they were able to use specialist beds. It was possible for patients at the end of their life to be nursed in single rooms, although some patients were being cared for in four bedded bays. Staff ensured that patients were provided care in a single room if requested. Relatives could stay on temporary beds in side rooms if needed. The specialist palliative care team were forming a business plan to support the implementation of specialist palliative care beds. They showed us recent research and evidence to suggest this was needed for the most complex of care for patients at end of life.



# End of life care

- Overall we saw facilities and premises that were appropriate for end of life care a mix of single rooms and four bedded bays.
- Those close to patients at end of life could use concessionary parking when visiting the hospital.

## Meeting people's individual needs

- Services were planned to take account of the needs of different patients, for example, on the grounds of disability, race, religion or belief or complexity. For example, those living with dementia or those with a learning disability. The trust had a learning disability and dementia nurse and we saw examples of where patients with a condition that increased confusion were being cared for one to one with additional staff to ensure safety.
- Reasonable adjustments had been made so that disabled patients could access and use services on an equal basis to others.
- Staff had been involved in care that took into account a person's advance care plan and preferred place of care. Of the referrals made to the specialist palliative care team, 43% of patients were discharged from hospital and 47% of those were supported to be discharged home. Figures from the specialist palliative care team annual report March 2015 for the period 1 April 2014 to 31 March 2015 show that 93 patients did not achieve the preferred place of care. Some patients chose to remain in hospital, chose care homes or hospice to receive their care at the end of their life. Of the 93 there were 58 who were unable to be discharged home due to rapid deterioration in condition. The team were working on increasing early referral and were proactive in working with the acute medical unit to ensure as early an identification of end of life as possible.
- The specialist palliative care team's annual report March 2015 acknowledged that the discharge process for patients receiving end of life care was complicated by different application processes and end of life care provision between the areas covered by the three clinical commissioning groups with whom the trust worked. In addition, delays in discharges had occurred due to capacity issues of the various care providers leading to an inability to source care packages especially in some more rural locations. There was often a lack of vacancies in care homes which prevented

patients achieving their preferred place of care. The team had continued to build working relationships with other community professionals from both statutory and voluntary services.

- We saw evidence that patients' spiritual, religious, psychological and social needs were not always documented in the patient record.

## Access and flow

- Patients accessed care and treatment in a timely way. We saw patients who had timely access to initial assessment, diagnosis and urgent treatment. Patients were able to access care and treatment on Monday to Friday at a time to suit them. We also saw evidence in patients records where appropriate de-escalation of treatment had occurred because the specialist palliative care team were available to review the patient's care. The decision to review care may have taken longer to reach if the patient had needed to be reassessed out of hours or at the weekend, then the specialist palliative care advice service was provided remotely by a third party.
- From April 2013 to March 2014 there were 836 cancer and 411 non cancer referrals to the specialist palliative care team, 67% and 33% respectively. Referrals for April 2014 to March 2015 were similar at 61% and 39%. Figures from the specialist palliative care team's annual report published March 2015 showed the team received 1326 referrals in the period April 2014 to March 2015 43% were discharged from hospital, 14% were discharged from the team while still in hospital, 36% died in hospital and for 7% the outcome was unknown. Of 757 discharges from hospital 47% from the team were discharged home, 13% went to care homes and 4% went to hospices.
- During a previous inspection the specialist palliative care team told us that obtaining sufficient information about a patient's medical history when patients had been admitted through acute medical unit was difficult. The specialist palliative care team was one of several in the country to be proactive and they had joined acute medicine unit board rounds to ensure patients' needs were identified to access end of life care. We saw evidence that the specialist palliative care team had worked with the acute medical unit with complex end of life patients to improve patient outcomes.
- The trust aimed to prioritise care and treatment for patients at end of life. Ward staff and the specialist

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palliative care team worked together when this was needed. We saw evidence of two situations where the specialist palliative care team and ward staff had gone to extreme lengths to ensure patients were returned home at end of life even when the discharge plan was not routine and included lengthy overseas journeys.

- The specialist palliative care team supported two outpatients clinics and ensured that where possible, patients attended only once ensuring that when two outpatients appointments were needed they occurred on the same day.
- Mortuary staff showed us additional capacity in the event that the mortuary became full which was an improvement the mortuary services manager had initiated from the previous inspection November 2014.

## Learning from complaints and concerns

- The specialist palliative care team had very few concerns and complaints raised with them. The specialist palliative care team had discussed in the end of life strategy group meeting that there was not a mechanism for identifying complaints specifically relating to death and dying. The clinical complaints system was being reviewed and the electronic system was being reviewed to incorporate a method.
- Patients and those close to them who used the service knew how to make a complaint or raise concerns. We saw evidence of this and there was information available to support patients to do so.
- When complaints were raised we saw evidence that complaints were handled effectively and a record kept. The outcomes of complaints were explained appropriately to the individual and there was openness and transparency about how complaints and concerns were dealt with.

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

Requires improvement



We rated end of life care as requires improvement for well-led because:

- The arrangements for governance and performance management of all end of life care in the trust did not always operate effectively.
- There was not a risk register in place for the specialist palliative care service or for end of life care. There were

risks identified during our inspection, for example, record keeping and infrequent formal supervision for chaplaincy, mortuary staff and bereavement officers which were known about. We did not see these recorded on a local or trust wide corporate risk register.

- Quality issues and priorities were understood but the action required to ensure change was not evident. It wasn't clear if performance information was used to hold management and staff to account. This included incident reporting in mortuary and completion of end of life care documentation on wards for example, treatment escalation plans and other patient documentation.
- The leadership for all staff involved in end of life care was not yet in place to support them and promote their positive wellbeing. Formal substantive leaders in end of life care were absent; for example, in the chaplaincy and bereavement services, although there had been a recent appointment to head of patient experience and some changes had been implemented. Some staff were not always clear about their roles and their accountability for quality. This had resulted in some team members not always feeling supported.

However:

- Leaders in end of life care from the director of nursing on the board to the leads in the specialist palliative care team and the head of patient experience modelled and encouraged cooperative, supportive relationships. Staff in the specialist palliative care team we spoke with felt they were respected, valued and supported.
- The trust supported the director of nursing and the specialist palliative care team to promote high quality person-centred end of life care.
- The specialist palliative care team had a clear statement of vision and values and end of life care was driven by the desire for quality and safety. The strategy was credible and strategic objectives had been identified recently as part of commissioning for quality and innovation and were supported by quantifiable and measurable outcomes. Despite the recent work, the strategy and vision for good end of life care had not yet been fully implemented on all wards, in the mortuary, bereavement services or the chaplaincy.
- The board representative for end of life care and the specialist palliative care team had the experience,

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capacity and capability to ensure that the strategy for end of life care could be delivered. Quality for end of life care received sufficient coverage in board meetings, and in other relevant meetings below board level.

## Vision and strategy for this service

- The vision, values and strategy had been developed by the specialist palliative care team and other partners in delivering end of life care. We saw evidence that end of life care was being led by specialist palliative care team leads to set the trusts local strategy. This was based upon the “Ambitions for Palliative and End of Life Care, national framework for local action 2015-2020”. The strategy for achieving the priorities of 2014/15 had not been achieved in all areas. Delivering good quality care was still embedding in wider clinical practice throughout the hospital. We saw evidence of a clear vision and a credible strategy to deliver good quality end of life care for 2015/16 through the specialist palliative care team and to enable ward staff to deliver quality end of life care. We saw evidence of specialist palliative care team leaders and the director of nursing identifying what would be needed to deliver a seven day service. Seven day services are key foundations of quality and reduced risk.
- Progress against delivering the strategy was monitored and reviewed by the end of life steering group and the strategy was shared with trust staff in education sessions.
- Not all ward staff were engaged in providing good end of life care. This was seen in the variable quality and consistency of recording in patients notes or dealing with do not attempt resuscitation forms and addressing mental capacity assessment and decisions making. Although when spoken with staff could clearly explain why ‘doing it correctly’ was an important part of their job.

## Governance, risk management and quality measurement

- The director of nursing was the executive lead for end of life care. However, there was no non-executive director for end of life care.
- The governance framework for end of life care did not ensure that responsibilities, quality, performance and risks were understood for end of life care at all levels. The governance framework to support the delivery of the strategy and good quality care wasn’t fully

embedded at ward, chaplaincy, bereavement officer and mortuary level. The trust had made progress in resolving this through the appointment of a head of patient experience who would support the chaplaincy and bereavement officers. The trust had also made elements of end of life care training mandatory for doctors and nurses for 2016. The end of life care strategy group met quarterly to discuss and act on clinical governance issues. Issues for concern had been identified. This included that ward staff lacked all of the skills to deliver ‘optimal end of life care’. There was also a high level of nonattendance of staff for end of life training. In addition ensuring all trust staff had optimal training in end of life care was a large task for a relatively small team.

- The specialist palliative care team were clear about their roles and they understood what they were accountable for. Some ward staff (doctors and nurses) were less clear and this was seen ultimately in the quality of record keeping.
- The challenges to achieving the strategy were understood by the end of life steering group, specialist palliative care team and the director of nursing. There were action plans in place but they had not had enough time to be fully effective at ward level to sustain change achieved earlier in the year. The trust had recently appointed a head of patient experience who was working with the director of nursing to ensure local leadership in the chaplaincy for the bereavement officers was effective.
- There were some assurance systems and service performance measures, which were reported and monitored on. It was not always clear where action was being taken to improve performance. For example audits of treatment escalation plans had not had enough impact on record keeping.
- There were arrangements in place to ensure that the information used to monitor and manage quality and performance was accurate, reliable, and relevant. Links between mortuary staff and bereavement officers and their leadership needed to improve. The leadership on wards for correct administration of the process of end of life care needed review.
- Arrangements for identifying, recording and managing risks and mitigating actions were absent. It wasn’t clear if there was alignment between what staff said was ‘on their worry list’ as the end of life care service did not have a local risk register. We asked the trust what risks

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were recorded relating to end of life care. We were told there were none on the medicine, or trust risk register. Despite the medical risk register being the place where end of life care risk could be recorded there were no formal risks identified with end of life care.

- Work plans and strategy were communicated to the board quality committee on a quarterly basis.

## Leadership of service

- We saw that the director of nursing, the consultant for end of life and the lead nurse had the skills, knowledge, experience and integrity needed to develop and lead the end of life care. The doctor and nurse lead for end of life and the director of nursing demonstrated a leadership and culture which encouraged openness and transparency and set the initial conditions for the promotion of good quality care. The leaders understood the challenges to good quality end of life care and since the move to the new site at Southmead had been building the end of life care strategy with action plans and owners of those plans. They were clear about the actions needed to address them. Some elements of the end of life care process did not have consistent leadership due to recruitment issues (chaplains and bereavement officers). The new head of patient experience had recently commenced supporting the two teams. The mortuary had good informal leadership, but there was lack of clarity in some areas. For example, did the trust supervision policy apply to mortuary staff, regularity of supervision and how incidents were reported and analysed to support learning.
- The clinical lead for end of life care (appointed in August 2015) was the consultant who had recently had protected time allocated to their job plan. They were well informed and engaged in the work of the specialist palliative care team. The service improvement lead was a band 8 nurse who was well recognised on wards and we saw evidence that protected end of life lead time was being formally negotiated.
- The director of nursing and end of life care leads were described as visible and approachable and we saw evidence of appreciative, supportive relationships among them and their teams in end of life care. The specialist palliative care team was valued by the trust board, we saw evidence that end of life care was a

priority at board level. There was still work to do within the trust overall, we saw plans for this change to be enabled through ongoing education and reinforcement of audit outcomes.

- Following guidance issued by the National Patient Safety Agency, syringe drivers used in adult palliative care were replaced in 2014. The specialist palliative care team had provided the training, produced guidelines and worked other local health providers to produce a syringe driver guideline for use in adult palliative care. The specialist palliative care team had good links with other stakeholders and providers of end of life care in the region.

## Culture within the service

- Ward staff we spoke with felt respected and valued but described increased workload, work pressures could change quickly with a few unplanned absences from the rota. End of life care was still considered a priority if this was happening.
- Staff we observed and spoke with demonstrated a culture centred on the needs of patients who used end of life services and needed care in general. However, the culture was still not delivering consistent, quality record keeping. Staff were open and honest when we spoke with them about the issues we had identified during inspection. For example, doctors and nurses understood points we made during inspection using examples of the incomplete or unclear 'resuscitation forms' and incomplete care plans. They could explain why they were completed in the way that they were, citing the need for education and reinforcement of that education at all levels including consultants. Staff understood on a day to day basis what care patient's needed and described this to us. Staff and teams were observed working collaboratively for example supporting each other with difficulties with a new electronic information system. They also shared responsibility when record keeping was highlighted.

## Public engagement

- Patients and those close to them, who were using or had used the end of life service, had been engaged through a VOICES survey coordinated by the team and were waiting on the results to be returned. The specialist palliative care team had gathered patients' views and experiences and plans were acted on to shape and improve the services and culture. We saw

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evidence that patient's and those close to them were actively engaged and involved in decision-making in end of life care. Some patient's chose to limit the interventions they had at the end of life some wanted more.

## Staff engagement

- Staff in the specialist palliative care team described active engagement by the trust and their views were reflected in the planning and delivery of services and in shaping the culture staff on the wards and specialist palliative care team had been engaged through a staff survey.
- All leaders and staff we spoke with understood the value of staff raising concerns. Although sometimes issues were dealt with as they happened and not raised formally. This prevented the trust from having a full view of potential learning across end of life care including from, bereavement officers, mortuary services and wards. Appropriate action was taken but learning was not embedded across the trust, for example some ward staff dealt with patients teeth as part of trust management of a deceased adult patient policy - last offices and an item which stayed with the patient, other wards treated them as property.




## Innovation, improvement and sustainability

- Since the specialist palliative care team had moved in May 2014 and the last inspection in November 2014 it

was clear that services had continuously improved and the foundation of sustainable end of life care was evident. The director of nursing and the specialist palliative care team leads had considered developments to the service and reviewed efficiency. The full impact of that work was not realised at the time of our inspection. The impact on quality and sustainability was assessed and monitored through achieving commissioning for quality and innovation payments and audit.

- The trust had not allowed financial pressures to compromise potential improvement and sustainability and two band 7 nursing posts funding had been retained when recruitment was difficult. The band 6 nurses in the specialist palliative care team were being developed, to support sustainability for the service. We saw leaders and staff in the specialist palliative care team striving for continuous learning, improvement and innovation which was supported by the trust board
- Information was used proactively to improve care and it was clear from the specialist palliative care team annual report that both contemporary research and 'hands on practice' informed the direction of strategy and action
- Improvements to quality and innovation were recognised and rewarded through commissioning for quality and innovation payments although we saw evidence of some initiatives that were not fully met.

# Outpatients and diagnostic imaging

Safe	Requires improvement	
Responsive	Requires improvement	
Overall	Requires improvement	

## Information about the service

North Bristol NHS Trust provided approximately 450,398 outpatient appointments between July 2014 and June 2015. Of these appointments 23% were first attendances and 44% were follow up. Outpatients appointments exclude approximately 7% Did Not Arrive (DNA's), 14% hospital cancelled and 12% patient cancelled.

The majority of the outpatient clinics were held in the main hospital building (the Brunel building).

During our inspection we visited radiology departments, various outpatient clinics, medical records and the booking centre. We observed five areas looking at patient flow through the departments and the environment and facilities available for patients.

We spoke with 22 members of staff, consisting of radiographers, radiographer and outpatient leads, nurses, receptionists and administration staff. We also spoke with two patients and one relative.

The diagnostic imaging department provided a large range of diagnostic services on behalf of GPs and other clinical specialities within the trust. The facilities included general x-ray, MRI scanning, CT scanning, ultrasound, nuclear medicine and angiography.

## Summary of findings

We judged the safety and responsiveness of the outpatients and diagnostic imaging service as requires improvement because:

- There were areas in outpatients where patients' medical notes were left unattended and records were stored insecurely.
- There were a high number (between 10 and 20%) of patient notes 'missing' in outpatient clinics. This posed a risk to patient safety. No data was collected on the number of patient appointments which were cancelled as a result.
- Patients did not always receive timely access to treatment. The trust were found to be breaching the standards for referral to treatment pathways

However,

- We found there were systems in place for all reported incidents to be investigated, staff were clear on the process for reporting and felt able to report appropriately.
- The cleaning of the outpatient and diagnostic areas was of a high standard, staff reported a responsive cleaning team to the needs of the services they provided.
- There were processes in place to assess and respond to patients risk and staff were trained to recognise and act upon abuse or suspicions of abuse in vulnerable people.
- We found the outpatient services and opening times were flexible to meet the needs of the general population.



# Outpatients and diagnostic imaging

- The staff were very knowledgeable in responding to the needs of patients living with dementia in the outpatient setting, enabling them time to adjust to a different environment and ensuring the patients received a tailored service

## Are outpatient and diagnostic imaging services safe?

Requires improvement



We judged the safety of outpatients and diagnostic imaging as requires improvement because:

- There were a high number (between 10 and 20%) of patient notes 'missing' in outpatient clinics. This posed a risk to patient safety. No data was collected on the number of patient appointments which were cancelled as a result.
- There were areas in outpatients where patient's medical notes were left unattended and stored insecurely.

However:

- There were systems in place to make sure that all reported incidents were investigated, staff were clear on the process for reporting and felt able to report appropriately.
- The overall cleanliness of the building, outpatients and diagnostic imaging was of a high standard. There was a responsive cleaning team in place who were able to respond to adhoc cleaning requests.
- Staff were trained to recognise and act upon abuse or suspicions of abuse of vulnerable people.
- There were processes in place to assess and respond to patients' risk. In-patients clinical needs were made aware to radiology prior to attending the department, unwell patients were provided with an escort.

### Incidents

- Staff were open and transparent about incidents. Systems were in place to ensure that incidents were reported and investigated appropriately. All staff told us that they would have no hesitation in reporting incidents and were clear about how they would report them. They also told us they were supported and felt confident to raise any concerns and that they would be listened to.
- Individual staff received an email confirming the reported incident and then received feedback about the incident from their manager. Any learning actions were put into place from this conversation. More complex serious incidents were discussed at team meetings.

# Outpatients and diagnostic imaging

- Radiology staff were aware of the need to complete a radiation incident form if necessary as well as normal incident reporting form. The ionizing radiation (medical exposures) regulations IR(ME)R lead was copied into all the radiation incidents, this lead sat on the clinical governance committee where issues of radiation were discussed. All incidents of radiation over exposure were reported to the care quality commission as set out in guidelines.
- A reported serious incident which was reported in the 12 months prior to our inspection had changed the way images were reported upon and documented upon. As a result overnight reporting was checked by the consultant radiologist the following morning and an addendum made to the initial report if required. This was then escalated to the requesting doctor.
- Outpatients accounted for about 6% of all incidents reported. The majority of incidents reported (386 about 68%) had resulted in no harm. Although the total number of incidents reported each month was variable, there had been a slight downward trend.
- A few months prior to the inspection a patient suffered a cardiac arrest in the waiting area of outpatients. This highlighted issues with transferring seriously unwell patients from outpatients to other parts of the hospital, whilst respecting their privacy and dignity. An exit strategy and a transfer plan had been developed as a result of the learning from this incident.
- Incidents related to documentation were the type most commonly reported in the outpatient clinic. These accounted for more than a fifth of incidents. This included incidents relating to records, identification and drug charts. However, documentation related incidents showed an overall downward trend which was in line with the downward trend in the total number of incidents reported within the trust.

## Duty of Candour

- Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, is a new regulation which was introduced in November 2014. This Regulation requires the trust to be open and transparent with a patient when things go wrong in relation to their care and the patient suffers harm or could suffer harm which falls into defined thresholds
- This regulation explains what providers should do to make sure they are open and honest with patients when something goes wrong with their care and treatment.

The trust had an incident reporting policy in place which stated the requirements of duty of candour and when it was required. Staff were able to demonstrate an understanding of this and senior nurses were able to describe how the duty of candour was part of their working practices.

## Cleanliness, infection control and hygiene

- We found all areas of the hospital we visited within outpatients and radiology to be clean and well kept. Patients we spoke with thought the hospital always looked clean. Staff told us that the cleaning teams were responsive to their requirements. Staff in radiology would try to see patients who were infected at the end of their list. Where this was not possible, the room was closed and the cleaning teams were available to complete a deep clean, usually within 30 minutes of a request being made.
- Clinical staff and reception staff were adhering to the uniform policy of 'bare below the elbows' when in clinical areas.
- We saw that nursing staff had their own weekly cleaning check lists and these had been completed. One of the senior nurses told us they complete an out of hours weekly check of all the outpatient areas and was aware of all the cleaning schedules.
- Toilet facilities and mother and baby changing areas were well signposted throughout the hospital. These areas were cleaned regularly and was recorded when the last clean had taken place.
- There were hand gel dispensers at the entrance to each sub waiting area. We did not see an abundance of hand gel as we expected, although there were hand gel dispensers in the consulting rooms. Hand hygiene audits were undertaken, radiology and outpatients were consistently compliant.
- All areas of outpatients and radiology had access to personal protective equipment, such as, gloves aprons and where necessary masks.

## Environment and equipment

- The waiting areas were well maintained with plentiful comfortable seating arrangements. There were some chairs with raised seats for patients with mobility issues.
- Each clinical area had a resuscitation trolley, we saw weekly checks had been made for those trollies which were tamper proof. There were some non-tamper proof resuscitation trollies, these were checked daily. We were

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informed that these trollies were locked away in a consulting room at the end of each day. Non-tamper proof resuscitation trollies were on order to replace the old ones.

- All new or modified radiology equipment was tested by medical physics and risk assessments were completed. Risk assessments were held in a folder in the departments.
- All radiology equipment had a programme of maintenance which was carried out by the original manufacturer. A replacement program of older equipment was built into the capital replacement plan. We did not see this replacement program.
- All imaging areas had the access controlled, which restricted access from unauthorised staff members and the public.

## Medicines

- Medicines were not generally kept in the outpatient or radiology departments, but where they did were saw adequate storage was available.
- Fridges were available for storing medications. We saw evidence of the temperature checks having been made daily, and the temperatures were within the recommended ranges.
- In the nuclear medicine department we witnessed radioactive medication being ordered, handled and checked by two trained radiographers.
- Patients were prescribed medications electronically; this went directly to the hospital pharmacy. Paper copies of the FP10 (prescription forms) were available should the electronic form not be available. These were kept securely in two clinic areas, there was a log book to sign prescription pads in and out of the locked area.

## Records

- Medical records department was off site, records were requested in advance of the outpatient clinics, the notes were prepared, traced and delivered to the health records department at the main Brunel building three days prior to the clinic. Any missing medical records were searched for electronically. The health records team were able to locate most patient records. If this was not possible the team were able to make a set of temporary notes which included a copy of the referral

letter. The team prepared notes three days in advance. We were informed preparation of temporary notes folder was reported as an incident, however we were not given information on how often this occurred.

- A daily audit was performed on the number of missing notes per clinic and the results were published monthly. The audit showed a period of 15 months from June 2014 to September 2015 and the percentage of missing notes was fairly consistent at approximately 10 to 20%, but this also varied between clinic. Data on cancellation of outpatient appointments due to missing medical notes was not captured.
- Most staff we spoke with told us that missing patients' records was a daily occurrence but clinics or individual patients were not cancelled as a result. Most information required for a consultation was available electronically. However, we did speak with a staff member in orthopaedic outpatients whose consultant had refused to see two patients that day as the notes were unavailable. The patients had another appointment made for them to return at a later date.
- A new electronic records system had recently been introduced and patients' notes were gradually being scanned into the system. This would eventually negate the issue with missing patient notes.
- We saw sets of notes continued to be stored insecurely in the urology clinic. We reported this during our inspection in November 2014. Medical notes were not kept in lockable containers. We also saw insecure storage of medical records in the pre-operative assessment clinic. Medical records were stored in a large cupboard without access control or lockable doors. Senior staff were fully aware of the situation and had requested locking mechanisms for this area but at the time of our visit it had not been acted upon. We were informed that insecure storage of notes was on the risk register for outpatients. We were also informed that no notes had gone missing and neither had there been a breach of confidentiality.
- Notes were being locked away in consulting rooms overnight to keep them secure.

## Safeguarding

- Staff were trained to recognise and act upon abuse or suspicions of abuse of vulnerable people. We saw a safeguarding policy in use which contained useful

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flowcharts for staff to follow. Staff we spoke with were able to describe their actions and the escalation process to either their manager or the safeguarding lead for their area.

- Radiology staff informed us they were trained to level two in safeguarding children. They felt confident to report any concerns they had to the doctor treating the child and would document in the patients notes. Informing the treating consultant is part of the trust policy.

## Mandatory training

- Staff told us they were up to date with mandatory training. All staff were contacted via email to let them know when they need to book their mandatory training via the electronic booking system. If the staff had not updated their training the managers were informed. Staff told us it was easy to book mandatory training online.
- We saw the mandatory training completion log for outpatient staff, staff were up to date apart from completing falls training, but this had recently been incorporated into the training matrix for outpatient staff.
- We saw evidence that staff in both areas were up to date with mandatory training.

## Assessing and responding to patient risk

- Radiation protection advisor and supervisors were available in each area of radiology and radiology staff were aware of who they were. Staff were able to show us where the local rules were kept and displayed in each area and where a copy of the ionizing radiation (medical exposures) regulations IR(ME)R 2000 could be found.
- Non-medical referrers were required to undertake IM(ME)R training and to be signed off as competent by the lead specialist. Protocols were in place for non-medical referrers to ensure the requesting of x-rays was in line with IR(ME)R regulations.
- Staff felt confident to discuss any concerns or issues with their line managers.
- Radiology staff wear a Thermoluminescent Dosimeter (TLD). A TLD measures ionizing radiation exposure. They were worn for a three month period and were then sent away for analysing the exposure the staff member

has encountered. Staff received feedback if the limits were higher than normal but this rarely occurred. Staff we spoke with had not received a higher than normal reading.

- In the radiology department all female patients between the age of 12 and 55 years were asked about their pregnancy status. If the patient was unsure the staff requested that a pregnancy test is undertaken. This would be documented on the x-ray form and electronic record prior to radiation exposure.
- There were safety systems and a critical findings policy in place for the radiology department to report any abnormal or important unexpected findings to GPs and or the consultants. The report was faxed and a request was made to respond to the receiving fax, this had become standard practice.
- Both areas, outpatients and radiology, had ownership of their own risk register. Outpatients highest risk was that of medical records and the management of the new electronic records system. Risks were reviewed every six months at clinical governance meetings. Risks for radiology were a concern for the build-up of backlogs of reporting.
- Patients' clinical requirements were identified on the electronic booking system for radiology, such as mobility, need for oxygen therapy and any infection. Clinically unwell patients were accompanied by a member of staff from the ward. If patients became unwell in the department staff were able to summon assistance through the telephone system.
- The trust had a policy for acute kidney injury and was following clinical guidelines which reflected the National Institute of Health and Care Excellence (NICE) guidelines.
- In November 2014 we found that the radiology department had a backlog of 4642 unreported images. Since then the trust had taken action to resolve this issue and had reduced the backlog to 57 images waiting longer than 28 days. This number was reduced by paying staff overtime to clear the backlog. To sustain this standard operating procedure set out the process for allocating the reporting to folders and the on-going monitoring of the outstanding reporting. Weekly monitoring was taking place and outstanding reporting was escalated to the managers.

## Staffing

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- Outpatients were fully staffed employing 65 whole time equivalent staff. Of these staff, 40% were registered nurses. Nurses with specialist skills were employed to work in each clinic area.
- The turnover of outpatient staff was approximately 11% this was 1.5% higher than the average turnover rate for nursing staff in the trust. The sickness rate had been reduced over the 12 months prior to our inspection from 12% to 6%; this was achieved by working closely with the occupational health team.
- Agency staff were not used for the outpatient area; however, bank nurses were used to cover periods of sickness and additional activity. All bank nurses received an induction and completed a checklist during their first shift in the area.
- Radiology were fully recruited with consultants; however, there was an issue with recruitment for band five radiographers. Turnover of staff had reduced from 15% to 11% in the previous 12 months. Staff stated they felt more settled in their roles. To attract staff, they had introduced an in house development program, radiographers were able to learn new skills such as facet joint injections.
- Radiology staff told us they felt more settled in the last year and felt as though morale amongst staff had increased.

## Major incident awareness and training

- The major incident plan was available on the intranet. The staff we spoke with were not sure if outpatients was part of the formal plan.
- In the case of a major trauma being admitted through the emergency department, radiology staff knew how to find their action cards for their roles.
- In the event of a spillage of radioactive isotopes within nuclear medicine, the area would be immediately shut down, spillage kits were available.

## Are outpatient and diagnostic imaging services responsive?

Requires improvement



We found that the service required improvement to respond to patients' needs because:

- Patients did not always receive timely access to treatment. The trust were found to be breaching the standards for referral to treatment pathways.
- However: Outpatient services were flexible to meet the needs of the population. The teams planned for the future provision of services. The building was clearly sign posted and there was good access to facilities for patients and visitors.
- We found the staff to be very knowledgeable in responding to the needs of patients living with dementia in the outpatient setting.

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

- Outpatient leads told us meetings were held to discuss the planning of future outpatient provision in conjunction with the speciality leads. The meetings looked at workloads and capacity planning. These meetings took into consideration the trust being the regional centre for neurosciences, plastics, burns, orthopaedics and renal services.
- The trust also provided outpatient radiology facilities at three other localities in order to meet the needs of the local population. Most radiology services were open from 8am to 8pm on Monday to Friday., However, a 24 hour service was provided to in-patients within the acute trust.
- The radiology team leaders, assistant general managers and general managers met on a weekly basis to discuss waiting time, capacity and demand and made plans accordingly. This included providing extra clinics should they be required
- We found the waiting room environments to have sufficient comfortable seating, with raised seats in some areas for patients with mobility issues. All the toilets were well signposted and changing areas for mothers and babies. Drinks machines were available in each of the waiting areas. In the main atrium of the hospital coffee shops were also easily accessible.
- The departments were clearly signposted, there were also volunteers available to assist patients with directions if required.
- Patients and staff did mention the problem of car parking. We were told how patients and carers would sometimes have to drive around for long periods of time looking for parking.

## Access and flow



# Outpatients and diagnostic imaging

- Patients did not always receive timely access to treatment. The trust had not been meeting the national standard time of the 18 week referral to treatment times for outpatient services. The data showed it had consistently breached the standard from August 2014 until May 2015 when the standard was abolished. This was replaced by an incomplete referral pathway of which 92% was the standard, which was also consistently breached. The incomplete pathway measures patients waiting to commence treatment and is measured at the end of each month, the measure is that no patient should wait longer than 18 weeks. This meant that 85% of patients were being seen and treated within the 18 week standard at North Bristol Trust, 7% below the standard.
- In the previous 12 months the trust had was not always meeting the cancer waiting target of two weeks to be seen by a specialist. Over the same period the trust breached the standard of 31 days for patients to commence their first definitive treatment.
- The percentage of diagnostic waiting times over six weeks was consistently higher than the England average from May 2014 to April 2015. Between May and August 2015 the percentage waiting more than six weeks was below the England average.
- Patients could wait up to 30 minutes to be seen by a clinician, this information was shown on the television screens in the main waiting areas. The same information was not available in the sub-waiting areas but patients told us they were kept informed verbally by the staff.
- We saw dashboards in the outpatient waiting areas displaying information as to the number of patients who had been seen in the previous month and the did not arrive information. For the month of October 2015 this was high at 9%, although the trust average was 7% in line with the England average. A text reminder system for appointments was in place.
- Patients were given dates and times to attend their outpatient appointment. However; if this was not convenient to them they were able to change the appointment. Patients were then given a choice of day and time within the target timescale.
- In October 15% of all appointments were changed by the trust, this was for a variety of reasons, such as booked leave or sickness.

- We visited the booking centre which was off site from the main building, there were plans to move to the new build in the near future. The backlog of appointment bookings had been addressed from the previous year, this was actioned by staff working over and above their contracted hours including weekends to clear the backlog. The trust had recently implemented a new computerised system, this had very slightly increased the number of backlogged non urgent appointments, however this had been recognised and staff numbers had been increased to deal with this. It was hoped to have completed the backlog a few days after our visit.

## Meeting people's individual needs

- The three most spoken languages were English, Polish and Somali. North Bristol had access to a translation service who were able to meet the needs of the largest minority groups. Staff informed us that interpreters were either booked prior to the appointment or were easily accessible by telephone. Information leaflets were easily available in English. We did see some written in Polish and were told leaflets written in other languages were available to be printed from the trust intranet.
- All staff spoke knowledgeably around caring for people living with dementia. Training had been provided as part of the mandatory programme. However, some staff had also attended some face to face dementia training. Staff were able to describe how they were able to increase the appointment times for patients known to have dementia to ensure the patients were given the time they required to process their thoughts and introduce them into an unfamiliar territory. Staff described how they tried to make the environment as calm and as relaxing as possible in order for them to establish a good rapport with the patient. Radiology staff explained how they would take the time to explain the procedures to patients living with dementia, but if the patients could or would not consent to the x-ray being taken staff would not proceed.
- The physiotherapist described how they had received a bespoke training programme delivered by the dementia specialist nurse.
- Transport was arranged for patients who required it for their outpatient appointments. Patients who required stretcher transportation were prioritised in the pre-operative assessment clinic and staff worked quickly together to enable the patient to be.



# Outpatients and diagnostic imaging

- Specialist bariatric clinics were held, run by specialist nurses. Bariatric equipment, such as chairs and couches were available in clinics.
- Plain x-ray received a complaint from a patient about the noise levels from the staff when performing an x-ray. This was discussed as a team and now staff are kept at a minimum in the x-ray room when patients were being x-rayed. Staff told us any complaints received were discussed at team meetings and changes put in place where able. We saw compliment and complaints forms readily available for patients to read and takeaway with them. Patients we spoke with were aware of how to make a formal complaint should they need to.

## **Learning from complaints and concerns**

- Staff we spoke with in all areas of outpatients and radiology were unaware of any formal complaints being made specifically about their own areas, however they were able to tell us that some patients did complain verbally at times if they were to wait for more than 30 minutes. They tried to keep patients informed of any waiting times and were happy to offer patients a verbal explanation and an apology in these circumstances.

# Outstanding practice and areas for improvement

## Outstanding practice

- As the major trauma unit for the Severn region the department was required to report all treatment results of major trauma patients to the national trauma audit and research network (TARN). Results for 2015 showed that the emergency department at Southmead hospital had the best survival rate of any trauma unit in England and Wales.
- Frontline staff and managers were passionate about providing a high quality service for patients with a continual drive to improve the delivery of care.
- Managers were strong and committed to the patients and also to their staff and each other.
- There was an outstanding example of responsiveness with the work of the dementia care team and the availability of 100 dementia champions in the trust including the Head of Facilities who was focussing on environmental changes.
- In the pre-admission clinic they had a pharmacist working full time who reviewed elective patients. They made sure their VTE assessment was completed. They reviewed patients' medications, wrote them up on the medication chart and gave advice to patients about their medication (what needed to be stopped prior to admission). The purpose for this was to reduce the amount of operations cancelled due to medication issues.
- The bereavement midwife visited women in the CDS and also followed women up at home at any time, even beyond the normal time limit for postnatal midwifery care. Family support was also offered for subsequent pregnancies
- The trust had developed some good training for staff in caring for patients living with dementia. Staff explained how they were able to offer extra time to this group of patients to ensure they were well cared for and made to feel relaxed and calm in an unfamiliar environment. Staff in the pre-operative assessment clinic were able to assess patient's cognition and report back to GPs if it was below expected levels.
- The specialist palliative care team was one of several in the country to join the acute medicine unit board rounds to ensure patients' needs were identified to access end of life care. We saw evidence that the specialist palliative care team had worked with the acute medical unit with complex end of life patients to improve patient outcomes.

## Areas for improvement

### Action the hospital MUST take to improve

#### Action the hospital MUST take to improve

The trust must:

- Improve patient flow within the hospital and ensure that there is a robust hospital-wide system of bed management so as to: significantly reduce delays in patient flow through the emergency department; reduce occupancy to recommended levels within medical services; and, ensure that there is capacity within the hospital so that patients can be admitted to and discharged from critical care at the optimal time for their health and well-being.
- Records must be fully completed and provide detailed information for staff regarding the care and treatment needs of patients.
- Take action to improve the safe storage of medical notes.
- Ensure patient information remains confidential through appropriate storage of records in the outpatient clinics and theatre departments to prevent unauthorised people from having access to them.

# Outstanding practice and areas for improvement

- Ensure that risk assessments in care records are consistently completed for all of the young people who use the community CAMHS service.
- Ensure that the environment at Monks Park is safe for the people who use the service and staff.

## Action the hospital SHOULD take to improve

### Action the hospital SHOULD take to improve

The trust should:

- Check equipment in the emergency department resuscitation room to ensure that it is ready to use.
- Review patient group directives in the emergency department to ensure they reflect current best practice.
- Ensure that psychiatric patients attending the emergency department at night have timely access to appropriate treatment.
- Ensure that the emergency department computer system is easy for staff to use and can provide information needed to manage current and future performance.
- Integrate new emergency department triggers for escalation action into the hospital full capacity protocol.
- Chemicals and substances that are hazardous to health (COSHH) should be secured and not accessible to patients and visitors to the medical wards.
- Opening dates or in used expiry dates should be added to medicines where appropriate.
- Controlled drugs cabinets should be of an adequate size for the required controlled drugs.
- Medicines refrigerator temperatures within surgical services should be monitored, recorded and actions taken in accordance with trust procedures.
- Equipment and medicines required in an emergency should be tamper evident.
- Make sure any changes to practice should be shared with bank and agency staff who work a number of shifts so they are update to date.
- Make sure auditing of safety checks of anaesthetic machines takes place to make sure they are being done.
- Make sure cleaning of all theatre equipment takes place and provide evidence to support this.
- Increase staff locker capacity in theatres to prevent storage of personal bags in the theatre room and to improve infection control practices in theatres.
- Review the cleaning of laryngoscope handles to make sure they are in line with the current guidance.
- Review the orange bags being used, as they were prone to leaking onto the cages used to transport clean linen in theatre.
- Look at ways of making theatre management more visible to staff and improving staff morale.
- The trust should improve the facilities for patients in interventional radiology if this is to be used as the escalation ward.
- Continue to work on improving the WHO safe checklist score to meet their target.
- Use the information from themes of complaints to make changes to practice to reduce the number of complaints received.
- Ensure mandatory training is given suitable priority so that compliance rates across the hospital meet trust targets.
- The system for checking resuscitation equipment should be consistent across the directorate.
- Staff should ensure patient notes have clear records of assessments and best interest decisions for patients who lack the mental capacity to make their own decisions.
- The security of confidential patient records should be reviewed to ensure they are safe from removal or the sight of unauthorised people.
- Continue to support new staff in critical care to attain a post-registration award in critical care to ensure a minimum of 50% of nursing staff hold such a qualification.
- Continue the recruitment programme in the critical care unit to ensure the recommended numbers of safe staffing, including supernumerary coordinators, are achieved at all times.

# Outstanding practice and areas for improvement

- Ensure store rooms in critical care are kept locked at all times when unattended.
- Ensure care records are available in a timely manner to allow useful mortality and morbidity reviews to take place.
- Review the critical care response to deteriorating patients within the hospital, and follow-up of patients discharged from critical care.
- Monitor the numbers of elective surgery that are cancelled as a result of no critical care beds being available.
- Consider instructions for cleaning baths between uses are readily available for staff use.
- Make available antibacterial hand disinfectant at the entrance from Quantock Ward to the Central Delivery Suite.
- Consider how they are to progress towards meeting the Royal College of Obstetricians and Gynaecologists guidance for dedicated consultant hours on the delivery suite
- Consider auditing the completion and submission of HSA4 forms in accordance with the legal requirements for termination of pregnancies.
- Ensure sufficient staff within the recovery area in the maternity theatre department to meet the Association of Anaesthetists of Great Britain and Ireland guidance which states that no fewer than two staff (of whom at least one must be a registered practitioner) should be present when there is a patient in the post anaesthetic recovery area who does not fulfil the requirement for discharge to the ward.
- Ensure that risk registers include risks associated with care for end of life.
- Ensure that care plans for end of life care and associated supporting documentation including resuscitation information demonstrate complete and consistent recording to provide staff with full detail regarding the patients' assessed care needs.
- Ensure that patient records for patients at end of life care demonstrate complete and consistent recording including the relevant consent and decision making assessment requirements for specific decision making in relation to the Mental Capacity Act 2005 and resuscitation decisions.

## Requirement notices

### Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	<p>Regulation 17 HSCA (RA) Regulations 2014 Good governance</p> <p>Regulation 17 The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good governance</p> <p>17(2)(c) maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided.</p> <p>Records were not always available within outpatient clinics</p> <p>Records were not fully completed and did not provide detailed information for staff regarding the care and treatment needs of patients. These did not provide detail on the individualised care needs and requirements of patients.</p> <p>The management of patient records in outpatients and the theatre department did not ensure patient's details were safe and that confidentiality was assured. We saw records were left accessible to the public and trolleys used for records storage were not secured or placed away from public access. Medical notes were not kept in lockable containers. We also saw insecure storage of medical records in the pre-operative assessment clinic. Medical records were stored in a large cupboard without access control or lockable doors.</p>
Regulated activity	Regulation
Treatment of disease, disorder or injury	<p>Regulation 9 HSCA (RA) Regulations 2014 Person-centred care</p>

## Requirement notices

Regulation 9 HSCA 2008 (Regulated Activities)

Regulations 2014: Person-centred care

Regulation 9 (1) The care and treatment of service users must –

1. be appropriate,
2. meet their needs,

A lack of available beds for critical care patients to be discharged to meant a high number of patients were not receiving care and treatment in the most appropriate location for their needs.

Patient bed occupancy exceeded recommended levels too frequently.