Care Quality Commission

Gloucestershire Hospitals NHS Foundation Trust

Gloucestershire Royal Hospital

Quality Report

Gloucestershire Royal Hospital
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Date of inspection visit: 24-27/01/2017, 06/02/2017
Date of publication: 05/07/2017

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

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

Summary of findings

Letter from the Chief Inspector of Hospitals

We carried out an announced inspection 24-27 January 2017 and an unannounced inspection at Gloucestershire Royal on 6 February 2017. This was a focused inspection to follow-up on concerns from a previous inspection. As such, not all domains were inspected in all core services.

The inspection team inspected the following seven core services at Gloucestershire Royal Hospital:

• Urgent and emergency services

• Medical care (including older people's care)

• Surgery

• Maternity and gynaecology

• Services for children's and young people

• End of life care

• Outpatients and diagnostic imaging

We did not inspect the critical care services (previously rated outstanding).

As we did not inspect all services we did not rate Gloucestershire Royal Hospital at this inspection.

Safe

We rated the safe domain as requires improvement in urgent and emergency services, medicine, surgery, maternity and gynaecology and also outpatients and diagnostic imaging. We rated it as good in children's and young peoples and end of life services.

- We had concerns about patient safety, particularly when the emergency department was crowded. Lack of patient flow within the hospital and in the wider community created a bottle neck in the emergency department, creating pressures in terms of space and staff capacity. This in turn increased the risk that patients may not be promptly assessed, diagnosed and treated.
- Crowding was compounded by an acute shortage of staff. There was an acute shortage of middle grade doctors and there were particular concerns raised by medical and nursing staff about medical cover at night. Consultants regularly worked longer hours to support their junior colleagues and there were concerns about whether this could be sustained. Analysis of demand patterns indicated that more senior decision-makers were required at night. The department was not fully staffed with nurses. There were a significant number of nurse vacancies and heavy reliance on bank and agency staff to fill gaps in the rota. The department was not consistently staffed to planned levels, and when the department was crowded staff felt vulnerable because planned safe staff to patient ratios could not be maintained.
- There was no senior (band seven) nurse employed to manage each shift as recommended by the National Institute for Health and Care Excellence (NICE).
- Support staff functions were not adequately resourced. Healthcare assistants performed housekeeping duties, doctors, nurses and managers moved patients, and the nurse coordinator was frequently occupied with administrative duties.
- Crowding in the emergency department meant that ambulance crews were frequently delayed in handing over their patients.

Summary of findings

- Patients were not always assessed quickly on their arrival in the emergency department. Initial assessment (triage) often consisted of a verbal handover from ambulance staff to the nurse coordinator without a face to face assessment of the patient.
- Record keeping was generally poor and we could not be assured that patients received prompt and appropriate assessment, care and treatment. In particular, we were concerned about the recording of observations and the calculation of early warning scores. Patient observations were not always carried out consistently or early enough and early warning scores were not consistently calculated.
- The mental health assessment room did not comply with safety standards recommended by the Royal College of Psychiatrists.
- Within the medical service, not all specialties held regular and structured mortality and morbidity meetings to ensure learning could be identified and shared.
- Staff did not always follow infection control procedures when entering wards and ensuring the cleanliness of equipment such as commodes.
- Wards did not display evidence of when areas such as toilets were last cleaned and we did not see environmental audit result displayed on the wards we visited.
- Staff did not always comply with legislation regarding the Control of Substances Hazardous to Health (COSHH).
- The fabric of the building did not always ensure efficient cleaning could be carried out.
- Daily checking of equipment such as resuscitation equipment was not carried out in all areas in line with the trust's policy.
- Medicines were not always managed correctly. Fridge temperatures were not monitored or actions taken where these fell out of normal range. There were a number of out of date patient group directives (PGD's) in use in maternity services.
- Records were not stored safely to ensure patient confidentiality was maintained at all times.
- Staff did not always assess risks to patients and follow up with mitigating care interventions.
- Nursing staffing levels were below establishment and wards, departments and operating theatres relied on bank and agency to cover shifts every day.
- The trust did not use a recognised tool to assess the acuity of patients daily to ensure safe staffing levels were in place on each shift and particularly at night.
- The number of surgical site infection rates for replacement hips and knees and spinal surgery had increased since our last inspection.
- Mandatory training for all staff was not meeting the trust's target.
- The day unit was being used as an inpatient ward but domestic cover had not been set up for weekends to provide environmental cleaning or drinks to patients.
- There was no cleaning carried out over the weekend in diagnostic imaging, and some outpatient treatment rooms and waiting areas were visibly dirty.
- Staff were finding it difficult to trace patient notes since the introduction of a new computer system, and there was not a reliable system to track the numbers of temporary notes being used since its implementation. There were also some ongoing issues with allocation of baby NHS numbers and records migrating to the new system.
- Some staff were unsure of their responsibilities in a resuscitation situation, and staff in ophthalmology did not know where to locate their nearest defibrillator.
- In some areas, a systematic check of emergency resuscitation trolleys was not documented as having being carried out on a daily basis. There were no up to date Resuscitation Council (UK) guidelines available on the resuscitation trolleys. Intravenous fluids on the emergency resuscitation trolleys were not stored securely to ensure they were tamper evident.
- Community midwives could not always print out clinical notes from the electronic system to go into women's handheld notes. They also reported poor mobile phone coverage which meant there was sometimes a delay in getting messages.

Summary of findings

- Junior doctors in obstetrics did not attend skills drills training when they started at the trust though they did carry an emergency bleep and co0uld be the first to arrive in the delivery.
- There were often long waiting times in the maternity triage area. Women were not seen within 15 minutes of attending the unit.
- Consultant presence, on labour suite, was below the recommendations of the Royal College of Obstetricians and Gynaecologists (RCOG) Safer Childbirth (2007) guidance**.**
- Not all outpatient waiting areas in the hospital had specific children's areas. Areas that were not solely for children's use in other parts of the hospital had waiting areas that were shared with adults.

However:

- Staff understood their responsibilities to raise concerns and report incidents using the electronic reporting system. There was a culture of shared learning from incidents.
- Staff spoke confidently about the duty of candour and gave examples of where it had been applied. Relevant staff had received training.
- Most areas we visited were visibly clean and tidy. Staff were seen adhering to the trusts infection control policies including 'bare below the elbows".
- There was a robust security system in place within the maternity unit, including locked doors, entry systems a baby security tagging system and CCTV.
- There were systems in place for recognising and reporting safeguarding concerns. Staff were confident to raise any matters of concern and escalate them as appropriate.
- There was good access to mandatory training within the maternity service, including skills drills training day and a one-day maternity update.
- The development of a training package for midwives to enable them to administer flu vaccinations to at risk women had meant that a high number of women who would otherwise have not had the flu vaccine had received it.
- The endoscopy unit had safe processes in place to ensure staff decontaminated and sterilised equipment in line with best practice.
- Within the emergency department, there were hourly board rounds undertaken by senior clinicians in the department. This provided an overview of the department's activity and provided an opportunity to identify and communicate safety concerns to the site and trust management teams. Patient safety checklists had been introduced, which provided a series of time-sequenced prompts. There was a well-structured medical staff handover where patients' management plans and any safety concerns were discussed.

Effective

We rated the effective domain as good in urgent and emergency services, surgery and end of life. We rated it as requires improvement in medical care, We did not inspect this domain in maternity and gynaecology or children's and young people's services

- People's care and treatment was mostly planned and delivered in line with current evidence-based guidance and standards.
- There was a range of recognised protocols and pathways in place and compliance with pathways and standards was frequently monitored through participation in national audits. Performance in national audits was mostly in line with other trusts nationally. There was evidence that audit was used to improve performance.
- Within the emergency department, nursing and medical staff received regular teaching and clinical supervision. Staff were encouraged and supported to develop areas of interest in order to develop professionally and progress in their careers.
- Care was delivered in a coordinated and multidisciplinary way.

Summary of findings

- The trust had been identified as a 'mortality outlier' in to relation reduction of fracture of bone (Upper/Lower limb)' procedures, which included fractured hip. However, the actions had implemented had made improvements and these were ongoing at the time of our inspection.
- Staff understood that end of life care could cover an extended period for example in the last year of life or patients and that patients benefited from early discussions and care planning.
- End of life care was delivered with the principles of the Priorities for Care of the Dying Person set out by the Leadership Alliance for the Care of Dying Patient's
- Within end of life care, medicines to relieve pain and other symptoms were available at all times. Wards had adequate supplies of syringe drivers (devices for delivering medicines continuously under the skin) and the medicines to be used with them.

However:

- Pain was not always promptly assessed and managed within the emergency department and we could not be assured that patients' nutrition and hydration needs were consistently assessed or met.
- The trust was not meeting the standard which requires the percentage of patients re-attending (unplanned) the department within seven days to be less than 5%.
- The new computer system was causing issues for staff resulting in 'work around' processes to prevent any risks to patients.
- Staff appraisals were not meeting the trust targets in all areas.
- Theatre utilisation figures were low however; the trust was looking at ways of improving this.
- Documentation relating to patients' mental capacity and consent was not always complete or immediately obvious in 'do not attempt cardio-pulmonary resuscitation' (DNA CPR) records.
- Explanations for the reason for the decision to withhold resuscitation attempts were not consistently clear. Records of resuscitation discussions with patients and their next of kin or of why decisions to withhold resuscitation attempts had been made were not always documented.
- There was no organisational oversight of staff competency with regards to syringe driver training as records were not held centrally.
- There was not a seven day face to face service provided by the in-patient and community end of life care team. The trust provided a face to face service 9-5 Monday to Friday. Out-of-hours there was a telephone advice line available 24 hours, 7 days a week for health care professionals.
- The learning needs of all staff delivering end of life care were not identified.

Caring

We rated the caring domain as good in all the services this domain was inspected (urgent and emergency services, medical care and end of life services).

- All of the patients we spoke with during our inspection commented very positively about the care they received from staff. This was consistent with the results of patient satisfaction surveys, which were mostly positive.
- Patients were treated with compassion and kindness. We saw staff providing reassurance when patients were anxious or confused.
- Patients were treated with courtesy, dignity and respect. We observed staff greeting patients and their relatives and introducing themselves by name and role.
- Patients and their families were involved as partners in their care. They told us they were kept well informed about their care and treatment. We heard doctors and nurses explaining care and treatment in a sensitive and unhurried manner.
- Staff took the time to interact with people who received end of life care and those people close to them in a respectful and considerate manner.

Summary of findings

- Staff and volunteers who worked with the department for spiritual support, bereavement officers and the mortuary were aware of and respectful of cultural and religious differences in end of life care.
- Emotional support for patients and relatives was available through the in-patient and community specialist palliative care team, through clinical psychology, social worker, ward-based nurse specialists and end of life champions, the chaplaincy team and bereavement services.

However:

- The discharge lounge was a mixed sex unit and did not have curtains to screen individual chairs and provide privacy for patients in their pyjamas or when assistance was needed with personal care needs.
- Whilst responses to the friends and family test was positive, response rates were frequently low.

Responsive

We rated the responsive domain as requires improvement in urgent and emergency services, medicine, surgery and outpatients and diagnostic imaging. We rated it as good in end of life services.

- The emergency department was consistently failing to meet the standard which requires that 95% of patients are discharged, admitted or transferred within four hours of arrival at the emergency department.
- Patients frequently spent too long in the emergency department because they were waiting for an inpatient bed to become available. Lack of patient flow within the hospital and in the wider community created a bottleneck in the emergency department, causing crowding.
- Crowding meant patients frequently queued in the corridor, where they were afforded little comfort or privacy. When the department became congested, relatives had to stand because there was insufficient seating.
- Patients with mental health needs were not always promptly assessed or supported, particularly at night time when there was no mental health liaison service. Adolescents who had self-harmed did not receive a responsive service and were frequently inappropriately admitted while awaiting specialist assessment and support.
- There was a lack of an appropriate welcoming space for patients with mental health needs.
- The delivery of cardiology services did not meet the needs of the local population.
- There were delays to discharges, which meant patient flow through the hospital was compromised.
- There was a waiting list for patients requiring an endoscopic procedure.
- The environment did not meet the needs of patients with dementia.
- The trust reported 32 breaches of mixed sex accommodation in the period from January 2016 to October 2016 of which 11 were in the acute medical admissions unit.
- The service was not always compliant with the accessible information standards and information leaflets were not readily available for patients for whom English was not their first language.
- Due to pressure for beds and the demand on services, some patients had to use facilities and premises that were not always appropriate for inpatients. At times of high operational pressure patients were temporary admitted to endoscopy and medical day unit wards however, these were not identified as 'escalation areas' in the inpatient capacity protocol.
- Elective operations were being cancelled due to the pressure on the beds within the trust and medical patients were being cared for on surgical wards to meet the demand.
- Not all patients had their operations re-booked within the 28-day timescale.
- Six patients had been waiting over 52 weeks for treatment, which is not acceptable.
- The hospital was not meeting the 62 day target for cancer patients.
- The diagnostic imaging department had a reporting backlog of 19,500 films and was not meeting its five day reporting target for accident and emergency x-rays.
- A significant typing backlog was causing delays in sending out patient letters impacting on patient safety.
- Implementation of new computer systems had impacted on waiting lists as some specialties could not see live waiting lists.

Summary of findings

- The trust was not meeting referral to treatment target in all specialities.
- There were no designated beds for people receiving care at end of life. Side rooms were used when available but could not be guaranteed.
- The percentage of patients dying in their preferred location and the percentage of patients discharged within 24 hours were not all known for all wards or hospital sites.
- End of life complaints were not always handled promptly and in accordance with trust policy.

However:

- The emergency and urgent care service had a number of admission avoidance initiatives in place to improve patient flow. These included the integrated discharge team who proactively identified and assessed appropriate patients who may be able to be supported in the community rather than admitted to the hospital.
- We saw evidence that complaints were used to drive improvement.
- The emergency department had recently developed a team known as the Gloucestershire elderly emergency care (GEEC), championed by an ED consultant. The aim was to raise awareness of the issues faced by frail elderly patients in the emergency department and to identify areas where the experience of this patient group could be improved.
- Multi-agency management plans had been developed for patients with mental health needs who were frequent attenders in the ED. These enabled staff to better support patients and had resulted in a reduction of both ED attendances and admissions to hospital.
- The trust's referral to treatment time (RTT) for admitted pathways for medical services has been better than the England overall performance.
- The average length of stay was for non-elective patients were better than the England average.
- Staff in theatres and recovery had guidance in place to help reduce the anxiety of patients living with dementia when they using their services.
- Rapid access assessment clinics were provided in some specialities, and some clinics were performing airway assessments via skype.
- The hospital had introduced a new waiting list validation process to discharge patient's ongoing follow up care to community based services such as GPs.
- A project placing therapists on wards had helped increased patient discharges, and radiographers attended ward briefings to identify inpatients waiting for scans.
- The in-patient specialist palliative care team was available to ward staff to provide advice and training regarding communication and end of life care; this included communicating with patients and carers.
- The trust was one of two sites in the country which had been developing a medical examiner role and improved death certification process project since 2008. Benefits included better support for relatives over the explanation and causes of death as well as ensuring better oversight of signing of death certificates
- The specialist palliative care team responded promptly to referrals, usually within one working day.

Well-led

We rated well-led domain as requires improvement in medical care and good in urgent and emergency care and end of life care.

- There was a strong, cohesive and well-informed leadership team within the emergency and urgent care service who were highly visible and respected. The service had a detailed improvement plan in place with clear milestones and accountability for actions.
- The emergency department produced high quality information which analysed demand capacity and patient flow, and was used to inform the improvement plan.
- There were robust governance arrangements in place within the emergency and urgent care service. Clinical audit was well-managed and used to drive service improvement. Risks were understood, regularly discussed and actions taken to mitigate them.

Summary of findings

- There were cooperative and supportive relationships among staff. We observed exceptional teamwork, particularly when the emergency department was under pressure. Here, staff felt respected, valued and supported. Morale was mostly positive, although to an extent was undermined by workload pressures. Service improvement was everybody's responsibility. Staff were encouraged and supported to undertake service improvement projects.
- The leadership and culture of the specialist palliative care team in the trust reflected the vision and values of the trust. Leadership encouraged openness and transparency and promoted good quality care. There were leads on the wards for delivery of end of life care which supported the development of high quality end of life care.
- The trust had a clear vision and strategy to deliver care at end of life linked to national best practice including Priorities for Care of the Dying Person set out by the Leadership Alliance for the Care of Dying Patient's.
- The governance framework for end of life care ensured that responsibilities were clear and that quality, performance and risks were understood and managed.
- Staff felt respected and valued. There was a strong emphasis on promoting the safety and wellbeing of staff delivering end of life care in the community.
- Services within specialist palliative and end of life care had been continuously improved and sustainability supported since the last inspection March 2015.

However:

- Safety concerns which we identified at our last inspection had not been addressed, despite the introduction of new processes. Patient flow remained the major barrier to progress. The emergency department's management team did not feel there was a culture of collective responsibility within the trust in relation to patient flow. There was frustration expressed that the emergency department bore a disproportionate level of risk, while the responsibility for the exit block sat with others. The emergency department was unable to influence the cultural shift which was required to address this significant barrier to improving patient flow and capacity.
- Pressures faced by staff in the emergency department in relation to crowding were well understood and articulated by the management team but it did not appear that the risks relating to staff wellbeing, resilience and sustainability, had been widely shared or escalated within the organisation and they were not included on the department's risk register.
- There was a limited approach to obtaining the views of people who used the service. Workload pressures prevented opportunities for staff reflection or meaningful staff engagement and involvement in shaping the service.
- There was no risk register specific to end of life care for the trust so there was no easy trust wide oversight of risk relating to the service.
- There was a program of internal and national audits for end of life care, which were on time. However most local audit activity had not yet benefited from a thorough analysis of the data produced.
- Within the medical service there was a lack of overview and governance around mortality and morbidity (M&M) meetings. Risks registered on the risk register were not always aligned with risks in the service.
- There was a lack of understanding of the risk to safe patient care, the acuity of patients have on daily basis.

We saw several areas of outstanding practice including:

- The diagnostic imaging department sent radiographers onto wards to liaise with staff to identify inpatients that were waiting for scans, in order to help speed up treatment and ultimately discharge.
- The therapies department had placed occupational therapists and physiotherapists on wards over Christmas to support and speed up patient discharges during a period of high pressure.
- The inpatient specialist palliative care team had won an annual staff award the trust - patient's choice award 2016. This was from patients and others who recognised the NHS staff who had made a difference to their lives.

Summary of findings

- The consultant in the end of life care team was part of a multi-disciplinary team who had won the national Linda McEnhill award 2016. The award was recognition by the Palliative Care of People with Learning Disabilities professional network of excellence in end of life care for individuals with learning disabilities. Work included improving how different teams worked better together.
- The development of a training package for midwives to enable them to administer flu vaccinations to at risk women had meant that a high number of women who would otherwise have not had the flu vaccine had received it.

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

Importantly, the trust must:

- Review processes to monitor the acuity of patients to ensure safe staffing levels.
- Ensure wards are compliant with legislation regarding the Control of Substances Hazardous to Health (COSSH).
- Review processes for ensuring effective cleaning of ward areas and equipment and patient waiting areas.
- Review the governance and effectiveness of care and treatment through participation in national audits.
- Ensure staffing levels meet the acuity of patients.
- Ensure patient records are kept securely at all times.
- Ensure equipment is replaced to ensure safe diagnosis and treatment.
- Ensure the medical day unit is suitable for the delivery of care and protects patients dingy and confidentiality.
- Ensure all staff are trained and understand their responsibilities in a resuscitation situation.
- Ensure resuscitation equipment is readily available and accessible to staff.
- Ensure steps are taken to reduce the current typing backlog in some specialities.
- Ensure specialities have oversight of all of their waiting lists.
- Ensure that all information related to patients' mental capacity and consent for 'Do Not Attempt Cardio-Pulmonary Resuscitation' (DNA CPR) is available in patient records.
- Ensure trust staff comply with all the requirements of the Mental Capacity Act (2005).
- Ensure the emergency department is consistently staffed to planned levels to deliver safe, effective and responsive care.
- Review support staff functions to ensure the emergency department is adequately supported.
- Ensure all staff are up-to-date with mandatory training.
- Ensure patients arriving in the emergency department receive a prompt face-to-face assessment by a suitably qualified clinician.
- Improve record keeping so that patients' records provide a contemporaneous account of assessment, care and treatment.
- Ensure patients in the emergency department receive prompt and regular observations and that early warning scores are calculated, recorded and acted upon.
- Ensure the mental health assessment room in the emergency department meets safety standards recommended by the Royal College of Psychiatrists.
- When using the day surgery unit for inpatients, provision must be made for the cleaning of the units at weekends and to provide patients with clean water jugs and drinks.
- Ensure emergency resuscitation trolleys are checked and have guidelines attached according to best practice guidance and in line with trust policy.
- Ensure the safe management of medicines at all times, including storage, use and disposal and the checking and signed for controlled drugs. Ensure all drug storage refrigerator temperatures are checked and the results recorded daily. Additionally if the temperatures fall outside of the accepted range action is taken and that action recorded.
- Ensure patient group directives are up to date and consistent in their information.
- Ensure women attending the triage unit within the maternity service are seen within 15 minutes of arrival.

In addition the trust should:

Summary of findings

- Ensure all staff are compliant with efficient decontamination of hands on entering wards.
- The medical service should collect information about mortality and morbidity (M&M) meetings electronically across all services to ensure an audit trail is maintained and outputs governed.
- Ensure emergency equipment (including resuscitation trolleys) is checked daily in line with trust policy and national guidance.
- Review processes to recognise and respond to blank boxes on prescription charts to make sure patients receive medicines as prescribed.
- Review the process to assess risks to patients and ensure a management plan is in place.
- Review process to comply with VTE assessment in line with trust policy and national guidelines.
- Ensure treatment pathways are reviewed and update to ensure best evidence-based treatment.
- Ensure all staff receive yearly appraisals in line with trust policy.
- Review process to ensure patients are reviewed by a consultant within 14 hours of admission in line with the London Quality Standards (2013).
- Review processes to ensure compliance with the accessible information standards.
- Ensure areas used to admit patients in times of high organisational pressures are suitable and staffed to ensure safe care and treatment of patients.
- Ensure effective monitoring of clinical improvement and audits, including compliance with accurate and timely NEWS assessments.
- Ensure timely response to complaints in line with trust policy.
- Ensure there are sufficient numbers of staff with appropriate skills and experience on each shift in diagnostic imaging.
- Ensure identification procedures in diagnostic imaging are robust and recorded.
- Ensure all staff are up to date with mandatory training.
- Ensure all patient's referral to treatment times do not exceed national targets including cancer wait targets.
- Ensure steps are taken to reduce the current reporting backlog.
- Ensure diagnostic imaging examinations are reported within target for the accident and emergency department.
- Ensure steps are taken to monitor and reduce the numbers of temporary notes in use.
- Ensure all hazardous chemicals and cleaning products are securely stored.
- Review facilities for staff to take breaks and make drinks away from clinical areas
- Ensure staff can effectively trace patient records through the hospital.
- Ensure disabled toilets have sufficient alarm systems.
- Ensure all risk identified relating to the provision of end of life care is included on a risk register.
- Ensure the training needs analysis for general staff on wards related to end of life care is completed by the trust end of life care quality group
- Consider involving specialist palliative care team and support teams in major incident plan practices or exercises.
- Review the signage and consider if the system of using 'white rose' symbols to assist location of trust mortuaries is effective
- Ensure specialist palliative care team are able to use the results of the safety thermometer information in relation to patients receiving end of life care.
- Continue to work in collaboration with partners and stakeholders in its catchment area to improve patient flow within the whole system, thereby taking pressure off the emergency department, reducing crowding and the length of time patients spend in the department.
- Ensure the emergency department is supported by the wider hospital and that there is more engagement from specialties in addressing the risks associated with patient flow.
- Ensure the workload pressures and impact on staff wellbeing, associated with crowding in the emergency department, are understood, identified on the risk register and that staff are supported as appropriate.
- Ensure all staff within the specialities is aware of Never Events and the learning needed to prevent a reoccurrence.
- Continue to make improvements with the reduction of surgical site infection rates.

Summary of findings

- Review the pre admission clinic area for comfort and suitability
- Provide resuscitation equipment for the pre admission unit to ensure if a patient collapsed, they receive the correct care in a timely manner.
- Review the equipment in the pre-admission unit to ensure it meets the needs of the service.
- Patient group directions (PGDs) should be reviewed as they were out of date and the correct authorisation signatures should be included.
- Continue to work on your action plan to address the shortfalls identified in the mortality outliers.
- Review the lack of 24-hour emergency theatre to ensure no patients will be put at risk.
- Continue to address issues resulting from the new computer system.
- Improve the number of staff appraisals completed.
- Reduce the number of patients who have their operation cancelled on the day of surgery, and reduce the number of patients not rebooked within 28 days.
- Ensure emergency trolleys on the neonatal and children's units have a system that easily highlights if an emergency trolley has been tampered with between routine checks.
- Support all children's services to contribute to infection prevention and control audits so that risk can be accurately assessed.
- Consider options of protecting children's safety when waiting for appointments in parts of the hospital that are not dedicated to paediatrics.
- Continue with strategies to maintain staffing levels that meet national guidelines.
- The trust should ensure electronic systems in place, especially for community midwives, enable them to input data in a timely way. Additionally they should have mobile phones with better connectivity to ensure they receive their messages in a timely way.
- The trust should ensure that all inpatient venous thromboembolism (VTE) risk assessments are completed.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services	Requires improvement 	We have rated this service as requires improvement overall because:

- We had concerns about patient safety, particularly when the department was crowded, which was a regular and frequent occurrence. Capacity was compromised because ED attendances were increasing, both in numbers and in terms of patient acuity. Lack of patient flow within the hospital and in the wider community created a bottle neck in the ED, creating pressures in terms of space and staff capacity. This in turn increased the risk that patients may not be promptly assessed, diagnosed and treated.
- Crowding was compounded by a significant shortage of staff. There were particular concerns with regard to the lack of senior decision makers at night. Consultants were regularly working additional hours to support more junior colleagues at night. Support staffing was also under-resourced, putting more pressure on clinical staff.
- The trust was consistently failing to meet the national standard which requires that 95% of patients are discharged, admitted or transferred within four hours of arrival at the emergency department. A significant number of four hour breaches were attributed to a shortage of inpatient beds. The trust was not meeting the standard which required that patients are reviewed by a doctor within one hour.
- Patients were not consistently assessed promptly on arrival and in some cases a face to face assessment did not take place for some time. Ongoing monitoring of patients was not undertaken with the required frequency. This meant there was a risk that seriously unwell or deteriorating patients may not be identified and managed promptly.
- Patients' records were not consistently completed to provide an accurate record of care and treatment provided. Record keeping was

Summary of findings

notably worse when the department was crowded. Records did not assure us that patients regularly had their pain or their skin integrity assessed or had been offered food and drink.

- Patients waited too long in the emergency department after the decision had been made to admit them to an inpatient bed. Patients regularly queued in the corridors in the emergency department and their relatives sometimes had to stand because there was insufficient seating. Despite the efforts of staff, patients' comfort and dignity could not be maintained in the corridor.
- Patients who attended the emergency department with mental health needs did not always access prompt assessment and support from mental health practitioners, particularly if they attended out of hours. Although there was a designated mental health assessment room, it did not comply with safety standards and was not a welcoming space.
- Pressures faced by staff in the emergency department in relation to crowding were well understood and articulated by the management team. However, it did not appear that the risks relating to staff wellbeing, resilience and sustainability had been widely shared or escalated within the organisation and they were not included on the department's risk register.
- Safety concerns which we identified at our last inspection had not been addressed, despite the introduction of new processes. Poor patient flow remained the major barrier to progress. The emergency department's management team did not feel there was a culture of collective responsibility within the trust in relation to patient flow. There was frustration expressed that the emergency department bore a disproportionate level of risk, while the responsibility for the exit block sat with others. The emergency department was unable to influence the cultural shift which was required to address this significant barrier to improving patient flow and capacity.

However:

Summary of findings

- The emergency department was taking steps to mitigate the risks associated with crowding. Hourly board rounds conducted by senior clinicians provided an overview of activity and provided an opportunity to identify and communicate safety concerns to the site and trust management teams.
- A patient safety checklist had been introduced, which provided a series of time-sequenced prompts for staff to undertake risk assessments, observations, tests and treatments. However, the use of this documentation was yet to be embedded in practice and was not consistently completed.
- There were few serious incidents reported in urgent and emergency care. We saw good evidence that when incidents occurred, lessons were learned and improvements were made. There was openness and transparency about safety. Staff were familiar with their responsibilities under the Duty of Candour regulation.
- There were effective processes in place for the identification and management of adults and children at risk of abuse and staff were familiar with these.
- There was a range of recognised treatment protocols and care pathways. Compliance with pathways and standards was monitored through participation in national audits. Performance in national audits was mostly in line with other trusts nationally. There was evidence that audit was used to improve performance, for example in the treatment of sepsis.
- Nursing and medical staff received regular teaching and clinical supervision. Staff were encouraged and supported to develop areas of interest in order to develop professionally and progress in their careers.
- Care was delivered in a coordinated way with support from specialist teams and services, such as the stroke team. There was a range of admission avoidance initiatives in place to improve patient flow. These included the discharge assessment team, the older people's assessment and liaison service, the mental

Summary of findings

health liaison service and the alcohol liaison service, who all worked closely and collaboratively with the emergency department. The clinical commissioning group had also commissioned a pilot whereby GPs worked in the ED on weekdays and appropriate patients were streamed to see either a GP or an advance nurse practitioner.

- The emergency department had recently developed a team known as the Gloucestershire elderly emergency care (GEEC), championed by an ED consultant. The aim was to raise awareness of the issues faced by frail elderly patients in the emergency department and to identify areas where the experience of this patient group could be improved.
- Multi-agency management plans had been developed for patients with mental health needs who were frequent attenders in the ED. These enabled staff to better support patients and had resulted in a reduction of both ED attendances and admissions to hospital.
- Complaints were listened to and acted upon. There was evidence that changes and improvements had been made in response to complaints.
- All of the patients we spoke with during our inspection commented very positively about the care they received from staff. This was consistent with the results of patient satisfaction surveys, which were mostly positive.
- Patients were treated with compassion and kindness. We saw staff providing reassurance when patients were anxious or confused.
- Patients were treated with courtesy, dignity and respect. We observed staff greeting patients and their relatives and introducing themselves by name and role.
- Patients and their families were involved as partners in their care. We heard doctors and nurses explaining care and treatment in a sensitive and unhurried manner.
- There was a strong, cohesive and well informed management team who were highly visible and respected.

Summary of findings

- There was an effective governance framework. Information was regularly monitored to provide a holistic understanding of performance, which included safety, quality and patient experience. Risks were understood, regularly discussed and actions taken to mitigate them.
- The emergency department had developed an improvement plan with clear milestones and accountability for actions.
- Staff morale was mainly positive, although this had been somewhat overshadowed by crowding and the pressures this placed on staff. Staff nevertheless felt valued and supported.
- There were cooperative and supportive relationships among staff. We observed exceptional teamwork, particularly when the department was under pressure.
- There was a strong focus on learning and improvement. Clinical audit was well managed and used to drive improvement. Mistakes were openly discussed and learning acted upon. Staff at all levels were encouraged to play their part in improving patient experience.

Medical care (including older people's care)

Requires improvement

We rated this service as requires improvement because:

- Nursing staffing levels were below establishment and wards relied on bank and agency to cover shifts every day.
- Theservice did not assess or record the acuity of patients on each shift and on each ward to ensure safe staffing levels.
- The medical service did not consistently review the effectiveness of care and treatment through national audits.
- The service had a strategy to understand and improve performance on hospital-based mortality indicators. While most specialities held mortality and morbidity (M&M) meetings monthly or quarterly we were concerned that not all specialties held meetings regularly and how effectively learning was shared.
- There were some concerns about the safe transfer of patients receiving intravous therapy during ambulance transfers to other hospitals.

Summary of findings

- Staff did not always follow infection control procedures when entering wards and ensuring the cleanliness of equipment such as commodes.
- Staff did not always comply with legislation regarding the Control of Substances Hazardous to Health (COSHH).
- Daily checking of equipment such as resuscitation equipment was not carried out in line with the trust's policy in all areas.
- Staff did not monitor fridge temperatures consistently or take actions where these fell out of normal range, which meant medicines were not always stored correctly.
- Staff were unsure of when to dispose of some medicines in line with manufacturer's recommendations.
- Records were not stored safely to ensure patient's confidentiality was maintained.
- Staff did not always assess risks to patients or follow up identified risks with mitigating care interventions.
- The medical service did not consistently review the effectiveness of care and treatment through national audits.
- Staff did not always put actions in place when patients were at risk of malnutrition.
- Compliance with annual appraisals were below the trust's target.
- There were delays in discharging patients; although this was largely caused by factors outside of the medical services remit.
- Information was not always accessible to staff including information about care and treatment pathways.
- The delivery of cardiology services did not meet the needs of the local population.
- There were delays to discharges, which meant patient flow through the hospital was compromised.
- The environment did not meet the needs of patients with dementia.

Summary of findings

- The service was not always compliant with the accessible information standards and information leaflets were not readily available for patients for whom English was not their first language.
- Risks registered on the risk register were not always aligned with risks in the service
- There was a limited approach to obtaining the views of patients and their relatives

However:

- Staff understood their responsibility to report incidents and there were processes in place to review incidents and ensure learning was shared across the trust.
- The endoscopy unit had safe processes in place to ensure staff decontaminated and sterilised equipment in line with best practice.
- Staff were aware of their responsibilities for identifying and reporting safeguarding issues.
- There were safe processes in place to review patients and ensure care and treatment plans were followed up.
- Patients were positive about the way they were treated and cared for in the medical wards. Where staff were observed treating patients with kindness, dignity, respect and compassion.
- Patients praised staff for providing further information when asked.
- There was a competence training and assessment framework in place to ensure nurses were competent to carry out extended skills and nursing staff were supported with revalidation processes.
- There was an effective framework for 'board round' and ward rounds and included input from staff from the multidisciplinary healthcare team.
- Processes were in place to ensure consultants reviewed patients seven days a week.
- Staff were aware of the mental capacity assessment and applications for deprivation of liberty safeguards.
- The trust's referral to treatment time (RTT) for admitted pathways for medical services was better than the England overall performance between November 2015 and October 2016.

Summary of findings

- The trust had a clear vision and some specialities within the medical division had a vision to expand and improve services.
- Staff felt supported by managers and senior management felt assured by the new executive team.

Surgery

We did not rate this service as we did not inspect all domains. However, we found:

- Since our inspection in March 2015, the number of surgical site infection rates had increased for replacement hips, knees, and spinal surgery.
- There had been two never events reported in surgery since our last inspection. These had been investigated and actions taken to prevent these happening again.
- Storage for patients' notes on some wards and units was not secure, which meant unauthorised people could have had access to these confidential records.
- Mandatory training for all staff was not meeting the trust's target.
- The surgical division was not meeting the trust's target for staff appraisals.
- Due to pressure for beds and the demand for services, some patients had to use facilities and premises that were not always appropriate for inpatients and support services were not always set up and staff did not know how to set them up.
- Elective operations were being cancelled due to the pressure on the beds within the trust, and surgical wards were being used to accommodate medical patients.
- The trust had introduced a new computer system prior to our inspection that was causing some issues for staff resulting in 'work around' processes to prevent any risks to patients.

However:

- The service encouraged openness and transparency from staff with incident reporting, and incidents were viewed as a learning opportunity. Staff felt confident in raising concerns and reporting incidents.

- The trust had been identified as a 'mortality outlier' in to relation Reduction of fracture of bone (Upper/Lower limb)' procedures, which included fractured hip. However, the actions they had implemented had made improvements and these were ongoing at the time of our inspection. For example, in the 2016 hip fracture audit which had shown an improvement on 2015 audit
- Training in safeguarding of adults and children had met the trust target for completion.

Maternity and gynaecology

We did not rate this service as we did not inspect all domains. However, we found:

- All areas had access to emergency resuscitation trolleys. However, in some areas, a systematic check of the trolleys was not documented as having being carried out on a daily basis. There were no up to date Resuscitation Council (UK) guidelines available on the resuscitation trolleys. Intravenous fluids on the emergency resuscitation trolleys were not stored securely to ensure they were tamper proof. This meant staff could not be assured the right equipment and guidance would be available in the case of an emergency.
- Not all drug storage fridge temperatures were documented daily. There was no process in place if a temperature fell outside of acceptable limits. This meant staff could not be assured medicines requiring refrigeration were being stored at the required temperatures.
- There were a number of out of date patient group directives (PGD's) in use in maternity services. The lists of medicines that were subject to PGD's had no doses or route of administration detailed on them. We drew this to the attention of senior staff and the PGD's were removed from use.
- Community midwives could not always print out clinical notes from the electronic system to go into women's handheld notes. They also reported poor mobile phone coverage which meant there was sometimes a delay in getting messages. This could have an impact on a woman who was trying to get some help or advice from a midwife.

Summary of findings

- An electronic patient record system had been introduced trust wide in December 2016. There were some ongoing issues with allocation of baby NHS numbers and records migrating to the new system. This meant that babies may miss out on vital tests following birth. Midwives had devised solutions to ensure each baby had an NHS number.
- Senior House Officers (SHO) did not attend skills drills training when they started at the trust. Those that spoke to us said whilst they did not cover the delivery suite they did carry an emergency bleep and if they arrived in the delivery suite first they often felt out of their depth.
- There were often long waiting times in the triage area. Whilst systems were being put in place to increase medical and midwifery staffing, women were not seen within 15 minutes of attending the unit. This could mean that urgent issues may be missed.
- Consultant presence, on labour suite, was below the recommendations of the Royal College of Obstetricians and Gynaecologists (RCOG) Safer Childbirth (2007) guidance**.**
- Speciality trainee doctors (ST3 and ST4) and some consultants felt that a senior house officer equivalent was needed at night as sometimes no other medical staff to assist with emergency caesarean sections were available. This also meant other patients, across maternity and gynaecology services, who needed to see a doctor sometimes had to wait for long periods of time.
- The morning medical handover was informal and there was no input from the co-ordinating midwife about the women in labour at the time of the meeting. The registrar who had been on duty overnight presented the cases but said they were often tired and did not always have the full up to date details of the women. This may mean that the most up to date information is not being given to the next staff coming on duty.

However:

Summary of findings

- Staff understood their responsibilities to raise concerns and report incidents using the electronic reporting system. There was a culture of shared learning from incidents.
- Staff spoke confidently about the duty of candour and gave examples of where it had been applied. Relevant staff had received training.
- All areas we visited were visibly clean and tidy. There were antibacterial hand sanitizers at the entrances to each unit/ward. Staff were seen adhering to the trusts infection control policies including 'bare below the elbows". This meant people visiting the maternity services were protected from the spread of infection.
- All rooms on the delivery suite, including the triage area had wireless cardiotochograph (CTG) machines for monitoring the foetal heart. The CTG machines were linked to a central monitor point, which allowed the co-ordinating midwife to review traces. The wireless aspect meant women could still be monitored whilst in a birthing pool.
- Doors into all wards/units were locked, with a buzzer entry system and CCTV. Although reception areas were not manned 24 hours per day; when there was no receptionist other staff on duty took on the role. A baby security tagging system was in place on the maternity unit.
- There were systems in place for recognising and reporting safeguarding concerns. Staff were confident to raise any matters of concern and escalate them as appropriate.
- A 'vulnerable women's team' had been developed that included a full time perinatal mental health midwife, substance misuse and teenage pregnancy midwife and the lead safeguarding midwife. The team were able to offer an enhanced service to those women identified as being at risk. The team also offered advice and support to midwives who had concerns.
- Staff said there was good access to mandatory training. Mandatory training for maternity

Summary of findings

services included a PROMPT (Practical Obstetric Multi-Professional Training) skills drills training day and a one-day maternity update for staff working within the maternity unit.

- The maternity services offered Birth Choices Clinic for women identified as being high risk but who requested midwife-led care. They were seen by a supervisor of midwives and a complex care plan devised in agreement with the woman and in discussion with an obstetrician.
- The service had a commitment to managing women's peri-natal mental health issues and were trying to establish a team to include a consultant psychiatrist.
- The development of a training package for midwives to enable them to administer flu vaccinations to at risk women had meant that a high number of women who would otherwise have not had the flu vaccine had received it.
- The gynaecology ward had been relocated, in December 2016, to a ward with less beds (20 beds to 13 beds) to reduce the incidence of outlying patients (that is patients from medical or surgical wards) which sometimes meant elective gynaecology surgery had to be cancelled. The ward sister said the number of outliers had reduced significantly and as a result there were less elective gynaecology procedures being cancelled.
- The clinical scorecard between April 2016 and November 2016 showed that staff were providing one-to-one care in labour 98% of the time.
- A telephone triage system staffed by midwives was located within an ambulance service hub. Midwives directed women to the most appropriate place for their care. The system had reduced the volume of calls directly to the triage area.
- There was 24-hour consultant on-call cover. The delivery suite had access to anaesthetists 24 hours a day, seven days a week. Doctors we spoke with said that consultants always came in at night if they were asked to.

Summary of findings

Services for children and young people

We did not rate this service as we did not inspect all domains. However, we found:

- There was an open reporting culture by staff who worked in the children's services. This helped to maintain the safety of treatment and care for babies, children and young people.
- There was evidence to show incidents, concerns or trends were investigated for learning opportunities and actions taken to improve practice.
- Staff understood their roles and responsibilities to safeguard children from potential risks or abuse and received supervision on a regular basis. The trust's safeguarding teams worked with community and social care colleagues to identify and support children who may be at risk.
- Systems for staff shift handovers promoted the safety of children. Staff were fully included in processes and encouraged to contribute.
- Records showed electrical and mechanical equipment was regularly maintained to ensure it was safe to use and review dates were clearly indicated.
- Risk assessments were used with all children to identify the level of care they needed. These were audited regularly to check they had been completed correctly and concerns had been escalated for further advice where necessary.
- Staffing levels were regularly reviewed and planned to follow national guidelines and standards. However, staffing levels had been challenged with unexpected staff absences. Managers were taking steps to fill gaps in the short term, recruit staff on a permanent basis and maintain staffing levels.

However:

- Compliance with audit processes for infection prevention and control was variable across the children's services and had not been consistently completed.
- Routine stock checks of some medicines were not always completed according to the trust protocol.

Summary of findings

End of life care

Good

We rated this service as Good because:

- End of life care provided at Gloucestershire Royal Hospital was safe, effective caring, responsive and well led because:
- The processes in place to keep people safe for end of life care were good. Staff in the end of life care team and other areas understood their responsibilities to raise concerns, record safety incidents and report them. Lessons were learned and improvements were made when things went wrong.
- Patient's records demonstrated that nutrition and hydration needs were assessed and appropriate actions were documented as followed in patients' individual care plans.
- Records documented discussions with relatives around what to expect with the dying process.
- Risks to patient's receiving care at end of life were assessed by ward staff with appropriate assessments recorded in medical records for example the prevention and management of pressure ulcers and falls.
- Staff we spoke with on the wards understood that end of life care could cover an extended period for example in the last year of life and also applied to patients with non-cancer diagnoses such as dementia. Staff, teams and services worked together to deliver effective care and treatment.
- Staff we observed on wards and in the community delivering end of life care to patients were compliant with key trust policies such as infection control.
- Arrangements in place for managing medicines kept patients safe. Medicines to relieve pain and other symptoms were available at all times. Wards had adequate supplies of syringe drivers (devices for delivering medicines continuously under the skin) and the medicines to be used with them.
- There were reliable systems, processes and practices in place to keep patients safe and safeguarded from abuse.
- The staffing levels and skill mix of the nurse and medical personnel in the specialist palliative care team were planned and reviewed and

Summary of findings

supported safe practice. We saw evidence of a yearly education programme of end of life care for medical, nursing and allied health professionals. This included: resuscitation, syringe driver training, quarterly end of life study days and symptom management.

- The specialist palliative care team responded promptly to referrals, usually within one working day.
- Patients were treated with kindness, dignity, respect and compassion. Staff took the time to interact with people who received end of life care and those close to them in a respectful and considerate manner.
- We saw many written compliments about how caring staff were in the inpatient and community specialist palliative care team. We saw that patients' and those people close to them, were involved as partners in their care.
- The specialist palliative care team and wards staff understood the impact a patients' care, treatment or condition had on their wellbeing and on those people close to them.
- Emotional support for patients and relatives was available through the in-patient and community specialist palliative care team, the chaplaincy team and bereavement services. Staff had access to support through their own teams when needed.
- Services were delivered and additional services planned in order to effectively meet patient's needs. Plans and actions included audit to inform future planning so that the end of life team could inform better decision making with patients they cared for
- The bereavement office was one of two sites in the country involved in a pilot project to improve death certification which was more supportive to bereaved relatives and provided better oversight of causes of death.
- There was a clear vision and strategy to deliver care at end of life. The governance framework for end of life care ensured that responsibilities were clear and that quality, performance and risks were understood and managed.

Summary of findings

- Leadership encouraged openness and transparency and promoted good quality care. There were leads on the wards who supported the development and delivery of high quality end of life care.
- Services within specialist palliative and end of life care had been continuously improved and sustainability supported since the last inspection March 2015.

However:

- Documenting 'Do Not Attempt Cardio-Pulmonary Resuscitation' (DNACPR) decisions had improved since the last inspection however concerns regarding DNACPR remained. For example not all DNACPR having relevant clinical information and not all patients or those close to them being recorded as involved in discussions about resuscitation. These concerns were not identified as a risk and did not feature on a risk register
- There were no centrally held training records for syringe driver training or competency for ward staff.
- There was not a full understanding of performance for all aspects of end of life care. For example the percentage of patients dying in their preferred location and the percentage of patients discharged within 24 hours were not known for all wards or hospital sites.
- There was no risk register specific to end of life care for the trust so oversight of all end of life risk was not easy.
- When we reviewed maintenance records some provided were out of date. The trust told us they were clear that equipment listed was not in use. We saw email communication from directors supporting this.
- There was not a seven day face to face service provided by the in-patient and community end of life care team. The trust provided a face to face service 9-5 Monday to Friday. Out-of-hours there was a telephone advice line available 24 hours, 7 days a week for health care professionals to access.

- Some of the 'white rose' symbols used to locate the mortuary at the hospital were not easy to follow. Signs were not always at eye level for someone walking or in a wheelchair and there were long gaps in signage that led to confusion. Mortuary and bereavement officers told us relatives had commented they were useful. Some relatives had reported they appreciated these signs. However bereavement office staff accompanied relatives when they knew people were attending the mortuary.

Outpatients and diagnostic imaging

We did not rate this service as we did not inspect all domains. However, we found:

- The service did not have sufficient arrangements to keep clinical and patient areas clean. There was no cleaning carried out over the weekend in diagnostic imaging, and some outpatient treatment rooms and waiting areas were visibly dirty.
- There was not a reliable system to track the number of temporary notes being used since the implementation of a new computer system, and staff were finding it difficult to trace patient notes.
- There were not sufficient arrangements to ensure staff had access to or knew where to access emergency equipment. Some staff were unsure of their responsibilities in a resuscitation situation, and staff in ophthalmology did not know where to locate their nearest defibrillator.
- Patients were not protected from avoidable harm in the therapies department as cleaning chemicals were not stored securely.
- The hospital was not meeting the 62 day waiting list target for cancer patients.
- Patients were experiencing delays in diagnosis and treatment because the diagnostic imaging department had a reporting backlog of 19,500 films, and was not meeting its five day reporting target for accident and emergency x-rays.
- A significant typing backlog was causing delays in sending out patient letters impacting on patient safety, diagnosis and ongoing treatment.

Summary of findings

- Implementation of new IT systems had impacted on waiting lists as some specialties could not see their live waiting lists.
- The trust was not meeting referral to treatment target in all specialities, and patients were waiting longer for to access care and treatment.

However;

- Incident reporting had improved and in one case the trauma and orthopaedic department to take steps to reduce pressure ulcers. Staff confirmed they now received feedback from incidents they reported.
- The diagnostic imaging department conducted investigations and had raised safety alerts with an equipment manufacturer which had resulted in changes to practice.
- Cleaning and infection control procedures had improved in ophthalmology since the last inspection, and there were good decontamination processes in other outpatient departments for equipment that was re-useable.
- Diagnostic imaging were negotiating one cost service and maintenance contracts for scanners and equipment.
- Patient were able to access services when they needed to and rapid access assessment clinics were provided in some specialities, and some clinics were performing airway assessments via skype.
- The hospital had introduced a new waiting list validation process to discharge patients' ongoing follow up care to community based services such as GPs.
- A project placing therapists on wards had helped increase patient discharges, and radiographers attended ward briefings to identify inpatients waiting for scans.

Gloucestershire Royal Hospital

Detailed findings

Services we looked at

<Delete services if not inspected> Urgent and emergency services; Maternity (community services); Maternity (inpatient services); Surgery (gynaecology); Spinal injuries centre; Medical care (including older people's care); Surgery; Specialist burns and plastic services; Critical care; Maternity and gynaecology; Services for children and young people; End of life care; Outpatients and diagnostic imaging; Chemotherapy; Radiotherapy; Renal; Elective orthopaedic centre; Sexual health services; Adult solid tumours; Haematology; Specialised rehabilitation

Detailed findings

Contents

Background to Gloucestershire Royal Hospital

Gloucestershire Hospitals NHS Foundation Trust provides acute hospital services to a population of around 612,000 people in Gloucestershire and the surrounding areas.

The trust has three main locations that are registered with the Care Quality Commission (CQC), which are Gloucestershire Royal Hospital, Cheltenham General Hospital and Stroud Maternity Hospital. There are 1,075 beds across these three hospitals. There are 683 beds at Gloucestershire Royal Hospital.

The trust was formed in 2002 with the merger of Gloucestershire Royal and East Gloucestershire NHS Trusts, and became an NHS foundation trust in July 2004.

The health of people in Gloucestershire is generally better than the England average. Deprivation is lower than average, however about 13.8% (14,600) of children live in poverty. Life expectancy for both men and women is higher than the England average. Life expectancy is 7.8 years lower for men and 6.3 years lower for women in the most deprived areas of Gloucestershire than in the least deprived areas.

In the latest financial year, 2015/16, the trust had an income of £498.9 million, and costs of £494.3 million, meaning it had a surplus of £4.6 million for the year. At the time of inspection, the trust predicted it would have a deficit of £18.7 million in 2016/17.

Activity and patient throughput. In 2015/16 the trust as a whole had:

- 127,369 A&E first attendances
- 114,328 Inpatient spells (51,932 non-elective, 62,396 elective)
- 451,771 Outpatient attendances
- 6,388 births
- 2,067 referrals to the specialist palliative care team

This was a focused inspection to follow-up on concerns from a previous inspection. As such, not all domains were inspected in all core services.

The inspection team inspected the following seven core services at Gloucestershire Royal Hospital:

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

Detailed findings

Our inspection team

Our inspection team was led by:

Chair: Anthony Berendt, Medical Director, Oxford University Hospitals NHS Foundation Trust

Head of Hospital Inspections: Mary Cridge, Head of Hospital Inspections, Care Quality Commission

The team included CQC inspectors and a variety of specialists: directors of nursing and governance, consultants and medical staff from medicine, surgery, emergency services, paediatrics, a junior doctor; a senior midwife; senior nurses in paediatrics, medicine, surgery, theatres, care of the elderly and palliative care. The team also included one expert by experience, analysts and an inspection planner.

How we carried out this inspection

Before visiting, we reviewed a range of information we held and asked other organisations to share what they knew about Gloucestershire Royal Hospital. These included the local clinical commissioning group, NHS Improvement, the local council, Gloucestershire Healthwatch, mental health and community partner organisations, the General Medical Council, the Nursing and Midwifery Council and the royal colleges.

People who used the services were able to share their experiences by email and telephone and on our website. We also collected feedback from patients and relatives on comment cards during the inspection.

We carried out an announced inspection 24-27 January 2017 and an unannounced inspection at Gloucestershire Royal on 6 February 2017. We held focus groups and drop-in sessions with a range of staff including nurses, junior doctors, consultants, student nurses, administrative and clerical staff, physiotherapists, occupational therapists, pharmacists, domestic staff, porters and maintenance staff. We also spoke with staff individually as requested.

We talked with over 180 staff and 60 patients. We observed how people were being cared for, talked with carers and family members, and reviewed over 60 patients' records of their care and treatment.

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

Facts and data about Gloucestershire Royal Hospital

Gloucestershire Hospitals NHS Foundation Trust provides acute hospital services to a population of around 612,000 people in Gloucestershire and the surrounding areas.

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Detailed findings

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Between Q1 2015/16 and Q2 2016/17, the trust's bed occupancy has been consistently higher than the England average by 2 to 8%. This was above the level, 85%, at which it is generally accepted that bed occupancy can start to affect the quality of care provided to patients and the orderly running of the hospital.

The executive team had recently undergone a period of significant change having been a previously stable and longstanding board. The previous chief executive retired in April 2016 having been chief executive since 1 May 2008. The new chief executive took up their role in June 2016. A new chairman joined the trust in November 2016. The finance director and two non-executive directors stood down in September 2016. The two non-executive directors had been replaced at the time of the inspection. There was an interim chief operating officer and an interim finance director in post.

CQC inspection history

Gloucestershire Hospitals NHS Foundation Trust has had a number of inspections since first registering with CQC. The last inspection occurred in March 2015 and was a full announced comprehensive inspection.

Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Good	Good	Requires improvement	Good	Requires improvement
Medical care	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Surgery	Requires improvement	Good	N/A	Requires improvement	N/A	N/A
Maternity and gynaecology	Requires improvement	N/A	N/A	N/A	N/A	N/A
Services for children and young people	Good	N/A	N/A	N/A	N/A	N/A
End of life care	Good	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Requires improvement	N/A	N/A	Requires improvement	N/A	N/A
Overall	Requires improvement	N/A	N/A	N/A	N/A	N/A

Urgent and emergency services

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

Information about the service

Urgent and emergency care and treatment is provided at Gloucester Royal Hospital (GRH) by the unscheduled care service, which forms part of the medical division. There is an Emergency Department (ED), otherwise known as the Accident & Emergency Department, which operates 24 hours a day, seven days a week. The ED saw 81,884 patients in 2015/16, of which 15,256 were children (under 17 years of age). Trust-wide, the proportion of ED attendances that resulted in a hospital admission was 33.5%, which was slightly higher than the previous year and significantly higher than the England average (22.2%). This may indicate that the department sees more acutely unwell patients.

The ED is designated as a trauma unit and provides care for all but the most severely injured trauma patients, who would usually be taken by ambulance to the major trauma centre in Bristol if their condition allows them to travel directly. If not, they may be stabilised at GRH and either treated or transferred as their condition dictates. The department is served by a helipad.

ED patients receive care and treatment in two main areas; minors and majors. Self-presenting patients with minor illness or injury are assessed and treated in the minors' area. There is a GP present in the department on some weekdays who sees people with minor illness. There are two waiting areas; one for adults and a second smaller area for children. Patients with serious injury or illness who arrive by ambulance are seen and treated in the majors' area, which includes a four bay resuscitation room. The majors' area is accessed by a dedicated ambulance entrance and the resuscitation room is located just inside this entrance.

This was a follow-up inspection to assess the progress made by the trust following our last comprehensive inspection, which took place in March 2015. Urgent and emergency services at that time were rated as 'requires improvement' overall.

We visited the department over one and a half weekdays as part of our announced inspection. We returned unannounced for a further day. We spoke with approximately 20 patients and relatives. We spoke with staff, including nurses, doctors, managers, therapists, support staff and ambulance staff. We observed care and treatment and looked at care records. We received information from people who completed comment cards or contacted us to tell us about their experiences. Prior to and following our inspection, we reviewed performance information about the trust and information from the trust.

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

Emergency and urgent services provided by the trust are located on two hospital sites, the other being

Urgent and emergency services

Cheltenham General Hospital (CGH). Services at CGH are reported on in a separate report. However, services on both hospital sites are run by one management team and within the trust are largely regarded as one service, with some staff rotating between the two sites. For this reason it is inevitable that there is some duplication contained in the two reports.

Summary of findings

We have rated this service as requires improvement overall because:

- We had concerns about patient safety, particularly when the department was crowded, which was a regular and frequent occurrence. Capacity was compromised because ED attendances were increasing, both in numbers and in terms of patient acuity. Lack of patient flow within the hospital and in the wider community created a bottle neck in the ED, creating pressures in terms of space and staff capacity. This in turn increased the risk that patients may not be promptly assessed, diagnosed and treated.
- Crowding was compounded by a significant shortage of nurses, junior and middle grade doctors. There was a heavy reliance upon bank and agency nursing staff, locums and consultants acting down to shortfalls in junior cover. There were particular concerns with regard to the lack of senior decision makers at night. Consultants were regularly working additional hours to support more junior colleagues at night. Support staffing was also under-resourced, putting more pressure on clinical staff.
- The trust was consistently failing to meet the national standard which requires that 95% of patients are discharged, admitted or transferred within four hours of arrival at the emergency department. A significant number of four hour breaches were attributed to a shortage of inpatient beds. The trust was not meeting the standard which required that patients are reviewed by a doctor within one hour.
- Patients were not consistently assessed promptly on arrival and in some cases a face to face assessment did not take place for some time. Ongoing monitoring of patients was not undertaken with the required frequency. This meant there was a risk that seriously unwell or deteriorating patients may not be identified and managed promptly.
- Patients' records were not consistently completed to provide an accurate record of care and treatment provided. Record keeping was notably worse when

the department was crowded. Records did not assure us that patients regularly had their pain or their skin integrity assessed or had been offered food and drink.

- Patients waited too long in the emergency department after the decision had been made to admit them to an inpatient bed. Patients regularly queued in the corridors in the emergency department and their relatives sometimes had to stand because there was insufficient seating. Despite the efforts of staff, patients' comfort and dignity could not be maintained in the corridor.
- Patients who attended the emergency department with mental health needs did not always access prompt assessment and support from mental health practitioners, particularly if they attended out of hours. Although there was a designated mental health assessment room, it did not comply with safety standards and was not a welcoming space.
- Pressures faced by staff in the emergency department in relation to crowding were well understood and articulated by the management team. However, it did not appear that the risks relating to staff wellbeing, resilience and sustainability had been widely shared or escalated within the organisation and they were not included on the department's risk register.
- Safety concerns which we identified at our last inspection had not been addressed, despite the introduction of new processes. Poor patient flow remained the major barrier to progress. The emergency department's management team did not feel there was a culture of collective responsibility within the trust in relation to patient flow. There was frustration expressed that the emergency department bore a disproportionate level of risk, while the responsibility for the exit block sat with others. The emergency department was unable to influence the cultural shift which was required to address this significant barrier to improving patient flow and capacity.

However:

- The emergency department was taking steps to mitigate the risks associated with crowding. Hourly board rounds conducted by senior clinicians provided an overview of activity and provided an opportunity to identify and communicate safety concerns to the site and trust management teams.
- A patient safety checklist had been introduced, which provided a series of time-sequenced prompts for staff to undertake risk assessments, observations, tests and treatments. However, the use of this documentation was yet to be embedded in practice and was not consistently completed.
- There were few serious incidents reported in urgent and emergency care. We saw good evidence that when incidents occurred, lessons were learned and improvements were made. There was openness and transparency about safety. Staff were familiar with their responsibilities under the Duty of Candour regulation.
- There were effective processes in place for the identification and management of adults and children at risk of abuse and staff were familiar with these.
- There was a range of recognised treatment protocols and care pathways. Compliance with pathways and standards was monitored through participation in national audits. Performance in national audits was mostly in line with other trusts nationally. There was evidence that audit was used to improve performance, for example in the treatment of sepsis.
- Nursing and medical staff received regular teaching and clinical supervision. Staff were encouraged and supported to develop areas of interest in order to develop professionally and progress in their careers.
- Care was delivered in a coordinated way with support from specialist teams and services, such as the stroke team. There was a range of admission avoidance initiatives in place to improve patient flow. These included the discharge assessment team, the older people's assessment and liaison service, the mental health liaison service and the alcohol liaison service, who all worked closely and collaboratively with the emergency department. The clinical commissioning group had also commissioned a pilot whereby GPs worked in the ED on weekdays and appropriate patients were streamed to see either a GP or an advance nurse practitioner.

Urgent and emergency services

- The emergency department had recently developed a team known as the Gloucestershire elderly emergency care (GEEC), championed by an ED consultant. The aim was to raise awareness of the issues faced by frail elderly patients in the emergency department and to identify areas where the experience of this patient group could be improved.
- Multi-agency management plans had been developed for patients with mental health needs who were frequent attenders in the ED. These enabled staff to better support patients and had resulted in a reduction of both ED attendances and admissions to hospital.
- Complaints were listened to and acted upon. There was evidence that changes and improvements had been made in response to complaints.
- All of the patients we spoke with during our inspection commented very positively about the care they received from staff. This was consistent with the results of patient satisfaction surveys, which were mostly positive.
- Patients were treated with compassion and kindness. We saw staff providing reassurance when patients were anxious or confused.
- Patients were treated with courtesy, dignity and respect. We observed staff greeting patients and their relatives and introducing themselves by name and role.
- Patients and their families were involved as partners in their care. We heard doctors and nurses explaining care and treatment in a sensitive and unhurried manner.
- There was a strong, cohesive and well informed management team who were highly visible and respected.
- There was an effective governance framework. Information was regularly monitored to provide a holistic understanding of performance, which included safety, quality and patient experience. Risks were understood, regularly discussed and actions taken to mitigate them.
- The emergency department had developed an improvement plan with clear milestones and accountability for actions.
- Staff morale was mainly positive, although this had been somewhat overshadowed by crowding and the pressures this placed on staff. Staff nevertheless felt valued and supported.
- There were cooperative and supportive relationships among staff. We observed exceptional teamwork, particularly when the department was under pressure.
- There was a strong focus on learning and improvement. Clinical audit was well managed and used to drive improvement. Mistakes were openly discussed and learning acted upon. Staff at all levels were encouraged to play their part in improving patient experience.

Urgent and emergency services

Are urgent and emergency services safe?

Requires improvement

We have rated this domain as requires improvement because:

- We had concerns about patient safety, particularly when the department was crowded, which was a regular and frequent occurrence. Capacity was compromised because ED attendances were increasing, both in numbers and in terms of patient acuity. Lack of patient flow within the hospital and in the wider community created a bottle neck in the ED, creating pressures in terms of space and staff capacity. This in turn increased the risk that patients may not be promptly assessed, diagnosed and treated.
- Crowding was compounded by an acute shortage of staff. There was an acute shortage of middle grade doctors and there were particular concerns raised by medical and nursing staff about medical cover at night. Consultants regularly worked longer hours to support their junior colleagues and there were concerns about whether this could be sustained. Analysis of demand patterns indicated that more senior decision-makers were required at night.
- The ED was not fully staffed with nurses. There were a significant number of nurse vacancies and heavy reliance on bank and agency staff to fill gaps in the rota. When the department was crowded staff felt vulnerable because planned safe staff to patient ratios could not be maintained.
- There was no senior (band seven) nurse employed to manage each shift as recommended by the National Institute for Health and Care Excellence (NICE).
- Support staff functions were not adequately resourced. Healthcare assistants performed housekeeping duties, doctors, nurses and managers moved patients, and the nurse coordinator was frequently occupied with administrative duties.
- Crowding in the emergency department meant that ambulance crews were frequently delayed in handing over their patients.
- Patients were not always assessed quickly on their arrival in the emergency department. Initial assessment (triage) often consisted of a verbal handover from ambulance staff to the nurse coordinator without a face to face assessment of the patient.
- Record keeping was generally poor and we could not be assured that patients received prompt and appropriate assessment, care and treatment. This was notably worse when the department was crowded. In particular, we were concerned about the recording of observations and the calculation of early warning scores. Records indicated that patient observations were not always carried out consistently or early enough and early warning scores, which may alert clinical staff that a patient's condition is deteriorating, were not consistently calculated.
- The mental health assessment room did not comply with safety standards recommended by the Royal College of Psychiatrists.
- Staff were not provided with any mental health awareness training as part of their mandatory training

However,

- There was openness and transparency about safety. There were few serious incidents but when these occurred, lessons were learned and well disseminated throughout the department.
- There were hourly board rounds undertaken by senior clinicians in the department. This provided an overview of the department's activity and provided an opportunity to identify and communicate safety concerns to the site and trust management teams.
- Patient safety checklists had been introduced, which provided a series of time-sequenced prompts.
- There was a well-structured medical staff handover where patients' management plans and any safety concerns were discussed.
- The department was well equipped and equipment, including consumable items, was readily available, checked and maintained.

Incidents

- The trust reported no never events in urgent and emergency care between December 2015 and November 2016. Never events are serious patient safety incidents that should not happen if healthcare providers

follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

- In the same reporting period, seven serious incidents were reported. These were as follows:
- December 2015: Delay to act on symptoms of severe sepsis – a root cause analysis (RCA) took place, the case was discussed at a mortality and morbidity (M&M) meeting, and learning was disseminated through ongoing education. All actions on the action plan were complete.
- February 2016: transfusion of blood intended for another patient. A RCA was undertaken and actions arising, including staff training and segregation and labelling of blood, were completed.
- March 2016: Failure to recognise a seriously ill patient. Delayed clinical review (two hours, 35 minutes) and inappropriate transfer of a ventilated patient. A root cause analysis took place and actions arising from this were completed, including simulation training.
- May 2016: Sudden deterioration of patient. Patient observations were not recorded for a period of four hours. A root cause analysis was undertaken. Actions arising, including ongoing promotion of safety checklist and hourly board rounds, were completed.
- July 2016: Prescribing error leading to acute kidney injury. A RCA was conducted and actions, including personal learning and reflection, and an email safety briefing, were completed.
- August 2016: Delayed ambulance response, delayed diagnosis in ED of subdural haemorrhage. A joint RCA was conducted with the ambulance service. An action plan was due to be completed in February 2017.
- November 2016: failure to escalate a deteriorating patient. This incident was under investigation at the time of our inspection.
- There was openness and transparency in safety in ED, where safety issues were regularly discussed. The department had a designated clinical governance lead who led regular reviews of incidents. Incidents were discussed at bi-monthly meetings and learning was disseminated in a number of ways:
- Message of the week: posters were displayed around the department to draw staff's attention to learning. Topics had included: making reasonable adjustments for people with learning disabilities, mental health, dementia or any condition where communication is impaired, referral of appropriate patients to the falls team, pain asessment, safeguarding children screening and sepsis treatment.
- Safety newletters were issued every two months.
- Mortality and morbidity (M&M) meetings were held every two months to review the care of patients who had complications or an unexpected outcome. Learning points were shared with staff and real incidents were used in simulation training. Mortality and morbidity trends were reported in monthly emergency pathway performance reports.
- Quarterly missed radiology newsletters, combined with teaching and the development of new pathways involving trauma and orthopaedics, had led to a decrease in missed abnormal radiology over time.
- Theme of the fortnight: learning was disseminated to trainee doctors, in addition to 'learning bites' at each early/late shift handover.
- Staff told us they were encouraged to report incidents and told us they received feedback when they did so. Staff did not routinely report concerns about crowding and capacity/staffing levels, despite this being their most significant worry. They told us they saw no point in raising concerns. We were concerned that crowding had become normalised. We were told this information was captured through the completion of hourly board rounds in the department. Incidents were only reported where capacity issues were linked to individual patient harm.

Duty of candour

- Staff were familiar with their responsibilities under the Duty of Candour regulation. Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, was introduced in November 2014. This Regulation requires the provider to notify the relevant person that an incident causing moderate or serious harm has occurred, provide reasonable support to the relevant person in relation to the incident and offer an apology. Consultants provided examples of where duty of candour had been applied. We saw patients and their families had been contacted and kept informed during the investigation of serious incidents.

Safety Thermometer

- The safety thermometer is used to record the prevalence of patient harm and to provide immediate

information and analysis for frontline teams to monitor their performance in delivering harm-free care. Measurement at the frontline is intended to focus attention on patient harm and its elimination. Data collection takes place one day each month. Data from the patient safety thermometer showed the trust reported no pressure ulcers, two falls with harm and no catheter urinary tract infections in urgent and emergency care between January 2016 and January 2017.

Cleanliness, infection control and hygiene

- The department was visibly clean and tidy. We saw cleaning in progress. There was one cleaner allocated to the emergency department throughout the 24 hour period. However, nursing staff felt that overnight support was not always adequate because the cleaner also covered the Acute Care Unit. We saw staff observed the 'bare below the elbow' policy. The department was equipped with adequate hand washing facilities. Staff wore protective clothing such as gloves and aprons. However, we observed nursing staff did not always clean their hands between patients.
- The department used evidence-based care bundles (a series of actions/care elements) to prevent healthcare associated infections when undertaking invasive procedures such as cannula and catheter insertion. Compliance with these safe systems was monitored on a monthly basis. Compliance in the period April to October 2016 was variable:
- Cannula insertion: compliance ranged from 50% to 100% (average 71%).
- Urinary catheter insertion ranged from 75% to 80%. Results were only reported for three out of the seven months.
- Hand hygiene compliance ranged from 70% to 100%. Results were only reported for three out of the seven months.
- Compliance with the 'bare below the elbow' policy ranged from 70% to 100%. Results were only reported for three out of seven months.
- There were two assessment/treatment rooms in majors where infected patients could be isolated and barrier nursed to prevent the spread of infection.

Environment and equipment

- The emergency department was designed, laid out and equipped to keep people safe. However, the department was frequently crowded and patients queued in the corridor and other non-clinical areas. This made it difficult to observe patients and to move trolleys around. We noted on occasions that the access to the resuscitation area was blocked by queuing patients. One consultant told us: "The department was designed to see 50,000 patients and it now sees 80,000 patients."
- Patients were not given bells so they could summon help from staff. We witnessed an elderly patient calling for help but their call was not heard by staff. The patient was trying to climb off their trolley in order to use the toilet. We intervened and asked a nurse to assist.
- We had previously raised concerns about poor lines of sight in both the adults' and children's waiting areas, which meant waiting patients were not adequately observed. This meant that a deteriorating patient or inappropriate behaviour may go unnoticed. The height of the reception desk meant that reception staff had a limited view of the main waiting area. This remained unchanged.
- The children's waiting area had appropriate restricted access via the waiting room and the area was not overlooked by the adults' waiting area. However, the area could be accessed via the majors/ minors areas. The area was not observed by staff to ensure that anxious parents and children could summon attention. We frequently entered the children's area and there were no staff visible.
- We checked a range of equipment, including resuscitation equipment in the ED. Resuscitation trollies were all in order and appropriately stocked. Regular checks were documented.
- The resuscitation area was well organised and equipment was well laid out and easily accessible. We checked consumable equipment, which was clean and in date.
- There were appropriate arrangements for the segregation, storage and disposal of waste and we saw staff comply with these safe systems.

Medicines (includes medical gases and contrast media)

- Medicines were appropriately stored in locked cupboards or fridges. There was evidence that fridge temperatures were regularly checked. Temperatures were within the correct range at the time of our inspection.

- Controlled drugs were stored appropriately and suitable records were kept. Controlled drugs are medicines which require extra checks and special storage arrangements because of their potential for misuse.
- Patients' allergy status was consistently recorded on medicine administration charts. This reduced the risk of patients receiving inappropriate medicines which may have a harmful effect.

Records

- Patients' records in the emergency department were generally not well completed. Records were in paper format and were scanned on to the hospital's electronic system when patients were discharged or transferred to a ward. We looked at a sample of 20 records. They were mostly legible and written entries were signed and dated but in some cases the time of the entry was not recorded. However, it was noted that the time of assessment, triage, clinical investigations and discharge were recorded on the clinical IT system.
- Patients' observations (vital signs) and early warning scores were not completed consistently (see assessing and responding to patient risk below) so we could not be assured that these assessments had taken place. A newly introduced safety checklist, which was required for all patients in the majors' area, was not consistently completed. This required the recording of a pain score, which we found was rarely recorded, even in cases where pain relief had been administered. There was little evidence that staff had assessed patients' skin integrity or offered them refreshments.
- Patients' records were appropriately stored to enable easy access for staff, whilst not being easily accessible for people who were not authorised to view them. However, records consisted of up to ten pieces of paper which were not always kept together, thus posing a risk of records going astray. For those patients who queued in the corridor awaiting transfer to a ward, loose paper records were stored on the back of the patient's trolley, and therefore were not secure.
- There were monthly audits of records relating to the recording of observations of vital signs and National Early Warning Scores (NEWS). NEWS is a recognised early warning score tool to assess patients' risk and their need for physical observations. Documentation audits formed part of the trust's audit plan to ensure regular monitoring.

Safeguarding

- There were processes in place for the identification and management of adults and children at risk of abuse (including domestic violence and female genital mutilation). Staff understood their responsibilities and were aware of safeguarding policies and procedures. There was a safeguarding lead nurse in the ED.
- There were identifiers visible on patients' records where patients were known to the service due to previous safeguarding concerns. Staff could then access management plans to support patients' ongoing care and treatment.
- The department was meeting most of the Safeguarding Children's Standards produced by the College of Emergency Medicine's Clinical Effectiveness Committee:
- Training records showed that in October 2016, 82.9% of medical staff had completed level 2 safeguarding training for adults and children. Nursing staff performed better, with 96.5% completing level 2 safeguarding adults training and 90.1% completing level 2 safeguarding children training.
- The trust told us that all consultants and middle grade doctors had received level 3 child protection training.
- The department had access to a senior paediatric and senior emergency medicine opinion 24 hours a day for child welfare issues.
- The patient record system identified previous child attendances in the last 12 months so that staff would be alerted to possible safeguarding issues.
- Frequent attenders (more than three attendances in last year with different conditions) were notified to the local safeguarding children services.
- Child attendances were notified to GPs, health visitors and school nurses.
- We were told that all skull or long bone fractures in children under one year were discussed with a senior paediatric or ED doctor during their ED attendance.
- At our last inspection we were concerned that there was no 'safety net' to ensure that child safeguarding referral rates were appropriate. There was a health visitor liaison team who attended the ED every few days to check referrals but they did not check all child attendances to see if any had been missed. In response to our findings the department strengthened processes to include a review of all child attendances by a children's' safeguarding nurse and completion of any missed paediatric liaison forms. In addition, they checked adult

attendances relating to overdoses, deliberate self-harm, drug or alcohol abuse and domestic abuse to see if they had any children and if so, ensure that paediatric liaison forms were completed and the necessary authorities informed.

Mandatory training

- Staff were required to complete mandatory training, including refresher training in 12 essential subjects. The trust's target for completion of mandatory training was 90%. Whist there were differences between nursing and medical staff, the overall compliance for all subjects was approximately 90%.

Assessing and responding to patient risk

- The trust used a recognised triage system (Manchester) in ED for the initial assessment of all patients. Guidance issued by the College of Emergency Medicine (Triage Position Statement dated April 2011) states that a rapid assessment should be made to identify or rule out life/limb threatening conditions to ensure patient safety. This should be a face-to-face encounter which should occur within 15 minutes of arrival or registration and assessment should be carried out by a trained clinician. This ensures that patients are streamed or directed to the appropriate part of the department and the appropriate clinician. It also ensures that serious or life-threatening conditions are identified or ruled out so the appropriate care pathway is selected.
- Staff used a mental health risk assessment tool to establish the level of risk associated with patients presenting with mental health needs.
- Trust-wide, the median time from arrival to initial assessment (emergency ambulance cases only) was worse than the England average for the 12 months from December 2015 to November 2016. In November 2016 the median time to initial assessment was 12 minutes, compared with the England average of seven minutes. During the week of our inspection performance against the 15 minute standard for patients brought by ambulance to the GRH ranged from 46.7% to 75.9%. Since raising our concerns the trust have introduced a triage nurse and receptionist at the point of entry to the emergency department to enable immediate ambulance handover and triage assessment.
- Patients arriving by ambulance were triaged by the majors' nurse coordinator. We observed that in most cases there was no face to face assessment of patients and the triage consisted of a handover from ambulance staff, who were then directed to transfer the patient to a clinical area or to the corridor.
- We followed a patient who had fallen from a height and had been brought into the ED by ambulance staff. The ambulance crew, in their handover to the nurse coordinator, advised it was unclear whether the patient had lost consciousness during their fall. The coordinator could not see the patient as they were in the corridor around the corner. They directed the ambulance crew to transfer the patient to wait in the corridor for assessment. There was no corridor nurse allocated at that time.
- We were concerned that following this handover, patients often waited too long before observations of vital signs were taken and an early warning score calculated. The emergency department used the national early warning score (NEWS) tool to identify seriously ill and/or deteriorating patients. NEWS scores are calculated by measuring and grading vital signs such as blood pressure respiratory rate and temperature. A high score may indicate the need for more frequent observations or immediate intervention. All patients in the majors' area were supposed to have their vital signs measured and a NEWS score calculated on an hourly basis.
- We looked at a sample of 20 records and found that patients' observations were not completed with the required frequency and early warning scores were not consistently calculated. Some patients did not have their observations recorded for periods of three to four hours.
- Compliance with the use of the early warning score tool was monitored monthly. Results ranged from 50% to 100% (an average of 85%) in the 10 months February to November 2016. The monthly audit also tested whether appropriate actions were taken in response to early warning signs. Performance was similarly variable, with results ranging from 10% to 100% (an average of 60%).
- The trust had introduced an emergency department safety checklist (known as SHINE) in June 2016. The documentation prompted staff to undertake observations, tests and treatments in a time-based sequence. Compliance with this new system was being

monitored via monthly audits. Whilst this was improving over time, the system was not well embedded in use. Performance ranged from 13% in September 2016 to 35% in November 2016.

- Of the 20 records we checked, only one had a safety checklist fully completed and some had not been commenced. In particular, the checks required in hours two onwards were not well completed. We saw little evidence for example that patients' skin was checked for pressure ulcers or that patients were offered food and drink.
- Self-presenting patients were assessed on arrival by a triage nurse, following their registration at the reception desk. The trust monitored the time that patients waited for their initial assessment. During the week of our inspection, performance against the 15 minute standard for self-presenting patients ranged from 40.2% to 89.3%.
- Receptionists in the minors' area told us they used their judgement and experience to recognise a seriously unwell/injured patient who needed immediate clinical attention. There was no written guidance about 'red flag' conditions and staff confirmed they had received no training to recognise red flags. They told us they summoned help either in person or by phone. The RCEM Triage Position Statement states: "Some elements of the triage process, such as initial recognition of urgency, may be undertaken by an unregistered health worker, e.g. reception staff using clearly defined "red flags" which identify urgency. For this reason non-registered health care workers in emergency settings should have basic training in red flag presentations and how to call for immediate assistance…".
- There was insufficient observation and monitoring of patients in the children's waiting room. Children were not supervised as recommended in Health Building Note (HBN) 15-01 which states "the waiting area should be provided to maintain observation by staff." We had raised this at our previous inspection but the situation remained unchanged. We frequently entered the children's waiting area during our inspection and there were no staff visible.
- The trust monitored ambulance turnaround times in the emergency department. At GRH, performance showed an upward (worsening) trend) between January 2016 and December 2016. In December 2016, 1,653 journeys had a turnaround time of 30 minutes or more and 202 had a turnaround time of 60 minutes or more.
- There was an hourly 'safety board round' conducted by the majors' coordinator and the consultant (or middle grade doctor) in charge. This was an opportunity to identify any safety concerns and update the escalation status of the department. The escalation status (defined in the department's escalation policy) described the department's ability to provide safe, timely and efficient care to patients. Factors affecting this ability included surges in activity, insufficient staff and a lack of patient flow within the hospital. There was a guide for shift leaders for managing escalation, which outlined the processes, including communication to alert the site management team of the department's status.
- There was a doctors' handover at 1pm every day, attended by all grades of staff, where patients' risks and management plans were discussed.
- There was a sepsis screening tool and care pathway in use and the safety checklist included a prompt to ensure staff considered sepsis. Staff told us that ambulance crews pre-alerted ED staff when an incoming patient was suspected to have sepsis. The patient would be taken directly to the resuscitation area on arrival where the screening tool would be activated. Where no pre-alert took place or where the patient self-presented, the first opportunity to identify possible sepsis was at triage. The sepsis screening tool prompted staff to consider sepsis if the patient early warning score was 3 or more.
- The emergency department measured performance against the standard which required applicable patients to be screened on arrival. In the period July to November 2016 performance was between 96% and 98%. The department also measured the time that patients were treated with antibiotics. The RCEM standard is that 50% of patients should receive antibiotics within one hour and 100% within four hours. Between July and November 2016 compliance with the one hour target increased from 41% to 62% with 83% receiving antibiotics within two hours and 100% by 4 hours.
- We retrospectively followed the pathway for a patient who attended the ED during our visit. They were triaged 15 minutes after their arrival and a sepsis screen was completed within 30 minutes. They were reviewed by a doctor after 40 minutes and received antibiotics within one hour and 20 minutes.
- We saw one patient who had been brought to ED by ambulance and the ambulance crew had noted a high

early warning score (6) and had highlighted the possibility of sepsis. The patient had no observations recorded for over two hours after their arrival and a sepsis screen was not undertaken. Lactate was measured nearly three hours after the patient's arrival. RCEM recommends that all patients with physiological derangement, an elevated NEWS score above trigger threshold, or with clinical suspicion of infection to be screened for the presence of sepsis, severe sepsis or septic shock and to have a serum lactate within 30 minutes of arrival. A senior nurse told us there were often delays in identifying patients with sepsis as observations were often delayed due to a shortage of nursing staff.

- Patients with mental health problems were risk assessed and prioritised using a mental health assessment pro forma. In the RCEM Mental Health in the ED audit 2014-15 the ED had performed poorly. Of particular concern was the score for the fundamental standard which requires that a risk assessment is taken and recorded in the patient's clinical record. The ED scored 49% against the RCEM standard of 100%. Actions taken to improve this included the provision of training in the use of the documentation at medical staff induction. The department was also training emergency nurse practitioners to undertake risk assessments. There were plans to re-audit this in July 2017. We reviewed four records for patients who had attended ED with mental health problems and found the mental health proforma had been used and completed appropriately.
- Crowding in ED was a serious and ongoing risk, which was identified on the department's and the trust's risk registers. There was a trust Escalation and patient flow policy, within which there was an emergency department escalation policy, including a guide for shift leaders; Maintaining safety in the emergency department. Shift leaders completed hourly board rounds where they allocated scores against defined trigger points, including the number of patients in the department, space available in majors and resuscitation and the number of ambulances queuing.
- There were a series of action cards for medical and nursing staff to follow in the event of escalation. Actions included reallocating staff, requesting additional staff and diverting patients to other EDs.
- There was a system in place to ensure that significant radiological pathology was not missed. All radiology reports were reviewed by a consultant the next working day and patients were notified if anything had been missed and were asked to re-attend the department. Funding had been secured for a project, led by an ED consultant, to work with radiology to monitor and learn from missed pathology. Learning was disseminated via teaching sessions, in addition to bi-monthly newsletters.

Nursing staffing

- The emergency department was not consistently staffed to planned levels of nursing staff and even when staffed to planned levels, safe staff to patient ratios could not be maintained in all areas of the department, particularly in times of crowding.
- At November 2016, the trust reported a vacancy rate of 14.7% at GRH. The matron told us that, following our last inspection, the department had reviewed staffing levels and skill mix in order to align staffing with patterns of demand. The nursing establishment had been increased by one nurse on the late shift. The matron told us that in majors a staff to patient ratio of one registered nurse to three patients was the planned staffing level, although one to four was considered acceptable. Due to the ongoing vacancy factor and difficulties with recruitment there were regular shortfalls in the rota. These were regularly filled by temporary (bank and agency) staff. Agency staff were block-booked to improve familiarity and continuity. We were told that planned staffing levels were achieved on most shifts. When we looked at the staffing allocation for the three weeks leading up to our inspection, we found that whilst some shifts were not fully filled, every shift had between one and four agency staff employed.
- There was a nurse allocated on each shift to care for patients queuing in the corridor; however this was not consistently maintained. We noted that one nurse was allocated to look after patients in the resuscitation area. However, when there were more than two patients in this area, a nurse from majors or the corridor was moved there. On 25 January we noted there were four to six patients on the corridor with no corridor nurse allocated over a period of 15 minutes. After 15 minutes a nurse was moved to the corridor, by which time they had ten patients to care for. Staff told us they were frequently asked to care for too many patients. One nurse told us that they had on one occasion been responsible for 17 patients.
- At our last inspection the trust was struggling to appoint senior nurses to undertake the floor manager role. This

continued to be a challenge and this position remained unfilled. This put tremendous pressure on the nurse coordinator and the matron was frequently providing 'hands-on' support. Guidance issued by NICE recommends that a senior (band seven) nurse should be deployed to manage each shift in emergency departments.

- There was one nurse allocated to care for patients on the corridors, when all cubicles were in use. This was frequently insufficient when the department was crowded. During our inspection there were regularly between four and ten patients being cared for on the corridors, in addition to patients waiting in the sub waiting area. Staff were pulled from other areas of the department, including nursing staff from the department's administrative function. Additional agency staff were also deployed to assist. Nursing staff told us they felt "vulnerable" at times due to the number of patients they were expected to care for, sometimes up to ten. They were worried about not being able to provide a safe level of care. Having raised these concerns with the trust at the time of the inspection, they have since informed us that a review of procedures and practice in respect of would be suitable to be cared for in the corridor, when demands require it, had been undertaken in order to ensure patients with more complex needs were identified and cared for in a cubicle as soon as possible.
- There was not a dedicated paediatric trained workforce in ED; however, the department was taking steps to upskill adult-trained nurses in order to meet the standards set out in the Royal College of Paediatrics and Child Health Standards for Children and Young People in Emergency Care Settings (2012). This guidance identifies that there should always be a registered children's nurse on duty in ED or trusts should be working towards this. The guidance recognises this is often not achievable but states "nursing staff caring for sick children require competence in emergency nursing, including organisational and clinical skills, and in the care of children." Nursing staff should be trained to at least Paediatric Intermediate Life Support (PILS) or Paediatric Life Support (PLS) level.
- The A&E risk register highlighted the risk of "inappropriate care of children by adult-qualified nurses". This was graded a moderate risk. Actions to mitigate the risk included the development of a rolling programme on paediatric illness and it was recorded that "all registered nurses in ED undergo detailed induction, ongoing training and paediatric resuscitation training to mitigate any risk." The department employed one registered children's nurse. All nurses received a half day's training (a general introduction to paediatrics) as part of their induction. Training records showed that approximately 20% of adult trained nurses had completed an acutely unwell/injured child course, with a further 6% due to start or complete the course in 2017. Approximately 60% had completed PLS or advanced paediatric life support training.

Medical staffing

- In November 2016 there was a vacancy rate of 18.5% in urgent and emergency care trust-wide. Many of the medical staff we spoke with raised concern about medical staffing at night. The ED risk register highlighted the "inability to provide safe and timely clinical care due to a lack of 24 hour middle grade doctors". The register was updated in August 2016 stating "demand and capacity work completed……..additional consultant, junior and ENP posts approved August 2016 and recruitment in progress; rota being developed to reduce middle grade gaps."
- The department was able to achieve the target of providing a minimum of an ST4 (specialist registrar year 3) or above in the department 24 hours a day, seven days a week. However, this was challenging due a shortage of middle grade doctors. Consultants worked 8am to midnight five days a week and 24-hour cover was provided two days per week, with consultants "acting down" to fill middle grade gaps in the rota. Concerns were expressed by both medical and nursing staff about the lack of senior decision makers at night. They told us that when there was only one senior doctor on duty (after midnight) they may be required to spend most of their time caring for patients in the resuscitation area. This left relatively junior medical staff to care for all other patients. We were told that, in addition to working some nights, consultants regularly worked beyond midnight to support their junior colleagues when the department was very busy. There were concerns expressed about how long this could be sustained. Concerns regarding sustainability and demands for medical staff are being addressed through a workforce strategy. There was dedicated Consultant workforce lead who actively took part in strategy and recruitment.

Since the inspection the trust have advised us they are actively recruiting a further consultant and have appointed a physician associate to commence September/October 2017

- During our inspection the department experienced a very busy afternoon and night, with between 50 and 70 patients in the department. The consultant rostered to be on duty until midnight did not go home until 8am the next morning. The specialty director joined them at 9pm, remaining in the department until 5.30 am. Despite the department being fully staffed (to planned levels) in the afternoon and additional medical staff helping at night, the department reported they had struggled to keep up with the workload. At one point there were waits of three hours for patients to be reviewed by a doctor. The department had undertaken a detailed analysis of demand and capacity and had benchmarked their staffing levels with other comparable emergency departments. Both of these pieces of work supported the case for additional medical staff and/or re-modelling of the service, although the status of this analytical work was unclear.
- There were structured handovers between medical staff at the beginning of each shift. We observed the 8am handover, which was well attended. There was a structured format which was clearly well practised and understood. All patients in the department were discussed and action plans were agreed. There was clear delegation of tasks and responsibilities for the forthcoming shift.
- All consultants and registrars were trained in advanced paediatric life support. Junior doctors received training on induction which covered safeguarding and the sick child. There were also written guidelines on paediatric care.
- There were two ED consultants dedicated to paediatrics. One was responsible for developing protocols and audit, while the other took the lead on children's' safeguarding matters. They had regular meetings with paediatrics and attended the paediatric risk meeting.

Other Staffing

- As noted above, the nurse coordinator was not supported by a floor manager. We noted also that they did not have the support of a dedicated receptionist in majors. This position was established to support the coordinator during the late shift. Their duties included registering patients, answering the telephone, patient transfers and transport and scanning patients' records. The position was not filled on any of the late shifts during our inspection. As a result the coordinator was frequently occupied with these administrative duties.
- Porters were employed in ED in overlapping shifts throughout the 24 hour period. This service was shared with the Acute Care Unit and, in effect, there was mostly one porter available for the department. There was a hospital-wide patient transfer team, staffed by two healthcare assistants, who could be called upon to assist but at times this was clearly not sufficient. We frequently saw nursing and managerial staff moving patients. On the day of our unannounced inspection we saw doctors, nurses, and managers moving patients. Whilst this demonstrated commendable commitment and teamwork, it highlighted the inadequacy of this support function. The patient transfer team was staffed by only one staff member that day so ED staff frequently accompanied them. Staff had raised concerns about a shortage of porters at our previous inspection. A business case had been submitted for additional staff but this had been turned down for financial reasons.
- Two healthcare assistants were employed on each shift. Senior staff told us they were responsible for cleaning and re-stocking the department each morning but they were frequently occupied serving breakfast to patients who had been in the department overnight because there were no housekeeping staff employed.
- There was one cleaner employed in the department. Nursing staff did not consider this was adequate, particularly at night when the staff member was shared with the ACU. This meant that nursing staff had to undertake cleaning duties.

Major incident awareness and training

- There was a major incident plan, including actions cards, which had been recently reviewed and was up-to-date. There was a training DVD available on the department's intranet: Initial Operational Response, produced by the Home Office with advice and guidance on managing incidents where patients were contaminated with hazardous materials (HAZMAT) or a chemical, biological, radiological or nuclear (CBRN) incident.
- Staff in the emergency department told us they felt safe. All staff carried personal alarms, which, when activated,

sounded throughout the department. Staff were provided with conflict resolution training; however only 74.3% of medical staff and 79.6% of nursing staff had completed this.

Are urgent and emergency services effective?

(for example, treatment is effective)

Good

We have rated this domain as good because:

- People's care and treatment was planned and delivered in line with current evidence-based guidance and standards.
- There was a range of recognised protocols and pathways. Compliance with pathways and standards was monitored through participation in national audits. Performance in national audits was mostly in line with other trusts nationally. There was evidence that audit was used to improve performance, for example in the treatment of sepsis.
- Nursing and medical staff received regular teaching and clinical supervision. Staff were encouraged and supported to develop areas of interest in order to develop professionally and progress in their careers.
- Care was delivered in a coordinated way with support from specialist teams and services. Specialist teams such as the stroke team, the discharge assessment team, the specialist nurse for older people, the mental health liaison service and the alcohol liaison service worked closely and collaboratively with the emergency department.
- Staff demonstrated knowledge and understanding of their responsibilities in relation to the Mental Capacity Act 2005 and consent.
- Information needed to deliver effective care and treatment was available to staff involved in patients' ongoing care when they were discharged or transferred to another service.

However:

- Pain was not always promptly assessed and managed.
- We could not be assured that patients' nutrition and hydration needs were consistently assessed or met.

Evidence-based care and treatment

- Care and treatment was delivered using recognised clinical guidelines, for example, National Institute for Health and Care Excellence (NICE) guidelines and the Royal College of Emergency Medicine's (RCEM) Clinical Standards for Emergency Departments. There were clear pathways, supported by proformas for the management of conditions such as stroke and sepsis. We saw evidence in patients' records that staff were familiar with these pathways and that they were followed.
- We observed the conscious sedation of a patient in the resuscitation area, which was undertaken in accordance with standards produced by the Royal College of Anaesthetists.
- We observed prompt, efficient assessment and referral of a stroke patient.
- Compliance with pathways and standards was audited on a regular basis and education took place to continuously improve knowledge of, and compliance with, good practice.

Pain relief

- When we inspected the emergency department in March 2015 we found that patients did not consistently receive prompt pain relief. The department had performed poorly in relation to pain management in the Royal College of Emergency Medicine audits in relation to renal colic (2012) and fractured neck of femur (2012-13).
- An internal re-audit of the management of fractured neck of femur was undertaken in 2016 and the department continued to score poorly in relation to the assessment and management of pain. The audit found that pain assessments were not consistently recorded at triage (this was consistent with our findings during our inspection) and many patients were not reviewed by a doctor within one hour, which delayed pain management. It was concluded that workload was a major contributing factor.
- The department had delivered teaching sessions to medical and nursing staff to raise awareness and improve performance. We observed that patients' pain relief was discussed at the medical staff handover meeting.
- The new safety checklist contained hourly prompts to assess and reassess pain; however, these checklists were not yet embedded in practice and we found they were not consistently completed.

- An audit of pain relief in children reported to the mortality and morbidity committee in August 2016 reported that the emergency department at GRH was not meeting RCEM standards.

Nutrition and hydration

- We noted in patients' records that staff rarely recorded that food and drink had been offered to patients who had been in the department for more than two hours. The new safety checklist included prompts at two, three and four hours but in the sample of records we reviewed, the checklist was rarely completed over this time so we could not be assured this was given adequate attention. We reviewed records of patients who had been in the department for up to 13 hours and saw no evidence of refreshments being offered or provided. There were visual reminders about nutrition and hydration displayed in cubicles. Whiteboards were supposed to be used to record when a patient had last eaten or drank. These were not completed. During our inspection, we were asked on a number of occasions by patients if they could have a drink and we relayed these messages to the nursing staff. One patient, who was waiting to be seen in the corridor, told us they were anxious about obtaining food because they were diabetic. This was not identified on their records. We informed a member of staff who assured the patient that they would arrange for a sandwich to be provided.

Patient outcomes

- Information about patient outcomes was routinely collected and monitored. The trust participated in national RCEM audits and internal audits so they could benchmark their practice and performance against best practice and other emergency departments. There was a designated consultant audit lead for the department, who oversaw the audit programme and the completion of action plans. Overall, the trust performed in line with other trusts nationally.
- In the RCEM 2015-16 audit of vital signs in children, GRH was in the top quartile for one of the six measures and in the lower quartile for three of the six measures. An action plan had been developed, although actions were incomplete at the time of our inspection.
- In the 2015-16 RCEM audit for venous thromboembolism (VTE) Risk in Lower Limb Immobilisation in Plaster Cast, Gloucestershire Royal performed:
- In the lower quartile for the measure 'If a need for thromboprophylaxis is indicated, there should be written evidence of the patient receiving or being referred for treatment'.
- Between the upper and lower quartiles for the measure 'Evidence that a patient information leaflet outlining the risk and need to seek medical attention if they develop symptoms for VTE has been given to all patients with temporary lower limb immobilisation'. An action plan was developed in response to the audit findings. Actions included teaching to medical staff and emergency nurse practitioners, the introduction of a plaster pack which would serve as an aide memoire and personal feedback to ENPs.
- In the 2015-16 Procedural Sedation in Adults audit GRH was in the upper quartile compared to other hospitals for five of the seven measures. The remaining two measures were between the upper and lower quartiles.
- The trust was better than the England average for standard which requires the percentage of patients re-attending the department unplanned within seven days to be less than 5% averaging between 1.3-1.8% of patients.

Competent staff

- The department had two practice development nurses who were responsible for planning, coordinating and delivering in-house training.
- There was a programme of ED competency based training and professional development training for each grade of nursing staff. Each staff member maintained their own training record which was overseen by their manager. The matron told us that all nursing staff received seven to eight days training per year, although evidence of this was not provided.
- Junior medical staff told us they were well supported and had access to regular training, including regular 'learning bites' at daily handover meetings. There was protected one-to-one time for one hour each month with consultants, where the subject was nominated by the junior doctor.

- Appraisal rates for the unscheduled care division trust-wide were as follows:
- Healthcare Assistant staff: 83%
- Other, including administrative and clerical staff: 87%
- Medical staff: 83%
- Nursing staff: 77%
- The General Medical Council (GMC) reported in their 2016 regional review that doctors in training had commented favourably about the willingness of ED consultants on the floor to teach. They also commented positively about multidisciplinary teaching, with educational sessions provided by mental health professionals and physiotherapists, and opportunities for simulation training. In the 2016 GMC survey there was positive overall satisfaction fed back by foundation year 1 doctors. Foundation year 2 doctors and core trainee doctors expressed some concerns about clinical supervision, particularly at night, handover and workload.

Multidisciplinary working

- Staff, teams and services mostly worked well together to deliver effective care and treatment. There was a good relationship with the mental health trust and regular multidisciplinary meetings with the ED, mental health trust and the police to discuss regular attenders.
- There was an Assisted Discharge Service provided by the British Red Cross from Monday to Friday from 10.30am to 10.30 pm. The team provided a transport and resettlement service for people in vulnerable circumstances to ensure their discharge from ED or the acute care unit was safe. Patients were offered two hours' support, which might include making sure their home was warm and safe and that they had food in the house. There was also a night sitting service available. The service was valued by ED staff but the department was not able to provide the volunteers with a permanent office base. They used the department's seminar room when it was not occupied but we saw they were frequently asked to vacate this area.
- There were two primary care pilots in the emergency department, commissioned by the local clinical commissioning group. In minors, self-presenting patients attending the emergency department on weekdays between 10am and 10pm were greeted by a clinical navigator (a nurse employed by the local ambulance service) who streamed appropriate patients (those with minor illnesses) to see a GP or an advanced nurse practitioner. There was also a GP based in majors from midday to 10pm who identified patients who could potentially be managed in the community. The GP worked closely with the integrated discharge team.
- ED staff reported that they were well supported by some specialties; however, there was a general feeling that there was a lack of ownership of the four hour ED target in the rest of the hospital. There were frequent difficulties in transferring patients from ED to appropriate beds once the decision to admit had been made. On the day of our unannounced inspection there were 22 patients in the emergency department waiting for beds at 8am. During our visit we saw patients who had been in the department for up to 13 hours. This exit block was a source of immense frustration amongst clinicians in the emergency department and there was a feeling expressed by some that more could be done by the rest of the hospital to support the emergency department.
- At our last inspection we were told that a performance measure had recently been implemented whereby specialties were required to accept admissions from ED within 30 minutes of the decision to admit. This was monitored by daily analysis of breaches. At this inspection we were told that although delays in specialist review were still monitored and reported on in weekly breach meetings and at the monthly emergency care board, internal professional standards had only recently been published. It was reported in the December 2016 emergency care pathway report that the implementation of internal professional standards for all specialties, which was an action of one of the emergency care board's work streams, was "not on track to deliver". It was reported that the work stream had managed to agree seven of the 'top ten' standards with key stakeholders. The report went onto say, "there remains some concern among the clinical body regarding some of the wording of the standards but the chief executive has asked the work stream to simply define the standards we are aspiring to achieve in order to establish the improvement actions required to deliver them".

Seven-day services

- There was senior medical staff presence in the ED seven days a week.

- Pharmacy services were available Monday to Friday only, although there was a pharmacist on-call out of hours. Senior staff in the emergency department were unhappy about the lack of service over the weekend.
- Radiology was available seven days a week.
- Mental health liaison was available seven days a week; however support for children and young people was reduced at weekends. Specialist support for patients presenting with drug or alcohol misuse was not available at weekends.
- Attendance/admission avoidance initiatives, including the primary care service in ED, the older people's assessment and liaison service and ambulatory emergency care were currently only provided Monday to Friday.

Access to information

- Information needed to deliver effective care and treatment was available to staff involved in patients' ongoing care when they were discharged or transferred to another service.
- Patients admitted to inpatient wards from the emergency department had their records scanned onto the hospital's electronic system before they were transferred to the ward. For those patients who were discharged from the emergency department, an electronic discharge summary was generated and sent to the patient's GP.
- There was a bespoke IT system which was real-time and allowed tracking of patients through the department. The status of both of the trust's EDs could be viewed on either site, thus enabling an overview of the workload. The system also allowed for statistical analysis and reporting of activity.
- A new patient record system had been introduced in December 2016. Staff described numerous difficulties with this system, which were time consuming and distracting.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We observed patients being asked for verbal consent. Doctors and nurses explained things to patients simply, checked their understanding and asked permission to undertake examinations or perform tests.
- The trust reported that at 31 October 2016 Mental Capacity Act 2005 (MCA) awareness training had been completed by 86.7% of all staff within Urgent and Emergency Care.
- Deprivation of Liberty Standards (DoLS) Awareness training had also been completed by 86.7% of all staff within Urgent and Emergency Care. However, the completion rate for both modules fell below the trust target of 90%.

Are urgent and emergency services caring?

Good

We rated this service as good because:

- All of the patients we spoke with during our inspection commented very positively about the care they received from staff. This was consistent with the results of patient satisfaction surveys, which were mostly positive.
- Patients were treated with compassion and kindness. We saw staff providing reassurance when patients were anxious or confused.
- Patients were treated with courtesy, dignity and respect. We observed staff greeting patients and their relatives and introducing themselves by name and role.
- Patients and their families were involved as partners in their care. They told us they were kept well informed about their care and treatment. We heard doctors and nurses explaining care and treatment in a sensitive and unhurried manner.

Compassionate care

- We observed staff interacting with patients and their relatives in a respectful and considerate manner. We observed staff greeting patients and their relatives and introducing themselves by name and role. We noted, however, that not all staff wore name badges.
- Patients and relatives we spoke with told us staff were caring, compassionate, friendly and engaging. We saw staff providing reassurance to patients when they were anxious or confused.
- We witnessed a staff member speaking with an injured child. They distracted them by asking about their interests, and reassured them about having an x-ray.

Urgent and emergency services

- Patients' privacy and dignity were respected where possible. However, at times this was challenging due to crowding. Patients frequently queued in the corridor because there were no cubicles available. Staff tried to keep one side room free so that patients requiring clinical tests, private conversations or toileting were given some privacy. However, this area was not always available. We observed a patient who was cared for in the corridor for a number of hours, despite suffering from diarrhoea.
- The trust used the friends and family test to capture patient feedback. Response rates had increased significantly since the introduction of a new digital methodology and in September 2016 was 27.5%. However, the percentage of respondents who would recommend the service started to decline in September 2016. In December 2016, 78% of responses were positive, compared with and England average of 86%.
- We spoke with approximately 20 patients and relatives. Whilst their feedback was not entirely positive - due to longs waits and a lack of comfort and privacy on the corridor - they were very positive about the staff and the caring attitude they displayed. Many patients expressed admiration and sympathy for staff working in such a busy and pressurised environment.

Understanding and involvement of patients and those close to them

- We witnessed doctors explaining treatment plans to patients and their relatives. They took time to check their understanding and asked them if they had any questions. Relatives told us they felt they had been involved in the decision-making process about the treatment of their family members.
- The nurse coordinator received numerous telephone calls from relatives enquiring about their loved ones. They dealt with these in a sympathetic manner and often took the phone to the patient so that they could speak with their relatives.

Emotional support

- We witnessed staff speaking compassionately with patients (and their relatives) who had presented with serious (potentially life-changing) illness. They spoke sensitively about treatment options and prognosis. During a medical staff handover meeting a doctor spoke about the needs of a relative who was finding it difficult coming to terms with their relative's diagnosis.

Are urgent and emergency services responsive to people's needs?

(for example, to feedback?)

Requires improvement

We have rated this service as requires improvement because:

- The trust was consistently failing to meet the standard which requires that 95% of patients are discharged, admitted or transferred within four hours of arrival at the emergency department.
- Patients frequently spent too long in the emergency department because they were waiting for an inpatient bed to become available. Lack of patient flow within the hospital and in the wider community created a bottleneck in the emergency department, causing crowding.
- Crowding meant patients frequently queued in the corridor, where they were afforded little comfort or privacy. When the department became congested, relatives had to stand because there was insufficient seating.
- Patients with mental health needs were not always promptly assessed or supported, particularly at night time when there was no mental health liaison service. Adolescents who had self-harmed did not receive a responsive service and were frequently inappropriately admitted while awaiting specialist assessment and support.
- There was a lack of an appropriate welcoming space for patients with mental health needs.

However:

- The service had a number of admission avoidance initiatives in place to improve patient flow. These included the integrated discharge team who proactively identified and assessed appropriate patients who may be able to be supported in the community rather than admitted to the hospital.
- We saw evidence that complaints were used to drive improvement.
- The emergency department had recently developed a team known as the Gloucestershire elderly emergency care (GEEC), championed by an ED consultant. The aim

was to raise awareness of the issues faced by frail elderly patients in the emergency department and to identify areas where the experience of this patient group could be improved.
- Multi-agency management plans had been developed for patients with mental health needs who were frequent attenders in the ED. These enabled staff to better support patients and had resulted in a reduction of both ED attendances and admissions to hospital.

Service planning and delivery to meet the needs of local people

- The trust was working closely with commissioners to identify system-wide strategies to improve patient flow.
- The ED was accessible. There was parking available close to the department and there was a covered drop-off zone. The helipad was directly opposite the ED with quick and easy access to the ambulance entrance.
- Facilities and premises were not wholly adequate. The department was frequently crowded. Patients queued in the corridor, some on arrival in the department, others while waiting to be seen, and some while waiting to be transferred to a ward. The trust monitored and reported on the average number of patients in the ED corridor per day. In November 2016 the average at GRH was 86.
- On the day of our unannounced inspection there was significant pressure on the emergency department due to a lack of patient flow within the hospital and in the wider community. Patients queued into the department from the ambulance entrance, stretching to the other end of the department. A second queue formed in the area known as majors one. In the afternoon a third queue was in place in the corridor between the emergency department and the X-ray department. Many patients in the queue had relatives with them, some of whom had to stand as there were insufficient chairs available. One of the patients queuing was a very elderly patient who was terminally ill. When we left the department at approximately 5pm they had been in the department for over 13 hours. From the time we arrived at 11am, until we left at 5pm, they were in the corridor.
- Doctors and nurses took medical histories from patients in the corridor in earshot of other patients, relatives and passers-by. They were afforded no privacy. Two relatives approached us to tell us their family members needed a bed pan. A third patient also asked us for our help. One told us they had asked a nurse three times for assistance and told us “there’s going to be a puddle on the floor in a minute.” Another told us they could not find a nurse. We could not find a nurse either so we informed the nurse coordinator. They expressed their frustration that they did not have enough staff to provide for these basic needs. After a wait of wait of 10 to 15 minutes, patients were taken in turn into a side room and given assistance.
- As the department became more congested, there was a shortage of trollies. We heard the coordinator ask the porter to find some more trollies. They were so inundated with requests that they did not have time to look. We saw the ED information manager assisting nursing staff to clean trollies so they could be put back into circulation.
- The children’s department was cramped and the waiting room was frequently crowded, with relatives having to stand. This was also the case at times in the sub-waiting area.
- There was a separate room which could be used to undertake mental health assessments. This did not comply with safety standards for liaison psychiatry services, developed by the psychiatric liaison accreditation network (PLAN). The room was also stark and unwelcoming. During our unannounced visit we found the room littered with discarded items, including a vomit bowl, cups and bottles. Staff told us the room was frequently used as an overflow assessment room for children and patients in minors so was not always available for patients with mental health problems when needed.
- The trust was working collaboratively with the local A&E delivery board and engaging with health and social care partners to ensure there was a system-wide approach to managing demand and the impact that fluctuating and increasing demand had on the ED.
- All health and social care partners, including Gloucestershire Hospitals NHS Foundation Trust, Gloucester Care Services NHS Trust, South Western Ambulance Service NHS Foundation Trust, the council and the Clinical Commissioning Group participated in a daily teleconference call to monitor patient flow and pressures and agree necessary action and escalation plans for the day ahead. At times of pressure, meetings took place several times a day.

Meeting people’s individual needs

- The service took account of the individual needs of patients but was not always able to provide a responsive service to patients with mental health needs.
- The department was accessible for people with limited mobility and people who used a wheelchair. There were wheelchairs available in the department and staff could access wheelchairs and trollies which could accommodate bariatric patients.
- The reception desk was too high for people of short stature to see the reception staff. We saw several people standing on tip toes at the desk. There was a lower section provided for people in wheelchairs. Staff told us the height of the desk was such in order to keep them secure, but we felt it had the effect of creating a barrier between them and the patients.
- The department had not taken any steps to ensure patient confidentiality at the reception desk. This was a problem particularly for the clinical navigator who sat at a temporary desk in front of the main reception desk. In this small waiting area we able to overhear private conversations.
- There was no hearing loop provided for people who were hard of hearing and used a hearing aid.
- Reception staff had some translation aids available for people whose first language was not English. Staff told us a telephone interpreter service could be provided.
- There were vending machines in the waiting area where patients and visitors could access food and drink. There was a muted television in the main waiting area, and some reading material had been provided.
- There were male and female toilets and nappy changing facilities were available in the children's area. There was a designated area for breast feeding mothers.
- There was a small separate waiting area for children, which was not overlooked by the adults' waiting area. It was suitably furnished, decorated and equipped with toys and a television. It was not appropriately equipped for teenagers and this was commented on to us by a teenager during our inspection.
- We witnessed discussion at a medical staff handover meeting about patients with particular identified needs and how these patients would be supported. This included a visually impaired patient, a patient with a learning disability and a patient whose first language was not English.
- There was a mental health liaison team which supported the ED and the Acute Care Unit from 8am to 10pm seven days a week. The team, who were employed by the local mental health trust, aimed to respond verbally to all crisis and urgent referrals for mental health advice or assessment and provide assessment within two hours. Between June and October 2016 the service received 120 urgent referrals, of which 55% were seen within two hours. Most non-urgent referrals were seen within 24 hours. Outside of these hours staff could contact the crisis home treatment service provided by the mental health trust, or the on-call psychiatrist. Staff told us this service was not responsive as there were limited resources and priority was given to people in the community, as opposed to patients who were regarded as being in a 'place of safety'.
- The trust had a policy that patients with mental health illness would not be admitted to an inpatient bed overnight, awaiting psychiatric assessment unless they had a physical illness or injury. Concerns had been raised about this policy by an ED consultant at the ED governance meeting in November 2016. It was reported that there had been a number of incidents where high risk patients had absconded from the ED because the department did not have the appropriate staffing to supervise these patients. The ED management team told us the mental health liaison team provision was to be extended to cover the full 24-hour period from February 2017.
- There was a mental health liaison team to support children under 16. This service operated from 8am to 8pm Monday to Friday and from 9am to 5pm at weekends. The ED risk register highlighted "The risk of providing care to an increasing number of adolescents presenting with self-harming behaviour who require a place of safety but do not require medical care." It went on to say: "There is significant risk of these patients further harming themselves or other patients, staff and visitors as the resources are unavailable - to monitor and manage these patients in an acute trust is limited, as there is not the specialist facilities and clinical expertise….There is also a risk of a delay in the effective treatment of their mental health condition." The ED consultant with lead responsibility for mental health told us that children and young people who presented in ED in mental health crisis were often admitted to hospital inappropriately because of delayed access to specialist assessment and support.
- In April 2015 the local mental health trust appointed a high intensity case worker to identify strategies to more

effectively manage people with mental health issues who frequently attended the emergency departments in Gloucestershire. One of the objectives was to produce multi-agency management plans to support frequent attenders. Data produced in June 2016 showed an overall reduction in both attendances and admissions where high intensity users were proactively case-managed. The patient records system identified patients with management plans in place (by use of an icon) so that staff could refer to their history and seek guidance on how to best manage each presentation. We were told patients were able to provide input into these plans; however, when we reviewed a sample of these plans there was no evidence of any patient input.

- There was a specialist alcohol liaison service which supported the ED Monday to Friday from 9am to 5pm. Patients attending ED who were identified as having harmful and dependent drinking behaviours were offered assessment, brief intervention and signposting to relevant services. ED staff assessed patients and, where appropriate, provided them with a leaflet and an appointment to see the alcohol liaison worker at the next available clinic slot or within 48 hours. People attending ED on Friday or Saturday would be given an appointment for the following Monday. It was noted in a report to the psychiatric lesion meeting in November 2016 that lack of service provision at weekend created a referral backlog and compensatory pressures on workflow during the early part of the week.
- There was guidance available for ED staff to assist them to identify and manage patients with a learning disability. There was a team of learning disability liaison nurses who could be called upon to support staff. Staff received awareness training as part of their induction. This included meeting the trust's learning difficulties team, understanding what their role was, how to contact them, and what they can offer patients. Support included the production of individual support plans for patients with a learning disability. These were produced in an easy-read format and included patients' likes and dislikes and preferences for care.
- Staff received dementia awareness training as part of their induction. They used purple butterfly stickers on patients' records and purple wrist bands to identify patients with cognitive impairment. The department provided 'twiddlemitts' for patients who were restless or anxious. Twiddlemitts are knitted mittens with items of varying texture attached inside and out. They are knitted by volunteers using bright coloured wool and lots of attachments. They provide simple stimulation for people with dementia and other memory conditions. They minimise agitation, increase flexibility of the fingers and soothe fidgety hands.
- During our unannounced inspection we saw an elderly patient being cared for on the corridor. They were clearly confused and disorientated; they told us they did not know why they were in the department. They were not wearing a purple wristband and there was no indication on their notes to indicate they may need extra support. Staff acknowledged that the corridor was not an appropriate place for this patient. Since the inspection, the trust have acknowledged patients were at high risk of a poor experience, at times of overcrowding. As a result actions were being put in place such as privacy screens for the corridors.
- The department had appointed a dementia champion who was a source of advice and support.
- The emergency department had recently developed a team known as the Gloucestershire elderly emergency care (GEEC), championed by an ED consultant. The aim was to raise awareness of the issues faced by frail elderly patients in the emergency department and to identify areas where the experience of this patient group could be improved. The consultant had recently recruited a nurse and a porter as GEEC champions and at the time of our inspection was in the process of publicising the aims of the group. They planned to hold a 'tea party' in the staff room the week following our inspection to encourage staff to join the group.
- Staff recognised the importance of supporting bereaved relatives. Deceased patients were moved to a side room where family members could spend time with them.

Access and flow

- People did not always receive care and treatment in a timely way. The trust was consistently failing to meet key national performance standards for emergency departments:

- The trust was consistently failing to meet the standard which requires that 95% of patients are discharged, admitted or transferred within four hours of arrival at A&E. The trust did not meet the standard between January and December 2016 and was worse than the England average, which was also below the standard.

However, the trust's performance had shown improvement over time. Performance for the emergency department at GRH during this period ranged from 69.7% in February (worst) to 86% in July 2016 (best).

- The trust also failed to meet the standard recommended by the Royal College of Emergency Medicine (RCEM) in relation to the time from arrival to treatment (one hour) in 10 out of 12 months in the period December 2015 to November 2016. In November 2016 the median time to treatment was 60 minutes, compared with a national average of 59 minutes. At GRH the median wait was higher, ranging from 85 minutes in October 2016 (best) to 106 minutes in February 2016 (worst).
- Another important indicator for patients who require admission to a hospital ward is the time it takes for their transfer to take place from the time of the decision to admit. Between January and December 2016, the trust's monthly percentage of patients waiting between four and 12 hours from the decision to admit until being admitted for this trust was generally better than the England average. The trust's performance had improved over time and in December 2016 trust performance was 12%, compared to an England average of 17%. Over the same reporting period, four patients waited more than 12 hours from the decision to admit until being admitted.
- The department consistently achieved the national target which requires the number of patients who leave the department before being seen by a clinical decision-maker to be less than 5%. This target is recognised by the Department of Health as being an indicator that patients are dissatisfied with the length of time they have to wait. Between December 2015 and October 2016 the trust's monthly median percentage of patients leaving the trust's urgent and emergency care services before being seen for treatment was better than the England average. The trust's performance was consistently between 1.2% and 2.3%. In November 2016, the trust's performance was 1.6%, compared to the England average of 3%.
- The emergency department operated a clinical model (known as UTOPIA), whereby all emergency admissions, including those patients referred by their GP, attended the ED. The principal driver for this was to ensure the earliest possible review of all patients by a senior decision maker who was capable of assessment and instigation of initial management plans. It also enabled some patients, who would otherwise have been admitted, to be assessed and discharged. There was recognition that the increasing numbers and acuity of patients, and poor patient flow within the hospital leading to crowding and associated risks, made this model unsustainable, given the current resourcing and capacity of the emergency department. We were shown a report which showed that on one day in the last month, 56 patients were referred by their GPs for assessment or admission. All of these patients presented at the emergency department and were assessed by ED staff, rather than specialist teams. Detailed diagnostic work was underway both within the emergency department and within the wider system to develop a model which was affordable and sustainable.
- There was detailed monitoring of breaches hour-by-hour in the emergency department and by the site management team. There was a weekly breach meeting chaired by the chief operating officer and monthly performance was reported to the emergency care board against a monthly trajectory agreed with NHS Improvement (NHSI). It was reported in the emergency pathway report that the NHSI recovery trajectory was met in quarter two (July to September) but performance in October and November were below trajectory. The report highlighted the multiple challenges in maintaining progress:

- The trust's emergency departments had seen a 4.9% increase in attendances in the 12 months to November 2016
- There was a significant shortage of junior and middle grade medical staff in the emergency department
- High bed occupancy levels, average length of stay, medically fit for discharge patients and delayed transfers of care. The report stated "Occupancy levels at Gloucestershire Hospitals have historically run at more than 95% for many years. The Trust considers this unacceptable and recognises the impact on the potential quality of care and the impact on staff. The Trust recognises a significant piece of work is required to sustainably reduce occupancy rates to acceptable levels of 92.5% and elements towards achieving a reduced occupancy sit across a number of work streams within the programme…"

Urgent and emergency services

- The trust's risk register recorded "Delayed discharge of patients who are on the medically fit list above the agreed 40 limit leading to detrimental effects on capacity and flow of patients through the hospital from ED to ward."
- Analysis of the main contributing factors to four hour breaches in November 2016 showed that bed availability was by far the biggest single cause of breaches (35.9%). The second biggest cause was 'awaiting assessment' (20.57%) and the third biggest cause was 'others' (this included waiting for diagnostics, porters, transport and specialists).
- The trust recognised that crowding in the ED presented a risk to patient safety, patient experience and performance against key waiting time targets. There was a trust Patient Flow and Escalation Policy (September 2016) which set out steps to mitigate these risks by ensuring that patient flow throughout the two hospitals was managed.
- There were regular capacity and flow meetings throughout the day and these were attended by a representative from the ED. The site management team maintained an organisational overview of capacity and issues affecting flow, and liaised closely with the ED coordinator.
- The escalation policy described and rated the escalation of each hospital, ranging from green (low risk) to black (very high risk). The escalation level was triggered by bed capacity or ED capacity (numbers and breaches) and was reviewed regularly. In the ED, escalation status was reviewed by the nurse coordinator and consultant at the hourly board round. The escalation status of the department was calculated using a score system which took into account incoming ambulances, total arrivals, majors' cubicles in use, resuscitation cubicles in use and total patients in department.
- Escalation status was communicated to, and reviewed by, the site manager and the designated trust duty manager. When the ED was at red or black status, the coordinator implemented the ED escalation policy.
- There was a series of action plans in place for each escalation status. Actions included opening additional beds, providing additional staff, cancelling training and diverting patients to other hospital sites. When escalation status was declared black, a major incident would be declared.
- The trust had developed a number of initiatives to prevent unnecessary ED attendance and/or admission to hospital and thereby improve patient flow.
- From September 2014 all GP calls for an ambulance were handled by the Gloucestershire Single Point of Access run by a local care trust, where alternatives to ED attendance would be considered first. However, the specialty director told us some GPs opted out of using this system.
- The trust's website provided advice to members of the public to encourage them to choose the most appropriate service when they needed urgent healthcare advice or treatment. The Advice ASAP campaign included a short video and a smart phone application which allowed people to search by service or by symptoms. There were links to a range of local services, including primary care (including out of hours), NHS 111, pharmacies and local minor injury and illness units. Live information was also posted on the website showing how busy each ED was and the average time patients would have to wait to be seen.
- The Older People's Assessment and Liaison (OPAL) team visited the emergency department each week day and proactively identified patients over the age of 80 for whom admission may be avoided if a suitable care package was put in place. The team consisted of a consultant in care of the elderly, supported by a registrar and a nurse.
- The OPAL team liaised closely with the integrated discharge team provided by a local care trust to work in the ED and on the Acute Care Unit. The team, made up of health and social care professionals, assessed appropriate patients and, where possible, directed them to other services in the community. It also supported patients (inpatients and ED patients) who needed ongoing health or social care services after they were discharged and helped to facilitate their early discharge. The service operated from 8am to 8pm Monday to Friday and from 9am to 5pm at weekends and over bank holidays.
- The trust was piloting a primary care service based in ED. The trial was a joint initiative with the local ambulance service and employed a GP in the department. A clinical navigator was based in the waiting room and directed appropriate patients (those with a minor illness) to see a GP or an advanced nurse practitioner.

Urgent and emergency services

Learning from complaints and concerns

- Between November 2015 and October 2016 there were 103 complaints about urgent and emergency care at GRH. Twenty- seven complaints (26%) were categorised as 'patient care'.
- The trust took an average of 38 working days to investigate and close complaints. This was slightly longer than stipulated in the trust's complaints policy, which stated complaints should be responded to in 35 working days.
- Staff we spoke with were with were familiar with the complaints procedure. They told us they would try to arrange for complainants to speak with a senior member of staff or direct them to the Patient Advice and Liaison Service (PALS). There were complaints leaflets in the department which advised people how to complain, and these were also available via the trust's website.
- Complaints were discussed at governance meetings. A consultant was the designated lead for complaints within the department and was responsible for identifying themes and disseminating learning. Communication methods included 'Message of the week' where short catchy reminders were displayed around the department.
- The trust had introduced a new digital methodology for the friends and family test in July 2016 and 0this had resulted in a big increase in the response rate for September 2016 (26% trust-wide).

Are urgent and emergency services well-led?

Good

We have rated this service as good because:

- There was a strong, cohesive and well-informed leadership team who were highly visible and respected.
- There was a detailed improvement plan in place with clear milestones and accountability for actions.
- The emergency department produced high quality information which analysed demand capacity and patient flow, and was used to inform the improvement plan.
- There were robust governance arrangements in place. Clinical audit was well-managed and used to drive service improvement. Risks were understood, regularly discussed and actions taken to mitigate them.
- There were cooperative and supportive relationships among staff. We observed exceptional teamwork, particularly when the department was under pressure.
- Staff felt respected, valued and supported. Morale was mostly positive, although to an extent was undermined by workload pressures.
- Service improvement was everybody's responsibility. Staff were encouraged and supported to undertake service improvement projects.

However:

- Safety concerns which we identified at our last inspection had not been addressed, despite the introduction of new processes. Poor patient flow remained the major barrier to progress. The emergency department's management team did not feel there was a culture of collective responsibility within the trust in relation to patient flow. There was frustration expressed that the emergency department bore a disproportionate level of risk, while the responsibility for the exit block sat with others. The emergency department was unable to influence the cultural shift which was required to address this significant barrier to improving patient flow and capacity.
- Pressures faced by staff in the emergency department in relation to crowding were well understood and articulated by the management team but it did not appear that the risks relating to staff wellbeing, resilience and sustainability, had been widely shared or escalated within the organisation and they were not included on the department's risk register.
- There was a limited approach to obtaining the views of people who used the service.
- Workload pressures prevented opportunities for staff reflection or meaningful staff engagement and involvement in shaping the service.

Vision and strategy for this service

- The vision for the service was for the provision of all strands of unscheduled care to be provided under one roof, 24 hours a day, seven days a week. This included the expansion of primary care services, mental health liaison and support, ambulatory emergency care, further development of the frail elderly care pathway

(including short stay beds), and the provision of larger and updated premises to accommodate these services. It was anticipated this would take several years to achieve.

- There was a trust-wide five year strategic plan and an operational plan for 2016/17. Priority areas were identified in the operational plan as:
- addressing the inability of the local health and social care system to manage demand within current capacity,
- matching workforce with clinical needs,
- developing the physical estate.
- The emergency care pathway was identified as a trust priority for improvement and plans were set out in the emergency care programme. A series of external reviews had taken place to examine the issues affecting operational effectiveness and patient flow. Most recently an improvement director appointed by NHS Improvement had undertaken diagnostic work which had resulted in the development of an emergency care programme. Recommendations had been incorporated into the trust's Emergency Care Board (ECB) plan and progress against milestones was closely monitored both by the ECB and the trust board.
- A work programme was developed under the umbrella of an economy-wide plan monitored by the A&E Delivery Board. Six work streams with defined objectives were developed and progress against each of the work streams was monitored by the emergency care board. Work streams were:

  - Emergency Department,
  - Site management,
  - Safer patient flow bundle,
  - Clinical patient flow model,
  - Bed distribution,
  - Remove delays to discharge.

- Within the emergency department work stream the objectives were:
- To review staffing and skill mix
- To review four hour breaches
- To increase ED capacity

Governance, risk management and quality measurement

- There was an effective governance framework. Information was regularly monitored to provide a holistic understanding of performance, including safety, quality and patient experience.
- There was a bi-monthly clinical governance meeting attended by senior nursing and medical staff. A standard agenda included incidents and risk management, patient experience, complaints, safety alerts, clinical guidelines and audit. Key messages were communicated by distribution of minutes, email, bulletins, teaching sessions and handovers. The emergency department clinical governance meeting reported to the divisional quality meeting, which reported ultimately to the board. Divisional quality reports monitored and reported on key safety and quality standards. There were also monthly operational meetings where items discussed included staffing and performance.
- One of the ED consultants took the lead overall for quality and governance. All ED consultants had designated specialist lead roles, such as clinical audit, complaints, mental health, paediatrics, elderly care, and missed radiological pathology.
- There was a monthly emergency pathway performance report to the board, detailing progress against the emergency care programme board milestone plan. Performance metrics included safety, patient experience, incidents, complaints, morbidity and mortality. There were a number of county-wide projects to streamline the urgent care system as detailed in a system-wide plan. This involved working with health and social care partners.
- The emergency department maintained a risk register which was regularly monitored and reviewed at departmental and divisional levels. Risks aligned with the areas of concern identified to us by managers and staff, with the highest risk being associated with demand, capacity and patient flow. However, risks in relation to staff wellbeing and resilience, whilst understood and articulated to us, were not identified in the risk register.
- There were good relationships with third party providers. For example, the director of nursing met regularly with their counterpart in the local mental health trust and there were regular meetings with ED and the mental health liaison service.
- There was a systematic programme of clinical audit which was used to monitor quality and safety. At our

previous inspection we raised concerns that the audit programme was not well-managed, actions arising from audits were not completed in a timely manner and we could not be assured that learning and improvements consistently took place. On this inspection we found this was much improved. Responsibility for managing the audit programme had been passed to another consultant, who had reviewed all audits going back to 2012/13, ensuring that all actions were completed. The lead consultant had a good overview of all ongoing audit, action plans and plans for re-audit. We reviewed a number of audits and saw action plans had been completed, discussed at mortality and morbidity meetings and learning points disseminated.

Leadership of service

- There was a local management triumvirate comprising of a specialty director, matron and general manager. They were supported by an operations information manager. They were a well-informed, cohesive team who were highly respected by staff. They demonstrated passion and drive to meet the significant challenges in unscheduled care and to develop and improve their service.
- Staff told us the local management team was visible, approachable and supportive. During our visit they were all highly visible in the department and provided assistance when there were capacity issues. The triumvirate team felt well supported by the divisional management team and the new chief executive was described as “a breath of fresh air”. However, there was frustration expressed that the emergency department bore the risks associated with lack of patient flow, while responsibility for managing the exit block sat with others and progress in addressing this was slow.

Culture within the service

- Staff in ED told us they felt respected, supported and valued by their immediate managers and their peers. Staff morale was mainly positive, with many staff citing teamwork as one of the best things about working in the emergency department. We observed exceptional teamwork during our visits, with all disciplines and grades of staff working together seamlessly and helping each other out when needed. We saw doctors taking blood when nurses were busy, and managers were frequently seen in the department helping out in any way they could to ease the pressure on clinical staff.
- Morale was inevitably undermined by workload pressure and managers expressed concerns about the impact that workload was having on the physical and mental wellbeing of staff. This was most acutely felt by nursing staff but there were also concerns about the frequency with which consultants were working additional hours to support the department, particularly at night. A workplace stress risk assessment undertaken in May 2016 had identified some concerning messages. It was reported that increasing ED attendances and patient acuity, combined with delays in diagnostic and specialty review, and reduced bed capacity, had led to an excessive increase in staff workload without any additional staff to deal with it. It was noted this had “a profound impact on the stress and wellbeing of staff.” This was highlighted by :

- High staff turnover
- Concerns about workload and the working environment
- Concerns about a lack of communication within the department (difficulty releasing staff to attend staff meetings and in house teaching activities).
- Staff feeling disconnected with changes at work.

- Positive feedback was received in relation to:

- The skills and abilities of staff being matched to the demands of the job and the provision of training
- Staff said they were encouraged to use their skills and initiative
- Staff felt supported by their colleagues
- Staff had adequate feedback and resources to enable them to carry out their role.

- An action plan was in place to address areas of concern.

Public engagement

- The ED used the friends and family test to capture patient feedback and this was discussed at governance meetings.
- The service provided us with no further examples of public engagement.

Staff engagement

- There were limited opportunities for face to face staff engagement, although staff were kept informed via email bulletins, newsletters and handover meetings. There were departmental meetings held for nursing staff. However, these took place infrequently and were poorly attended due to operational pressures.

- Nursing staff had not been actively engaged so that their views were reflected in the planning and delivery of services and in shaping the culture. None of the ED staff we spoke with could articulate the department's vision or strategy.
- Staff told us they were encouraged to raise concerns and they felt they were listened to.

Innovation, improvement and sustainability

- There was strong sense of drive to improve the service. There was an emergency department improvement plan which had been developed in response to a number of drivers, including our previous inspection report, recommendations from Monitor (now NHS Improvement), commissioning targets and audit findings.
- The trust was linking with other centres where innovative approaches to junior doctor roles have attracted candidates and were also reviewing non-medical practitioner models as a means of addressing medical staffing vacancies.
- There was a Quality Improvement Academy established in the trust in June 2015. Staff were supported to undertake projects which were identified as areas which could make improvements to quality and safety. Projects in the emergency department included Biers Block with collies fractures, early management of chest pain and ECGs, early management of asthma, improvement of pain management in emergency departments.

Medical care (including older people's care)

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

Information about the service

Gloucester Hospital Foundation NHS Trust provides inpatient medical services at Gloucestershire Royal Hospital and at Cheltenham General Hospital. Services at Cheltenham General Hospital are reported in a separate report. However, both locations are overseen by one management team (the medical division) and as such, are regarded as one service within the trust with some staff rotating between the two locations. For this reason, some duplication in the two reports is inevitable.

The Medical care service at the trust provides care and treatment for nine specialties. There are 548 Medical inpatient beds located across 22 wards. In August 2016, there were 358.42 nursing whole time equivalents (WTE) and 274.79 other clinical WTE for the medical services.

A site breakdown can be found below:

• Cheltenham General Hospital: 200 beds are located within nine wards

• Gloucestershire Royal Hospital: 354 beds are located within 13 wards

The trust had 72,120 medical admissions between April 2015 and March 2016. Emergency admissions accounted for 30,633 (42%), 1,671 (2%) were elective and the remaining 39,816 (55%) were day case.

Admissions for the top three medical specialties were:

• General Medicine 28,108

• Medical Oncology 19,813

• Gastroenterology 10,486

Gloucestershire Royal Hospital (GRH) has 11 medical wards, an acute medical assessment unit and an ambulatory care unit. At the time of our inspection, two additional wards were in use for medical patients to cope with increased demand due to winter pressures.

We inspected the medical services between 24 and 27 January 2017 and also visited the service unannounced on 6 February 2017. During the inspection, we visited the inpatient wards: Gallery Wing 1 (General medicine), Ward 4A (general old age medicine and endocrine), 4B (Elderly care), 6A/B (stroke care), 7A (dermatology), 7B (renal care), 8B (respiratory care), 9B (general old age medicine) and the cardiology wards 1, 2 and the cardiac care unit. We also visited the acute assessment unit (ACUA), medical day care unit, the ambulatory care unit, discharge lounge and the endoscopy unit.

We spoke with 71 members of staff including nurses, doctors, allied health professional such as pharmacist, physiotherapist, occupational therapists, ward clerks, housekeeping staff and volunteers. We spoke with 20 patients, three relatives and we reviewed 17 sets of medical notes. We observed interactions between staff and patients, attended bed meetings and multidisciplinary meetings, observed part of ward rounds and looked at the environment in the different ward areas.

Medical care (including older people's care)

Prior to, during and after the inspection we looked at information requested and sent to us by the organisation, which included audit results, minutes of meetings, organisational policies, incidents, complaints and positive feedback.

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

The team included CQC inspectors and a variety of specialists including a retired consultant cardiologist, a ward manager and a nurse.

Summary of findings

We rated this service as requires improvement because:

- Nursing staffing levels were below establishment and wards relied on bank and agency to cover shifts every day.
- The service did not assess or record the acuity of patients on each shift and on each ward to ensure safe staffing levels.
- The medical service did not consistently review the effectiveness of care and treatment through national audits.
- The service had a strategy to understand and improve performance on hospital-based mortality indicators. While most specialities held mortality and morbidity (M&M) meetings monthly or quarterly we were concerned that not all specialties held meetings regularly and how effectively learning was shared.
- There were some concerns about the safe transfer of patients receiving intravous therapy during ambulance transfers to other hospitals.
- Staff did not always follow infection control procedures when entering wards and ensuring the cleanliness of equipment such as commodes.
- Staff did not always comply with legislation regarding the Control of Substances Hazardous to Health (COSHH).
- Daily checking of equipment such as resuscitation equipment was not carried out in line with the trust's policy in all areas.
- Staff did not monitor fridge temperatures consistently or take actions where these fell out of normal range, which meant medicines were not always stored correctly.
- Staff were unsure of when to dispose of some medicines in line with manufacturer's recommendations.
- Records were not stored safely to ensure patient's confidentiality was maintained.
- Staff did not always assess risks to patients or follow up identified risks with mitigating care interventions.
- The medical service did not consistently review the effectiveness of care and treatment through national audits.

Medical care (including older people's care)

- Staff did not always put actions in place when patients were at risk of malnutrition.
- Compliance with annual appraisals were below the trust's target.
- There were delays in discharging patients; although this was largely caused by factors outside of the medical services remit.
- Information was not always accessible to staff including information about care and treatment pathways.
- The delivery of cardiology services did not meet the needs of the local population.
- There were delays to discharges, which meant patient flow through the hospital was compromised.
- The environment did not meet the needs of patients with dementia.
- The service was not always compliant with the accessible information standards and information leaflets were not readily available for patients for whom English was not their first language.
- Risks registered on the risk register were not always aligned with risks in the service
- There was a limited approach to obtaining the views of patients and their relatives

However:

- Staff understood their responsibility to report incidents and there were processes in place to review incidents and ensure learning was shared across the trust.
- The endoscopy unit had safe processes in place to ensure staff decontaminated and sterilised equipment in line with best practice.
- Staff were aware of their responsibilities for identifying and reporting safeguarding issues.
- There were safe processes in place to review patients and ensure care and treatment plans were followed up.
- Patients were positive about the way they were treated and cared for in the medical wards. Where staff were observed treating patients with kindness, dignity, respect and compassion.
- Patients praised staff for providing further information when asked.
- There was a competence training and assessment framework in place to ensure nurses were competent to carry out extended skills and nursing staff were supported with revalidation processes.
- There was an effective framework for 'board round' and ward rounds and included input from staff from the multidisciplinary healthcare team.
- Processes were in place to ensure consultants reviewed patients seven days a week.
- Staff were aware of the mental capacity assessment and applications for deprivation of liberty safeguards.
- The trust's referral to treatment time (RTT) for admitted pathways for medical services was better than the England overall performance between November 2015 and October 2016.
- The trust had a clear vision and some specialities within the medical division had a vision to expand and improve services.
- Staff felt supported by managers and senior management felt assured by the new executive team.

Medical care (including older people's care)

Are medical care services safe?

Requires improvement

By safe, we mean people are protected from abuse and avoidable harm. We rated safe as requires improvement because:

- Nursing staffing levels were below establishment and wards relied on bank and agency to cover shifts every day.
- The service did not assess or record the acuity of patients on each shift and on each ward to ensure safe staffing levels.
- Staff did not always follow infection control procedures when entering wards and ensuring the cleanliness of equipment such as commodes.
- The wards did not display evidence of when areas such as toilets were last cleaned and we did not see environmental audit result displayed on the wards we visited.
- Staff did not always comply with legislation regarding the Control of Substances Hazardous to Health (COSHH).
- The fabric of the building did not always ensure efficient cleaning could be carried out.
- Daily checking of equipment such as resuscitation equipment was not carried out in line with the trust's policy in all areas.
- Fridge temperatures were not monitored or actions taken where these fell out of normal range, which meant medicines were not always stored correctly. Staff were unsure of when to dispose of some medicines in line with manufacturer's recommendations.
- Records were not stored safely to ensure patient confidentiality was maintained.
- Staff did not always assess risks to patients and followed up with mitigating care interventions.

However:

- Staff understood their responsibility to report incidents and there was evidence of learning from incidents across the organisation.
- The endoscopy unit had safe processes in place to ensure staff decontaminated and sterilised equipment in line with best practice.
- Staff were aware of their responsibilities for identifying and reporting safeguarding issues.
- There were safe processes to review patients and ensure care and treatment plans were reviewed.

Incidents

- There had been no never events reported in the medical services in the period from December 2015 to November 2016. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event. However, there had been a never event (misplaced nasogastric feeding tube (NG)) in another service within the hospital. As a result, learning had been shared with other services/ departments in the trust. We asked staff on ward 6B about checking the correct placement of NG tubes prior to commencing feeding as we noted five patients with NG feeding in progress. Staff demonstrated robust knowledge of safe practices following the never event in the hospital. Changes had been introduced and now two members of staff were required to check for the correct position before NG feeding commenced. Staff also described the process for escalation if this could not be confirmed. We noted this was all documented in the medical notes.
- In accordance with the Serious Incident Framework 2015, the trust reported seven serious incidents (SIs) in medical care, which met the reporting criteria set by NHS England from December 2015 to November 2016. Of these, the most common type of incidents reported was slips/trips/falls and healthcare associated/acquired infection control incident, both with two reported incidents.
- There was a good incident reporting culture and staff were actively encouraged to complete electronic incident reports. Staff were aware of their responsibility to report incidents. We saw evidence that lessons were learnt and improvements were made when things went wrong.
- The clinical risk lead reviewed reported incidents from the medical services. Any potential serious incidents were discussed with the ward staff and additional information gathered. Serious incidents were reviewed at a scoping meeting and an investigator allocated to carry out an investigation of the circumstances and

outcomes. Incidents that were not considered to be serious incidents were investigated appropriately and actions identified and taken. Feedback was provided to the original reporter of the incident.

- Trends and patterns of incidents were analysed by the clinical risk team and reported to the medicine divisional leads. The top five incidents reported within the medicine division were falls, pressure damage, violence and aggression, medicine errors and staffing.
- Staff reported incidents using an electronic incident reporting system. Staff understood their responsibility to report incidents and found the system easy to use. We asked staff about changes in practice attributed to lessons learnt from reported incidents and many staff gave us examples. For examples, staff on the respiratory ward told us how they had changed the method for delivering non-invasive ventilator support, as they had found the previously used masks to cause pressure damage to the ears. They now used a facemask and had not had one incident of pressure damage since. The ward sister on ward 8B told us how learning from a serious incident had resulted in an extra registered nurse at night and tracheostomy training was updated every three months to ensure staff kept their skills updated.
- Nurses told us about changes to supporting patients with nasogastric (NG) tubes to ensure correct position before NG feeding was commenced. There was guidance on how to check the position of NG tubes, which was an assessed competence and the NG tube had to be checked and confirmed by two nurses before NG feeding was commenced. If there were any concerns about NG placement, they would refer to a doctor and the patient may have an x-ray to confirm position. Other changes because of incidents included increased frequency of care rounds and the introduction of 'falls alarms' for patients at high risk of falling.
- Staff on ward 7B described a change of practice following a serious incidence when a patient developed a pulmonary embolism following line insertion in preparation for dialysis. The 'line room' was previously staffed by a doctor and a healthcare assistant, but this was changed and the doctor was now supported by a registered nurse.

Duty of Candour

- The duty of candour refers to Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 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 were aware of the 'duty of candour' legislation although not all staff had attended training or read the policy relating to it One ward sister stated they had been too busy to look at the intranet to see if there was training or a policy but suspected that information would be available.
- We looked at investigations into serious incidents. There was a section within the standard framework, which detailed support given to patients and carers. However, there was no specific evidence that the outcomes of the investigations were shared with patients and their carers as appropriate.

Safety thermometer

- The hospital reported data on patient harm to the NHS Health and Social Care Information Centre each month. This was nationally collected data providing a snapshot of patient harms on one specific day each month. This included hospital-acquired (new) pressure ulcers (including only the two more serious categories of harm) and patient falls with harm.
- Ward staff in all areas told us they regularly undertook monthly safety thermometer audits, which were sent to the clinical audit department.
- Managers kept safety thermometer audits in files in the manager's office and displayed the safety thermometer results in most ward areas as 'harm free care'.
- Staff collected data one day each month to monitor performance in delivering harm free care. Data from the Patient Safety Thermometer showed that the trust reported 86 pressure ulcers, 39 falls with harm and 38 catheter urinary tract infections between November 2015 and November 2016.The data showed that the prevalence of pressure ulcers and falls were both reducing over the period and there was a similar trend for catheter urinary tract infections.
- There had been an increase in reporting of pressure ulcers because staff were now required to report all pressure ulcers (grade 1-4) as an incident. Although there was an increase in pressure ulcers reported, all grade 2 pressure ulcers were now reviewed by a tissue

viability specialist nurse and as a result, there had been a decrease in pressure ulcers deteriorating and subsequently, fewer grade 3 and grade 4 pressure ulcers.

- The trust used medical photography to help document the severity of the pressure ulcers when first noted, which helped staff to evaluate the effectiveness of treatment and care. Each ward had a pressure ulcer dressing trolley with dressings suitable for each category of pressure ulcers from grade 1 to 4. The trolleys also contained the 'European pressure ulcer advisory panel' (EUPAP) grading tool, the trust's skin care protocol, care plan (SSKIN bundle), patient information leaflets, wound care assessment chart and different types of dressings.

Cleanliness, infection control and hygiene

- There were not always reliable systems in place to prevent and protect patients from healthcare associated infections.
- We found some ward areas, including corridors, were cluttered and untidy with visibly dusty floors, and doors left open to both treatment rooms as well as sluice facilities. Not all equipment had stickers to indicate when they were last cleaned (including commodes, although we could see that seats had been lifted). We also saw some clinical waste bins overflowing with aprons and gloves.
- Wards had fabric curtains to help provide privacy and maintain dignity for patients. However, ward staff, including domestic staff and ward managers, did not know when the curtains were last washed. We were told by the staff, the domestic staff would always change the curtains if a bed space, side room or ward bay was deep cleaned following the discharge of a patient with an infectious disease. The supervisor in the linen department told us that they changed the curtains every three months regularly, more often if visibly dirty, or following the discharge of patient with an infectious disease. The linen department kept records of changes to ensure this happened regularly and to help plan the work load. An outside contractor collected the curtains and laundered these off site. They told us this followed the trust's 'curtain procedure policy and action plan'. We checked the Department of Health: Health Building note 00-09: Infection control in the built environment' and concluded that practice was in line with recommendations for curtains in clinical area.
- Staff wore clean uniforms and had their hair tied up if applicable, however, staff did not always follow policy on the use of hand gel when entering wards. On ward 6B we saw eight members of staff enter the ward without using hand gel some of these staff did not also comply with the policy to be 'bare below elbows'. On ward 7B we observed four members of staff enter the ward without using the hand gel.
- Staff on the wards decontaminated their hands in line with NICE guidance (QS 61 statement three, 2014) which states that people should receive healthcare from healthcare workers who decontaminate their hands immediately before and after every episode of direct contact or care. Staff were required to complete hand hygiene audits monthly. However mangers did not always display the results on the wards for patients and visitors to see. Audit results demonstrated compliance was between 91% and 100% for clinical staff in the period from April to October 2016, against a target of 95%.
- Registered nurses on most wards used tabards when administering medication to help prevent interruptions. On some wards, these were fabric and only washed once a week or more frequently if visibly dirty. On ward 8B we observed staff wearing plastic tabards that could be disposed of after each use.
- The wards did not display evidence of when areas such as toilets were last cleaned and we did not see environmental audit result displayed on the wards we visited. On the cardiac wards, we saw a toilet, which was untidy, with personal toiletries left, and a used bedpan liner on the floor. Wards did not display records of when domestic staff had last cleaned the toilet facility
- There was not a consistent method of informing staff when commodes were clean prior to patient use on several wards. Staff told us that the sticky labels were unreliable and they left the commode lid upside down to show it had been cleaned. Several wards had laminated notices, which they put on the clean commodes.
- Staff did not always comply with legislation regarding the Control of Substances Hazardous to Health (COSHH). On ward 9B we saw there were two containers with chlorine tables in an unlocked cupboard. On the acute medical assessment unit (ACAU), we saw three containers of chlorine tablets and diluted chlorine solution was accessible in the unlocked sluice. On ACAU, we saw nine small and one large sharps bins placed on

a trolley in the ward area awaiting collection for disposal. These were accessible to patients and visitors to the ward and although closed appropriately there was a risk of access to contaminated sharp equipment such as needles.

- We observed practices for barrier nursing patients with potential infectious diseases. Staff wore personal protective equipment such as gloves, apron and masks as identified through risk assessment. We observed staff challenging people if they entered the isolated area without personal protective equipment and if somebody (other than the patient) sat on the bed.
- In 2016, the majority of nursing staff had completed their training in infection prevention and control. The trust target of 90% was met and exceeded with 94.6% of the nursing staff having undertaken infection, prevention and control training. However, medical staff were not meeting the trust target for infection prevention and control training. The trust target of 90% was not met as 85.4% of medical staff had undertaken the training.
- The endoscopy unit had facilities to maintain infection control procedures safely. The unit had a decontamination area, which was separate from clean areas and had separate doors. There were four autoclaves for sterilising the equipment and staff wore personal protective equipment such as apron, gloves and a face shield. The unit had procedures in place to ensure safe practice if patients were admitted with known transmittable infections such as tuberculosis which included carrying out the procedure at the end of the day and follow this with a deep clean of the area. Staff had access to infection control policies such as guidance on infection control practice in patients with blood borne virus or Creutzfeldt-Jakob disease (CJD). The unit also had a separate isolation recovery room.
- The renal ward had processes in place to prevent and protect patients from blood borne viruses. There was specific policies available to staff and processes in place to prevent cross contamination from patient with known infections. The unit had processes in place for testing the water quality weekly for Legionella. Any abnormalities were reported as serious incidents and to public health authorities as per national guidance.
- The trust reported one case of methicillin-resistant staphylococcus aureus (MRSA) bacteraemia and 12 cases of clostridium difficile (CDiff) multiple drug resistant organisms, between August 2016 and January 2017. The standard set was nil cases of MRSA bacteraemia. The standard for Cdiff infections (post 48 hours as an inpatient) was 30 cases of Cdiff per year (running total). The trust monitored this and the number of cases did not exceed this standard from January to October 2016.

Environment and equipment

- The design, maintenance and use of facilities did not always keep people safe.
- Staff did not always check bed spaces to ensure emergency equipment was present following discharge of a patient. On the cardiac ward, we checked an empty bed space, which was declared ready for admission of another patient. There was no oxygen tubing and no suction chamber, which meant that both of these were not ready for use in an emergency.
- On ward 7B the floor of the main corridor on the ward was worn and looked dirty. Both wards 7A and 7B were cluttered with equipment stored in the corridor and generally shabby. The paint on the ceiling tiles in ward 7B was chipped and dilapidated. Ward 7A had a room designated as the dayroom; however it was not fit for purpose. The blood fridge and a hoist were stored in it. The skirting board had come away from the wall and the flooring was worn; which meant that effective cleaning would be difficult. There were no storage facilities on ward 7B for cleaning products for domestic staff. The ward manager told us of a plan to re-locate the specialists nurses based on the ward and their office changed into storage space.
- However, ward 7B had a dedicated treatment room for the placement of tunnelled lines under ultra sound guidance. We checked equipment and consumables and found them to be in date. Staff locked the room when not in use.
- The medical day unit comprised of two, six bedded bays with ten chairs in each. A variety of short term and long term medical conditions were treated in the unit, which included pre-operative anaemia, liver conditions and inflammatory bowel conditions. There was a wide range of treatments carried out such as blood transfusions, iron infusions, infliximab infusions, and a deep vein thrombosis service. The service treated up to 35 patients in a day. The bays were cramped and patients had very little space between chairs, several patients had visitors with them and this made the bay even more cramped. This compromised patient's dignity and confidentiality.

- In cardiology the equipment used for trans oesophageal echocardiogram (a test that allows medical staff to take detailed images of the heart using high pitched sound waves), did not produce clear images. As a result, all such procedures for both in patients and outpatients were being undertaken at Cheltenham General Hospital whist a replacement was being procured.
- Not all wards had their own resuscitation trolley. For example, the discharge lounge shared resuscitation equipment with the ambulatory care unit and the medical day case unit. Staff were clear about where to access it and also about responsibility for daily checking of the trolley.
- However emergency equipment such as resuscitation trolleys were not checked daily. We visited many ward areas and none of them had 100% compliance for daily checking. For example, staff on cardiology ward two had not checked the resuscitation trolley on four days between 1 and 25 January 2017 and the defibrillator had not been checked on six days in the same period. There was not always a checklist to audit daily checking of defibrillators throughout the medical services. For example, ward 9B did not have a list to log daily checking. When we raised this with a senior ward nurse, they appeared unaware that staff should log this daily.
- As some areas, such as bathrooms, did not have access to piped oxygen or suction in the event of an emergency, portable equipment was located next to the resuscitation trolley. However, there was an inconsistent approach to checking the safety and working order of portable equipment. Staff did not always know when the equipment was last checked and there was no auditable list to provide this information.
- The trolleys contained medication and equipment used in the event of a cardiac or respiratory arrest. Medication within the trolleys was stored in tamper-evident containers. However, none of the drawers within the trolleys were themselves tamper-evident, so medicines could be removed between checks without this being apparent.
- The trust had introduced new blood sugar monitoring equipment, which was automatically calibrated daily. However, not all departments had the new equipment, for example, the ambulatory care unit used the old blood glucose meter, which required staff to calibrate the machine daily. We found gaps in the documentation for daily calibration, for example in January 2017 staff had not calibrated the machine on 11 days out of 20 days (not counting weekends, as the unit was not regularly open at weekends).
- Some wards had daily/weekly cleaning check lists but this was not consistent on all wards. These were kept in the domestics cleaning cupboard, which was locked. It was therefore not possible for patients or visitors to the wards to see when areas had last been cleaned.

Medicines

- Arrangements for managing medicines did not always keep patients safe.
- Medicines were mostly stored securely in locked trolleys, were generally tidy and were securely locked to the wall when not in use. However, we found the trolley in the coronary care unit was not secured to the wall. We pointed out to staff a on the unit who took immediate action to secure the trolley. In the treatment room on Ward 7B we found a drug cupboard unlocked. The ward sister locked it immediately when we pointed this out.
- Most patients had drug pods in their lockers. Therefore, staff did not use medicine trolleys but used a dressing trolley for the medication round. We found Paracetamol loose on the trolley, which we raised with the ward sister who locked them away.
- Nurses were not clear what the trust policy was for the storage of liquid medicines. We saw an opened bottle of morphine sulphate 10mg per 5ml in use. This medicine should be destroyed 90 days after opening however, the date of opening had not been recorded. Other bottles of liquid medicine were also not annotated with the date of opening. We also noted a bottle of Latanoprost eye drops in use. Eye drops should be disposed of 28 days after opening however, these had been in use for longer than that. We highlighted this to the nurse who removed the eye drops. The pharmacy department recognised that the trust policy was not clear and as a result the guidance was being reviewed by the medicine information department.
- Refrigerated items were also found to have expired. We found an antibiotic liquid that had expired on 11 January 2016 and a vial of insulin that had expired on 19 January 2016. We highlighted this to staff who then destroyed the medicines.
- Staff were required to record maximum, minimum and actual medicine refrigerator temperatures once per day and take appropriate action when fridge temperatures

fell outside of acceptable limits. Many wards were not compliant with this. For example, on ward 6A, staff recorded 28 out of 30 minimum temperatures for November 2016 between -1 and -4°C, which is below the recommended storage temperature for medicines (2-8°C). Staff did not record what action was taken but we were told that there had been a problem with the thermometer. In the ambulatory care unit staff did not record the fridge temperature checks in line with policy.

- On ward 7A we found the lock on the medicines fridge was broken. The ward manager told us that a new fridge was on order and was to be delivered within a week. However, medication including vials of insulin, insulin pens, Xylocaine and Chloramphenicol were still stored in it. Fridge recordings were not in range and staff had not been recorded the temperatures since 5 January 2017. The fridge was in a locked room but there was no risk assessment carried out to regarding the storage of the medicines. The ward manager told us that the ward pharmacist had allowed this and checked the fridge on a daily basis.
- Oxygen cylinders were stored in the clean utility room on Ward 9B. However, this room was unlocked and there was no signage on the door to indicate that the area was used as storage for oxygen.
- We carried out spot checks on controlled drugs on some wards (Ward 9B and the coronary care unit) and found that these corresponded with the records. However, the daily checking was not always completed, for example, on ward 9B the controlled drugs were not checked on five days in the period from 1 to 25 January 2017 and in the coronary care unit controlled drugs were not checked on nine days in the same time period. Nurses did not always sign the received section of controlled drugs order book when receiving delivery of controlled drugs. This was against the trust policy, good practice and meant that the trust would not easily be able to investigate incidents involving delivery of controlled drugs. However, the controlled drugs were stored in appropriate cupboards and the keys were separate from the main bunch of keys and kept on a registered nurse at all times.
- The endoscopy unit followed the 'conscious sedation' policy for patients undergoing some endoscopy procedures. Staff were knowledgeable about the medication that was used and had emergency equipment which was checked daily. The unit stocked and administered controlled drugs as required. The controlled drugs (CDs) were kept in a locked cupboard and were signed out by registered nurses. We noted that on four entries there were not two signatures to confirm witnessed administration. This was not in line with guidance from the national institute of clinical excellence (NICE CG46: controlled drugs: safe use and management. April 2016). We raised this with the nurse in charge who explained that drugs were removed and checked by a trained nurse who passed it to the consultant who administered the drug and then signed the 'CD book'. They stated they would take immediate action to remind staff to follow correct procedures when handling CDs.
- On the respiratory ward staff used a patient group direction (PGD) in order to titrate the administration of oxygen according to oxygen saturation levels.
- The nurses administered medicines in a safe, caring and dignified way. Medicine administration was tailored to the needs of the individual patient. Nurses observed patients taking their medicines and were patient with people who took a while to take their medicines and signed the prescription chart.
- We reviewed six prescription charts on ward 6A and found these were correctly filled in with details about patient details, weight and allergies. All the prescriptions were signed and dated but we found 22 blank boxes across six charts with no record of actions taken in response to blank boxes. This meant there was no record of the administration of the medicines, which included painkillers and antibiotics. This was against a 'zero blank box' standard set in the trust's policy. However, we also reviewed three patient medication charts on the acute medical assessment unit (ACAU) and saw that nurses administered medicines as prescribed. Nurses signed and dated when they administered or omitted medications and documented an explanation, using agreed codes, when a medicine had been omitted.
- Registered nurses could give some medicines even if they were not prescribed under a patient group direction (PGD). The endoscopy unit had seven PDGs and there were 12 generic PDGs; Pharmacists reviewed these directions regularly and all we looked at were in date.
- We checked medicines in the resuscitation trolleys and found that they were tamper evident. This is in line with recommendations by the Resuscitation council (2016) however, the guidance is not clear about the safe

storage of intravenous fluid use in resuscitation and where immediate access is required. The trolleys we inspected, did not all have daily checks documented to demonstrate medicines had been checked to ensure they were present and had not been tampered with. The trolleys were generally stored in areas that were busy with different staff groups around that may observe if non-authorised people interfered with the trolleys however, staff did not challenge any members of the inspection team when openly checking the trolleys.

- The medical day unit administered one cytotoxic drug. All staff who administered this drug were given training by a specialist oncology nurse. Competencies had to be completed and practice observed before staff were assessed as competent.
- Pharmacy staff, including pharmacy assistants, medicines management technicians and pharmacists, visited the wards on a planned basis from Monday to Friday. We saw the necessary medicines reconciliation to ensure that patients were taking the correct medication.

Records

- Patient's individual care records were not always managed in a way that kept patients safe and did not always comply with best practice, which meant that the patients' confidentiality may have been breached. Trolleys with patients' medical records were not always secured and stored in an appropriate area that ensured the safe keeping of medical records. For example on ward 9B the trolleys did not have a digilock and were pushed into a bathroom at night, which was not locked. When we returned unannounced, we saw many patient records that were placed on desks and in unlocked trolleys on the wards we visited.
- Staff accessed information about patients on computers. Most of the time staff logged out when leaving the computer but we found a computer in the coronary care unit, which was left with information about patients open.
- The trust had recently introduced a system for electronic records but this had caused many teething problems and although it was improving, staff spoke of ongoing problems using the system. The problems included issues of discharging patients of the system and doctors had difficulties populating information about medicines when patients were discharged. In the ambulatory care unit, the system did not allow clinicians to look at information about patients referred by GPs. This meant, when patients entered the unit and were assessed, they were sometimes referred to the emergency department as the needs of their condition could not be met safely in the ambulatory care facility. Senior management team had some concerns about nurses' ability to complete real time documentation due to other priorities. This meant that information about patients would not be current and up-to-date. If the ward had a high percentage of agency staff, substantive staff completed electronic patient records on behalf of agency nurses as agency staff did not have access to the system
- We reviewed the medical and nursing documentation used to assess and plan the care and treatment. This was recorded on a pre-printed assessment sheet and staff were required to tick the correct box to indicate the care needs for each patient and that these were met. There was not an associated care plan to provide detailed guidance and instruction for staff on the individual needs of patients. For example, staff had identified a patient required assistance with personal care but there was no information about what this assistance was or how to promote their independence.
- In a nursing handover, we heard that one patient's condition had deteriorated and family members had been informed and were on the ward supporting the patient. However, there was no indication in their nursing notes that their condition had deteriorated or that they required additional nursing care to maintain their comfort and wellbeing.
- Staff informed us that due to working on a busy ward with, at times, reduced numbers of registered nurses, the completion of care plan documentation was not completed in full. Registered nurses told us that often they stayed behind after the end of their shift to complete the documentation. We saw this happened on ward 9B during our inspection.
- The patient records in use on the acute medical assessment unit (ACAU) were stored in the treatment room, which was secured with a keypad entry system when unattended. However, we saw two bags of patients' notes, which were awaiting collection for return to the medical records department. The bags contained 11 sets of patient records whose confidential and personal information was not protected.
- The trust undertook documentation audits and we reviewed the audit from ACUC May 2016. Staff audited

compliance with 15 different themes including prescription charts, filling, care plans and discharge summaries completed. In the completed audit from ACUC (May 2016) the audit highlighted low compliance in some areas, for example, having a legible name present on entries in the medical care record scored 64% against a target of 100%. The staff member carrying out the audit had also identified suitable action to improve this, such as raising it in ward meetings and communications with medical staff. Documentation audits formed part of the trust's audit plan to ensure regular monitoring.

- We listened to a telephone handover about a patient's transfer to a ward from the emergency department. Staff followed a set template when receiving a patient and recorded the detail provided regarding the medical history and care and treatment needs. The onus of obtaining the information and completing the form was on the receiving ward. Staff told us they felt this process could be more streamlined if the discharging ward handed over the pertinent information they were aware of. They commented that going through the set template was time consuming and duplicated information that would be contained within the care records accompanying the patient.

Safeguarding

- There were safeguarding systems, processes and practices in place to keep people safe. The trust provided safeguarding training in children's and adult safeguarding. The training included safeguarding awareness and safeguarding training at level two. The trust had a target of 90% for completion of children's and adult safeguarding training and reported on training compliance across both hospitals. The trust met and exceeded its target completion for nursing staff for all four safeguarding modules and for medical staff for safeguarding adults awareness and safeguarding children awareness but fell slightly below target for the Level 2 children's and adults safeguarding at 89.8%.
- Staff were aware of their responsibilities for identifying and reporting safeguarding issues. Staff we spoke to knew how to report concerns about disrespectful, discriminatory or abusive behaviour or attitudes through the trusts' electronic incident reporting system concerns. Staff were also familiar with how to escalate concerns, sign and symptoms of female genital mutilation (FGM). Staff knew how to make referrals to the mental health liaison team and how to contact the crisis team if required
- Staff knew how to make referrals to the mental health liaison team and how to contact the crisis team if required.

Mandatory training

- The trust provided mandatory training in 12 subjects including basic adult life support, fire, infection control and manual handling and the trust had set a target of 90% compliance. The trust reported on compliance across both hospitals for different healthcare professionals. The trust met their target for medical staff for four of the twelve modules. The remaining eight modules were only just below the target with completion rates between 84% and 89.7%. The trust met their target for nursing staff for nine of the twelve modules. The remaining three modules were only just below the target with completion rates between 87% and 88.3%.
- Staff we spoke with told us they were able to attend regular mandatory training in subjects such as manual handling, fire and infection control.

Assessing and responding to patient risk

- There were processes in place to ensure consultants or senior medical clinicians reviewed patients during daytime hours Monday to Friday. However, medical staff told us patients were not always seen within the recommended 14 hours of admission because of the large amount of patients admitted overnight, as the emergency department in Cheltenham was closed overnight. The different specialities had consultant cover during the week from 8am to 8pm. There was a daily 'board round' on the wards at 8.30am, which was attended by doctors, nurses, physiotherapists and discharge coordinators and who discussed each patient to identify actions to support the treatment, care and discharge planning. There was a consultant ward round and a second 'board round' (staff meet to discuss patients' condition and treatment plan away from the bedside) followed this at 3.30pm to ensure staff had achieved all actions. The wards used a 'red/green' action framework to ensure all patients had received a positive action to progress their recovery.

Medical care (including older people's care)

- We spoke with medical staff on ward 4A (a short stay unit with a target to discharge or transfer patients to other medical ward within 72 hours) who described the challenges of discharging patients because of different medical teams covering each day which meant there was a lack of continuity. Junior doctors described how they struggled to get a consultant opinion, as there was confusion about whom the admitting consultant was and whose care the patient was under.
- There was a standardised approach to detecting deteriorating patients. The trust used a recognised national early warning score (NEWS).We reviewed 12 NEWS charts on wards 8A ,8B and ACAU which had all been completed correctly and demonstrated appropriate escalation where the score required this. Staff had escalated appropriately and medical staff had reviewed the patients in a timely manner. However, we also reviewed a NEWS chart on ward 6A which was wrongly calculated and there were no documented evidence that the elevated NEWS score had been escalated. Auditing of NEWS scoring did not form part of the annual clinical improvement and audit plan (2015-2016) and we did not see a plan for 2016-2017.
- Staff we spoke to understood and followed the trust sepsis policy. We saw one completed sepsis care plan and we saw that patients showing signs of sepsis were recognised and reviewed with appropriate treatment started in a timely manner and according to best practice.
- Whilst risks were identified, we found examples of where actions to mitigate the risks had not always been completed. For example, on ward 9B, a patient was identified of being at risk of developing a pressure ulcer. Staff commenced a care plan with a turn chart stating the patient needed assistance to be moved/turned every two to four hours. However, staff had not assisted the patient to alter position for five and half hours or checked for cleanliness and comfort. This was despite evidence of previous incontinence which would increase the risk of pressure ulcers developing. There was also no recorded evidence of mouth care documented in the care records in the last 24 hours despite this being identified as a need.
- Staff in the acute assessment unit did not often complete patient risk assessments and there were little evidence of structured care planning. Staff explained this was because of the high turnover of patients throughout the day. Staff added that some patients stayed on the unit for a short period and therefore they did not always have time to complete all risk assessments or all of the care record. This meant there was a risk that individual care needs would not be met if specific risks had not been identified.
- Staff completed an assessment of cannulae (a small plastic tube inserted into a vein) used for intravenous medicines or drips. They used a tool (visual infusion phlebitis (VIP) score) which they were required to complete daily. We looked at records and found this was not done consistently and we found one patient who had a cannula inserted for four days without any documented evidence of assessment of the skin and vein. The presence of such invasive devices increase the risk of infection and should be checked daily.
- We noted inconsistencies within the risk assessments relating to venous thromboembolism. (VTE) This is a life threatening condition where a blood clot forms in a vein. Medical staff were required to assess the risks to patients from VTE on two occasions although we heard that it was considered to be the joint responsibility of the nursing, medical and pharmacist staff to note omissions and ensure the assessments were completed. We saw this process had been followed for some patients but in two sets of notes on ward 9B, it had not been followed. On ward 4B, we checked the VTE assessment for eight patients and found medical staff had not completed the second risk assessment for four of the patients. The manager raised this with the medical staff immediately.
- Non-invasive ventilation (NIV) is the administration of ventilator support without using an invasive artificial airway. Staff managed NIV well at the hospital and ensured patients only received this treatment with correct support. Staff transferred patients, who required NIV, from their place of care to ward 8B. This was to ensure that staff with the right skills provided this specialised care.

Nursing staffing

- Staffing levels and skill mix did not always keep patients safe. Staffing levels were below the planned levels and there was a high usage of bank and agency staff.
- The trust reported their actual staffing numbers were below their establishment for medical care. In December 2016, the trust's overall vacancy rate for Band 5 nurses was 8.9% however, within general old age medicine (GOAM) the vacancy rate for Band 5 nurses

was 29.6%. There were no vacancies for healthcare assistants in the medical service at the time of our inspection. Sickness level was 3.6% for registered staff and 4.9% for healthcare assistants but the turnover rate for both registered nurses and health care assistants was high at 15.5% for registered staff and 18.7% for healthcare assistants. The trust was committed to address this and had several projects in place to support recruitment. There was an established recruitment campaign in place for all areas across the trust. These included supporting overseas nurses to achieve the required English language qualification, engagement in role development and working in a strategic partnership with the local university to 'grow their own' nurses.

- Almost all the wards we visited had nurse staffing vacancies and most predominantly for registered nurses. For example, ward 7A had 7.8 full time equivalents (FTE), the cardiac wards had eight FTE, and ward 6A had 4.6 FTE vacancies. Ward managers spoke of difficulty in recruitment of staff. Many wards had overseas nurses working as healthcare assistants until they had passed the international English language testing system (IELTS) and obtained their UK registration with the nursing and midwifery council (NMC). The trust supported overseas nurses with course fees to encourage recruitment.
- The cardiac services had 40 beds included a coronary care unit with eight bed spaces. The cardiac ward was staffed by seven registered nurses, of which three were allocated to work in the coronary care unit during the day. However, on the night shift, this was reduced to two registered nurses for eight patients with varying acuity, a term used to describe the level of care required. We asked the specialist director about staffing levels depending on the acuity of the patients. They explained the trust reviewed nurse staffing establishment twice a year using the 'Hurst model'. The service did not assess or record the acuity levels of patients on each shift or on a daily basis to ensure the correct staffing was always on duty. If the nurse-in-charge felt more nurses were needed, to ensure safe patient care, this would be escalated. This happened for example if they had patients at risk of falling. We asked if any incidents had happened that could be attributed to inadequate staffing levels. We were told that staff worked hard to ensure the patients are kept safe and would go without a break if the needs of the patients were such that they deemed it unsafe to take a break.
- We spoke with the associate director of nursing, who undertook safe staffing assessment, and asked for clarification of the acuity model they used. They explained they used the association of UK university hospitals (AUKUH) acuity and dependency tool' twice a year to plan the nursing establishment of the medical services and the trust did not measure acuity on a daily basis. However, we asked for the latest assessment and found the trust had last assessed staffing levels in August 2015. The lack of acuity assessment on a shift-to-shift basis was not in line with the guidance outlined in the National Quality Board: How to ensure the right people, with the right skills, are in the right place at the right time. The national institute for clinical excellence (NICE) guidelines: Safe staffing for nursing in adult inpatient wards in acute wards (2014) also recommend a systematic assessment of the available nursing staff for each shift or at least daily to ensure it is adequate to meet the actual nursing needs of patients. It further recommends so-called 'red flag events' (incidents that may be prevented if adequate staffing was available) are monitored; these events includes nurses missed breaks.
- The AUKUH tool describes the levels of care depending on certain criteria and care required. Patients in a coronary care unit often require an increased level of care, referred to as level 2 care. Patients may receive non-invasive ventilator support, continuous infusion of vasoactive drugs and intravenous pain management and therefore require closer monitoring. However, staff did not assess on a shift-to-shift or daily basis and therefore we could not be assured there were adequate staffing levels particularly at nights to ensure safe patient care. The British Association of Critical Care nurses (BACCN) recommends a staff to patient of one nurse to two patients when patients acuity is at level 2.
- The trust had escalation/roster management action cards to ensure there were adequate staff to maintain safe care of patients. This included a clear escalation process and the use of a 'decision tree' to gain authorisation to book agency nurses if required.
- Consultants in cardiology told us about issues relating to the transfers of patients from Gloucester Royal Hospital to Cheltenham General Hospital for primary cardiac intervention. The private company that provided the transport service was unable to transport patients with an intravenous infusion in progress unless

there was a nurse escort, meaning medical staff discontinued the infusion while in transit if a nurse escort could not be found. The specific contract was under review at the time of our inspection

- Patients requiring non-invasive ventilation therapy (NIV) were admitted to ward 8B. Staff did not assess acuity of the patients to ensure sufficient staff to provide safe care. Staff risk assessed the number of patients receiving NIV against established staffing levels, which allowed for three to four patients on NIV. There was a plan to develop a high care area for patients receiving NIV.
- Band 6 nurses were often working as ward co-coordinators with little or no time allocated for administrative duties however, because of the high use of temporary staff they also felt their presence and clinical experience was needed on the wards.
- Some ward managers used secure social media apps to help cover shifts when these were not covered. Staff received this approach positively and staff did not feel obliged to come in on their days off. Managers said it worked well and in some wards, for example the acute assessment unit, they managed to cover most of their shifts with their own staff and mainly used agency staff for one to one nursing of difficult to manage patients.
- Bank or agency staff were booked when patients required specialist one to one support. For example, we saw a registered mental nurse (RMN) support one patient on the acute medical assessment unit (ACAU). This ensured that the numbers of staff on duty were not reduced. We read the Director of Nursing's report to the board (November 2016) which confirmed that actual staffing of HCA care staff were over establishment because of providing one to one care for patients with increased risk of falling.
- Because of nurse staffing vacancies, we found many wards to be reliant on using agency staff to cover. Some ward managers block booked agency staff they knew had the right skills to work in the ward area whenever possible. For example, the ward manager on ward 4A (a ward for short stay and endocrinology patients) had asked agency staff to leave previously due to lack of skills required and now block booked known agency staff to cover shifts on the ward. The use of agency was high throughout the medical division with some wards being staffed by 50% agency nurses on the days we visited. We also looked at staff rotas and identified that this was a continuing trend when managers planned rotas for the month ahead.
- Not all agency staff received a local induction on the commencement of their shift. We spoke with an agency nurse on the cardiac wards who had never worked on the ward before and who had not received the 'local induction of temporary staff' checklist. The checklist ensured an introduction to the layout of the ward and emergency procedures. However, on ward 4A where there was a high usage of agency staff, they included agency staff in teaching sessions on the ward to make them feel included in the team.

Medical staffing

- The trust supported the medical division with a 24-hour consultant led services. During the day, consultants worked within their speciality areas supported by junior doctors who were ward based. Consultants and registrars supported junior doctors (F1/F2 foundation doctors). Junior doctors rotated across specialities and they therefore had access to a wide range of learning opportunities throughout medicine. Out of hours, there was a consultant on call with registrars on site supporting junior doctors at night. We spoke with medical staff across the specialities and they told us they were busy but felt well supported.
- There were some consultant vacancies in the trust. For example, the cardiac services had a locum covering a consultant vacancy, which had been open for the last 12 months. The service also had a consultant who was retiring which would leave a second vacancy. Recruitment to consultant vacancies was difficult and some consultants felt there were also additional problems because the workforce was divided across the two sites of Cheltenham General and Gloucester Royal hospitals. The hospital was actively recruiting to the vacancies.
- The acute medical assessment unit (ACAU) had six whole time and two part time acute medicine consultants in post. There were junior doctors on the unit over the 24-hour period who escalated concerns to a registrar and ultimately the consultant. Nursing staff reported they had never had trouble in accessing medical support for patients. The permanent

consultants or colleagues from other medical specialities provided the consultant cover at the weekends on ACAU. A consultant led ward round took place each day.
- Medical staff handed over care at the end of each staff and this included information about medical patients on surgical wards. We observed a medical staff handover and found it to be structured, comprehensive and clear.
- We reviewed medical patients on surgical wards. Staff knew whom to contact for medical input, which was an easy process during daytime hours. However, at weekends and overnight it was more challenging to ask for medical reviews as there was only the on-call doctors available. This sometimes led to delay in assessment and treatment of patients.

Major incident awareness and training

- The trust had major incident and business continuity plans in place. We spoke to senior nursing staff who knew what action to take if a major incident took place. However, junior members of the nursing staff were not always able to tell us about arrangements in case of a major incident or find the policy on the trust intranet. When we asked what action they would take, they told us they would inform the nurse-in-charge and said that they may be required to work elsewhere in the hospital to help with emergency admissions. Staff were not aware of any specific training or exercises to help prepare for major incidents.
- While we inspected the hospital there were winter pressure arrangements in place with two surgical wards closed or with reduced capacity for surgical patients. These wards were used as medical wards to cope with an increased number of medical admissions.

Are medical care services effective?

Requires improvement

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

- The medical service did not consistently contribute to and review the effectiveness of care and treatment through national audits.
- The service had a strategy to understand and improve performance on hospital-based mortality indicators. While most specialities held mortality and morbidity (M&M) meetings monthly or quarterly we were concerned that not all specialties held meetings regularly and how effectively learning was shared.
- There were some concerns about the safe transfer of patients receiving intravous therapy during ambulance transfers to other hospitals.
- The trust had evidence-based care pathways but these were not always reviewed and updated in a timely manner.
- Staff did not always put actions in place when patients were at risk of malnutrition and dehydration.
- Compliance with annual appraisals was below the trust's target.
- There were delays in discharging patients although this was largely caused by factors outside of the medical services remit.
- Information was not always accessible to staff including information about care and treatment pathways.

However:

- Staff were supported with revalidation practices.
- There was a competence training and assessment framework in place to ensure nurses were competent to carry out extended skills.
- There was an effective framework for 'board round' and ward rounds and included input from staff from the multidisciplinary healthcare team.
- Processes were in place to ensure consultant reviews seven days a week.
- Staff were aware of mental capacity assessment and applications for deprivation of liberty safeguards applications.

Evidence-based care and treatment

- Staff delivered patient care and treatment in line with best evidence-based practice. We saw many examples of medical services following best evidence-based practice and staff were knowledgeable about national guidelines and how to access the guidelines and pathways to ensure best practice was followed. For example, there were core care plans for patients known to have dementia based on the Royal College of Nursing: SPACE model for dementia care in hospitals

2012; for patient with peripherally inserted central catheters (PICC) care practices followed best guidance from the Royal Marsden NHS Trust Manual of Clinical Procedures third edition

- The trust had a policy for assessing patients' risk of developing a deep vein thrombosis and the prescription of prophylactic treatment to prevent clot formation. This policy was based upon evidence-based practice including guidance from the National Institute for Health and Care Excellence (NICE): Venous thromboembolism (2015). The service monitored compliance and reported to the quality committee. Risk assessment compliance was 88-94% between January and October 2016 against a target of 95%.
- Staff in the endoscopy unit followed guidelines for invasive procedures in line with national safety standards for invasive procedures (NATSIPPS). Nurses spoke of these procedures, which demonstrated they were embedded in their practice.
- On ACAU we saw referral pathways for many different conditions. Staff thought these were helpful to ensure the right treatment for patients with different conditions
- We saw evidence in patient records that staff followed treatment pathways for chest pain, based on guidance from the national guidance for coronary heart disease, acute kidney injury and for patients with suspected or confirmed sepsis. However, despite the trust being classified as a Dr Foster outlier for mortality in patients admitted with cellulitis or subcutaneous skin infections, the cellulitis treatment pathway was out of date with a proposed review date of September 2015. Although the trust concluded the increased mortality was related to miscoding of primary cause of death, we could not be assured that patients received best evidence-based care for cellulitis or subcutaneous skin infections.
- The cellulitis treatment pathway was out of date with a proposed review date of September 2015. However, the trust was classified as a Dr Foster outlier for mortality in patients admitted with cellulitis or subcutaneous skin infections. Although the trust concluded the increased mortality was related to miscoding of primary cause of death, we could not be assured that patients received best evidence-based care for cellulitis or subcutaneous skin infections
- We found no documentation to show that patients with diabetes had their feet assessed on admission to hospital as per the NICE guidance 19 and staff we spoke to were not aware of this requirement. Staff also told us it was difficult to get the diabetic podiatrist to visit patients on the ward although they would offer advice over the phone.

Pain relief

- Staff assessed pain as part of undertaking observation of vital signs and documented on the national early warning score (NEWS) chart and on completion of the 'Gloucester Patient Profile', which was the document used to document care given. Patients told us nurses regularly asked them about their pain and offered them painkillers if required. Staff used the 'Abbey Pain Scale' tool to assess whether patients were experiencing pain and when they had difficulty communicating. The trust also had a pain management chart with a pictorial pain score assessment tool but we did not see this in use.

Nutrition and hydration

- Patients' nutrition and hydration needs were not always assessed and met. Staff used the Malnutrition Universal Screening Tool (MUST) to calculate and record patients' nutritional risk. We reviewed five inpatient's records on ward 7A, where three MUST scores had not been calculated and the appropriate actions not put in place to support patient's hydration and nutrition. The trust audited compliance with MUST assessment in January 2016 (published June 2016) and found that of 175 audited patient records, 69% had their first assessment completed on the day of their admission. 22% (38) of these patients these were assessed as 'red' with a need for a care plan, but of these, 25 patients, (66%) did not have a nutrition care plan in use. This meant there was low compliance with the trust's standards for assessment of patients' nutrition needs and a risk to the patient that they would not receive the nutritional support required in a timely manner. Action points were identified and the trust planned to re-audit in December 2016. However, this had not commenced at the time of inspection.
- There were magnetic boards above each bed where information/pictures were displayed about food and drinks to suit the needs of the patient. These boards supported staff awareness of individual patient needs.
- Patients had access to water on their bedside tables and these were changed regularly. Staff offered patients hot drinks and ensured drinks were within reach. The

endoscopy unit provided refreshments (tea/coffee and biscuits) after procedures when patients were fully recovered after their procedure prior to leaving the department.

Patient outcomes

- The medical divisional audit lead described mortality and morbidity (M&M) reviews conducted in the medical service. These occurred for about 60% of patients who died in the trust under the care of the medical division, although an independent medical examining team reviewed all deaths and reported to the local coroner. Following our last inspection, a framework had been developed and agreed with future monitoring through the divisional quality report. We reviewed the medical divisional board report from September, October and November 2016 and found the new framework (a structured judgement review) was introduced in October 2016. Each speciality had a clinical M&M lead and every sub-speciality held M&M meetings at least every quarter, whilst others held M&M meetings every month. We did not see any evidence that meetings were held in cardiology and endocrinology in 2016. Most data was collected electronically however, cardiology and endocrinology kept written notes only which were held by the consultants. Minutes of M&M meetings showed presentation of case notes, although we did see one example of notes that clearly described learning following patients' death, which was shared with colleagues via email
- The medical service did not regularly contribute and review the effectiveness of care and treatment through national audits. Information about outcomes of patient's care and treatment was not routinely collect. The trust provided the latest available audit results from 2016 for the Sentinel Stroke National Audit (SSNAP),the Heart Failure Audit (reflecting data from 2015) the National Diabetes Inpatient Audit (reflecting 2015 data) and the Lung Cancer Audit (reflecting 2015 data). Following the inspection, the trust provided evidence of up to date the Myocardial Ischaemic National Audit Project (MINAP)MINAP data submission covering 2015/16.
- The trust took part in the quarterly Sentinel Stroke National Audit programme, however data was not available for each of the hospitals separately. On a scale of A-E, where A is best treatment, the trust achieved grade D in latest audit, between April 2016 and June 2016. The hospital showed improvements in the overall grade having previously achieved grade E for the last three quarters. The trust had shown improvements across five patient centred domains and four team centred domains. The domain relating to discharge processes was the only domain to shown a decline in both patient centred and team performance. The stroke service undertook an internal audit in September 2016, which assessed the effectiveness of an improved stroke pathway. This pathway included a hyper acute assessment unit, designated stroke consultant weekly rota, computerised tomography (CT) scanning en-route to wards and increased physiotherapy and occupational therapy support. The data demonstrated an improvement with a reduction in length of stay and improved care for patients with reduced prevalence of infections.
- Results in the 2015 Heart Failure Audit were better than the England and Wales average for one of the four (Cardiology inpatient) relating to in-hospital care and better than the England and Wales average for three of the seven standards relating to discharge.
- Though the hospital were not currently participating in the MINAP audit, they had scored better than the England average for all three metrics in the 2013/14 audit, in particular the metric for non ST elevated myocardial infarct ('NSTEMI') patients who were referred for or had angiography (including after discharge) (85.7% versus the England average of 77.9%). The remaining two metrics scored lower than the England average.
- The hospital took part in the 2015 National Diabetes Inpatient Audit. They scored better than the England average in two metrics; however they scored worse than the England average in 15 metrics. There was an improvement in ten metrics when compared to the 2013 audit. We discussed the lack of 2016 data with a consultant diabetologist, who explained the two endocrinology wards in the trust had not participated due to lack of resources to support data collection and submission. As a result the service was unable to benchmark themselves against services delivered elsewhere in the country.
- The trust participated in the 2015 Lung Cancer Audit. The proportion of patients seen by a Cancer Nurse Specialist, at 84.1%, was worse than the audit minimum standard of 90%. Other results were not significantly different from the national level, for example, the

proportion of patients whose histologically confirmed Non-Small Cell Lung Cancer (NSCLC) receiving surgery was 22.6%; the proportion of fit patients with advanced (NSCLC) receiving chemotherapy was 48.5%; and the proportion of patients with Small Cell Lung Cancer (SCLC) receiving chemotherapy was 61.1%.

- The trust was a 'Dr Foster' mortality outlier for increased mortality rates for patients admitted with skin and subcutaneous tissue infections. There had been 11 deaths between October 2015 and March 2016 compared to an expected 6.7 deaths. A thorough review of each patient's notes was carried out. The trust concluded that this was a group of patients with complex and multiple medical problems in whom cellulitis was incorrectly identified as the primary diagnosis.
- The endoscopy unit had not yet achieved Joint Advisory Group (JAG) accreditation. The last assessment was in April 2016 with two key recommendations: reduce waiting times and capacity training. The trust had taken actions to ensure compliance by recruiting two nurse endoscopists and employed agency nurses to manage the waiting list. The endoscopy unit aimed to comply with all requirements and achieve accreditation by February 2017.

Competent staff

- Not all staff had received an appraisal in the last year. In the year 2016/17, 78% of staff within the medical care division at the hospital had received an appraisal compared to a trust target of 90%. Nursing staff achieved 79%, medical and dental staff 75%, allied health professional 91%, healthcare assistants 78%, administration and clerical staff achieved 74%. Without an appraisal, learning needs may not be identified and an appropriate plan put in place to support staff to develop their practice.
- There was no formal or regular clinical supervision planned or recorded for registered nursing staff within the medical division. However, we were shown evidence of ad hoc supervision in personal files kept by a ward manager.
- Medical staff told us they received regular appraisals and offered timetabled teaching however, they were only able to access about 75% of the teaching offered because of organisational pressures to ensure ongoing patient care and treatment. Medical staff said study leave varied between departments and divisions.
- Junior medical staff stated they felt supported by their consultants and registrars, but in some areas also felt challenged by the number of junior doctors and the high turnover of patients.
- The trust had a competency assessment programme for registered nurses, which included: nasogastric tubes, tympanic thermometer, pulse oximetry (a device used to check pulse and oxygen levels), male and female catherisation, phlebotomy (obtaining venous blood samples), cannulation, aseptic non-touch technique and the use of warming blankets. There was refresher training on each of these every year, which staff could access via the trust intranet.
- In coronary care staff were supported to complete a post registration course (adult coronary care) run by a local university. At the time of our inspection, 15 out of 45 nurses had completed this course. Nurses completed competence assessments in extended skills such as 'balloon pump therapy'. The service was planning to develop a competency based framework for all nurses as part of the induction training package.
- Staff who had recently joined the trust felt they had a good induction with a corporate induction day followed by e-learning and competence assessment in the ward area. The induction period also included a period of time where new staff were supernumerary and worked alongside colleagues. One healthcare assistant described being rostered to work alongside a colleague for two weeks but this was extended, as they did not feel confident in their role.
- Newly qualified nurses spoke of a comprehensive preceptorship programme, which they had attended one day a month for 12 months. We saw the induction leaflet that staff on ward 6B used for new members of staff and students. This booklet included competence assessment of ward specific objectives and extended information about medicines often used to support treatment in patients who have suffered a stroke.
- Managers supported registered nurses through the revalidation process. Between April 2016 and November 2016 463 nurses were due to revalidate in the trust of which one nurse had been non-compliant with revalidation requirements. The trust had a revalidation team to provide workshops, one to one guidance and to support ward managers with discussions and

confirmation sessions required. Individual ward managers monitored registered nurse revalidation in the medical division and we saw evidence of spreadsheets monitoring this.

- On ward 8A and 8B ward managers showed us competence folders for all grades of staff, with the evidence of extended clinical skills such as male catheterisation, caring for chest drains and non-invasive ventilation (NIV). Care of tracheostomy training had to be completed every 3 months to retain competency and had come about as a result of learning from a serious incident.
- Nurses in the respiratory wards could apply for post registration courses in the management of the acutely unwell adult, which was provided by a local university. At the time of the inspection, there were six nurses across both sites who had completed this course. Nurses completed competence assessments in extended skills such as NIV.
- Two advanced nursing practitioners (ANP) in the ambulatory care unit had completed postgraduate qualifications including the nurse prescriber course with a further two nurses working towards these.

Multidisciplinary working

- Effective multidisciplinary working was evident in all areas of the medical and specialist services we inspected .We observed multi-disciplinary board meetings where staff worked together to assess and plan ongoing care, treatment and discharge planning. All necessary staff, including those in different teams and services was involved in assessing, planning and delivering patient's care and treatment.
- Staff worked well together to deliver effective care and treatment. For example, we observed a daily meeting in the coronary care unit where the nurse in charge, a doctor, a physiotherapist and a discharge coordinator discussed each of the patients to identify 'red actions' to ensure all patients had had a positive experience in progressing towards discharge. Staff then reviewed these 'red actions' in a 3pm 'huddle' to ensure all actions was completed. This was in addition to any treatment plans that consultants may have added during the consultant ward round. Staff felt it worked well and kept the team focussed on agreed actions.
- Staff on the acute medical assessment unit (ACAU) communicated well with each other, with clinicians from other specialities and with staff from an external provider who were part of an integrated assessment team to support patient discharge. . We saw effective communication with clinicians from the neurology speciality regarding the care and treatment of a patient on the unit. We observed this team involved with the discharge arrangements for a patient with complex care needs. They reviewed the patients' medical records, liaised with the medical staff and had a tentative plan in place for the patients discharge. However, nursing staff on the ward were not made aware of this possible and imminent discharge. This meant they may not be made aware of plans and actions to support the discharge could be missed.
- Staff were aware of the mental health team's role in managing patients with mental health issues, how to refer to the team and how to get hold of the 'crisis team' when needed.
- We looked at data about delayed discharge and found that in November 2016 the trust recorded 2015 delayed discharges of which the three most common reasons were: completion of assessment (876), arrangement of care package in patient's own home (615) and further non-acute NHS care such as transfers to community hospitals (412). Ward staff spoke of the difficulties in arranging discharge of patient who required a package of care in the community. Patients were only assessed once they were 'medically fit for discharge' however, it would then take an additional one to two weeks to arrange care in the community, which delayed discharge. The trust was working with the community care provider to address these concerns. The respiratory ward was piloting an assisted discharge scheme to help timely discharge and included nurses visiting patients in their home.

Seven-day services

- The service did not always meet the NHS services: seven day service priority standards for time to first consultant review. We looked at patients records and found that of some patients were not seen on a 'post take' round (a ward round by the consultant responsible for the ongoing treatment of the patient) within 14 hours of admission. One patient was seen after 18 hours whilst another patient was not seen by a consultant for 24 hours. This meant the medical service was not complaint with the London Quality Standards (2013) which recommend that patients are reviewed by a relevant consultant within 14 hours of the decision to

admit a patient to hospital. A consultant stated the service did not meet the timeframe for post take consultant round largely because of the large number of patients admitted overnight.

- The trust did not provide a seven-day service for patients admitted with myocardial infarction (heart attack) requiring percutaneous coronary intervention (PCI) (a procedure used to open blocked coronary arteries). During the week, patients were transferred to Cheltenham General Hospital where they had the facilities (cardiac catheterization laboratory) to carry out PCI procedures. There were some concerns regarding the transfer of patients requiring intravenous therapy during the transfer. These transfers required a nurse escort for the transfer. If this could not be arranged, we were told the intravenous therapy would be discontinued for the duration of the transfer. This had been entered on the trust risk register but remained a safety risk. At weekends and out of hours patients requiring PCI were transferred to other NHS trusts. The service had transferred 30 to 35 patients out of ours to other NHS trust in the last year. In order to iprove the service, there were plans to combine the two cardiac units at some point in the future.
- At the time of our inspection, there were two surgical wards closed to surgical patients and reassigned as 'winter pressure' wards, housing medical patients. In addition to this, there were 18 medical patients admitted to non-medical wards around the hospital. The trust had a medical outlier team consisting of a consultant and two senior house officers who reviewed all medial outliers Monday to Friday. However, they did not provide this service out of hours and at weekends. As a result, support was limited to the emergency on-call team, which sometimes led to delays in reviewing patients.
- Consultants provided on site cover between 8am and 8pm during the week and 8am to 5pm at weekends at both sites except in cardiology where there was no sufficient cover to cover both days at both sites. There was also a second consultant acute physician on duty at Gloucester Royal Hospital at weekends from 9am to 1pm to review new patients on winter pressure wards and medical patients admitted to surgical wards. At all other times consultants were available via on call arrangements out of hours.
- Pharmacist or pharmacist technicians visited the wards every day Monday to Friday. The pharmacy was open on Saturdays for staff to order specific medication for patients admitted out of hours. On Sundays, only on call pharmacy support was available.
- Staff had access to support and advice from the mental health liaison team and the older peoples mental health liaison team seven days a week as well as
- Physiotherapy and occupational therapy for patients who had suffered a stroke was available Monday to Friday where each patient received six sessions a week over five days. Staff felt that a seven-day service would help to discharge patients earlier.
- The endoscopy unit provided services seven days a week although there was reduced capacity at weekends. Staff were on call to cover out of hours emergencies and there was consultant on-call cover 24 hours per day in line with recommendations by the National Confidential Enquiry into Patient outcome and Death (NCEPOD) 2015: Time to get control guidance.
- Patients had access to the ambulatory care unit Monday to Friday from 8 am to 6pm. The hospital employed a medical locum registrar on a long-term contract who was allocated to the unit during opening hours. They were supported by an acute consultant physician between 10am and 6pm. On occasions at weekends and bank holidays the unit was also open; however this was dependant on the ability to provide sufficient staff. At times, when the unit was open over the weekend, medical staff from the emergency department were allocated to cover the unit.

Access to information

- The trust had effective processes in place to review patients every day. We asked about arrangements for ward rounds, which varied a little from ward to ward. On ward 9B there were effective processes for consultant ward rounds every day Monday to Friday, with consultants reviewing new admissions or very sick patients over the weekend. There was also a 'board round' every morning where allied health professionals also attended and at 3pm, another meeting (known as a huddle') where staff reviewed achievements of planned actions for the day. To do this they used a 'red/green day' tool to ensure all patients had positive interactions and planned care was achieved for the day. The trust audited the effectiveness of the board rounds to include

data, such as who was present, the length of time, the use of red/green framework and actions to help discharge planning; however, it was not clear how the service planned to use this information.

- We observed handover between nursing staff at the commencement of the late shift. During one handover, staff that were coming onto shift and in attendance of the handover were interrupted by patients and other staff. This meant that they missed part of the handover, which caused a risk of them not being aware of vital information for patients they were caring for
- The medical service sent care summaries to GPs on discharge to ensure continuing care. The trust audited patient discharge summaries sent to GPs within 24 hours. In October 2016, the result across the trust exceeded the target of 85% with 88.2% of summaries being sent to GPs within 24 hours. Staff also gave patients a copy of the discharge summaries when they left to ensure they had up-to-date information about their health in case of emergencies.
- However, staff did not always have access to electronic information about care. We spoke with a band 5 staff nurse who had recently returned from maternity leave. They had not had any induction/supernumerary time to update themselves with any changes for example resetting computer passwords. This meant they could not access information about patients, policies or updates unless a colleague logged them into a computer. The trust used a large proportion of agency staff to ensure adequate staffing, however agency nurses did not have access to electronic resources including guidance about care and medicines. We asked what the impact of this was, but were told agency staff always worked alongside permanent members of staff who supported them to access the information they required.
- Information about resuscitation status was kept in the front of medical notes. We reviewed three 'do not attempt cardiac pulmonary resuscitation' (DNACPR) forms and found that these were generally correctly completed although it was not always recorded that discussion with the patient and their next of kin/family had taken place even though this was ticked on the form. There were four different DNACPR decisions, which meant varying medical input would be but in place, if a patient's condition deteriorated. In most cases, staff communicated these decisions at handovers and when patients moved between departments.
- Medical records were in a paper format and obtained from the medical records department. Staff commented these arrived promptly when requested.
- The trust introduced a new electronic patient record system in December 2016. This had caused problems for staff initially with the inability to access the records cited as a concern. Patient feedback on the acute medical assessment unit (ACAU) within a completed family and friends survey had identified that the new records system had caused chaos on the unit whilst they were a patient in December 2016.We discussed this with staff who stated there had been issues with the electronic patient record system but the system was improving.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients' consent to care and treatment was sought in line with legislation and guidance. Staff were aware of the importance of obtaining consent before any care or treatment interventions. We observed a therapy session on ward 6B where staff obtained verbal consent from the patient before commencing the session.
- Staff received training in awareness of 'mental capacity act' (MCA) and 'deprivation of liberty safeguards' (DOLS). Training compliance for these topics were at 88.9% for MCA training and 88.9% compliance for DOLS training for all staff (medical staff, nurses, healthcare assistants and administration support staff) within medical care (October 2016). The compliance fell slightly below the trust's target at 90%. However, 90.8% of nursing staff and 90.6% of medical staff had completed both MCA and DOLS training.
- Staff we spoke to had an understanding of the Mental Capacity Act 2005, Deprivation of Liberty Safeguards and patient consent. Doctors completed mental capacity assessments for patients. We reviewed 'do not attempt resuscitation' forms and found that where applicable there was evidence that medical staff had assessed the patients' mental capacity. However, we reviewed patient records and noticed that a mental capacity assessment had not been undertaken and recorded for one patient who was identified as lacking mental capacity.
- Senior nurses were knowledgeable about the processes involved with DOLS applications and when the applications should be reviewed and renewed if applicable. Junior nurses were aware of the mental capacity assessment and DOLS but said they would ask more senior nurses for help and advice if they had to

deal with a DOLS application, as this did not happen regularly. Staff also told us they could access support form a social worker if required when completing DOLS applications. We reviewed the completed application paperwork for one patient and found this to hold all relevant information.

Are medical care services caring?

Good

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect. We rated caring as good because:

- Patients were positive about the way they were treated and cared for in the medical wards.
- We observed staff treat patients with kindness, dignity, respect and compassion.
- Patients praised staff for providing further information when asked.
- We observed caring interactions from staff when patients showed signs of being in distress

However:

- The discharge lounge was a mixed sex unit and did not have curtains to screen individual chairs and provide privacy for patients in their pyjamas or when assistance was needed with personal care needs.
- Information about patients was not always kept confidential.
- Whilst responses to the friends and family test was positive, response rates were low.

Compassionate care

- Patients were treated with kindness, dignity, respect and compassion while they received care and treatment. We observed pleasant interactions between staff and patients and witnessed sensitive and compassionate handling of discussions with patients about 'do not resuscitate' status.
- We spoke with patients who told us that nurses were good. Some said that nurses could be stern and blunt but that they quite liked that approach.
- We observed many examples of how staff sought to maintain patient's privacy and dignity, such as staff pulling curtains around the bed space when assisting with personal hygiene or other care interventions.

However, the discharge lounge was a mixed sex unit and did not have curtains to screen individual chairs and provide privacy for patients in their pyjamas or when assistance was needed with personal care needs.

- The Friends and Family Test response rate for medical care at the trust was 14%, which was worse than the England average of 25% between November 2015 and October 2016. The response rate at Gloucestershire Royal Hospital was just 13%. We looked at responses from October 2016 and found that some wards scored 100% but the number of patients who had completed the questionnaire were low at between three to six people. The cardiac wards had received feedback from 71 patients and scored 96% whereas the Gallery ward scored 83% from 12 responses and the acute assessment unit (ACUA) scored 85% from 26 responses.
- The trust's average score for privacy, dignity and wellbeing from a patient led assessment of the care environment (PLACE, 2016) was 80.7% against a national average of 84.2%. Seven medical wards were included and the highest score was Ward 6A with a score of 96.7% while the lowest score was 66.7% on the acute medical assessment unit (ACUA) unit.
- Information relating to previous patient experiences was located on noticeboards on the wards. Patients were asked to complete surveys following their stay on the ward. For example, the outcome from the surveys on Ward 9B showed that in December 2016, 75% of those completing the survey would recommend the ward. In November, 86% recommended the ward and in October 2016, 100% of patients completing the survey made positive comments. A common theme from the surveys related to positive comments about the staff attitude towards patients.
- Information on the ACAU showed that in December 2016, 14 completed surveys had been received, with 93% of patients saying they would recommend the unit. Comments included a good staff attitude and patients thought that the nurses and doctors were professional.
- Patients discharged from ward 7A between January and March 2016 were sent a questionnaire asking about their experiences. It was not clear how many patients took part and the results varied from the least positive experience with only 24% of patients said they were not able to find a member of staff to talk to about their

worries or fears. The most positive responses related to planning, where 83% of patients said that staff discussed whether they might need any further health or social care services after leaving hospital.

Understanding and involvement of patients and those close to them

- Patients and those close to them were involved as partners in their care. We spoke with patients who praised the communication skills of the staff when they needed further information or asked questions. They told us that they were involved in decision making with doctors and nurses about their care and treatment.
- A ward manager gave us an example of meeting a patient's individual needs; a patient's only relative lived in Australia. Staff organised a password with the patient's permission, so staff could discuss progress and discharge planning with them.
- Some patients told us they were given conflicting information about their treatment from different consultants. Some patients felt concerned for other patients who were unable to communicate and felt staff were not well informed of patient's needs
- Some patients expressed frustration that they had to repeat themselves a lot for example information about specific instructions about personal care needs, as there were so many different staff.

Emotional support

- Patients received the support they needed to cope emotionally with their care, treatment or condition. We observed caring interactions from staff when patients showed signs of being in distress. For example, while we were shown around a ward, we noticed a patient who was visibly upset and the sister immediately went to the patient to listen to their concern and reason for being upset.
- We spoke with a patient in the cardiac ward who had witnessed the sudden deterioration of another patient in the night. They spoke of the professionalism of the team of doctors and nurses assembled to care and treat the patient and of the support the nurses offered to the other patients in the same bay. Staff were described as kind and compassionate in the way they handled the situation.
- However, some patients expressed they were beginning to feel very low in mood or depressed because of the uncertainty about when they could go home, the boredom and the restricted opportunities for exercising and moving around.

Are medical care services responsive?

Requires improvement

By responsive, we mean that services are organised so that they meet people's needs. We rated responsive as requires improvement because:

- The delivery of cardiology services did not meet the needs of the local population.
- There were delays to discharges, which meant patient flow through the hospital was compromised.
- There was a waiting list for patients requiring an endoscopic procedure.
- The environment did not meet the needs of patients with dementia.
- The trust reported 32 breaches of mixed sex accommodation in the period from January 2016 to October 2016 of which 11 were in the acute medical admissions unit.
- The service was not always compliant with the accessible information standards and information leaflets were not readily available for patients for whom English was not their first language.

However:

- The trust's referral to treatment time (RTT) for admitted pathways for medical services has been better than the England overall performance.
- Staff knew how to arrange for translation services if required.
- Complaints were dealt with in a timely manner and there was evidence of change of practice as a result.

Service planning and delivery to meet the needs of local people

- Medical service were planned and delivered to meet the needs of people. However, senior staff in cardiology services spoke about a change in the delivery of care, as this did not meet the needs of local people. Cardiac services were situated in both locations however; the service provision did not always meet the needs of

patients. Patients were admitted to the cardiac wards at Gloucester Royal Hospital from the emergency department but if they required percutaneous coronary intervention (PCI) (a procedure used to restore the blood flow in the heart), they were transferred from the emergency department to Cheltenham General Hospital to the cardiac catheterisation laboratory (cath lab). However, the cath lab in Cheltenham was not open seven days a week and the emergency department in Cheltenham did not admitted patients brought in by ambulance from 8pm. This meant that patients were transferred to other NHS hospital trusts

- There was daily teleconference with commissioners, the local authority, the ambulance service and both hospital locations to discuss the availability of beds and any patient flow issues. There was a separate teleconference where staff discussed bed availability and the potential number of discharges, as well as any staffing issues that may compromise capacity.
- Specialist respiratory nurses worked with the community healthcare provider as a link to enable patients with long-term respiratory disease to stay in their home or help facilitate early discharge.
- The renal service identified a need within children and young person's population for a transition clinic from children's to adult services and Ward 7B planned to start a new monthly transition clinic from January 2017.
- However, we spoke with consultants in the stroke care team about the results of the Sentinal stoke audit. They identified that there were delays in timely intervention because they were not always able to admit patients to the stroke unit in a timely manner. Often the reason for this was, that they were not allowed to 'ring fence' beds for emergency admission of patients, who had suffered a stroke.

Average length of stay

- Between April 2015 and March 2016, at Gloucestershire Royal Hospital, the average length of stay for elective patients was 8.2 days (higher than the England average) and 6.4 days for non-elective patients (lower than the average). Neurology had the highest average length of stay at 13.3 days compared to the England average of 5.8 days, followed by non-Geriatric Medicine 12.6 days versus the England average of 9.8 days.
- However, between March 2015 and February 2016, patients had a lower than expected risk of readmission for the top three specialties for all non-elective and elective admissions.

Access and flow

- The trust had processes in place to monitor access and flow issue during the day. The site management team held meetings at intervals throughout the day to review and assist with the flow of patients through the hospital. The frequency of the meetings during the day was dependent on the status of the hospital. For example, when the hospital was in 'black escalation' which indicated there were few or no free beds but patients still in the emergency department waiting for beds, meetings were more frequent. A policy was in place to guide and inform staff on the site management meeting schedules, who needed to attend which meetings and the responsibilities of certain staff at the meetings depending on the escalation status. These were referred to as action cards. Meetings focused on potential patient discharges and any support needed to achieve this.
- The matrons within the medical division, held a further and separate telecom each morning to assess the staffing levels and skill mix on each ward. This enabled them to review the acuity of patients on the medical wards and establish if there were any problems with planned discharges. This helped to assist with the flow of patients through the hospital.
- The trust had an occupancy rate of 92-94% between January and June 2016. It is recognised that a bed occupancy rate above 85% may affect the flow of patients from admission to discharge and affect the quality of care and treatment. The board report from November 2016 showed there were 2,355 bed days occupied by patients deemed medically fit for discharge in October 2016. In the same month, there were also 45 delayed discharges.
- The trust had a single point of access strategy, which meant that all patients were admitted via the emergency department. From there, patients were allocated beds in suitable ward areas, of which the acute assessment unit (ACUA) was often the ward of choice for further assessment of care and treatment requirements. Patients were either discharged or moved to beds within the most suitable specialities for their condition once a further assessment was completed.

The unit admitted on average 30-47 patients per day. Between September 2015 and August 2016 the trust had 16,643 patient admissions. The trust monitored how many times patients moved wards during an admission. In the same period, 4,722 patients moved wards once, 974 moved twice, 772 moved three times and 254 patients moved wards more than four times during the admission to medical services in Gloucester Royal Hospital.

- Patients were admitted from the emergency department throughout the 24-hour period including at night. At times staff were also required to transfer patients from the ACAU to other wards at night to ensure beds were available. We asked the staff if there was a protocol to reduce the movement of patients unless necessary during the night but were told there wasn't, with the exception of patients being moved to external care providers. However, we noted two patients in the space of one week in January 2017 had been moved to external hospitals at 11pm. The trust audited how often patients were moved after 10pm and reported an average of 496 patients per month who were moved from AUCA to other wards after 10pm. Documentation on the ACAU identified that patients were often transferred from ED in groups during the evenings rather than steadily during the day. This affected the availability of nurses to admit the patient to the unit and move patients during the evening and night to be able to provide a bed.
- The ambulatory care unit received patients also received patients via GP referrals. The aim was to operate as 'one stop services' and therefore the unit had two designated computerised tomography (CT) scanning slots daily including Saturdays. The unit treated 15-30 patients a day but they were hoping to expand this by moving the location of the service to an area closer to the emergency department. This would allow them to accept patients with for example seizures or chest pain. The unit was open Monday to Friday from 8am to 6pm however; they did not accept referrals after 4pm to ensure all patients had completed interventions or treatment by 6pm. If patients remained on the unit beyond that time, nursing staff stayed later until all patients had left the unit. The ambulatory care unit spoke of some frustration about issues with the new electronic care records system. The system prevented them from accessing information about patients referred by GPs. As a result, patients sometimes arrived at the unit and were assessed, but then referred to the emergency department as the patient's condition could not be treated as an ambulatory admission. This meant that access to treatment was sometimes delayed for patients.
- Between November 2015 and October 2016, the trust's referral to treatment time (RTT) for admitted pathways for medical services has been better than the England overall performance. The latest figures for October 2016 showed 93% of this group of patients were treated within 18 weeks compared with the England average of 90%. The trust's performance had been consistently better than or in line with the England average with the exception of July 2016 when their performance fell slightly below the average.
- The discharge lounge was open Monday to Friday from 7.45 am to 8 pm but wanted to expand to 'seven day service' to help patient discharge over the weekend. Staff in the discharge lounge spoke of increasing demands on the service with the numbers of patients increasing and included patients attending appointments in the medical day unit and ambulatory emergency are unit. The impact of increasing numbers meant the discharge lounge often stayed open until 9pm although officially it closed at 8pm. Staff stayed late to ensure patients were care for. This was largely due to delayed transport of patients to their homes.
- We met discharge coordinators on the wards where they took part in 'board rounds' to help facilitate timely discharge. However, patients were only assessed once they were declared medically fit for discharge. This meant patients may stay in hospital longer while waiting for care packages to be arranged or placement in a community health facility. On one day (25 Jan 2017) during our inspection, there were 130 patients medically fit for discharge awaiting safe discharge.
- The trust had appointed two non-medical endoscopists (these are not medical doctors by background but often nurses who receive specialist training and supervision) to help address the backlog of patients waiting. As a result, the number of patients waiting for a procedure had fallen from 600 to 428 in November 2016

Meeting people's individual needs

- The service took account of the needs of different people, including those in vulnerable circumstances. For example, staff told us there was an excellent language

translation service provided by phone, or face-to-face interpreters could be booked in advance. We were told the trust priority was not to use staff members as interpreters.

- Staff in the ambulatory care unit administered intravenous medication such as antibiotics daily to patients for the duration of their prescribed course. Patients could go home and did not need to be admitted for treatment. Staff gave patients a choice whether they wanted to go home with the cannula (a small tube place in a vein) in situ or have a cannula inserted every day. There was a leaflet for patients choosing to go home with the cannula in situ; however, staff did not always give this out to patients. We asked how staff risk assessed patients for their suitability to leave with the cannula in site and found there was no policy to guide staff but they used their intuition.
- The trust had a dementia strategy and introduced 'dementia champions' on many wards. The strategy outlined actions to provide dementia friendly care, provide processes to assess and refer patients with dementia and ensure staff received training in caring for patients with dementia.
- Clinical guidelines produced by the national institute for clinical excellence (NICE, CG42 (2006, last updated September 2016)) recommends that all staff have access to dementia training. After the inspection we asked for information about how many staff had attended training and found 84% of nursing staff were 84% had attended dementia awareness level 2. However, only 25% of medical staff had attended and there was no figures given to demonstrate attendance for allied health professionals.
- The trust had a dementia strategy, which included a vision to enhance the healing environment. However, we did not find the room used for a dementia support group on ward 9B, to be dementia friendly. The room was clinical in appearance with little colour. There were noticeboards in one corner of the room that that contained clinical information for staff regarding dementia. There were activities available for patients such as jigsaws and craft materials. In a patient-led assessment of the care environment (PLACE, 2016), the score for dementia awareness on medical wards ranged from 46 % on ward 8A to 96% in the cardiology ward.
- We spoke with a healthcare assistant who was also a 'dementia champion'. They told us about activity groups for patients with dementia on ward 9B, which provided cognitive stimulation therapy (CST) by facilitating arts and craft activities, bingo, and work with a psychiatrist.
- Dementia leads spoke of plans to roll the dementia group work out to other wards and other initiatives to help and support patients with dementia. These included the use of 'twiddle muffs' (single use) which helped to stop patients with dementia pull at infusion lines or catheters which could cause harm. Staff also told us about 'John's campaign,' which was an initiative to invite relatives of patients with dementia to come in outside of normal visiting hours to assist with meal times and personal care if appropriate.
- The trust was in the process of introducing 'this is me' diaries for patients with dementia, where relatives could add information about the patient to help inform nurses and other healthcare professionals of specific likes and dislikes of the patient which would promote understanding and communication. Most wards had large dementia friendly signage. Staff told us that they are considering purchasing large clocks for the wards for the visually impaired though we did not see any in any clinical areas we visited.
- The acute medical assessment unit (ACUA) reported 11 incidents of mixed sex breaches between October 2015 and August 2016. This meant that patients had received care in an environment that could have compromised their dignity and privacy. The trust reported 32 breaches of mixed sex accommodation in the period from January 2016 to October 2016.
- Patients commented on how busy and noisy wards were. They told us bells could ring for up to 30 minutes before they were answered, but they could not be sure it was always the same bell. During the inspection we found staff usually answered the call bell within three rings. However, on ward 8A, the call bell for a patient rang for 10 minutes and was not answered until we asked the ward manager for someone to answer the bell. Staff on ward 7A supplied newly admitted patients with an admission pack which included an eye mask and ear plugs however, there did not seem to be a plan to investigate the reason for the need to supply these and to reduce noise and light at night.
- Staff knew about arrangements for people who needed a translation service. However, we could find no evidence of patient information leaflets in other

languages on the wards. Staff did not consistently obtain information about people's communication needs, which did not comply with the information standards. The Accessible Information Standards (2015) directs and defines a specific and consistent approach to identifying, recording, flagging, sharing and meeting information and communication needs of patients, where those are related to a disability, impairment or sensory loss. While the trust used visual reminders to alert staff to additional care or communication needs, we found that the assessment documentation was not consistently completed.

- Additional support was available to ward staff when caring for patients with a learning disability Staff knew how to access the Learning Disability nurse who was involved in discharge planning for patients with learning disability. We observed staff discuss the care needs of a patient with a learning disability at length during a medical handover to ensure the patient's involvement in decision-making and care and treatment was appropriate. The trust employed two learning disability nurses and had access to the mental health crisis team via electronic referrals.
- The patients view on the hospital food was good. Most patients felt the portion size and menu choice was more than sufficient, and food was described as enjoyable. However, a patient-led assessment of the care environment (PLACE) audit from 2016 included an assessment of food on the acute medical assessment unit (AUCA), ward 6B and cardiology ward CW1; the results scored 64% to 84% for satisfaction from patients. Patients could access food late in the evening as staff had access to sandwiches and snacks. We observed notices for protected mealtimes on the wards and flexible visiting for carers to come in and feed their relatives.
- Staff in the discharge lounge told us that medicines to take home did not always arrive with the patient from the wards. This meant that administration of medicines to patients were sometimes delayed as the discharge lounge did not keep any stock medicines.
- We were told the transition from paediatric to adult facilities was not very good and. Staff on the renal ward told us they were about to start a new monthly clinic for the transition process. They had only had one clinic so it was too really to tell how successful it was.

Learning from complaints and concerns

- People's concerns and complaint were listened and responded to and used to improve the quality of care.
- Between November 2015 and October 2015 there were 109 complaints about medical care across the trust. The trust took an average of 40 working days to investigate and close complaints. This was not in line with their complaints policy, which states 95% of cases should be responded to within 35 working days. Patient care was the most complained about theme with 34 complaints, followed by admission & discharges with 31 complaints. The profession 'nursing' received 64 complaints. At Gloucestershire Royal Hospital, there were 78 complaints of which patient care received the highest number of complaints, 24 (31%).
- On ward 8A, we saw a 'niggle board' for patients and relatives to write on informing the ward what niggled them. A patient wrote that he was unable to use the hard buttons of the nurse call system. The ward then purchased two soft button call bells to ease the problem.

Are medical care services well-led?

Requires improvement

By well-led, we mean that the leadership, management and governance of the organisation assures the delivery of high-quality person-centred care, support learning and innovation, and promotes an open and fair culture. We rated well-led as requiring improvement because:

- There was a lack of overview and governance around mortality and morbidity (M&M) meetings.
- There was a lack of understanding of the risk to safe patient care, the acuity of patients on daily basis have.
- Risks registered on the risk register were not always aligned with risks in the service.
- There was a limited approach to obtaining the views of patients and their relatives.

However:

- The trust had a clear vision and some specialities within the medical division had a vision to expand and improve services.
- The trust had a risk register and the medical division had a separate risk register; management appeared to follow up identified risks with mitigating actions.

- There were processes in place to review incidents and ensure learning was shared throughout the trust.

Leadership of service

- Leadership of the medical division encouraged openness and promoted good quality care. However, we found there had been limited progress made since our last inspection in 2015.
- Divisional leads told us there was now an established management team and that this provided stability. There was an organised management structure, which was focussed with clear direction and people were held to account. However, some staff had not met or seen the new chief executive in their ward area and some staff felt only senior managers engaged with the executive team.
- Managers appeared competent, enthusiastic and knowledgeable about their services and well informed about the wider challenges within the medical division. Managers felt well supported by the matrons and we observed matrons visiting many wards during the time of the inspection.
- Nursing staff told us managers were very accessible and operated an 'open door' policy Senior ward nurses and ward managers felt well supported by matrons. Staff felt they could raise concerns about care to managers or matrons if required.
- Medical staff told they felt well supported by senior medical staff and consultants

Vision and strategy for this service

- The Trust's vision was to provide the best care for everyone and spoke of five pillars of transformation to achieve this. These included, building capacity and capability, improving patient flow, modernising their hospitals, working in partnership and delivering best value. Staff were aware of the trust's values and information was displayed inwards and corridors.
- We spoke to some service leads about their vision for the service:
  - The stroke service had a vision for the development of stroke service including seven day service (thrombolysis) and hoped to achieve better audit results.
  - The specialist director of cardiac services, the ward manager and consultants all spoke of plans to combine cardiac services across both Gloucester Royal and Cheltenham General Hospital onto one location. They felt this would improve patient care and treatment, help to recruit and retain staff and enable consistency in training opportunities for nurses.
- Staff were aware of plans to improve service delivery. More senior nurses demonstrated a more in depth awareness but staff were unsure about the time scale for these changes.
- Ward 6B had an introduction booklet, which they used for all new staff and students. The ward's mission statement/vision and strategy was clear described within the booklet.

Governance, risk management and quality measurement

- The trust had a governance framework that set out responsibilities for managing quality, performance and risks. There was a clear divisional structure and monthly quality and performance committee meetings and monthly quality reports. These were presented to board meetings for discussion about quality and performance.
- The trust held morbidity and mortality (M&M) meetings to identify learning and formulate actions to improve care and treatment of patients. However, there was a lack of overview and governance of how often the reviews took place and we were not assured that the trust complied with their M&M meeting schedule. We reviewed which M&M meetings were held in the last 12 months. There were regular meetings in most services but we did not see any reference to a cardiology M&M meeting held in 2016. Where meetings were held learning points were identified and shared via email with colleagues However, in the neurology/stroke service only two meetings were held in 2016 and no actions or learning was identified. This led us to conclude that meetings were not held regularly or consistently applied across all medical specialities.
- The trust with had an annual clinical Improvement and audit plan 2015-2016 for local and national audits. This included venous thrombo-prophylaxis, confusion proforma/dementia screening, acute kidney injury and the escalation policy/DNACPR. Audit results were submitted to the strategic clinical improvement and audit committee. We asked for the current audit plan as part of the data obtained prior to the inspection. The audit plan in use was that dated 2015-16.
- There was a trust risk register and a medical division risk register with identified risk which could affect the

effectiveness or safety of the service. The risk register for the medical division was maintained electronically with risks added by the general managers and matrons. We followed up two of the listed entries to the risk register to assess the effectiveness of actions taken to reduce the risks.

- Risk of harm to patients due to inadequate numbers of skilled/trained nursing staff. Nursing staff vacancies were highlighted in almost all conversations we had with managers and other clinical staff. The trust had plans in place to increase recruitment and retention and the director of nursing submitted a monthly report to the board. However, there was a lack of understanding of the impact greater acuity had on safe nursing staffing levels to keep patients safe. The annual assessment of nursing staff establishment was not adequate to ensure safe staffing levels on a day-to-day basis.
- Harm to patients due to errors in the prescribing of insulin. We spoke with a consultant about actions taken to improve practice. They told us a specific insulin chart allowing daily adjustments had been introduced and that these were audited; in addition, plans were in discussion about the feasibility of introducing specific insulin rounds across the hospital.
- We spoke with ward managers and consultants about issues that may be identified as a risk to either the safety of the patients or the effectiveness of the service. They spoke with confidence about the role of the risk register and how this fed into a robust governance framework. However, they did not always add risks which when we asked they acknowledged should be on the risk register. This meant that there was not a service level or organisation overview of risks to patients' safety or service delivery.
- The medical division health and safety committee met every month to review any issues that had arisen. The committee submitted a report every six months to the trust wide health and safety committee. This included, amongst others, incidents of needle stick injuries, falls, spillages, infection control and stress management. The health and safety committee also presented information for staff each month on a relevant topic, the most recent being stress. Staff were signposted to information on how to deal with stress, such as the trust policy and a checklist for teams to assess stress levels.
- The clinical risk lead reviewed reported incidents from the medical services. Any potential serious incidents were discussed with the ward staff and additional information gathered. Serious incidents were reviewed at a scoping meeting and an investigator allocated to carry out an investigation of the circumstances and outcomes. Incidents that were not considered to be serious incidents were investigated appropriately and actions identified and taken. Feedback was provided to the original reporter of the incident.
- Trends and patterns of incidents were analysed by the clinical risk team and reported to the medicine divisional leads. The top five incidents reported within the medicine division were falls, pressure damage, violence and aggression, medicine errors and staffing.
- The clinical risk team prepared reports, which they shared with senior staff in meetings. Flyers with information about learning from specific incidents were distributed to staff by email. The most recent flyer had informed staff that there was a concern about the lack of escalation following deteriorating NEWS scores and the action that was required to be taken.
- When staff reported an incident on the electronic incident recording system, they received an email acknowledging and thanking them. Once an investigation was complete, staff also received a report of any actions or outcomes associated with the incident.

Culture within the service

- The senior divisional management team felt there was a shared vision and that they were a part of a strong team and part of the solution. The divisional management team felt positive about plans for the future.
- Staff mostly felt positive about working for the hospital although all staff said they were always very busy with high volume of patients, staff shortages and the high usage of temporary staff.
- Staff knew how to escalate concerns including whistleblowing and knew how to access the policy if required.
- We observed good working relationships between managers and staff on the wards. Managers spoke highly of the commitment of staff and stated they were proud of the teamwork, care and compassion demonstrated by staff.

Public engagement

- The trust encouraged patients to comment on the care and treatment they had received in the medical services through the friends and family test, however the

response rate was generally low at about 25%. There were posters displayed in ward areas encouraging patients and their relatives to complete the test and the wards displayed feedback from these.

- Patients from ward 7A who completed a survey about care, were invited to join the staff at a focus group to help draw up action plans to address the three main areas that the survey highlighted as areas where improvements could be made. As a result, the ward introduced admission packs including eye masks and ear plugs, and a new 'It's OK to ask' campaign encouraging patients to ask about their care and treatment was due to start in the next few weeks. It was too early to evaluate the effectiveness of this campaign.

Staff engagement

- The trust undertook a staff survey in 2016 and from the results an action plan was formulated to help improve staff engagement. Amongst the actions identified for the medical division were: re-branding and re-introduction of staff forums, re-launch of 'walk abouts' at speciality and divisional level and to increase networking including exploration of safe use of social networking apps.
- However, although actions were identified with timescales and responsibility assigned to different people it was unclear how effective these actions were. For example, we did not meet with any staff who had attended a staff forum in the medical division and staff were not sure when these were happening.
- Staff were generally enthusiastic about their work despite the business of the hospital and felt they would be supported to develop services. For example, a nurse suggested to the tissue viability specialist nurse that it would be useful to have a designated trolley for wound dressings and had helped to set this up. The manager on ward 9B promoted an 'ideas board' to encourage staff to participate in and take ownership of service improvement initiatives.

Innovation, improvement and sustainability

- Falls assessment stickers had been introduced to improve assessment and documentation. The sticker prompted medical staff to make a clear management plan to follow up and review falls prevention. This project also included a post fall assessment protocol and a falls register both of which were included in the falls prevention care bundle. The use of the stickers had been audited and results demonstrated an increase in post fall assessment of signs of fractures, head injury and neurological assessments.

Surgery

Safe	Requires improvement
Effective	Good
Responsive	Requires improvement
Overall	

Information about the service

Surgical services provided by Gloucestershire Hospitals NHS Foundation Trust are carried out at two hospital sites: Gloucestershire Royal Hospital and Cheltenham General Hospital. Services provided at Cheltenham General Hospital are reported on in a separate report. Surgical services for the trust are run by one management team (the surgery division) and, as such, are regarded by the trust as one service. For this reason, it is inevitable there is some duplication in the two reports.

Gloucestershire Royal Hospital provides both elective (planned) and emergency surgery. Patients are admitted as both day-case patients, and to wards as inpatients. The surgical specialties include general surgery, trauma and orthopaedics, breast, ear, nose and throat (ENT), oral and maxillofacial surgery. The operating department at Gloucestershire Royal Hospital has 14 theatres. There is a 19-bed recovery room within the main theatres. There are separate facilities for children. Gloucestershire Royal Hospital has six surgical wards, a day surgery unit and a surgical admissions suite.

We visited the following areas: wards 2a, 2b, 3a, and 5b, the surgical admissions suite, the preadmission clinic, the day surgery unit and theatres. As part of the trust's escalation plans, due to winter and the increased pressure on its beds, wards 3b and 5a were being used as medical wards during our inspection. At other times, these wards would be designated for surgical patients.

We spoke with 43 staff, including the theatre matron, head of nursing, ward matrons, ward sisters, consultants, doctors, trainee doctors and nurses. We talked with, healthcare assistants, pharmacy staff and physiotherapists. We spoke with 16 patients. We observed care and looked at 13 sets of patients' records. We reviewed data provided in advance, during and after the inspection.

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

In the year April 2015 to March 2016, Gloucester Royal Hospital had 24,779 surgical admissions. Of these, 50% were day-surgery patients, 20% were elective (planned), and 30% were emergency-surgery patients.

Surgery

Summary of findings

We rated this service as requires improvement because:

- Since our inspection in March 2015, the number of surgical site infection rates had increased for replacement hips, knees, and spinal surgery.
- There had been two never events reported in surgery since our last inspection. These had been investigated and actions taken to prevent these happening again.
- Storage for patients' notes on some wards and units was not secure, which meant unauthorised people could have had access to these confidential records.
- Mandatory training for all staff was not meeting the trust's target.
- The surgical division was not meeting the trust's target for staff appraisals.
- Due to pressure for beds and the demand for services, some patients had to use facilities and premises that were not always appropriate for inpatients and staff were not aware of how to set up support services.
- Elective operations were being cancelled due to the pressure on the beds within the trust, and surgical wards were being used to accommodate medical patients.
- The trust had introduced a new computer system prior to our inspection that was causing some issues for staff resulting in work arounds to prevent any risks to patients.

However:

- The service encouraged openness and transparency from staff with incident reporting, and incidents were viewed as a learning opportunity. Staff felt confident in raising concerns and reporting incidents.
- The trust had been identified as a 'mortality outlier' in to relation Reduction of fracture of bone (Upper/ Lower limb)' procedures, which included fractured hip. However, the actions they had implemented had made improvements and these were ongoing at the time of our inspection. for example, in the 2016 hip fracture audit which had shown an improvement on 2015 audit
- Training in safeguarding of adults and children had met the trust target for completion.

Are surgery services safe?

Requires improvement

We rated safe as requires improvement because:

- Since our last inspection, the number of surgical site infection rates for replacement hips and knees and spinal surgery had increased.
- There had been two never events reported in surgery since our last inspection. These had been investigated and actions taken to prevent these happening again.
- There was a lack of secure storage for patient's notes on some wards and units. This meant unauthorised people could have access to these confidential records.
- Mandatory training for all staff was not meeting the trust's target.
- The day surgery unit was being used as an inpatient ward but staff were not aware of how to arrange domestic cover for weekends to provide cleaning and drinks to patients when staff were busy.

However:

- The service encouraged openness and transparency about incident reporting and incidents were viewed as a learning opportunity. Staff felt confident in raising concerns and reporting incidents.
- Safeguarding training in adults and children for all staff in the surgical division was meeting the trust's target for completion.

Incidents

- Not all staff were receiving feedback from incident reporting. Staff told us they were encouraged to report incidents on the computer system. This lack of feedback had been identified at our last inspection. At that time, the divisional surgical management team told us they were working on how to improve the feedback to staff following incident reporting. However, some senior staff we spoke with on the wards told us they did provide feedback to their staff following incident reporting and incidents were also discussed at team meetings. Following our inspection the trust told us staff were able to view the outcome to their incident report using this system.

- All staff employed by the trust (excluding agency staff) were able to report incidents electronically via the intranet.
- We spoke to a band 7 (senior) nurse in theatres whose role was to spend three-quarters of their time on managing risk. They were responsible for ensuring all clinical incidents were investigated thoroughly and learning was identified and shared with all staff. The theatre team aimed to fully investigate all clinical incidents within 28 days. Each investigation would start with a scoping meeting, which involved all grades and specialties of staff to identify where things went wrong and how to ensure that it would not happen again.
- From September to December 2016, there had been an increase in needle stick injuries (injuries from needles). The theatre risk nurse had produced a quarterly update and circulated this to all staff to remind them about the safe use of sharps. Following this, they reported a decrease in the number of needle stick injures in January 2017.
- The trust had reported two never events in surgery in the year from December 2015 to November 2016. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event. One incident involved a piece of equipment, which was left in a patient by mistake, and the other the insertion of the wrong strength intra ocular lens. Both incidents were attributed to Cheltenham General Hospital, but both were investigated by the trust and learning shared across the surgery division. Areas identified as needing improvement to reduce the risk of this happening again had action plans, or actions in the process of being agreed. Staff we spoke with were aware of both never events and confirmed learning had been shared. One of the never events was discussed among the staff at one of the multidisciplinary operational meetings we attended.
- Actions were taken from near miss events. A near miss is an unplanned event/incident that did not result in injury to a patient or staff, or damage to equipment or premises, but had the potential to do so. The incident we reviewed related to an implant used in orthopaedic surgery. During the procedure, the wrong implant was given to the surgeon. However, it was not used as the surgeon identified it was the incorrect implant prior to being used. We saw a copy of the action plan detailing all the changes made following this incident. All actions had been completed. Staff were able to describe and show us the changes made to practice to avoid this incident recurring.
- In accordance with the NHS England Serious Incident Framework 2015, the trust reported 10 serious incidents (SIs) in surgery in the year from December 2015 to November 2016. Of these, there were two incidents reported of 'surgical/invasive procedure incident meeting SI criteria' and two of 'healthcare acquired infection/infection control incident meeting SI criteria'. The other incidents were all unrelated. Where incidents of infections were reported, the service had carried out investigations and taken actions to reduce the risk of a reoccurrence.
- There had been an increase in incidents of surgical site infections. Staff within the wards and operating theatres were aware of this increase and actions had been taken. Actions taken in the operating theatres to reduce the surgical site infection rates included, for example, changes to dress policy. Staff were no longer permitted to wear scrubs in shops and cafes on the hospital site. A new testing regime had been introduced. Swabs were taken of equipment in theatres, including tourniquets, surgeons' and scrub staff's hoods used in orthopaedic theatres, to evaluate cleaning regimes. Environmental rules in orthopaedic operating theatres stated no one was permitted to enter the theatre once skin preparation had started unless in a sterile gown and wearing facemasks.
- Each of the surgical specialities reviewed patient mortality and morbidity (M&M). We reviewed sets of minutes provided for the general surgery division, which included colorectal, upper gastro-intestinal, vascular and urology. In the majority of meetings, they used the Clavien-Dindo classification tool. This tool is used to rate surgical complications for audit, clinical investigation and as a tool for quality improvement. We found there was variable input, content, and insufficient evidence to show how agreed actions were delivering improvements. In some where presentations were made staff discussed individual cases and the learning required. However, the minutes did not demonstrate if or how staff were accountable for all actions agreed

from the reviews or demonstrate improvements from actions taken. The trust told us following our inspection that the governance leads had overall responsibility for ensuring actions were met.

Duty of candour

- Staff were able to tell us about the principles of the Duty of candour regulation. Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 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 told us the regulations were about being open and transparent with patients following incidents and apologising to them.

Safety thermometer

- NHS Safety Thermometer information was routinely displayed in most ward areas. The NHS Safety Thermometer is a local improvement tool for measuring, monitoring and analysing patient harms and harm-free care. This tool enabled wards and units to measure harm and the proportion of patients that were harm-free from pressure ulcers, falls with harm, urinary tract infection with catheters, and venous thromboembolism (VTE, or blood clots) during their working shifts.
- Data from the Patient Safety Thermometer showed that the trust reported 34 pressure ulcers, 20 falls with harm and 25 catheter urinary tract infections in surgery from November 2015 and November 2016.
- The prevalence rate for pressure ulcers had increased over time however; from October 2016, this had started to reduce. Ward 5b had the most hospital acquired pressure ulcers for the Gloucestershire Royal Hospital (GRH) from January 2016 to October 2016, with 19 reported. Staff told us this was because they had medical outliers and surgical patients with a number of co morbidities that increased their risk of pressure ulcers. Staff were undertaking actions to reduce this risk by reviewing risk assessments and completing intentional or comfort rounds more frequently. The trust told us after our inspection that for monitoring purposes and good practice all pressure ulcers from grade 2 to grade 4 were reported.
- The prevalence rate for falls with harm was also reducing over time, but had seen a sharp rise in September 2016 and October 2016. November 2016 showed the prevalence rate to have fallen to zero. Ward 3b had reported the most falls for GRH from January 2016 to October 2016 with 73.
- We saw that venous thromboembolism (VTE) assessments had mostly been completed on patients within 24 hours of admission. This was to make sure their risk of developing a blood clot in their leg or lungs had been assessed and actions put in place to reduce the risk.

Cleanliness, infection control and hygiene

- Reliable systems were mostly in place to maintain standards of cleanliness and hygiene to reduce the risks to patients of catching a healthcare associated infection. For example, each theatre had an 'end of the day cleaning checklist' that needed to be completed.
- Hand hygiene results from January 2016 to October 2016 were rated as green but ward 5b was rated as red for October 2016 and mostly amber for the rest of period. Senior staff on ward 5b told us they were now rated as green. The trust used a rating system based on red, amber and green. Green being the ward had met the trust target and red the ward was below the target set by the trust.
- At our last inspection, we found auditing of MRSA screening on emergency and elective patients was not taking place. However, the trust has since carried out audits. One was undertaken in September 2015, the results showed that screening from the nose and groin was over 90%. The data was taken over both hospital sites on one day and showed for surgery 14 emergency admissions patients had not been screened. This was less than 10% of total admissions that day. The trust was monitoring and investigating all new cases of MRSA and Clostridium difficile (C diff) and taking actions where needed.
- We observed staff in theatres maintaining strict infection control procedures to prevent the risk of infection for patients undergoing operations. We observed scrub staff and surgeons 'scrubbing' (this was where staff washed their hands up to their elbows using specialist soap and single use scrubbing brushes) and wearing sterile gloves and theatre gowns. All staff in the theatre made sure they did not touch these members of staff so they were as sterile as possible to prevent the risk of cross-infection.

- In theatre skin preparation was used to clean the operation site to make sure their risk of infection was minimised. In orthopaedic theatres, there were strict procedures for all staff to follow once this procedure was underway. For example, staff were not allowed to enter the theatre unless they were in a sterile gown and wearing a facemask.
- We observed staff in recovery cleaning and checking equipment at the start of their shift to make sure it was safe to use and clean. Staff told this was done daily and we saw records to demonstrate this.
- A care plan bundle was in place for the insertion of cannula (tube into a vein). This required staff to complete on insertion and respond to questions. For example, did they undertake hand hygiene prior to insertion and the use of specialist skin preparation to reduce the chance of an infection. The use of cannula had to be reviewed daily and staff were required to consider whether it could be removed as not being used or if there were signs of infection when it must be removed.
- We observed staff following the infection control policy. This included being bare below the elbow and ensuring long hair was tied back.
- Patients who were known to be cross-infection risk were placed in rooms with clear labelling to indicate that appropriate cross-infection procedures should be carried out prior to entering. We saw all staff wearing aprons and washing their hands before entering the room.
- Clinical waste was managed in line with the trust's policy. Single-use items of equipment were disposed of appropriately, either in clinical waste bins or sharp-instrument containers.
- The day surgery unit was being used as a ward due to the demands on beds at GRH. This meant inpatients were cared for on this unit 24 hours a day. However, at weekends staff told us they had no domestic support to assist with cleaning the unit, for example, patient toilets, which was unacceptable. A senior member of trust staff said the day unit was able to arrange domestic cover but the staff on the unit were not aware of how to do this.

Environment and equipment

- Gloucestershire Royal Hospital main tower block was built back in the 1970s and additional wards and departments have been added to the surrounding grounds. The surgical wards, day surgery unit, surgical admissions suite and theatres were all located in the tower block at Gloucestershire Royal Hospital, which had lifts to assist patients in accessing these areas. The pre admission clinic was held in a building at the back of the hospital. Ward 2a had been upgraded to be used as the fractured neck of femur and orthopaedic ward. The ward had for example, larger toilets for patients following surgery and more space to store equipment needed.
- Staff on the day surgery unit told us improvements had been made to the environment since our last inspection. These included a new store cupboard for equipment and a new cupboard for domestics to store their cleaning equipment and the waiting/day room had been turned into another bay for patients. However, for inpatients on the day surgery unit there was still no space for lockers in the female bays. Patients told us they had to put their belonging on or under their chair next to their bed. Space was also reduced when compared to a ward designed for inpatient stays. Staff told us when they had inpatients on the unit they had to remove the trolleys they normally used for day surgery to replace with beds.
- Resuscitation equipment on each ward, unit and in recovery/theatres was checked daily, with records in place showing completion. However, the day surgery unit did not have their own defibrillator but shared with an area within the theatre department. Medication within the resuscitation trolleys on the wards, unit and theatres was stored in tamper-evident containers. This is in line with the guidance issued by the Resuscitation Council (UK).
- The hospital had a central sterile services department (CSSD) on site, which decontaminated large volumes of medical equipment. The department had been accredited internally and externally, and was compliant with ISO13485 Medical Devices (this is an external accreditation to ensure the quality, safety and effectiveness of medical devices). The department aimed for a 24-hour turnaround time, and theatre staff told us urgent equipment could be turned around in about 3 hours. Theatre staff spoke extremely positively about this service. Equipment provided by Central Sterile Services Department (CSSD) was also traceable. Staff showed us the process for tracking and tracing surgical equipment. This included removing stickers

from the equipment and placing them in patients' notes. This allowed full traceability in the event of an issue being identified with either the patient or the equipment following any procedure.
- CSSD also attended the daily meeting with theatres/ recovery, day surgery unit and the surgical admissions suite. Staff told us any issues with equipment would be discussed at this meeting with CSSD. In addition, they could contact them at any time.
- Safety checks were undertaken on anaesthetic equipment daily to make sure it was safe to use.
- We saw stickers on electrical and medical equipment that stated when it was last serviced and when it was due again. This was mostly done in house. These were all in date.
- Management in theatre told us that there is no equipment replacement programme. However, if a piece of equipment was broken they were able to submit a bid for it to be replaced. Staff told us that some of the operating tables were old and that this led to difficulties with maintaining a sterile environment. The trust had a system in place for all wards, departments and units to request equipment. Meetings took place monthly, attended by senior trust staff where decisions for the purchase of equipment over £5000 were made. For equipment costing over £100,000 a business case was also required before a decision was made by senior staff from the trust
- Staff on ward 2a were provided with equipment to improve the outcomes for patients following a fractured neck of femur operation, for example, bladder scanners (to identify if a patient was in retention of urine) and specialist chairs to enable easy of movement for patients.
- We were told operating tables had pressure-relieving qualities included to reduce the risk of patients developing pressure ulcers.
- Equipment was available for bariatric patients to include beds, hoists and some of the operating tables.
- On the surgical admission suite, we found the domestic cupboard was unlocked and chemicals covered by the Control of Substances Hazardous to Health (COSHH) Regulations were in an unlocked cupboard. For example, chlorine cleaning tablets. This was unsafe practice because patients and visitors could be exposed to these chemicals.

Medicines

- There were arrangements in place for the safe management of medicines and these were mostly followed.
- Medicines were stored securely in locked trolleys and cupboards and were kept locked when unattended and secured when not in use.
- Patients who attended pre admission clinic were given advice from the staff about when to stop certain medication prior to their operation to make sure they did not interfere with their operation.
- On the other wards we visited, we found fridge temperatures were recorded daily and no out of date medication was found, however, on the day surgery unit staff did not record the refrigerator temperatures daily. This was important to make sure the medicines were stored at the correct temperature to keep them safe to use. During December 2016, the temperature was not recorded on 22 days and through January 2017; the temperature had not been recorded on six days. The temperature was recorded out of the recommended range (2-8°C) on three days in December and January. The staff did not record what actions had been taken. The fridge contained three vials of insulin. As well as being stored out of temperature range, we also found them to be past their expiry date. This was highlighted to staff that then destroyed the medicines.
- Controlled drugs in the day surgery unit were stored securely. Random stock checks were undertaken by staff, which showed balances were correct as per the register. Two nurses were involved in checking controlled drugs (CDs) for administration and two signatures were seen in CD record book. This was the same on wards 2a, 3a and 5b. CD keys were separated from the main bunch of keys but kept inside one of the medicine cupboards next to the CD cupboard. This meant that the CDs could be accessed by the member of staff that had the main bunch of keys, which may not be a person, authorised to access controlled drugs. This was not in line with trust policy or good practice. Following a discussion with the ward manger we were told the CD keys would be remain separated from other keys but be in the possession of a registered nurse at all times. Nurses did not always sign the received section of CD order book when receiving delivery of controlled drugs. This was against the trust policy and good practice. This meant that the trust would not easily be able to investigate incidents involving delivery of CDs.

Staff signed the porter slips who delivered the CDs but they were only kept for one month. From November 2016, we saw CD orders 52, 56, 60, 61, 63, 64, 72 and 73 had not been signed as received.

- FP10 prescriptions (these are prescription pads used by doctors to prescribe medications for patients) were stored securely and their use was tracked on a log sheet.
- The day surgery unit did not receive a clinical pharmacy service. Staff told us they thought this was a clinical risk as patients frequently stayed for more than one day, and they found it difficult to resolve all the issues with the medicines. This was evidenced on the three prescription charts seen where no medicine reconciliation had been completed. This was not on the surgery risk register.
- We reviewed three prescription charts and found all had allergies recorded, two out of three patients had their VTE assessment completed, all patients details were correct (name, date of birth etc.), all prescriptions were signed and dated and the length of course and indication for use was recorded for antibiotic prescriptions. The standard set in the trust policy was 'zero blank boxes' within medicines administration charts. These were the boxes completed to show the drug had been administered or reasons why it had not. We found one blank box for fragmin 5000 units on a prescription chart where there was no signed evidence it had been administered.
- In recovery, we saw that oxygen requirements were recorded in the anaesthetic chart by the anaesthetist and all staff knew where to find this. If a patient required oxygen for transfer to the ward and post operation this was then prescribed on their prescription chart.
- Staff on the wards and theatres/recovery told us that all medication errors were reported via their incident reporting system so they could be investigated and actions taken to reduce them from happening again. The nursing metrics for GRH showed the number of medication errors from January 2016 to October 2016. Ward 5b had the most with 14. Ward 5a had two in the same period and ward 2b had reported no medication errors.

Records

- Patient records were mostly stored securely and were in line with the patient's nursing needs and medical reviews. At the last inspection, we found patient notes were not being stored securely on wards 2b and 3b. New lockable trolleys had been purchased for each ward. However, at this inspection, we found ward 3a and 5b did not have secure storage facilities. On 5b in the surgical admissions unit, they were stored on a trolley in the small office area, which gave potential for unauthorised access.
- On ward 5b we found one of the medical students had written up the notes from the ward round and had slipped the piece of paper directly into the patient's folder without securing it. This was reported to senior staff, as this could have easily been lost. It contained very little detail to identify the patient if it had got lost, reducing the likelihood of reconciliation.
- Nursing records were mostly held at the end of patients' beds. However, on ward 3a these were stored in folders in the bays.
- Care pathways were in place for surgery patients. These included separate pathways for patients undergoing day surgery. Both nursing and medical were included in these. Records were comprehensive and included details of the patient's admission, risk assessments, treatment plans, and records of therapies provided. We saw preoperative records, including completed preoperative assessment forms. Medical records accompanied patients to and from theatre.
- All consent forms we viewed were completed in full, signed, and dated by the patient and the consultant. All risks associated with the operation were also documented.
- Core risk assessments and care plans were in place for patients with mental health illnesses, for example, disorientation and memory loss, alcohol withdrawal management plan and patients at risk of self-harm. On the wards we visited and the patients records we reviewed none of the patients required these plans, however staff were aware of where they could access these.

Safeguarding

- Arrangements were in place to safeguard adults and children from abuse and staff understood their responsibilities to report allegations. Staff told us they knew how to make a safeguarding referral and were aware of who were the safeguarding leads for the trust for adults and children.
- Information about safeguarding was displayed on a number of noticeboards across the surgery wards and units.

- The surgical division had exceeded the trust target of 90% completion of all four areas of training. These were; safeguarding awareness, safeguarding adult's level 2, safeguarding children awareness and safeguarding children level 2. This was for medical/dental staff and nursing staff.
- The surgical divisional management team told us that patients over the age of 70 with fractured hips could have access to an orthogeriatrian.

Mandatory training

- Staff were mostly up to date with training in safe practice, processes and systems. The trusts mandatory training for all staff included, basic adult resuscitation, blood transfusion, code of conduct, conflict resolution, equality and diversity, fire, infection control, information governance, manual handling theory and practical, medicines management and safety awareness.
- The surgical division across both sites had met the trusts target of 90% for three of the 12 modules for the medical and dental staff group, equality and diversity, information governance and safety awareness. The remaining nine modules were just below the target having completion rates between 83.1% and 89.9%.
- The surgical division across both sites had met the trusts target of 90% for nine of the modules for the nursing staff group. The remaining three modules (basic adult resuscitation, conflict resolution and manual handling practical) were just below the target having completion rates between 83.8% and 86.6%.
- Staff in theatres told us they had time put aside to undertake mandatory training and this was called audit days. A half-day audit period was due to take place on the last day of our inspection. Practical training took place during this time, for example, moving and handling pertinent to theatres. Staff also had mandatory training to complete on the trusts e-learning system.
- Staff told us they had received training on sepsis identification and management.

Assessing and responding to patient risk

- Risks to patients who were undergoing surgical operations/procedures had been assessed and their safety monitored and maintained. Patients for some elective surgery attended a preoperative assessment clinic where all required tests were undertaken, for example, MRSA screening and blood tests. If required, patients could be reviewed by an anaesthetist. When additional tests were ordered, the pre-operative assessment clinic had a process in place to follow these up and inform the surgeon or anaesthetist if any issues were identified. Some patients had telephone assessments if they met a certain criteria and staff told us they sent the MRSA testing kit and instructions to their address. During the pre-admission clinics some patients were reviewed by clinical nurse specialists, for example, stoma nurses could help prepare patients for changes to their life style following surgery.
- We observed the use of the World Health Organisation (WHO) surgical safety checklist in all theatres. The National Patient Safety Agency recommended that this process be used for every patient undergoing any surgical procedure. It involved a number of safety checks designed to ensure that staff avoided errors.
- We saw the results of the WHO audit undertaken in theatres dated June 2016. This had some areas rated as green where they met the target and some areas were rated as amber or red. The audit had identified areas where clinical engagement was still an issue resulting in them not meeting their target of 100%. A new process had been started in December 2016 but at the time of our inspection, this had not been re-audited.
- We observed a surgical safety operating list briefing, which included what operations were taking place on that list and the staffing numbers. We also saw the WHO checklist being completed which included sign in time and sign out time.
- We spoke with the lead coordinator for the emergency theatre. They met with the on call lead anaesthetist and consultant surgeons who had patients for the list each morning. The order of the list was agreed based on clinical assessment of each patient.
- The trust used the National Early Warning Score (NEWS). This tool is used to aid recognition of deteriorating patients, based on scored observations including temperature, pulse, blood pressure and respiratory rate. A high total score activated an escalation pathway outlining actions required for timely review, to ensure appropriate interventions for patients; these were clearly documented on the form. Staff explained how they used this tool and when they would contact doctors for additional support. The trust audited their NEWS scores monthly. The figures sent to us for October

2016 showed that they were at 100% completed as per their policy for all surgery wards. The frequency of observations undertaken in line with NEWS procedure audit all showed each surgery ward was at 100%.

- A pathway was in place to provide guidance for staff to follow and when to obtain medical advice.
- Staff on the wards told us that if a patient was assessed or known to have a mental illness they referred them to the mental health teams, for example, crisis team, alcohol liaison and for older people. However, not all staff felt they were quick to respond. For patients on ward 2a (fractured neck of femur ward and orthopaedics) they had access to mental health qualified nurse in a senior role. The trust had devised core risk assessments and care plans for a number of mental health illnesses as mentioned under the records heading.

Nursing staffing

- ▪ Staffing levels and skill mix were planned and reviewed but there were vacancies for nursing staff in some of the surgery wards and theatres. The trust was working hard to address the vacancies. For example, they had several projects in place to support recruitment. These included supporting overseas nurses to achieve the required English language qualification, engagement in role development and working in a strategic partnership with the local university to 'grow their own' nurses.

  ▪ The surgical division used 'The Keith Hurst' tool, often referred to as the Safer Nursing Care Tool, which helps determine safe nurse staffing for acute wards based on patients' level of sickness and dependency. This tool has the added benefit of benchmarking staffing as it included data on skill mix, levels of clinical dependency, clinical speciality and quality markers as part of the overall staffing assessment. The trust told us this tool had acuity measurements included and they did not undertake any other acuity reviews.

  ▪ At August 2016, all six surgery wards and day surgery unit were below establishment. Overall there was a deficit of 20.5 Whole Time Equivalent (WTE).The day surgery unit had the largest deficit of 7.17 WTE. The trust sent us figures following the inspection of their safer staffing summary. For example, ward 2a from September 2016 to December 2016 showed their actual safer staffing qualified nurses figures for day shifts was higher than their planned figures except for December 2016 due to some changes taking place on the ward. This was also the same for care staff. For ward 3a for the safer staffing figures from September 2016 to December 2016 for day shifts also showed that the planned number of qualified staff on duty was above the actual staffing figures. This was also the same for care staff. The only change was in December 2016 when they had slightly less trained and care staff on duty compared to their planned numbers. We were not sent the safer staffing figures for the day surgery unit as they had high usage of bank/agency staff between December 2015 to November 2016 ranged from 27.3% to 48.1% so we could not compare planned verses actual staffing levels. Staff told us bank and agency staff were used at times to cover these vacancies.

- Theatre staffing levels were based on the Association for Perioperative Practices (AfPP) guidelines and on the number of theatre sessions per day. Staff told us that there were higher levels of vacancies within the orthopaedic teams, which they felt was due to the workload. Three agency nurses had been working with them for a long period, and permanent staff felt they worked well as part of the team. Theatre managers told us that they were in the middle of a major push on recruitment, including offering staff to attend an operating department practitioner's course, and holding open days.

- Sickness levels within theatres were low at 3.0%, and managers told us that this was managed well with support from occupational health when required, although there was a backlog.
- In November 2016, the trust reported a vacancy rate of 16.9% for surgery trust wide, though for Gloucestershire Royal it was above at this rate at 18.2%.
- Turnover rates at November 2016 trust wide for surgery was reported as to be a rate of 12.2%. For Gloucestershire Royal this was 13.3%, which was worse than trust figure.
- Sickness rates at November 2016 for surgery trust wide was reported at a rate of 4.6% with Gloucestershire Royal at 4.7% worse than the trust figure.
- From December 2015 to November 2016, the trust reported an average monthly bank and agency staff

usage of 9% across the surgical division. For Gloucestershire Royal Hospital, this was below at 8%. Where possible wards, departments and theatres used the same staff for continuity of care for patients.

- Staff on ward 5a told us they felt de-skilled and had a busier workload due to the high numbers of medical outlying patients on the ward. Some staff told us they were leaving because of this. However due to the pressure on beds within the hospital and increased workload, they were able to have an extra health care assistant on the day shifts.

Surgical staffing

- From 1 August 2016 to the 31 August 2016, the proportion of consultant staff reported to be working at the trust was higher than the England average and the proportion of junior doctors (foundation year 1-2) staff was lower. The surgical division management told us they had a shortage of junior doctors, which had an impact on their services. They had appointed Advanced Nurse Practitioners (ANP) to support junior doctors in undertaking some of their roles so the junior doctors could spend more of their time diagnosing patients. Use of locum doctors in the surgery division was reported by the trust to be average compared to other trusts. Between December 2015 and November 2016, the trust reported an average monthly bank and locum staff usage of 10%.
- We spoke to an anaesthetist who told us they had 50 senior anaesthetic staff across the trust. These included staff grades (who are classed as middle grade doctors but not yet as senior as a registrar or consultant). Thirty of these worked at Gloucester Royal. Junior doctors in training were extra to these numbers. There was an on call rota for covering surgery. Anaesthetic cover for the critical care unit was managed separately.
- All surgery specialities had on call consultants and a team of junior doctors, For example, trauma and orthopaedics had a consultant on call from the hours of 8am to 8pm and after this time; one consultant covered both hospital locations. A trauma meeting took place every morning, which was attended by a proportion of the orthopaedic team, trauma coordinator, theatre and anaesthetic staff. The orthogeriatian consultants did not attend these meetings. This meeting was used to discuss all patients who had been admitted. At weekends, we were told that all new hip fracture patients over the age of 70 years were seen by an orthogeriatian and those that were one-day post operation.
- Nursing staff we met said they felt well supported by the surgery teams. Consultants and doctors carried out appropriate ward rounds mostly at set times, although on the day surgery unit they reported a variable practice at times. 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. When we visited the hospital on both the announced and unannounced visits, we observed doctors reviewing patients and coming onto wards when requested by nursing staff. Some of the wards and day surgery unit had reported difficulties at times in getting medical outlying patients reviewed by medical teams.

Major incident awareness and training

- Arrangements were in place to respond to emergencies and major incidents. The trust had a major incident plan, which was available to staff on the intranet.
- Staff in theatres told us one of the actions they had to take if a major incident took place was to stop all elective operations.
- If they suffered an electrical power cut they had generators in place to be able to complete operations safely until the power was restored.
- During our inspection, the trust had implemented their winter pressure plan, which included changing two surgical wards to medical wards to cope with an increased number of medical admissions. This had resulted in a number of cancelled elective operations.

Are surgery services effective?

Good

We rated effective as good because:

- The trust had been identified as a 'mortality outlier' in to relation reduction of fracture of bone (Upper/Lower limb)' procedures, which included fractured hip. However, the actions had implemented had made improvements and these were ongoing at the time of our inspection.

- Staff were using national guidance to improve the outcomes for patients.
- Patients were having their pain levels assessed appropriately and overall patients were pain free.
- There was good multidisciplinary working across all staff groups to make sure patients care was coordinated.

However:

- The trust had introduced a new computer system prior to our inspection. This was causing issues for staff resulting in 'work around' processes to prevent any risks to patients. The trust was working to address these.
- Staff appraisals were not meeting the trust targets.
- Theatre utilisation figures were low however; the trust was looking at ways of improving this.

Evidence-based care and treatment

- Staff on the ward, units and in theatres had access to policies and procedures that were based on national recognised guidance, for example National Institute for Health and Care Excellence (NICE) guidance.
- Standard Operating procedures in theatre were based on national guidance, for example, those set by the Association for Perioperative Practice (AfPP). We were shown several of these as evidence.
- Staff in theatres told us they had some input into policies and procedures that were developed by the education team specifically for them.
- We observed staff in theatres and recovery meeting National Institute for Health and Care Excellent (NICE) guidance, for example, Hypothermia: prevention and management in adults having surgery. In order to maintain a patient's body temperature above 36 degrees centigrade, patient warming devises were seen being used and staff were seen using devices to warm intravenous fluids. Practice was also seen to follow NICE guidance CG74 surgical site infections: prevention and treatment.
- We saw in the patient records we reviewed that all patients had a venous thromboembolism (VTE) assessment completed on admission as recommended in the NICE guidance QS3. This also recommends patients be reviewed within 24 hours. In most but not all the patient records we reviewed this had taken place.
- The colorectal surgeons followed the Enhanced Recovery programme for some patients who met set criteria. These pathways provided evidence-based protocols to ensure patient recovery was maximised.
- Staff in the pre-admission clinic told us they discussed with patients about how to make sure they were fit for their operation. For example, advice was given about smoking and alcohol intake.

Pain relief

- Patients had their pain assessed and managed. The trust had a consultant led dedicated pain team, supported by senior nurses. Staff in recovery and on the wards told us the pain team were aware of patients who would require epidurals and patient-controlled analgesia machines prior to their surgery. The team provided support and advice to ward staff and patients regarding pain control and for patients with epidurals and patient-controlled analgesia. Out of hours and at weekends an anaesthetist provided this support.
- We saw pain scores recorded on the patients NEWS chart and staff told us they monitored these and provided patients with pain relief as and when required. We observed this taking place in recovery and following administration of analgesia staff then re checked their pain score.
- A protocol was in place for pain management as part of the care pathway for day case patients, which included types of analgesia and dose range.
- The majority of patients we spoke with about their pain told us it was well controlled and they would ask the nurses if they needed more pain relief. However, on the day surgery unit three patients told us they had to wait a long time to receive pain relief after they had requested it.
- A specialist pain score tool was used for patients with communication difficulties. For example, it had a number of faces showing facial expressions that patients were asked to pick to help identify their pain level.

Nutrition and hydration

- Patients had their nutrition and hydration needs assessed and monitored. The Malnutrition Universal Screening Tool (MUST) was used to monitor patients who were at risk of malnutrition. The tool (an accredited screening tool) screens patients from risks of malnutrition but also for obesity. Where patients were

identified, as at risk, nutritional care plans were developed to encourage intake, a food chart was commenced, and there was involvement from a dietician. We saw in one patient record a referral to a dietician based on their clinical need and MUST score.

- Staff at the preadmission clinic told us there was guidance for patients about when they should be 'nil by mouth' from, depending on their operation time. It also mentioned patients should not have sweets or chewing gum. Patients were able to have water up to two hours prior to surgery. Information about fasting was also included on the trust's website.
- Some patients who were undergoing colorectal surgery were prescribed pre-operative drinks. These drinks were used to improve the patients' nutrition prior to their operation and to encourage a quicker recovery.
- In recovery, we saw patients were assessed, monitored for nausea, and vomiting. On the medication administration records we saw anti-emetics were prescribed for patients. We spoke with anaesthetists who told us most patients were given anti-emetic medication whilst undergoing their operations to prevent any nausea and vomiting post operation. They said this was part of their protocol. We spoke with six patients whilst in recovery and all said they had no nausea or vomiting.

Patient outcomes

- Information about the outcomes of patients care and treatment were routinely collected and monitored. In the 2015 bowel cancer audit, overall performance was better than the England average. However, 67% of trust patients undergoing a major resection had a post-operative length of stay greater than five days. This was worse than the national average but an improvement on the 2014 figure of 51%. Mortality rates were better or within the expected limits.
- In the 2016 Oesophago-Gastric Cancer National Audit (OGCNCA), the trust was within the expected limits compared to other trusts.
- In the 2016 Hip Fracture Audit, the risk-adjusted 30-day mortality rate was 10.4% which is worse than expected but shows improvement versus the 2015 figure of 12.5%. The proportion of patients having surgery on the day of or day after admission was 73.2%, which does not meet the national standard of 85% and is worse than the 2015 figure of 80.6%. The perioperative surgical assessment rate was 96.4%, which does not meet the national standard of 100% but shows improvement versus the 2015 figure of 90.9%. The proportion of patients not developing pressure ulcers was 98.4%, which falls in the middle 50% of trusts. The 2015 figure was 98.1%. The length of stay was 10.4 days, which falls in the bottom 25% of trusts but has decreased versus the 2015 figure of 12.5 days.
- In the 2016 National Emergency Laparotomy Audit (NELA), Gloucestershire Royal achieved green (above 80%) ratings for the proportion of cases with access to theatres within clinically appropriate time frames and the proportion of highest-risk cases admitted to critical care post-operatively. They were rated amber (50-69%) for the number of cases with pre-operative documentation of risk of death and for the proportion of high-risk cases with a consultant surgeon and anaesthetist present in the theatre. The risk-adjusted 30-day mortality rate was within expectations.
- The hospital had mixed performance for Patient Reported Outcome Measures (PROMs) between April 2015 and March 2016. Patients reported their outcome following surgery for groin hernias, hip replacements, knee replacements, and varicose veins. The groin hernia and knee replacement indicators showed that overall the trusts performance was similar to the England average. The hip replacement and varicose vein indicators showed that fewer patients' reported an improvement in health after treatment and more patients' reported a worsening in health after treatment, compared to the England average.
- There had been an increase in surgical site infections in some procedures. At our last inspection, the surgical site infection (SSI) rate for Gloucestershire Royal Hospital from October 2014 to December 2014 for total knee replacement surgery was 0.1% lower (better) than the five year England national average of 2.2%. The rate for hip replacements was 0.9% lower than the five year England national average of 1.3%. However, since then the trust had experienced a marked increase in SSI at both Gloucestershire Royal and Cheltenham hospitals. The trust was identified by Public Health England as 'high outliers' in 'inpatient/readmission' SSI at both hospitals for the period of July 2015 to August 2016. This was due to a particular rise identified in July to September 2015. The trust told us their current rate for most up to date quarter does not place them as outliers with Public Health England as improvements have been seen.

Surgery

- Latest figures from the data sent to us by the trust showed for the trust as a whole for SSI in hip replacement surgery between July 2016 and September 2016, was 4% GRH 4%, CGH0%). This was higher (worse) than the national average of 1.1%. This figure represented five cases.
- The latest figures from the data sent to us by the trust showed for the trust as a whole for SSI for knee replacement surgery for the same period was 7.6% (GRH 3.4%, CGH 0.8%). This was higher (worse) than the national average of 1.5%. This figure represents seven cases.
- For spinal surgery at Gloucestershire Royal only for the same period, the overall SSI rate was 2.7%. This was higher (worse) than the national average of 1.8%. This figure represents two cases.
- The latest data we had for reduction of long bone from January 2016 to March 2016 was 2.4% (GRH 2.1%, CGH 2.9%) which is higher (worse) than the national average of 1.5%**.** This figure represents four cases.
- For fractured neck of femur for the period January 2016 to April 2016, the rate was 0.5% (GRH 0.8%, CGH 0%) which is lower (better) than the national average of 1.5%. This figure represents one case.
- The surgical division management team told us they had investigated the increase in surgical site infection rates but were not able to identify a specific cause. They were using 'Getting it right first time' (GIRFT) which had been adopted by the Department of Health. This guidance looks at solutions to reducing surgical site infection rates. An action plan had been devised to look at ways of reducing the risks to patients.
- The surgical admissions suite was due to take part in an audit the week after our inspection to look at improving patients' hydration levels pre operation to help their post operation recovery. This was to take place across both hospitals.
- The standardised risk of readmission for elective surgery was better than the England average for all specialities except for ear, nose and throat (ENT) which was worse than England average. For non-elective surgery, all specialities were better than England average again except for ENT.
- The formation of a Theatre Transformation Board was in progress to look at ways of improving theatre utilisation and session efficiency due to low usage figures For example between June 2016 to August 2016 these ranged across all theatres from 52% to 82%. Cancelled operations would have also had an impact on this.
- The trust had been identified as being a mortality outlier for Reduction of fracture of long bone (Upper/Lower limb)' procedures. The trust had reviewed all deaths between 1 February 2015 and 31 January 2016 to find out why there was an increase in mortality between these dates. Eighteen of the 26 of these patients who died were identified as hip fracture patients. This review identified areas of good practice and areas where improvement was needed. The findings were incorporated into an action plan that also covered the outlier for fractured neck of femur. At our last inspection, the surgical divisional management team told us the trust had commissioned an independent review by the Royal College of Surgeons, as their own investigations had not been able to identify the reason for the increase in mortality rates. This review took place in April 2015. Findings were incorporated into an action plan which we followed up. Changes to the location of the ward had been made and patients were now on ward 2a. Environmental changes had been made to aid recovery, for example, larger toilet areas and space for storing equipment so it was not in the way when patients were mobilising. We spoke with the advanced nurse practitioner who was appointed to support junior doctors. A practice educator was also in place on this ward focussing on the deteriorating patient. An updated hip fracture admission proforma was also implemented. This contained a management protocol for all staff to follow and included the emergency department as well as surgery wards. It included for example, pain management, nutrition, pressure ulcers and mentioned the possibilities of post operation delirium. A further review by The British Orthopaedic Association had taken place in November 2016 as the trust had agreed to take part in the Health Foundation sponsored (HIP QIP) quality improvement programme. This project involves replicating the learning from other trusts to improve outcomes for patients from trusts who were struggling to provide safe, high quality hip fracture care to patients. The sites were selected based on poor outcomes in the National Hip Fracture Database annual report. The project aims to help these trusts to provide hip fracture care of the highest quality, ensure recent evidence and national standards are systematically implemented, and

provide improved patient experience. The report was in draft form during our inspection and therefore we were not able to use information from it. However, it focused on their achievements and areas for improvement. The trust told us an internal audit of their mortality rate had shown they were back within the standard range.

Competent staff

- Staff had access to training to improve their skills and knowledge. Staff in theatres told us they had competency assessments in place they had to meet. These varied depending on their role and grade. The majority of staff were evaluated for their competence. In recovery, for example, staff followed the guidelines of the Royal College of Anaesthetists. Standard sets of competencies for nurses and operating department practitioners (ODPs) were in place to enable staff to demonstrate competency to the Association for Perioperative Practices and to enhance skills and knowledge within operating departments, associated areas and sterile services departments.
- The surgical division was below the trust target of 90% of appraisals completed for all staff groups, allied health care professionals, health care assistants, medical and dental, nursing and others to include clerical staff. These ranged from 67% to 83%. New staff were required to work a period of supernumerary time on wards, units and theatres/recovery. There was a set period of time, which could be extended based on the needs of the member of staff. They were also required to complete competency tests to assess their skill base.
- The wards, units and theatres/recovery had link nurses for specific areas, for example pressure ulcers and dementia. These staff could then share their additional knowledge with other staff.
- Medical staff were evaluated for their competence. Medical staff took part in the revalidation programme. This is a General Medical Council requirement for all UK licenced doctors to demonstrate they are up to date and fit to practise. This is tested by doctors participating in a robust annual appraisal leading to revalidation by the GMC every five years.Appraisals of medical staff were carried out each year and they were below the trust target of 90% at 75%
- Staff on the wards and theatres told us they did not have training specifically about mental illness but most had completed the dementia and learning disability awareness e- learning training. Figures provided by the trust showed that 72% of nurses had completed dementia awareness level one; 86% had completed level two dementia awareness training and 92% in learning disability. The trust told us following our inspection that health care assistants were able to access training on how to care for patients who self harm and on how to provide one to one care.
- Senior staff told us there was a process in place for identifying and managing poor or variable staff performance. They said staff were supported to improve their practice and offered additional training to meet their needs.

Multidisciplinary working

- All necessary staff, including those in different teams and services, were involved in the assessing, planning and delivery of patients care and treatment. In theatres, they had daily teams meetings for each theatre and then these fed into the daily multidisciplinary operational meetings, which also took place each morning. Representatives included a member of staff from each theatre, theatre management, staff from the day unit, the surgical admissions suite and Central Sterile Stores Department (they were responsible for supplying and cleaning of theatre kits). Staff were able to discuss any issues they might have that day with for example, staffing, equipment etc. so others were aware and resolutions could be found.
- We observed 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 and took part as required.
- We observed physiotherapists and occupational therapists working with patients on the wards and day surgery unit and they liaised with the nursing staff and medical teams who were involved in the patients care.
- We observed a daily board round which took place on the ward 2a and this included nursing staff and therapists where each patients planned care was discussed. These rounds also took place on the other surgery wards.
- To assist the staff on the surgery wards a discharge liaison team was available for patients who had complex needs and required detailed planning before they could be discharged. They provided support for the ward staff, for example, they would liaise with external professionals, including care homes. We observed this team on the surgery wards during our inspection.

Surgery

Seven-day services

- The hospital provided emergency surgery services around the clock. There was a designated emergency theatre and team on site 24 hours a day with surgeons and support staff on call. This theatre was available for any surgical speciality. There was system in place for booking patients onto the emergency list that was overseen by a senior member of staff in charge of the theatre.
- The hospital sterilisation and decontamination services (CSSD) also operated seven days a week to make sure all equipment needed was available.
- Some surgical patients were reviewed daily by a consultant, including weekends. However, consultants did not routinely review elective orthopaedic patients at weekends.
- There was no out-of-hours cover for occupational therapy (OT). However, on the elective orthopaedic ward there was OT support on a Saturday morning as part of the care pathway.
- For physiotherapists, criteria were in place for weekend visits. This included for elective orthopaedic ward patients, new patients and patients needing to be discharged. A physiotherapist was also on call at nights.
- The dedicated pain team did not work weekends. The on-call anaesthetist provided any support required.
- Dieticians did not provide an out-of-hours, on-call or weekend service. As a result, patients admitted over the weekend in need of dietetic referral had to wait until Monday to be seen
- Staff told us they had access to an out-of-hours pharmacy and imaging. The pharmacy was open at weekends for set hours and a pharmacist was available on call outside of these times.
- We saw the out-of-hours rota for surgery for each specialty. It included junior doctors, registrars and consultants. A consultant was on call at all times for each of the specialties, alongside a registrar and junior doctors.

Access to information

- Information needed to deliver effective care and treatment was not always available for relevant staff in a timely and accessible way. Staff we spoke to at all levels told us of their frustration with the new online theatre system introduce as part of the upgrade to the patient administration system prior to our inspection. We were shown examples where the procedures that patients were due to have in theatre was not identified in the information provide at the start of the day to theatre staff. Administrative staff were entering this information into the 'comments box' and staff raised concerns that this was a risk as there was an increased risk of wrong site surgery. The expected length of time for the procedure was arbitrary. Theatre lists no longer showed who the attending anaesthetist would be, and the surgeons name was not always accurate. Staff also told us that they were concerned that there was a risk that patients could be missed as the reporting was inaccurate. For example, one patient had arrived in the surgical admissions unit but was not expected by staff. Theatre managers told us of concerns they had that patients cancelled from theatre lists could be lost from the system. They also told us that theatre scheduling staff were spending on average an extra 30 hours per month to produce theatre lists. Staff also described being unable to get usable reports from the system, such as efficiency target data. The trust was working hard to address the issues identified by staff.
- When patients were transferred between wards, departments and units all their nursing and medical records were transferred with them. Staff also provided a verbal handover as well as the written records.
- We observed a handover between a recovery nurse and a ward nurse. Important information was given to the ward nurse about the patient and documentation was completed.
- When a patient was discharged to other services, for example, into the care of community nurses, practice nurses and care homes they completed a letter that included details of the patient's needs and what support and treatment was needed.
- We spoke with two junior doctors who told us they completed GP summaries to be sent out. They were unsure what happened to the summary in the computer system once they had completed their section. During our unannounced inspection one ward told us they were having problems with the new computer system and sending out of GP summaries, (they were sent electronically) however they were able to rectify this. On the day surgery unit, not all staff having the correct access to the new computer system As a result, they also

experienced issues with sending out GP summaries. This posed a risk to patients as a delay in GP's receiving this information could have an impact on their continued care.
- However, there was good access to intranet-based guidance, policies and protocols. The trust intranet was open and available to all authorised staff.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff understood the relevant consent and decision making requirements of legislation and guidance. Patients we met said they had been asked to provide consent both verbally and by signing a consent form. The nurses in the clinic or nurse specialists told patients who attended the pre admission clinic about the operation. On the day of their operation, the consultant and anaesthetist saw patients prior to their operation. Patients told us they had been told all the risks and benefits of the operation/procedure and were able to discuss what impact the procedure would have on their wellbeing.
- Staff told us they had four different types of consent form, including one for children and one for patients who lacked capacity to consent to their procedure/ operation. The consent forms we saw were appropriate forms according to the patients' needs were completed in full and had been signed by the doctor and patient. Forms included details about the procedure/operation and any possible risks or side effects.
- Staff on the wards understood about best interest decisions and where these needed to be recorded. At the last inspection, we found a best interest decision had not been recorded in the patients' notes. We did not witness this at this inspection as all of the patients' notes we examined referred to patients who had the capacity to make their own decisions.
- Staff said they knew how to make a Deprivation of Liberty (DOLs) application if it was required and they could access support from a social worker if required when completing DOLS applications. There were no patients on the surgery wards who were under a DOL's during our inspection.
- The trust reported that as of October 2016, Mental Capacity Act (MCA) training had been completed by 90.4% of all staff in within surgery. Deprivation of Liberty training had been completed by 90.3% of all staff. The completion rate for both modules met the trust target of 90%.

Are surgery services responsive?

Requires improvement

We rated responsive as requires improvement because:

- Due to pressure for beds and the demand on services, some patients had to use facilities and premises that were not always appropriate for inpatients.
- Elective operations were being cancelled due to the pressure on the beds within the trust and medical patients were being cared for on surgical wards to meet the demand.
- Not all patients had their operations re-booked within the 28-day timescale.
- Six patients had been waiting over 52 weeks for treatment, which is not acceptable.
- Some surgery wards had problems having medical patients reviewed by medical doctors and therefore this affected their discharge.

However:

- The trust's referral to treatment time (RTT) for admitted pathways for surgical services between January 2016 and November 2016 has been about the same as the England overall performance.
- The average length of stay was for non-elective patients was better than the England average.
- At our last inspection, the day surgery unit was having difficulties accessing doctors and other health care specialists for their inpatients. At this inspection, we were told this had improved.
- Staff in theatres and recovery had guidance in place to help reduce the anxiety of patients living with dementia when they using their services.

Service planning and delivery to meet the needs of local people

- Services were planned and delivered to meet the needs of local people and the demands of the service. The surgical division management team told us they had plans to review how surgery services functioned across both hospital sites. A number of surgical specialities had

been reconfigured to one of the hospitals, for example, ear, nose and throat surgery was based at Gloucester Royal Hospital and ophthalmology was carried out at Cheltenham General Hospital where vascular services were also situated.

- As part of service planning due to winter pressures and the increase demand on beds in the trust two surgical wards were being used for medical patients. This had an impact on the number of elective operations that could be undertaken. The day surgery unit was being opened both day and night and at times had medical inpatients when the demand for beds within the hospital was high. Despite this, the number of surgical admissions trust wide had increased by over 1000 patients since our last inspection.
- An emergency surgical ambulatory care unit was being developed on ward 5b, with the overall aim being to take direct surgical admissions rather than patients having to go through the emergency Whilst the unit was open it wasn't fully operating as a surgical ambulatory care unit as they also had medical outlier patients. Plans were also in place to improve the elective surgery pathway with the aim to improve patients experience and outcomes. This included, looking at staggered admissions times so patients are not waiting for long periods and a one-stop clinic and pre operation assessment. This work was also ongoing during our inspection and changes to practice had yet to be implemented.

Access and flow

- Between January 2016 and November 2016, the trust's referral to treatment time (RTT) for admitted pathways for surgical services has been about the same as the England overall performance. The latest figures for November 2016 showed 72% of this group of patients were treated within 18 weeks versus the England average of 71%.Ophthalmology, ENT and general surgery were above (better than) the England average for admitted referral to treatment times whilst urology and oral surgery were below (worse than) the England average.
- There were 1,172 cancelled operations for the period October 2015 to September 2016, of which 7.8% (91) were not re-booked for surgery within 28 days. A last-minute cancellation is a cancellation for non-clinical reasons on the day the patient was due to arrive, after they have arrived in hospital or on the day of their operation. If a patient has not been treated within 28 days of a last-minute cancellation they are recorded as having breached the standard. As a result, the patient should be offered treatment at the time and hospital of their choice. Cancelled operations as a percentage of elective admissions for the period October 2014 to September 2016 at the trust were greater (worse) than the England average. The number of operations where patients were cancelled more than once between January 2016 and November 2016 was 778, with February 2016 being the most at 108.
- The trust told us they had seven patients who had waited over 52 weeks for treatment. One patient has since declined treatment until May and the others were all reviewed in February 2017.
- Some elective patients were admitted directly to the surgical admissions suite where they were prepared for theatre. They were then taken to a ward post operation. The aim of the admissions suite was to help improve the flow of patients through the hospital by giving the wards extra time to discharge patients to free up beds. This unit was open from Monday to Friday, from 7am to 5pm.
- Due to pressure on beds, the trust had been using the day surgery unit as an inpatient ward. This had also been taking place at our last inspection. The action plan the trust sent us after our last inspection stated that funding for trust staff had been agreed from Monday morning until Saturday lunchtime, however staff told us the unit was open full time. However, we noted the unit did close over the Christmas period.
- There was an updated escalation plan used when the hospital was experiencing pressures on beds. This stated that patients would not be placed on the day surgery unit if they were going to be in hospital for longer than 24 hours. However, this was not always happening. We spoke to several inpatients that had been on the day surgery unit for longer than 24 hours. We received some feedback from patients prior to this inspection about being cared for on the day surgery unit who felt their needs were not being met, such as medication not sent with them from the ward they were transferred from and limited space.
- From April 2015 to September 2016, the trust's bed occupancy has been consistently higher than the England average by between 2 and 8%. This put extra pressure on their services and beds.
- Between April 2015 and March 2016, the average length of stay for surgical elective patients at the trust was 3.3

days, compared to 3.3 days for the England average. For surgical non-elective (emergency) patients, the average length of stay was 5.0 days, compared to 5.1 for the England average.

- At Gloucestershire Royal Hospital, the average length of stay for elective patients was 2.8 days (lower than the England average) and 4.8 days for non-elective (emergency) patients (lower than the average). The non-elective specialty trauma and orthopaedics had the highest average length of stay at 7.8 days but was lower than the England average of 8.8 days.

- Each speciality was responsible for devising theatre lists. The staff ere spoke with told us they had been doing this job for a long time and as a result were aware of how long operations took. Patients were added to the waiting list by the clinicians and they were assessed to see if the operations were urgent. Staff liked to have lists compiled well in advance so they could be sent to theatres to make sure equipment was ordered and staffing in place. However, with the new computer system this process was taking longer so operation lists were not compiled so far in advance. There was no reports of any issues for patients
- In the two weeks leading up to our inspection all elective orthopaedic surgery had been cancelled as the ward was being used as a medical ward as part of the escalation plans. Staff in theatres told us the only operations taking place were for patients with cancer, identified as urgent, or patients who had been cancelled on two previous occasions. At the time of the inspection, staff were waiting to hear when the ward would be returned to surgery so they could book patients in for their operations.

- Since November 2016, there had been seven times where patients had been nursed in recovery as there were no HD beds available. Day surgery patients were also discharged directly from recovery as the day surgery unit as being used for inpatients. Staff said of the 19 beds in recovery they had only five that they would call active recovery beds.
- One patient told us they had their operation cancelled twice before finally having it at the time of our inspection. However, they were happy with their experience once admitted and were pleased to have had their operation.
- On the last day of our inspection, we observed the cancelation of one patient's elective operation due to an emergency admission. We asked the matron in theatres why this was had occurred but they were not aware of the cancellation. It was unclear who had made the decision to cancel the patient. On further investigation, it was apparent that there might not have been a need to cancel the patient if the overall utilisation of the theatre suite had been taken into account, as there was capacity to take the patient onto another theatre list. By the time this was identified, the patient had drunk. The patient was offered another date immediately.
- On the day of our unannounced inspection, there were six elective operations cancelled. Staff said they did not cancel patients whose operations were due to cancer and would try their best not to cancel patients who had been cancelled previously.
- Wards 3a, 3b and 5a told us during our unannounced inspection they had been experiencing issues with getting their medical outlying patients reviewed by medical doctors. They had escalated this to senior staff. All the surgery wards we visited during our unannounced inspection had medical outlying patients on them.

Meeting people's individual needs

- Services were planned to take account of the needs of different people. For example, staff had access to translation services, both in person and by the telephone. A member of staff told us about a patient who had surgery during our inspection who had an interrupter with them.

- A learning disability liaison team supported staff to care for and support patients with complex needs and their carers during their stay in hospital. Carers were able to stay with them and join them in recovery following their operation.
- Patients living with dementia were identified by the 'purple butterfly scheme', which indicated to staff they needed more support. Staff in theatres and recovery had devised guidance for staff to follow. For example, in recovery, patients were to be admitted into the quiet and calm bays and overhead lighting was kept to a minimum. The patient's family member or carer was also able to be with them in recovery if needed.
- Staff in recovery also had access to 'twiddle- mitts' for patients living with dementia. Twiddle mitts are basic knitted hand muffs with items attached such as large

buttons or knitted flowers, which a patient can 'twiddle' in their hands. These were used to reduce patients stress when they were faced with a situation that was unknown to them.

- Staff told us there was little food provision outside of meal times, for example, if a patient was in theatre or off the ward for an investigation, they would have to have sandwiches, toast or cereals. The majority of patients told us the food was good. However as the meals were ordered a day in advance they could not always cater for alternative dietary requirements. For example, on the day surgery unit one patients was a vegetarian but they did not have any meals left suitable for them. The trust told us following our inspection that the central kitchen was open 24 hours a day and staff from the wards could request food for patients from them.
- At our last inspection staff on the day surgical unit told us they often had difficulties in accessing other services for patients, for example specialist diabetic nurses and physiotherapists. At this inspection, staff told us this had improved and we saw physiotherapists, occupational therapists assessing, and reviewing patients.
- As the day surgery unit was being used as a ward staff told us that at weekends they had no domestic to provide patients with refreshments, for example to clean and replace their water jugs. This was left to the staff on the unit but if they were busy, it was often missed. However patients were not left without access to drinks. A senior member of trust staff told us the unit was able to arrange this but it was clear from talking to staff on the unit they were not aware they did this. There were also issues with maintaining privacy and dignity on the day surgery unit in the main female bay as the nurses' station was positioned in the area. Due to lack of space, patients were able to hear for example, nurses on the telephone, doctors talking to other patients and to other staff. However, two patients told us the night staff did their very best to keep noise level to a minimum at night so they could get some sleep.

Learning from complaints and concerns

- Patients we spoke with knew how to make a complaint or raise concerns and they were confident to speak up. The majority were happy with the care they had received and did not feel they needed to make a complaint. Patients told us that if they wanted to make a complaint they would speak with a member of the nursing staff. The trust's complaints and comments procedure was displayed on noticeboards around some of the surgery wards, departments and units.
- Patients' concerns and complaints were used to help improve the quality of care. Complaints were discussed at ward and divisional level. Staff told us learning from any complaints was shared with staff.
- From November 2015 to October 2016, there were 108 complaints about surgical care. The trust took an average of 39 working days to investigate and close complaints, which was not in line with their complaints policy, which states complaints should be responded to in 35 working days. The trust's internal standard states 95% of cases should be responded to within 35 working days.
- Patient care was the most complained about theme with 30 complaints, followed by clinical treatment with 16 complaints. The profession 'nursing' received 51 complaints.
- Gloucestershire Royal hospital received 71 complaints of which patient care received the highest number of complaints, 20 (28%). In contrast, Gloucestershire Royal Hospital as a whole for this period received 651 complaints and of these, patient was care was the highest at 114 (18%).

Maternity and gynaecology

Safe	Requires improvement

Overall

Information about the service

Maternity and gynaecological services provided by Gloucestershire Hospitals NHS Foundation Trust are located on two hospital sites, Gloucestershire Royal Hospital and Cheltenham General Hospital. In addition, maternity services are also provided at Stroud Hospital. However, services on all sites are run by one management team (within the women's and children's division) and, as such, are regarded within the trust as one service.

Gloucestershire Royal Hospital provides maternity and gynaecological services to the local community and the surrounding areas. Gynaecological care is provided in a 13 bed gynaecological ward (Ward 9a) and a gynaecological outpatient area which also provides an early pregnancy assessment service. On-site gynaecological theatres are run and managed by the surgical division.

Midwife-led and obstetrician-led services are provided for early pregnancy, antenatal, induction of labour, delivery and postnatal care, along with community care including a home birth service. There is an antenatal clinic that includes a day assessment unit, which has six reclining chairs and one couch. Inpatient care is provided on the maternity ward (46 beds providing both antenatal and postnatal care in a mixture of side rooms and four-bedded bays). The delivery suite consists of a triage area with five beds and 12 birthing rooms. One room is equipped with a pool and is promoted for use by high risk women requesting a more normal birth experience. There is a bereavement suite that has a delivery bed, a lounge area, en-suite facilities and a kitchenette. There is access to the suite from outside of the labour suite. Two rooms are also used to provide high dependency care, though they can also be used as birthing rooms, and another of the rooms is used to admit women awaiting elective caesarean section (all rooms other than the latter being en suite). The theatre suite adjacent to the delivery suite has two dedicated obstetric operating theatres and a four bed recovery area. In addition, midwife-led care is provided in the birth unit on the floor above the main obstetric unit. It has six birthing rooms, two of which are equipped with pools.

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

Obstetric and specialist clinics are run by obstetricians and other specialist consultants, for example diabetologists and anaesthetists. Antenatal clinics are held from Monday to Friday.

Maternity and gynaecology

Summary of findings

- All areas had access to emergency resuscitation trolleys. However, in some areas, a systematic check of the trolleys was not documented as having being carried out on a daily basis. There were no up to date Resuscitation Council (UK) guidelines available on the resuscitation trolleys. Intravenous fluids on the emergency resuscitation trolleys were not stored securely to ensure they were tamper proof. This meant staff could not be assured the right equipment and guidance would be available in the case of an emergency.
- Not all drug storage fridge temperatures were documented daily. There was no process in place if a temperature fell outside of acceptable limits. This meant staff could not be assured medicines requiring refrigeration were being stored at the required temperatures.
- There were a number of out of date patient group directives (PGD's) in use in maternity services. The lists of medicines that were subject to PGD's had no doses or route of administration detailed on them. We drew this to the attention of senior staff and the PGD's were removed from use.
- Community midwives could not always print out clinical notes from the electronic system to go into women's handheld notes. They also reported poor mobile phone coverage which meant there was sometimes a delay in getting messages. This could have an impact on a woman who was trying to get some help or advice from a midwife. The trust told us women were always asked to contact maternity triage in the first instance if they had any concerns. This was available 24 hours a day and was not reliant on mobile phone coverage.
- An electronic patient record system had been introduced trust wide in December 2016. There were some ongoing issues with allocation of baby NHS numbers and records migrating to the new system. This meant that babies may miss out on vital tests following birth. Midwives had devised solutions to ensure each baby had an NHS number.
- There were often long waiting times in the triage area. Whilst systems were being put in place to increase medical and midwifery staffing, women were not seen within 15 minutes of attending the unit. This could mean that urgent issues may be missed.
- Consultant presence, on labour suite, was below the recommendations of the Royal College of Obstetricians and Gynaecologists (RCOG) Safer Childbirth (2007) guidance.
- Speciality trainee doctors (ST3 and ST4) and some consultants felt that a senior house officer equivalent was needed at night as sometimes no other medical staff to assist with emergency caesarean sections were available. This also meant other patients, across maternity and gynaecology services, who needed to see a doctor sometimes had to wait for long periods of time.
- The morning medical handover was informal and there was no input from the co-ordinating midwife about the women in labour at the time of the meeting. The registrar who had been on duty overnight presented the cases but said they were often tired and did not always have the full up to date details of the women. This may mean that the most up to date information is not being given to the next staff coming on duty.

However:

- Staff understood their responsibilities to raise concerns and report incidents using the electronic reporting system. There was a culture of shared learning from incidents.
- Staff spoke confidently about the duty of candour and gave examples of where it had been applied. Relevant staff had received training.
- All areas we visited were visibly clean and tidy. There were antibacterial hand sanitizers at the entrances to each unit/ward. Staff were seen adhering to the trusts infection control policies including 'bare below the elbows". This meant people visiting the maternity services were protected from the spread of infection.
- All rooms on the delivery suite, including the triage area had wireless cardiotochograph (CTG) machines for monitoring the foetal heart. The CTG machines

were linked to a central monitor point, which allowed the co-ordinating midwife to review traces. The wireless aspect meant women could still be monitored whilst in a birthing pool.
- Doors into all wards/units were locked, with a buzzer entry system and CCTV. Although reception areas were not manned 24 hours per day; when there was no receptionist other staff on duty took on the role. A baby security tagging system was in place on the maternity unit.
- There were systems in place for recognising and reporting safeguarding concerns. Staff were confident to raise any matters of concern and escalate them as appropriate.
- A 'vulnerable women's team' had been developed that included a 0.85 whole time equivalent (34 hours a week) perinatal mental health midwife, substance misuse and teenage pregnancy midwife and the lead safeguarding midwife. The team were able to offer an enhanced service to those women identified as being at risk. The team also offered advice and support to midwives who had concerns.
- Staff said there was good access to mandatory training. Mandatory training for maternity services included a PROMPT (Practical Obstetric Multi-Professional Training) skills drills training day and a one-day maternity update for staff working within the maternity unit.
- The maternity services offered Birth Choices Clinic for women identified as being high risk but who requested midwife-led care. They were seen by a supervisor of midwives and a complex care plan devised in agreement with the woman and in discussion with an obstetrician.
- The service had a commitment to managing women's peri-natal mental health issues and were trying to establish a team to include a consultant psychiatrist.
- The development of a training package for midwives to enable them to administer flu vaccinations to at risk women had meant that a high number of women who would otherwise have not had the flu vaccine had received it.
- The gynaecology ward had been relocated, in December 2016, to a ward with less beds (20 beds to 13 beds) to reduce the incidence of outlying patients (that is patients from medical or surgical wards) which sometimes meant elective gynaecology surgery had to be cancelled. The ward sister said the number of outliers had reduced significantly and as a result there were less elective gynaecology procedures being cancelled.
- The clinical scorecard between April 2016 and November 2016 showed that staff were providing one-to-one care in labour 98% of the time.
- A telephone triage system staffed by midwives was located within an ambulance service hub. Midwives directed women to the most appropriate place for their care. The system had reduced the volume of calls directly to the triage area.
- There was 24-hour consultant on-call cover. The delivery suite had access to anaesthetists 24 hours a day, seven days a week. Doctors we spoke with said that consultants always came in at night if they were asked to.

Maternity and gynaecology

Are maternity and gynaecology services safe?

Requires improvement

We rated safe as requires improvement because:

- All areas had access to emergency resuscitation trolleys. However, in some areas, a systematic check of the trolleys was not documented as having being carried out on a daily basis. There were no up to date Resuscitation Council (UK) guidelines available on the resuscitation trolleys. Intravenous fluids on the emergency resuscitation trolleys were not stored securely to ensure they were tamper proof. This meant staff could not be assured the right equipment and guidance would be available in the case of an emergency.
- Not all drug storage fridge temperatures were documented daily. There was no process in place if a temperature fell outside of acceptable limits. This meant staff could not be assured medicines requiring refrigeration were being stored at the required temperatures.
- There were a number of out of date patient group directives (PGD's) in use in maternity services. The lists of medicines that were subject to PGD's had no doses or route of administration detailed on them. We drew this to the attention of senior staff and the PGD's were removed from use.
- Community midwives could not always print out clinical notes from the electronic system to go into women's handheld notes. They also reported poor mobile phone coverage which meant there was sometimes a delay in getting messages. This could have an impact on a woman who was trying to get some help or advice from a midwife. The trust told us women were always asked to contact maternity triage in the first instance if they had any concerns. This was available 24 hours a day and was not reliant on mobile phone coverage
- An electronic patient record system had been introduced trust wide in December 2016. There were some ongoing issues with allocation of baby NHS numbers and records migrating to the new system. This meant that babies may miss out on vital tests following birth. Midwives had devised solutions to ensure each baby had an NHS number.
- There were often long waiting times in the triage area. Whilst systems were being put in place to increase medical and midwifery staffing, women were not seen within 15 minutes of attending the unit. This could mean that urgent issues may be missed.
- Consultant presence, on labour suite, was below the recommendations of the Royal College of Obstetricians and Gynaecologists (RCOG) Safer Childbirth (2007) guidance.
- Speciality trainee doctors (ST3 and ST4) and some consultants felt that a senior house officer equivalent was needed at night as sometimes no other medical staff to assist with emergency caesarean sections were available. This also meant other patients, across maternity and gynaecology services, who needed to see a doctor sometimes had to wait for long periods of time.
- The morning medical handover was informal and there was no input from the co-ordinating midwife about the women in labour at the time of the meeting. The registrar who had been on duty overnight presented the cases but said they were often tired and did not always have the full up to date details of the women. This may mean that the most up to date information is not being given to the next staff coming on duty.

However:

- Staff understood their responsibilities to raise concerns and report incidents using the electronic reporting system. There was a culture of shared learning from incidents.
- Staff spoke confidently about the duty of candour and gave examples of where it had been applied. Relevant staff had received training.
- All areas we visited were visibly clean and tidy. There were antibacterial hand sanitizers at the entrances to each unit/ward. Staff were seen adhering to the trusts infection control policies including 'bare below the elbows". This meant people visiting the maternity services were protected from the spread of infection.
- All rooms on the delivery suite, including the triage area had wireless cardiotochograph (CTG) machines for monitoring the foetal heart. The CTG machines were linked to a central monitor point, which allowed the co-ordinating midwife to review traces. The wireless aspect meant women could still be monitored whilst in a birthing pool.
- Doors into all wards/units were locked, with a buzzer entry system and CCTV. Although reception areas were

not manned 24 hours per day; when there was no receptionist other staff on duty took on the role. A baby security tagging system was in place on the maternity unit.
- There were systems in place for recognising and reporting safeguarding concerns. Staff were confident to raise any matters of concern and escalate them as appropriate.
- A 'vulnerable women's team' had been developed that included a 0.85 whole time equivalent (34 hours a week) perinatal mental health midwife, substance misuse and teenage pregnancy midwife and the lead safeguarding midwife. The team were able to offer an enhanced service to those women identified as being at risk. The team also offered advice and support to midwives who had concerns.
- Staff said there was good access to mandatory training. Mandatory training for maternity services included a PROMPT (Practical Obstetric Multi-Professional Training) skills drills training day and a one-day maternity update for staff working within the maternity unit.
- The maternity services offered Birth Choices Clinic for women identified as being high risk but who requested midwife-led care. They were seen by a supervisor of midwives and a complex care plan devised in agreement with the woman and in discussion with an obstetrician.
- The service had a commitment to managing women's peri-natal mental health issues and were trying to establish a team to include a consultant psychiatrist.
- The development of a training package for midwives to enable them to administer flu vaccinations to at risk women had meant that a high number of women who would otherwise have not had the flu vaccine had received it.
- The gynaecology ward had been relocated, in December 2016, to a ward with less beds (20 beds to 13 beds) to reduce the incidence of outlying patients (that is patients from medical or surgical wards) which sometimes meant elective gynaecology surgery had to be cancelled. The ward sister said the number of outliers had reduced significantly and as a result there were less elective gynaecology procedures being cancelled.
- The clinical scorecard between April 2016 and November 2016 showed that staff were providing one-to-one care in labour 98% of the time.
- A telephone triage system staffed by midwives was located within an ambulance service hub. Midwives directed women to the most appropriate place for their care. The system had reduced the volume of calls directly to the triage area.
- There was 24-hour consultant on-call cover. The delivery suite had access to anaesthetists 24 hours a day, seven days a week. Doctors we spoke with said that consultants always came in at night if they were asked to.

Incidents

- Staff understood their responsibilities to raise concerns and report incidents using the electronic reporting system.
- A trust-wide list of incident categories and maternity-specific categories was in use. This gave staff clear guidance on what constituted an incident, for example third and fourth degree tears, any unplanned admission to the neonatal unit, and postpartum haemorrhage.
- Ten serious incidents (SI's) had been reported within the maternity services since August 2015. These had been investigated, and actions were monitored through the maternity clinical governance meeting. Staff were able to describe changes that had occurred as a result, for example the introduction of a stamp when a high vaginal swab (HVS) was taken and a paper copy of the results sent to the clinic to ensure results were acted upon. The importance of the use of the green 'cause for concern' forms had been introduced into midwives induction programme and included on mandatory training; this improved access to previous notes.
- There were four SI's in an eight week period so the maternity services asked for a trust level review. This was carried out and no themes were identified.
- Less serious incidents were investigated at ward and department level by the midwife or nurse with lead responsibility for that area. All incidents described as moderate were reviewed by the lead nurse/midwife for quality and governance. The gynaecology nurse consultant reviewed and commissioned a root cause analysis for any moderately rated incidents. Actions identified were monitored for completion through the maternity clinical governance and the gynaecological clinical governance groups. These were fed into the divisional board governance meetings.

- Unplanned admissions to the neonatal unit were reported as incidents. These were investigated and trends monitored via the maternity service dashboard.
- Community midwives could not always print out clinical notes from the electronic system, to go into women's handheld notes. The midwives said they reported this as an incident when it happened as it could impact on the information about the woman and her pregnancy available to other professionals who needed to look at the notes.
- When an incident was described as 'red' (meeting the trust's threshold as a serious incident requiring investigation), the lead nurse/midwife for quality and governance, senior managers and clinicians undertook a rapid review and escalated the incident to trust level. Investigators were then identified, including someone external to the division, and a full investigation took place. Actions identified were monitored for completion through the maternity clinical governance and the gynaecological clinical governance groups. These fed into the divisional board and onward to the trust-wide safety experience review group, which was a sub-group of the board with overall responsibility to review safety measures in place.
- Lessons learned following investigated incidents were disseminated via the monthly 'team talk' bulletin. The risk managers were involved in mandatory training sessions so were able to discuss risks and they also circulated 'lessons learnt' to staff via email to reach a wider audience. Risk management meetings included the consultant lead for risk, matrons, supervisors of midwives and risk midwives. The minutes were circulated to all staff.
- Minutes from the Maternity Risk management meeting (September 2016) detailed a variety of cases for discussion. The minutes were also seen by the Safety Experience Review Group (SERG) and then by divisional leads who agreed the action plans formally.
- Morbidity and mortality meetings were held monthly, where cases were reviewed and outcomes discussed for learning. These were attended by medical staff, senior midwives and risk midwives and any learning cascaded to the relevant staff.

Duty of Candour

- Staff spoke confidently about the duty of candour and gave examples of where it had been applied. Relevant staff had received training.
- Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 is a regulation. 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
- We reviewed investigations into incidents and found that a 'Duty of Candour' letter was sent to the patient.

Safety thermometer

- The gynaecology ward and the maternity unit participated in the NHS Safety Thermometer. This was a process to collect information with respect to patient safety related to falls, catheters, urinary tract infections and pressure sores. These rates were in line with the England average. Patient safety information was displayed in clinical areas for patients, visitors or staff to see.
- Maternity services had taken part in the new maternity specific NHS Safety Thermometer, which was to take the place of the general NHS Safety Thermometer for maternity services. There were not yet any results available.

Cleanliness, infection control and hygiene

- Incidences of infection were reported as required.
- All areas we visited were visibly clean and tidy. We were told there was a system in place for washing of linen curtains and this was arranged by the linen team, although we did not see any documentation to support this. We saw disposable curtains in some areas. These had dates that indicated when they were next to be changed.
- Antibacterial hand cleanser was available at the entrances to all the wards and departments, birthing rooms and consulting rooms.
- Staff were seen adhering to the trusts infection control policies including 'bare below the elbows", hand washing between patients and the use of personal protective equipment such as gloves and disposable aprons.
- All consulting rooms had hand washing sinks that complied with Health Building Note 00-09: Infection control in the built environment (3.29 – 3.34). They also

had liquid soap, paper hand towels and pedal bins. We were told consulting couches were cleaned in between each patient and saw antibacterial wipes and rolls of paper sheets in each room to support this.
- There was a sticker system in place that indicated when a piece of equipment had been cleaned. We saw several pieces of equipment with the stickers in place.
- Birthing pools, on delivery suite and on the birthing unit, were cleaned between cases with a suitable detergent following trust policy and guidance, although there was no record made of the cleaning. Daily flushes of the birthing pools were recorded.
- We looked at cleaning schedules in a variety of areas we visited. They had been signed as completed. Staff told us they had regular cleaning staff who knew how to manage their particular area.
- We saw that Sepsis 6 (a bundle of medical therapies designed to reduce the mortality of patients with sepsis) was well promoted and staff we spoke with had a good awareness of the subject.
- Cleaning of the obstetric theatres between cases was carried out by health care assistants from the delivery suite. General obstetric theatre cleaning was carried out by the general theatre team.
- On ward 9a (gynaecology) there was carpet along the corridors. This was in place when the ward was relocated from ward 2a. The ward sister told us it had been risk assessed and there was a cleaning schedule in place. The carpet was being removed and more suitable flooring laid in March 2017.
- Cases of methicillin-resistant Staphylococcus aureus (MRSA) and Clostridium difficile rates were within an acceptable range were within the accepted range. Maternity services were not identified as outliers for these infections.

Environment and equipment

- Emergency call bells were available on the wards and in individual consulting rooms.
- All areas had access to emergency resuscitation trolleys. However, in some areas, a systematic check of the trolleys was not documented as being carried out on a daily basis, as required by trust policy and recommended by The Resuscitation Council (UK). In some areas at low risk of emergencies, for example the ante natal clinic, the trust policy allowed for weekly checking and this was consistently completed. There were no up to date Resuscitation Council (UK) guidelines available on the resuscitation trolleys.
- There was a postpartum haemorrhage (PPH) emergency trolley, stored in the recovery room on the delivery suite. There was up to date guidance about emergency PPH management with the trolley.
- Staff reported they had access to up to date equipment and equipment was fixed quickly once reported as faulty. All equipment we saw had stickers on them identifying when they had last been serviced/calibrated.
- All rooms on the delivery suite, including the triage area (since January 2017) had wireless cardiotochograph (CTG) machines for monitoring the foetal heart. The CTG machines were linked to a central monitor point, which allowed the co-ordinating midwife to review traces. The wireless aspect meant women could still be monitored whilst in a birthing pool.
- The triage area had equipment to safely monitor and assess pregnancy. An ultrasound machine was available to confirm the presence or absence of a foetal heartbeat and was also used to confirm the position of a baby.
- There was access to bariatric equipment (used for women with high body mass index) throughout the maternity services at Gloucester Royal Hospital.
- Birthing rooms and bed spaces on the wards had piped oxygen and suction available. Staff said there were sufficient numbers of resuscitaires available for neonatal resuscitation.
- Rooms in the birth centre were large and had a calming atmosphere; they had subdued lighting and non-flame candles (LED). Birth couches were provided rather than beds. Two rooms were equipped with birthing pools. In addition there were birthing stools, balls and mats available to facilitate mobility in labour. Most of the rooms there also had 'pull down' double beds, which meant partners were able to stay overnight. All rooms had en suite facilities. Emergency evacuation equipment was available for use in the event of a maternal collapse in the pool. Transfers out of the pool were practised, and manual handling was included in mandatory training for all maternity staff.
- Partners were able to stay with women on the delivery suite, but there were no facilities for them to remain overnight after birth, with the exception of bereaved parents. The two bereavement rooms were equipped

with sofa beds to allow partners to stay. In addition, they had toilet facilities and kitchen area where drinks could be prepared. A cold cot was available if bereaved parents wanted to spend time with their baby. The bereavement rooms could be accessed independently of the delivery unit.

- Equipment was serviced regularly by the trust's maintenance department. They held an inventory of what equipment areas had and when it was due to be serviced/calibrated. We saw the service dates on a variety of pieces of equipment, including pumps, resuscitaires and monitors.
- Doors into all wards were locked, with a buzzer entry system and CCTV. Reception areas were not manned 24 hours per day; when there was no receptionist other staff on duty took on the role.
- A baby security tagging system was introduced in 2015 in order to increase the security of babies within the maternity unit. This was reported as working well.
- Community midwives reported poor mobile phone coverage which meant there was sometimes delay in getting messages. The trust told us women were always asked to contact maternity triage in the first instance if they had any concerns. This was available 24 hours a day and was not reliant on mobile phone coverage. Connectivity issues meant community midwives sometimes had to return to base to log work and carry out administrative tasks on online, which meant their working days were often extended. This related to mobile lap top computers. New computers had been ordered but had not yet been delivered.

Medicines

- Not all medicines were securely stored. Medicine cupboards were locked on all wards and departments, however, intravenous fluids on the emergency resuscitation trolleys were not securely stored. Medicines stored on adult and neonatal emergency resuscitation trolleys were stored within tamper-evident containers.
- Some rooms, that contained medications, were secured with digital keypads. However, the codes for these were rarely changed.
- Drug storage fridge temperatures were documented daily. However on the maternity ward there were days when the temperatures had not been recorded: October 2016 – 11 days, November 2016 – 4 days, December 2016 – 9 days and January 2017 – 6 days. There was no process in place if a temperature fell outside of acceptable limits. For example on the labour suite the fridge was between 12 and 18 degrees on nine consecutive days with no note of any action taken.
- Midwives were able to administer some medicines under patient group directives (NHS documents permitting the supply of prescription only medicines to groups of patients without individual prescriptions). Training for this was included during the midwives' preceptorship programme and included in mandatory training updates. However we saw some out of date PGD's in use in maternity services. For example lists of medicines that were subject to PGD's with no doses or route of administration. We drew this to the attention of senior staff and out of date information was removed from use. However, the trust told us the official PGD webpage contained up to date PGD's for staff to use. The trust head of pharmacy had an action plan to review and update all PGDs. Stated to be completed by April 2017. We were not made aware of what staff were referring to in the interim period, there was some confusion over where, on the system, maternity staff looked for relevant PGD's.
- In one of the post-natal patient records we reviewed there was no review or stop date for a prescribed antibiotic and no General medical Council (GMC) number or bleep number detailed and the signature was illegible.
- There was an on-call pharmacy service for supply and advice outside of pharmacy opening hours.
- There was a facility on the intranet for staff to see what medicines were stocked around the hospital to help locating medicines when the pharmacy was closed.
- A rolling replacement of resuscitaires with blended gases was ongoing. This would ensure all resuscitaires across the maternity services would be the same reducing the risk of confusion. This had been an item on the risk register since 2014.

Records

- During the inspection we looked at 12 sets of patient records. They included detailed risk assessments for example ante natal venous thromboembolism (VTE) assessments, mental health assessments, modified

early obstetric warning system (MEOWS) completed post natally and allergy details. However in two of the three post-natal notes reviewed there was no inpatient VTE risk assessment completed.

- Women carried their own records for the duration of the pregnancy. Once delivered, women were issued with their postnatal records to enable their ongoing care/ support to be documented and a child health record (red book) for their baby.
- There was good access to previous medical records. We saw that previous records were routinely obtained when a woman booked for her care during pregnancy.
- Midwives conducted audits of record keeping as part of their annual supervisory review. Their records were audited and reviewed by their supervisor any actions required were identified. The trust was planning a model of midwifery supervision to use to ensure these practices continued when the statutory supervision of midwives ceases to be a legal requirement in 2017.
- An electronic patient record system had been introduced trust wide, in December 2016. There were some ongoing issues with allocation of a baby NHS numbers and records migrating to new system. However a workaround had been developed and staff were able to ensure all babies had an NHS number.

Safeguarding

- Staff received training in safeguarding vulnerable adults and children. Where appropriate, staff within the maternity service were trained to safeguarding level 3. Staff on the gynaecology ward had safeguarding training to level 1 or 2, dependent upon their role. The trust set a target of 90% for completion of safeguarding training. Midwifery and nursing staff met their target, with 93% of staff having completed adult and children safeguarding awareness training, 93% had completed level 2 safeguarding adults training and 91% had completed level 2 safeguarding children training. Medical staff had also met their target, with 100% having completed safeguarding children level 1 and 3 and 90% having completed safeguarding adult's level 1 and safeguarding children level 2.
- There were systems in place for reporting safeguarding concerns. Midwives described how they would raise concerns. Staff were confident to raise any matters of concern and escalate them as appropriate. Information was available to staff in all areas we visited on how to escalate safeguarding concerns.
- Systems were in place to identify women and babies at risk. This included the use of a 'green form', filed in the confidential section of the maternity notes, that detailed any safeguarding concerns or other vulnerabilities such as learning difficulties.
- A 'vulnerable women's team' had been developed that included a 0.85 whole time equivalent (34 hours a week) perinatal mental health midwife, substance misuse and teenage pregnancy midwife and the lead safeguarding midwife. The team were able to offer an enhanced service to those women identified as being at risk. The team also offered advice and support to midwives who had concerns.
- Midwives were offered a vulnerable women training day that was said to be well attended. Safeguarding training covered female genital mutilation, child sexual exploitation and PREVENT (counter-terrorism awareness).
- Midwives attended safeguarding case conferences and strategy meetings in partnership with the local authority where appropriate. Information about women/families where there were safeguarding concerns was written on a white board in the sister's office on delivery suite. However it could not be seen by people passing the office. The same information was kept in a red folder on the delivery suite to help to maintain confidentiality. Access to the safeguarding database was available to band 7 midwives and above, for confidentiality purposes. This was kept updated by the 'vulnerable women's team' (VWT) who ensured a monthly update was sent to team leaders to enable planning for high risk cases. Midwives requiring additional information could contact the VWT or line managers at any time (a band 7 midwife was available within the trust 24 hours a day).
- Community midwives said there was a safeguarding forum that team leaders attended. The forum was also open to all midwives who wanted to attend. They added there was sometimes a lack of information sharing from the local social services. This had been escalated to the midwife safeguarding lead.

Mandatory training

- The trust had set a target of 90% for completion of mandatory training. As of October 2016 the target was met in eight out of 12 modules for midwifery and nursing staff and included basic adult resuscitation, infection control and safety awareness. The four modules that did not meet the target (conflict

resolution, manual handling practical, manual handling theory and medicines management) had compliance rates of 82- 89%. The target in October 2016 was met in 11 out of 12 modules for medical staff and included prescribing, conflict resolution and basic adult resuscitation. The one module that did not meet target was manual handling practical (85%).

- Staff said there was good access to mandatory training. Mandatory training for maternity services included a PROMPT (Practical Obstetric Multi-Professional Training) skills drills training day and a one-day maternity update for staff working within the maternity unit. The training covered CTG training and peri-natal mental health. The trust employed practice development midwives, who monitored attendance at mandatory training. Staff were automatically booked onto mandatory training annually. Failure to attend was escalated to managers for action.
- Senior House Officers (SHO) did not attend PROMPT skills drills training when they started at the trust. Those that spoke to us said whilst they did not cover the delivery suite they did carry an emergency bleep and if they arrived in the delivery suite first they often felt out of their depth. The trust told us that it was made clear to junior doctors at the start of their attachment to obstetrics that management of patients on labour ward was outside of their remit. However they recognised the message was not as clear as it should have been and more instruction about junior doctors responsibilities would be given to them within the first week of their attachment to obstetrics.

Assessing and responding to patient risk

- Staff used a communication tool known as RSVP (reason, summary, vital signs and plan). We observed handovers following that format. We saw notes that showed that RSVP was followed to assess patients and develop a plan of care.
- The trusts annual birth unit report 2015 showed that around 50% of women booked for maternity care in Gloucestershire were booked for midwifery led care. Around 30% gave birth at home or in a midwife led birthing unit. This compared to a national average of 13% (National Maternity Review 2015). This showed women were risk assessed appropriately before making a decision to use a midwife led unit.
- The maternity services offered Birth Choices Clinic for women identified as being high risk but who requested midwife-led care. They were seen by a supervisor of midwives and a complex care plan devised in agreement with the woman and in discussion with an obstetrician. These plans were stored within the woman's notes and also on the supervisor of midwives' shared computer drive to ensure each supervisor of midwives and all band 7 midwives were fully aware of the agreed plan of care. The midwife led birthing suite staff participated in the clinics to help women decide where to have their baby.
- The service had a commitment to managing women's peri-natal mental health issues and were trying to establish a team to include a consultant psychiatrist. The service recently appointed a 0.85 whole time equivalent (34 hours a week) midwife to work only in peri-natal mental health. A visiting consultant psychiatrist held a clinic session in the unit monthly and was accessible to staff via email. Assessment of mental health documentation in patient notes was audited annually. A liaison psychiatric team was available daily between 8am and 10pm and then on call. There was also a crisis team available 24 hours a day seven days a week. Although they usually worked in the community they would attend the hospital if necessary.
- Records we looked at showed the World Health Organisation 5 Steps to Safer Surgery checklists were in use and completed in full.
- Activity in triage had steadily increased over the last few years. A maternity pathways review in 2014 highlighted triage as an area that could have significant pressures and sometimes meant women had to wait for long periods of time to be seen and assessed. This increased the risk to the women and their baby. Two serious incidents had occurred in the last two years that could have been avoided if the women had been seen more quickly. In October 2016 90% of women waited up to 30 minutes to be seen, with 3% waiting longer than 60 minutes. This was an improvement from September 2016 when 83 % of women had to wait up to 30 minutes to be seen and 9% waited longer than 60 minutes. A telephone advice line was set up, as a one year pilot between August 2015 and August 2016, to direct women to the most appropriate service. This enabled midwives working in triage to concentrate more on face to face assessments. This was successful and funding has been received to enable the service to continue. Additionally a bid for an extra midwife to work in triage was submitted to the trust. The maternity services have

been actively recruiting to the post. Until it could be filled, from March 2017 onwards, triage was going to be part of the midwifery staff rotation to ensure staff staffing levels were maintained. Having the CTG readings now linked to a central monitoring point so the co-ordinating midwife could review the readings also helped to increase the safety of the triage system. There was a consultant obstetrician starting work in March 2017 specifically to work in triage and co-ordinate the implementation of the rapid assessment and treatment (RAT) pathway to ensure women were seen within 15 minutes of arrival.

- Midwives practised 'fresh eyes' (an independent review of progress by a midwife not previously involved in the patient's care) on the delivery suite every two hours. This was undertaken by a core delivery suite midwife, usually the coordinating midwife who was not directly involved in the woman's care. It comprised a review of the foetal heart and progress in labour.
- Where risks had been identified antenatally, appropriate care plans were developed. For example, staff described care of women with gestational diabetes, raised body mass index (BMI) and co-existing medical problems.
- Public Health England (PHE) had asked maternity units to help with the uptake of flu vaccinations. The ante natal clinic sister had developed a training pack that included PHE slides and anaphylaxis training, which took four hours to complete. The staff had to be observed and signed off, to ensure competency. The flu vaccinations were then offered to women as part of the day to day work. This had seen significant numbers of women have the vaccination in 2015/6 with a good number continuing to have the vaccination in 2016/7.
- There were a limited number of midwives who had undertaken additional courses in high dependency care. Where high dependency care was required following delivery, women were transferred to the high dependency unit, on the maternity unit, where there was a midwife trained in high dependency care on duty or the intensive care unit.
- Staff on the gynaecology ward and in the maternity unit completed the modified early warning score or National Early Warning Score (NEWS) system for recording vital signs. This indicated to staff when observations required repeating or concerns needed to be escalated. We saw evidence in notes we reviewed that concerns had been escalated appropriately.
- The gynaecology ward had been relocated, in December 2016, to a ward with less beds (20 beds to 13 beds) to reduce the incidence of outlying patients (that is patients from medical or surgical wards) which had sometimes meant elective gynaecology surgery had to be cancelled. The ward sister said the number of outliers had reduced significantly and as a result there were less elective gynaecology procedures being cancelled.
- The gynaecology outpatients department held a nurse led early pregnancy clinic Monday to Friday 08.30am until 5pm and also on Saturday and Sunday mornings. There was access to the on call medical team. This meant women did not have to wait long to be seen if they had concerns. If women needed to be seen out of hours they would be asked to go to the emergency department.
- The medical induction of labour rate varied from 15.5% in May 2016 to 19.7% in October 2016. This was above the trust target of below 10% and slightly higher than the England average of 13.6%.
- All post-partum haemorrhages (PPH) above 1500mls triggered a root cause analysis (RCA) investigation. Between April 2016 and November 2016 there had been four months where the numbers of PPH had been above the trust target of 3%. There had been no trends identified following the RCA's.
- The average Caesarean section rate (for both elective and emergency procedures) was 20.5% which was below the trust target of 25%.
- The number of 3rd and 4th degree tears per operative vaginal births was above the trusts target of more than 5% of all vaginal births, at 5.9% to 11.3% between June and October 2016. Although this was not classed as an outlier according to the Royal College of Obstetricians and Gynaecologists (RCOG), an audit was underway during the inspection and there was a plan to investigate techniques applied to see if any trends could be identified.

Midwifery staffing

- The Royal College of Obstetrics and Gynaecology guidance (Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour, October 2007), states there should be an average midwife-to-births ratio of 1:28. The funded midwife-to-births ratio was 1:29.5, which is worse than the England average of 1:29. The monthly maternity

dashboard reported the midwife-to-birth ratio against establishment (average of 1:29) and the actual staffing levels that were an average of 1:31 which falls below expected levels. The trust did not include registered midwives who were not working clinically or any health care or midwifery care assistants in their data, as some other organisations did. Staff said midwife levels were safe on delivery suite.

- In August 2016 the maternity services were 1.63% below establishment numbers. In November 2016 Gloucester Royal Hospital reported a vacancy rate for maternity and gynaecology of 1.2%. We were told recruitment was ongoing.
- Midwives worked as core unit midwives, community midwives or rotational midwives within the main hospital. Rotational midwives moved work areas every six months, whilst core and community midwives remained in the same working area. Triage was to be included in the rotation from March 2017.
- There were 10 midwives per shift on the delivery suite. This included one midwife who was assigned the role of delivery suite coordinator who worked in a supervisory position. At times of increased activity and in order to provide one-to-one care to women in labour, staff were redeployed from other areas of the maternity services.
- The clinical scorecard between April 2016 and November 2016 showed that staff were providing one-to-one care in labour 98% of the time.
- Midwifery and nursing handovers were at 08.30am and 8.30pm, when staff changed shifts. The multidisciplinary team, not including medical staff, present on the delivery suite attended the handover meetings.
- Acuity (patient dependency) was measured using the birth rate plus acuity tool, with acuity monitored four-hourly. This meant midwifery managers were able to benchmark staffing against patient dependency.
- The delivery suite had receptionist cover provided Monday to Friday, 8.30am to 10pm, and on Saturdays from 9am to 5pm. Outside these times, all calls, administration and managing of access to the delivery suite were the responsibility of the midwives on duty. This was often the midwife working in the triage area, meaning that sometimes the midwife was away from patient care.
- Midwives were allocated to work in triage from the delivery suite. Triage was staffed with one midwife at any one time and was open 24 hours a day, seven days per week in addition, midwifery care assistant cover was provided from 12.30 – 9pm. There were seven band 6 midwives and one band 7 midwife who worked as the core team on triage. From March 2017 midwife cover for the triage area was to become part of the six monthly midwife rotation meaning there would be increased midwife cover.
- A telephone triage system staffed by midwives was located within an ambulance service hub. Midwives directed women to the most appropriate place for their care. The system had reduced the volume of calls directly to the triage area.
- A clear escalation policy detailed how additional staff were to be obtained in the event of increased sickness or high activity and/or acuity/dependency within the maternity services. This included additional support from the senior midwifery team and supervisors of midwives and community midwives. The on-call rota for each of these was displayed in the delivery suite. When staff shortages occurred, incident forms were completed in order to monitor the frequency of such situations.
- The midwifery sickness rate across maternity and gynaecology services was 4.6% in December 2016.
- Expected and actual staffing levels were displayed on Ward 9a (gynaecology), on the maternity ward, on delivery suite and on the birth centre. At the time of the inspection, the safe staffing information indicated there were the expected numbers of staff on each shift on Ward 9a. Gynaecology staff reported that staffing levels had fluctuated recently as staff had left due to the pressure of large numbers of outlier patients (that is patients from other specialities such as medicine and surgery). That pressure had become much less since the move to ward 9a and staffing levels were now more consistent.
- The trust had a bank of nursing and midwifery staff. This meant there was little use of agency staff across the gynaecology service. The sister in gynaecology outpatients said it was difficult to get bank nurses to cover for their specialist service but sickness and leave were usually covered by existing staff working extra shifts. Agency midwives were not used across maternity services.

Medical staffing

- The trust reported 75 hours of dedicated consultant cover on the delivery suite. This was below the recommended 168-hour consultant presence to meet

the recommendations of the Royal College of Obstetricians and Gynaecologists (RCOG) Safer Childbirth (2007) guidance. However, staff told us consultants attended when called out of hours and felt the consultant presence on the delivery suite was currently at safe levels.

- The maternity services clinical scorecard between April 2016 and November 2016 showed little use of locum consultants with six out of the nine months using one whole time equivalent (WTE) and three months using two WTE.
- There was 24-hour consultant on-call cover. The delivery suite had access to anaesthetists 24 hours a day, seven days a week. Doctors we spoke with said that consultants always came in at night if they were asked to. They reported the on call rota was manageable and gaps were usually filled by existing staff. Consultants had oversight of the on call rota. Speciality trainee doctors (ST3 and ST4) and some consultants felt that a senior house officer equivalent was needed at night as sometimes there were no other medical staff to assist with emergency caesarean sections which meant the scrub nurse had to assist. An example was given of a woman with a raised body mass index (BMI) of over 40 who needed a caesarean section; the other ST grade doctor was carrying out an instrumental delivery so was not available which meant the doctor had no medical assistance. The midwife assisted until they had to 'take the baby' and then a scrub nurse assisted. This had happened the previous night so had not been reported as an incident at the time of the inspection. The situation also meant that gynaecology emergencies in the emergency department sometimes had long waits to be seen because the doctors were busy in delivery suite and sometimes telephone advice had to be given to the maternity and gynaecological wards as there was not time to see the patient. The consultants and the Royal College of Obstetricians and Gynaecologists (RCOG) were aware and funding for two extra posts had been requested but not granted. The Severn Deanery (regional organisation responsible for postgraduate medical training) was also aware stating that this was the only unit in their area to not have a senior house officer equivalent on call.
- The medical rota showed there was obstetric medical presence on the delivery suite 24 hours per day, seven days per week.
- Medical handovers were at 8.30am, 1.30pm, 5.30pm and 8.30pm on the delivery suite. We observed one handover and saw it reviewed all patients following the RSVP ('reason, summary, vital signs and plan') communication format. This gave consistency and ensured aspects of the patients' care and planning were included in discussions. The handover was informal and there was no input from the co-ordinating midwife about the women in labour at the time of the meeting. The registrar who had been on duty overnight presented the cases but, registrars told us, they were often tired and did not always have the full up to date details of the women.
- Medical staff from the delivery suite provided cover for the triage unit and for women who had not been discharged from the day assessment unit before it closed. At times, these women waited for long periods for review. Staff told us accessing medical review could be difficult at times, particularly when the delivery suite was busy. There was a consultant obstetrician starting work in March 2017 specifically to work in triage and co-ordinate the implementation of the rapid assessment and treatment (RAT) pathway to ensure women were seen within 15 minutes of arrival.
- There were two obstetric theatres with senior nurses and operating department assistants from the general theatres team working alongside midwives and obstetricians. There were elective caesarean section lists between 8.30am and 4pm each weekday. Outside of these hours, for emergencies, there was a general theatre team on call and on site. Women were recovered from anaesthetic in the four bed recovery bay on delivery suite. If a patient had higher dependency needs post operatively they may be recovered in general surgery recovery. The baby would stay on delivery suite.
- Out-of-hours medical cover was provided by registrars and on-call consultants in both maternity and gynaecology. Reduced medical cover meant, at times, a delay occurred in a non-emergency review.

Major incident awareness and training

- Staff were aware of processes to follow in the event of a major incident. The trust-wide major incident plan was available to all staff on their intranet. The operational policy for each maternity service had a section on the 'role in major incident' and 'business continuity and contingency'. Each operational policy had a link to each service's contingency plan.

Maternity and gynaecology

- There was a maternity escalation policy for staff to use if there was a major event or high activity within the maternity unit that could not be managed with available resources. It described steps to be taken to decide if the unit had to be closed and patients diverted to other units for a period of time.

Services for children and young people

Safe	Good
Overall	

Information about the service

Gloucestershire Hospitals NHS Trust provides inpatient and community services for children and young people under the age of 18 years. These include a neonatal unit located close to the maternity services and a dedicated children's unit in a different area of Gloucestershire Royal Hospital.

All children's services are located at Gloucestershire Royal Hospital with the exception of specialist day case eye surgery and some outpatient facilities. These services were provided at Cheltenham General Hospital but staffed by nurses from Gloucester children's unit.

The range of services provided within the children's unit includes; oncology, surgery, medicine, neonatal intensive care, physiotherapy and support services such as play and education. There are 52 beds which include:

- 29 general beds, which were arranged as one six-bedded bay, two double-bedded bays and 19 individual cubicles.
- One four-bed oncology unit
- One four-bed high dependency unit.
- An area of eight beds for children undergoing procedures as a day-case
- One seven-bed paediatric admissions unit (PAU).

There was also a neonatal intensive care unit with 28 cots for babies needing high dependency or short-term intensive care.

A team of clinical nurse specialists is based on the children's unit and provides an outreach service across the county for patients with cystic fibrosis, asthma, diabetes, endocrine and dermatological conditions.

Children's and young people's outpatient services are located in the children's unit and at Cheltenham General Hospital, although some of these patients may be seen in the general outpatients department depending on the consultant they are seeing. Some consultants provide services for children in the community and see patients at community hospitals and schools that provide education for children with additional needs.

We spoke with eight parents and observed care of three children and young people during our inspection. We spoke with 26 staff, including nurses, consultants, medical staff, managers and support staff. We visited all the areas within the children's unit. We observed care and looked at 12 patient records and other documents provided by the trust. Before and during this inspection we reviewed Gloucestershire Hospitals NHS Trust performance information.

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

Services for children and young people

Summary of findings

This was a focussed inspection to follow-up on concerns from a previous inspection. Our inspection team only inspected the safe domain. The trust's previous CQC inspection was in March 2015. At this inspection safety for patients attending the children's service was rated as requiring improvement. This was because there were concerns about the medical cover for middle grade doctors on both the neonatal and children's units and the lack of staff available to deal with safeguarding referrals in a timely way.

During this inspection we rated safe as good because:

- There was an open reporting culture by staff who worked in the children's services. This helped to maintain the safety of treatment and care for babies, children and young people.
- There was evidence to show incidents, concerns or trends were investigated for learning opportunities and actions taken to improve practice.
- Staff understood their roles and responsibilities to safeguard children from potential risks or abuse and received supervision on a regular basis. The trust's safeguarding teams worked with community and social care colleagues to identify and support children who may be at risk.
- Systems for staff shift handovers promoted the safety of children. Staff were fully included in processes and encouraged to contribute.
- Records showed electrical and mechanical equipment was regularly maintained to ensure it was safe to use and review dates were clearly indicated.
- Risk assessments were used with all children to identify the level of care they needed. These were audited regularly to check they had been completed correctly and concerns had been escalated for further advice where necessary.
- Staffing levels were regularly reviewed and planned to follow national guidelines and standards. However, staffing levels had been challenged with unexpected staff absences. Managers were taking steps to fill gaps in the short term, recruit staff on a permanent basis and maintain staffing levels.

However:

- Compliance with audit processes for infection prevention and control was variable across the children's services and had not been consistently completed.
- Routine stock checks of some medicines were not always completed according to the trust protocol.

Services for children and young people

Are services for children and young people safe?

Good

During this inspection we rated safe as good because:

- There was an open reporting culture in the children's services which helped to maintain the safety for babies, children and young people. Any incidents, concerns or trends were investigated for learning opportunities and actions taken to improve practice.
- Safeguarding practices were good and continued to improve, with communication between departments being encouraged. Staff understood their role in safeguarding children and received supervision on a regular basis. Safeguarding teams worked with community and social care colleagues to identify and support children who may be at risk.
- Systems for handovers of patient care protected the safety of children. Staff were fully included in the process and encouraged to contribute.
- Electrical and mechanical equipment was regularly maintained to ensure it was safe to use and review dates were clearly indicated.
- Risk assessments were used for all children to identify the level of care they needed. These were audited regularly to check they were completed correctly and concerns had been escalated for further advice where necessary.

However:

- Compliance with audit processes for infection prevention and control was variable across the children's services. Audit results were not always completed by children's services.
- Routine stock checks of some medicines were not always completed according to the trust protocol.
- Not all outpatient waiting areas in the hospital had specific children's areas. This meant there was a potential safeguarding risk for children who may be unsupervised by parents, guardians or hospital staff. Areas that were not solely for children's use in other parts of the hospital had waiting areas that were shared with adults.

Incidents

- Children's services' staff demonstrated understanding of what types of issues to report and how to do this. They used investigations from incidents to improve safety for children, young people and their families. Senior managers for children's services monitored and reported any incidents in accordance with the Serious Incident Framework 2015.
- The children's service reported no incidents which were classified as never events for the reporting period of December 2015 and November 2016. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- The trust reported one serious incident between December 2015 and November 2016 in children's services, which met the reporting criteria set by NHS England. This was regarding risk assessments that had not been well completed for a child whose condition deteriorated. Records showed this was investigated and learning from the incident was shared with staff to prevent a reoccurrence. This included changes to processes by ensuring prescribers had quiet space to complete prescriptions and reminding staff to check records for any allergies.
- There was a strong culture of identifying and reporting any risks to improve safety for children and young people. Staff followed the trust policy for raising concerns about safety incidents and near misses. They used an electronic system and received feedback regarding progress of any investigation.
- Minor incidents were followed up by the ward manager and more serious concerns were escalated to the risk and safety manager for further investigation. Multi-disciplinary risk meetings would be held to discuss solutions and any changes in practice to improve the service. Records showed they included any staff involved in the incident as well as senior managers. As an example, an incident involving the out of hours service had prompted paediatric staff to contribute to improving public information about how and when to use out-of-hours and emergency services for children.

Duty of Candour

- Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 is a regulation

which was introduced in November 2014. This Regulation requires the 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. We saw how this was implemented following a drug error incident. Parents had received an apology in a timely way with an explanation of the possible effects and actions needed for their child.

Mortality and Morbidity

- Staff from the neonatal unit attended monthly mortality and morbidity meetings for their department. During these meetings any neonatal deaths and severe medical conditions were reviewed to identify where actions might improve outcomes for babies. Records showed these meetings were attended by a range of senior clinicians and nursing staff and learning was shared.
- A paediatrician from the children's unit discussed child deaths at multi agency child death and overview panel meetings, which were held every two months. Action points for improvement were identified and allocated to a named person and monitored for completion at subsequent meetings. Information was shared with staff at team meetings.

Safety Thermometer

- The children's unit had been monitoring the safety of care provided by contributing to the NHS safety thermometer since September 2016. The NHS safety thermometer is a local improvement tool for measuring, monitoring and analysing patient harm and 'harm free' care on a set day every month. It provides information on a 'snapshot' in time. For children this included monitoring paediatric early warning scores, infections following intravenous therapy, pain assessments and any moisture lesions related to a device such as nasogastric tube.
- Ward managers had made a decision that four months of data was not sufficient to give valid information on trends of care and planned to review the results in June 2017. However, they were monitoring the results and staff received feedback individually on the results of this monthly audit
- Safety thermometer information was displayed on the ward for staff, visitors and patients to see.

Cleanliness, infection control and hygiene

- The trust had policies for infection prevention and control which followed national guidelines.
- Staff on the children's unit were pro-active in identifying and acting on risks for infection prevention and control. However, compliance with audits was variable across the children's and neonatal unit. In January 2016 children's unit staff had investigated reasons for the incidence of a small cluster of infections in children who had central lines in place. This had resulted in ensuring that training provided for staff was relevant and that staff had accessed training in aseptic non-touch techniques.
- There were no reported incidents of health care associated infection for the children's service between June and October 2016.
- Staff compliance with trust policies on basic techniques for hand hygiene and the care of peripheral venous cannulas were audited monthly and results were rated each quarter as red, amber or green. Anything below 100% was considered to be a risk. On the children's unit, care of peripheral venous cannulas ranged from 70% compliance in April 2016 to 90% in October 2016.
- Staff compliance with hand hygiene techniques was between 80% and 100%. The neonatal unit showed 100% compliance with hand hygiene for the same period but had not returned any audits on the other measures. This meant no judgement could be formed on what actions staff were taking to protect babies from infection. Audit results and action plans were reported to the Women's and Children's directorate quality group every three months for review.
- All staff we observed carried out appropriate hand washing practises and ensured visitors followed the same protocol.
- Hand cleansing gel was available in all entry areas children attended with instructions for how to use the gel.
- The children's unit and the neonatal unit had individual rooms that could be used to nurse patients and protect them and others from an infectious condition.
- We saw staff using personal protective equipment such as aprons and gloves. These were in plentiful supply and easily accessible.
- All the areas we visited were clutter free and equipment looked clean. A member of nursing staff used a template to audit environment and equipment each month. Records showed actions that were required to maintain good infection prevention and control measures.

- Reusable "I am clean" labels were used to indicate which equipment had been cleaned and was available for further use. The November audit on the children's unit had identified that "I am clean" labels were not being used consistently. Actions were to remind staff about correct use of labels and the January audit showed an improvement. We saw these labels used appropriately on multi-use equipment.
- Staff ensured toys were cleaned regularly and we saw records documenting this. Nursing staff placed contaminated toys in a protective bag and play specialists used the appropriate cleaning method which followed trust protocol.

Environment and equipment

- The environment and equipment used by the children's and neonatal unit were maintained in a way that reduced risks to patient safety. Ward areas on the children's unit and neonatal unit were spacious enough to allow staff to attend to patient's needs without causing an obstruction. Equipment was placed in storage cupboards when not in use.
- The children's unit had two rooms which had been adapted to provide sensory distractions. This was used for children living with conditions such as autism, behavioural and sensory disorders. This included colour changing water tubes and soft music.
- Some individual rooms could be easily adapted to maintain safety for children and young people with emotional health needs. Adaptations included a screen that eradicated ligature risks and access to oxygen/ suction equipment, and making bathrooms accessible to staff whilst maintaining patient privacy.
- Areas that might have been a risk to children, such as kitchens and storage rooms, either had locked doors or had a barrier which prevented young children from accessing them.
- The operating department had a recovery area that kept children and adults separate, which met national guidelines for the care of children undergoing anaesthesia.
- Secure external areas were available for children to play, overlooked by the ward areas which helped to maintain safety.
- In the children's recovery area, children's unit and neonatal unit, resuscitation equipment was available for all ages and accessible for staff. We saw records which showed staff documented equipment had been checked as safe and available to use. We saw one resuscitation trolley that had not been checked for a number or days and this was brought to the attention of ward staff.
- The trolleys used to store the emergency equipment were covered with a cloth screen which would not show evidence of tampering. Staff followed a policy of replacing any equipment that had been used but other people could remove items without staff knowledge. This caused a potential risk of equipment being unavailable in an emergency situation.
- Staff undertook a monthly health and safety audit which included waste management and the state of repair of any fixtures, fittings and equipment. Any repairs needed were requested from the appropriate department and progress on completion was monitored at the next audit.
- Storage of items for disposal was appropriately managed at the time of our visit and items were kept out of the reach of children.
- All electrical equipment we saw had been maintained appropriately and had labels documenting when it was next due for a service.

Medicines

- Arrangements were in place for the safe management of medicines and medical gases which met national standards.
- Children's weights and known allergies were clearly documented on children's and babies' medicine charts for staff to review when prescribing medicines. Heights were recorded in the medical record if the child's medical condition made this possible but we did not see any heights recorded on the medicine charts we reviewed.
- Audits showed that staff compliance with trust policies was inconsistent on the children's unit. For example, refrigerator temperatures were not always checked (57% - 100% compliance), treatment room doors were not always locked (25% - 100% compliance) and medicines were sometimes left out in treatment rooms (50% - 75% compliance). The neonatal unit areas of non-compliance for the same period were for medicines left out (0% -100%), and medicine refrigerators not locked (0%), although these refrigerators were situated within the nurseries where staff were present. This information was shared with ward managers who reminded staff about actions they needed to take to

follow the trust policy. Records showed the children's unit continued to monitor these actions in their monthly health and safety audit of the children's and neonatal units. At the time of our visit we saw refrigerator temperatures had been documented as checked daily and protocols for reporting temperatures outside of accepted levels were attached. Doors were locked appropriately and no medicines were left out of cupboards unattended.

- Staff followed the trust policy of checking that controlled drugs were checked by two registered members of staff each time they were used. They also checked the stock of these medicines every 24 hours as an additional safety check. However, on the children's unit records showed five occasions during January 2017 when these stock checks had not been documented as completed. The neonatal unit checked stocks of controlled drugs three times daily using two registered nurses. And we saw these had been completed.
- Pharmacy staff provided support to the children's and neonatal units by visiting the ward daily between Monday and Friday. Pharmacy staff were responsible for replenishing stocks and reviewing medicine charts for appropriate prescribing.
- Any errors found in medicine prescribing or administration were reported using the trust incident reporting system. The children's unit managers received feedback on each incident. They had found an increase in the incidence of medicine errors and investigated potential causes. Changes in practice following this investigation included measures to protect staff from distraction when prescribing and administering medicines. We saw staff wearing 'do not disturb' tabards when administering medicines to enable staff to concentrate on medicines and reduce the risk of errors. Staff were encouraged to use a quiet area of the ward when prescribing.
- Some nursing staff had additional competencies and followed trust documents which allowed them to provide commonly available medicines for children and young people. These were called patient group directions and we saw five that needed to be updated. Staff told us and managers confirmed that these were in the process of being reviewed by the pharmacy director.
- Each emergency trolley we looked at had tamper evident emergency medicine boxes. There was a quick calculation reference document attached for the administration of emergency medicines to children. This was written in accordance with national guidelines.

Records

- Patient records were written in a way that kept children and young people safe and were kept securely in trolleys by nursing stations. All records for patients on the children's unit were accessible for staff.
- Paper records were kept for each patient and were updated by professionals involved in the child's care. A separate nursing folder held assessment charts of a child's condition such as temperature, heart rate, blood pressure, and skin and pain assessment. These were regularly reviewed by nursing staff.
- A daily audit of five records was carried out by the ward co-ordinator. Included in the audit was whether risk assessments had been completed accurately, entries to medical records were signed and dated and whether fluid charts were totalled for the previous 24 hours. Any discrepancies were fed back to staff at the time of the audit.
- We reviewed 12 sets of patient care records and saw they were clearly written, signed and dated by the health professional who had seen the child. It included specialist advice from other professionals such as speech and language therapists. This allowed practitioners to review changes in the child's condition and treatment using up-to-date information.
- Staff were informed of any safeguarding concerns regarding a child being admitted to the unit. Both paper and electronic records had alerts which clearly highlighted if there were any safeguarding concerns.
- We saw each patient's GP was informed of a child's care needs when they were discharged from hospital. Duplicates of letters sent to GPs were stored in each patient's care file. GPs were also able to refer children in to the paediatric assessment unit and letters were kept in the patient record.

Safeguarding

- The trust had policies to identify and act on safeguarding children concerns which followed national guidelines. Staff we spoke with about safeguarding children were aware of their responsibilities and what processes to follow.

Services for children and young people

- The trust team for safeguarding children included leads from the executive team, a non-executive director and senior medical and children's nursing teams. The team worked closely with the local safeguarding children's board and the clinical commissioning group's designated doctor for safeguarding children. The team attended a range of meetings with partner agencies such as community and social services and the local safeguarding children's board to share best practice and promote a consistent approach.
- The trust safeguarding team were in the process of forming links with similar organisations in the south west region to provide peer support. We saw updates and information was cascaded to staff through departmental and team meetings and the vulnerable women's safeguarding forum.
- The women's safeguarding team had been recently formed and included staff from midwifery, substance misuse, teenage pregnancy and neonatal services. The team met monthly and shared information on risks for babies on the neonatal unit.
- Systems were in place to process safeguarding referrals and were provided 24 hours a day, seven days a week by staff within children's services. Advice was available for trust staff and outside agencies such as police and social care. Community paediatricians were available during the day and paediatric consultants were available in the evenings and on call after 10pm. Concerns had been raised at the previous CQC inspection about a waiting list of children who were requiring a child protection medical examination. The safeguarding leads were clear that all children needing a medical examination were seen on the same day as the referral and there was no waiting list.
- Reports were presented to the trust quality and performance committee every three months and annually to the trust board of directors. These reports included safeguarding children activity, staff training and national developments.
- Staff were supported with child protection and safeguarding concerns with regular supervision opportunities by staff who had undertaken additional training in safeguarding children and supervision of staff. This included combined group supervision for nurses and doctors and individual support if staff requested it. Learning from local and national serious case reviews was shared during the supervision sessions. Learning from case reviews had prompted other safety information being developed. For example, information was developed and provided for new parents on how to deal with a crying baby in order to prevent parents shaking their babies.
- All staff we spoke with knew who to contact if they needed advice regarding safeguarding children issues. Any issues of concern for babies being discharged were reported to staff in community services. This had included a recent case related to female genital mutilation.
- The trust worked in partnership with the local community service provider to provide termination of pregnancy. If a pregnant child under 13 years of age attended staff would follow safeguarding procedures to protect the child from potential abuse.
- Some children and young people were seen in outpatients departments in other areas of the hospital. There were occasions when they shared waiting areas with adults which could create a potential safeguarding risk if parents were not present. We saw records of how a safeguarding concern had been raised by staff in the general outpatients and had resulted in positive outcomes for the child.
- Tools and guidance were available for staff if they were concerned about domestic abuse. This included a quick reference guide and a more detailed check list.
- The neonatal unit followed the trust abduction policy and operated a tagging system to prevent babies from being taken from the unit without authorisation. Any unauthorised removal of a baby would sound alarms and lock doors. This system could be overridden by staff on the unit if there were safety reasons to open the doors. Visitors to the neonatal unit needed to be let in or out by staff and were monitored using closed circuit television. Visitors to the paediatric unit were let in by staff and could exit using a door release place too high for young children to access.

Mandatory training

- Training programmes were provided for staff to attend on a mandatory basis to ensure they were up-to-date with processes to maintain safety for children, young people and their visitors. This was started on employment as an induction programme and continued with regular updates.
- The trust monitored staff attendance at 12 modules and had set a target of 90% attendance. The children's

service met this target for one module, equality and diversity awareness, for the medical staff group. The remaining 11 modules had compliance rates between 79.4% (manual handling practical) and 88.2% (manual handling theory).

- The children's service nursing staff group met their compliance target for all but two of the 12 modules. The two modules that were not met were basic adult resuscitation (89.3%) and conflict resolution (72.7%). Plans had been put in place to address this, including additional training days during 2017. Planned training included subjects specifically relevant to children and young people such as; mental health, management of diabetes and the deteriorating patient.
- Children's service staff had training in paediatric life support and safeguarding children's training modules to attend which were in line with national statutory guidance. The trust met their 90% target for medical staff in three of the four modules, level two safeguarding adults being the only module below the target. Nursing staff met the 90% target in all four modules. Staff in other departments had safeguarding training, such as the radiology department. This was used by adults and children and had two radiographers who had level three children's safeguarding training.
- Staff were trained to respond to emergency situations for children of all ages. The majority of neonatal staff (94%) were trained in new born life support. The children's unit had 13 new members of nursing staff and 79% of the team had attended paediatric life support training. Another 16% were booked on to courses. Advanced paediatric life support had been attended by 53% of nursing staff.

Assessing and responding to patient risk

- The trust followed national guidelines to ensure that potential risks to patient safety could be assessed and responded to appropriately. Staff were trained to use assessment tools which supported their professional knowledge and skills.
- Risk assessments completed for patients were comprehensive and action plans reviewed. Nursing staff on the children's unit used paediatric early warning score (PEWS) charts to monitor a child's condition. This recorded observations of temperature, heart rate, respiration rate and blood pressure measurements. Guidance was included for staff to follow if a child's condition deteriorated. We saw records of children who had undergone surgical procedures who had been assessed for their risk of developing venous thromboembolism.
- Staff compliance with completing the PEWS charts was monitored daily. The ward co-ordinator completed an audit form and fed back findings to staff at the time of audit. The ward coordinator had found the daily audit difficult to complete when workload was high and were planning to share the task with other nursing staff.
- The rate of compliance with PEWS was reported to the national patient safety thermometer on a monthly basis. In September 2016 one occasion of a child's deteriorating condition had not been escalated appropriately and staff had been reminded of correct escalation procedures. Following this audit, results we saw for September 2016 had shown 100% compliance. The children's unit also used a newly produced sepsis screening and action tool which included a flow chart to guide staff on appropriate actions.
- The neonatal unit had completed trials of a comprehensive risk assessment booklet to be used for each baby in the unit. It included assessment tools for skin ulceration, pain and wound management and had been used by staff in the unit for two months
- Staff followed the trust policy for any child who was seriously unwell and needed to be transferred to a more specialist hospital. This included detail on how to communicate with transport organisations, staff at the receiving unit and what level of staff would be needed to accompany the child.
- Theatre and recovery staff who had paediatric experience and were trained in paediatric life support cared for children and young people post-operatively. This met national guidelines for the care of the child immediately after anaesthesia.
- The children's and neonatal unit had a member of staff on duty at all times, who had advanced life support training appropriate for the age of children being cared for.
- Children who attended the hospital due to emotional issues were assessed for their risk of self-harming. The local mental health trust provided support for staff and would provide additional support for a child who was an inpatient on the children's unit. This was done to maintain the child's safety.

- Staff used the World Health Organisation checklist for safer surgery appropriately. Each member of the surgical team was engaged with the process.
- Parents told us they felt their child was safely cared for on the children's unit. The paediatric assessment unit reviewed patients who had been referred by GPs or the emergency department. All referrals were discussed with a paediatric consultant and patients could be cared for on the ward, seen in follow up clinics or discharged home. Parents of children who attended the paediatric assessment unit received a phone call the day after their attendance to check on their child's condition. Parents told us they found this reassuring.

Nursing staffing

- Recruiting to substantive posts and maintaining nursing staffing levels had been a concern for ward managers. However, staffing rotas showed levels were appropriate for the children's and neonatal units and followed national guidelines including the 2013 Royal College of Nursing and the British Association of Perinatal Medicine (BAPM). The children's unit arranged nurse staffing to patient ratios of one registered nurse for four patients and increased staffing if there were children under the age of two years, or patients needed high dependency care. This was only achieved by using additional bank staff because there were not enough substantive posts in place at the time of our visit. However, children's service managers had reviewed and developed a workforce plan in order to improve and maintain the recommended staffing levels. This plan identified where shortfalls were and methods of recruiting registered nursing staff. This had included recruiting internationally, recruiting nursing staff who were about to complete their training and having paediatric nursing jobs advertised on a rolling basis. Not all of the newly recruited nursing staff had started work on the children's unit and this left some gaps in the rota. These could be filled with existing staff working additional hours, bank and agency staff. Financial incentives were offered to existing staff to fill the gaps which staff felt provided more efficient working arrangements and continuity for the patient.
- Established staffing figures for the children's unit met the recommended guideline proportion of 70% registered to 30% unregistered nursing staff. Nursing staff worked flexibly across all areas of the children's unit. Staff rotas showed the appropriate numbers of staff on duty in each area.
- A senior member of staff was allocated the role of co-ordinator for each shift and was available to offer advice for less experienced nursing staff. Managers told us difficulties arose when there were more than two patients in the high dependency unit.
- The neonatal unit followed BAPM guidelines and staffed the unit accordingly with one registered nurse for every four babies in special care, and one registered nurse for every two babies requiring high dependency care. The unit were very close to meeting the BAPM recommendation that 70% of nursing staff on the neonatal unit had accessed additional training and were qualified in their specialty. There were 68% of nursing staff who were qualified in their specialty and another nurse was due to complete their additional training.
- Nursing handovers included a safety brief update. This included an overview of patients' needs, those due for admission, discharge and staffing numbers for the shift. A senior nurse who had attended the medical handover ensured that information was shared with nursing staff at this time.

Medical staffing

- Our previous inspection identified concerns regarding the number of doctors available to safely cover the paediatric and neonatal unit. A medical workforce planning group had been identifying ways to cover the rotas and increase numbers of doctors. They had achieved a full establishment of medical staff for six months until individual events, such as maternity leave, had created gaps. There were plans to interview a specialist grade registrar in the near future to fill one of the posts available. Since the previous inspection two advanced neonatal nurse practitioners (ANNP) had completed their additional training which allowed them to take part in the medical rota for the neonatal unit. This meant there were two experienced ANNPs who could support the rota at middle grade level and two ANNPs who would be able to support the rota from a junior medical grade level.
- Paediatric areas were safely staffed by doctors with advice available from experienced paediatricians. This

had been achieved by rearranging the hours consultants were present at the hospital and using consultants to work as a middle grade doctor when there were gaps in the rota.

- Throughout August 2016 the proportion of consultant staff reported to be working at the trust was higher than the England average, and the proportion of junior (foundation year 1-2) staff was about the same as the England average.
- Doctors who were more junior to consultants were able to access support from consultant paediatricians at all times. A consultant was present for each paediatric area during times of peak activity. Between 9am and 10pm a consultant was present for the paediatric admissions unit and inpatient ward. For the neonatal unit there were two consultants available from 9am until 5pm. After 10pm middle grade doctors were present in the hospital and supported by consultants who were off-site but on-call.
- Any gaps in the medical rota that could not be filled by a locum doctor were fulfilled by consultants who would 'act down' to ensure medical cover remained at safe levels for patients.
- Staff shift handovers were held twice daily, led by a consultant paediatrician and attended by a member of nursing staff. We saw these were facilitated to encourage staff to contribute to discussions and were used as learning opportunities for medical trainees. Safety briefings were included in the handover and social issues and safeguarding concerns were discussed as a priority.
- The requirements to provide a medical review of patients met national standards for paediatric care. Records confirmed each patient had been seen by a middle grade health professional and a consultant in a timely way. Consultants followed best practice guidelines and operated a system of 'hot weeks' when they were the admitting consultant for that week. Each child had a review of their medical needs before they were discharged.

Major incident awareness and training

- The effects of winter pressures on the paediatric service were discussed regularly at the senior paediatric nurses' meetings. Ward managers described actions they would take to meet increased service demands. This included assessing patients who could be discharged and speeding up the process of obtaining medicines to take home by contacting pharmacy when there was higher demand. Children's services had beds and cot spaces they could use flexibly depending on the needs of the babies and children. The neonatal unit could increase their cot spaces from 28 to accommodate 32 babies. Paediatric day case beds could be used to increase numbers of beds for overnight stays on the children's unit by using the eight day-case unit beds.
- Staff were aware of emergency procedures such as evacuation for fire and action cards that described the roles of each member of staff were displayed.
- If a crisis situation in the hospital increased demand for registered children's nurses, a bank of nurses could be contacted and with manager's approval agencies could be approached to provide additional registered children's nurses.

End of life care

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

Information about the service

End of life care included all care given to patients who were approaching the end of their life and following death. This could be provided on any ward or within any service in the trust and was provided by a range of staff. It included essential nursing care, specialist palliative care, and bereavement support and mortuary services.

The trust's specialist services for end of life care were provided through two teams who were managed through a divisional structure that covered both of the hospitals within the trust. Some staff worked at both sites of Gloucestershire Royal Hospital and Cheltenham General Hospital. End of life care followed trust policy at both sites so similarities between the content of the two end of life care location reports occur in both hospital location reports.

The in-patient and community specialist palliative care team delivered a face to face service from 9am to 5pm, Monday to Friday. There was an out-of-hours telephone advice line available 24/7 for health care professionals.

The two end of life teams provided support and advice for any adult patients throughout the hospital or at the request of clinical staff identified with complex care and/or complex symptom management. Support was also provided to relatives of end of life patients. The in-patient and community teams provided care for patients discharged from both hospitals.

The teams worked with two full time doctors one a consultant in palliative medicine and the other a specialty doctor in palliative medicine. Both teams worked with a psychologist

The team that provided specialist end of life care for in-patients for the trust consisted of five advanced nurse practitioners and four clinical nurse specialists. Two of the five advanced nurse practitioners were based at Gloucestershire Royal Hospital with one working across both sites. Two advanced nurse practitioners worked with the advanced nurse practitioners at Cheltenham general Hospital.

The community team consisted of three advanced nurse practitioners and twelve clinical nurse specialists based at Gloucestershire Royal Hospital who provide end of life care for patients discharged from both hospitals. The team that provided care for community patients discharged from Cheltenham General Hospital was based at Gloucester Royal Hospital with additional work bases at three hospices in the area."

A social worker and an occupational therapist were part of the multidisciplinary team employed by the trust and worked with the specialist palliative care team.

This was a focused announced follow up inspection. Following the previous inspection in March 2015 end of life services for the trust had been rated as requires improvement for safe, effective and for well-led. The trust had been rated as good for caring and responsive.

As part of this inspection, CQC piloted an enhanced methodology relating to the assessment of mental health care delivered in acute hospitals; the evidence gathered

using the additional questions, tested as part of this pilot, has not contributed toour aggregation of judgements for any rating within this inspection process. Whilst the evidence is not contributing to the ratings, we have reported on our findings in the report.

Summary of findings

We rated this service as Good because:

- End of life care provided at Gloucestershire Royal Hospital was safe, effective caring, responsive and well led because:
- The processes in place to keep people safe for end of life care were good. Staff in the specialist palliative care team and other areas understood their responsibilities to raise concerns, record safety incidents and report them. Lessons were learned and improvements were made when things went wrong.
- Patient's records demonstrated that nutrition and hydration needs were assessed and appropriate actions were documented as followed in patients' individual care plans.
- Records documented discussions with relatives around what to expect with the dying process.
- Risks to patient's receiving care at end of life were assessed by ward staff with appropriate assessments recorded in medical records for example the prevention and management of pressure ulcers and falls.
- Staff we spoke with on the wards understood that end of life care could cover an extended period for example in the last year of life and also applied to patients with non-cancer diagnoses such as dementia. Staff, teams and services worked together to deliver effective care and treatment.
- Staff we observed on wards and in the community delivering end of life care to patients were compliant with key trust policies such as infection control.
- Arrangements in place for managing medicines kept patients safe. Medicines to relieve pain and other symptoms were available at all times. Wards had adequate supplies of syringe drivers (devices for delivering medicines continuously under the skin) and the medicines to be used with them.
- There were reliable systems, processes and practices in place to keep patients safe and safeguarded from abuse.
- The staffing levels and skill mix of the nurse and medical personnel in the specialist palliative care team were planned and reviewed and supported safe practice. We saw evidence of a yearly education

End of life care

programme of end of life care for medical, nursing and allied health professionals. This included: resuscitation, syringe driver training, quarterly end of life study days and symptom management.
- The specialist palliative care team responded promptly to referrals, usually within one working day.
- Patients were treated with kindness, dignity, respect and compassion. Staff took the time to interact with people who received end of life care and those close to them in a respectful and considerate manner.
- We saw many written compliments about how caring staff were in the inpatient and community end of life care teams. We saw that patients' and those people close to them, were involved as partners in their care.
- The specialist palliative care team and wards staff understood the impact a patients' care, treatment or condition had on their wellbeing and on those people close to them.
- Emotional support for patients and relatives was available through the in-patient and community end of life care team, the chaplaincy team and bereavement services. Staff had access to support through their own teams when needed.
- Services were delivered and additional services planned in order to effectively meet patient's needs. Plans and actions included audit to inform future planning so that the end of life team could inform better decision making with patients they cared for
- The bereavement office was one of two sites in the country involved in a pilot project to improve death certification which was more supportive to bereaved relatives and provided better oversight of causes of death.
- There was a clear vision and strategy to deliver care at end of life. The governance framework for end of life care ensured that responsibilities were clear and that quality, performance and risks were understood and managed.
- Leadership encouraged openness and transparency and promoted good quality care. There were leads on the wards that supported the development and delivery of high quality end of life care.
- Services within specialist palliative and end of life care had been continuously improved and sustainability supported since the last inspection March 2015.

However:

- Documenting 'Do Not Attempt Cardio-Pulmonary Resuscitation' (DNACPR) decisions had improved since the last inspection however concerns regarding DNACPR remained. For example not all DNACPR having relevant clinical information and not all patients or those close to them being recorded as involved in discussions about resuscitation. These concerns were not identified as a risk and did not feature on a risk register
- There were no centrally held training records for syringe driver training or competency for ward staff.
- There was not a full understanding of performance for all aspects of end of life care. For example the percentage of patients dying in their preferred location and the percentage of patients discharged within 24 hours were not known for all wards or hospital sites.
- There was no risk register specific to end of life care for the trust so oversight of all end of life risk was not easy.
- When we reviewed maintenance records some provided were out of date. The trust told us they were clear that equipment listed was not in use. We saw email communication from directors supporting this.
- There was not a seven day face to face service provided by the in-patient and community end of life care team. The trust provided a face to face service 9-5 Monday to Friday. Out-of-hours there was a telephone advice line available 24 hours, 7 days a week for health care professionals to access.
- Some of the 'white rose' symbols used to locate the mortuary at the hospital were not easy to follow. Signs were not always at eye level for someone walking or in a wheelchair and there were long gaps in signage that led to confusion. Mortuary and bereavement officers told us relatives had commented they were useful. Some relatives had reported they appreciated these signs. However bereavement office staff accompanied relatives when they knew people were attending the mortuary.

End of life care

Are end of life care services safe?

Good

Overall we have rated safe as good because:

- There were processes in place to keep people safe whilst in receipt of end of life care. Staff in the end of life care team and other areas understood their responsibilities to raise concerns, record safety incidents and report them. Lessons were learned and improvements were made when things went wrong
- During the inspection we visited six wards where patients were receiving care in their last year of life. Compliance with relevant trust policies was good.
- The maintenance of equipment was compliant with policy and promoted safe patient care.
- Arrangements for managing medicines kept patients safe. Guidance for staff on end of life medicines was included as part of patients' care plans which supported the management of a range of end of life symptoms.
- Potential risks to patients were assessed by ward staff. Identified patient safety risks were monitored and maintained.
- There were reliable systems, processes and practices in place to keep patients safe and safeguarded from abuse.
- The staffing levels and skill mix of the nursing, medical and other staff in the specialist palliative care team were planned and reviewed which supported safe practice. The nursing complement was complete for both inpatient and community teams.

However:

- The completion of 19 do not attempt cardio pulmonary resuscitation (DNACPR) forms we reviewed were of variable quality.
- There were no centrally held training records for syringe driver training or competency for ward staff.
- Some maintenance records provided were out of date although trust directors provided us with assurance via email that the equipment was not in use.
- The end of life team were unable to use the results of the safety thermometer specifically in relation to patients receiving end of life care as it was not possible to sort data for all patients who might be in their last year of life.
- There was a trust major incident and business continuity plan. However, the chaplaincy service, mortuary staff, bereavement officers and in-patient and community palliative care teams had not been involved in the major incident plan practice exercises.
- Though a system of 'white rose' signs were in place to signpost people to the mortuary, they were not all easy to follow.

Incidents

- There were processes in place to keep people safe whilst in receipt of end of life care. Staff in the end of life care team and other areas understood their responsibilities to raise concerns, record safety incidents and report them. Lessons were learned and improvements were made when things went wrong For example: learning from incidents August to October 2016 was incorporated in a recent end of life care presentation which included learning related to medications for patients to take home and improvements in ward care for patients transferred to the mortuary.
- The specialist palliative care team discussed relevant incidents and planned actions during regular meetings. Actions taken were recorded when they had been completed. Information and actions were shared during staff one to one meetings or via email updates. Staff said this ensured feedback and learning was shared and understood by the whole team. Issues were escalated when required to the quality and performance committee.
- Between December 2015 and November 2016, there were no incidents for end of life care reported which were classified as Never Events. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- During this same period there were also no serious incidents reported for end of life care. Between November 2015 and October 2016 the trust reported 82 incidents related to end of life care. The two incident categories most commonly reported were medicines not ready for discharge 13 (16%) and pressure ulcers 11 (13%). The trust also reported 28 mortuary incidents from 24 January 2016 to 11 August 2016. Most mortuary

incidents were related to not following care of the dying policy. There had been 16 (19.5%) incidents at Gloucestershire Royal Hospital. Actions had been taken to reduce the risk of such incidents reoccurring.

Safety thermometer

- There was no palliative or end of life care ward at the hospital. We visited six wards at Gloucester Royal Hospital where patients where receiving care in their last year of life. All wards reported to the national patient safety thermometer. This was used to record the prevalence of patient harm and to monitor ward performance in delivering harm free care for wards where patients were receiving end of life care. Measurement on the wards was intended to focus attention on patient harm and prevention.
- Data collection took place one day each month. Data from the Patient Safety Thermometer showed that the trust reported 123 pressure ulcers, 67 falls with harm and 67 urinary tract infections associated with urinary catheter use between November 2015 and November 2016.
- Results showed a reduction in pressure ulcer prevalence and a decrease in falls.

Cleanliness, infection control and hygiene

- Staff were observed following trust policies. For example, staff were bare below the elbows, used antibacterial hand gel between patient care, wore personal protective equipment and disposed of waste correctly. This ensured that patients receiving end of life care who could be more susceptible to infection were cared for as safely as possible.
- Processes were followed by most staff which ensured that after death the health and safety of everyone that came into contact with the deceased patient's body was protected. However, mortuary staff had recorded and reported occurrences where 'last offices' or the care of the deceased policy had not been fully followed. This included four instances where an infection risk or last offices policy had not been followed. Actions had been taken to reinforce use of policy. For example reinforcing 'care of the dying policy'.
- Whilst the trust monitored the number of cases of methicillin resistant staphylococcus aureus (MRSA) and Clostridium difficile (C'Diff) and methicillin-sensitive staphylococcus aureus (MSSA) the number of cases attributed to end of life patients could not be identified.

Environment and equipment

- Processes were followed to safely maintain equipment. For example all syringe driver pumps in use were maintained and used in accordance with manufactures recommendation.
- There were adequate numbers of syringe drivers available to meet patient's needs. There were no incidents raised about shortage of syringe drivers.
- The trust used one brand of syringe driver across all wards. This reduced the likelihood of confusion or error by staff, particularly temporary (bank or agency) staff.
- We reviewed the maintenance records for syringe drivers. 17 out of 110 recorded syringe drivers maintenance records provided were out of date. We notified the trust who said that the units showing as out of date were not being used. An alert had already been raised by the medical engineering department. The alert was escalated to the district nursing leads across the county and also the nursing home support team to reinforce servicing of syringe drivers. The alert reinforced the system that supported safe management. All syringe drivers were managed by the medical equipment libraries. Staff removed any syringe driver from use if it was identified as near to or past its service due date.
- The mortuary was difficult to find. The trust had implemented a system of 'white rose' symbols to assist location, however some of the signs were not easy to follow. Signs were not always at eye level for someone walking or in a wheelchair and there were long gaps in signage that led to difficulty in locating the mortuary. When we spoke with mortuary staff and bereavement officers we were told that relatives had commented the signs were useful, however they were accompanied to the mortuary for viewings by staff so the signs were not relied on.
- The mortuary viewing area was visibly tidy and appropriately located and furnished. The bereavement office was easily accessible.
- The chapel, the department of spiritual support, chaplain's office and two multi-faith rooms were all easily accessible, visibly clean and tidy.

End of life care

- The multi faith rooms consisted of two rooms which were separate from the hospital chapel. One room was for male use and one for female use. Both rooms contained ablution areas.

Medicines

- Processes were followed to safely manage medicines. Guidance for staff on end of life medicines was included as part of patients' care plans. Staff said this supported the assessment, management and review of a range of end of life symptoms.
- Wards kept stocks of commonly used end of life medicines so they were available for prompt use. Records we reviewed showed that patients had medication provided when needed.
- In the records we reviewed we saw that patient's needs were met with anticipatory medication being prescribed appropriately. Anticipatory medications are medications prescribed 'just in case' or for when symptoms known to occur at end of life are predicted to occur. There was an anticipatory prescribing medication chart available for use and linked to the trust's shared care record for the expected last days of life. We saw this was used. The medicine chart was prepopulated with five of the most common symptoms, and pain-relieving medicines, with guidance for dose and frequency.
- We reviewed four sets of prescribing information from four wards - 7b, 7a, 6a and 9b. All records had been completed appropriately.

Records

- Most of the individual care records were written and managed in a way that kept patient's safe. Records contained all relevant documentation, prescribing information, unwell patient forms or treatment escalation plans and 'do not attempt cardio pulmonary resuscitation' forms.
- We reviewed 23 sets of notes of patients who had received end of life care. This included a review of four medication prescribing records and 19 do not attempt cardio pulmonary resuscitation (DNACPR) forms. All were stored securely. Discussions between clinical staff and patients and relatives were recorded legibly and sensitively.
- Patients' records included advance care planning and detailed conversations. These included explicit records of what patients and relatives understood or wanted to be informed of, their concerns and wishes. Actions for staff to take in accordance with these wishes and advice for ward staff were clearly documented and reviewed by the in-patient specialist palliative care team.
- All clinical staff we spoke with were familiar with the trust's shared care record for the expected last days of life. The shared care record included risk assessments of patients' nutrition, mobility and pressure area care. This document had been re-launched trust-wide during January 2015. The record provided prompts for clinicians which emphasised supporting patients' comfort and dignity. For example, in addition to guidance to manage pain and other symptoms, the document included actions to maintain mouth care and provide spiritual support and space to record what had been done
- However, we found variable quality in the completion of do not attempt cardio pulmonary resuscitation (DNACPR) forms. We looked at 19 and identified:
- There was a clearly documented decision with reasoning & clinical information in only 11 out of 19 records (58%).
- Records also showed that the patient was not always involved in discussions in seven out of 19 (37%) of records.
- Discussions or the reasons why decisions had not been discussed had not been recorded on the DNACPR form. In 16 out of 19 (84.2%) records this had not been recorded in each patient's health record with sufficient detail
- However, completion of DNACPR had improved from the last inspection in March 2015. We saw results from the last two audits completed in both hospitals undertaken following this. These showed an improvement in compliance with policy from between 46% and 64% compliance for the first audit. The trust achieved 75% compliance in December 2016.

Safeguarding

- There were reliable systems, processes and practices in place to keep patients safe and safeguarded from abuse. The specialist palliative care team and ward staff we spoke were knowledgeable regarding processes to follow if they had any vulnerable adult or children's safeguarding concerns. Staff were able to explain what signs might alert them to safeguarding issues, how to escalate these concerns and who to escalate them to.

- Records showed that the majority of members of the specialist palliative care team had in date mandatory safeguarding vulnerable adults and safeguarding children training.
- The trust had set a target for all staff of 90% for completion of adult and children's safeguarding training. The trust had met its target for medical staff for all four safeguarding modules at October 2016. Records showed that between 93.2% and 90.1% of medical staff had completed safeguarding training.
- The trust had met its target for nursing staff safeguarding training for all but one of the four safeguarding modules. Records showed that between 94.4% and 93.8% of nursing staff had completed safeguarding training. Level two safeguarding children fell just short at 89.8%

Mandatory training

- The trust had set a target for all mandatory training of 90%. The specialist palliative care team, nurses and doctors were not compliant with the trust target of 90%.
- The specialist palliative care team, nurses and doctors were not fully compliant with all of these, however there were now plans in place to address this shortfall now the team were at full establishment. Areas of compliance included Safety Awareness, Equality and Diversity Awareness, Basic Adult Resuscitation, Information Governance, Manual Handling Practical and Conflict Resolution.
- However the team fell short of this target in Blood Transfusion (85%), Code of Conduct (88%), Fire (88%), Infection Control (88%), Manual Handling Theory (85%), Medicines Management (82%) and Prescribing (75%).

Assessing and responding to patient risk

- Risks to patient's receiving care at end of life were assessed by ward staff, and their safety was monitored and maintained.
- We reviewed 23 sets of patient records and saw risk assessments for nutrition, mobility including falls and pressure area care had been completed and risk management plans had been developed. For example we saw patient's mouth care had been assessed and actions put in place. In addition, medication had been regularly reviewed in response to increased risks and changes recorded.
- Staff identified and responded appropriately to changing risks to patients who used services, including deteriorating health and wellbeing. They used the national early warning score (NEWS) to identify the deteriorating patient and responded with increased treatment when appropriate. Community end of life staff also told of when NEWS might be inappropriate to use as part of the dying patient's care.

Nursing staffing

- The staffing levels and skill mix of the nurses and other staff in the specialist palliative care team were reviewed and planned to support safe practice. The trust had an in-patient and a community specialist palliative care team. The nursing complement was complete for both inpatient and community teams and no bank or agency staff had been used in the past year.
- Following recent investment the nurse team for the inpatient specialist palliative care team was provided by
- Five advanced nurse practitioners (band seven) and four clinical nurse specialists (band six). Two advanced nurse practitioners were based at Gloucestershire Royal Hospital with one working across both of the trust hospital sites. Two clinical nurse specialists also worked with the advanced nurse practitioners at the hospital.
- The team that provided care for community patients was provided by
- Three advanced nurse practitioners (band seven) and twelve clinical nurse specialists (band six) who were based at the hospital. This team provided end of life care for patients discharged from both Cheltenham General Hospital and Gloucestershire Royal Hospital. Clarified bullet. The team that provided care for community patients discharged from Cheltenham General Hospital was based at Gloucester Royal Hospital with additional work bases at three hospices in the area.
- **Medical staffing**
- The staffing levels and skill mix of the medical staff in the specialist palliative care team were planned and reviewed to meet patient needs. They did not use agency or locum staff.
- The trust employed one consultant in palliative medicine full time. They covered both hospitals and worked with another full time specialty doctor in palliative medicine. A community consultant in palliative care was due to start 6 February 2017 which was a newly created post of 32 hours over four days (0.8WTE).
- Out of Hours cover was provided via telephone from trust and hospice consultants (weekend and nights)

End of life care

Other staff

- A social worker and an occupational therapist were part of the multidisciplinary team employed by the trust and worked with the specialist palliative care team.
- Chaplains were appointed by the trust to provide spiritual, pastoral and religious care to the whole hospital whether a patient, a carer, or a member of staff.
- There were 141 chaplaincy volunteers that provided support across the trust in total (93 chaplaincy and 48 Roman Catholic chaplaincy). All volunteers including chaplaincy volunteers were Disclosure and Barring Service compliant and checked. All volunteers had completed a course to ensure they were competent to attend wards and support patients with spiritual and emotional issues.
- The chaplaincy volunteer service had received 12 long service awards in 2016.

Major incident awareness and training

- There was a trust major incident and business continuity plan. However the department for spiritual support, mortuary staff, bereavement officers or in-patient and community specialist palliative care team for the trust had not been involved in a major incident plan practice or exercise.
- However, staff we spoke with were aware of major incident prompt cards to assist with processes and the trusts policy. When we visited the chaplain's office, we saw major incident cards were visible on the walls.
- Risks to the provision of care was anticipated and planned for in advance. The arrangements for the response to emergencies and major incidents by mortuary staff included the ability to transfer temporary mortuary storage between the two hospital sites.

Are end of life care services effective?

Good

We rated effective as good because:

- Staff we spoke with understood that end of life care could cover an extended period for example in the last year of life or patients. They were also aware that patients benefited from early discussions and care planning and this extended to patient groups with non-cancer diagnoses such as dementia.
- The end of life care was delivered with the principles of the Priorities for Care of the Dying Person set out by the Leadership Alliance for the Care of Dying Patient's
- There was a 35 point action plan created in response to the trusts performance in the National Care of the Dying audit published March 2016. This included maintaining and where possible increasing education of non-specialist staff and repeating the national voices survey. Some actions had already been completed such as appointing a non-executive to the board to represent end of life, improved symptom control and documentation.
- Medicines to relieve pain and other symptoms were available at all times. Wards had adequate supplies of syringe drivers (devices for delivering medicines continuously under the skin) and the medicines to be used with them.
- The patient's records we reviewed demonstrated that patient's nutrition and hydration needs were assessed and appropriate actions followed in patients' individual care plans. The records documented discussions with relatives around what to expect with the dying process.
- The specialist palliative care team had worked towards achieving improvements in patient outcomes and improvements were seen in the 2015/16 National Care of the Dying Audit.
- There was a yearly programme of end of life care education for some medical staff which covered symptom management, levels of care, diagnosing dying, resuscitation and communication skills. There was also some evidence of a programme of non-medical staff education for nursing and allied health professionals for example , covering resuscitation, syringe driver training, quarterly end of life study days and symptom management
- There was evidence of multidisciplinary working to deliver effective care and treatment.

However:

- Documentation relating to patients' mental capacity and consent was not always complete or immediately obvious in 'do not attempt cardio-pulmonary resuscitation' (DNA CPR) records.
- Explanations for the reason for the decision to withhold resuscitation attempts were not consistently clear.

Records of resuscitation discussions with patients and their next of kin, or of why decisions to withhold resuscitation attempts had been made were not always documented.

- There was no organisational oversight of staff competency with regards to syringe driver training as records were not held centrally.
- There was not a seven day face to face service provided by the in-patient and community specialist palliative care team. The trust provided a face to face service 9-5 Monday to Friday. Out-of-hours there was a telephone advice line available 24 hours, 7 days a week for health care professionals.
- Whilst in some cases the possibility of dying had been recognised and communicated clearly, decisions made and actions taken in accordance with the person's needs and wishes, not all appropriate patients experienced this.
- Most local audit activity had yet to benefit from a thorough analysis of the data produced. Despite that the in-patient and community specialist palliative care team for the trust were acting on initial evidence from audit which supported national guidance and informed improvement projects such as improving discharge planning arrangements.
- The learning needs of all staff delivering end of life care were not identified.

Evidence-based care and treatment

- Patient's needs were assessed and care and treatment was delivered in line with legislation, standards and evidence-based guidance.
- National Institute of Health and Care Excellence guidance includes staff recognition of patients thought to be approaching the last year of life. We saw evidence that staff understanding of this had increased since our last inspection. We saw patients who might be approaching the last few days or hours of life receiving end of life care within the trust.
- Staff we spoke with on the wards understood that end of life care could include patients with non-cancer diagnoses such as dementia. Staff understood patients could benefit from discussions about their care and wishes early on in the end of life care pathway.
- The in-patient and community palliative care team in conjunction with the end of life quality group were responsible for leading the development and setting standards of end of life care used. This was achieved through using evidence-based guidance, standards, best practice and legislation to develop how services, care and treatment were delivered.
- End of life care was delivered in line with the principles of the Priorities for Care of the Dying Person (Leadership Alliance for the Care of Dying Patient, date) For example the possibility of dying had been recognised and communicated clearly with the patient and those close to them. Decisions were documented and actions taken in accordance with the patients' needs and wishes. These were regularly reviewed.
- The needs of families and others identified as important to the dying person had been actively explored, respected and met as far as possible.
- Individual plans of care, which included food and drink, symptom control and psychological, social and spiritual support were in place, co-ordinated and delivered with compassion.
- The trust had participated in the National Care of the Dying audit published March 2016 and had created an action plan where improvement was identified as being needed. Some actions had already been completed such as appointing a non-executive to the board to represent end of life, improved symptom control documentation, the development of wards performance monitoring of for example number of patients receiving assessment of spiritual needs and the development of the end of life quality group.
- The trust had an annual audit plan for end of life care. However most local audit activity had not yet benefited from a thorough analysis of the data produced. Despite that, the specialist palliative care team had acted on the initial evidence from audit including improving discharge planning arrangements (which included a team member located on a ward to work with staff) and expanding advance care planning.
- We did not see any discrimination on grounds of age, disability, gender, gender reassignment, pregnancy and maternity status, race, religion or belief and sexual orientation. The trust supported patients with potentially life limiting conditions such as dementia and learning disability and employed two nurses to support patients with learning disabilities. We saw evidence that they worked with the specialist palliative care team when necessary.

Pain relief

End of life care

- Medicines to relieve pain and other symptoms were available at all times. Wards had adequate supplies of syringe drivers (devices for delivering medicines continuously under the skin) and the medicines to be used with them.
- If a patient was provided with a syringe driver and was subsequently discharged, the syringe driver was replaced by the district nurse team, who returned the original syringe driver to the trust. This ensured that any patient's pain and symptoms were managed in a continuous and consistent way.
- Pain was regularly assessed and reviewed. Staff demonstrated an understanding of how to assess patients' pain when they were not able to articulate their needs, by assessing body language or using a recognised assessment tool called the Abbey Pain Scale.
- We saw patient records that showed how patients should take pain relief, likely effectiveness and what to do if there were side effects, plans for further follow-up, and how to get help out of hours.
- We reviewed four end of life patient's medicine records. All patients had appropriate pain relief prescribed including anticipatory medicines.
- The trust had participated in the Cancer Patient Experience Survey 2015. They had been ranked in the top 20% of trusts for two of the 34 questions which included: 'hospital staff did everything to help control pain all of the time'.
- Patients and relatives were offered support with emotional and psychological pain by the end of life care teams. This included a specialist psychology service, chaplaincy service, ward staff and the bereavement offices. Relatives we spoke with confirmed how they had been offered or received support, and we saw this was documented in care records.

Nutrition and hydration

- Patient's nutrition and hydration needs were assessed using a Malnutrition Universal Screening Tool (MUST) and was followed by appropriate actions such as referral to dieticians for nutritional support which was documented in patients' individual care plans.
- The records documented discussions with relatives around what to expect with nutrition and hydration as part of the dying process.
- We saw mouth care was provided to patients when required to assist with nutritional and hydration needs.

Patient outcomes

- Staff demonstrated an understanding that the end of life care was for patients diagnosed with any life limiting condition and not solely related to patients' with cancer. This was also reflected in the specialist palliative care team's referral audit information.
- The specialist palliative care team provided a trust-wide service so monitoring systems were set to analyse data combined from both Gloucestershire Royal and Cheltenham General Hospitals.
- The trust took part in the Royal College of Physicians National Care of the Dying Audit in 2014. At this time the hospital achieved compliance with only one of the seven key organisational performance targets. This was for having protocols in place for the prescription of medicines for the five main end of life patient symptoms for example breathlessness, anxiety.
- Since the audit in 2014 improvement had been seen with some patient care outcomes now being achieved. The trust had participated in the End of Life Care Audit: Dying in Hospital in 2015/2016 which was published March 2016. This scored participating trusts against seven organisational and 10 clinical key performance indicators. Based on the most recent National Care of the Dying Audit the trust, in comparison with other trusts had:
  - Performed better than the England average for one of the five clinical indicators. (Health professionals had discussed recognition that patient may die in hours or days)
  - Performed the same as the England average for one of the clinical indicators (recognition documented that patient may die in hours or days)
  - The trust scored lower for 'Is there documented evidence that the needs of the person(s) important to the patient were asked about?' scoring 30% versus the national average of 56%. This meant that some patients were not being consulted about what was important to them.
  - The specialist palliative care team had completed two audits of the shared care record (June – July 2014 and August 2015 – February 2016) and concluded that symptom observation charts were very useful, documentation of the reasons for diagnosing a patient as likely to be dying had

improved and communication levels were high. However completion rates of the shared care record had fallen. Teaching had been implemented and further audit was planned.

- We observed a community team meeting where seven patients needs were planned using Gold Standard Framework (GSF). The community team who provided specialist palliative care for patients discharged from Gloucester Royal and Cheltenham General Hospital used GSF coding to assess and plan priorities for care and treatment for patients. GSF is a systematic evidence based approach to enable the quality of care and the coordination between teams to, enable more people to live and die well reducing inappropriate hospital admission.

Competent staff

- The learning needs of staff delivering end of life care were not all identified. When we requested the training needs analysis for general staff on wards related to end of life care it had not yet been completed. The trust told us establishing and maintaining records for training needed improvements. The trust planned to improve systems through the newly established trust end of life care strategic group who would aim to complete the action by September 2017.
- When we requested evidence of current nursing competency for syringe driver training we were told there were no centrally held records. Records for attainment of competency were held at ward level so there was no organisational oversight of compliance. As a result, we were unable to judge the level of competency for this essential equipment.
- We saw some evidence of a yearly programme of end of life care education for some medical staff. This included: symptom management, levels of care, diagnosing dying, resuscitation and communication skills. For example 44 junior foundation doctors attended a care of the dying session August 2016, and 33 in September 2016. Other sessions were planned to cover symptom control, ethics and legal issues and communication. These were new sessions that had not occurred at the time of the previous inspection.
- Nursing and allied health professionals also had access to additional training covering resuscitation, syringe driver training, quarterly end of life study days and symptom management.
- The specialist palliative care team took opportunities to educate staff in practice by providing micro (short or brief) teaching sessions. This was done when any of the team attended ward multidisciplinary team meeting or were visiting clinical areas. Ward staff we spoke with said recent micro teaching sessions had included symptom management and setting up syringe drivers. Feedback we saw described staff finding the teaching sessions were helpful
- The specialist palliative care consultants had also delivered 'grand round' case study presentation training in December 2016 and January 2017. This was based on end of life care and the role of the trust wide end of life quality group. The presentations had been to other consultants, junior doctors, chaplains, healthcare assistants, professions allied to medicine and nurses at both hospitals. The sessions received a high level of positive feedback.
- Not all staff in the end of life team had received appraisals. 50% of the doctors and 70% of the nurses in the team had received an appraisal; however dates for outstanding staff appraisals were booked.
- The bereavement service staff had training to support bereaved visitors appropriately. This included counselling, bereavement care and conflict resolution training.

Multidisciplinary working

- Staff, teams and services worked together to deliver effective care and treatment. The in-patient end of life care team met every morning to discuss current work and new allocations. Work was allocated based on patients' need and urgency. The team worked closely with the community specialist palliative care team, district nurses and GPs. This supported effective transfer of clinical management and follow-up reviews of patients upon discharge.
- The specialist end of life team held weekly multidisciplinary meeting to discuss patients care in detail and review treatment plans. The consultant completed ward rounds every week to review patients' care with other hospital staff. The in-patient end of life care team worked closely with the community end of life care team. This was done to share key information about older patients with complex discharge planning needs.

- The team worked with staff from other specialties and services. These attended the team meetings when available and when required. Staff said this ensured patients received holistic end of life care and support.
- We saw the shared care record (SCR) in use. This had been designed to record the communication and collaboration between multi-professionals team members, patients and their families. The SCR helped a range of staff identify and care for patients at the end of their life
- The chaplaincy service was integrated with the end of life care in patient and community care teams and other services in order to provide and promote good end of life care. The team worked effectively. The team had an established group of volunteers and links with other faith groups.

Seven-day services

- There was not a seven day face to face service provided by the in-patient and specialist palliative care team. This was not in line with national guidance. Although the trust provided a face to face service 9-5 Monday to Friday, out-of-hours there was a telephone advice line available 24 hours, 7 days a week for health care professionals.
- The chaplaincy service was available seven days a week, 24 hours a day, in order to be responsive to patients' needs. Staff said this ensured most patients' religious or spiritual needs could be met.
- The hospitals dispensing pharmacy was open from Monday to Friday during the week, and during the mornings on Saturday and Sunday. If wards required additional or alternative palliative medicines out of hours, clinicians could access a computer database and identify other areas that had stocks. These medicines were then obtained elsewhere until the pharmacy reopened. These systems supported end of life patients' fast-track discharge home or into community services out of hours, and ensured adequate pain relief was available at all times.

Access to information

- Staff on the wards had all the information they needed to deliver effective end of life care and treatment to patient's, we saw paper records that contained
  - risk assessments,
  - care plans,
  - case notes and
  - Test results.
- There had been a recent implementation of a new type of electronic record. This had caused some difficulties in accessing records. However the specialist palliative care team managed to coordinate information between different electronic and paper based patient record systems which supported access for staff to patient records. The trust was in the process of implementing a single electronic system to support better access and exchange of information.
- When patients moved between teams and services, including at referral, all the information needed for their ongoing care was shared appropriately and in a timely way. This included for discharge, transfer and transition of care.
- Each patient's GP received a letter which informed them of clinical details of the end of life care provided. This was sent when the patient had been discharged or transferred.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff we spoke with in the specialist palliative care team understood the relevant consent and decision making requirements of the Mental Capacity Act 2005. They also completed documents appropriately. However, we observed some practice by ward based staff that resulted in incomplete records so full information relating to patients consent to care and treatment was not always available in patient records.
- We reviewed 19 do not attempt cardio pulmonary resuscitation (DNACPR) forms and found that
  - Where patients were identified as lacking mental capacity or where it was not clear, a mental capacity assessment had not been undertaken and recorded correctly in 12 out of 19 records were not completed correctly (65%)
  - Relatives were not involved in discussions in 12 out of 19 (65%). This meant that it was not clear which patients lacked the decision making capacity for resuscitation and who needed decisions to be made for them through the 'best interests process' or whether the correct people had been involved.
- While we found variable quality of completion of DNACPR records, there was evidence of improvements from the last inspection March 2015. We saw results from the last two audit of completion in both hospitals since March 2015. The DNACPR forms showed a steady

improvement from between 46% and 64% compliance in first audit. The trust had achieved 75% compliance in December 2016. The December 2016 audit of completion stated "…significant improvement but we remain a distance away from 100% compliance" with a recommendation to continue education.

- However, relatives we spoke with told us they had been involved by staff in decisions when their relative who was a patient was no longer able to make decisions independently.
- 100% of nurse and non-medical staff within end of life care teams had completed Mental Capacity Act (MCA) Awareness training and 90% of medical staff had completed Mental Capacity Act (MCA) and Deprivation of Liberty training.
- Ward staff we spoke with had an understanding regarding processes to follow if a patient's ability to provide informed consent to care and treatment was in doubt. General decisions about care were made by clinical staff and often involved the patients' relatives when the patient was no longer able to give informed consent. Staff demonstrated that they understood that more complex decisions needed to include best interests' discussions and meetings in accordance with the Mental Capacity Act 2005.

Are end of life care services caring?

Good

We rated caring as good because:

- Patients and their relatives were treated with kindness dignity respect and compassion while they received care and treatment. We saw many written compliments about how kind and caring staff were
- Staff took the time to interact with people who received end of life care and those people close to them in a respectful and considerate manner.
- Staff and volunteers who worked with the department for spiritual support, bereavement officers and the mortuary were aware of and respectful of cultural and religious differences in end of life care.
- Patients and those people close to them were involved as partners in the care and this was clearly documented in patient notes.
- Staff we spoke with understood the impact that a patients' care, treatment or condition had on their wellbeing and on those close to them, both emotionally and socially.
- Emotional support for patients and relatives was available through the in-patient and community end of life care team, through clinical psychology, social worker, ward-based nurse specialists and end of life champions, the chaplaincy team and bereavement services.

Compassionate care

- We spoke with a patient receiving end of life care at the hospital and one in the community. We also spoke with relatives of patients who were receiving end of life care. All described being treated with kindness dignity respect and compassion while they received care and treatment.
- Staff took time to interact with people who received end of life care and those close to them in a respectful and considerate manner. We observed sensitive communication taking place between staff and the dying person, and those identified as important to them.
- We saw many written compliments about how kind and caring staff were on the wards and how the trust in-patient and community palliative care team worked so well for patients and their relatives.
- Where possible, patients receiving end of life care were accommodated in side rooms to increase dignity and privacy for them and those visiting.
- Whilst the hospital had very limited accommodation for relatives, staff supported the needs of relatives as much as they could when visiting for long periods. For example, relatives were offered a pillow and a blanket when staying in chairs.
- We were told that bereaved relatives had found it difficult in the past to navigate from the bereavement office to the mortuary. Staff recognised that distressed relatives found it difficult to follow navigation instructions between the two services. To improve this, the mortuary staff had designed a white rose symbol used with arrows that marked an easy-to-follow route from the bereavement office to the mortuary. Some relatives had reported they appreciated these signs. However bereavement office staff accompanied relatives when they knew people were attending the mortuary. Or they arranged for others to accompany

relatives as the signs were not easy for all to follow. During inspection some building work obscured the signs at Gloucester and the signs not obscured on both sites were not always clear of where people should go.
- Staff on wards, staff and volunteers who worked with the department for spiritual support, bereavement officers and the mortuary were aware of and acted accordingly on cultural and religious differences in end of life care. For example: bereavement office staff were aware of the importance of being able to provide a death certificate in timely manner. Mortuary staff understood the need to be able to release recently deceased patients quickly. This supported the spiritual and cultural wishes of the deceased person and their family and carers whilst making sure legal obligations were met.

Understanding and involvement of patients and those close to them

- We saw that patients who received end of life care services were involved as partners in their care. We reviewed care records and saw that staff delivering end of life care had recorded some discussions with patients and relatives. These included discussions about care and treatments and their implications. We also saw records of actions staff should take in response to patients' and relatives' wishes. These included requests to speak with a member of the chaplaincy.
- Ward staff communicated sensitively with patients and those people close to them so that they understood their care, treatment and condition.
- Patients approaching the end of life were given the opportunity to create a shared care record and an advance care plan. This included wishes and any advanced directives they wished care staff to take on their behalf.
- In the Cancer Patient Experience Survey 2015 the trust was in the top 20% of trusts for two of the 34 questions, in the middle 60% for 28 questions and in the bottom 20% for four questions. One of the two questions where the trust was in the top 20% was 'all staff asked patient what name they preferred to be called by'

Emotional support

- Staff we spoke with understood the impact that a patients' care, treatment or condition had on their wellbeing and on those close to them, both emotionally and socially. Although some staff told us they found it difficult to start a conversation with a patient when the ward was full and staff were busy. Despite this we saw many staff engaging with patients and those close to them.
- Emotional support for patients and relatives was available through the in-patient and community end of life care team, through a clinical psychology, social worker, ward-based nurse specialists and end of life champions, the chaplaincy team and bereavement services.
- Patients who received end of life care and those people close to them received the support they needed to cope emotionally with their care, treatment or condition. Patients were enabled to have contact with those close to them and to link with their social networks or communities although there was limited space for relatives to stay. Chaplaincy volunteers were clear that their role was to provide non-religious as well as religious support. Often offering time for the patient to 'just' talk with no other purpose than to listen. Staff knew how to contact chaplaincy volunteers and the department for spiritual support at any time.
- Patients were empowered and supported to manage their own health, care and wellbeing and to maximise their independence

Are end of life care services responsive?

Good

We rated responsive as good because:

- Services were being planned and delivered in order to respond more effectively to the needs of patient's. Audit was used to inform future planning of the service.
- Systems and processes were being reviewed so that the specialist palliative care team could better understand and respond to service development plans created for 2017.
- We saw that patients and relatives had been consulted about care and their individual wishes had been clearly recorded in care plans.
- The in-patient specialist palliative care team was available to ward staff to provide advice and training regarding communication and end of life care; this included communicating with patients and carers.

End of life care

- The trust was one of two sites in the country which had been developing a medical examiner role and improved death certification process project since 2008. Benefits included better support for relatives over the explanation and causes of death as well as ensuring better oversight of signing of death certificates
- The specialist palliative care team responded promptly to referrals, usually within one working day.
- Lessons were learned and improvements were made from complaints. This learning was used to improve the quality of care.

However:

- There were no designated beds for people receiving care at end of life. Side rooms were used when available but could not be guaranteed.
- The percentage of patients dying in their preferred location and the percentage of patients discharged within 24 hours were not all known for all wards or hospital sites.
- The trust did not have systems in place to identify all patients in the hospital who had been identified as approaching end of life.
- End of life complaints were not always handled promptly and in accordance with trust policy. The trust took an average of 53 working days to investigate and close complaints, which was not in line with their complaints policy of 35 working days.

Service planning and delivery to meet the needs of local patient's

- Services were being planned and delivered in order to respond more effectively to the needs of patient's. Plans were underway to:
  - Accurately identify all patients at end of life in the trust.
  - Audit to inform future planning such as discharge planning projects based at Cheltenham General Hospital, advance care planning and data collection so that the end of life team could inform better decision making with older, frail patients.
  - Establish a baseline for key performance indicators which would involve information at ward level
  - Improve coding for the new electronic system so that the trust and specialist palliative care team could understand incident reporting and complaints relating to their service better.
- Senior staff attended a countywide group attended by commissioners, other providers and relevant stakeholders. The aim was to share good end of life practice and consistency in services through the development of a county plan for end of life care for 2016 - 2019. Other professionals who attended these meetings included staff from three local hospices and staff from other health and social care - services. Outputs from the steering group included the development of the shared care record for the expected last days of life. This was produced and piloted in partnership with the community palliative care services, the clinical commissioning group and the local hospice.
- Where possible, senior end of life care staff attended the clinical governance meetings at the local hospice. They also took part in a number of working groups which stemmed from the countywide end of life group. Consultants in specialist palliative care team also met twice a year with the end of life care teams in surrounding areas to inform care pathways and improved communication.
- The bereavement office had been involved in a pilot project with another acute trust since 2008 for the introduction of medical examiners and reforms to death certification in England and Wales. The trust was one of two large sites in the country which was developing the role with the department of health and together had reviewed over 23,000 deaths. Benefits acknowledged in the review 'reforming death certification: introducing scrutiny by medical examiners lessons from the pilots of the reforms set out in the Coroners and Justice Act 2009' (May 2016) were better support for relatives over the explanation and causes of death as well as ensuring better oversight of signing of death certificates. The reforms were not yet implemented across the UK and were planned for April 2018.
- The trust recorded the number of patients at any one time who had a learning disability or dementia in order to help plan what services might be needed in future.

Meeting patient's individual needs

- We saw that patients and relatives had been consulted and their individual wishes had been clearly recorded in care plans.
- The specialist palliative care team was available to ward staff to provide advice and training regarding end of life care. This included communicating and breaking bad

news to patients and carers. This information was also available on the trust's website. This ensured staff had access to support when required to provide sensitive patient information.

- Services took account of the needs of different patient's with life limiting conditions as well as those patients in vulnerable circumstances. For example the trust recorded 2125 patients who had 'complex needs' who had been in-patients in 2015/16. The trust also recorded 540 people with a learning disability had received in-patient care in the last year. In order to support staff to meet the needs of this group of patients, the trust employed two learning disability nurse specialists who worked with the specialist palliative care team when appropriate.
- The trust had a policy to support staff to effectively process patient deaths from different faiths and cultures. Staff we spoke with on wards and in the mortuary service were aware of this.
- Translation services were available for end of life patients and relatives. Staff who had used these services said they were prompt and efficient in responding to needs.
- The chapel and two multi faith rooms had a broad range of religious texts including Christian bibles, Hindu Bhagavad Gitas, Muslim Qurans and other literature relating to spiritual and non-religious support.
- There were limited family rooms and overnight accommodation was not available for relatives. This had been discussed at the end of life care quality group meeting in January 2017. The action recorded was to remind the trust's 69 end of life champions on wards to share knowledge of what was available and help relatives to know what they could expect of the limited availability. Staff were able to direct relatives of patients receiving end of life care to areas where they could wash if needed during prolonged stays.
- The inpatient specialist palliative care team won an annual staff award the trust patient's choice award 2016, patients and others recognised the NHS staff who had made a difference to their lives.
- The consultant in the specialist palliative care team was part of a multi-disciplinary team who had won the national Linda McEnhill award 2016. The award was recognition by the Palliative Care of People with Learning Disabilities professional network of excellence in end of life care for individuals with learning disabilities. Work included improving how different teams worked better together.

Access and flow

- Whilst referral into the service was dependant on staff identifying appropriate patients, the end of life team responded promptly to referrals, usually within one working day. Ward staff demonstrated they understood how to make a referral to the specialist team and consistently reported that the team responded promptly. This information was documented in the main medical notes. The service undertook an audit of 44 patients referred during a two-week period during February 2015. Of these, 71% were seen on the same day of referral and 95.6% were seen within one working day of referral.
- However the trust was unable to identify the total number of patients in the hospital within a central record receiving end of life care. The trust was planning to adopt a new electronic patient record with the ability to identify patients who had an advance care planning document or to be able to search for patients being cared for at end of life or identify specific needs around end of life care had been built in. The system was not yet in use as it had been delayed.
- Access to the spiritual support provided by the chaplaincy service was audited. This was done in order to identify areas of high demand and low use and to understand if staff needed to be made more aware off the support available, including future planning of the spiritual support department.
- Gloucester Royal Hospital chaplaincy call-outs (2016)
- Seven wards had not called on call chaplaincy
- 19 wards had called on call chaplaincy
- Ward and other staff had called on call chaplaincy on a total of 100 occasions
- 144 out of hours call-outs across trust
- A review of preferred place of care for patients was undertaken between July and August 2016. In 21 cases 65.6% successfully achieved a preferred place of care or death (PPD) where information was recorded. This review highlighted potential difficulties with the planned electronic patient record and recording of the data. As a result, the importance of clearly documenting PPD was raised and where discussion was not

appropriate or not wanted by the patient, to ensure this was known by the team. The specialist palliative care team also planned to liaise with team developing the new electronic patients record so that information was able to be identified trust wide

- The trust planned for discharges for patients at end of life to be completed within two hours of booking. Discharges could be booked the day prior to discharge to ensure a planned approach. Ambulance services recognised the Do Not Attempt Cardio Pulmonary resuscitation (DNACPR) documentation and this was provided to them at the point of patient transfer. Ward staff and the rapid discharge team said that most end of life discharges were achieved within 24 to 48 hours, although there were sometimes delays for patients who lived in rural areas.
- Discharge for patients at end of life took place at an appropriate time of day. All relevant teams and services were informed and discharge took place only when any ongoing care was in place. Most delays experienced for end of life care were attributed to the lack of availability of care in the community.
- Between October 2015 and September 2016, the main reasons recorded for delayed transfer of care for all patients from the trust were 'waiting further NHS non-acute care' (35.1%), followed by 'completion of assessment' (29.8%). The trust's percentage share for 'waiting further NHS non-acute care' was almost double the percentage share for the England average. There were no specific figures available for end of life discharge delays.
- There were 1693 referrals to the specialist palliative care team between April 2014 March 2015. Cancer related referral accounted for 1175 (69%) and non-cancer 518 (31%). There were 2067 referrals between April 2015 and March 2016 pf which Cancer referrals numbered 1587 (77%) and non-cancer 480 (23%).
- A policy was in place for the rapid release of a deceased patient from the mortuary which supported the respect of cultural wishes of deceased patients. Medical and mortuary staff demonstrated an understanding of the processes to follow, and we saw documentation confirming this.

Learning from complaints and concerns

- Lessons were learned and improvements were made when care provided was not as good as expected. Significant learning was focussed on improving bereaved relatives experiences in the mortuary and care of those who had recently died.
- Patients who used the service and those close to them knew how to make a complaint or raise a concern and were encouraged to do so. Between November 2015 and October 2016 there were a total of 18 complaints about end of life care.
- A formal complaint record was maintained. This showed complaints were handled confidentially, with a regular update provided for the complainant.
- However complaints were not always handled effectively. The trust took an average of 53 working days to investigate and close complaints, which was not in line with their complaints policy, which stated complaints should be responded to in 35 working days.
- Patient care was the most complained about theme with 13 complaints, followed by admission and discharges with two complaints.
  - There were 15 complaints for Gloucestershire Royal Hospital: of which 'patient care' received the highest number of complaints; 11 (73%)
- Processes were in place for the learning from complaints to be visible at board level.

Are end of life care services well-led?

Good

We rated well-led as good because:

- The leadership and culture of end of life the specialist palliative care team in the trust reflected the vision and values of the trust.
- The trust had a clear vision and strategy to deliver care at end of life linked to national best practice including Priorities for Care of the Dying Person set out by the Leadership Alliance for the Care of Dying Patient's.
- The governance framework for end of life care ensured that responsibilities were clear and that quality, performance and risks were understood and managed.
- Priorities were identified at the specialist palliative care team meetings for consideration at the trust's quality committee meetings.

End of life care

- Systems were in place to learn from incidents that occurred in end of life care.
- Leadership, encouraged openness and transparency and promoted good quality care. There were leads on the wards for delivery of end of life care which supported the development of high quality end of life care.
- Staff felt respected and valued. There was a strong emphasis on promoting the safety and wellbeing of staff delivering end of life care in the community.
- Services had been continuously improved and sustainability supported since the last inspection.
- We saw examples where leaders and staff took part in contributing to their own and others continuous learning, improvement and innovation

However:

- There was no risk register specific to end of life care for the trust so there was no easy trust wide oversight of risk relating to the service.
- There was a program of internal and national audits for end of life care, which were on time. However most local audit activity had not yet benefited from a thorough analysis of the data produced.

Vision and strategy for this service

- The trust had a clear vision and strategy to deliver care at the end of life. The vision was developed by the end of life quality group and was presented to the quality and performance committee in December 2016. The vision was to embed pride in end of life care delivery across the trust to ensure that end of life care was good as it can be for every individual and those important to them, every time. Following the previous inspection, work had been completed by members of end of life care team on the vision and strategy. We saw a realistic action plan to achieve the 10 actions considered most important by the team for the Board. Compliance was monitored by the executive and non-executive leads for end of life care through an action plan with set deadlines.
- The end of life vision also included improving patient experience, clinical effectiveness, the establishment of the end of life care group and patient safety. The strategy and vision was presented to the quality and performance committee. Following the presentation the committee agreed that end of life care should form part of the essential training for the trust. We saw three different levels of training proposed during inspection with end of life champions being in the first wave and staff of the trust all completing an end of life module. The recommendation was referred to the education and learning development unit. The trust charter for end of life care (an explicit statement of what various parts of the trust would do to support end of life care) was underway. The charter, once finalised, was to be presented to the Board.
- The specialist palliative care team understood what the vision and values were. Some general staff on wards were aware of it, most usually end of life champions and ward sisters. The specialist palliative care team and the trust were at an early stage of development and the written strategy for the hospital with defined work plan priorities for the present and future recently completed.
- The strategy reflected the learning and development within the specialist palliative care team and findings of previous inspection reports. It reflected the current challenges the trust faced in relation to end of life care services. Which were
  - Continuing and improving education
  - Understanding of performance and safety
- The trust had included a quality priority in the 2016/17 quality account which was to improve end of life care.

Governance, risk management and quality measurement

- The governance framework for end of life care ensured that responsibilities were clear and that quality, performance and risks were understood and managed. The strategic end of life group reported directly into the trust quality and performance committee, chaired by the Chief Executive. The membership of the quality and performance committee included. The medical director, the specialist palliative care team consultant and a range of other staff including the non-executive director, senior ward nurses, chaplain and patient experience manager.
- Processes were followed to provide assurance to the board regarding safety issues. The end of life care quality group and medical director provided regular reports to the board.
- Although there was no specific risk register for end of life care, risk management processes were followed. However oversight of all end of life risk was not easy.

Priorities were identified at the specialist palliative care team meetings for governance and fed into divisional meetings and on through to the trust's quality committee.

- Systems were in place to learn from incidents that occurred in end of life care for example mortuary incidents and discharge planning for patients at end of life.
- There was a program of internal and national audits for end of life care, which were on time. However most local audit activity had not yet benefited from a thorough analysis of the data produced. This was due to some deadlines and projects only being implemented recently due to recent reduction in staff shortages within the specialist palliative care team. Staff shortages had not affected other aspects of end of life care practice.
- However the trust had a programme and strategy to understand and improve on hospital based mortality indicators related to end of life patients. In January 2017 the known challenges were listed as;
  - The coding of palliative care input was low by national comparison. As a cancer centre a higher level of patients falling into a palliative category had been expected. This was currently under review between the specialist palliative care team and the coding team. Better coding was hoped to lead to better information about numbers of patients and any delays they experienced.
  - The trust was aware of the delayed discharge of patients. Some patients then became too unwell for transfer due to the delay. The improved discharge of those patients choosing to receive their end of life care at home would give a key indication of a system driven by high quality care.
  - Work was currently underway to review admission pathways as part of the emergency pathway review. This was planned to allow more specialist input into patient care prior to admission. This would improve accuracy of initial diagnosis and ensure more appropriate admissions and avoid inappropriate end of life admissions.

Leadership of service

- The leadership and culture of specialist palliative care team in the trust reflected the vision and values of the trust. Leadership, encouraged openness and transparency in decision making.
- The medical director was the executive lead for end of life care responsibilities. The non-executive lead contributed by challenging timescales and decisions regarding end of life care planning and delivery. Staff described them as understanding the issues within the hospital and being active, visible and supportive.
- The specialist palliative care team were led by the specialist consultant with support through five in patient advanced nurse practitioners. Two of the five advanced nurse practitioners were based at Gloucestershire Royal two were based at Cheltenham General Hospital with one working across both sites. Leadership was also through three community team advanced nurse practitioners based at Gloucestershire Royal Hospital and with additional work bases at three hospices in the area.
- There were 69 end of life champions in the trust based on wards The 'champions' provided additional local ward leadership with senior ward nurses for the delivery and development of high quality end of life care.

Culture within the service

- There was an open culture within the service where staff were able to raise concerns. Staff felt respected and valued and there was a strong emphasis on promoting the safety and wellbeing of staff delivering end of life care.
- The culture was centred on the needs and experience of people who received end of life care. Ward staff felt end of life care was an important part of their work. However when busy felt it was something that was difficult to ensure was a priority.
- Staff and teams worked collaboratively, to deliver good quality care.

Public engagement

- Patients and those close to them who used the end of life care were engaged and involved. Patients and those close to them shared their experiences with both the in-patient and community specialist palliative care team. Some experiences were used anonymously to inform staff training and to improve process such as enabling better discharge planning.
- While there was no specific Friends and Family Test for those in receipt of end of life care, the overall hospital response was generally worse than the England average between November 2015 and October 2016. In the latest

period, November 2016 trust performance was 95.2% which is the same as the England average of 95.2%. The trust's performance had stayed consistently between 93% and 97%.
- In the Cancer Patient Experience Survey 2015 the trust was in the top 20% of trusts for two of the 34 questions, in the middle 60% for 28 questions and in the bottom 20% for four questions.

Staff engagement

- Staff we spoke with in specialist palliative care team felt actively engaged and that their views were reflected in the planning and delivery of services and in shaping the culture.
- Leaders and staff understood the value of raising concerns and appropriate action was taken as a result of concerns raised. For example we saw that concerns over team resources had been responded to with increased recruitment.
- There was a trust wide end of life care steering group or committee, which was representative of the breadth of staff involved in end of life care which ensured decisions where informed by a range of staff involved.
- We saw records which showed that the majority of staff who attended training courses facilitated by the end of life care team gave positive feedback. Staff said this was used to plan and improve future training sessions.

Innovation, improvement and sustainability

- Improvements had been made to the service since the last inspection. Staff had considered developments to services and, the impact on quality and sustainability was assessed and monitored which had led to an increase in nurse and doctor provision.
- End of life care performance measurements were being developed and implemented
- There was a trust wide end of life care quality group, established during September 2016. The group had a membership of medical nursing, allied health professionals, non-executive, chaplaincy and hospital site management. This group were aiming to implement the countywide and local end of life care strategy.
- Think '333' was a prompt for improved discharge planning which required prescriptions, communication and documentation needed from wards to facilitate smooth discharge for patients receiving end of life care. The tool was beginning to be widely used by the hospital wards, having been developed by nurses in the specialist palliative care team and medical staff following responses to incidents recorded.
- There were a team of end of life champions, based across the inpatient wards. They supported the delivery of end of life care on wards. They attended regular trust meetings and were developing an end of life care work programme.
- Since 2008 Gloucester Royal Hospital and the bereavement office had been involved in a pilot project with another acute trust for the introduction of medical examiners and reforms to death certification in England and Wales. Benefits acknowledged in the review 'reforming death certification: Introducing scrutiny by Medical Examiners Lessons from the pilots of the reforms set out in the Coroners and Justice Act 2009' (May 2016) were better support for relatives over the explanation and causes of death as well as ensuring better oversight of signing of death certificates.

Outpatients and diagnostic imaging

Safe	Requires improvement
Responsive	Requires improvement
Overall	

Information about the service

This report focuses on our inspection of the outpatient and diagnostic imaging departments located at Gloucestershire Royal Hospital.

Gloucestershire Hospitals NHS Foundation Trust provides outpatient and diagnostic imaging services to a population of over 600,000 people. These services are provided in outpatient and diagnostic imaging departments at the Cheltenham General Hospital and the Gloucestershire Royal Hospital. The same team of senior staff, who work between both sites, manage the general outpatient and diagnostic imaging departments at both hospitals. Some outpatient departments are managed by the specialties themselves, for example the trauma and orthopaedic department.

Across all Gloucestershire Hospitals NHS Foundation Trust sites, between April 2015 and March 2016, there were 815,638 new and follow-up outpatient appointments of which 407,362 were held at Gloucestershire Royal Hospital. During the inspection, we visited a range of outpatient clinics on the Gloucestershire Royal Hospital site including physiotherapy, oncology, dermatology, ophthalmology, respiratory medicine, general medicine, general surgery, ear nose and throat, urology, audiology, rheumatology, trauma and orthopaedics, gynaecology, pain clinic and clinical psychology.

We also visited the radiology department, including plain film imaging, magnetic resonance imaging, computed tomography, ultrasound, nuclear medicine, screening and medical physics.

Between January 2016 and October 2016 the diagnostic imaging department at Gloucester Royal hospital reported on 102,888 examinations.

On our last inspection in March 2015, the diagnostic imaging and outpatient departments were rated as requires improvement for both safe and responsive domains. There were three areas requiring improvement which included storage of records, referral to treatment times and availability of emergency resuscitation equipment.

During this inspection a team of inspectors and specialist advisors spoke with 37 members of staff, including managers, sisters, nurses, healthcare assistants, consultants, radiographers, physiotherapists, receptionists, secretaries and bookings staff.

We reviewed six sets of patient records, and spoke with 17 patients and their relatives to seek their views of the services provided.

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

Outpatients and diagnostic imaging

Summary of findings

- The service did not have sufficient arrangements to keep clinical and patient areas clean. There was no cleaning carried out over the weekend in diagnostic imaging, and some outpatient treatment rooms and waiting areas were visibly dirty.
- There was not a reliable system to track the number of temporary notes being used since the implementation of a new computer system care, and staff were finding it difficult to trace patient notes.
- There were not sufficient arrangements to ensure staff had access to or knew where to access emergency equipment. Some staff were unsure of their responsibilities in a resuscitation situation, and staff in ophthalmology did not know where to locate their nearest defibrillator.
- Patients were not protected from avoidable harm in the therapies department as cleaning chemicals were not stored securely.
- The hospital was not meeting the 62 day waiting list target for cancer patients.
- Patients were experiencing delays in diagnosis and treatment because the diagnostic imaging department had a reporting backlog of 19,500 films, and was not meeting its five day reporting target for accident and emergency x-rays.
- A significant typing backlog was causing delays in sending out patient letters impacting on patient safety, diagnosis and on-going treatment.
- Implementation of new IT systems had impacted on waiting lists as some specialties could not see their live waiting lists.
- The trust was not meeting referral to treatment target in all specialities, and patients were waiting longer for to access care and treatment.

However;

- Incident reporting had improved and in one case the trauma and orthopaedic department to take steps to reduce pressure ulcers. Staff confirmed they now received feedback from incidents they reported.
- The diagnostic imaging department conducted investigations and had raised safety alerts with an equipment manufacturer which had resulted in changes to practice.
- Cleaning and infection control procedures had improved in ophthalmology since the last inspection, and there were good decontamination processes in other outpatient departments for equipment that was re-useable.
- Diagnostic imaging were negotiating one cost service and maintenance contracts for scanners and equipment.
- Patient were able to access services when they needed to and rapid access assessment clinics were provided in some specialities, and some clinics were performing airway assessments via Skype.
- The hospital had introduced a new waiting list validation process to discharge patients' on-going follow up care to community based services such as GPs.
- A project placing therapists on wards had helped increase patient discharges, and radiographers attended ward briefings to identify inpatients waiting for scans.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services safe?

Requires improvement

We rated safe as requires improvement because:

- There was no cleaning carried out over the weekend in diagnostic imaging, and some outpatient treatment rooms and waiting areas were visibly dirty.
- Staff were finding it difficult to trace patient notes since the introduction of a new computer system, and there was not a reliable system to track the numbers of temporary notes being used since its implementation.
- Some staff were unsure of their responsibilities in a resuscitation situation, and staff in ophthalmology did not know where to locate their nearest defibrillator.
- Cleaning chemicals were not stored securely in the therapies department.

However;

- The trauma and orthopaedic department was taking steps to reduce pressure ulcers, and had improved the reporting of these incidents. Staff confirmed they now received feedback from incidents they reported.
- The diagnostic imaging department conducted investigations and raised safety alerts, and had changed practices as a result.
- Cleaning and infection control procedures had improved in ophthalmology since the last inspection, and there were good decontamination process in the outpatient departments for equipment.
- Diagnostic imaging were negotiating one cost service and maintenance contracts for scanners and equipment.

Incidents

- Staff consistently reported incidents and understood their responsibilities to raise concerns using the electronic reporting system. Staff understood why it was important to record safety incidents, concerns and near misses, both internally and externally. An example of this was in the trauma and orthopaedics department, where staff had noticed a number of grade one and two pressure ulcers developing in patients with plaster casts.
- Since our last inspection, incident reporting had increased when compared to other similar services and England averages. Between November 2015 and October 2016 the diagnostic imaging and outpatient department reported 605 incidents. 512 were graded as no harm, 77 minor harm, 9 as moderate harm, 4 as major harm, 0 as death. Staff told us they understood how incident reporting helped the trust identify and monitor patient safety.
- A trust wide focus work group for leads from the fracture clinic was focussing on the prevention of pressure ulcers from grade 2 to grade 4. Work was aimed at not only inpatients with fitted plaster casts and appliances, but for patients in the community and nursing homes. We saw information leaflets on preventing pressure ulcers and 'care of your cast', which patients were discharged with. The team had developed over the last six months a plaster, splint and brace observation chart. The ward staff used the observation chart which included checks for signs of rubbing, capillary refill, soiled casts and odour and ensuring the patient had been given a care of cast leaflet.
- When things went wrong in the outpatient and diagnostic imaging departments, thorough and robust reviews or investigations, including all staff involved, were carried out. In one example we heard how in diagnostic imaging a patient suffered blistering to the hand after an iodinated contrast injection had leaked into the tissue around the injection site. The investigation identified a problem with the type of intravenous cannula used for these types of pressurised injections. As a result, the cannulas were removed from use and replaced with a different type of cannula.
- When things went wrong in outpatients and diagnostic imaging, lessons were learned and action was taken a result of investigations. Staff we spoke with told us they received feedback from incidents they reported although this was sometimes verbal. As a result of the example incident above, we saw the identified cannulas were withdrawn from use, and the policy to re-cannulate inpatients when they required a pressurised contrast injection was revised. All staff we spoke to in diagnostic imaging were aware of the new cannulation policy, and confirmed all failed contrast injections were reported via the trust electronic incident reporting system. However, senior staff identified the possibility that there may be patients with delayed reactions who they did not know about, as they had gone to their GPs for treatment after their investigation.

- People who used services were told when they were affected by an incident and given an apology and they were informed of any actions taken as a result. We saw that the patient with blistering to the hand, had received an apology and been sent for further medical treatment for the blistering. We also saw that they had been told about the actions the diagnostic imaging department had taken around the type of cannula used, which included raising a safety alert via the health and safety committee and to the manufacturer.

Duty of candour

- Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 is a regulation, which requires the organisation to be open and transparent with patients when things go wrong in relation to their care and the patient suffers harm or could suffer harm, which falls into defined thresholds. Staff we spoke with were aware of this legislation and demonstrated good understanding of their responsibilities under it.

Cleanliness, infection control and hygiene

- Reliable systems were in place to prevent and protect people from healthcare-associated infections. For example the outpatient and diagnostic imaging departments collected twice monthly data about hand hygiene, and the most recent data available showed 99% compliance in July and 100% compliance in August and September 2016 across both hospital sites.
- Standards of cleanliness and hygiene were maintained in all clinical areas we visited, and staff could explain how this was consistently achieved. For example in the trauma and orthopaedic outpatients department, a nurse was responsible for cleaning and topping the stores up in each clinic room. Trained nurses had a daily checklist to complete which covered suction equipment, oxygen, and blood glucose equipment. Of the two weeks of lists checked all were signed and dated.
- Most areas we visited were visibly clean and clutter free. However; in the orthodontics department we saw staff tea making facilities in the clinical area, and in ophthalmology we saw visibly dirty surfaces in several treatment rooms and the patient waiting area. Staff told us the waiting areas were cleaned by the domestic team, but clinical areas were cleaned by the clinic staff, however we did not see any cleaning schedules or checklists to support this.
- On our previous inspection we saw there was no visible system to enable staff to identify if a piece of equipment was clean prior to use. On this inspection staff told us there was still no such system in place, and if equipment was in a store cupboard, it was assumed to be clean as it was part of the cleaning of that store cupboard. Cleaning took place in the mornings before clinics started, and was carried out by the clinic staff. We saw cleaning checklists were complete and up to date, and mentioned pieces of equipment in the cleaning tasks outlined on the checklist.
- Staff in the Ear, Nose and Throat (ENT) department had good procedures for the cleaning of reusable equipment, and showed us the decontamination protocol for the nasoendoscopes used in the clinics. This involved a three step disinfection process, which was in line with Department of Health best practice guidance HTM 01/06 and hospital policy. In the Orthodontics department, staff explained how all dental equipment used in clinics was sent to the central sterile services department (CSSD) for decontamination in line with Department of Health best practice guidance HTM 01/05 and hospital policy.
- The trust had set a target for 100% of staff to undertake infection prevention and control training. The most recent data available showed this had not been met in July 2016 (94% compliance) and August 2016 (93% compliance).
- Staff we spoke with could explain the importance of hand washing, and understood when to use soap and water or antibacterial hand gel. We saw staff were either washing their hands before and after patient contact or using antibacterial hand gel which was in line with National Institute for Health and Care Excellence (NICE) guidance quality statement 61. We also saw all clinical staff were bare below the elbow, in line with trust policy.
- We saw antibacterial gel dispensers in all consulting rooms and patient waiting areas. Staff were able to access hand wash basins throughout the clinics and departments and posters displaying best practice for hand hygiene technique were displayed.
- Staff took appropriate precautions when seeing patients with suspected communicable diseases or infections. For example, patients with suspected or confirmed

communicable diseases were placed at the end of appointment lists to allow thorough cleaning to take place after the scan or investigation, and to help minimise contact between patients.

- Personal protective equipment, such as aprons and gloves were readily available in all areas and staff could describe how and when to use this equipment. Staff could explain how this equipment protected both patients and staff from the possible spread of healthcare associated infections, but also explained how it was not a replacement for good hand hygiene.
- Staff in ophthalmology told us of changes they had made to their cleaning procedures as a result of learning from a review of infections in patients receiving intravitreal eye injections at the Cheltenham General Hospital clinic. Changes were made to cleaning procedures across all ophthalmology clinics. Staff were awaiting audit data to assess if the infection rate had reduced as a result.
- In diagnostic imaging there was one dedicated cleaner who was responsible for the whole of the department. Sometimes the cleaner was re-located to inpatient wards when domestic staffing was low which staff said had an impact. The cleaner worked 07.00-15.30 three days a week and 07.00 -13.30 on two days. Staff told us there was no cleaning carried out in the diagnostic imaging department outside of these hours, unless requested

Environment and equipment

- Facilities and premises in the main outpatient department were designed in a way that kept people safe. The general outpatient department was a relatively new part of the hospital with large amounts of glass used in the walls making it light and airy. However, we were told the area could be very cold in winter and very warm in summer, and despite escalating this to the company who owned the building, they had not found a way to regulate the temperature effectively. This issue was recorded on the department's risk register as it had been on our previous inspection, as patients had reported feeling faint in warmer months.
- Equipment was regularly and adequately maintained by the medical electronics department and through a number of external maintenance contracts in diagnostic imaging. Staff used equipment safely and we were shown standard operating procedures for equipment. All electrical safety test stickers we saw on equipment were within their service dates.
- Senior staff in diagnostic imaging told us they were looking into new ways of negotiating maintenance contracts, which would involve a one off cost and include all parts and labour associated with servicing diagnostic imaging equipment. Staff hoped this would be useful in future budget management as all costs would be known. Senior staff told us they had recently had to replace three x-ray tubes (through normal wear and tear) which had not been included in service contracts and had required additional funding.
- Senior staff in diagnostic imaging told us a magnetic resonance imaging (MRI) scanner had been authorised for purchase, but had been put on hold for over a year due to financial and budget pressures. The purchase was now going ahead again. There had been no impact on patients from the delay and staff had been able to manage their waiting lists with minimal impact.
- There were systems for managing waste and clinical specimens including sharps bins, and in all clinical areas we visited we saw sharps bins were temporarily (partially) closed in-between use as recommended by the Department of Health management of healthcare waste HTM 07-01 (2013).
- Resuscitation equipment was not readily available in each outpatient area we visited but equipment we did look at was stored and checked in line with Resuscitation Council best practice guidance. The therapy department did not have its own resuscitation trolley, but staff could explain the procedure for summoning help and knew where the nearest resuscitation trolley and defibrillator could be found. However, in ophthalmology we saw the resuscitation trolley did not have a defibrillator, and staff we spoke to did not know where the nearest defibrillator was kept. On our previous inspection we found the trauma and orthopaedic department did not have its own resuscitation trolley. Since then a risk assessment had taken place which showed risks had been considered with the outcome that staff would summon help from the accident and emergency department located next to the trauma and orthopaedic department.
- In the ophthalmology department, we did not see any resuscitation equipment for children, and staff told us

this had been risk assessed by the resuscitation department and the risks were mitigated by the crash team bringing dedicated paediatric equipment with them when they attended the crash call.

- The trust risk assessment used to decide which areas in the outpatient clinics did not need resuscitation equipment used information from previous 2222 incidents and discussions with clinical managers to decide where trollies were placed. If an area had not had a cardiac arrest in the last five years, a trolley was not placed there. Staff also told us that if the use of an area changed, then an immediate reassessment by the resuscitation team was done.
- The imaging service ensured that non-ionising radiation premises, in particular MRI scanners, had arrangements in place to control the area and restrict access. All MRI scanners had coded locked doors, to prevent people accessing the scanner accidentally and being exposed to the magnetic field.
- Toilet facilities for the trauma and orthopaedic department and diagnostic imaging waiting areas were limited as there were two cubicles for both departments which were used by both patients and staff. Pictorial signage identified which cubicles were for men and women and which included facilities for disabled users and baby changing.
- Access to disabled toilets throughout the outpatient department was appropriate although, there were no pull alarm cords in several of these meaning anyone using them may not be able to summon help in an emergency or if they required assistance . Alarm buttons were situated on the wall by the door, but would be inaccessible if a patient fell and could not reach the button.
- Staff in the trauma and orthopaedic outpatients department had tea and coffee making facilities in the clean utility room. Staff then walked through the department with hot drinks to consume them in the clinic rooms, and told us there was not easy access to a break area or staff room.

Medicines

- There were reliable systems for recording and storing of medicines, medical gases and contrast media. The outpatient and diagnostic imaging departments monitored minimum and maximum temperatures of the refrigerators and rooms where medicines were stored and we saw records of this which were complete and up to date. Staff could explain what to do if temperatures had exceeded certain thresholds and had an understanding about the effects temperature fluctuations could have on the medicines they held stock of.
- All of the refrigerators we looked at in outpatients and diagnostic imaging had daily check sheets recording minimum and maximum temperatures, which were all signed and up to date, with no entries missing.
- The trust provided staff with medications management training, and staff showed us policies relating to medications management were available to them on line. However, the trust had set a target for 90% of staff to have completed medication management training, and in the outpatient department this target had not been met, with 84% of staff receiving this training.
- There were systems in place to maintain up to date records and alerts on the Control of Substances Hazardous to Health (COSHH) in some areas we visited. We saw evidence in the trauma and orthopaedic outpatients departments of folders with up to date information. However, in the therapies department we saw an unlocked room with chemicals which were subject to COSHH left out on a cleaner's trolley.
- There were systems in place to ensure the safety of controlled drugs administered in outpatients. All controlled drugs were stored securely in locked cupboards. We carried out random checks of a number of controlled drug record books which showed all entries were complete and up to date, with no omissions.
- Prescription pads (knows as FP10 forms) were stored securely and were signed in and out of each clinic at the start and end of each clinic session. We saw FP10's stored in plastic wallets, with a record sheet containing each FP10 reference number, the patient's hospital number and the signing doctor's name and date. Staff told us they cross checked the sheet with the remaining prescriptions to check all of the prescriptions were accounted for. Staff could describe what to do if a prescription had gone missing, but could not recall an occasions when this had happened. We saw all FP10s were locked in secure cupboards in unattended clinic rooms.

- The nuclear medicine service did not take account of The Medicines (Administration of Radioactive Substances) Regulations 1978 (MARS), as we did not see an up to date list of practitioners who could approve nuclear medicine procedures.
- Diagnostic imaging had worked with the pharmacy department to provide competency based training for healthcare assistants working in diagnostic imaging which allowed them to administer sodium chloride as a flush for patients having contrast injections, under a trust wide patient specific directive (PSD).
- An outpatient survey carried out in August 2016 had been completed across all trust sites and 32% of patients who took part in the satisfaction survey reported that they were not fully involved in decisions over best medication, 12 % of patients said they had not been told how to take their new medications, 13% had not been told how to take their current medications, 17% had not had the reason for a change to medications explained and 40% were not told of side effects. These results showed the trust was doing better with regard to medications satisfaction when compared to some other trusts. The trust had an action plan which focussed on 13 areas for improvement identified within the survey, including improvements around better communications with patients before and during appointments, and continuity of care.

Records

- Patient care records were accurate, legible, compete and up to date, and we found this to be true of the six sets of records we looked at. There were systems in place for managing records which were communicated to staff, which included a delivery and collection service. Notes were delivered to a lockable room in the trauma and orthopaedic outpatients department and a staff member was assigned to go through these notes in preparation for the following day's clinics. However, in two outpatient clinics we saw an unlocked, unattended room used to store patient records which were accessible from patient waiting areas.
- There was a reliable system for ensuring medical records availability for clinics which was audited regularly. The trust reported that across all sites 1.5% of patients were seen without their full medical record being available between January 2016 and November 2016. Any records that were not available were substituted with a set of temporary records. These temporary records contained a copy of the referral, discharge summary or letter from a previous appointment depending on the patient pathway. Clinicians also had access to pathology results, diagnostic imaging results and clinic letters electronically within the outpatient department via other hospital internal IT systems.
- Staff in the outpatient departments told us missing notes were reported as incidents. Since the introduction of new IT system in December, staff said the instances of temporary and missing notes had increased; however, no data had been collected to show this. The new IT system was currently used to track patient notes and schedule appointments. Future roll outs of the project were planned to include electronic copies of patient care records. This was currently limited to outpatient referral letters, inpatient discharge summaries, emergency department attendance records and some obstetric records.
- Medical records staff told us that since the introduction of a new computer system, staff were not booking notes in and out correctly, which made tracking the notes difficult leading to an increase in the numbers of temporary files being made up. We requested data collected after the introduction of the new IT system for numbers of temporary notes but none was provided.
- Measures had not been taken to increase compliance with notes availability; however some records, including GP and clinic letters were available electronically when paper records were unavailable. Staff told us the next role out of the new system would address some of the notes issues, however, they felt the notes traceability issue was due to poor staff training on the system.
- We were told of a situation in an outpatient's clinic where staff had problems setting up a clinic on the new system. This resulted in the clinic being double booked and increasing from 31 to 62 patients. An extra Consultant was obtained and the patients were all seen however the notes could not be ordered in time, and patients were seen without compete medical records.
- There were systems in place to record which patients required additional support in order to aid their care and treatment. We were told that at this stage of implementation the new system did not alert staff to patients who had mental health conditions, learning disabilities or dementia. If patients were known to be living with a diagnosis of dementia then a purple butterfly was attached to their records.

- Staff told us that a yellow sticker was placed on the front of notes to let clinic staff know if a patient was living with a mental health diagnosis. Staff in the trauma and orthopaedic outpatients department told us that the mental health liaison team would pre alert staff when they knew a patient living with a mental health issue would be attending clinic.

Safeguarding

- There were systems, processes and practices in place to keep people safe, and these systems and processes were communicated to staff. The trust had set a target for 90% of clinical staff to have completed safeguarding level two training for both adult and children. The trust had met this target for medical staff; however 83.9% of nursing staff had completed safeguarding level two training for children.
- There were arrangements in place to safeguard adults and children from abuse that reflected the relevant legislation and local requirements, and staff understood their responsibilities. We saw information displayed in most outpatient areas we visited, which was clear and contained contact information for patients and staff. In the outpatient departments we visited, we saw staff carrying laminated cards with flow charts detailing what to do in case a safeguarding concern for a child or adult needed to be raised. There was a clear process of how to escalate concerns and who to contact, which staff were aware of.
- Staff told us in one outpatient clinic at another site, a young person had been treated as having adult capacity when they attended alone for an appointment. We saw evidence of learning from this incident shared across the whole trust and staff we spoke to were aware of this.
- In the diagnostic imaging department, two members of staff acted as safeguarding champions, and had been trained to level three in both adult and child safeguarding. We were shown a spread sheet which the staff used to monitor the diagnostic imaging departments compliance with safeguarding training against the 90% trust target, which the department had met.
- There were processes in place to ensure the right person received the right radiological scan at the right time, however, we saw radiographers carrying out identification checks with patients from memory, as they did not have a computer in the scan room to check against, and had to leave the scan room to check the identification information given by the patient was correct. Between February 2016 and January 2017, the diagnostic imaging department notified CQC of eight incidents across all sites involving referral or patient identification errors, resulting in unnecessary scans taking place.
- We saw two radiographers checking patient identification details entered on the scanner with those entered on the radiology booking system, to ensure the correct patient had been selected on the scanner monitor; however we did not see this recorded anywhere after the verbal checks were completed.

Mandatory training

- Staff received regular mandatory training updates, and the trust had set a target for 90% of relevant staff across all sites to have competed all 12 mandatory training modules. Subjects covered included manual handling, information governance, infection control and equality and diversity awareness for all staff, with the addition of some specialist modules for medical staff which included blood transfusion and prescribing. The trust met its 90% target in three of the 12 modules for medical staffing and eight of the 12 modules for nursing staff.
- Staff received updates on health and safety training throughout the year. The health and safety department sent out briefings on a topic of the month. All staff were requested to read these updates and sign to say they had done so. A form was required to be returned to the health and safety department to officially confirm staff were updated.
- All staff were offered 'awareness' training to help them identify and respond to patients with mental health illnesses, learning disabilities, autism or dementia, and staff had training in mental health awareness included as part of their mandatory training. 96% of staff in the trauma and orthopaedic outpatients department had completed this training.
- The trust reported that at 31st October 2016 Mental Capacity Act (MCA) Awareness Act training had been completed by 100% of staff within outpatients
- Staff understood the difference between lawful and unlawful restraint practices and staff were aware how to seek authorisation for a deprivation of liberty. Deprivation of Liberty training had been completed by 94.3% of staff in the outpatient departments.

Outpatients and diagnostic imaging

Assessing and responding to patient risk

- The Radiation Protection Advisor (RPA) was easily accessible for providing radiation advice and covered all Cheltenham and Gloucester hospital sites. Staff could describe how and why they would contact them, and understood their responsibilities to report certain diagnostic imaging incidents to the Care Quality Commission (CQC) under the Ionising Radiation (Medical Exposures) Regulations 2000. These regulations help protect patients from unnecessary harm caused by over exposure to ionising radiation. Staff could give us an example of an incident that had been reported to the RPA and CQC, around the misidentification of a patient.
- The imaging services had appointed Radiation Protection Supervisors (RPS) in each clinical area. The imaging service ensured that the 'requesting' of an X-ray or other radiation diagnostic test was only made by referrers in accordance with IR(ME)R, and held lists of approved referrers for staff to check requests against. Staff told us this list was regularly reviewed and updated, and we saw the current list.
- There were adequate signs and information displayed in the diagnostic imaging department waiting area informing people about areas and rooms where radiation exposure took place. However, in nuclear medicine we saw that the room used for storing unsealed radioactive sources (such as vials of radiopharmaceuticals for injecting) was propped open and was not always occupied by a member of staff. This was raised with senior staff member who immediately closed and locked the door to prevent any accidental or unauthorised access by patients or other staff.
- The imaging service ensured that women who were or may be pregnant always informed a member of staff before they were exposed to any radiation. For example we saw radiographers using the 28 day rule to confirm pregnancy before examinations were carried out (if a patient is unsure if they are pregnant and their last menstrual period is overdue, the radiographer or radiologist may consider postponing the examination until pregnancy can be confirmed or ruled out). This was in line with Royal College of Radiologists (RCR) best practice guidance, however we did not see any signs displayed in waiting areas or changing cubicles telling patients to inform staff if they were or could be pregnant, which meant patients may not have told staff they may have been pregnant before their x-ray examination.
- There were local policies for the risk assessment and prevention of contrast induced nephropathy, and staff were aware of these policies. Staff told us clear written information was given to patients about hydration before and after contrast examinations which we saw. These policies were in keeping with National Institute for Health and Care Excellence (NICE) guidelines and the RCR standards for intravascular contrast agent administration.
- There were not clear pathways and processes for the assessment of people within all outpatient clinics and diagnostic imaging departments who were clinically unwell and required hospital admission. Staff could describe how to summon help by dialling 2222, however, some staff were unsure of their responsibilities in a resuscitation situation, and one member of staff said they would not attempt resuscitation until the crash team arrived to take charge of the situation. All staff in diagnostic imaging had undertaken basic life support (BLS) training, but had not been trained in the use of the automatic defibrillators which were found on most resuscitation trolleys in the outpatient and diagnostic imaging departments.
- In the trauma and orthopaedic department, staff told us the digital dictation system had crashed, losing many clinic letters. Staff said an investigation had shown the cause was IT failure, however an unknown number of letters had been lost, and they did not know which patients had been affected until they attended for their follow up appointments. Staff told us each patient identified was reported as an incident via the trusts electronic reporting system. However; staff were unaware if the issue was on the directorate risk register.
- Most staff demonstrated understanding of consent and decision making requirements of legislation and guidance, including the Mental Capacity Act 2005 and the Children Acts 1989 and 2004. The process for seeking consent was monitored by an audit programme which showed 82% of notes audited had documented evidence of consent.
- Patients were adequately supported to make decisions, and a patients' mental capacity to consent to care or treatment was assessed during clinic appointments and this assessment was recorded in the patient's notes.

When patients lacked the mental capacity to make a decision, staff made 'best interests' decisions and were aware how to do this in line with legislation. For example, staff we spoke with in the pain management service knew how to access on site liaison psychiatry if they were concerned about risks associated with a patient's mental health.

- There were appropriate risk assessments in place for those who needed them on account of issues relating to their mental health, learning disabilities, autism or dementia diagnoses and staff were aware of them, however we saw an out of date mental health risk assessment form in the trauma and orthopaedic outpatient department that had not been updated since 2014.

Nursing staffing

- Staffing levels and skill mix were planned and reviewed so that people were protected from harm. At Gloucester Royal Hospital, the outpatient department was staffed by 17.9 (53%) unqualified staff, and 15.7(47%) qualified staff, which was better than the trust's target staffing ratio.
- Staff worked across all areas of the outpatient department, and covered additional hours through the hospital bank staff system. We saw that no agency staff were used on the rotas we reviewed.
- Across both hospital sites, the outpatient departments had a sickness level of 4.9% in September 2016, which was above the trust target of 3%, however some departments were meeting this target, such as the ENT department at Gloucester Royal Hospital where between January 2016 and December 2016 the department had an average sickness rate of 3%.
- The highest level of sickness across both hospital sites was in the orthodontics departments which was 8.2%.

Allied healthcare professional staffing

- Staffing levels and skill mix were planned and reviewed, however actual staffing levels were often less than planned staffing. Staffing levels for the department showed between 40 to 41 planned qualified staff (radiographers) and six planned non-qualified (radiography assistants) on a week day and 18 qualified and four non-qualified on a weekend. Actual staffing levels for the department showed the planned staffing was frequently not met by between one to six staff for qualified staff, and one to two for non-qualified staff. One week day showed there were 27 qualified staff against a planned establishment of 41 staff. Another weekend day showed a shortfall of five staff against a planned establishment of 18 qualified staff. Staff told us some weekend shifts were understaffed and had led to increased waits for non-urgent patients.
- At the time of our inspection, the diagnostic imaging department across both sites, had seven band 5 radiographer vacancies, and seven band 6 radiographer vacancies, and staff said some shifts were often down a member of staff. Managers told us of an on-going recruitment plan to engage with universities to encourage newly qualified staff to apply to the hospital to help fill the band 5 positions.
- Data supplied for both hospital sites showed diagnostic imaging had a sickness rate of 3.6% in September 2016, which was above the trust target of 3%, and a staff turnover rate of 1.7%.

Medical staffing

- The diagnostic imaging department currently had 5.5 whole time equivalent vacancies for radiologists, with an advert currently live. Staff told us radiographers had been used to help clear the reporting backlog, as the existing radiologists did not have capacity to clear it, and meet current reporting targets.
- In cardiology, we were told a consultant had recently left due to health problems, and had not been replaced which was contributing to capacity and flow problems in the service.
- Currently, there were four full time cardiology consultants and one locum consultant based at Gloucester Royal Hospital, however, the locum was due to finish in March 2017, and staff were unaware of any plans to extend their contract.

Major incident awareness and training

- Potential risks such as seasonal fluctuations in demand, the impact of adverse weather, or disruption to staffing were taken into account when planning services. We saw an up to date business continuity plan which covered adverse weather arrangements for staff to follow to ensure essential treatment could still be carried out.
- There were reliable arrangements in place to respond to emergencies and major incidents. For example the trauma and orthopaedic outpatient department had a major incident plan in place and told us which patients

would be evacuated in case of an emergency situation, a list of all staff to be called and a lock down policy. It was not possible to lock down the whole of the department but certain areas were lockable from the inside. We visited the pain management and psychology department and were shown a room which could be locked down in case of an incident.

- There were effective arrangements in place in case of a radiation or radioactive incident occurring and staff could explain how they would contain a spillage of a radiopharmaceutical, and knew who to contact and how to report the incident.

Are outpatient and diagnostic imaging services responsive?

Requires improvement

We rated responsive as requires improvement because:

- The hospital was not meeting the 62 day target for cancer patients.
- The diagnostic imaging department had a reporting backlog of 19,500 films and was not meeting its five day reporting target for accident and emergency x-rays.
- A significant typing backlog was causing delays in sending out patient letters impacting on patient safety.
- Implementation of new IT systems had impacted on waiting lists as some specialties could not see live waiting lists.
- The trust was not meeting referral to treatment target in all specialities.

However;

- Rapid access assessment clinics were provided in some specialities, and some clinics were performing airway assessments via Skype.
- The hospital had introduced a new waiting list validation process to discharge patients on-going follow up care to community based services such as GPs.
- A project placing therapists on wards had helped increased patient discharges, and radiographers attended ward briefings to identify inpatients waiting for scans.

Service planning and delivery to meet the needs of local people

- Information about the needs of the local population was used to inform how services were planned and delivered. Commissioners and local GPs had been involved in developing a process for reviewing all pending and follow up patients. In June 2016, local GPs had begun to identify patients who were currently under the care of the hospital, who could be discharged back to community services such as community hospitals and GP surgeries for their on-going care and follow up. This had begun to free up more capacity in the hospital clinics to accept new patients.
- Where patient's needs were not being met, this was identified and used to inform the planning and development of services. For example, it had been identified that some services were not planned in a way which met people's needs, and some patients were remaining on follow up lists for too long after their treatment. This in turn was preventing the services from seeing new patients. For example, in dermatology following the removal of some non-cancerous skin lesions, some patients were returning to the hospital for wound checks. Staff had identified this group of patients as being suitable to have wound checks carried out in GP surgeries, and were working to develop a care plan for GPs to follow when patients were discharged from the dermatology service.
- Services were planned and delivered to take account of the needs of different people. For example staff told us of a consultation which was on-going to engage patients in the planning of future cardiology services. Patients were invited to share their views through online surveys or to share their stories by email.
- The therapies department had increased the numbers of occupational therapists and physiotherapists on wards over a five day period at Christmas. The teams had reported they had been able to discharge between two to three additional patients each day as a result, although no formal collation of this data had taken place at the time of our inspection.
- The services tried to provide choice and continuity of care, and several patients told us they had used the 'choose and book system' to book their clinic appointment, which offered a selection of appointments for them to choose from. One patient told us that where changes had been made to the clinic, in particular the doctor they were seeing, this had been communicated to them in a letter keeping them informed.

- Some clinics in thoracic medicine used online video calls as an alternative to face to face appointments. Patients attended for blood tests at the hospital and received an airway assessment from an anaesthetist based in another large hospital in Bristol, which meant patients did not have to travel to see the doctor in person.
- The environment of the outpatient clinics and diagnostic imaging department was not always appropriate and patient centred. For example we saw changing cubicles in waiting areas, and saw patients sat in waiting areas in hospital gowns compromising their privacy and dignity.
- The facilities for children in waiting rooms were not always adequate. For example in the ophthalmology department children and adults waited in the same areas, and there was a small section of children books, but no toys.
- Patients were able to locate the outpatient and diagnostic imaging departments because they were clearly signposted within the hospital and there were volunteers available to help. However, in ophthalmology we saw the signage was not adapted for visually impaired patients, and one patient told us it was difficult to read.
- Patients told us information was provided to them before their appointments, which included a hospital map and directions, their consultant's name and parking and travel information.
- There were no dedicated quiet areas where patients could wait without being forgotten if they found busy environments distressing. Staff told us in the dermatology and trauma and orthopaedic outpatient clinics, if the main waiting rooms were too stressful an environment they would access empty clinic rooms to accommodate patients with mental health conditions, learning disabilities, autism or dementia. Receptionists left a note on the patient's records to say where they were waiting.

Access and flow

- Care and treatment was prioritised for people with the most urgent needs, and rapid access outpatient clinics were available each day for patients who required chest pain assessment, urgent ophthalmology assessment, ear nose and throat (ENT) appointments or access to trauma and orthopaedic clinics. A telephone triage system in ophthalmology helped staff identify patients who needed to attend accident and emergency.
- Between April 2015 and March 2016, the follow-up to new rate for Gloucestershire Royal Hospital was lower than the England average. This meant the trust was seeing more new patients when compared with the rest of the hospitals across England.
- Between November 2015 and October 2016 the trust's referral to treatment time (RTT) for non-admitted pathways has been worse than the England overall performance. The latest figures for October 2016 showed 82.5% of this group of patients were treated within 18 weeks versus the England average of 89.4%. Whilst the trust was following the national trend of decline in this measure, it was declining at a faster rate than the England average. However, of out of the 16 specialties reported, six were meeting the RTT. These included ophthalmology, trauma and orthopaedics, general medicine, general surgery and gastroenterology.
- Between November 2015 and October 2016 the trust referral to treatment time (RTT) for incomplete pathways has been overall better than the England overall performance but worse than the operational standard of 92%. The latest figures for October 2016 showed 89.9% of this group of patients were treated within 18 weeks versus the England average of 90.1%. The trust's performance had followed the England average until May 2016 when performance started to decline over time. However, despite this decline the trust's performance was better than the England average in September and October 2016. Of the 17 specialities reported, 11 were meeting or exceeding the RTT. These included, ophthalmology, dermatology, gastroenterology, trauma and orthopaedics and general surgery. For specialties not meeting their RTT targets, recovery plans were drawn up which included speciality specific measures to improve their performance. In oral surgery outpatients, 983 patients waited over 18 weeks for treatment. The trust identified the shortfall in capacity, and had recruited a speciality doctor and an additional consultant to provide the additional capacity needed.
- The waiting times for patients needing cancer treatment were described in relation to the 'cancer wait' targets set by NHS England. The trust was performing worse than the 93% operational standard for people being seen

within two weeks of an urgent GP referral between October 2015 and September 2016. However, since April 2016, this had begun to improve, and during our inspection, we saw data which showed the trust had met the 93% target in October and November 2016, but had declined slightly in December to 92.5%. The overall situation had improved since our last inspection.

- Between October 2015 and September 2016 the trust was consistently performing better than the 96% operational standard for patients waiting less than 31 days before receiving their first treatment following a diagnosis (decision to treat). However, the trust was performing worse than the 85% operational standard for patients receiving their first treatment within 62 days of an urgent GP referral. This was similar to what was found on the previous inspection.
- Between November 2015 and October 2016 the percentage of patients waiting more than six weeks for their test or scan was higher than the England average for five of the twelve months.
- The diagnostic imaging department across all sites, had a reporting backlog of 19,500 plain films, which it was working to reduce, and provided weekly updates to the board. We were told the department had employed a number of reporting radiographers to reduce the backlog, which had been over 40,000 films in September 2016. The department had prioritised outstanding CT and MRI scans, which had allowed the plain film backlog to rise. At the time of our inspection there were 250 CT scans outstanding, and 270 MRI scans.
- Clinicians in the diagnostic imaging department reminded referrers of their responsibilities for reviewing and documenting findings from X-rays they requested, which insured no images were going un-reviewed by a clinician. The clinical lead for diagnostic imaging had a proposal to clear all of the outstanding reporting, which required funding approval from the board. If this was unsuccessful, the department was planning to audit patient notes to assess if referrers were documenting their findings, which is a requirement of IR(ME)R 2000 and an extra assurance of patient safety.
- The diagnostic imaging department had set a target for all examinations to be reported within five days. Data submitted for October 2016 showed that 87.2% of examinations were reported within five days and 12.8% over five days. Accident and emergency examinations had a three day target for report turnaround, which the department was meeting for CT, MRI, Nuclear medicine, ultrasound and fluoroscopy examinations, however, 57.8% of plain film X-rays were waiting over five days for a report, which meant patients were waiting longer to get their official report, which may impact on their on-going treatment.
- Action was taken to minimise the time people have to wait for treatment or care. For example in diagnostic imaging in October 2016, 53% of outpatients attended for their examinations within two weeks of a referral being accepted, and radiologists worked to verify reports within 24 hours to minimise delays in sending out results. In October 2016, 98.2% of were verified within 24 hours.
- The diagnostic imagining department was sending radiographers onto the wards to attend morning briefings to help identify patients who were waiting for scans. In order to accommodate more inpatient and emergency scans at Gloucester Royal Hospital, routine patients were being sent appointments to have their scans at Cheltenham General Hospital, and staff told us most patients were happy to do this once it was explained why.
- The cardiology department had a typing backlog of 1114 letters in December 2016. Staff told us medical secretaries were spending an increasing amount of their time speaking with patients and GPs over the phone, who were chasing clinic letters which was in turn affecting their ability to work through the typing backlog. Senior staff told us they had been given authority to outsource some typing in December 2016, but this had not yet happened. Senior staff had escalated the lack of action to the executive board the week before the CQC inspection. The executive board reaffirmed the outsourcing should take place as soon as possible, and senior staff were waiting for this to be completed by managers. Data submitted since our inspection showed the trust was planning to outsource reporting from February 2017, and had made a contingency available to each specialty to use the outsourcing company in future to maintain their typing backlogs.
- Bookings for most outpatient clinics were made through the offsite central bookings office, with the exception of some specialist clinics which were booked by the consultants. The trust had recently introduced a new computer system to oversee all aspects of patient care including bookings. Staff told us the system had left

them unable to view some waiting lists, and staff were using data from the end of November to book appointments. Senior staff told us the next role out of the system would rectify some of these issues.

- Care and treatment was only cancelled or delayed when absolutely necessary. Between June 2016 and September 2016, the trust cancelled between 3 - 3.2% of all outpatient appointments across all sites with less than six weeks' notice, and between 4.9 – 6.4% of clinics with over six weeks' notice. The most frequent reasons for these cancellations were clinicians' annual leave and the junior doctor strike.
- Patients told us that cancellations were explained to them, and they were supported to access care and treatment again as soon as possible. For example, one patient told us they had received a phone call about a cancelled appointment, but the member of staff had made sure the patient had a new appointment at a time to suit them, before they had finished the call.
- Patients told us that the waiting times for appointments were always communicated, and this was echoed on the trust website in its information about the outpatient department.
- We saw that some clinics usually ran on time. During our inspection we saw staff kept patients informed during clinic sessions using whiteboards where they recorded the individual delays for each clinic. We saw how staff in the outpatient departments apologised to patients when their appointments were delayed.
- The diagnostic imaging department recorded the time that patients were kept waiting once they arrived in the department. Data collected between May 2016 and October 2016 indicated that patients for plain film imaging were being seen on average within six to eight minutes of booking into the department. Patients for Computed tomography waited on average between 48-50 minutes and nuclear medicine patients between 76-110 minutes, however, this was due to the complexity of the scans which often required patients to wait for a set period of time prior to their scan.
- The trust did not record the time that patients were kept waiting if they required an additional appointment for example diagnostic or imaging, and reported that data recorded to try and capture this had been unreliable.
- The outpatient service rates of non-attendance for appointments were below the England average for Gloucestershire Royal Hospital between April 2015 and March 2016. Action had been taken to reduce this rate, such as using text messages to remind patients of their upcoming appointments.

Meeting people's individual needs

- The trust ensured appropriate support was available for bariatric patients. For example in the diagnostic imaging department, equipment had been purchased with bariatric patients in mind. Several CT and MRI scanners had wider bores and larger weight limits on tables, which meant services could be readily accessed by this group of patients.
- The outpatient departments did not arrange appointments so new patients were given time to ask questions and staff told us this was often the reason clinics fell behind, however, the trust did not collect ant data to support this.
- In the main reception for outpatient clinics and the trauma and orthopaedic outpatients department, patients were not always able to speak to the receptionist without being overheard.
- Support for people with learning disabilities was available. For example we saw leaflets and signs for staff and patients which contained details of the learning disabilities liaison nurse team, and staff we spoke with were aware of this team, and knew how to contact them for advice.
- Staff also told us they advised patients and their relatives who had learning disabilities or were living with dementia to attend the clinic ahead of their appointment time, and when patients did this, they attempted to slot them into lists early.
- Translation services were always readily available if required. Staff told us that the booking office would pre book translators, if an occasion arose that a translator was not pre booked then a telephone translation service was used.
- Staff told us about occasions when reasonable adjustments were made so that people with a disability could access and use the outpatient and diagnostic services. For example, staff in the dermatology outpatient clinic told us that they had used stories in the form of a picture book to explain what happened in a hospital clinic.
- Hearing loops were installed in clinic reception areas and the main outpatient reception waiting area to assist patients with hearing loss.

Outpatients and diagnostic imaging

Learning from complaints and concerns

- Patients knew how to make a complaint or raise concerns and told us they felt confident to speak up about concerns if necessary. We saw leaflets displayed in most clinical areas about the complaints process and these were available in different languages and easy read formats.
- Patients who we spoke with said they would be happy to raise a complaint, but none had felt the need to do so.
- Between November 2015 and October 2016 there were 390 complaints about the outpatient departments across all sites. The trust took an average of 36 working days to investigate and close complaints, which was not in line with their complaints policy, which stated 95% of cases should be responded to within 35 working days.
- Across all sites the most complained about areas were appointments with 99 (25.3%) complaints, and clinical treatment with 77 (19.7%) complaints.
- Gloucestershire Royal Hospital received 249 complaints between November 2015 and October 2016 about the outpatient departments. The most complained about area was appointments, which accounted for 66 complaints (27%) of all complaints received.

Outstanding practice and areas for improvement

Outstanding practice

- The diagnostic imaging department sent radiographers onto wards to liaise with staff to identify inpatients who were waiting for scans, in order to help speed up treatment and ultimately discharge.
- The therapies department had placed occupational therapists and physiotherapists on wards over Christmas to support and speed up patient discharges during a period of high pressure.
- The inpatient specialist palliative care team had won an annual staff award the trust - patient's choice award 2016. This was from patients and others who recognised the NHS staff who had made a difference to their lives.
- The consultant in the specialist palliative care team was part of a multi-disciplinary team who had won the national Linda McEnhill award 2016. The award was recognition by the Palliative Care of People with Learning Disabilities professional network of excellence in end of life care for individuals with learning disabilities. Work included improving how different teams worked better together.
- The development of a training package for midwives to enable them to administer flu vaccinations to at risk women had meant that a high number of women who would otherwise have not had the flu vaccine had received it.

Areas for improvement

Action the hospital MUST take to improve

- Review processes to monitor the acuity of patients to ensure safe staffing levels.
- Ensure wards are compliant with legislation regarding the Control of Substances Hazardous to Health (COSSH).
- Review processes for ensuring effective cleaning of ward areas and equipment and patient waiting areas.
- Review the governance and effectiveness of care and treatment through national audits.
- Ensure patient records are kept securely at all times.
- Ensure equipment is replaced to ensure safe diagnosis and treatment.
- Ensure the medical day unit is suitable for the delivery of care and protects patients dingy and confidentiality.
- Ensure all staff are trained and understand their responsibilities in a resuscitation situation.
- Ensure resuscitation equipment is readily available and accessible to staff.
- Ensure steps are taken to reduce the current typing backlog in some specialities.
- Ensure specialities have oversight of all of their waiting lists.
- Ensure that all information related to patients' mental capacity and consent for 'Do Not Attempt Cardio-Pulmonary Resuscitation' (DNA CPR) is available in patient records.
- Ensure trust staff comply with all the requirements of the Mental Capacity Act (2005).
- Ensure the emergency department is consistently staffed to planned levels to deliver safe, effective and responsive care.
- Review support staff functions to ensure the emergency department is adequately supported.
- Ensure all staff are up-to-date with mandatory training.
- Ensure patients arriving in the emergency department receive a prompt face-to-face assessment by a suitably qualified clinician.
- Improve record keeping so that patients' records provide a contemporaneous account of assessment, care and treatment.
- Ensure patients in the emergency department receive prompt and regular observations and that early warning scores are calculated, recorded and acted upon.
- Ensure the mental health assessment room in the emergency department meets safety standards recommended by the Royal College of Psychiatrists.
- When using Kemerton and Chedowrth Suite for inpatients, provision must be made for the cleaning of the units at weekends and to provide patients with clean water jugs and drinks.

Outstanding practice and areas for improvement

- Ensure emergency resuscitation trolleys are checked and have guidelines attached according to best practice guidance and in line with trust policy.
- Ensure the safe management of medicines at all times, including storage, use and disposal and the checking and signed for controlled drugs. Ensure all drug storage refrigerator temperatures are checked and the results recorded daily. Additionally if the temperatures fall outside of the accepted range action is taken and that action recorded.
- Ensure patient group directives are up to date and consistent in their information.
- Ensure women attending the triage unit within the maternity service are seen within 15 minutes of arrival.

Action the hospital SHOULD take to improve

- The medical service should collect information about mortality and morbidity (M&M) meetings electronically across all services to ensure an audit trail is maintained and outputs governed.
- Ensure all staff are compliant with efficient decontamination of hands on entering wards.
- Ensure emergency equipment (including resuscitation trolleys) is checked daily in line with trust policy and national guidance.
- Review processes to recognise and respond to blank boxes on prescription charts to make sure patients receive medicines as prescribed.
- Review the process to assess risks to patients and ensure a management plan is in place.
- Review process to comply with VTE assessment in line with trust policy and national guidelines.
- Ensure treatment pathways are reviewed and update to ensure best evidence-based treatment.
- Ensure all staff receive yearly appraisals in line with trust policy.
- Review process to ensure patients are reviewed by a consultant within 14 hours of admission in line with the London Quality Standards (2013).
- Review processes to ensure compliance with the accessible information standards.
- Ensure areas used to admit patients in times of high organisational pressures are suitable and staffed to ensure safe care and treatment of patients.
- Ensure effective monitoring of clinical improvement and audits, including compliance with accurate and timely NEWS assessments.
- Ensure timely response to complaints in line with trust policy.
- Ensure an up to date list of all practitioners under IR(ME)R is maintained.
- Ensure there are sufficient numbers of staff with appropriate skills and experience on each shift in diagnostic imaging.
- Ensure identification procedures in diagnostic imaging are robust and recorded.
- Ensure all staff are up to date with mandatory training.
- Ensure all patient's referral to treatment times do not exceed national targets including cancer wait targets.
- Ensure steps are taken to reduce the current reporting backlog.
- Ensure diagnostic imaging examinations are reported within target for the accident and emergency department.
- Ensure steps are taken to monitor and reduce the numbers of temporary notes in use.
- Ensure all hazardous chemicals and cleaning products are securely stored.
- Review facilities for staff to take breaks and make drinks away from clinical areas
- Ensure staff can effectively trace patient records through the hospital.
- Ensure disabled toilets have sufficient alarm systems.
- Ensure all risk identified relating to the provision of end of life care is included on a risk register.
- Ensure the training needs analysis for general staff on wards related to end of life care is completed by the trust end of life care strategic group
- Consider involving specialist palliative care team and support teams in major incident plan practices or exercises.
- Review the signage and consider if the system of using 'white rose' symbols to assist location of trust mortuaries is effective
- Consider the availability of family rooms associated with wards for overnight accommodation for those close to patients at end of life.
- Ensure staff in specialist palliative care team are able to use the results of the safety thermometer information in relation to patients receiving end of life care.

Outstanding practice and areas for improvement

- Continue to work in collaboration with partners and stakeholders in its catchment area to improve patient flow within the whole system, thereby taking pressure off the emergency department, reducing crowding and the length of time patients spend in the department.
- Ensure the emergency department is supported by the wider hospital and that there is more engagement from specialties in addressing the risks associated with patient flow.
- Ensure the workload pressures and impact on staff wellbeing, associated with crowding in the emergency department, are understood, identified on the risk register and that staff are supported as appropriate.
- Ensure all staff within the specialities is aware of Never Events and the learning needed to prevent a reoccurrence.
- Continue to make improvements with the reduction of surgical site infection rates.
- Review the pre admission clinic area for comfort and suitability
- Provide resuscitation equipment for the pre admission unit to ensure if a patient collapsed, they receive the correct care in a timely manner.
- Review the equipment in the pre-admission unit to ensure it meets the needs of the service.
- Patient group directions (PGDs) should be reviewed as they were out of date and the correct authorisation signatures should be included.
- Continue to work on your action plan to address the shortfalls identified in the mortality outliers.
- Review the lack of 24-hour emergency theatre to ensure no patients will be put at risk.
- Continue to address issues resulting from the new computer system.
- Improve the number of staff appraisals completed.
- Reduce the number of patients who have their operation cancelled on the day of surgery, and reduce the number of patients not rebooked within 28 days.
- Ensure emergency trolleys on the neonatal and children's units have a system that easily highlights if an emergency trolley has been tampered with between routine checks.
- Support all children's services to contribute to infection prevention and control audits so that risk can be accurately assessed.
- Consider options of protecting children's safety when waiting for appointments in parts of the hospital that are not dedicated to paediatrics.
- Continue with strategies to maintain staffing levels that meet national guidelines.
- The trust should ensure electronic systems in place, especially for community midwives, enable them to input data in a timely way. Additionally they should have mobile phones with better connectivity to ensure they receive their messages in a timely way.
- The trust should ensure that all inpatient venous thromboembolism (VTE) risk assessments are completed.
- The trust should ensure that senior house officer equivalent doctors attended PROPMT skills and drills training.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 regulation 15 Premises and equipment 15 – (1) (a) All premises and equipment used by the service provider must be clean. The fabric of the building did not always ensure efficient cleaning could be carried out. The premises used for the delivery of services in ophthalmology outpatients were visibly unclean, with dirty fans in use in clinical procedure rooms. Staff did not always comply with legislation regarding the Control of Substances Hazardous to Health (COSHH). When Kemerton and Chedworth Suite were opened at weekends, there was no provision for cleaning of the unit 15 – (1) (c) All premises and equipment used by the service provider must be suitable for the purpose for which they are used The medical day unit comprised of mixed sex bays were cramped. Patients had very little space between chairs, several patients had visitors with them and this made the bay even more cramped and did not ensure patient's dignity or confidentiality

This section is primarily information for the provider

Requirement notices

The mental health assessment room did not comply with safety standards recommended by the Royal College of Psychiatrists

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance 17 (2) (a) There must be systems and process in place to monitor and improve the quality of and safety of services. The processes and systems used to monitor and process the number of outstanding clinic letters were not effective, and several specialities had significant backlogs of typing. There was no oversight of competency for the use of syringe drivers. The medical service did not consistently participate in and review the effectiveness of care and treatment through participation in national audits. 17 (2) (b) Assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity; The processes and systems in place to identify and assess risks to the health and safety of people who used the services were not effective. The lack of oversight of the backlog of pending and follow up waiting lists placed patients at risk of harm due to increased delays in treatment and assessment.

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
	17 (2) (c) maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided; People who used the services were not protected from the risk associated with unauthorised access to confidential patient records. Patient records were not securely kept at all times. Documentation relating to patients' mental capacity and consent was not always complete or immediately obvious in 'do not attempt cardio-pulmonary resuscitation' (DNA CPR) records.
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment 12 (2) (a) assessing the risks to the health and safety of service users of receiving the care or treatment: There were some concerns regarding the transfer of patients receiving intravenous therapy during the transfer. These transfers required a nurse escort for the transfer and if this could not be arranged, we were told the intravenous therapy would be discontinued for the duration of the transfer 12 (2) (c) ensuring that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely; The systems and processes in place to protect patients from harm in emergency situations were not effective. Staff were unsure of their responsibilities in a

Requirement notices

resuscitation situation and did not feel sufficiently trained or confident to undertake immediate emergency care, and resuscitation equipment was not readily available, or easily located in all clinical departments.

Not all staff were up to date with mandatory training.

Risks to patients were not always mitigated because staff did not follow plans and pathways. Patient observations were not consistently undertaken with the required frequency in the emergency department to ensure that any deterioration in a patient's condition was identified. Risk assessments in respect of skin integrity and nutrition and hydration were not consistently undertaken.

Patients arriving in the emergency department did not always receive prompt, face to face initial assessment by a clinician.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent (1) Care and treatment of service users must only be provided with the consent of the relevant person. (3) If the service user is 16 or over and is unable to give such consent because they lack capacity to do so, the registered person must act in accordance with the 2005 Act*. Explanations for the reason for the decision to withhold resuscitation attempts were not consistently clear.

This section is primarily information for the provider

Requirement notices

Records of resuscitation discussions with patients and their next of kin or of why decisions to withhold resuscitation attempts were not discussed or were not documented.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing (1) Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this part. (2) Persons employed by the service provider in the provision of a regulated activity must— (a) receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform, (c) where such persons are health care professionals, social workers or other professionals registered with a health care or social care regulator, be enabled to provide evidence to the regulator in question demonstrating, where it is possible to do so, that they continue to meet the professional standards which are a condition of their ability to practise or a requirement of their role. There were not always sufficient numbers of suitably qualified, skilled and experienced nursing staff in the emergency department. There were insufficient numbers of senior medical staff employed at night in the emergency department to ensure patients received timely diagnosis and treatment.

This section is primarily information for the provider

Requirement notices

Support staffing in the emergency department was inadequate, which meant clinical staff were frequently required to undertake administrative, cleaning and portering tasks.