Somerset Partnership NHS Foundation Trust

RH5

Urgent care services

Quality Report

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Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RH5F8	West Mendip Community Hospital		
RH5F7	Shepton Mallet Community Hospital		
RH5Y4	Minehead Community Hospital		
RH5G5	Frome Community hospital		
RH5X3	Chard Community Hospital		
RH5X2	Burnham on Sea War Memorial Hospital		
RH5X1	Bridgwater Community Hospital		

This report describes our judgement of the quality of care provided within this core service by Somerset Partnership NHS Foundation Trust. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by Somerset Partnership NHS Foundation Trust and these are brought together to inform our overall judgement of Somerset Partnership NHS Foundation Trust

Summary of findings

Ratings

Overall rating for the service	Requires improvement
Are services safe?	Requires improvement
Are services effective?	Requires improvement
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Requires improvement

Summary of findings

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Summary of findings

Overall summary

Overall rating for this core service Requires improvement l

Overall the minor injury unit services require improvement.

The service did not manage risk effectively. Staff did not properly identify, record or take action to reduce risks. Staff recorded some risks in local registers but did not always record them promptly or clearly. Some significant risks relating to the minor injury units were not recorded. These significant risks included engagement with system wide major incident or accident scenarios, staff stress levels caused by feeling that they could take breaks only by keeping patients waiting, staff working alone without carrying personal alarms in line with trust policy and not providing management and clinical supervision in line with trust policy.

Quality and performance were measured and understood by service and trust leaders through audits, commissioning for quality and innovation targets and performance figures. A broad selection of local audits was completed in relation to minor injury units, although the analysis and conclusions drawn were minimal in the records audit where the quality of patient records was mixed. Risks to patients' health were managed through an emergency nurse prescriber's assessment on arrival. However, not all patients received an assessment or triage within 15 minutes of arrival.

Many patients left the minor injury units having been assessed and treated without the need for referral elsewhere. The trust consistently discharged, admitted or transferred over 99 percent of patients within four hours of their arrival at a minor injury unit, exceeding the 95% national standard.

There were enough staff to provide a safe service for patients, although patient numbers and the increasing level of illness for some patients had been noted which had resulted in an impact on staff break times, finishing times and increasing numbers of patients seen by individual staff.

Staff understood their responsibility to raise concerns. However, the lessons learned from incidents were not clear. Medicines were kept safely although drugs used in resuscitation were not all kept in tamper evident containers.

The environment was clean and tidy and minor injury units scored highly in a recent infection control audit. However, we were not assured that the maintenance of the equipment used was up to date.

We saw staff gaining consent to care and treatment, although evidence to show that patients' needs were assessed and care and treatment were delivered in line with legislation, standards and evidence-based guidance was sometimes incomplete in patients' records. A recent audit identified that patients received timely pain relief although not all patients had the relevant information recorded about pain assessment.

Staff had and continued to develop the skills, knowledge and experience necessary to deliver effective care and treatment for minor injuries. However, assessment and treatment of minor illnesses was an area in which some staff felt they needed more training because of the number of patients who were presenting with a greater acuity. The trust had training programmes in place to support this.

The service worked with other providers to support patients' minor injuries and illnesses. Pathways to more urgent and emergency care were also followed. Staff, teams and services worked together to deliver care and treatment and staff had the information needed to deliver effective care and treatment to patients who use services from their electronic records system.

Staff treated patients and other people with kindness, dignity, respect and compassion while they waited for and received care and treatment. Patients were given appropriate and timely support to cope emotionally with their care, treatment and conditions, and such support was offered equally across all patient age ranges. Staff showed an encouraging, sensitive and supportive attitude to patients who used services and those close to them.

Summary of findings

Governance responsibilities for the minor injury units were through board representation via the chief operating officer. The service was then managed by a divisional lead who worked with the service manager and, the nurse consultant. The emergency nurse practitioner leads supported teams of emergency nurse practitioners and other members of the team. Emergency nurse practitioners did not receive scheduled one to one supervision. There were other methods of support available. The overall culture of the minor injury unit service was one of openness and transparency. This culture promoted good quality care and in general patients were satisfied people with the service provided. Members of the public were engaged through the friends and family test and while there were some complaints the feedback was over whelmingly positive.

Summary of findings

Background to the service

Information about the service

The minor injury units in Somerset Partnership NHS Foundation Trust are located at seven community hospitals across Somerset. The sites are Frome, Glastonbury (also known as West Mendip), Shepton Mallet, Chard, Bridgwater, Minehead and Burnham on Sea. The minor injury units are run by a service manager, clinically led by a nurse consultant and staffed by emergency nurse practitioners, nurse, healthcare assistants and receptionists. Emergency nurse practitioners are senior registered nurses specialising in advanced emergency and urgent care. They have extensive post-registration education and clinical experience and are registered as independent prescribers. X-ray services, including radiographers, were provided by from Taunton and Somerset NHS Foundation Trust, with the exception of the services at Shepton Mallet and Frome. Shepton Mallet had services provided by the Shepton Mallet NHS Treatment Centre and Frome Community Hospital had services provided by Royal United Hospitals Bath NHS Foundation Trust.

Somerset Partnership NHS Foundation Trust minor injury units provided urgent unplanned patient care for all non-life threatening clinical conditions. They treated and provided care for the majority of patients and then discharged them home. They also referred the remaining patients (2.6%) to other services for other care as needed, for example orthopaedic clinics, general practitioners or acute services. Minor injury unit staff aimed to stitch cuts, remove foreign bodies from ears and noses, remove splinters, dress minor wounds, cuts and grazes, apply plaster casts, provide screening and treatment for Chlamydia and treat sprains and strains, minor broken bones, minor burns and scalds, minor head injuries, insect and animal bites, minor eye injuries and other minor injuries. They also assessed and treated minor illnesses such as sore throats.

Between 1 August 2014 and 31 July 2015 Somerset Partnership NHS Foundation Trust minor injury units saw 107,520 patients. 97.6% of patients were assessed, treated and discharged without the need for referral elsewhere. This was an increase of approximately 10,000 patients seen in a year since 2012.

Somerset Partnership NHS Foundation Trust was created on 1 May 2008. On 1 August 2011 the trust acquired Somerset Community Health and is now the principal provider of community health, mental health and learning disabilities services in Somerset. The trust employs more than 4,000 staff.

The regulated activities we inspected were:

- Diagnostic and screening procedures
- Nursing care
- Treatment of disease, disorder or injury

As part of this inspection the five members of the inspection team inspected all seven minor injury units.

The inspection team spoke with 22 patients (20 adults and two children), two relatives and three carers who used the service. We also spoke with a range of staff including 20 emergency nurse practitioners, one lead , emergency nurse practitioner, a nurse consultant and service manager, nurses and health care assistants. We also spoke with six receptionists providing the service at the locations. We observed approximately 24 staff interactions and episodes of care with 22 patients. We met with seven people who were carers or relatives. We also reviewed care or treatment records of 27 people who used services.

Our inspection team

Our inspection team was led by:

Chair: Kevan Taylor, Chief Executive Sheffield Health and Social Care NHS Foundation Trust

Team Leader: Karen Bennett-Wilson, Head of Hospital Inspection, Care Quality Commission

Summary of findings

The team included CQC inspectors and a variety of specialists: Two registered nurses, one an emergency nurse practitioner and a registered physiotherapist.

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Why we carried out this inspection

We inspected this core service as part of our comprehensive community health services inspection programme.

How we carried out this inspection

To get to the heart of people who use services' experience of care, we always ask the following five questions of every service and provider:

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

We reviewed a range of information that we hold about the core service prior to the inspection. We also asked other organisations to share what they knew. We carried out an announced visit to seven locations as two teams between and including 7, 8, 9 and 10 September 2015. During the visit we interviewed staff and observed care being delivered.

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What people who use the provider say

We spoke with several patients and carers and received overwhelmingly positive comments. For example:

In Shepton Mallet a patient said, "…I was helped after falling", "…everything is good…" (the service), "…the nurse makes things quicker…", "after a fall it is easier to come straight [here] than to the GP…", and "….finding out no injury is reassuring…" When asked about making a complaint, the same patient said, "I've never needed to."

In Chard a carer of a patient said, "it's a very good unit."

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider MUST take to improve:

- Strengthen governance arrangements to ensure that maintenance logs for equipment used on and with patients are up to date and show where equipment is not maintained.
- Strengthen governance arrangements to ensure that all risks to service delivery are outlined in the service's

local risk register, and where appropriate are included on the corporate risk register. Also ensure that there are clear management plans to address risks and that these management plans are regularly reviewed.

- Strengthen supervision or one to one arrangements to ensure that all staff receive one-to-one management and clinical supervision in line with trust policy. Ensure that the minor injury unit service is compliant with statutory and mandatory training.

Action the provider SHOULD take to improve:

- Take steps to strengthen the clinical audit process through clear action plans which are implemented based on audit recommendations. This strengthening will help to ensure that evidence is available that could improve care and show that best (evidence-based) practice is consistently followed.
- Develop a triage policy that sets out how initial patient assessments should be carried out. Include who should carry out the assessments within what timescale. Also review the time that a patient is first seen by a registered healthcare practitioner after arrival in the department and ensure that there are systems in place that follow national recommendations for urgent care settings.
- Take steps to ensure that there is objective evidence available in patient records of all adults and children receiving appropriate safeguarding assessments.
- 'Ensure that non-controlled resuscitation drugs (including intravenous fluids) are stored ready for use in tamper-evident containers.
- Review the arrangements for moving and handling patients from chairs or the floor to trolleys in minor injury units settings.

Somerset Partnership NHS Foundation Trust

Urgent care services

Detailed findings from this inspection

Requires improvement

Are services safe?

By safe, we mean that people are protected from abuse

Summary

We rated the minor injury unit services as requires improvement. Not all potential risks had been fully considered in relation to minor injury units. For example, engagement with system wide major incident or accident scenarios, staff stress levels in response to their perception of not being able to take breaks. The quality of records was an area in which minor injury unit service managers had noted areas for improvement including recording of safeguarding and other information such as pain scores. Following a recent records audit the outcomes noted were minimal although an action plan was in place in order to support improvement.

The minor injury unit environment was clean and tidy. The minor injury units had scored highly in a recent infection control audit. However, we were not assured that the equipment maintenance log used was accurate or up to date.

There were enough staff to provide a safe service for patients, although increase in patient numbers and increasing level of clinical need for patients had been noted by staff including service managers. Staff sometimes found it difficult to take breaks due to incoming patient numbers which had also resulted in an impact on staff finishing times and the overall increase in numbers of patients seen by individual staff. Risks to patients' health were managed through an emergency nurse prescriber's assessment on arrival. However, not all patients received an assessment or triage within 15 minutes of arrival. Emergency nurse practitioners used various assessments, for example acting in accordance with the trust physiological observations policy for inpatients and minor injury units.

Staff understood their responsibility to raise concerns and lessons were learned and improvements made when things went wrong. There were systems, processes and practices in place to keep children and adults safe and safeguarded from abuse although a review of patients notes and the notes audit demonstrated that recording of safeguarding was incomplete. Controlled drugs were managed safely.

Detailed findings

Incident reporting, learning and improvement

- Staff understood their responsibilities to raise concerns, to record safety incidents, concerns and near misses. Staff we spoke with said that whenever an incident happened they would try to resolve any issues locally with involvement of senior staff (senior emergency nurse practitioner) and record as an incident through

the electronic incident system. We saw evidence of incident reporting and of emails from the nurse consultant to emergency nurse practitioners exploring issues relating to investigation of an incident.

- There were 145 incidents recorded for minor injury units between 24 September 2014 and 12 September 2015. We saw evidence of 72 hour reporting as required for serious incidents. The incident reports from the trust described that all actions were taken that should have been; however, the lessons learned were not clear or always recorded. We saw evidence that patients and relatives were notified in line with Duty of Candour regulation.
- Staff described a wide range of what should be reported as an incident from; abuse to them, the need to dial 999 for police assistance to clinical incidents such as drug errors, emergency ambulance delays or delay in X-ray reporting. The incident reports we saw reflected a good range of issues reported from deaths to faulty equipment. We saw some evidence that shared learning from incidents happened at quarterly continuing professional development staff meetings. A staff member described a recent serious incident (a death) where learning shared had changed where certain drugs were kept. We saw evidence of this during the inspection
- Most staff we spoke with said they got feedback from raising incidents and generally saw change as a result. For example, staff shortages and levels affecting safety resulted in temporary changes to minor injury unit opening hours to spread staff across other sites. Feedback was also shared with other service partners, such as the ambulance service, at regular meetings.

Duty of Candour (DoC)

- People who used the minor injury unit service were told when they were affected by something that went wrong, given an apology and informed of any actions taken as a result. We spoke with a range of staff and although they were not all familiar with the term 'Duty of Candour', when it was explained they were able to respond that it was about being honest and open when something happens and sharing what has happened with the patient. Some staff were able to describe a session on Duty of Candour which they had during their induction programme.
- From a review of incidents and complaints, we saw an example of when notification about an incident had been given, support provided and an apology given in line with the Duty of Candour regulation.

Safeguarding

- In a records audit from June 2015, 54% of adults were identified as having had a vulnerable adult assessment completed against 46% the previous year. While there were systems and processes in place to protect people from abuse the audit and a review of patients records showed us that they were not always followed. However, all the minor injury units had adult and children safeguarding and child protection arrangements flow charts to follow if staff felt they needed to raise any concerns. Contact information and what to do to raise a concern when abuse was suspected to an adult or a child was available in all minor injury units, on the walls in public and staff areas and on stickers on telephones. We saw evidence in patient records of consideration given to safeguarding for children and there was evidence of appropriate reporting of safeguarding for children in a complaint raised to the trust.
- Statutory and mandatory training attainment for the minor injury unit staff group in Safeguarding Children Level 1 was 97.4% and Safeguarding Children Level 2 was 92.2%. Safeguarding Adults attainment rate for Level A was 90.9%. This was better than the trust target of 90%.
- Staff in minor injury units also gave us several examples of potential safeguarding cases and how they had acted on their concerns. We saw evidence in incident reporting and complaint investigation of safeguarding procedures being followed for adults who had attended the minor injury units.
- We were shown the National Institute of Health and Care Excellence (NICE) guidelines used by staff for when to suspect child maltreatment, which staff said supported their decision making.
- One complaint involved a parent raising issues with how staff had instigated safeguarding procedures. The complaint was not upheld. Staff had acted appropriately on the concerns.
- All children seen in minor injury units had letters sent to General Practitioners, school nurses and health visitors, which helped to maintain up to date information regarding health and social care for children who may come into contact with other professionals.

- Staff also described additional measures they would take if they were concerned about the well-being of a child, for example they would contact the paediatric registrar/consultant at the nearest acute hospital to discuss the situation.

Medicines

- The arrangements for managing medicines, kept people safe. This included obtaining, prescribing, recording, handling, dispensing, safe administration and disposal. The minor injury units were following the trust resuscitation policy and the medical emergencies management policy (non-cardiac). Drug stock that we checked was sufficient and in date, drugs that were supposed to be locked away were securely locked, for example controlled drugs.
- However there were three incidents within minor injury units that were drug errors (three of 145 incidents reported, one dosage under prescribed, one incorrect labelling and one incorrect presentation prescribed); they had been reported and investigated. Remedial action had been taken to ensure they did not happen again.
- The arrangements for storage and security for some drugs and intravenous fluids were that they were kept in rooms where patients and others could occasionally be left unattended at busy times. We raised this with the staff at one unit and the nurse consultant resolved the issue on the day. The trust was balancing learning from a recent incident where rapid access to resuscitation drugs is recommended and maintaining safety of drug integrity for other patients. No risk assessment or entry in the local risk register was available for this issue. The trust policy issued September 2015 did not cover storage and they were compliant with this policy. Controlled drugs were secured in a suitable controlled drug cabinet in line with the trust medicines policy and controlled drug policy. During inspection all drug fridges we checked were operating within the correct temperature range, except for one. Staff had noticed it at the time we were on site and it was later replaced by the minor injury units senior emergency nurse practitioner lead
- We saw that fridges were checked daily and records kept by minor injury unit staff. At Chard we were made aware that prior to our inspection a drug fridge had been accidentally unplugged for a period of time, which had resulted in the drug stock having to be disposed of. Fridges we inspected were at risk of being unplugged or switched off in error. A fridge at West Mendip would not have been able to be heard if an appropriate mechanism for alerting staff to the fridge being out of range needs to be fitted. This put the medication inside them at risk of being stored above recommended storage temperature making them unfit for use. The unplugged drug fridge issue was not on the record of incidents list supplied to us by the trust, nor was it recorded on the local risk register as a wider risk for other minor injury units (yet issues relating to a plaster saw were). We were told that from September 2015 a plan to ensure improved safety for medication stored in fridges would be in place. Medicines management technicians were planned to audit compliance with the requirement for daily fridge monitoring in all the areas they visit as part of their core duties.
- Patient group directives (PGDs), used for administering certain drugs by staff, were maintained online but we also saw PGD paper files that were out of date. When we spoke with minor injury unit staff at West Mendip they said that they would dispose of them and retain the specimen signature sheets used to identify signatures of staff.
- Emergency nurse practitioners and registered nurses were responsible for checking and ordering controlled drugs weekly and completed a monthly audit for minor injury units. A quarterly audit was completed by medicines management pharmacy technicians. All other drugs were checked weekly by a registered nurse. The arrangements for drug and fridge checking ensured drug stock, suitability and expiry dates were checked. In the recent pharmacy audit in August 2015 all seven minor injury units scored 100%.
- Sharps bins for the disposal of used needles were not overfilled and there were enough for use.

Environment and equipment

- The design, maintenance and use of facilities and premises kept people safe. All examination rooms we inspected were private, clean and well equipped. The examination room in Shepton Mallet was divided by a curtain from other parts of the minor injury units but it was far enough away from public waiting area to be private.
- Staff at Minehead minor injury unit described needing to go to the main hospital site to transfer some patients if they needed to use a hoist to assist patients from a

chair onto a trolley. The hoist was not compatible with transferring patients from and to trollies in the minor injury unit environment. For example bariatric (obese) patients. This risk was not entered onto the local risk register.

- Minor injury units had a variety of equipment to provide safety to staff and others, including cameras that viewed car parks and entrance areas. However, cameras on reception at one minor injury unit could only be seen on the ward. Staff felt that this could leave those who work in the evening and weekend vulnerable. The risk was not recorded on the local risk register.
- Reception areas provided good visibility for reception staff to observe patients; however, some units did not have receptionist cover at all times of opening, which could lead to patients not being able to be seen at all times (Chard minor injury unit).
- Minehead minor injury unit had one way glass and an 'air lock' (controlled double door) access to manage people attending the unit on their way in or out; others had single doors controlled electronically. Most doors were shared with other parts of the hospitals.
- An incident was reported at Frome minor injury unit when visitors to the hospital were nearly locked in overnight when they had followed people in through a controlled access. This occurrence had been reported as an incident although any learning was not recorded on incident log and the issue was not included on the local risk register related to security.
- Staff told us they only opened the minor injury unit when the second staff member arrived. This supported staff maintaining personal security. Staff were also able to point out fixed alarm call points in clinic rooms which they could use to summon assistance.
- Staff in minor injury units were not adhering to trust lone working policy. At one minor injury unit we were told that there were no personal alarms; during other site visits we saw there were personal alarms issued by the trust on shelves not being used. Staff told us they would wear the personal alarms if they were going to the other end of hospital. We spoke with the nurse consultant regarding this issue and they were aware of it. The nurse consultant described a level of complacency amongst staff regarding the use of personal alarms. We reviewed the lone working policy for the trust and guidance was given in it regarding alarm use. Personal alarms were recorded on the local risk register as a mitigating factor for lone working. The risk of non-compliance with the lone working policy or use of personal alarms was not recorded on the local risk register. Lone working was also recorded as a low risk on the risk register. When we requested the risk assessment for lone working in minor injury units it was explained that minor injury unit staff do not lone work. This was confusing. This is at odds with the trust policy definition of lone working "…any situation or location in which someone works without a colleague nearby or when someone is working out of sight or earshot of another colleague'." Non-compliance with trust policy could delay assistance being called in event of an attack.
- Defibrillators were checked daily and logged to ensure they were ready for use. All resuscitation equipment on defibrillator or 'crash' trolleys we were able to check was present. At two sites we were unable to check defibrillator or 'crash' trolleys due to the room being used. None of the trolleys we saw were tamper-proof or tamper-evident. There were a few occasions where patients, relatives and/or their carers or friends could be left alone in the room. When we requested a risk assessment regarding the maintenance of integrity of unlocked drugs and intravenous fluids we did not receive one and we were told practice was in accordance with trust policy. On reviewing the policies we did not find any information relating to the storage of the items.
- All medical gases (Oxygen and a pain relieving gas) were present either through a wall supply or in cylinders and in sufficient quantity in the department.
- We saw evidence that scales for weighing babies were checked weekly for accuracy.
- We saw a service level agreement that said medical devices were managed on behalf of the trust by a local NHS trust. For some other devices, for example, in Frome minor injury unit we saw labels on them that suggested equipment was maintained by a second acute trust, for Burnham and Chard minor injury unit we saw evidence that suggested a third acute trust was used for equipment maintenance. Equipment we checked visibly was in date with servicing except for one unit. At Frome minor injury unit there were some items that had not been maintained, for example two thermometers showed the last check was 2013. An additional thermometer showed 2012 as last recorded date of checking. Therefore, we could not be assured that this equipment had been maintained appropriately

to keep people safe. We requested the last report on whether minor injury unit as a service was compliant or not with servicing and return of items, we did not receive this. The information we were provided with was a record of when serviced and when some of the equipment was next due for service. It was not reliable as some dates were not completed. It was not clear what the servicing frequency was for medical devices.

- During one inspection we observed water taps being run in accordance with the trust policy on legionella as the taps were outlets which were used less than three times a week for at least one minute. There was written evidence of flushing recorded locally in each hospital.
- A hospital matron we spoke with said they were responsible for the sites where minor injury units were located and supported staff with estates issues. During an inspection visit one matron resolved an estates issue rather than defer the decision making to the minor injury unit service manager who was on leave.

Quality of records

- We saw an audit of clinical practice and record keeping (published June 2015. The records audit showed improvement year on year in the areas requiring improvement, for example 54% of adults having a vulnerable adult assessment completed against 46% the previous year It also showed a fall in other areas, for example at the point of discharge - advice given to be recorded - the attainment was 93% down from 95%.
- We reviewed 27 patient records and saw that most were completed in line with trust guidance.
- Notes contained information relating to gaining consent, safeguarding algorithms completed, observations complete for presenting condition, allergies noted and a plan. However, three of the notes reviewed did not have observations recorded as they were 'reasoned out' for example an adult attending a minor injury unit with a cut finger (minor wound) would have relevant information recorded proportionately in line with policy. This was consistent with the outcome of the clinical audit of notes June 2015 (results of which were fed back to individual clinicians). Clinical practice and record keeping had been reviewed in February 2014 and June 2015 with improvement noted in most areas. Conclusions of the audit included; documentation remains an important issue for the service, in most areas there was ongoing improvement and further improvement needed in pain scoring, neurological assessment and vulnerable adult and falls assessment. In the audit there was 100% 'Bolitho compliance' in the recording of clinical decision making in patient's notes. Bolitho compliance is the evidence of an explanation of the 'logical basis' underlying the standard of care and treatment that was given by a practitioner.
- We looked at a set of children's notes at Shepton Mallet. The baseline physiological observations – were not recorded as they were 'reasoned out' (for instance happy, attentive child with minor injury/illness therefore some observations not taken). This was compliant with the trust physiological observations policy which stated "vital signs (physiological observations) will be recorded on individual patients when deemed clinically appropriate to the presenting complaint."
- At Burnham on Sea we reviewed four sets of adult notes and they were compliant with trust policy. At West Mendip (also known as Glastonbury) seven adult sets notes were reviewed and they were compliant with trust policy.
- We also reviewed three sets of notes for children and two sets for adults at Chard. None of children's notes had a record of pain scores being completed but an assessment of pain was recorded as text. While the note taking audit from 2014 and 2015 had a standard that 'pain score must be recorded' it is clear that it is not occurring in all cases. In 204 it was 46% for 2015 it was 55%. Pain relief was given as needed in 98% and 97% respectively. For the two sets of adults notes we saw the pain score was crossed through, as was the observation chart; the minor injuries that were treated however were recorded. This means that emergency nurse practitioners were choosing not to enter some information at the time of treatment as they considered it not relevant due to the level of injury and how the patient presented to the minor injury unit.

Cleanliness, infection control and hygiene

- There were reliable systems in place to prevent and protect people from a healthcare-associated infection. All minor injury units we visited were clean, tidy and well maintained. Most buildings were relatively new.
- For infection prevention and control purposes minor injury units were audited separately from the hospital sites. The completed audits for Bridgwater, Burnham on Sea, Shepton Mallet and Chard Hospitals scored 100%,

99%, 97% and 95% overall for the following areas, hand hygiene facilities, personal protective equipment, ward environment, decontamination of equipment and clinic room, cleaning and disinfection and linen management.

- We were not able to obtain information for Minehead, Frome and West Mendip Hospitals as the audits were being completed during our inspection.
- At Minehead we were told of how jobs to maintain a clean environment were shared across the team. Some jobs were unable to be completed when staff were absent or minor injury units were very busy. This had been reported via the electronic reporting system.
- We observed compliance with other key trust policies, for example hand hygiene when staff were preparing to assess and examine patients, all staff working in clinical areas were 'bare below the elbows'.
- We saw sinks that were appropriately sited, and hand gel dispensers that were working.

Mandatory training

- Most staff received effective mandatory training. Staff said that mandatory training online was easy to access and complete. However, not all staff were up to date with their statutory mandatory training. Minor injury units were compliant with all except one of the statutory/mandatory training modules. All modules were above the minimum target of 90% except for moving and handling level 1 which was 57.1%. We were not aware of what plans the minor injury unit service had in place to address this and the issue was not was not on the risk register.
- We did not check all reception staff training records. Those we did were up to date. Staff working on reception were not managed by minor injury unit but by the hospital site manager where they were located.
- We were provided with a record of skill level and current competency of all staff employed (non statutory non mandatory). We spoke with one of the three senior emergency nurse practitioners who provided assurance of the programme that was in place to ensure compliance with all competencies where needed. We saw evidence of this work at one minor injury unit we visited. We were also provided with an action plan and timescale for the work needed to ensure evidence of competency attained was recorded for all minor injury unit staff. The plan was for emergency nurse practitioner leads to review ongoing competencies for new staff, any competency folders not on site to be recalled for checking and progress to be monitored at the emergency nurse practitioner leads meeting at end of Sept 2015 for review at end Oct 2015.

Assessing and responding to patient risk

- All patients who were seen did not receive an initial clinical assessment by a registered healthcare practitioner within 15 minutes of the time of arrival. From October 2014 to September 2015 the percentage of patients seen who received an initial clinical assessment by a registered healthcare practitioner within 15 minutes of arrival was Bridgwater 22.7%, Burnham 41.9%, 45.8%, Frome 33.7%, Minehead 31.9%, Shepton Mallet 40.2%, West Mendip 29.1% with an average overall of 32%. This was worse than the recommendations of The College of Emergency Medicine's guidance (Triage Position Statement April 2011) that a patient should be rapidly assessed on arrival in order to identify or rule out life or limb threatening conditions and ensure patient safety. Triage is a face to face encounter/assessment which should occur within 15 minutes of arrival or registration. The trust did not have a triage policy.
- In an audit in June 2015 minor injury units scored 55% for recording pain scores and 97% for expediting analgesia. Children's and adults' pain was recorded via a 'smiley face' tool which enabled it to be scored. The audit recommended a key improvement needed was pain scoring. Despite the outcome of the audit the issues raised were not included on the local risk register.
- All patients attending the minor injury units were registered by a receptionist who used an electronic system with screen, which also showed on a separate screen at the nurse's station or desk. The nurse consultant explained that the minor injury units operated a system of emergency nurse practitioners prioritising (which is also known as triaging) and did not rely on receptionists to triage or complete initial assessments. The nurses prioritised who they treated first from their screen and from their initial assessment. Reception staff advised patients that they would be seen in order of priority of severity of injury or illness. However, if injuries were similar and no other factors present then patients were treated in order of attendance. This decision was made by the emergency nurse practitioner. The emergency nurse practitioner was also responsible for appropriately delegating

nursing and other tasks to other competent team members. When patients attended the minor injury unit the reception staff followed 'alert criteria guidelines' to inform their judgement as to whether they called a nurse immediately regardless of the nurse monitoring the screen.

- The guidelines informed the receptionist that if any people with one or more of the following conditions attend minor injury unit then they call the emergency nurse practitioner or nurse immediately; chest pain, shortness of breath/unable to speak in sentences, acute headache, bleeding, acute abdominal pain, pain where pain relief is needed, over dose, signs of stroke, any reason giving cause for concern and in addition floppy pale children or unwell children with rash. The guidelines posted at the reception desk and next to the screens and visible at all times was formulated by the nurse consultant for minor injury unit.
- Emergency nurse practitioners and nurses we spoke with were confident that any change in an adult or child patient's condition was able to be monitored through using the recommended physiological observations outlined in the trust policy, as well as knowing when to call for assistance. Observations ranged from pulse, blood pressure, oxygen saturation as well as pupil size and reaction and other clinical signs and included patient at risk scoring, paediatric Glasgow coma scale and professional judgement. When we spoke with the nurse consultant they told us they were planning to move to a Modified/National Early Warning Scoring system supported by NICE guidelines, which was recognised nationally and felt to be a better system for predicting and monitoring deterioration. Children's vital signs were able to be monitored (we saw various sizes of blood pressure cuff) and emergency nurse practitioners acted on their experience, professional advice from other minor injury unit or acute settings and followed NICE guidelines.
- Where necessary emergency nurse practitioners could dial 999 or speak with the nearest relevant emergency department team for advice regarding assessment, diagnosis and treatment. They could also request support via telephone when they had assessed a patient who had a heart condition. The support was from a medical consultant led national external provider of cardiology advice.

Staffing levels and caseload

- Staffing levels and skill mix were planned and reviewed so that people received safe care and treatment at all times. However actual staffing levels had minimal capacity for flex to absorb busy spells and things like staff breaks. Use of bank, agency and locum staff was low. Whenever the minor injury unit service needed to use agency or bank staff they used a preferred agency which had the job description for the emergency nurse practitioner role in order to be able to supply appropriately skilled staff. Bank and agency use for the minor injury units overall averaged out as 2.5% over a 52 week period from 13 October 2014 to 5 October 2015 with a maximum of 6% and some weeks with no bank and agency use at all.
- Shift handovers were verbal between staff.
- When we inspected the minor injury units there was always a Band 7 emergency nurse practitioner and a Band 6 nurse or a developing emergency nurse practitioner (Band 6) or a Band 7 emergency nurse practitioner and a Health Care Assistant. There was sufficient staff in line with Unscheduled Care Facilities Minimum requirements for units which see the less seriously ill or injured for minor injury unit recommendations (July 2009). The service manager and other seniors in minor injury unit were able to call on agency and bank as needed. We saw evidence of the recommended staffing model per minor injury unit and that the staff were present when we were inspecting. Frome/Shepton/ West Mendip were the only group of minor injury units that had a vacancy at time of inspection (0.8 whole time equivalent at Band 5). The local risk register identified more vacancies but was dated 24 May 2013 and recruitment had occurred since then. We were also supplied with a comprehensive option appraisal for the minor injury unit service from March 2015. The appraisal showed current staffing, what was needed to sustain the service and the anticipated increase in demand on service based on the last four years. In the proposal for succession planning for the provision of minor injuries service across Somerset (March 20150) minor injury unit as a service was noted as having had an increase in clinical activity of 5.5% in the last three years with much greater increases in some areas.
- At several of the minor injury unit's staff told us that taking breaks was difficult. They also spoke about situations where they have worked over their allocated shift. This was due to not being able to turn anyone

away close to the end of their shift and when demand on minor injury unit was high. This can happen at times such as holidays and can be more difficult at the 'holiday destinations' such as Minehead, Burnham on Sea and West Mendip (Glastonbury). Staff found it difficult to take a break due to having to make a decision to leave people waiting in waiting areas while they took a break. We spoke with the nurse consultant about the issues. They acknowledged that it was difficult but staff had been told that they should take breaks and this had been recorded in minutes of a team meeting. The nurse consultant acknowledged that this had caused some anxiety for emergency nurse practitioners who were concerned for the waiting time for patients but said that it was up to individual clinicians to manage their breaks. Nurses had raised these issues on the incident reporting system and staffing was under review. This issue was not recorded as a risk on the local register

- If an emergency nurse practitioner was due to work and was not available the issue was escalated to senior managers who would agree and source bank or agency cover. If cover was not available the unit would not open and patients would have to attend minor injury units in other areas or dial 111. Units have occasionally opened with one staff member due to patients already being in waiting areas and short notice absence of minor injury unit staff. This was recorded in incident reports.
- We spoke with the divisional lead responsible for minor injury units about sickness rate. The sickness rate for the seven minor injury units in both January and June 2015 was 2.7% below (better than) the trust target of 4%.
- From 1 April 2014 to 31 March 2015 there were 17 staff that left the trust of a group of approximately 77. For minor injury unit overall there was a 7.1% vacancy rate. For the trust overall it was approximately 14.4% for this period.
- At Chard minor injury unit we were told that there was no reception staff working at weekends and emergency nurse practitioners had to book patients in. This caused the emergency nurse practitioners workload to increase as they also had to organise things like fracture clinic appointments; staff had reported this issue as an incident as not a good use of time that delayed them seeing patients. This issue was not recorded as a risk on the local register.

Managing anticipated risks,

- Staff were able to anticipate most risks to patients who used the service. In order to manage anticipated risk they had access to medical support via a patient's general practitioner, or emergency department staff via telephone. They also had access to support via the telephone from out of hours general practice cover at the weekend and at evenings and nights. They could also use 111 but felt this was quite time consuming. There was a senior emergency nurse practitioner on call rota that provided cover for evenings and weekends.
- Emergency nurse practitioners had access to advice and opinion from an external cardiology provider that was consultant led and analysed any electrocardiogram (ECG).
- There were examples of potential risks being taken into account when planning services. During our inspection we were told that minor injury units were changing the 'IT' system they used for recording patient attendances and monitoring other data. The changeover will result in a need for a temporary electronic solution that is planned to rely on some paper based information. During this time minor injury units would use a temporary electronic system before then joining the trust wide system. The nurse consultant described contingency plans for critical information transfer during this time. They would do general practice, health visitor and school nurse letters via word documents and safeguarding notifications would remain unchanged as they were paper based anyway. The transition was expected to occur at the end of October 2015. Staff were aware of this and they anticipated some issues re patient tracking. The IT issue was recorded on the local risk register dated 15 June 2015 and appropriate plans were recorded against the issues raised.

Major incident awareness and training

- The arrangements that were in place to respond to emergencies and major incidents were incomplete as minor injury units had not practised or reviewed the process. Staff were able to describe what they would do to respond to any 'major incident', for example in periods of adverse weather they would attend the next nearest minor injury unit site. Staff described the trust having access to four wheel drive vehicles to assist. Adverse weather risk was on the risk register dated 1 April 2010; plans against the risk related to the safety of the worker only.

Requires improvement

Are services safe?

- Staff were able to locate major incident policies when asked and understood they needed to attend the nearest minor injury unit or would be utilised to support the emergency response. There was no information relating to a 'major incident' other than weather disruption on the minor injury unit risk register. We asked the trust for the learning outcomes for the last major incident exercise for minor injury units or involving minor injury units, however we did not receive this information. They told us about Burnham on Sea Hospital closing due to water supply disruption on 1 May 2014 when the trust business continuity plans were enacted. There were some learning points noted, but, it was not clear in the learning points what other arrangements were made when the outpatient department and minor injuries unit were closed. There was evidence that a heatwave plan and information from Public Health England had been shared at the minor injury best practice group meeting 26 May 2015.

Requires improvement

Are services effective?

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.

Summary

We rated the minor injury services as requires improvement. Supervision was not carried out according to trust policy for emergency nurse practitioners. For instance it was not carried out on a scheduled one-to-one basis for emergency nurse practitioners. Patient records were sometimes incomplete.

Patients' care and treatment outcomes were monitored in a number of ways including audits, reviews of notes and treatment plans. However, some audits showed discrepancies in recording a patients clinical observations and other important information. Evidence to show that patients' needs were assessed and care and treatment were delivered in line with legislation, standards and evidence-based guidance was sometimes incomplete. Recent audits of notes and clinical practice had identified this issue. For example inadequate recording of the maximum rate of breathing out or peak expiratory flow rate in patients with asthma and pain scores not completed. To support actions to improve recording in patient records occurred , these issues could have been raised in scheduled management and clinical one to one supervision sessions; however, these meetings did not always occur for emergency nurse practitioners. This would have supported the group, peer and other forms of support to staff.

All emergency nurse practitioner leads, service managers and nurse consultants had open-door policies which offered some one to one support. This contributed to good care delivery although it wasn't clear if all the meetings were recorded. Emergency nurse practitioner leads worked clinically with staff within the departments and held management and clinical sessions on site as and when arranged which also contributed to good care delivery. We saw evidence of one to one meetings being carried out by the nurse consultant with the three senior emergency nurse practitioners.

Staff had, and continued to develop, the skills, knowledge and experience necessary to deliver effective care and treatment for minor injuries. However, assessment and treatment of minor illnesses was an area in which some staff felt that they needed more training because of the number of patients who were presenting with a greater acuity. The trust had training programmes in place to support this. There was evidence that staff were gaining consent to care and treatment. Patients also received pain relief and their nutrition and hydration was supported.

Staff worked with other providers to support patients' minor injuries and illnesses, and pathways to more urgent and emergency care were followed. Overall, staff, teams and services worked together to deliver care and treatment. Emergency nurse practitioners and other staff had the information needed to deliver effective care and treatment to people who used services from their electronic records system.

Detailed findings

Evidence based care and treatment

- Patient's needs were assessed and care and treatment was able to be delivered in line with legislation, standards and evidence-based guidance. Emergency nurse practitioners had access to paper and online National Institute of Health and Care Excellence (NICE) guidelines. For example they also had access to trust guidance and patient group directives.
- Patients' needs were assessed and their care planned and delivered in line with this evidence based guidance. The service manager and nurse consultant worked with staff on clinical shifts and relied on lead or senior emergency nurse practitioners for staff compliance and maintenance of standards and best practice. They also used continuing professional development meetings to support compliance.

Pain relief

- Patients who were in pain received pain relief in a timely manner. We observed patients receiving pain relief and none of the patients we spoke with said that they had to wait to receive pain relief. An audit of notes was carried out December 2014 and published June 2015, which showed that 97% of patients received pain relief, but in only 55% of patients' records was the patient's pain score recorded. Emergency nurse practitioners used a

pain score where they considered it was relevant in line with the trust physiological observations policy. For example a pain score might not be recorded as a score if an adult presented with a cut finger (emergency nurse practitioners would record as pain present as free text).

Nutrition and hydration

- We observed staff arrange drinks for a patient and carer; we also saw water provided for a patient.

Technology and telemedicine

- Equipment was used to enhance the delivery of effective care. Staff had access to remote consultant-led electrocardiogram (ECG) analysis and interpretation that provided quick and accurate diagnosis for patients and supported emergency nurse practitioners to make decisions based on clinical information.
- They also had access to digital X-rays and the ability to send them to acute hospitals for second opinion/advice.

Patient outcomes

- The minor injury unit service received overwhelmingly positive comments from people who used the service. There were107520 patients seen in the minor injuries units between 1 August 2014 to 31 August 2015. The trust provided us with evidence that 13 complaints (less than 1%) were received by minor injury units in the previous 12 months leading up to the inspection. Of those 13 eight were upheld by the trust (Bridgwater three, Burnham on Sea two, Frome two, Minehead one, Shepton mallet four and West Mendip one). There were 145 incidents raised although not all related to patients (and those that did relate to patients not all were clinical issues). Of the 145 two were serious incidents requiring investigation.
- All patients we saw that attended the minor injury units were reassessed by emergency nurse practitioners before their discharge from the department. This was in line with best practice to ensure best possible outcome and to support other nurses and health care assistants to deliver optimum care. The clinical audit conducted in 2014 and 2015 did not have any data in it for this aspect of care.
- The minor injury unit service staff had also taken part in a number of recent local audits:
- The Re-audit of Clinical Practice and Record Keeping within Minor Injury Units June 2015 highlighted a number of areas of good practice and further improvement needed. The re- audit involved a random sample of 10 sets of notes per emergency nurse practitioner and five sets of notes per staff nurse (total number of notes audited 509). The audit showed improvement in most areas of practice from 2011 to 2015.The outcomes of the audit was discussed and actions planned were evident in minutes of the Best Practice Group. The summary of strengths in the audit were discharge advice, musculoskeletal examination and 'Bolitho' compliance, or the evidence of an explanation of the 'logical basis' underlying the standard of care that was given by a practitioner. Areas for development were increasing the recording of vulnerable adults, falls assessment, neurological assessment and pain scoring.
- In the Asthma audit (4 February 2015), key strengths for minor injury units were 100% of treatment was administered within one hour of presentation., All patients had a discharge summary sent to their GP within two working days. The minor injury unit nurse consultant noted a key area for improvement was that the recording of peak expiratory flow rate (PEFR) was not performed for the majority of patients. PEFR is a person's maximum speed of breathing out and is an objective measurement of narrowness and tightness of airways in lungs. Only 10 patients (31%) had a record of their PEFR. The remaining 22 patients (69%) did not have a record of their PEFR, either initially or following treatment. These patients were spread across all minor injury units and no children were in this group. An objective, assessment should include a record of PEFR; compliance for the standard was 31%. However, whilst compliance for this standard was low the overall time to appropriate treatment was not compromised.
- For the Infection Control audit (20 March 2015) minor injury units are audited separately from the hospital sites. The completed audits for Bridgwater, Burnham on Sea, Shepton Mallet and Chard Hospitals scored 100%, 99%, 97% and 95% overall for the following areas: hand hygiene facilities, personal protective equipment, ward environment, decontamination of equipment and clinic room, cleaning and disinfection and linen management. We were not able to obtain information for Minehead, Frome and West Mendip Hospitals as they were still being completed during our inspection

- Minor injury units also ran a urinary tract infection (UTI) in infants, children and young people on 31 March 2015, and were involved in Patient Experience in Adult NHS Services 27 January 2015.

Competent staff

- The arrangements for supporting and managing staff were not compliant with trust policy. Trust policy stated that one to one or supervision (be it individual, group, peer, triad or action learning set - terms used by the trust), was to be held at least every six weeks for some groups possibly more frequent (sec 5.3 clinical supervision policy). We requested dates of one to ones or supervision (management or clinical or otherwise) carried out by the three lead emergency nurse practitioners for staff that they line manage for the last year. We were told that management and clinical supervision for the emergency nurse practitioners was not carried out on a scheduled one to one basis. This was because the lead emergency nurse practitioners worked across a number of sites as well as managing a clinical caseload. According to the nurse consultant in minor injury unit all leads had an open door policy and worked clinically with all staff within the departments and had held sessions on site as and when appropriate. Although there was evidence of regular one to one meetings and annual appraisals for the senior emergency nurse practitioners these did not consistently take place for all other staff groups. We saw evidence of one to one meetings being carried out by the nurse consultant with the three senior emergency nurse practitioners. Appraisals were in date for them. We were not assured that the management and clinical supervision for emergency nurse practitioners was carried out on a scheduled basis for other emergency nurse practitioners or nurses. In the minutes of a best practice group meeting 28 July 2015 a staff member had been tasked with setting up a new clinical supervision log and to set up a folder to store the logs we did not see this.
- Staff rotated through different minor injuries units to ensure consistency in their competence. This was because some minor injury units were busier than others and there was opportunity to reinforce competence in busier environments. We spoke with a senior or lead emergency nurse practitioner for one of the three minor injury unit clusters who described the learning system in place for minor injury unit. There were mandatory quarterly continuing professional development (total 12 hours) and monthly meetings. There were also reflective learning logs and opportunities to have informal opportunistic one to one meetings and teaching. This helped, support staff for continuing professional development and best practice to be shared. This was supported by other staff we spoke with and we saw minutes of meetings. Two consultants from a local emergency department attended monthly continuing professional development meetings to support minor injury unit staff learning via talks and presentations in relation to minor injury unit and emergency nurse practitioner practice.
- Staff had an option to use reflective learning logs to share with other staff when on duty. Some staff described being uncomfortable with learning logs in the department as they showed what they did not know to others (and felt perhaps they should). This could limit learning opportunities because staff may not identify areas for learning in this way.
- The nurse consultant and the service manager had completed clinical shifts at a number of locations of minor injury units, which supported their skill retention, provided support and gave opportunity for other staff to speak with managers.
- Staff had appropriate training to meet their learning needs and the needs of the service and were encouraged and given opportunities to develop. All staff had to complete image retrieval medical assessment training before they were competent to order X-rays. At the time of our inspection 37 of the 43 emergency nurse practitioners were able to provide the relevant documents and therefore competency, of the remainder four were new in post and as developing emergency nurse practitioners had training planned at a later date. The other two staff had not completed the documentation for the records at the time of our inspection. All staff would be part of a review of all competencies planned for the end of October 2015.
- The nurse consultant told us of ongoing plans for all emergency nurse practitioners to complete minor injury and minor illness in children training. The funding from Health Education South West had been agreed at end of 2014 and the first staff started the training in January 2015. This supported the development of knowledge in assessing and treating children beyond the skill set attained from the emergency nurse practitioner course.

We also saw evidence in minutes of best practice group meetings 30 June 2015 of plans for training for staff nurses (adult and paediatric principles in emergency care for staff nurses) in January 2016.

- Nurses that were not emergency nurse practitioners were able to administer medication under the patient group directives in place within the trust. They described this as an incremental step up to improving their competencies and a step up in development and building confidence in practice.
- Some emergency nurse practitioners described being more familiar with minor injury treatment than with minor illness. However, staff were aware of the availability of supporting information to assess and treat minor illness; for example, through NICE guidelines on the internet/intranet, access to support of emergency nurse practitioners at other minor injury units and to support from staff in acute trusts and primary care.
- One receptionist described the role as daunting at times and several minor injury unit receptionists told us that consideration should be given to a receptionist-specific type of training programme in minor injury unit to give greater confidence working as a receptionist with patients with minor injury and illness. It was clear they were not assessing or triaging patients, but they felt there was a gap in their training. Training had not been offered to the receptionists we spoke with. We did not speak about this with the hospital matrons who line managed this staff group.
- We saw evidence of the action for emergency nurse practitioner leads to review ongoing competencies for staff, and progress was to be discussed at an emergency nurse practitioner leads meeting in September 2015 with a further review in October 2015.
- Most staff felt it was easy to attend taught sessions at quarterly continuing professional development meetings. However some found it hard to attend the taught sessions due to covering some shifts when staff were absent at short notice, and had to rebook training.

Multi-disciplinary working and coordinated care pathways

- There were good examples of multi-disciplinary working, for example between specialities including onsite therapists or radiographers when advice was needed about certain clinics or bookings. There was also evidence of good informal relationships between the managers of the sites that a minor injury unit was based in and the staff who worked there.
- We saw evidence of good examples of external multi-disciplinary working , for example, transfers between sites with admission to ward processes where needed, liaison with emergency departments elsewhere, links with external electrocardiogram (ECG) providers and with social services and general practitioners.
- There was a working relationship with ambulance service providers. Emergency nurse practitioners described ambulance staff contacting the minor injury unit before attending to discuss if a patient was appropriate to be treated in the there. Sometimes emergency nurse practitioners assessed the patient with ambulance staff before making a decision as to where best to treat the patient. We saw evidence of minor injury unit senior staff meeting with ambulance service staff to resolve process issues, which reduced delay or inappropriate use of both services.
- Staff in minor injury units worked with other providers, such as consultants at acute trusts and general practitioners (GPs). We were told of a GP assisting in the interpretation of a chest x ray. The condition was one with potentially serious implications when not diagnosed correctly and GPs would not routinely be involved in minor injury unit work.
- All minor injury units cited a good relationship with social services with regard to safeguarding concerns, and with mental health crisis teams. One practitioner described a telephone conversation that had taken place with a mental health practitioner who visited the unit to carry out further assessment and treatment for someone who had attended with a mental health issue. The treatment could have been delivered by the emergency nurse practitioner but they did not feel comfortable with this as they did not consider themselves an expert in mental health. The mental health team attended and the person received the appropriate treatment.
- The minor injury units were involved in a wider network of support for urgent care providers. This included, for example, emergency department consultants and were part of continuing professional development from acute

Requires improvement

Are services effective?

trusts outside of Somerset. The minor injury unit staff also attended the Peninsular emergency care forum which ensured the service lead maintained awareness of other urgent and emergency care initiatives.

Referral, transfer, discharge and transition

- Staff worked together to assess and plan ongoing care and treatment in a timely way when people were due to move between teams or services. We saw evidence of patients with a range of injuries being referred on to orthopaedic clinics, enabled to self-refer for musculoskeletal clinics and referrals to attend dressing clinics.
- From April 2015 to August 2015 97.4% of patients had their needs met in the minor injury units. The remaining 2.6% of patients attending were: referred to an outpatient clinic in another trust (people visiting the area); or transferred to another health care provider (for example to general practice) or admitted to an acute hospital. The percentage of patients who had an unplanned return to minor injury unit within seven days of discharge was under the national target of 5% for six of the minor injury units (Bridgwater 1.8%, Chard 4.6%, Frome 1.6%, Minehead 2.4%, Shepton Mallet 1.7%, and West Mendip 1.7%). The minor injury unit that was over the 5% target was Burnham with a score of 5.1% it is possible that this reflects the seasonal demand from holiday makers in the summer returning for wound care and dressings.

Access to information

- All staff were able to access patient details and previous attendances on the electronic system, there were also systems in place to recall notes for when patients re attended the minor injury unit to complete treatment or for reassessment.
- It was possible to identify repeat attendances that children may have made at other minor injury units and emergency departments in the county which supported identification of safeguarding.
- Information when a child attended was shared with general practitioners, health visitors and school nurses.
- Staff were able to access NICE guidelines online to support clinical decision making.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- We saw that staff understood how to obtain consent and the requirements of legislation and guidance relating to mental capacity. The mental capacity for making decisions for adults was determined during verbal interaction between the emergency nurse practitioner and patient (as well as with any carer). Staff in the minor injury unit were able to demonstrate the assumption of capacity as set out in the S1 Mental Capacity Act 2005.
- Training in the Mental Capacity Act 2005 was included in annual safeguarding training. Training regarding consent was part of annual statutory mandatory training and 96.1% of staff were trained.
- We saw several examples of consent having been sought from patients or in some cases children and their parents when we reviewed patient's notes which evidenced staff were acting according to the Mental Capacity Act 2005.

Good

Are services caring?

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

Summary

We rated the minor injury unit services as good. Staff treated patients and other people with kindness, dignity, respect and compassion while they waited for and received care and treatment. Patients were given appropriate and timely support to cope emotionally with their care, treatment and conditions, and such support was offered equally across all patient age ranges. Staff showed an encouraging, sensitive and supportive attitude to patients who used services and those close to them. Patients and those close to them were also involved as partners in their care with discussion about planned treatment and options offered.

Compassionate care

- Staff took the time to interact with patients who used the service and those close to them in a respectful and considerate manner. Patients dignity and privacy was respected, doors were closed when staff left clinic rooms and where a curtain was used (Shepton Mallet), it was drawn across. Reception staff recorded patients details in a confidential manner and reception areas were suitable for carrying out conversations that would not be overheard.
- Feedback from patients during our inspections visits was overwhelmingly positive. We spoke with several patients about their care and no one complained about the service or the staff. A carer of a patient who has attended the minor injuries unit in Chard said that it was a very good unit. We heard emergency nurse practitioners give clear advice and we observed that they were caring in manner as were other staff. A parent who attended with a child as the patient described the service as good and that they didn't have to wait long. They also described being involved in the discussions about treatment. The child said that they had been involved and that everything had been explained to them.
- The trust used the Friends and Family Test (FFT) to capture feedback. During 2014/2015 respondents said they were likely (18%) or extremely likely (78%) to recommend the service to friends or family. Bridgewater minor injuries unit had a significantly lower response rate than the rest of the minor injury units in both quarters at 5.5% and 3.5% respectively.

Understanding and involvement of patients and those close to them

- One patient described the minor injury unit as fantastic saying how they were involved in treatment. We observed the emergency nurse practitioner spent time explaining the treatment needed and ensured that the patient understood what was happening.
- Through observation and discussion with patients we found that they and their and carers were given sufficient time for explanations of the assessments made, treatment carried out and outcomes expected.
- We saw an emergency nurse practitioner caring for a patient with complex needs and the patient was referred to an acute trust for further investigation, the emergency nurse practitioner copied the paper record and gave this to the patient to take with them when they attended their next appointment (we saw copy of notes given).
- Staff explained to another patient risk regarding driving with their injury and potential implications for insurance.
- Staff showed an encouraging, sensitive and supportive attitude to patients who used services and those close to them for example we saw a child with an injury treated gently, and an explanation was given to both the child and their mother.
- A patient who used the minor injury unit was empowered and supported to manage their own health, care and wellbeing to maximise their independence. We observed an episode of care where the emergency nurse practitioner had refused to provide a piece of medical equipment that was requested by a patient. The emergency nurse practitioner based their refusal on the assessment and treatment they had carried out as the treatment would not have been clinically appropriate. This was managed professionally and gave confidence to the patient to manage their own health needs after assessment and treatment without unnecessary interventions or prescriptions.

Good

Are services caring?

Emotional support

- Patients were given appropriate and timely support to cope emotionally with their care, treatment and condition. For instance we observed one young child who was brought to a minor injury unit with a carer. The child was clearly in distress, facial grimace and crying loudly, because of an injury. From observation of the carer they appeared to be quite anxious. The child was calmed by a 'distraction' technique employed by the nurse. Within a few moments the child smiled started playing and laughing. Treatment followed without issue. The carer also looked visibly relaxed at the time and gave a positive sign when we asked how they were.

Good

Are services responsive to people's needs?

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

Summary

We rated the minor injury unit services as good. Patients were able to access care and treatment in a timely way. The trust consistently discharged, admitted or transferred over 99% of patients within four hours of their arrival at a minor injury unit, exceeding the 95% national standard.

Minor injury unit services were planned and delivered to meet the needs of people that Somerset Partnership NHS Foundation Trust were responsible for through working with clinical commissioning groups. This planning and delivery was evident from the high numbers of people who left minor injury units having been assessed and treated without referral elsewhere. The service took account of patient groups' varying needs. For example, there were accessible departments for people who used wheelchairs or other mobility aids such as walking frames.

Patients who attended were given patient information leaflets and information was available in a range of languages. Patients were treated as individuals. Concerns and complaints were listened to, investigated and responded to and the outcomes were used to improve the quality of care.

Detailed findings

Planning and delivering services which meet people's needs

- There was a clear plan for the delivery of a service to meet people's needs. We saw examples of service level agreements that described the service that was to be provided. We also saw a copy of a document that outlined what was needed to ensure the service met ongoing demand. Performance figures demonstrated that 97.4% of attendees had their needs met by the minor injuries unit.
- Some areas covered by the trust were more highly populated in the summer months due to the influx of tourists. To manage increased patient demand there were extended opening hours during this period. For example, Burnham on Sea War Memorial Hospital was open seven days a week from 10am to 6pm April to October and between 11am to 3pm from November to March. Staff had raised some concerns when patient demand exceeded staff capacity (we saw this in incident reporting). The general issue of any longer term, sustained increase in demand on the service was not on the risk log however reference to problems of travel associated with arrangements for a local festival was. The risk was entered 1 June 2013. It is not clear from the risk register how managers of the minor injury unit service had identified issues of increased demand and resources needed to address it nor what the implications for service provision would be if not addressed.
- The service manager and nurse consultant with support from senior emergency nurse practitioners proactively managed any day to day increase in demand. This included using staff flexibly across all sites to cover, there is also an agreement with specialist nursing agencies to cover shortfall. Redeployment of existing staff from base hospital to meet service needs is utilised and we saw evidence of this. Minor injury units used agency/locum emergency nurse practitioners to maintain service when no other option exists. The service manager, consultant and senior emergency nurse practitioners reviewed the staffing daily to ensure cover.
- We saw several examples of patients individual needs being met, there were Chlamydia testing kits at the front door of the minor injury unit which were easy to collect and use without having to interact with staff and others unless the patient wanted to. This was intended to reduce embarrassment for patients enabling them to reassure themselves regarding test results or enabled easier access to treatment if needed.
- Some patients said they had attended because they had received a more relevant service to their needs. A patient said the reason they had visited the minor injuries unit was because it was easier than visiting the GP who they thought would refer them onto the minor injuries unit anyway

Equality and diversity

- We saw staff work with patients as individuals and this was exhibited in staff's behaviour and attitudes. For example people who were older were not spoken with as if they were children during assessment or treatment.

Good

Are services responsive to people's needs?

- Translation services were available via telephone and there were leaflets in different languages, for example Turkish, Portuguese, Polish and Lithuanian.
- Reasonable adjustments had been made for instance with regard to reception desk height being lower for people who use wheelchairs.

Meeting the needs of people in vulnerable circumstances

- The service took account of the individual needs of different patient groups.
- The minor injury units were accessible, well-lit floors were smooth and did not cause difficulty to people with walking or moving.
- Patients who attend minor injury unit who were suspected to have undiagnosed dementia or similar condition would be referred their GP in line with the trust's commissioning for quality and innovation target for identifying patients with dementia and delirium. Some staff were aware of this target. We were told people with dementia or suspected dementia were assessed in the same way as anyone else. Emergency nurse practitioners were confident in contacting mental health services for advice if they felt they were not skilled enough in dealing with mental health issues.
- We did not see any patients who had attended that had a diagnosed learning disability or other cognitive or sensory issues beyond those who needed assistance to mobilise or see and hear.
- One minor injury unit in particular was described by an emergency nurse practitioner as having a relatively high proportion of older people in the local population and public transport was 'not good'. Patient groups such as older people and those who have difficulty accessing healthcare via public transport had their needs met locally by the minor injury unit which had good links with the community hospital which was on same the site. There were pathways for admitting patient to the wards if needed.
- We saw an emergency nurse practitioner dealing with one patient with complex needs and the patient was referred to an acute trust for further investigation. The emergency nurse practitioner copied the paper record and gave this to the patient to take with them when they attended their next appointment. Another patient who also had complex needs was able to be treated in the minor injury unit. The carer who was with the patient was complimentary about the service and the information.

Access to the right care at the right time

- The minor injury unit service prioritised care and treatment for people with the most urgent needs through a system led by the emergency nurse practitioner in each minor injuries unit. The nurse consultant described the process where patients were prioritised based on the patient's condition. This was in conjunction with NICE best practice guidelines. Receptionists supported the emergency nurse practitioner and other nursing staff in minor injury unit by following criteria for alerting clinical staff to any concerns when recording attenders on the electronic system. Nurses monitored arriving patients via the computer and prioritise accordingly. We saw this process in action.
- Patients had timely access to diagnosis or treatment. From October 2014 to September 2015 patients waited less than an hour for their treatment to begin in the following minor injury units. Bridgwater, median wait 48 mins, Burnham, median wait 36 mins, Chard, median wait 31 mins, Frome, median wait 52 mins ,Minehead, median wait 48 mins, Shepton Mallet, median wait 58 mins, except for West Mendip, median wait 71 mins. Overall for the 7 minor injuries units the average wait was 49 minutes. The figures compare favourably with emergency departments that see more than 100,000 patients a year where 49.21% of patients are seen by a decision maker within less than 60 minutes from arrival to treatment (The drive for quality How to achieve safe, sustainable care in our Emergency Departments? System benchmarks & recommendations The College of Emergency Medicine 2013)
- The trust was consistently exceeding the national standard that 95% of patients were discharged, admitted or transferred within four hours of arrival at the minor injury unit. Their performance was consistently over 99%. We saw evidence in notes of some patients who had attended the minor injury unit, had been assessed and had been discharged in approx. 20 mins. Trust records showed that 107520 patients were seen in the minor injuries units 1 August 2014 and 31 August 2015. Of those patients 61% were seen within one hour of arrival; 30.4% between one and up to two

hours ; 6.7% between two and three hours and1.3% between three and four hours. Only 0.5% of patients were seen after four hours of waiting. . We were told the time started when the patient was clerked in at the desk by the receptionist onto the electronic system.

- For the same period the percentage of patients that left the minor injury unit department before being seen by a clinician was better than the Department of Health target of 5%. Rates at the individual units were. Bridgwater 1.4%, Burnham 0.6%, Chard 0.9%, Frome 1.2%, Minehead 1.1%, Shepton Mallet 1.0%, West Mendip 1.6%.
- Practice in minor injury units was for all patients to be seen/reassessed by the emergency nurse practitioner before discharge this ensured that assessment and treatment was reviewed by appropriately qualified staff. This was not measured in the most recent audit of notes.
- There was access to a remote cardiology provider which guaranteed consultant input into every electrocardiogram for those over the age of 18 years. Opinions could be requested for patients who were younger.
- Access to X-ray services was variable at the time of our inspection. Some minor injury units had X-ray facilities and some were without X-ray services either temporarily due to a fault or only on particular days of the week as commissioned. Some were not available at the weekend. For example people who attended Burnham on Sea minor injuries unit had to attend Weston General Hospital or Bridgwater Community Hospital for X-rays.
- Emergency nurse practitioners said ambulance staff occasionally contacted them to discuss whether some patients could be treated by them for instance when patients had dialled 999 appropriately but the injury did not require transport to an emergency department. They also confirmed if the unit was able to accept if it was a particularly busy holiday period where any delay in treatment might adversely affect a patient or availability of resources. Emergency nurse practitioners were able to admit patients to wards through accepted pathways when clinically appropriate. For example patients with bony injuries admitted to community hospitals after injuries from falls.
- At two minor injury units some staff we spoke with suggested that general practice can inadvertently cause minor injury units to be used inappropriately. For example, where patients needed wounds re-dressing attended minor injury units at weekends. One emergency nurse practitioner described covering for practice nurses if a GP was unable to arrange practice nurse cover. Patients attended the minor injury unit instead of the general practice. There was evidence of this in trust incident reporting.
- We saw evidence that there have only been two occasions where minor injury units had been closed for any length of time due to staff shortages. Neither of these was for a period of more than five hours.

Learning from complaints and concerns

- There were 13 complaints from 1 April 2014 to 10 March 2015. Of those complaints eight were upheld. One was referred to the Parliamentary and Health Service Ombudsman but the complaint was not upheld at that stage. Learning from complaints was incorporated into future practice.
- We saw evidence of learning from complaints and concerns at continuing professional development meetings where staff went through each complaint to discuss issues, findings and responses. Some learning was recorded in outcomes of incidents from incident reporting and minutes.
- The trust provided evidence that the outcome of complaints had been explained appropriately to people.
- There was information available in minor injury units to support patients and carers to make complaints.
- Staff were aware of how to inform patients of how to raise a complaint. At one hospital we were made aware of a misunderstanding between a patient and staff member which was resolved at the time.
- Not all staff said they felt supported when involved in a complaint. Other staff described being encouraged to become emotionally detached from any complaint in order to see both positive and negative aspects of their involvement to support learning.

Requires improvement

Are services well-led?

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

Summary

We rated the minor injury unit services as requires improvement. Quality and performance were understood and managed at a local level by a service manager and the nurse consultant who reported to a divisional lead. However, risks to the service were not always made explicit on the local risk register. Not all issues that could be perceived as risks had been fully considered in relation to minor injury units. For example: major incidents; staff stress levels in response to a perception of not being able to take breaks; and staff non-compliance with lone working policy. The local risk register did not take account of staff 'worry lists'.

Quality and performance were measured by service and trust leaders through audits, commissioning for quality and innovation and use of performance figures. We saw evidence of a broad selection of local audits completed in relation to minor injury units. The analysis and conclusions drawn from some audits for example patients' records audit were minimal. The learning points or action plans in incident reporting we saw were not always clearly identified. Where learning was available we saw evidence that it was shared.

Governance responsibilities for the minor injury units was through board representation via the chief operating officer. The service was then managed by a divisional lead who worked with the service manager and, the nurse consultant. The emergency nurse practitioner leads supported teams of emergency nurse practitioners and other members of the team. The overall culture of the minor injury unit service was one of openness and transparency. This culture promoted good quality care and in general patients were satisfied people with the service provided. Members of the public were engaged through the friends and family test and while there were some complaints the feedback was over whelmingly positive.

Detailed findings

Service vision and strategy

- The trust had a clear vision and set of values which we saw displayed on posters; however, these were not always clearly articulated by staff. Staff were able to articulate principles such as working in partnership and providing quality care. Some staff felt that they were not involved in development of the trust vision.
- There was a credible local strategy to deliver good quality care and to develop the service to be able to respond to any changes in the needs of the community towards urgent care. We saw a trust strategy document which assessed the organisation's ability to implement this strategy which described options to develop the service. This was submitted to commissioners March 2015.
- Staff described a need for further integration of mental and physical health and social care services building on current relationships to support service vision and strategy. Not least involving better integration with general practice. Staff did not talk about this in the context of integration phase two (IP2) as part of an overall corporate strategy.

Governance, risk management and quality measurement

- Recent changes to the governance and responsibilities framework were clear. There was board representation for minor injury units via the chief operating officer, through the divisional lead to the minor injury unit service manager and nurse consultant, then through emergency nurse practitioner seniors or leads into teams of emergency nurse practitioners and other members of the team.
- The register was not effective for identifying, recording and managing risks, issues and mitigating actions. The risk register identified the service manager and senior emergency nurse practitioner as leads in the description of the risks. Of the 15 risks entered 11 were dated 2010, one risk had no date entered two were from 2013 onwards and one was from 15 June 2015. Although all risks were for annual, quarterly and weekly review, the progress of actions undertaken and the recorded progress update was not clear enough to assure us that they had received recent scrutiny. The service manager had requested at a best practice group meeting any risk

assessments that were not currently on the local risk register for minor injury units to be sent to them 26 May 2015. Of the 15 risks on the register the only risk after that date was for the electronic information system.

- There was not alignment between the recorded risks and what staff said was 'on their worry list'. For example, staff 'worry lists' included not enough staff for them to feel comfortable in taking breaks while patients waited for treatment; not enough staff to manage spikes in demand (although these issues had been raised as incidents); and not all staff received formal one to one meetings in line with the trust policy. Some staff described the need for more formalised one to one support to complement the other support available if the service was to work with patients who had greater need. The trust clinical supervision policy stated that managers should ensure the service has a systematic process of support and supervision to facilitate staff in their development.
- We spoke with the nurse consultant about lone working. The nurse consultant described a level of complacency regarding the use of personal alarms. We reviewed the lone working policy for the trust and guidance that was given regarding personal alarm use. Personal alarms were recorded on the local risk register as a mitigating factor for lone working. The risk of non-compliance with the lone working policy or personal alarm use was not recorded on the local risk register. Lone working was also recorded as a low risk on the risk register. When we requested the risk assessment for lone working in minor injury units it was explained that minor injury unit staff did not lone work. This was at odds with the trust policy definition of lone working "…any situation or location in which someone works without a colleague nearby or when someone is working out of sight or earshot of another colleague.". Non-compliance with trust policy use of personal alarms could delay assistance being called in event of an attack.
- Quality and performance were measured and understood by service and trust leaders through, audits, commissioning for quality and innovation and performance figures.
- We saw evidence of a broad selection of local audits completed in relation to minor injury units, although, analysis and conclusions was minimal in the records audit and learning points were not clearly identified.

Leadership of this service

- Leaders of minor injury unit services had the skills, knowledge, experience needed. When we spoke with staff they told us that both the service manager and nurse consultant worked clinical shifts. While they were visible to minor injury unit staff the service manager and nurse consultant were unable to visit all minor injury units as regularly as they would like.
- The nurse consultant understood the challenges to the service and had identified actions needed with the service manager in a paper for the clinical commissioning group (March 2015) to address service capacity and skill level.
- The trust had reorganised the leadership of the service in the three weeks prior to the inspection. When we spoke with the divisional lead that had been in post for three weeks they were clear about key elements of staffing the service, such as vacancy rates and sickness absence and they were starting to understand the minor injury unit service as a provider of minor injury and illness assessment and treatment that was in demand.
- In the minutes of the minor injury operational group meeting 28 October 2014 Phase 2 integration information had been emailed to emergency nurse practitioner leads and the service manager had requested that the information be cascaded. Most staff we spoke with felt they were not be able to describe the trust programme for better health and social care integration (IP2 or integration phase 2) succinctly. Staff did speak about some experiences of integrated service delivery, for instance work with mental health so that a patient received appropriate support from the right team.

Culture within this service

- We observed strong supportive teams who were able to deal with whatever arrived at a minor injury unit.
- We also experienced a culture that encouraged candour, openness and honesty. For example, staff at all levels shared their concerns during inspection and what might be needed to resolve issues.
- Overall the culture was one of openness and transparency and this was described by staff as a means to promote good quality care. Despite issues raised about breaks and the demand on the service at times, most staff we spoke with described feeling valued.

Requires improvement

Are services well-led?

- Staff we spoke with felt the trust tried to live by the six Cs of care, compassion, competence, courage, communication and commitment, and that the trust focus was on the patient.
- **We saw staff not complying with the lone working policy. For instance staff we spoke with and observed did not wear personal alarms that were provided. There were opportunities for staff to come to harm while they were not in direct sight or hearing of another person. Staff said they would wear alarms if they were to go to another part of the hospital (more remote and later at night). Staff did not seem to recognise the potential for harm to them if they could not reach a fixed alarm point.**

Public engagement

- The trust used the Friends and Family Test (FFT) to capture feedback from people who used the service. During 2014/2015 respondents said they were likely (18%) or extremely likely (78%) to recommend the service.
- People who use the Somerset Partnership NHS Foundation Trust minor injury unit service had responded through the Friends and Family test (FFT) by returning 5152 responses for the period January 2015 to August 2015 of a total of 14715 for the trust overall. Minor injury units were used by 107502 people in the period 1 August 2014 to 31 August 2015. The response rate reported by the trust in quarter 1 for the period 2015/2016 for FFT for Bridgwater minor injury unit which had the lowest response rate was 5.5% with Chard the highest with 53.5%. In quarter two for the period 2015/2016 for FFT Bridgwater had the lowest response rate of 3.5% with Frome the highest at 49%. During 2014/2015 respondents said they were likely (18%) or extremely likely (78%) to recommend the service.
- Response rates dropped in April 2015 when the FFT system of recording changed from a token based system to paper records. Comments and response rates from minor injury unit were broken down as follows. Less than 1% of people said they were extremely unlikely to recommend the service for a variety of reasons such as I don't live here, long wait times. Less than 1% people said they were unlikely to recommend the service for a variety of reasons such as I am on holiday here, wait times too long, 18% people said they were likely to recommend the service for a variety of reasons such as fast service, approachable staff, 78% of people said they were extremely likely to recommend the service for a variety of reasons such as fast efficient service, pleasant staff, my 'issue was resolved'.
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Staff engagement

- Some emergency nurse practitioners felt that they had not been consulted enough about how urgent care provision might develop. Some staff were concerned about the greater acuity of patients attending minor injury units and the implications for them and the service.
- Staff attended regular best practice group and operational group meetings with the nurse consultant and the service manager
- Most staff used the electronic incident reporting system to raise concerns and managers of the service had engaged with them about issues raised. The feedback had also been accompanied by change also.
- Staff we spoke with understood the potential need for change in the service if patients and commissioners wanted it.

Innovation, improvement and sustainability

- We spoke with the nurse consultant who was the lead nurse for minor injury units for the trust. They described the potential future development of the minor injury units. One strategy was to move to an urgent care model managing an increase in complexity providing a service which bridged the gap between minor injuries units and emergency departments. They had a clear vision outlined for responding to future commissioning intentions that mirrored Transforming Urgent and Emergency Care Services in England safer, faster, better: good practice in delivering urgent and emergency care a guide for local health and social care communities, August 2015. They were clear that further staff and public engagement would be needed before any future development.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises Health and Social Care Act 2008 (regulated activities) Regulations 2014 (part 3) Regulation 15(1)(e). The provide had failed to ensure that all premises and equipment used by the service provider were properly maintained, People who use services were not protected against the risks associated with unsafe equipment because the trust were not able to produce evidence of adequate maintenance.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services Health and Social Care Act 2008 (regulated activities) Regulations 2014 (part 3) Regulation 17(1) and (2)(b) The provider had failed to ensure that there were systems or processes established and operated effectively to 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; Local risk registers were not complete or up to date and did not reflect current risks or contain clear action plans for addressing the risks.

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents Health and Social Care Act 2008 (regulated activities) Regulations 2014 (part 3) Regulation 18(2)(a) The provider had failed to ensure that all staff received appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. Not all staff were receiving appropriate ongoing or periodic supervision in their role to make sure competence is maintained. Not all staff were compliant with statutory mandatory training for moving and handling