The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust

Royal Bournemouth Hospital

Quality Report

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Royal Bournemouth Hospital is the larger of two hospitals provided by The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust. The trust gained foundation status in 2005 and provides services, to a population of 550,000 in the Dorset, New Forest and south Wiltshire areas, which rises in the summer months due to an influx of visitors to the area.

We inspected the trust and Royal Bournemouth Hospital as part of our comprehensive inspection programme.

The Royal Bournemouth Hospital has approximately 600 inpatient beds and 123 day case beds. The hospital provides urgent and emergency care, medical care, surgery, critical care, end of life care, outpatient and diagnostic services. There is a limited maternity and gynaecology service, including a three bedded birthing unit and community midwife service. The children and young person's service is limited to eye surgery and outpatients. The main centre for obstetrics and gynaecology and paediatric services is at a nearby NHS hospital in Poole.

We inspected eight core services at the hospital: urgent and emergency care, medical care, surgery, critical care, maternity and gynaecology, children and young people, end of life care, outpatient and diagnostic services. Detailed findings on children's outpatient dermatology service is also included in this location report under children and young people's core service.

We carried out an announced inspection visit to the hospital 20 -22 October 2015 and additional unannounced inspection visits 27 October, 4 and 9 November 2015. The inspection team included CQC managers, inspectors, and analysts. Doctors, nurses, allied healthcare professionals, senior NHS managers and 'experts by experience' were also part of the team.

We rated Royal Bournemouth Hospital as 'requires improvement ' overall and requires improvement for providing safe, effective, responsive and well led care. We rated urgent and emergency care, medical care, maternity and gynaecology services as requires improvement overall. We rated caring overall as good across most services and outstanding in children and young people services, but as requires improvement in medical and older people services. We found surgery, critical care, services for children and young people, end of life care and outpatient and diagnostic imaging services were good overall.

Our key findings were as follows:

Are services safe?

- Staff were encouraged to report incidents. However, this process was not embedded in all areas. Some staff did not always receive direct feedback. There was investigation and learning to improve the safety of services.
- The rate of incidents (NRLS) per 100 admissions was below the England average with 98% of incidents being low or no harm incidents. There were 47 serious incidents in the 12 months to April 2015, of which four were Never Events. The rate of serious incidents was below the median of all trusts (2013/14). The majority of serious incidents were pressure ulcers and falls. In October 2015, the trust was at 91% for harm free care and not meeting its own targets (95%).
- The initial clinical assessment of emergency patients arriving at the emergency department during the day was timely within the national standard of 15 minutes. However, at night the assessment was not timely or appropriately performed and this put some patients at risk.
- Patients were assessed and monitored by nursing staff using electronic hand held devices. However, some staff did not always complete risk assessments in a timely and effective manner whilst getting used to the new nurse electronic risk assessment process.
- The early warning score system needed to be used more consistently for the escalation of patients whose condition might deteriorate.

Summary of findings

- In some operating theatres, staff did not follow the five steps for surgical safety consistently or accurately, to minimise the risks of patient harm.
- There was not an up-to-date protocol to remove a collapsed woman from a birthing pool in the event of unforeseen complications during labour or birth. Staff were not consistently able to describe emergency procedures in the birth centre.
- Medicines were not consistently managed safely across the hospital. In some areas medicines were not stored securely, or stored safely at correct temperatures. Staff did not always follow trust policy when administering medication or destroying controlled drugs.
- Staff generally adhered to infection control procedures, but there were some lapses in hand hygiene and some practices did not fully support effective infection control and prevention.
- Some clinical areas such as emergency department and critical care unit were cramped. The corridor between Derwent Suite and the main hospital, used for transfers, was not suitable for patients. Most wards and clinical areas were clean but we found dust and cobwebs in some operating theatres.
- Equipment was checked and stored appropriately in most areas but this needed to improve in the emergency department, critical care and some medical and surgical wards, specifically for emergency and transfer equipment.
- Overall, staff had a good understanding of safeguarding adults and children
- More staff needed to complete mandatory training, compliance was below the trust target in most areas.
- Although there had been recruitment of nursing staff, vacancy levels were still high on some wards, and there was evidence that requests for additional staff to provide cover were not always met. On occasions there was a lack of consideration of the skill mix when agency and bank staff were covering vacant shifts. Wards that had a high number of temporary staff on duty did not have sufficient numbers of permanent staff to provide guidance to the temporary staff about meeting patient individual needs in a safe manner.
- There was appropriate medical staffing levels in most areas, although consultants in emergency departments were not present in the department for 16 hours a day as recommended by the Royal College of Emergency medicine. The critical care unit was left without medical cover after 11pm if the one junior doctor was called for an emergency elsewhere.
- In diagnostic imaging, staff were confident in reporting ionised radiation medical exposure (IR(ME)R) incidents and followed procedures to report incidents to the radiation protection team and the Care Quality Commission.
- Senior clinical staff were aware of the Duty of Candour regulation and the importance of being open and transparent with patients and families. The considerations and documentation around this regulation needed to be happen in sexual health services, on one occasion.
- The majority of do not attempt cardio pulmonary resuscitation (DNACPR) forms had been appropriate completed.

Are services effective?

- Mortality rates in the trust were within expected range. Mortality rates had improved (downward trend) over the last 18 months. There was no difference between weekend and weekday mortality rates. Seven day services in emergency medicine, acute medicine gastroenterology, cardiology, and critical care supported this positive trend
- The treatment and care provided in most services took account of current evidence-based guidelines. However, evidence-based guidelines for the care and treatment of patients in the emergency department were not always followed.
- The end of life care services had introduced personalised care plan for the last days of life (PCPDL). Wards we visited were aware of this documentation which was a replacement following the national withdrawal of the Liverpool Care Pathway in July 2014. The trust was piloting AMBER Care Bundle on some wards.
- Most services participated in national and local audits which showed improving and good outcomes for patients. Emergency care patient outcomes varied and the results of audits were not always used to improve treatment techniques. The midwifery service did not collect information on patient outcomes and there was no programme of audits in place.

Summary of findings

- Pain relief, drinks and food were not always given in a timely manner in the emergency department. Patients received good pain relief and nutrition across all other services.
- Most patients had access to services seven days a week and were cared for by a multi-disciplinary team working in a co-ordinated way. However the allocation of multidisciplinary support to the critical care unit, including pharmacy and physiotherapy, was lower that recommended. The wider multidisciplinary team did not attend the consultant led ward round on the unit.
- The critical care unit was working with the Specialist Nurses in Organ Donation (SNODs) to improve organ donation rate.
- There was a low staff appraisal rate following the introduction of a new system, we found its use was improving and most staff completed training relevant to their roles. There was a comprehensive training programme for medical staff but little evidence of nursing staff competency training in the emergency department. Not all staff had access to clinical supervision
- Access to information was mostly effective. In some services patient information was held in a variety of formats which meant it could sometimes be difficult to use and time consuming to find. Electronic patient records were recently implemented in outpatient clinics which staff were using. However, this was accompanied by increases in administrative time and difficulty in finding some records which did have an impact on timeliness of information access and potential for risks to patients. The trust had a plan to address staff concerns around this.
- Staff followed consent procedures and had a good understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards which ensures that decisions are made in patients' best interests.
- Children and young people were consented appropriately and correctly.

Are services caring?

- Across the hospital we found staff worked hard to ensure that patients were treated with dignity and respect, despite the challenges sometimes presented by the environment. However in medical and older people services, patients did not always receive care in a way that respected their privacy and dignity.
- Patients were asked for their views and response rates were high, with a high proportion of patients recommending care and treatment.
- Patients told us, and we observed, that staff were kind and compassionate, putting the patient at the centre of care.
- Patients, relatives and families were kept informed of plans for care and treatment. They told us they felt involved in the decision-making process and had been given clear information about treatment options.
- Patients and their families were supported by staff emotionally to reduce anxiety and concern. There was also support for carers, family and friends for example, from the chaplaincy, bereavement services for patients having end of live care, and counselling support where required.

Are services responsive?

- Bed occupancy in Royal Bournemouth Hospital range between 90-95%. This was consistently above the England average. It is generally accepted that at 85% level, bed occupancy can start to affect the quality of care provided to patients, and the orderly running of the hospital.
- Performance in meeting national emergency access target for 95% of patients to be admitted, transferred or discharged within 4 hours varied through the year. The target was not met for 36 of the 52 weeks to March 2015. The trust had achieved the target (95.3%) July-September 2015.
- A lack of available beds in the hospital had resulted in delays in treatment for patients brought by ambulance and meant the emergency department was often full and this impacted on patient privacy.
- The number of ambulances waiting more than an hour to hand over patients had reduced significantly since the introduction of a rapid assessment and treatment area (BREATH) but still averaged four per month.
- There were long delays for patients with fractured hips to be transferred to Poole Hospital that treated trauma patients. The trust was taking action to introduce a formal pathway.

Summary of findings

- The acute medical unit (AMU) and Treatment Investigation Unit (TIU) had been set up to manage the increasing pressures on beds due to an increasing demand.
- There were 55 medical outliers at the time of inspection. Their patients were appropriately assessed and followed by a team of medical consultant and junior doctors.
- The hospital performed above the England national average for the referral to treatment standards for patients to wait less than 18 weeks (May to July 2015). Previously, it had not met this standard on any of the 12 months to April 2015.
- Access to critical care beds within four hours was similar to comparable units. There were low rates of surgery cancellation due to lack of critical care beds. There was a higher than average number of delayed discharges, which resulted in mixed sex breaches, sometimes across several days. The service was performing better than similar services in avoiding out of hours discharges.
- The hospital's cancellation rate for operations was below the England average for all quarters in 2014/15
- The trust was meeting national waiting times for diagnostic imaging within six weeks. However in October 2015 the percentage of patients Trust wide waiting over 6 weeks for all diagnostics was 6.2% compared to the England average of 2 – 2.5%. In diagnostic imaging no patients were waiting over 6 weeks in October 2015.
- Outpatients referral to treatment for patients was meeting the standard to wait less than 18 weeks. The trust short notice cancellation rate for appointments were lower (better) than the England average.
- Cancer waiting times for urgent referral appointments were below the national standard of two weeks (June 2014 – March 2015). However the trust was meeting the standard (April – June 2015). The trust was not meeting the standard for decision to treatment within 31 days (June 2014 – June 2015). The standard for 62-day cancer referral to treatment time was not met, specifically for urology and colorectal surgical treatments (June 2014 – June 2015). The trust was taking steps to reduce delays in these pathways.
- Most patients were seen by the hospital palliative care team within 24 hours. The rapid discharge service for discharge to a preferred place of care was responsive to the needs of patients and families.
- The hospital had implemented an improvement programme to reduce patient length of stay in hospital, and had identified specific barriers which they were addressing. There was a high number of delayed transfers of care. The main cause of delays was waiting for NHS non-acute care and patient and family choice, to meet patients' ongoing needs. The provision of community services, especially care home and nursing home places, also caused delays.
- The environment did not always support patient needs. Women on the urogynaecology ward had to walk past male patient bays to access toilet facilities. Not all wards had been refurbished to improve the environment for patients living with dementia, but this was planned.
- Clinical staff knew how to access information to support them in meeting the needs of patients with a learning disability or living with dementia. They demonstrated an understanding of adjustments that could be made to support patients.
- There was a robust complaints handling process and responses to complaints were detailed and considerate. Staff understood how to manage complaints and there was evidence of learning from concerns and complaints. However, complaints were not being responded in a timely manner, in July 2015, only 50% of complaints were responded to within the trust target of 25 days.

Are services well-led ?

- The trust had published its vision, values, mission statement and objectives, and had taken action to assess and improve staff understanding of these. The trust had recently introduced values based appraisal and staff had better understanding of trust values if they had completed appraisal.
- The trust described its five-year strategic plan for patient care, underpinned by six strategic objectives, taking into account the two possible outcomes of the clinical services review. The wider strategic direction of services was largely contingent on the ongoing outcome of the Dorset wide clinical services review. Service leads agreed with the trust's preferred option to become the major emergency hospital in the area.

Summary of findings

- Most services had local strategic plans and were monitoring progress although this varied. The end of life care overarching strategy was produced in response the inspection, but had not been through consultation or approval by the board.
- Most services had had effective clinical governance arrangements to monitor quality, risk and performance. However, governance processes in urgent and emergency care , maternity and gynaecology were not always effective in identifying issues and making improvements to safety and quality
- Local risk registers did not always reflect all of the concerns described to us by staff, or provide sufficient detail on actions being taken. Information about risk and quality issues were not always shared with staff.
- Staff were positive about the local leadership and the trust management focus on improving the hospital's culture. However many staff noted a lack of visibility of the senior executive team.
- Staff commented positively on local culture and teamwork. They said they would raise concerns about patient care if they witnessed poor practices.
- Patient feedback was mainly through survey feedback or FFT, but there were some patent focus groups and the hospital had worked the local Healthwatch to obtain patient views.
- Ideas to innovative and improve services were encouraged. There was participation in research and quality improvement projects
- There was a cost improvement transformation group for every directorate in the trust. The service leads considered 'safety and quality' as a priority in the cost improvement plans (CIPs).

We saw areas of outstanding practice including:

- The interventional radiology department had been awarded exemplar status by the British Society of Interventional Radiology for continuous audit, review and research in the unit, and improving patient experience. This award had been retained twice. The staff team were particularly proud of this achievement, particularly as they were not linked to a teaching hospital.
- In Maternity and Gynaecology the Sunshine team offered support to women that were assessed as being vulnerable. They could be vulnerable due to mental illness or learning disability, but also from alcohol and substance misuse. The team worked with the local centre that cared for women who had been trafficked to Britain. The Sunshine team worked across health and social care and had excellent relationships with the police, education and the mental health. The service had been recognised by an all-party parliamentary group for its work with vulnerable women.

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

Importantly, the trust must ensure :

- At all times, emergency department patients are assessed and treated according to nationally agreed standards, particularly those for sepsis and fractured neck of femur
- Emergency department transfer equipment is checked regularly to ensure that it is always ready for use.
- All incidents are reported using the trusts incident reporting process and staff receive feedback.
- Pain relief, drinks and food are given in a timely manner .
- All staff comply with good hand hygiene and infection control practices
- Equipment is appropriately labelled, maintained, checked, cleaned and tested.
- Equipment that poses a risk of cross contamination is disposed of promptly
- That all premises and environments used by patients are clean, secure and safe for use including theatres and the corridor between Derwent suite and main hospital.
- All emergency equipment is checked and maintained in working order
- All medicines are stored securely, correctly and within a safe temperature range .
- Patient medicines are checked and recorded to ensure they receive the correct medicines when admitted to hospital
- Medicines are administered in a safe manner, following national guidance and trust procedures
- Patient risks are assessed and documented in a timely manner and escalated appropriately

Summary of findings

- A policy, protocol and appropriate equipment is available to remove a collapsed woman from a birthing pool, and staff are trained in its use.
- Sufficient numbers of suitably qualified, competent, skilled and experienced persons are deployed at all times. Including sufficient numbers of permanent staff to provide guidance to the temporary staff about meeting patient individual needs in a safe manner.
- Staff receive appraisal annually in line with trust policy and procedures and access to clinical supervision improves .
- Privacy and dignity of patents is protected during care and treatment.
- The hospital escalation procedures are improved so that delays to ambulance patients are minimised
- Delays in discharge are reviewed to prevent patient stay in an inappropriate location and mixed sex breaches, particularly in critical care services.
- There are effective systems to identify, assess, monitor and improve the quality and safety and mitigate risks across departments, in particular maternity and gynaecology services and the emergency department .

In addition the trust should ensure:

- There is always a band 7 nurse in charge of each shift in the Emergency Department
- There is a consultant presence in Emergency Department for 16 hours each day.
- Appropriate monitoring takes place check that changes in practice are effective
- There is a robust competency framework in place for nursing staff in the Emergency Department.
- Junior medical staffing levels on critical care are reviewed as there are at times when staff are called away from the unit to other wards.
- All PDGs are up-to-date and available for staff to use, in particular midwives and sexual health staff
- Oxygen cylinders are stored safely in theatre areas.
- Improvements in safety and communication around the critical care patient handover.
- Policies and procedures are comprehensive and up to date within theatres and critical care.
- Critical care clinical guidelines are up to date and appropriately approved and monitored.
- There is a checklist for all critical care patient transfers
- Multi-disciplinary team working improves in critical care services to ensure patients receive care according to recommendations and there is effective communication centred around the patient.
- Improved multi-disciplinary working with the SNODs to increase the organ donation rate
- Records are accessible in a timely way and there are improvements to the electronic patient record system
- Where relevant, mental capacity assessments are completed on DNACPR forms.
- Patients are offered the opportunity to wash their hands before meal times.
- There is consideration of the provision of eating utensils and how food is presented at meal times
- The environment on wards is suitable for people living with dementia
- Privacy is improved for patients in the major treatment area in the emergency department
- The accommodation of medical patients on surgical wards is minimised.
- Facilities for relatives of patients in critical care and end of life care are improved.
- There are separate toilet and washing facilities of the urogynaecology ward, so that women do not have to walk past male patients to access these facilities.
- There is awareness of the interpreter service throughout the hospital
- Regular team meetings or forums are set up to encourage shared learning amongst paediatric staff; especially paediatric nurses across the trust.
- There is a sustainability/succession plan in place for paediatric dermatology service
- Feedback from patients improves in critical care services
- Staff engagement improves on critical care services .
- there is consultation on the overarching end of life strategy with internal and external stakeholders.
- Patient information is available in an easy to read format, and in other languages than English
- The general décor of the chapel is improved

Summary of findings

- Chaplaincy provision review and timelines of delivery of good quality pastoral, spiritual and religious care
- Patient outcomes data is collected and used to improve services in maternity and gynaecology
- Duty of candour is appropriately considered in all cases where there is harm, a potential for harm, including psychological harm.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services	Requires improvement 	We rated the service in the emergency department as requires improvement for safe, effective, responsive and well-led services. Care of patients was good. Learning from incidents was not always embedded in practice. Initial clinical assessment of patients during the day was quick and, on the whole, effective. However, at night assessment was not timely or appropriate and this put patients at risk. Much of the department was cramped and poorly ventilated. Some staff did not follow appropriate hand hygiene procedures and medicines were not always stored correctly. Patient records were fragmented and some were poorly completed. The department had appropriate medical staffing levels although consultants were not present in the department for 16 hours a day. There were good nurse staffing levels and skill mix. There was active recruitment to existing vacancies. There was a lead children's nurse and a qualified children's nurse on each shift. The requirements for safeguarding of children, young people and vulnerable adults were understood and implemented by staff. Although there were easily accessible evidence-based guidelines for the care and treatment of patients these were not always followed. There were occasions when staff did not follow professional standards for the treatment of sepsis and fractured neck of femur. Pain relief, drinks and food were not always given in a timely manner. Patient outcomes varied and the results of audits were not always used to improve treatment techniques. There was a comprehensive training programme for medical staff but we could find little evidence of nursing staff competency training. There was good multi-disciplinary working and access to radiology and pharmacy was available 24 hours a day, seven days a week. Access to mental health services was limited out of hours. Staff provided compassionate care and worked hard to ensure that patients were treated with dignity and respect despite the challenges

Summary of findings

sometimes produced by a crowded department. There were good results from the national emergency department patient survey. Patients that we spoke with were positive about the care they received, and the attitude of motivated and considerate staff. Patients, relatives and families were kept informed of plans for care and treatment. They told us they felt involved in the decision-making process and had been given clear information about treatment options.
Delays in admitting patients to a hospital bed meant that the emergency department was often full and could not immediately treat new patients. The number of ambulances waiting more than an hour to hand over patients had reduced significantly since the introduction of the rapid assessment and treatment area (BREATH). An ambulatory emergency centre had been developed by the hospital but we could see little evidence that it had improved treatment for ED patients.
The treatment of patients with complex needs lacked focus. Response to complaints was timely, comprehensive and considerate.
Governance and quality monitoring processes were not always effective and the risk register did not reflect all of the concerns related to us by staff. Departmental leaders were described as having the knowledge, skills and integrity to carry out their roles. There was a good sense of teamwork and staff felt supported by their colleagues and managers. A number of improvements had been made to the service in order to enhance the treatment of patients.

Medical care (including older people's care) — **Requires improvement**

There were areas of good and innovative practice in most areas of medical and older people services. But we found medical and older people services overall, required improvement.
Safety of the service needed to improve as there were risks for patients posed by some practices and staffing numbers and skill mix. Staff knew how to report incidents, but not all incidents were reported. Medicines were not consistently managed in a safe and effective manner. Medicines were signed as administered without observing whether the patient had taken the medicines. In some areas

Summary of findings

were not stored in a secure manner. Inaccurate monitoring of medicine drug fridges meant it was not assured refrigerated medicines were stored at correct temperatures.

The electronic risk assessment process did not always support staff to complete risk assessments in a timely and effective manner. For some patients there was no current record of identified risks or plan of actions to mitigate risks, as risk assessments were overdue by up to three days.

Although staff adhered to infection control practices in relation to hand hygiene and personal protective equipment, other practices did not fully support effective infection control and prevention practices. Patients were not consistently offered the opportunity to wash their hands prior to meals and on one ward there were dirty clinical items (blood stained gauze and sharps bins and trays) left next to patient's bedside which posed risk of cross infection.

There were vacancies of nursing staff on all the medical and older people wards. During the unannounced inspection we saw patient's wellbeing was put at risk because there a lack of consideration was paid to the skill mix when agency and bank staff were covering vacant shifts. Poor compliance with mandatory training and appraisal rates meant patients were at risk of being cared and treated by staff who lacked updated knowledge and skills.

Patients did not consistently receive care that respected their privacy and dignity. We observed patients were left exposing the lower half of their body, a patient was administered an injection without pulling curtains around them, lifting their gown up for the injection in view of patients and staff. Patients were left in nightwear on the wards, when they preferred to wear their own clothes. A patient said they had to pass urine in a pad, rather than be supported to use the toilet, because staff took so long to answer call bells.

The treatment and care provided followed current evidence-based guidelines. Medical services participated in national and local audits which showed improving and good outcomes for patients.

Patients had access to services seven days a week and were cared for by a multi-disciplinary team

Summary of findings

working in a co-ordinated way. Patients told us they felt involved in decision making about their care. Where patients lacked capacity to make decisions for themselves, staff acted in accordance with legal requirements.

Services were developed to meet the needs of the local population. The trust was working with partners to decrease delayed patient discharges, and was also working to improve its internal processes to ensure daily discharge targets could be met.

Innovative and new working practices supported the trust to improve patient flow and patient experience. A GP led ward for older patients medically fit for discharge, but whose discharge was delayed, released acute beds in the hospital for unwell patients to be admitted and treated by the hospital medical staff.

There were new services that worked in a multidisciplinary manner, including working with community services, which improved outcomes for patients and reduced their length of stay in hospital. This included the heart failure service and working in partnership with Dorset Adult Integrated Respiratory Service. with provided a holistic and multidisciplinary service for patients with heart failure which had result in improved outcomes and reduced length of stay in hospital for patients with heart failure. Employment of an Acute Kidney Injury (AKI) nurse specialist, providing education, outreach bleep service Monday to Friday and development of care pathways resulted in reduced length of stay and reduced mortality rates for patients with AKI. New pharmacy working practices on ward 26, which included two pharmacists embedded into the multidisciplinary team, resulted in improved effectiveness and outcomes for patients.

Governance processes promoted reviews of the service provision and identified areas for improvement. However, risk registers at department and trust level did not identify all risks posed to the service and patients. The culture within medical services was caring and supportive. Staff were actively engaged and the division supported innovation and learning.

Summary of findings

Surgery

Good

This core service was rated as good. We rated safe as requires improvement and found effective, caring, responsive and well led were good.

We rated safe as requires improvement because of shortfalls in areas of medicines management, cleaning, the environment and equipment, surgical checklist compliance and staffing levels. For example, staff were not always monitoring medicine storage temperatures or following trust policy when destroying controlled drugs. We found dust and cobwebs in some theatre areas, although ward areas were visibly clean. The routes for patients to move from the main hospital wards to the Derwent unit were not suitable for patients, and some items of equipment were not stored safely or were not accessible. Although there had been recruitment of nursing staff, vacancy levels were still high in some areas, and there was evidence that requests for additional staff to provide cover were not always met. We found that in some theatres, staff did not follow the five steps for surgical safety accurately. There were systems in place to assess and respond to patient risks however, and records were generally legible and comprehensive. If they were completed electronically, they were automatically monitored for compliance.

Staff commented that access to information was not always effective. Patient information was held in a variety of formats which meant it could sometimes be difficult to use and time consuming to find.

Patients received care and treatment that followed national clinical guidelines and staff used care pathways based on evidence-based research. Staff audited patient treatment and care, and used the findings to improve outcomes for patients. Patients commented positively about the skills of staff, the quality of food and the provision of pain relief. Reports showed appraisal rates were improving following the introduction of a new system. Staff completed training relevant to their roles, but overall their compliance with mandatory training was below the trust target.

There was effective team working within and across different staff groups. This included multi-disciplinary working to provide person

centred care. Staff commented that local leadership was good and there were opportunities for personal and professional development. Some staff, however, felt isolated and disconnected from the senior management team. This was mainly theatre staff.

Patients told us that staff provided care in a kind and compassionate manner and they were involved in decisions about their care. They were asked for their views and response rates were high, with a high proportion of patients recommending treatment. Results of patient feedback, as well as quality and safety data, were displayed for patients and visitors to view on ward areas.

There was an effective governance structure to review performance and there was evidence of formal reviews of risks, incidents, deaths, complaints and audits. Performance data showed the hospital was achieving the referral to treatment times and its cancellation rate for operations was below the England national average. Medical patients were frequently allocated beds on surgical wards however, and this presented a risk to patient experience and care. Staff worked hard to minimise this risk by working to admission criteria and re-allocating staff to reflect patient needs.

Critical care

Good

We rated critical care services as good overall, the service required improvement for responsiveness. There was a higher than average number of delayed discharges, which at times resulted in mixed sex breaches, sometimes across several days.

There was a culture of reporting and learning from incidents, the majority of staff received feedback from reported incidents. There was a low rate of hospital acquired infections, but infection control practices were not always adhered to.

The unit was built before specific building regulations, it was cramped and cluttered. There were safety systems for management of medicines, records and equipment. However, there was not always evidence that equipment was checked and ready to use.

There were processes for identifying and responding to risks and deteriorating patients on the unit.

Summary of findings

The unit was consultant led and staffing levels met national guidelines, however the one doctor on duty at night was sometimes called away to the wards. The number of staff completing mandatory training was below trust target.
The critical outreach team was available 24 hours a day to respond to respond to requests to assess deteriorating patients across the hospital. The team followed up all patients discharged from the unit.
The treatment and care provided was evidence based. National and local audits and data showed there were good outcomes for patients. A number of critical care policies and clinical protocols were in the process of being reviewed.
There was access to multi-disciplinary services seven days a week. The wider multidisciplinary team did not attend the consultant led ward round the ward round. The allocation of multidisciplinary support to the unit, including pharmacy and physiotherapy, was lower that recommended.
Nurses were competent and trained in critical care nursing, with access university validated training. There was a low staff appraisal rate since introduction of a new process.
There was evidence of innovation and three research nurses undertook trials which aimed to improve patients care and outcomes. The critical care unit had won an award for developing a patient transfer course.
There was timely access to the unit and low rates of cancellation of operations due to lack of beds. The service was performing better than similar services in avoiding out of hours discharges.
Staff understood how to manage complaints and there was evidence of learning from concerns and complaints. Processes for formally obtaining patient and relative feedback were limited to the family and friends test on discharge.
Governance processes promoted reviews of the service quality and identified areas for improvement. Staff reported a strong consultant centred hierarchical culture on the unit and this was limiting delegation and multi-disciplinary team working.
Staff were caring and patients were treated with dignity and respect, staff tried to anticipate their needs and to enhance their experience on the unit.

Summary of findings

Patients and relatives gave positive feedback about the care they received and confirmed they had been informed and involved in the decision making regarding care and treatment. Staff offered on going emotional and psychological support to bereaved families.
The critical care unit was working to improve organ donation rate.

Maternity and gynaecology — **Requires improvement** 

Maternity and gynaecology required improvement in the effectiveness and leadership of services. The services were safe, caring and responsive.
Incidents were reported by staff, and these were investigated appropriately. However, learning from incidents was shared locally and not more widely.
There were attempts to ensure governance processes were carried out robustly. However, the sharing of patients with Poole Hospital made this complex, it was not always clear who owned the actions around quality and risk from governance meetings.
There were appropriate numbers of appropriately trained staff on the maternity unit and gynaecology service. There was a high midwife to birth ratio in the maternity service.
The storage and management of medicines was mostly safe. However, medicines that required to be stored in a refrigerator were not stored consistently at the correct temperature.
There was no up-to-date protocol to remove a collapsed woman from a birthing pool in the event of unforeseen complications during labour or birth.
Staff participated in mandatory training, but completion of some courses was low against the trust target. Good infection control and prevention measures were seen. Action was taken when audits showed that hand hygiene was not satisfactory at the birth centre.
Good infection control and prevention measures were seen. Action was taken when audits showed that hand hygiene was not satisfactory at the birth centre.
The service provided a caring and supportive environment for women in pregnancy and those

undergoing gynaecological surgery. Women were happy with the care they received from the services and this was consistently demonstrated by patient feedback.
The service did not collect outcomes from patients to allow them to monitor progress against targets and ensure that the service was providing effective care and treatment. Although there was a programme of audits in place, no results from them were available. The service was not collating sufficient assurance that evidence based care was being provided.
The service was responsive to the needs of women with access to the midwife led birth unit available across 24 hours. Community midwives provided antenatal care and support in GP surgeries and in children's centres. Community midwives were able to support women with a low risk of complications, to give birth at home if that was the woman's wish. Midwives provided effective coordination of a woman's care through pregnancy, birth and the post-natal period. There was a designated team of midwives to support women that were vulnerable. Appointments for investigations required in gynaecology were available at times to suit patients. There was emotional support available for women and their families.
The trust had identified that there were potential risk associated with the changes to leadership for maternity service.

Services for children and young people

Good

Children and young people received compassionate care that respected their privacy and dignity. They told us they felt involved in decision making about their care. We found staff were caring and compassionate. Without exception, parents of the children we spoke with praised staff for their empathy, kindness and caring. Children's emotional needs were highly valued by staff and were embedded in their care and treatment.
Process and procedure was followed to report incidents and monitor risks. Staff were encouraged to report incidents. The environment was clean and equipment was well maintained. The children's eye ward provided a 'child-friendly' environment with a variety of age appropriate toys and play equipment

Summary of findings

and access to play areas. Staff across all services described anticipated risks and how these were dealt with. Safeguarding protocols were in place and staff were familiar with these.
Infection control practices were followed. Staff regularly washed their hands in between patients, used personal protective equipment such as gloves and aprons, and adhered to the trust's 'bare below the elbows' policy.
Children whose condition deteriorated were appropriately escalated and action was taken to ensure harm-free care. The five steps to safer surgery checklists were completed for children and young people undergoing surgery.
Nursing staffing on the children's eye ward and outpatient clinics was adequate. There were three ophthalmology consultants with a paediatric specialist interest who operated on children for eye surgery. The trust employed two paediatric anaesthetic consultants to provide anaesthetic and analgesic advice in the eye theatre. The children in dermatology unit were seen by dermatology consultants with a paediatric specialist interest.
Staff provided care to patients based on national guidance, such as National Institute for Health and Care Excellence (NICE) guidelines. The trust did not participate in any national audits related to children and young people.
Arrangements were in place to ensure that staff had the necessary skills and competence to look after patients. The acute referral eye unit at the Royal Bournemouth Hospital (RBH) offered a seven-day service for children and young people suffering with acute eye problems. The unit was open between 8am and 6pm every day of the week. Staff received statutory and mandatory training, and described good access to professional development opportunities.
Children and young people were consented appropriately and correctly. Young people were presumed to be able to give consent depending on their maturity and the nature of the decision. Staff undertook competency assessment and, when a patient was found not competent, only a person with parental responsibility was able to give consent.

Summary of findings

There was clear guidance for staff on 'which patients to accept for eye surgery' at the eye unit at RBH. Children aged less than one year of age and those with multiple comorbidities and traumatic eye injury were referred to Poole hospital or Southampton hospital for treatment.
Complaints were handled appropriately in line with trust policy and these were reviewed to improve the service.
There was no documented vision or strategy for services provided for children and young people. Staff were aware of the trust's strategy and described high quality patient care as key components of the trust's vision. There were effective governance arrangements and staff felt supported by service and trust management.
The culture within children and young people services was caring and supportive. Staff were actively engaged and innovation and learning was supported. There was good local leadership at ward level.

End of life care

Good

There was a good track record and steady improvements in safety. Staff were aware of their responsibilities to report incidents and they received feedback on these incidents. Learning from incidents had taken place. Improvements to safety were made and the resulting changes monitored.
There were clearly defined and embedded systems to keep people safe. Arrangements to minimise risks to patients were in place including measures to prevent falls, and pressure ulcers. Patients had comprehensive assessments of their needs and were appropriately monitored. Staff demonstrated a good understanding of the early identification of a patients whose condition might deteriorate. The mortuary was appropriately clean. . All wards had documentation of the new care plan that the trust had introduced in July 2014 to replace the Liverpool Care Pathway
People's care and treatment was planned and delivered based on current national and evidence-based guidance. There were local guidelines for the management of the five key symptoms at the end of life. The end of life care team had successfully introduced personalised care

Summary of findings

plan for the last days of life (PCPDL). Wards we visited were aware of this documentation which was a replacement following the national withdrawal of the Liverpool Care Pathway in July 2014. The trust was piloting AMBER Care Bundle on some wards. This was in response to an overarching vision and six ambitions identified in the National Framework of Ambition for Palliative and End of Life Care, 2015-2020.

There was participation in relevant local and national clinical audits. The trust participated in the National care of the dying audit for hospitals (NCDAH) 2013/14 and performed worse than average for six out of seven organisational indicators. However, a trust audit in August 2015 demonstrated that the trust had achieved progress in five out of seven indicators and there were ongoing plans for improvement.

Feedback from people who use the service was consistently positive about the way staff treat people. Patients were cared for by compassionate and caring staff and we observed patients being treated with dignity and respect.

Patients told us they were well informed in their treatment and care. For example staff spent time talking to people to discuss and allay their fears.

There was a clear statement of vision of end of life care. This vision was based on promoting quality of care and a culture of patient safety. The trust, after our visit, produced a document with an overarching strategy for end of life care based on existing strategic objectives and actions to meet national guidance and standards. This had not been subject to consultation or consideration by the trust board.

A consultant in palliative care was the clinical lead who championed end of life care and palliative care, and the associate medical director provided leadership and support. There was a steering group to monitor performance against national standards. Strategic objectives were supported by quantifiable and measurable outcomes, which were cascaded throughout the organisation.

The end of life steering group met regularly and had identified an audit programme to monitor the quality of the service. The end of life care team had

developed their own performance dashboard based on national standards and local guidance. This was presented to the trust board on a monthly basis, for discussion.

Outpatients and diagnostic imaging

Good

The outpatient and diagnostics imaging departments provided good safe, caring, responsive and well led services for patients.
Staff were encouraged to report incidents and the learning was shared to improve services. In diagnostic imaging, staff were confident in reporting ionised radiation medical exposure (IR(ME)R) incidents. They followed procedures to report incidents to the radiation protection team and the Care Quality Commission where necessary. The Duty of Candour was understood by senior staff, but it was not appropriately documented and considered. There was not however, a clear breach of the regulation.
The environments were visibly clean and staff followed infection control procedures. Equipment was maintained regularly and medicines were appropriately managed and stored. However, in sexual health services the patient group directions for administration of medicines had expired.
Electronic patient records were used in outpatient clinics; this had been a recent implementation. Staff felt they were using the system well but there was concern about the increases in administrative time on clinic staff and the management of records information to reduce risk to patients.
Patients were assessed and observations were performed, where appropriate. However, there was no assessment tool available to identify patient's whose condition might deteriorate in outpatients.
Nurse staffing levels were appropriate and there were few vacancies. Radiographer vacancies were higher but recruitment was underway, some candidates had recently been appointed.
People's care and treatment was planned and delivered in line with current evidence-based guidance, standards, best practice and legislation. This was monitored to ensure consistency of practice. There were local audit programmes to monitor clinical standards. Staff had access to training and had annual appraisal but did not have formal clinical supervision.

Summary of findings

Staff followed consent procedures and had a good understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards which ensures that decisions are made in patients' best interests. Patients consistently told us that they had experienced a good standard of care from staff across outpatients and diagnostic imaging services. We observed compassionate, caring interactions from nursing, medical and radiography staff. Patients and relatives told us that they were included in the decision making process regarding their care and treatment. Staff recognised when a patient required extra support to be able to be included in understanding their treatment plans. There was good evidence of service planning to meet people's needs. For example, the breast clinics within the Jigsaw building offered access to one stop clinics, patients were able to see a clinician, have a biopsy and see a radiologist if required. Ophthalmology patients had access to a one stop cataract clinic. National waiting times were met for outpatient appointments and cancer referrals. There were some clinics cancelled at short notice, but this was lower than the England average. The waiting times for diagnostic imaging within six weeks met national targets on average over the year. However, In October 2015 the percentage of patients waiting over 6 weeks for diagnostics was 6.2% compared to the England average of 2 – 2.5%. There was good support for patients with a learning disability or living with dementia. Clinicians had access to translation services and most staff knew how to access the service if required. The service received very few complaints and concerns were resolved locally. Staff were not aware of complaints across the trust or the learning from complaints. The outpatient department had a strategy and were developing a plan to improve new patient referral waiting times. There were plans to deliver advice and guidance via telephone clinics, to assess where follow up care should be provided. There were various one stop and nurse led clinics already in place. Staff were not aware of how the strategy would develop for the future within their own

departments. In diagnostic imaging they were working toward the '2020 strategy' with staff representatives who were assisting to move the strategy forward.
Governance processes to monitor risk and quality were well developed within the outpatient departments and in diagnostic imaging.
Some staff were clear about the overall vision and values of the trust. Nurses and radiographers spoke highly of their immediate line managers and told us they worked in caring, supportive teams which they valued.
There were good examples of local innovation and improvement to services. Particularly in ophthalmology, diabetes and endocrine services and in respiratory medicine.

Royal Bournemouth Hospital

Detailed findings

Services we looked at

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

Detailed findings

Contents

Background to Royal Bournemouth Hospital

Royal Bournemouth Hospital is the main hospital in The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust. The trust gained foundation status in 2005. It provides services, to a population of 550,000 in the Dorset, New Forest and south Wiltshire areas, which rises in the summer months due to an influx of visitors to the area.

Services at Royal Bournemouth Hospital are accessed by patients across both Bournemouth and Christchurch districts. These districts are in the 4th and 2nd quintiles of the 2010 English Indices of Deprivation respectively – where the 1st quintile is the least deprived.

The Royal Bournemouth Hospital has about 600 inpatient beds and 123 day case beds. Services at the hospital include urgent and emergency care, medical care, surgery, critical care, end of life care, outpatient and diagnostic services. There is a limited maternity and gynaecology service, including a three bedded midwife led birthing unit and community midwife service. The children and young person's service is limited to ophthalmic surgery and outpatients.

We inspected the hospital as part of our comprehensive inspection programme. We inspected eight core services at the hospital: urgent and emergency care, medical care, surgery, critical care, maternity and gynaecology, children and young people, end of life care, outpatient and diagnostic services. Detailed findings on children's outpatient dermatology service at Christchurch Hospital are included in this location report under children and young people's core service.

Our inspection team

Our inspection team was led by:

Chair: Bronagh Scott, Deputy Chief Nurse, NHS England London

Head of Hospital Inspections: Joyce Frederick , Care Quality Commission

The team of 44 included CQC managers, inspectors and analysts, and a variety of specialists including: Consultant in intensive care medicine, consultant gynaecologist and obstetrician; consultant surgeon; consultant geriatricians; consultant radiologist; consultant paediatrician; specialist registrar doctors with experience in emergency medicine, paediatric ophthalmology, and medicine; respiratory physician. Emergency care nurse, midwife; senior surgical nurse; theatre nurse; medical nurse; paediatric nurse, palliative and end of life care nurse;

critical care consultant nurse; sexual health nurse; board-level clinicians and managers, a governance lead; a safeguarding lead; a student nurse; and three experts by experience.

How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider: Is it safe? Is it effective? Is it caring? Is it responsive to people's needs? Is it well-led?

We carried out an announced inspection visit to Royal Bournemouth Hospital 20 -22 October 2015. We visited unannounced late evening 27 October, during the day and evening 4 November and morning 9 November 2015

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

We held stalls and listening events at a library, shopping centre, leisure centre and an evening meeting Bournemouth on Wednesday 7 October 2015. People shared their views and experiences of The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust.

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

During our inspection we spoke with patients and staff from all areas of the hospital, and accompanied palliative care team on a home visit. We observed how people were being cared for and talked with carers and/or family members and reviewed personal care or treatment records of patients.

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

Facts and data about Royal Bournemouth Hospital

Facts and Figures: The Royal Bournemouth NHS Foundation Trust- Trust wide

This organisation has two locations The Royal Bournemouth Hospital and Christchurch Hospital

1. Context

- There are 601 inpatient beds and 130 day-case beds at this trust, in 2014-15 there were 264,443 bed days.
- The main Clinical Commissioning Groups (CCGs) for this trust are Dorset CCG and West Hampshire CCG.
- The trust serves a population of approximately 550,000 people in the Dorset, New Forest and south Wiltshire areas, which rises in the summer months due to an influx of visitors to the area.
- As at summer 2015, the trust employed 4,477 staff (3,818.8 Whole Time Equivalents, WTE). During 2013/14 2.9% of WTE staff were bank or agency; we do not have comparable figures for 2014/15.
- The trust has an annual turnover of £266.4m, and in 2014/15 the deficit was £5.2m.

2. Activity

- Inpatient admissions: 112,141 (2014/15).

- Outpatient attendances: 313, 070 (Jan – Dec 2014) of which 38% were first attendances and 62% were follow up
- A&E attendances: 86, 441 (/2014 /15).
- Births: 380 (2014/15).
- Deaths: 1,171 (Jan – Dec 2014).

3. Bed occupancy

- General and acute:

Q1 2014/2015: 92%;Q2 2014/2015: 94%;Q3 2014/2015: 95%

Q4 2014/15: 93%

This was higher than both the England average of 88% and the 85% level at which it is generally accepted that bed occupancy can start to affect the quality of care provided to patients, and the orderly running of the hospital.

- Maternity range was 17% - 42% bed occupancy (April 2013 to March 2014) lower than the England range 55% - 60%.
- Adult critical care average was 67% (33% – 92%) bed occupancy (April 2013 to March 2014) lower than the England average 84% (77% – 88%).

4. Intelligent Monitoring

- In the latest Intelligent Monitoring report (May 2015), this trust had three risks and no elevated risks.
- The priority banding for inspection for this trust was six (the lowest priority band), and their percentage risk score was 1.58%.

The risks identified were as follows:

- Composite indicator: In-hospital mortality – Neurological conditions
- Composite of knee related PROMS indicators
- SSNAP Domain 2: overall team-centred rating score for key stroke unit indicator

5. Safe

- 'Never events' in past year: Four (May 2014 – April 2015).
- Serious incidents: 47 (May 2014 – April 15). Rate of incident reporting was below the England average.
- National Reporting and Learning System (February 2014 – January 2015): 6,913 events reported, of which 28 (0.4%) caused death or severe harm to the patient.

Deaths

0.001%

England Average 0.1%

Severe harm

0.003%

England Average 0.4%

Moderate harm

2.0%

England Average 4.0%

Low harm

32.1%

England Average 21.8%

No harm

65.8%

England Average 73.7%

- There were 23 cases of Clostridium difficile (May 2014 – May 2015) and one case of MRSA – no evidence of risk.
- Data from the Patient Safety Thermometer showed that there were 20 Falls with Harm, 122 Pressure Ulcers, and 26 cases of catheter-acquired urinary tract infections (CUTIs) between July 2014 and July 2015.

Waiting times

- A&E – Time to initial assessment: above (better) England average and 15 minute standard (2014/15)
- A&E - Time to treatment: above (better) England average and 60 minute standard (2014/15)

6. Effective

- April 2014 - March 2015: the Hospital Standardised Mortality Ratio (HSMR) in this Trust was 101.77; the HSMR was within the expected range for weekdays and weekend admissions.

Detailed findings

- October 2013-September 2014: the Summary Hospital-level Mortality Indicator (SHMI) in this Trust was 103; the SHMI was within the expected range for weekdays and weekend admissions.
- There were no mortality outliers in this trust in 2014/15.

7. Caring

- CQC Inpatient Survey (10 areas): similar to other trusts.
- Friends and Family Test inpatient: Significantly above the England Average (March 2014 – February 2015).
- Friends and Family Test A&E: above the England Average (March 2014 – February 2015). However, the response rate was low.
- Cancer Patient Experience Survey (34 questions): similar to other trusts for 37 questions; and highest scoring 20% for five questions, below other trusts for two question. (2012/13 - 2013/14)
- Patient-Led Assessments of the Care Environment - below England Average: cleanliness, food, privacy, similar to the England average - dignity and wellbeing and facilities.

8. Responsive

- Between April 2014 and March 2015, this trust received 360 complaints. 190 (53%) were upheld or partially upheld. Average number of working days to close a complaint: 31 days. Average number of days for open complaints: 106 days.
- A&E four-hour standard – not met; below the England average and 95% target (April 2014 to December 2015).
- For patients on the incomplete pathway, the Referral to Treatment (RTT) performance in June 2015 was 94.4%, above the standard of 92% (2014/15)

For Q1 2015/16

- 96.4% of cancer patients were seen by a specialist within two weeks of an urgent GP referral, which is above the operational standard of 93 %.
- The proportion of cancer patients waiting less than 31 days from diagnosis to first definitive treatment was 94.9%, below the standard of 96%.
- 85.8% of cancer patients waited less than 62 days from urgent GP referral to first definitive treatment, which is above the standard of 85%.
- Delayed transfers of care: Reasons similar to the England average, although 22% of those awaiting patient or family choice, above the England average of 13%.

9. Well- Led

- NHS Staff Survey (2014): This trust performed in the top 20% of trusts for four key findings, and in the bottom 20% of trusts for one key findings. For the remaining 24 key findings analysed, the trust had a similar performance to other trusts. The response rate in this trust was 49% (higher than the England average of 42%, but below the rate in 2013 – which was 55%).

	All	White	BME	Difference
KF18 - Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months*	30%	31%	37%	6%
KF19 - Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	25%	24%	33%	9%
KF28 - In the last 12 months have you personally experienced discrimination at work	12%	10%	39%	29%
KF24 - % of staff that would recommend this trust as a place to work or receive treatment	3.71	3.69	3.96	0.27

* Unusually, for KF18, the values for the 'White' and 'BME' groups are both higher than the Trust values. 13 of the 409 respondents appear not to have declared their ethnicity.

- Staff Sickness rate was 3.9% - below the England average (Nov 2014 – Oct 2015)
- Use of bank and agency staff (medical) – below the England average.
- General Medical Council National Training Scheme Survey (2015): Within expectations. Negative outlier – induction and feedback.

10. CQC Inspection History

- There have been nine inspections at the Trust since 2011.

Detailed findings

- The trust had seven compliance inspections against outcomes. 11 outcomes were inspected, and the hospital was compliant with 10 of these. The non-compliant with Medicines management in September 2011 (RBH).
- The trust had a comprehensive inspection (no ratings) in October 2013. The trust was non-compliant with - care and welfare, privacy and dignity and governance. A follow up focused inspection in August 2014, identified significant improvements.

Our ratings for this hospital

Our ratings for this hospital are:

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

Notes

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

Urgent and emergency services

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

Information about the service

The emergency department (ED) at Royal Bournemouth Hospital is open 24 hours a day, seven days a week. It treats people with serious and life threatening emergencies and those with minor injuries which need prompt treatment such as lacerations and suspected broken bones. Major trauma cases go directly to Poole Hospital.

The department has a three-bay resuscitation room. One resuscitation bay contains equipment for children although children requiring an ambulance are taken to the specialist children's department at Poole Hospital. There is 13-bay major treatment area and a rapid assessment and treatment area known as BREATH (Bournemouth Rapid Evaluation and Assessment Hub). Less seriously ill or injured patients are seen in the minor treatment area which has 11 cubicles. The department has a separate children's treatment area with its own waiting room. There is an eight bedded observation ward and well-equipped x-ray facilities. Outside is a helipad for an air ambulance. The emergency department last year (ending March 2015) saw almost 79,000 adult patients and 9,000 children. Approximately 20,000 patients required admission to a ward.

We last inspected the department in August 2014 and found there were no breaches of regulation but some improvements needed to be made. These were regarding aspects of privacy and dignity, the mental health care pathway and admission arrangements for young people ages 16 and 17 years. There was also a need to check that emergency transfer equipment was appropriate and ready for use.

We visited between 20 and 22 October 2015 and undertook an unannounced inspection during the evening of 27 October 2015. We observed care and treatment of patients and looked at 26 treatment records.

During our inspection we spoke with approximately 30 members of staff including nurses, consultants, doctors, receptionists, managers, support staff and ambulance crews. We talked with 17 patients and two relatives. We received comments from patients and the public at our listening events, and we reviewed performance information about the department.

Urgent and emergency services

Summary of findings

We rated the service in the emergency department as requires improvement for safe, effective, responsive and well-led services. Care of patients was good.

Learning from incidents was not always embedded in practice. Initial clinical assessment of patients during the day was quick and, on the whole, effective. However, at night assessment was not timely or appropriate and this put patients at risk. Much of the department was cramped and poorly ventilated. Some staff did not follow appropriate hand hygiene procedures and medicines were not always stored correctly. Patient records were fragmented and some were poorly completed.

The department had appropriate medical staffing levels although consultants were not present in the department for 16 hours a day. There were good nurse staffing levels and skill mix. There was active recruitment to existing vacancies. There was a lead children's nurse and a qualified children's nurse on each shift. The requirements for safeguarding of children, young people and vulnerable adults were understood and implemented by staff.

Although there were easily accessible evidence-based guidelines for the care and treatment of patients these were not always followed. There were occasions when staff did not follow professional standards for the treatment of sepsis and fractured neck of femur. Pain relief, drinks and food were not always given in a timely manner. Patient outcomes varied and the results of audits were not always used to improve treatment techniques.

There was a comprehensive training programme for medical staff but we could find little evidence of nursing staff competency training. There was good multi-disciplinary working and access to radiology and pharmacy was available 24 hours a day, seven days a week. Access to mental health services was limited out of hours.

Staff provided compassionate care and worked hard to ensure that patients were treated with dignity and respect despite the challenges sometimes produced by a crowded department. There were good results from the national emergency department patient survey. Patients that we spoke with were positive about the care they received, and the attitude of motivated and considerate staff. Patients, relatives and families were kept informed of plans for care and treatment. They told us they felt involved in the decision-making process and had been given clear information about treatment options.

Delays in admitting patients to a hospital bed meant that the emergency department was often full and could not immediately treat new patients. The number of ambulances waiting more than an hour to hand over patients had reduced significantly since the introduction of the rapid assessment and treatment area (BREATH). An ambulatory emergency centre had been developed by the hospital but we could see little evidence that it had improved treatment for ED patients.

The treatment of patients with complex needs lacked focus. Response to complaints was timely, comprehensive and considerate.

Governance and quality monitoring processes were not always effective and the risk register did not reflect all of the concerns related to us by staff. Departmental leaders were described as having the knowledge, skills and integrity to carry out their roles. There was a good sense of teamwork and staff felt supported by their colleagues and managers. A number of improvements had been made to the service in order to enhance the treatment of patients.

Urgent and emergency services

Are urgent and emergency services safe?

Requires improvement

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

We rated safe as 'requires improvement'.

- The learning from incidents was not always embedded in practice.
- Much of the department was cramped and poorly ventilated. Some staff did not follow appropriate hand hygiene procedures.
- Medicines were not always stored correctly and equipment was not always checked to ensure it was safe to use.
- Patient records were fragmented and some were poorly completed.
- Initial assessment of ambulance patients during the day was quick and, on the whole, effective. However, at night assessment was not timely or appropriate and this put patients at risk.
- The national early warning score (NEWS), which is used to identify patients whose condition might deteriorate, was not being used appropriately.

However,

- Incidents were reported and investigated in a timely, honest and thorough manner
- The requirements for safeguarding of children, young people and vulnerable adults were understood by staff.
- The department had appropriate medical staffing levels although consultants were not present in the department for 16 hours a day as recommended by the Royal College of Emergency medicine. There were appropriate nurse staffing levels and skill mix and active recruitment to existing vacancies. There was a lead children's nurse and a qualified children's nurse on each shift.

Incidents

- There were two serious incidents in the emergency department (ED) in 2013/14. The department had investigated these incidents in a timely, honest and thorough manner. All contributing factors were taken into account and measures were identified to help prevent a repeat of similar incidents. Learning points from incidents were clearly described in the investigation reports and in governance meeting minutes.
- One of the incidents involved a patient with a clotting disorder and one of the learning points was the introduction of a new venous thrombo-embolism (VTE) risk assessment. Despite this we found several patients whose risk had not been assessed. A consultant told us that an audit was underway to monitor preventative treatment for VTE.
- As a result of another incident a new safety process had been implemented to ensure that all abnormal x-rays were acted upon. However, there was no audit planned to ensure that the new process was working properly.
- We looked at the ED incident reports from March to June 2015. These had been logged on the hospital incident reporting system. Incidents were clearly described and appropriate remedial action taken when necessary. Although some staff said that they did not receive feedback after they had reported incidents, we were shown a newsletter that was available to all staff that summarised incidents and the actions that had been taken.
- Mortality and morbidity discussions were incorporated into quarterly risk and governance meetings but there was limited attendance from the multidisciplinary team.
- The Duty of Candour requires healthcare providers to disclose safety incidents that result in moderate or severe harm, or death. Any reportable or suspected patient safety incident falling within these categories must be investigated and reported to the patient, and any other 'relevant person', within 10 days. Organisations have a duty to provide patients and their families with information and support when a reportable incident has, or may have occurred.
- All staff that we spoke with understood the principles of openness and transparency that are encompassed by the Duty of Candour. Senior staff demonstrated detailed knowledge of the practical application of this new responsibility

Cleanliness, infection control and hygiene

- The ED was visibly clean and tidy. We observed support staff cleaning the department throughout the day.

- Hand washing facilities were available throughout the department but two of the hand gel dispensers were empty when we tried to use them.
- We were shown audits of infection prevention and control practices which included monthly audits of hand washing. These showed that compliance with good practice was between 90% and 100%. However, when the department was busy there were several occasions when nurses had not washed their hands before undertaking a new clinical activity. For example, we observed a nurse preparing and administering intravenous drugs without washing their hands or wearing gloves. On two occasions we observed a nurse lifting a clinical waste bin lid by hand then attending to a patient without cleaning hands.
- The sluice was clean and well organised and clinical waste was handled and disposed of safely.

Environment and equipment

- Staff told us that the major treatment area had been adapted from a previous ward area and, as a result, ventilation was poor. This meant that during the day an external fire door had to be propped open in order to allow fresh air to circulate.
- The children's treatment area was well equipped but small. It became hot and crowded when all the patient cubicles were in use and there was more than one parent or carer with each child. Although portable fans had been provided there were not enough work surfaces available to allow them to be positioned safely.
- The helipad for the air ambulance was easily accessible from the department.
- There was a good range of resuscitation and monitoring equipment. This was clean and well maintained. Equipment in the resuscitation room was checked daily and this was recorded on a standard checklist.
- There was no checklist for the transfer equipment used when taking patients to intensive care; it was not possible to know when it had last been checked. We found an item of equipment with an expiry date of September 2015. This indicated that it had been at least a month since this resuscitation equipment had been checked to make sure that it was ready for use.
- The observation ward consisted of two four-bedded bays, one for women and the other for men. It did not have a separate resuscitation trolley. Staff told us that they would collect relevant equipment from the resuscitation room but this may have caused delays in an emergency.

Medicines

- Most medicines were stored correctly in locked cupboards or fridge. However we did find some examples where good practice was not followed. For example, we observed a half-filled syringe of intravenous sedation placed next to a patient in the resuscitation room. There was no nurse with the patient to ensure that the medication could not be incorrectly administered by a non-clinical person.
- Cases of transfer equipment also contained anaesthetic and resuscitation medication which were unsecured. The cases were stored in an unobserved area of the department which was easily accessible to the public. This meant potentially dangerous medication could have been stolen or abused. We brought this to the attention of the nurse in charge who took immediate action to ensure that the medication were made safe.
- There was a locked storage container for patients' own medication in the major treatment area but it was not always used. We observed open packets of a patient's own medication left on the treatment trolley beside them. The storage container in the observation ward was left unlocked as it did not have a padlock.
- Medicines were prescribed using a variety of different documents which we considered was confusing for staff and could lead to some doses of medicines being overlooked. Some medicines charts consisted of a single sheet of A4 paper which was easy to lose amongst a number of other forms in the patients' files. It also meant that allergies to medication were not recorded on every prescription chart medicines administration record.
- Hospital medication charts were not used for patients admitted to the observation ward even though many stayed there for up to 24 hours. This posed a particular risk for patients who were on long term medicines which were not always given to them when they were in the observation ward.
- We observed staff administer intravenous fluids safely and correctly. They completed accurate details on the medication chart although the fluid balance chart was not always completed.

- There were no audits of microbiology protocols or the administration of antibiotics for ED patients.

Records

- When a patient was registered their details were entered onto a computer system that showed how long people had been waiting and the investigations they had received. Patient records and information stored on computer was protected by passwords and backed-up to keep it secure.
- The system produced patient records in a paper format so that all healthcare professionals could record care and treatment using the same document.
- When patients left the department the paper record was scanned on to the computer system to allow access to records for patients who have previously attended the department. Paper records were disposed of using a secure shredding service that ensured patients information was kept safe.
- We found the paper records to be fragmented and poorly completed. Different documents were used for different treatment areas which seemed to cause confusion for staff. For instance, staff could not always show us where pain scores or early warning scores (NEWS) were recorded.
- Records included space for risk assessments for pressure ulcers and falls and there was a checklist to assist staff to identify patients who were vulnerable or at risk of mental health problems. These were often not completed.
- We looked at the records of 12 patients in the major treatment area and resuscitation room. Six had no NEWS scores and four had no pain scores. Nine patients required a pressure ulcer risk assessment but only two had been completed.
- During our unannounced inspection, two patients with intravenous infusions and urinary catheters had no fluid balance charts completed.
- We asked to see copies of record-keeping audits to see if this was a long-standing problem. We were told that the department did not audit their records to check that they were completed correctly.
- Records for children included consideration of safeguarding checks. The Paediatric Early Warning System (PEWS) was used for children.

Safeguarding

- Staff that we spoke with were aware of their responsibilities to protect vulnerable adults and children. They understood the safeguarding procedures that were in place and how to report concerns. The “At risk” register was checked for all children attending the department, up to and including the age of 17 years.
- All clinical records for children contained a risk assessment tool aimed at quickly identifying any concerns regarding child welfare. These had been completed correctly.
- All staff were expected to do level 2 child protection training and senior clinical staff were expected to undertake level 3 training. At the time of our inspection 68% of senior doctors and all senior nurses had completed level 3 children’s safeguarding training. 83% doctors and 96% nurses had completed level 2. Adult safeguarding training had been completed by 95% of nurses and 83% of doctors.
- The records of all children that had attended the department were reviewed by a level 3 trained nurse to ensure that there were no risk factors for child abuse, and to check that health visitors and GPs had been informed of the attendance.

Mandatory training

- Mandatory training included essential topics such as fire training, health and safety, infection control, information governance and medicines management. Training records up to June 2015 showed intermittent uptake of this annual training. Rates of attendance varied from 28% for information governance by doctors to 94% for infection control and blood transfusion by nurses. This was below trust target 95%.

Assessing and responding to patient risk

- Patients that arrived by ambulance as a priority (blue light) call were taken immediately to the resuscitation area. Such calls were phoned through in advance so that an appropriate team could be alerted and prepared for the arrival of the patient.
- During the period November 2014 to March 2015, the trust had a relative low number of ambulance handover delays of over 30 minutes when compared to other trusts.
- From 10am-10pm other adult patients arriving by ambulance were taken to the rapid assessment and

treatment (BREATH) area where diagnostic tests and initial treatment were undertaken by senior nursing and medical staff. Once the patient's condition had been assessed and stabilised they were transferred to another treatment area within the department.

- Senior staff told us that, since this new area had been established, delays for ambulance patients had reduced significantly. Hospital figures showed that, in the year ending June 2015, an average of 22 ambulance patients a month waited more than 60 minutes to be assessed by A&E clinical staff. Since June this had reduced to a maximum of six per month.
- After 10pm we observed ambulance crews brought patients to the corridor between the major treatment area and the resuscitation room. One member of the ambulance crew would find the nurse in charge and give a verbal handover. Based on this conversation the nurse would decide whether the patient was seriously ill or not and in which part of the department they should be treated. A summary of the conversation would be entered into the departmental computer system before the patient was registered. The nurse did not go to see the patient or assess them in any way. This meant that the patient's condition was at risk of deteriorating while they waited to be seen by an emergency department clinician.
- A national target has been set that states ambulance patients should be handed over to the care of ED staff within 15 minutes. The hospital was failing to meet that target. After the verbal handover we observed seriously ill and injured patients waiting in the corridor for up to 50 minutes. Although the ambulance crew stayed with the patients they did not actively monitor the patient's condition. Therefore patients were at risk of deteriorating during that time.
- We raised our concerns with senior managers within the hospital and were shown a protocol for the initial assessment of patients brought by ambulance. The protocol identified what they should to for nurse assessment. However, our observations were not doing an assessment if the patient at handover after 10pm, and this involved more than one nurse. It was custom and practice to bypass the protocol when the department was busy.
- The ambulance service took children directly to Poole hospital where there was a specialist children's ED.
- Patients who walked into the department, or who were brought by friends or family were directed to a receptionist. Once initial details had been recorded the patient was asked to sit in the waiting room. They were told that they would be rapidly assessed by a senior nurse. This assessment was required in order to determine the seriousness of the patient's condition and to make plans for their on-going care. This is often known as triage.
- Guidance from the Royal College of Nursing and Royal College of Emergency Medicine (RCEM) states that "Triage is a face to face encounter which should occur within 15 minutes of arrival." The A&E department at the Royal Bournemouth Hospital was not meeting this standard. From January 2013 – July 2015 the trust median time for initial assessment was between 1 – 2 minutes (lower than the England average of 5 minutes). However, during our inspection we often saw patients waiting 40 minutes to be triaged.
- Staff in the department found it difficult to monitor triage delays accurately. Details of ambulance patients were obtained from the crew by the triage nurse and entered on to the computer system before the patient was assessed or registered. Although this saved time when ambulance crews arrived it meant that the median time to initial assessment may not have been accurate.
- The assessment room was situated next to the waiting room and nursing and reception staff were able to observe activity there. This helped to ensure the safety of people when they first arrived.
- Although staff told us NEWS was used, this was not found in practice where it would have been appropriate. This is a quick and systematic way of identifying patients who are at risk of deteriorating. Once a certain score is reached a clear escalation of treatment is commenced.
- However, during our inspection staff only occasionally used NEWS for some patients in the major treatment area. It was not used for sicker patients in the resuscitation room. We observed a patient who was at high risk of cardiac arrest being treated by a junior doctor. Calculation of an early warning score would have alerted staff to the need of rapid treatment by a senior doctor. We prompted a referral to the doctor in charge of the department who commenced the correct treatment
- There was a protocol in place for the assessment and treatment of patients with sepsis, but it was not always followed. During our inspection, a patient with signs of

sepsis was not seen by a doctor for one hour and 50 minutes. This meant that the opportunity to give antibiotics, oxygen and intravenous fluids in the first hour was missed.
- Patient risk assessments such as those for venous thromboembolism (blood clots) and, pressure ulcers were not completed appropriately. Although there was space in the patient records for these to be recorded, they were often not completed.
- Overall, from January 2013 to July 2015, the trust median time to treatment was below the England average (approximately 50 – 55 minutes) and below the standard of 60 minutes. The time ranged from 40 to 65 minutes.

Nursing staffing

- The ED matron used an acuity tool to calculate the number of nurses required, by monitoring the number of patients that normally attend and the seriousness of their illnesses or injuries. In addition, nurse to patient ratios were checked against guidance issued by the National Institute of Health and Clinical Excellence (NICE).
- We looked at nurse staffing for the month prior to our inspection and found that, on the whole, there were sufficient nurses to meet the NICE guidance. There were a number of vacancies for band 5 nurses. The nurse in charge explained that senior nurses were moved from more specialist roles to work in treatment areas when necessary. Very few agency nurses were used and a senior nurse told us that most of the agency nurses worked regularly in the department and were familiar with local working practices.
- A band 7 sister was present in the department on every shift in line with NICE guidelines.
- There was at least one registered children's nurse on duty at all times.

Medical staffing

- The department employed seven consultant doctors and an eighth was due to start in 2016. The department did not comply with the recommendations of the Royal College of Emergency Medicine to have a consultant present in the department for 16 hours a day. Instead, consultants commenced work at 8am and finished at 9pm during the week and from 8am to 5pm at weekends.
- Consultants were on-call from home after these hours but were also on-call for the ED at Poole Hospital. We were told by one consultant that they had never been called out to both hospitals at the same time.
- Staff told us that the department had not been allocated any senior specialist trainees doctors by the regional deanery. Instead they employed middle grade doctors and provided them with in-house training.
- There were four vacancies for a middle grade doctors. These were being filled by internal locum doctors who were normally employed elsewhere in the hospital. They had undergone appropriate induction training and were familiar with the workings of the department.
- Junior doctors rotated between day and night shifts and currently worked seven 11 hour shifts followed by four days off. Two doctors told us that they found this very tiring. We discussed this with a consultant who showed us the results of a consultation with junior doctors that had taken place in December 2014. The majority had stated that they preferred to work seven nights in a row.
- Junior doctors spoke positively about working in the ED. They told us that the consultants were supportive and accessible, but at night and weekends, when there were no consultants, senior advice was more difficult to obtain. In-house teaching was well-organised and comprehensive and teamwork was good.
- We saw consultants working clinically in the department. They led the treatment of the sickest patients, advised junior doctors and co-ordinated the morning clinical handover of patients.
- There was one handover per day where all doctors were involved. This was at 8am.The handover that we witnessed was brief and unstructured. No reference was made to early warning scores and opportunities for clinical teaching were missed, despite that fact that there was a patient whose treatment had not complied with RCEM standards. No mention was made of waiting times for admission even though at least one patient had been in the department for three and a half hours.

Major incident awareness and training

- The hospital had a major incident plan (MIP), which was up-to-date and detailed. The MIP provided clinical guidance and support to staff on treating patients of all age groups and included information on the triaging and management of patients suffering a range of injuries. These included injuries caused by burns, blasts or chemical contamination. It also described how to

contact support staff, voluntary services and chaplains to provide additional support for the large numbers of people who may attend the hospital enquiring about family and friends.
- Staff in the department were well-briefed and prepared for a major incident and could describe the processes and triggers for escalation. Similarly they described the arrangements to deal with casualties contaminated with chemical, biological or radiological material (HAZMAT). Major incident training had taken place in the last year.
- Equipment and documentation was kept in two large locked cupboards. The key was kept in a locked cupboard in the resuscitation room but was accessible within one minute.
- Nursing staff told us that security staff responded promptly when called. They had been trained in conflict resolution and the safe restraint of violent individuals.

Are urgent and emergency services effective?
(for example, treatment is effective)

Requires improvement

By effective, we mean that people's care, treatment and support achieves good outcomes,

promotes a good quality of life and is based on the best available evidence

We rated effective as "requires improvement".

- There were evidence-based guidelines for the care and treatment of patients however, these were not always followed.
- Staff did not always follow standards for the treatment of patients with sepsis, although performance was being monitored and had improved.
- Staff did not always follow best practice guidelines for the treatment of patients with fractured neck of femur. The trust had recently introduced a checklist to improve this.
- Pain relief, drinks and food were not always given in a timely manner.
- Patient outcomes varied and the results of audits were not always used to improve treatment.
- There was a comprehensive training programme for medical staff but we could find little evidence of a nursing staff competency framework.
- Access to mental health services was limited out of hours.

However,

- There was good multi-disciplinary working including effective relationships with GPs, therapists and specialty doctors.
- Access to radiology and pharmacy was available 24 hours a day, seven days a week
- There was good access to information via the departmental computer system. Staff had a good understanding of consent and the Mental Capacity Act (2005).

Evidence-based care and treatment

- The ED department used a combination of NICE and Royal College of Emergency Medicine (RCEM) guidelines to determine the treatment that was provided. Guidance was discussed at risk and governance (RaG) meetings, disseminated and acted upon as appropriate.
- A range of clinical care pathways and proformas had been developed in accordance with guidance produced by NICE. These were easily accessible via the departmental computer system. They included diabetic keto-acidosis, sepsis and assessment of severe headache. We could not find guidance for the treatment of acute alcohol withdrawal or a rapid tranquilisation policy. Both situations occurred commonly in the department. At quarterly governance meetings any changes to guidance and the impact that it would have on practice was discussed.
- The department satisfied the requirements of the national "Standards for children and young people in Emergency Care settings".
- The ED participated in a number of national audits, including those carried out on behalf of the Royal College of Emergency Medicine (RCEM).
- There was also a local audit programme including topics such as oxygen prescribing, older person's assessments and the treatment of dislocated shoulders, head injuries and blood clotting disorders. Despite these audits, we found little evidence that the results

were used to improve practice. For example very few patients had risk assessments for venous thrombo-embolism and we could find no older person's assessments undertaken by ED staff.

Pain relief

- We observed that nurses administered rapid pain relief when they assessed patients who had walked into the department. On occasion, we witnessed long delays for patients arriving by ambulance. One patient with a broken hip waited for two hours and another with chest pain waited four hours.
- During our inspection we observed timely pain relief administered to children. The results of the pain relief were monitored and additional treatment given if necessary.
- Although formal pain scores were not always assessed, all the patients that we spoke with reported that they had been offered appropriate pain relief. Records showed that this had been administered in line with hospital policy.
- The trust scored similar to other trusts in the A&E Survey 2014 for questions on pain relief

Nutrition and hydration

- Following the assessment of a patient, intravenous fluids were prescribed and administered and recorded when clinically indicated.
- Although we saw staff offering refreshments during the course of our visit this was not done on a regular basis and was not always recorded in the patient record. Three of the patients that we spoke with told us that they were hungry and had not been offered any food.
- Patients in the observation ward did not have a jug of water provided for them even though there length of stay could be up to 24 hours. We brought this to the attention of senior staff at the time of our inspection. When we returned the following week all patients in the observation ward had been provided with water.
- The trust scored similar to other trusts in the A&E Survey 2014 for the question on nutrition and hydration.

Patient outcomes

- The ED participated in a number of national audits, including those carried out on behalf of the Royal College of Emergency Medicine (RCEM).
- The 2014 RCEM audit for sepsis showed the department performed better than the average for other hospitals in England. However, some aspects, for example, blood glucose measurement and high flow oxygen, did not meet professional standards. During our inspection assessment and treatment did not always comply with professional standards. Local policies for treatment of sepsis, administering intra-venous drugs and assessment of older people were not always adhered to. The trust had a quality improvement project for Sepsis. There had been an improvement in the management of Sepsis. For example, the administration of antibiotics within one hour had increased from 26% in 2014 and from 49% to 52% (January – March 2015). The trust understood they still had a way to go to improve timeliness.
- There had been improvements in the management of patients with acute strokes since the introduction of a specialist stroke team at the hospital.
- There were poor results from the 2012/13 RCEM audit of fractured necks of femur (broken hips). Despite this the department had not developed a treatment pathway and had not carried out another audit. We observed poor care and treatment of this injury during our inspection. When we returned for our unannounced inspection we were told that a treatment checklist had been put in place.
- Results from the 2013 RCEM clinical audit relating to 'consultant sign-off' were poor compared other hospitals in England. The audit measured a number of outcomes including: whether a patient had been seen by an ED consultant or senior doctor in emergency medicine prior to being discharged from the ED when they have presented with non-traumatic chest pain (patients aged 17 years of age or older), children under one year of age presenting with a high temperature and patients who present back to the ED within 72 hours of previously being discharged. Although there had been an increase in the numbers of consultants no further audits have taken place in order to demonstrate whether the situation had improved.
- Other RCEM audits that had taken place looked at childhood asthma, management of mental health problems and dementia assessment. Results were similar to, or better than, other hospitals in England.
- The unplanned re-attendance rate varied between 5% and 6.5% January 2013- March 2015 which was better than the England average of 7.2%.

Urgent and emergency services

Competent staff

- Trust data on appraisal rates in ED showed that only 42 % of nursing staff had an appraisal in the last year. Appraisal rates for medical staff in ED were higher at 82%.
- Middle-grade doctors had had their registration successfully re-validated and nurses were aware of the new revalidation process that was about to start.
- The department employed a senior nurse (Band 7) to facilitate education programmes and assist staff with education and training. They were not available during our inspection and other senior nurses were not aware of the competency levels amongst nursing staff. We were later supplied with a document that showed attendance at training days by band 5 nurses. The training days focussed on different clinical areas such the resuscitation room and minor treatment area. We were also supplied with an example of a competency document, but no records of the number of nurses who had achieved those competencies.
- Training records were fragmented and poorly organised. Many of them related to familiarity with resuscitation equipment but there did not appear to be a competency framework tailored to the needs of the emergency department.
- Nurses that we spoke with told us that they had undertaken the Resuscitation Council's Intermediate Life Support course, and others had also attended paediatric resuscitation training. However, we could find no records that demonstrated how many nurses had gained these qualifications. We asked for these to be sent to us and documents supplied stated that "38 staff had completed Immediate Life Support training during 2015 and 11 staff had completed Paediatric Immediate Life Support during 2015. There was no record of whether these staff were doctors, nurses or support staff.
- Junior doctors described a comprehensive induction programme and told us they received regular supervision from the emergency department consultants, as well as weekly teaching sessions.

Multidisciplinary working

- There was effective multidisciplinary working within the emergency department. This included effective working relations with speciality doctors and nurses, therapists and GPs.
- Medical and nursing staff and support workers worked well together as a team. There were clear lines of accountability that contributed to the effective planning and delivery of patient care.
- There were good working relationships with the child safeguarding team and with the community paediatric teams.
- Staff in the ED reported effective links with the psychiatric liaison service. However, during our inspection we witnessed poor response times from the in-patient psychiatric team which was provided by another organisation. For instance, one patient arrived in the emergency department at 7.20am one morning and was not admitted to a psychiatric ward until the afternoon of the following day. There was no separate alcohol or substance misuse liaison team.

Seven-day services

- The ED consultants were not present in the department 24 hours a day. However they did provide senior clinical advice 24 hours per day, seven days per week, either directly within the department or on-call from home.
- The department had access to radiology support 24 hours each day, with rapid access to CT scanning when indicated.
- There was an effective pharmacy on-call service with pharmacists often present in the hospital late into the evening.
- There was poor support from mental health services at nights and weekends. These were provided by the crisis team of the local community health service. We were told that they rarely responded to referrals out of hours. During our inspection there were invariably one or two patients in the observation ward who had been waiting overnight to be assessed and supported by the mental health team.
- We had raised this issue with the hospital at our last inspection in August 2014. During this inspection we were shown minutes of meetings demonstrating that regular negotiations had taken place with the mental health trust in order to improve the service. A new out-of-hours crisis service is due to commence in December 2015.

Access to information

- The Joint Children's Protection Register (a system for checking if children have been at risk of abuse) was

available for checking within the department. This system allowed any other agencies involved in the protection of the child to be notified if they attended the emergency department.
- All paper patient records generated during an episode of care were scanned onto an electronic record when the patient was discharged or transferred out of the department. This meant that there was immediate access to records for any patients re-attending the ED.
- Information about previous hospital admissions was available in paper and electronic formats.
- Access to all electronic records was protected with passwords.
- Treatment protocols and clinical guidelines were on the trust intranet and we observed staff referring to them when necessary

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We observed that consent was obtained for any procedures undertaken by the staff. This included both written and verbal consent.
- Consent forms were available for people with parental responsibility to consent on behalf of children they were responsible for.
- The staff we spoke with had sound knowledge about consent and the Mental Capacity Act (2005).
- Where patients lacked the capacity to make decisions for themselves, such as those who were unconscious, we observed staff making decisions that were considered to be in their best interest. We found that any decisions made were appropriately recorded within the medical records.

Are urgent and emergency services caring?

Good

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

We rated caring as good.

- Staff provided compassionate care and worked hard to ensure that patients were treated with dignity and respect despite the challenges sometimes presented by a crowded department.
- Feedback from patients and those close to them and was positive about the way staff treat people. People were treated with dignity, respect and kindness.
- There were good results from the national A&E department patient survey.
- There were positive comments from patients about the care received, and the attitude of motivated and considerate staff. They told us they felt supported and said staff cared about them.
- Patients and their relatives and families were kept informed of on-going plans and treatment. They told us they felt involved in the decision-making process and had been given clear information about treatment options.
- Staff responded compassionately when people needed help and supported them to meet their basic personal needs as and when required. People's privacy and confidentiality was respected as much as was possible within the facilities available.
- Staff helped patients and those close to them to cope emotionally with their care and treatment. People's social needs were understood.

Compassionate care

- During our inspection we saw several examples of patients being treated with compassion, dignity and respect. Staff spoke in a respectful and considerate manner and maintained people's confidentiality.
- Communication with children was well thought out and effective. Staff took time to distract and comfort them during injections and wound cleaning. Parents were involved in the assessment and treatment of their children and clear explanations were given.
- We spoke with 17 patients and two family members. On the whole they reported a positive experience. For example, one patient said "I like the people here and I do feel safe."
- The 2014 national A&E survey indicated that Bournemouth ED staff were particularly good at keeping people informed and reassuring people who were distressed. Bournemouth performed better than most other hospitals in England.

Urgent and emergency services

- Staff welcomed family members when they arrived in the department. We observed them offering cups of tea and finding chairs so people could sit down.
- We heard staff updating relatives about patients' progress whilst maintaining confidentiality.

Understanding and involvement of patients and those close to them

- There was clear information on the notice board in the reception area about the department. This included details of the patient advice and liaison service.
- Some patients were confused about the identity of staff. Few of the staff wore name badges and so it was difficult to know who they were.
- Staff introduced themselves by name and explained treatment plans in terms that were easily understood. We overheard one doctor checking that relatives understood clinical information and then expressing it in different terms to make it easier to understand.
- Patients that we spoke with all said that they had been involved in the planning of their care and had understood what had been said to them.
- We observed staff spending considerable time trying to contact the relatives of a terminally ill patient. They lived a long distance away and staff kept them updated during their journey to the hospital. Staff ensured a quiet environment for the patient and spent time ensuring the dignity and respect that was needed.

Emotional support

- We observed staff giving emotional support to patients and their families. They gave open and honest answers to questions and provided as much reassurance as possible.
- There was a quiet sitting room where distressed relatives could sit in a private space. This was large enough to accommodate several people and was appropriately equipped.
- Multi-faith chaplaincy services were available day and night for people who would benefit from spiritual support.
- Specific support and counselling was available for victims of domestic violence.

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

(for example, to feedback?)

Requires improvement

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

We rated responsive as 'requires improvement'.

- A lack of available beds in the hospital had resulted in delays in treatment for patients brought by ambulance. Delays in admitting patients to a hospital bed meant that the emergency department was often full and could not immediately treat new patients. The cramped environment impacted on patient privacy.
- The number of ambulances waiting more than an hour to hand over patients had reduced significantly since the introduction of a rapid assessment and treatment area (BREATH) but still averaged four per month.
- There were long delays for patients with fractured hips to be transferred to Poole Hospital that treated trauma patients. The trust was taking action to introduce a formal pathway.
- ED staff were aware of the hospital escalation policy. However, some senior hospital staff that we spoke with were unclear about the actions to take during a heightened state of escalation alert
- Although senior staff were expected to treat people with complex needs there was no assessment tool to help staff identify specific patients. There was no evidence of learning disability training for nurses. Although dementia training had been provided there were few facilities or adjustments to enhance the care of these groups of people.

However,

- The trust had introduced BREATH so that the most acutely ill patients had rapid access to diagnosis and treatment during the day. This was also reducing the overall length of time that patients had to spend in the department.
- An ambulatory emergency centre had been developed aimed at reducing the number of people who needed to be admitted for treatment. Although there was little evidence that this was having a direct impact on ED patients.

- There was a robust complaints handling process and responses to complaints were detailed and considerate.

Service planning and delivery to meet the needs of local people

- Senior staff told us that the department was designed for 50,000 patients but now sees 87,000. In order to accommodate the additional patients an adjacent ward area had been incorporated into the ED and was used as a major treatment area. The alterations made to the space had been minimal resulting in small patient cubicles with no partitions between them, only curtains. This meant that confidential conversations were easily overheard.
- The number of people attending the ED had continued to increase each year. In order to respond to this two new consultants had recently been recruited and we were told that more senior nurses were now in post.
- This had enabled the implementation of a rapid assessment and treatment area (BREATH) so that the most acutely ill patients had rapid access to diagnosis and treatment during the day. It had also reduced the overall length of time that patients had to spend in the department.
- The BREATH area had space for two patients to lie on trolleys but four other patients were assessed in chairs. These chairs were touching each other which meant that privacy and the maintenance of confidentiality was impossible. There was no room for friends or relatives.
- There was no clear pathway for the treatment of patients with broken hips. The department did not have a structured protocol for the diagnosis and immediate treatment of this condition as recommended by the Royal College of Emergency Medicine. On-going care for these patients took place at Poole Hospital and the transfer arrangements had recently changed. However, the emergency department had not responded to this change, resulting in long delays for patients who needed to be transferred. We raised this with senior managers in the hospital who took action to improve the situation and were developing formal arrangements with Poole Hospital.
- Treatment of patients with minor injuries was now led by emergency nurse, allowing doctors to treat patients with more complex conditions.
- The observation ward consisted of two four bedded bays, one for women and the other for men. There were no lockers for patients to store their belongings or on which refreshments could be placed.
- Staff told us that they had given a great deal of thought to the design of the viewing room. This was a large private room where people could spend time with a deceased relative. It had been moved so that it was next door to the relatives' sitting room. An inter-connecting door had been installed so that people could move between the two rooms without having to walk along the public corridor. Staff told us that families could stay as long as they wished when saying goodbye to a loved one.

Meeting people's individual needs

- It was difficult to maintain patient's privacy in the major treatment area. The area was cramped and curtains were rarely drawn around the bed or patient trolley. When all the cubicles were full we observed patients being left in the middle of the treatment area with no screens around them. On one occasion a nurse brought a chair over so that a relative could sit down but this had to be moved in order for other patients to be wheeled past.
- There was no formal assessment tool for patients with complex needs. We were told that they would be treated by a senior doctor who had the experience necessary to meet their requirements.
- Staff were able to describe the translation services that were available to the department. They were familiar with their use.
- Children's needs were met by the provision of age appropriate toys and activities, a separate waiting area and specific pain scoring tools.
- There was a clear pathway in place for the admission of children aged 16 or 17 years.
- Although staff were aware that the hospital had a lead nurse for people with a learning disability, they were unaware of the help that she could provide to patients in ED. Few staff had received specific disabilities training and we were told that they would be guided by carers should the need arise.
- Nurses that we spoke with could not recall the details of the training that they had received in responding to the needs of people living with dementia. We observed one

patient living with dementia who was waiting to be admitted to a ward. Although they had been moved to the quieter environment of the observation ward, staff struggled to communicate effectively. They were unaware of techniques to assess pain in people with dementia and so there was a delay in administering effective pain relief. The staff we spoke with were unaware of the changing nutritional and hydration needs of people with dementia.

- Frail elderly patients with complex needs were referred to the older person's assessment and liaison (OPAL) team but very few assessments were undertaken by ED staff. We observed the OPAL team responding promptly to referrals. Their skills and knowledge were appreciated by the ED team.

Access and flow

- Black breaches occur when an ambulance has arrived with a patient but it is not possible to handover care to ED staff for over an hour. The hospital reported 252 black breaches for the year ending September 2015. Half of these (51%) occurred in the three months from December 2014 to February 2015. A lack of available beds in the hospital was the main reported reason for this. The number of black breaches had reduced significantly since the introduction of new processes to rapidly assess and treat ambulance patients. There was an average of four per month between July and September 2015 compared to 16 per month in the same time the previous year. During our unannounced inspection we saw ambulance patients waiting for up to 40 minutes in a corridor before being brought into a treatment area.
- A computer screen displaying the number of ambulance patients on their way to the hospital was available to staff but this information was rarely used to inform or improve patient flow.
- Patients who did not need to be admitted were seen quickly, as data showed that the average total time patients' (admitted and non-admitted patients) spent in ED was 2 hours 15 minutes.
- NHS England has set a national standard which requires that 95% of patients in emergency departments wait less than four hours to be admitted, transferred or discharged. Performance at Bournemouth has varied between 87% in April 2015 to 98.5% in June. There have been improvements in recent months and over the last quarter (July-September 2015) the trust had achieved the target (95.3%).
- The hospital had bed occupancy of 90% - 95% and this had caused problems with patient flow and had led to some patients waiting in the department for 4-12 hours before being admitted to a ward. The numbers varied from 1% of emergency admissions in May 2015 to 16% in February 2015.
- The hospital had developed an ambulatory emergency clinic (AEC) which aimed to treat people without them being admitted to a ward. There was no guidance for ED staff to help them decide which patients could be transferred to the AEC and none were transferred during our inspection. Figures provided by the hospital showed that an average of four patients a month were sent from the ED to the AEC and so there was little advantage for ED patients.
- 2.5% of patients left the ED without being seen, less than the England average.
- The nurse in charge of ED attended the bed management meeting twice a day. This was to update hospital managers on the capacity of the emergency department and to understand bed availability across the hospital. During our inspection there were a number of delays in admitting patients from the ED but discussions at the bed management meeting were not able to provide any solution to the delays.
- Senior staff in the ED were familiar with the hospital escalation policy. During a hospital bed management meeting we observed ED staff complying with its requirements. However, other senior hospital staff displayed less awareness. For example, the policy states that when "demand for medical beds exceeds medical bed capacity but there is potential capacity within the trust" the hospital alert level should be raised to level 2. This was the situation at the time with no high acuity medical beds available and no hyper-acute beds available in the stroke unit. Two patients had been waiting in in the ED for a hospital bed for more than eight hours. Despite this the hospital alert level was not considered at the bed management meeting and no definitive action was taken to find beds for the patients in the ED.
- During our unannounced visit there were 13 patients in the ED waiting to be admitted to the ward. We were told

that the hospital was on red alert but senior hospital managers who came to the department were unable to describe many of the actions that were required by the escalation plan.

Learning from complaints and concerns

- Complaints were handled in line with the trust policy. If a patient or relative wanted to make an informal complaint they were directed to the nurse in charge of the department. If the concern was not able to be resolved locally, patients were referred to the Patient Advice and Liaison Service, that would formally log their complaint and attempt to resolve their issue within a set period of time. PALS information was displayed on noticeboards throughout the department.
- Formal complaints were investigated by a consultant or the ED matron and replies were sent to the complainant in an agreed (PALS) timeframe. The department employed a complaints officer who ensured that all complaints were investigated quickly and appropriately. Replies that we saw were detailed and considerate.
- We saw that learning from complaints was discussed at ED governance meetings and at nursing staff meetings.

Are urgent and emergency services well-led?

Requires improvement

By well led, we mean that the leadership, management and governance of the organisation assures the delivery of high-quality person-centred care

We rated this well led as 'requires improvement'.

- Governance and quality monitoring processes were not always effective. Areas for improvement identified from clinical audits did not always result in a change in practice.
- There were no follow-up audits to see if patient outcomes had improved.
- The risk register did not reflect all of the concerns described to us by staff.
- Information about risk and quality issues were not always shared with staff in the department.

However,

- The emergency department strategy was for a larger, more modern department and to become the major trauma unit for Dorset. It was recognised that it would take a number of years to achieve this.
- Staff felt actively engaged by the departmental leaders who were described as having the knowledge, skills and integrity to carry out their roles. There was a good sense of teamwork and staff felt supported by their colleagues and managers.
- A number of improvements had been made to the service in order to enhance the treatment of patients.

Vision and strategy for this service

- The strategic direction of services was open to review at the time of the inspection, as a result of the Dorset Clinical Commissioning review. The trust described its five-year strategic plan for patient care, underpinned by six strategic objectives.
- The strategic plan for the department identified the need for a "larger, more modern department". There was an ambition to become the major trauma unit for Dorset.
- Staff that we spoke with identified with these aims, although they realised that they would take some years to achieve.
- The trust had set up a new care group structure, with three main care groups made up of departmental specialties. Few staff that we spoke with understood the reasons for this new structure. It was not possible to discuss it with the lead consultant or ED matron as both were on leave during our inspection.

Governance, risk management and quality measurement

- There were processes in place to identify, monitor and address current and future challenges to high quality care and treatment. However, they were not always effective. Audit results showing poor compliance with professional standards such as consultant sign-off and fractured neck of femur did not appear to have changed practice. There were no follow-up audits to see if standards had improved.
- Although practice was changed as a result of adverse incidents, there were no checks to make sure that the new practice was effective. For instance, new safety

process had been implemented to ensure that all abnormal x-rays were acted upon. However, there was no audit planned to ensure that the new process was working properly.

- The department maintained a risk register which defined the severity and likelihood of risks in the department causing harm to patients or staff. It documented the measures to be taken to reduce the risk but did not record how often the risks were reviewed. Some of the concerns described by staff in the department were not accurately reflected by the risk register. For example, long delays in admitting patients to a ward were documented as an "accepted risk". Recent adverse changes to admission arrangements for patients with certain fractures had not been entered onto the risk register by senior staff.
- The leadership team had not identified that basic risk assessments such as VTE, pressure ulcers and NEWS scores were not being completed. Document audits were not carried out in order these shortcomings.
- Complaints, incidents, audits and quality improvement projects were discussed at governance meetings but nurses rarely attended and so their knowledge of these issues was limited. Minutes of the meetings were not discussed at nurses meetings.
- Governance meetings were held quarterly which meant that risks to patients were not always reviewed in a timely fashion.

Leadership of service

- Leadership and management of ED were shared between a senior consultant (Clinical lead), the ED matron and the directorate manager.
- The clinical lead and matron were both away during our inspection but staff told us the leadership team had the skills, knowledge, experience and integrity required to carry out their roles.
- One nurse told us "Matron is really good. She stands up for us and makes sure we have enough nurses to look after the patients".
- Staff that we spoke with said that leaders were visible and approachable and took an active part in the day-to-day activities of the department.
- Staff told us they felt fully supported by their clinical leads and senior managers and they were confident that they would address any concerns reported to them.

Culture within the service

- Staff told us that they felt respected and valued by their colleagues and the leadership team within the ED.
- A variety of staff told us that concerns were investigated in a sensitive and confidential manner and those lessons were shared and acted upon.
- Staff told us that the support that they received from their colleagues in the department helped them cope with the pressure which resulted when the department was very crowded.

Public engagement

- Patient engagement happened through surveys and complaints. The ED matron kept copies of patient feedback and letters of comment or complaint. Up-to-date details of the results friends and family test were displayed on noticeboards in the department.

Staff engagement

- Staff felt actively engaged by the ED leadership in the planning and delivery of services. They spoke enthusiastically about recent developments such as BREATH and the increased role of emergency nurse practitioners in the minor treatment area.
- We were told that the chief executive and director of nursing were contactable by e-mail. They responded appropriately to issues raised with them. Staff told us about visits that the chief executive had made to the department.

Innovation, improvement and sustainability

- The introduction of major treatment advanced practitioners (MAPS) had decreased diagnosis and treatment times for patients in the major treatment area. It was hoped that further training will be available in the future so that they may become nurse consultants.
- The implementation of BREATH (Bournemouth rapid evaluation and treatment hub) had reduced delays for ambulance patients.

Medical care (including older people's care)

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

Information about the service

The Royal Bournemouth and Christchurch NHS Foundation Trust provides cardiology, gastroenterology, respiratory medicine, endocrinology, haematology, oncology and Stroke services within the medical services. The trust also provides services to elderly patients and those living with dementia. This relates to a total of 403 inpatient beds within the medical services. There is also a Treatment Investigation Unit (TIU). All these services are provided from the Royal Bournemouth Hospital. As part of the Older Persons directorate a day hospital is located in Christchurch hospital providing assessment, treatment and rehabilitation for older people. The Day Hospital had 9254 attendances in the period January-December 2015. The day hospital service has been reported in the Christchurch hospital location report as part of the outpatient and diagnostic imaging services.

We inspected all medical wards. Findings for all areas are included in this report. We spoke with 50 patients including their family members, 12 patient relatives,107 staff members including clinical leads, service managers and matrons, ward staff, therapists, junior doctors and consultants other non-clinical staff. We observed interactions between patients and staff, considered the environment and looked at care records and attended handovers. We reviewed other documentation from stakeholders and performance information from the trust.

Summary of findings

There were areas of good and innovative practice in most areas of medical and older people services. But we found medical and older people services overall, required improvement.

Safety of the service needed to improve as there were risks for patients posed by some practices and staffing numbers and skill mix. Staff knew how to report incidents, but not all incidents were reported. Medicines were not consistently managed in a safe and effective manner. Medicines were signed as administered without observing whether the patient had taken the medicines. In some areas were not stored in a secure manner. Inaccurate monitoring of medicine drug fridges meant it was not assured refrigerated medicines were stored at correct temperatures.

The electronic risk assessment process did not always support staff to complete risk assessments in a timely and effective manner. For some patients there was no current record of identified risks or plan of actions to mitigate risks, as risk assessments were overdue by up to three days.

Although staff adhered to infection control practices in relation to hand hygiene and personal protective equipment, other practices did not fully support effective infection control and prevention practices. Patients were not consistently offered the opportunity

Medical care (including older people's care)

to wash their hands prior to meals and on one ward there were dirty clinical items (blood stained gauze and sharps bins and trays) left next to patient's bedside which posed risk of cross infection.

There were vacancies of nursing staff on all the medical and older people wards. During the unannounced inspection we saw patient's wellbeing was put at risk because there a lack of consideration was paid to the skill mix when agency and bank staff were covering vacant shifts. Poor compliance with mandatory training and appraisal rates meant patients were at risk of being cared and treated by staff who lacked updated knowledge and skills

Patients did not consistently receive care that respected their privacy and dignity. We observed patients were left exposing the lower half of their body, a patient was administered an injection without pulling curtains around them, lifting their gown up for the injection in view of patients and staff. Patients were left in nightwear on the wards, when they preferred to wear their own clothes. A patient said they had to pass urine in a pad, rather than be supported to use the toilet, because staff took so long to answer call bells

The treatment and care provided followed current evidence-based guidelines. Medical services participated in national and local audits which showed improving and good outcomes for patients. Patients had access to services seven days a week and were cared for by a multi-disciplinary team working in a co-ordinated way. Patients told us they felt involved in decision making about their care. Where patients lacked capacity to make decisions for themselves, staff acted in accordance with legal requirements.

Services were developed to meet the needs of the local population. The trust was working with partners to decrease delayed patient discharges, and was also working to improve its internal processes to ensure daily discharge targets could be met.

Innovative and new working practices supported the trust to improve patient flow and patient experience. A GP led ward for older patients medically fit for discharge, but whose discharge was delayed, released acute beds in the hospital for unwell patients to be admitted and treated by the hospital medical staff.

There were new services that worked in a multidisciplinary manner, including working with community services, which improved outcomes for patients and reduced their length of stay in hospital. This included the heart failure service and working in partnership with Dorset Adult Integrated Respiratory Service. with provided a holistic and multidisciplinary service for patients with heart failure which had result in improved outcomes and reduced length of stay in hospital for patients with heart failure. Employment of an Acute Kidney Injury (AKI) nurse specialist, providing education, outreach bleep service Monday to Friday and development of care pathways resulted in reduced length of stay and reduced mortality rates for patients with AKI. New pharmacy working practices on ward 26, which included two pharmacists embedded into the multidisciplinary team, resulted in improved effectiveness and outcomes for patients.

Governance processes promoted reviews of the service provision and identified areas for improvement. However, risk registers at department and trust level did not identify all risks posed to the service and patients. The culture within medical services was caring and supportive. Staff were actively engaged and the division supported innovation and learning.

Medical care (including older people's care)

Are medical care services safe?

Requires improvement

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

We rated safe as requires improvement.

- Not all incidents were reported. In AMU incidents of patients electronically discharged but still being treated on the unit were not always reported. There was no formalised process to monitor these risks and no formalised actions to reduce these occurrences.
- Patients were not consistently offered the opportunity to wash their hands prior to meals and on one ward there were dirty clinical items (blood stained gauze and sharps bins and trays) left next to patient's bedside which posed risk of cross infection.
- Checks on emergency equipment at the Royal Bournemouth Hospital was incomplete. This meant that in the event of an emergency staff could not be assured emergency equipment was available and in working order.
- Staff did not consistently manage medicines in a safe and effective manner. Administration practices did not always comply with trust's policies or National Midwifery Council (NMC) guidance. Medicines were signed as administered without observing whether the patient had taken the medicines. Medicines were not always stored securely or labelled accurately. Inaccurate monitoring of medicine drug fridges meant it was not assured refrigerated medicines were stored at correct temperatures. The management of drug prescription and administration charts presented a risk to patients missing medicine doses.
- The trust target for mandatory training was not met, this meant patients were at risk of being cared and treated by staff who lacked updated knowledge and skills. The trust target for safeguarding training was not met by some clinical staff on the medical wards.
- In some areas of the service, risk assessments were not completed in a timely and effective manner using the newly introduced electronic system
- There were vacancies of nursing staff on all the medical wards at Royal Bournemouth Hospital. Temporary agency and bank nurse were used to fill shortfalls in staffing numbers. However, temporary staff were not always available. During the unannounced inspection we saw patient's wellbeing was potentially put at risk because there was a lack of consideration paid to the skill mix when agency and bank nursing staff were covering vacant shifts. Wards that had a high number of temporary staff on duty, did not have sufficient numbers of permanent staff to provide guidance to the temporary staff about meeting patients individual needs in a safe manner.

However,

- Staff knew how to report incidents and processes and procedures were followed to report incidents and monitor risks.
- Staff followed infection control practices. Numbers of unit-acquired infections were in line with the national average. Staff adhered to the trust policy of bare below the elbows and the use of personal protective equipment.
- Staff demonstrated a good understanding about safeguarding procedures.
- Paper and electronic records detailed patient care, assessments and plans. Paper nursing and medical records were well maintained. At Christchurch day hospital all safety procedures were being followed appropriately.
- Medical staffing was appropriate and covered medical outliers well.
- Patients were appropriately escalated if their condition deteriorated.
- Staff knew where to access major incident plans, should they be needed.

Incidents

- Between July 2014 and July 2015 medical services reported 32 serious incidents through the National Reporting and Learning System (NRLS). Of these incidents, grade 3 and 4 pressure ulcers and slips, trips or falls accounted for the highest number of incidents.
- Staff used the trust's electronic recording system to record incidents. These included incidents such as accidents, pressure ulcers, medicine errors and falls. However, we were not assured that all incidents were recorded. In AMU we identified, that due to human error, a patient had been electronically discharged from the unit, when they were still being treated on the unit. This

meant there were no electronic records of their risk assessments on the unit. Staff said this was not an unusual occurrence and was the second time it had occurred that day. Discussions with staff showed that although they had not previously considered these to be situations that required reporting as incidents, they were now going to report them using the trust's incident reporting system. Review of reported incidents occurring on AMU between March 2015 and July 2015 showed that, that despite staff saying this was not an unusual occurrence; no similar incidents had been reported. This indicated not all incidents were reported.

- The haematology ward had good procedures for the escalation of safety issues.
- Themes from incidents were discussed at ward meetings and staff were able to give examples where practices had changed as result of incident reporting. One example was the redesign of nasogastric tube (NG) feed charts to prompt staff to check when the feed needed changing.

- Incidents reviewed during our inspection demonstrated investigation and root cause analysis (RCA) took place and actions were developed to reduce the risk of a similar incident reoccurring.
- There had been two Never Events relating to medical services. (Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.) Both these concerned the insertion of specific intravenous lines. Discussion with relevant staff members and review of documents evidenced learning and changes in practices were made to reduce the risk of similar occurrences.
- The trust had systems and processes for action and dissemination of the Central Alerting System (CAS) alerts. CAS is a web-based cascading system for issuing patient safety alerts, important public health messages and other safety critical information and guidance to the NHS and others, including independent providers of health and social care.
- The new regulation, Duty of Candour, states that providers should be open and transparent with people who use services. It sets out specific requirements when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, giving truthful information and an apology. Staff we spoke with were familiar with the concepts of openness and transparency and could give us examples of how these were actualised when managing safety incidents.

Safety thermometer

- The NHS safety thermometer is a monthly snap shot of the prevalence of avoidable harms, in particular new pressure ulcers, catheter-related urinary tract infections, venous thromboembolism (VTE) and falls. This information was displayed on ward notice boards, where patients, visitors and staff could view the results and trends.
- The safety thermometer data for medical services showed 78 pressure ulcers (grade 2-4), 17 falls resulting in harm to the patient and 15 catheter related urinary tract infections during the period June 2014 to July 2015.
- Ward sisters explained actions they took to minimise the risk of avoidable harms. They monitored risk assessments compliance and fluid charts. Where they found issues relating to care, they raised them with staff directly. They also used the morning safety brief to reinforce messages relating to patient safety.

Cleanliness, infection control and hygiene

- Most of the wards we visited were visibly clean and cleaning schedules were clearly displayed on the wards. Cleanliness of all clinical areas was monitored and audited monthly . Equipment was cleaned and was marked as ready for use with 'I am clean' labels.
- However, as part of the unannounced inspection on we visited ward 5, which was untidy and had dirty items left next to patients, which posed risk of cross infection. For example, a gauze square with what appeared to be dried blood on it was in the bedside table of one patient. On the chair next to a second patient, there was a sharps bin and tray.
- Staff adhered to the trust's 'bare below the elbows' policy in clinical areas.
- Hand hygiene gel was available at the entrance to every ward, along corridors, and at the bottom of each patient's bed. Hand hygiene audits were completed monthly. Results for June 2015 showed for cardiology and AMU there was 100% compliance with the trust's hand hygiene policy and procedures, for general medicine there was 97% compliance and the older person's medical wards 91% compliance.

- Infection prevention and infection control training was part of the mandatory training that all staff had to complete. However the data showed that compliance for nursing staff with this training was between 85% to 100%, (418 out 470 nurses had completed the training) and for medical staff between 52% to 79% (117 out of 179 medical staff had completed the training.) The trust had a 95% compliance target for all staff to complete mandatory training. Staff were not meeting this target.
- Between May 2014 and May 2015 the trust had had only one case of hospital acquired MRSA and 23 cases of hospital acquired clostridium difficile. CQC intelligent monitoring evaluated this data did not indicate any risk associated with the prevalence of these infections. In medical services, eight patients had a positive MRSA screen between January 2015 and June 2015.
- Six monthly audits of the use of antibiotics measured adherence with trust policies, which promoted appropriate use of antibiotics in order to reduce risk of antibiotics becoming ineffective.
- There was a risk patients were eating their meals with dirty hands as we saw they were not consistently offered the opportunity to wash their hands prior to meal times. Discussion with patients confirmed they were not offered the opportunity to wash their hands before eating meals. This posed a potential risk of food becoming contaminated by dirty hands and posing a risk to the health and wellbeing of the patient.
- We saw there was protective equipment such as aprons and gloves in varying sizes. We observed staff using this equipment and discarding them between each patient contact.

Environment and equipment

- Each ward and clinical area, including Christchurch day hospital, had sufficient moving and handling equipment to enable patients to be cared for safely. Equipment was maintained and checked regularly to ensure it continued to be safe to use. Clearly labelled equipment showed the date when the next service was due.
- Labels on equipment indicated portable appliance testing (PAT) was up to date.
- Daily checks of resuscitation equipment were completed on wards and clinical areas and these checks were documented. We reviewed the records for the checks on wards and found they were completed daily. We reviewed the audit completed by the critical care outreach team of all emergency trolleys at the Royal Bournemouth Hospital in October 2015. This identified that for the month of September 2015 for most clinical areas there had been days when the check lists were not signed to demonstrate the trolley had been checked. The audit detailed three areas that did not have suction equipment plugged in and one area that did not have the defibrillator plugged in. This meant the equipment was not charging. Six areas had equipment missing or incorrect equipment on the emergency trolley. This meant in the event of an emergency staff could not be assured emergency equipment was available and in working order.
- Equipment such as commodes, bedpans and urinals were readily available on the wards we visited.
- Ward staff told us they had good access to equipment needed for pressure area care.
- We saw there was a trust list for replacement of equipment which showed drug trolleys and recliner chairs had been approved for older persons medical wards and the stroke unit
- Staff knew how to report faulty equipment and said faulty equipment was attended to promptly and if required replacement equipment was provided in a timely manner. This meant they had the equipment needed to provide safe care and treatment.

Medicines

- Medicines were not consistently managed in a safe and effective manner.
- We saw administration practices that did not comply with the trust's policies or NMC guidance. During the unannounced inspection, we saw medicines left on patient's bedside tables for them to take. Nurses signed medicine administration charts to detail the patient had taken the medicine without observing that the patient had taken the medicine. We asked one patient, who had a pot with a tablet in it on their bedside table, if they knew what the tablet was for and whether they should be taking it. The patient did not know what it was for and did not know whether they were supposed to take it. On a second ward, we observed a nurse asked a patient if they could take the tablets on their own. When the patient said yes the nurse moved away, leaving the tablets with the patient, and did not observe whether the patient had taken the tablets. We saw the patient's visitors support them to take their tablets. The visitors told us it was common practice that staff did not

support or observe their family member taking their medicines. They said staff did not take into consideration the patient was living with dementia and would say yes to any question they were asked.

- During the unannounced inspection, we saw a medicine trolley left unattended and unsecured. The trolley lid was closed, but not locked.
- On ward 21 it could not be assured diabetic patients received their own insulin because insulin pens were not labelled with the patient's name. On the same ward, management of ordering medicines failed to ensure there was sufficient stock for a patient to have their regular prescribed medicines. We informed the ward staff about these concerns. Ward staff spoke with pharmacy staff to arrange for insulin pens to be labelled with the patient's details. The issue regarding ordering and maintaining required stock of medicines to meet patients' needs was being addressed by ward staff. Whilst that was being resolved, staff took immediate and appropriate action to obtain the patients medicine to make sure there was no further delay in administering the medicine.
- In the discharge lounge, health care assistants (HCAs) were responsible for collecting medicines to take home (TTAs) from pharmacy and giving them to patients to take home. The Standard Operating procedure for the Discharge Lounge version 4 dated October 2015 detailed, "All TTA's in the Discharge Lounge to be checked by a member of the Discharge Lounge staff who has completed an approved training programme." Following the inspection we were provided with evidence to support the fact that HCA's working in the discharge lounge had completed training about checking discharge medicines in the discharge lounge.
- Storage of medicines in the discharge lounge was not secure. We saw packets of medicines left unattended on work surfaces where anyone could access them.
- If patients required medicines whilst in the discharge lounge HCA's had to find a trained nurse in one of the other departments to administer the medicines. We were told the medication charts and medicines were not always available. There was a risk patients would miss doses of medicines. This was exacerbated when patients had to wait more than four hours for transport or medicines.
- The trust could not be assured that refrigerated medicines were safe to use or were fully effective because the trust's policy on the management of refrigerated pharmaceuticals was not always followed. Thermometers that recorded maximum and minimum temperatures were not used. Thermometers were not reset after reading. We saw the maximum temperature on one fridge we recorded as 18.7 degrees centigrade and on another fridge as 10 degrees centigrade. National guidance details temperature for medication fridges should be between two to eight degrees centigrade. At temperatures outside this range, there was a risk medicines that should be stored in a cold environment were not effective.
- Patients told us they were usually given their medicines on time. They also said medicines were explained to them and they were told about risks associated with taking medication.
- Oxygen was usually piped to patient areas and where cylinders were used, for example on emergency trolleys, they were correctly stored and there was an online system to request replacement cylinders

Records

- Some patient records did not support the safe care and treatment of patients. On the Acute Medical Unit (AMU) staff found the nursing electronic patient risk assessment record did not support timely completion of patient risk assessments. This resulted in risk assessments for some patients being three days overdue. Staff explained the process for completing the electronic risk assessments was lengthy and cumbersome. They prioritised delivering patient care and completing informal, though not documented, risk assessments whilst delivering the care, rather than the lengthy task of completing the electronic risk assessment record.
- Patients medicine prescription and administration records on all wards were spread over three different charts. Some were stapled together, some were paper clipped together. We saw that not all sheets had patient names detailed on them. There was a potential risk for medicine charts to be mislaid and staff not realise there was a missing chart and for patients to miss doses of medicines. When we carried out the unannounced inspection, we saw action had been taken to address these potential risks. Each patient had a separate medication folder that contained all their medicine administration charts to reduce the risk of charts being mislaid.

- Records were in both paper and electronic formats. Patient paper records were well maintained and completed with clear dates, times and designation of the person documenting. The records we examined were written legibly and assessments were comprehensive and complete, with associated action plans and dates.
- The trust was transferring all patient documents to electronic records. Once the patient had been discharged from the hospital, records were sent to a central scanning team, who scanned the records onto the electronic recording system. Staff reported that this posed some difficulties if a patient contacted the ward or department for advice after they had been discharged, as they did not have access to the notes to refer to.
- Medical records of patients demonstrated medical consultants and junior doctors reviewed them regularly; this included medical patients being treated on wards other than medical wards (outliers).
- Patient information and records were stored securely on all wards.
- For patients with swallowing difficulties, individualised and detailed food prescription charts provided by Speech and Language Therapists (SALT) provided clear guidance for staff and patients to ensure safe eating practices.

Safeguarding

- There was a safeguarding policy and procedures in place and staff were aware of these.
- However, in conversations, staff demonstrated a good awareness of safeguarding adult and children procedures. They described situations in which they would raise a safeguarding concern and how they would escalate any concerns.

Mandatory training

- Mandatory training covered a range of topics including fire safety, health and safety, basic life support, manual handling, hand hygiene, conflict resolution, medicine management and information governance training.
- Detail provided by the trust showed a target of 95% compliance with mandatory training. However, figures they provided dated 30 October 2015 showed this target was not being met. The figures showed nursing staff working in the older person's medical wards achieved a compliance rate of 23% to 97%, those working in cardiology wards a compliance rate of 63% to 100% and for those working on the general medical wards a compliance rate of 29% to 100%. Both the cardiology ward and older person's medical wards achieved compliance of 95% or over in only one mandatory training subject and staff on the general medical wards archived this for two subjects. This meant patients were at risk of being cared and treated by staff who lacked updated knowledge and skills
- The same data showed that medical staff compliance with mandatory training was lower than that of nursing staff, with the range for all medical staff working in medical service being between 0% to 94% and none reaching the trust target of 95% compliance. Data for Allied Health Professions showed compliance between 0% and 100% and for administrative staff between 0% to 86%.

Assessing and responding to patient risk

- Some patient records did not support the safe care and treatment of patients. Staff completed electronic nursing assessments on hand held tablets, using a format designed in-house to prompt staff to report assessments in a timely way. The risk assessments related to malnutrition, skin integrity, dementia, mobility and frailty, falls, use of bedrails and venous thromboembolism. This was a new system and staff were still adapting to its use. Data from the system was used for audit and monitoring purposes. The system promoted staff to review and update assessments. However, on the Acute Medical Unit (AMU) staff found the nursing electronic patient risk assessment record did not support timely completion of patient risk assessments. This resulted in risk assessments for some patients being three days overdue. Staff explained the process for completing the electronic risk assessments was lengthy and cumbersome. They prioritised delivering patient care and completing informal, though not documented, risk assessments whilst delivering the care, rather than the lengthy task of completing the electronic risk assessment record.
- For some areas of risk, the electronic process relied on nurse's subjective assessment. For example in the tissue viability risk assessment nursing staff had to score patients from 0 – 6 for whether they had any neurological deficit, and its severity. There was no guidance about how to use the scoring system, which meant there was a risk of lack of consistency of scoring

across the hospital. As scores provided guidance about mitigating action, there was the risk patients might not receive the appropriate treatment and care to reduce risks, if scoring system was not accurate.

- However, on all wards and clinical areas patients assessed formally or informally at risk of falls were, where able, cared for in one area so they were visible to staff and staff could support them.
- The medical wards and the AMU used the Early Warning Score (EWS), a scoring system that identifies patients at risk of deterioration or needing urgent review. These scores were recorded on an electronic device. Medical and nursing staff were aware of the appropriate action to be taken if patients scored higher than expected. The completed EWS records we looked at showed that staff escalated patients appropriately. This included medical patients on outlier wards (non-medical wards). Repeat observations were taken within the necessary time frames. There was a trust procedure and flow chart for contacting the critical care outreach team. There was a trust procedure and flow chart for contacting the critical care outreach team for support in the care and treatment of a deteriorating patient.
- Nursing staff felt well supported by doctors when a patient's deterioration was severe and resulted in an emergency.
- Health Care Assistants (HCA), who staffed the discharge lounge, said they had received no formal training about responding to patients who deteriorated. They said "they just know" when someone was unwell. They described incidents when patients fainted in the discharge lounge and they sought assistance from the emergency department or AMU in these circumstances. The trust told us the Standard Operating Procedures for the use of the Discharge Lounge version 4 issued October 2015 clearly identified the escalation process to be followed in the event if a discharged patient becoming unwell whilst awaiting transport. We reviewed this document. There was no guidance for staff about the actions they needed to take if a patient's condition deteriorated. The only guidance about escalation was "Any adverse incidents to be reported to Discharge Coordination Team Lead in the first instance and escalated the Clinical Manager for Discharge Services."
- Processes for sharing information about patient's health risks did not fully protect patients in the discharge lounge. All patients were booked into the discharge lounge via an electronic referral form which included special dietary considerations including diabetes. However, during the inspection we found HCAs working in the discharge lounge were not always aware of patient's individual health needs and risk associated with their health needs. This was demonstrated when a patient with diabetes waiting in the discharge lounge told us they were worried about having a hypoglycaemic episode as it had been a long time since eating anything. The staff in the discharge lounge did not know the patient was diabetic, but when advised by the patient and CQC, they provided a sandwich for the patient before they went home.
- On wards a practice of twice daily safety briefings ensured staff were aware of risks to patients. This included detail about patients whose condition was deteriorating, patients at risk of falls, tissue damage, patients who required fluid and nutritional monitoring and patients who had the same or similar surnames.
- Patients admitted at night were either seen by the on call consultant or the next morning by the consultant in charge of their care. We observed that patients with raised EWS were escalated appropriately to the 'hospital at night' team. The action plan for these patients was discussed at the night handover.

Nursing staffing

- Nurse staffing levels were planned using the Royal College of Nursing guidance and professional assessment of the needs of each clinical area. Staffing levels were reviewed every six months. Monthly planned and actual staffing hours were published on the trusts internet site. Planned and actual staffing levels for each shift were displayed in clinical areas. It was possible to identify whether staffing levels were at the planned numbers.
- We looked at rotas for two wards which showed a high use of temporary staff to achieve the recommended guideline of one registered nurse to eight patients.
- All staff we spoke with from the management team to health care assistants recognised nursing recruitment as a major safety risk to the service. The management team told of various measures, such as open recruitment days and overseas recruitment initiatives they had put in place in an effort to decrease the vacancy factor. All ward based staff were aware of these initiatives and were supportive of them. There was general agreement that recruitment and retention of nursing staff was seen as a priority by the trust.

Medical care (including older people's care)

- Where shortfalls in nursing numbers were identified temporary staff from the National Healthcare Service Professionals (NHSP) or from an agency were used to ensure that there were adequate numbers of nursing staff to meet patients' needs. However, records of root course analysis investigations into incidents on AMU indicated that temporary staff were not always available to ensure adequate numbers of staff were on duty. From the record of incident investigations, we saw that it was common practice for staff not to have their breaks due to low staffing numbers.
- On ward 5 (Older persons medicine), during the unannounced inspection, at night, there were only two members of staff (a registered nurse and a HCA) on duty who were permanent members of staff on the ward. The remaining two members of staff were a bank HCA who had worked on the ward previously and an agency registered nurse who had not worked on the ward previously. The nurse in charge escalated their concerns about the staffing levels and skill mix in relation to the dependency and needs of patients to the night site management team, who provided another HCA to help. However, we saw, despite the additional member of staff, there were risks to the safety of patients. One patient who was agitated had their leg draped over the bed rail and was at risk of entrapment in the bedrail. As part of the electronic nursing assessment all patients had a bed rails risk assessment completed which took into account the risk of entrapment. However, this patient at the time of the inspection was at risk of entrapment or injuring themselves on the bedrails. Staff were attending to other patients, so were not able to monitor and support this patient to reduce the risk of injury. Staff did not have time to tidy; we saw clinical items including items that posed cross infection risks were not removed or disposed of. We saw the level of staffing was causing anxiety for some members of staff. One member of staff looked very anxious and stressed whist trying to manage patients who were confused and wandering. We escalated our concerns to the site manager, who reviewed the staffing and said they would provide a nurse who had experience of older person's medicine to support the nurse in charge.
- Ward sisters of the older person medicine wards said it was difficult to recruit and retain staff on the wards. They attributed this to staff wanting to work on less busy and emotionally challenging wards. It is recognised that recruitment of staff in older person's medicine is a challenge nationally. The Trust had invested in a number of initiatives to recruit staff including a 2% uplift, focused Older Persons Medicine (OPM) recruitment drives including overseas and 'return to acute nursing' programmes. This had resulted in the improvement from 44.6 whole time equivalent vacant posts in March 2015 to 23 WTE vacant posts in October 2015. The nursing vacancy factor in OPM at the time of the inspection was 8.2%.
- Staff on the medical and care of elderly wards told us they were often requested to attend other wards or AMU where there were shortages in staffing level to ensure the safety and care of patients on those wards. They felt this was occurring routinely and found it unsettling.. For the months August, September and October 2015 there had been a total of 66 occasions when registered nurses had to work on wards that were not their permanent place of work and 38 occasions when health care assistants worked on alternative wards. Of these occasions, there were 20 occasions when the registered nurse had to take charge of a ward they did not usually work on.
- Medical patients were regularly cared for on surgical or other non-medical wards. Where ever possible staff tried to ensure these patients were clinically stable, had lower dependency and acuity needs so their needs were met by the staff and skill mix on non-medical wards.
- Requests for extra staff were made when patients required 1:1 care. This included when patients needed extra support if they were agitated or distressed. We observed evidence of this on AMU and the older person's medicine ward
- Patients had mixed experiences of the numbers of staff on duty. Patients on the general medicine and cardiology wards said there was always sufficient nursing staff to attend to their needs. However, this view was not the same on the stroke ward. One patient told us there was sometimes not enough staff they said "when you call, it can take 15 minutes and you could be dead." A second patient said it sometimes took up to 20 minutes for call bells to be answered. They explained that this meant that instead of being supported to use the toilet they had to pass urine into a pad whilst in bed or sat in a chair. They also commented that it could take up to 20 minutes for a call bell to be answered, and said this was more noticeable after the evening meal.

However, these views were not reflective of the care campaign audits, undertaken by hospital volunteers and supplied by the Trust which evidenced that 95-100% of patients on the Stroke unit reported that their call bell was answered in a timely manner and 100% of patients on the Stroke unit reported that they always received assistance to prevent an accident..

- Patients and relatives who contacted the Commission before the inspection also raised concerns about staffing levels on the older person's medical wards. One relative said they observed one night the ward was obviously short staffed and that it was "bedlam, the noise was horrendous." A second relative commented that "weekends are appalling" due to lack of staff and that it felt like a Monday to Friday service.

Medical staffing

- To promote continuity of care on the older person's medicine wards, each ward had an allocated consultant and middle grade doctor. This meant the senior medical team knew each patient individually and were fully aware of their risks and quickly identified when patients conditions were changing. However medical staff vacancies in the older person's medicine directorate remained the highest in the medical directorate at 17.9%.
- There was a vacancy for a stroke consultant which was being covered by a locum consultant whilst waiting for the newly recruited consultant to commence in January 2016.
- There was a consultant cover on the AMU from 8am – 10pm seven days a week. Consultant ward rounds on AMU took place twice a day. During the day all new patients on the AMU were seen by a consultant within one hour following their admission.
- Staff told us there were sufficient consultants and doctors on the wards during the week. Junior doctors felt there were adequate numbers of junior doctors on the AMU and wards out of hours and that consultants were contactable by phone if they needed any consultant support.
- Guidance from the Society for Acute Medicine and the West Midlands Quality Review Service (2012) suggests that a consultant should be on site or be able to reach the acute medical unit within 30 minutes. Medical staff and the service leads confirmed that this guidance was being met across the medical services.
- There was a doctor trained in the speciality of General Internal Medicine or Acute Internal Medicine at level ST3 or above or equivalent staff and associate specialist (SAS) grade doctors available at all times on the AMU, in line with the above guidance.
- The trust had developed a specific role for 'out of hours' consultant. The 'hospital at night' team was led by the lead consultant for out of hours. We observed the medical handover with the 'hospital at night' team. The team consisted of surgical senior house officers (SHO), one medical SHO, one medical registrar, a junior doctor, two night nurse practitioners. In the handover staff discussed each patient that was highlighted on the doctor's work list (which was an electronic handover for doctors), their progress and any potential concerns. There was a clear discussion around the action plans for all the high acuity patients across the medical services.
- Medical patients who were on wards other than medical wards were seen daily by junior doctors. Medical consultants and medical doctors saw these patients at least twice a week.
- The consultants saw patients who were admitted to the acute bays of the stroke ward daily. Patients admitted to rehabilitation bays of the stroke ward were seen by the consultant twice a week

Major incident awareness and training

- Staff we spoke to were aware of the procedure for managing major incidents, winter pressures on bed capacity and fire safety incidents.
- Emergency plans and evacuation procedures were in place. Staff were trained in how to respond to major incidents.
- There was a bed management system that aimed to ensure patients' needs were met when there was an increased demand on beds and medical patients had to be cared for on a surgical ward. Senior nursing staff on all the medical and older people wards and AMU attended daily bed management meetings. These meetings enabled mangers and staff to gain updated information as to the activity in the emergency department and availability of beds on ward areas.
- There were major and prolonged road works near the hospital, which had the potential to restrict access to and from the hospital and delay on call clinicians attending emergencies. We raised concerns with the trust and risk assessments and contingency plans that had been developed were provided.

Medical care (including older people's care)

Are medical care services effective?

Good

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

We rated effective as good.

- Care provided was based on national best practice guidelines. Clinical audit was being undertaken and there was good participation in national audit with overall good outcomes. Where outcomes had not been good action was taken make improvements.
- There were arrangements for ensuring patients received timely pain relief.
- Patients at risk of malnutrition or dehydration were risk assessed by appropriately trained and competent staff and referrals to and assessments by dieticians or speech and language therapists were made within expected timescales.
- Multidisciplinary working was widespread and the trust had made significant progress towards seven day working.
- Staff had access to patient information.
- Staff had an understanding of the Mental Capacity Act 2005, and its application to their area of work. There was evidence that formal and informal consent was obtained, along with evidence of best interest decision making processes taking place

However,

- Staff had mixed experiences of access to competency based assessments. Annual appraisals were not consistently completed with completion rates for nursing staff between 67% to 92% and for medical staff 69% to 89%.
- However, there were some occasions when patient information, on transfer from AMU to general wards, was not fully accurate.

Evidence-based care and treatment

- Patients received care based on national guidance such as National Institute for Clinical Excellence (NICE) guidelines. There were specific pathways and protocols for a range of conditions, these included heart failure, stroke, diabetes, respiratory conditions, blood transfusions, and pressure ulcer prevention. For patients who had heart failure or had suffered a stroke care pathways were integrated, promoting effective care and treatment from the full multidisciplinary health team.
- In AMU, they had developed guidelines based on NICE for identification of possible sepsis. Doctors and nurses had clear information on recognising sepsis and action they should take. Patients identified as possibly having sepsis followed a care pathway which included administration of oxygen, blood tests, antibiotics and fluids management.
- In the cardiac units staff followed a patients' cardiac catheter pathway for pre and post procedure to promote good outcomes for patients.
- We saw practices and treatments on the haematology ward followed national best practice guidance.
- Local policies such as the pressure ulcer prevention and management policy were written in line with national guidelines and staff we spoke with were aware of these policies.
- The medical services participated in national clinical audits that it was eligible for. For some national audits, such as Adult Bronchiectasis and Adult Community Acquired Pneumonia, the trust made the decision not to take part. They considered their own local audits to be more useful in assessing the effectiveness of the care and treatment provided to patients with these conditions.
- Audits showed staff followed care pathways in respect to conditions such as sepsis and acute kidney injury.
- The trust did not collect medicine reconciliation data. This meant the trust could not be assured patients always received the correct medicines when admitted to the hospital and were not meeting the NICE guidance (NG5) that recommends medical reconciliation is completed within 24 hours of admission to the acute hospital.

Pain relief

- We observed nurses and medical staff monitoring the pain levels of patients pain levels were recorded on patient daily records and the electronic EWS recording system.
- Patients we spoke with said they were given pain relief when they needed it and nursing staff checked if it had been effective.

- Conversations with staff evidenced, for patients with cognitive impairment, they assessed patients' pain levels by observing non-verbal signs, such as facial expressions as well as changing behaviours.

Nutrition and hydration

- Patients' nutrition and hydration status was assessed and recorded using the electronic assessment system.
- Food and nutrition charts were completed where assessments identified the need. We saw these were completed detailing how much of each meal the patient had taken. Patients who required intravenous infusions in order to maintain hydration, had these fluids recorded and monitored accurately on appropriate charts.
- Patients spoke highly about the quality and quantity of food. Comments included, "the food is very good," and "nothing to complain about and food always hot." Patients with diabetes commented that they were well catered for. One patient told us, "I'm diabetic and it's been brilliant. I could eat properly here on the wards." However, this was not the same experience for patients waiting to go home in the discharge lounge.
- Comments received from patients and relatives before the inspection showed some had concerns with the provision of food and drinks on the older person's medical wards. One relative described a patient who required mashed food was provided with a normal diet which they were unable to eat. They described that in the hot weather patients had no access to drinking water. The relative said staff told them this was because patients "keep knocking it over." Other relatives commented that patients were not encouraged to have drinks.
- Since the last inspection in August 2014 nursing staff on the stroke unit had received training to equip them with skills to assess whether patients could swallow safely. This meant all stroke patients were assessed as to whether they could swallow safely and when required prompt referrals were made to relevant clinicians to provide appropriate support in meeting nutritional and hydration needs.

Patient outcomes

- Medical services took part on a number of local and national audits. The results of national audits were considered in order to make improvements to their services.
- The stroke unit provided data to the Sentinel Stroke National Audit Programme (SSNAP). This programme aims to improve the quality of stroke care by auditing stroke services against evidence-based standards and national and local benchmarks. When we inspected the service in August 2014 the Stroke Unit had an overall score rating of D which was below (worse than) the national clinical standard of C. The stroke unit had made changes to the service provision. This included the introduction of a Stroke Outreach service, new processes for nurse requested CT scans for suspected stroke patients, and recruitment of an additional stroke consultant. The Stroke Unit scored B in the April to June 2015 SNAPP results. This meant the unit was performing above the national clinical standard of C.
- Results from the national heart failure audit (2012-2013) showed that Royal Bournemouth Hospital results were worse than England and Wales averages for the majority of in-hospital care and discharge indicators. The trust reacted to the results, developing a new heart failure service that included a heart failure ward, rapid access clinics based on national guidance, establishment of a multidisciplinary heart failure team, new clinical pathways and protocols and heart failure study days. Internal monitoring showed that patients were receiving a more responsive service and length of stay for patients in hospital had reduced.
- The trust's performance in 2013 and 2014 was better than the national average in the Myocardial Ischemia National Audit Project (MINAP), a national clinical audit of the management of heart attack.
- The trust performance in the National Diabetes Inpatient Audit (NaDIA) 2013 was better than expected when compared to England average for 14 of the 21indicators. Seven indicators were worse than expected when compared to England average. These were patient admissions with a foot disease, foot risk assessments within 24 hours, after 24 hours and during the patient's hospital admission, meals choice, staff knowledge about working together and staff awareness of diabetes.
- Risk of Readmission was below the England averages for both elective and non-elective admissions (Dec'13-Feb'15).
- The endoscopy department was working towards accreditation with the Joint Advisory Group (JAG). The department had lost their previous JAG accreditation because they were not able to comply with the required

patient waiting times for treatment. Action was being taken, that included clinics on Saturdays and increased staffing with the aim of reaching compliance with the waiting time of six weeks. The department continued to manage unit infrastructure policies, operating procedures and audit arrangements to ensure they meet best practice guidelines in the manner they would do if they had JAG accreditation.

- The introduction of new pharmacy working practices on ward 26, which included two pharmacists embedded into the multidisciplinary team, resulted in improved effectiveness and outcomes for patients. This included improved timescales for provision of discharge medicines (20 minutes in comparison to the trust target of two hours), reduction in missed medicine doses, reduced length of patient stay and reduced readmission rate to the ward.
- Trust-wide the average length of stay in hospital was shorter than the England average for elective admissions, but slightly longer for non-elective admissions

Competent staff

- Nursing staff reported mixed experiences about having annual appraisals completed. Some staff said they had annual appraisals where development goals were set and adhered to. Other staff told us they had not had an appraisal in the last year. A new appraisal system was introduced in April 2015. Ward managers monitored and reported on appraisal completion rates. Governance reports showed that the overall rates were improving with appraisal booked for staff where needed.
- Appraisal completion rates for nursing staff ranged from 67% to 92% and for medical staff 69% to 89%.Data provide by the trust showed that between April 2014 to March 2015, compliance with appraisals for nursing staff on the cardiology wards was 92%, older persons wards was 67% and for medical wards 68%. The same data showed significant improvements from the previous year in the appraisal rates for nursing staff working on the cardiology and medical wards showed that the results for appraisals for staff working on the older person's wards were worse than the year April 2013 to March 2014, when it was 75%. However, the data showed that the results for appraisals for staff working on the older person's wards were worse than the year April 2013 to March 2014, when it was 75%. Appraisals for medical staff across the same areas between April 2014 to March 2015 ranged from 69% to 89%.
- Staff did not receive formal supervision. Staff, however, were supervised clinically and felt that handovers, ward rounds and board rounds provided them with learning opportunities.
- Staff had access to specific training to ensure they were able to meet the needs of the patients they delivered care to. For example, staff on the stroke ward had completed training for undertaking swallowing assessment.
- Staff working in the endoscopy unit told us they were supported to attend external training and conferences about endoscopy procedures. Staff on the endoscopy unit told us that training had improved on the unit. The unit manager had introduced six weekly training sessions, where the unit was closed in the afternoon for all staff to attend training.
- Staff had mixed experiences as to whether they had to complete competency assessments to demonstrate they had the appropriate skills for the area they worked in. Staff working on ward 1, the acute lung unit, told us ward sisters informally assessed nursing staff, but there were no competency assessments to complete. They said the thoracic unit education facilitator organised training and the outreach critical care team also provided some training. In contrast, staff on ward 22 had to complete a folder of competencies within four months of commencing work on the ward.
- In the General Medical Council (GMC) National Training Scheme Survey 2014, the trainee doctors within medical specialities rated their overall satisfaction with training as similar to other trusts. The overall satisfaction and experience in respiratory medicine was above the national average. Local teaching in cardiology, and access to study leave for endocrinology and older person's medicine was below the national average. However, trainee doctors we spoke to said they were well supported and the hospital was a safe place to work.
- Data from the 2015 survey identified overall satisfaction of junior doctor training in respiratory medicine continued to be above the national average. Clinical supervision in haematology was above the national average but quality of handover was below.

- There were medical outliers from for example, the stroke unit or older person's medical wards, on surgical and other non-medical wards. Although staff tried to ensure that these patients were more stable with lower level of needs, nursing staff on some of the non-medical wards were accessing training to equipment them with skills to provide care for these patients.
- New members of staff told us that they had been well supported since joining the hospital. They had completed a trust wide induction programme and a local induction programme for their area of work. The nursing staff had also been supernumerary on the ward for a couple of weeks giving them an opportunity to understand processes and procedures.
- Overall, patients expressed the view that staff were skilled in their work. One comment included, "They're competent. I feel confident in their treatment of me."
- Nursing staff were aware of the need to revalidate their registration. They told us the trust provided support and information sessions to support them in the revalidation process.

Multidisciplinary working

- Throughout our inspection, we saw evidence of multidisciplinary team working in the ward areas.
- Junior doctors and nursing staff told us nurses and doctors worked well together within the medical speciality. We saw evidence of this on the AMU, medical wards and care of elderly wards.
- Multidisciplinary Team Meeting (MDT) meeting took place on the stroke ward once a week to discuss current and new patients. Staff told us this meeting was attended by various health professionals such as nurses, doctors, physiotherapist, occupational therapist, speech and language therapist and social worker.
- Speech and language therapists attended the stroke ward daily and patients were also referred to clinical psychologists if necessary.
- Patients' records across medical services showed they were referred, assessed and reviewed by physiotherapists, dieticians and the pain team.
- Patients on the stroke unit confirmed the multidisciplinary team was present on the ward daily. One patient told us "daily a woman comes in to do exercises with my arm and leg."
- The heart failure team worked across the acute hospital, community teams and the palliative care team to provide a holistic service for patients with heart failure.
- There was effective multidisciplinary working between nursing staff and AHPs at Christchurch Day Hospital. They worked with community colleagues to develop individualised care and treatment plans for patients. This included working with GP practices, local social services, community nursing and therapy teams and the local ambulance service provider.

Seven-day services

- There was medical consultant cover on AMU seven days a week. Nursing staff and junior doctors told us consultants were on call out of hours and were accessible when required.
- On all the care of elderly wards we visited, consultant ward rounds took place daily. Each ward had a named consultant. Over the weekend, all new and deteriorating patients were seen by the on call care of elderly consultant. The consultant also took a detailed board round over the weekend.
- Patients on the Coronary Care Unit (CCU) were seen daily by the cardiology consultant. All new and deteriorating patients were seen either by the consultant or the medical registrar during the day time and were seen by on call consultant over the weekend.
- Consultants worked seven days a week for stroke services. The on call stroke consultant would see new admissions on the stroke ward and would take a ward round over the weekends.
- There was a daily consultant gastroenterologist on call for emergency gastro-intestinal bleeding (GI bleed) patients. Seven-day endoscopy service was available.
- Seven day physiotherapy service was available for patients with respiratory conditions between 9am and 8 pm. There was also a night on call physiotherapy service for patients with respiratory conditions.
- Physiotherapy and occupational therapy services were available for patients on medical wards, stroke ward and AMU over the weekend.
- Routine radiology ran at the weekends with an on-site radiologist from 9am to 6pm. CT scans were available over the weekend and at night. A service level agreement with an external provider, meant reporting on CT scans carried out overnight was completed in a timely manner.
- The pharmacy department was open seven days a week but with limited hours on Saturday and Sunday. On call pharmacist was available to dispense medicines over the weekends.

Medical care (including older people's care)

Access to information

- Staff told us they had access to patient related information and records. However, some staff described problems accessing patient records once they had been discharged. This was because, when a patient was discharged, their records were immediately sent to the scanning team. This meant if a patient contacted the ward for advice, notes were not available for staff to refer to.
- Agency and locum staff had access to the information in care records and electronic assessments to enable them to care for patients appropriately.
- Staff told us when the patient was transferred from AMU to a ward appropriate information about the patient's condition and needs was provided to them in a transfer summary. However, reviewing the record of incidents reported between indicated there were occasionally incidents when that information was not fully accurate. Between March 2015 to June 2015 there were seven occasions when a patient was transferred from AMU to a general ward when the AMU description of the patients pressure areas did not match that found by staff on the ward they were transferred to.
- Nursing staff told us when patients were transferred between wards or teams staff received a handover of the patient's medical condition and on-going care information was shared appropriately in a timely way.
- Discharge summaries were timely (within seven days) and were provided to GPs to inform them of patient's medical condition and treatment they had received when they were discharged.
- Medical staff accessed patient EWS scores from any computer terminal or hospital hand held device, which meant they could access patient's vital information promptly and remotely if needed.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients were consented appropriately and correctly. Where patients did not have capacity to consent, formal best interest decisions were taken in deciding treatment and care patients required.
- Staff received training about Mental Capacity Act and Deprivation of Liberty safeguards (DoLS). Discussion with staff of all grades evidenced most understood their roles and responsibilities regarding the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DOLs).
- Patient records showed the capacity of patients was considered when discussions about treatment and care were taking place. We saw evidence of best interest decisions that included the views of patients and involvement of relevant representatives of the patient.
- Staff understood how to act when restriction or restraint might become a deprivation of liberty. Staff were aware of the trust's policy if any activities, such as physical or pharmaceutical restraint, met the threshold to make an application to the local authority to temporarily deprive a patient of their liberty. Reviewing patient records, we saw applications for DoLS authorisations were made appropriately.

Are medical care services caring?

Requires improvement 

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

We rated caring as requires improvement.

- During the inspection we observed some staff interactions that demonstrated patients privacy and dignity was not always protected. On two wards we observed patients were left exposing the lower half of their body. On another ward a patient was administered an injection without pulling curtains around them, the patient lifted their gown up for the injection in view of patients and staff.
- Patients were left in nightwear on the wards, when they preferred to wear day clothes; they were not given a choice. Patients were discharged home in nightwear, rather than outdoor clothing. On one ward, at night, all patients were dressed in hospital gowns, rather than their own nightwear indicating a lack of consideration of patient's individuality and wishes regarding their clothing.
- Delays in answering call bells presented a risk to protecting patient's dignity. We observed delays and the

trust care audit demonstrated delays. A patient on the Stroke Unit said they had to pass urine in a pad, rather than be supported to use the toilet, because staff took so long to answer call bells.

- Feedback from patients and relatives who contacted us identified the common themes of patients on the older person's wards not being supported to mobilise, which resulted in them losing their mobility, not being able to access toilets and becoming incontinent.
- In the discharge lounge some patients commented they felt their emotional needs were not met. One comment included that "staff don't seem to want to spend time with me. Don't realise they need to talk to us, not just kick us out."
- Patient meal times varied in terms of the presentation of food, support provided and the sensitivity of staff approach.

However,

- Feedback from patients and their relatives was mostly positive about the way staff treated them. Patient and relative feedback evidenced there was a caring and supportive culture in medical services.
- The results of the Friends and Family test between April 2014 to February 2015 demonstrated overall good satisfaction of the patients with medical services.
- Patients and relatives we spoke with said they were well informed and involved in the decision making process regarding their treatment. There were arrangements to provide emotional support to patients and their families.
- Patients who received care and treatment at Christchurch day hospital spoke highly about the caring manner in which they were treated by all staff.

Compassionate care

- Overall results of the NHS Friends and Family Test (FFT) for medical services showed satisfaction with the service provided. Response rates were above the English national average. Results were displayed in the ward areas and on the hospital's website. Between March 2104 and February 2015, 96% of patients said they would recommend the service to their family and friends.
- The 2014 CQC Inpatient Survey found the trust scored similar to other trusts on all the indicators.
- The 2013/14 Cancer Patient Experience Survey found the trust scored similar to other trusts on 27 out of 34 indicators, better for five indicators and worse than other trusts for the remaining two indicators.
- Throughout our inspection we observed patients mostly being treated with compassion, dignity and respect. However, we did observe some incidences where staffing numbers resulted in patient's dignity being compromised. On one ward, at night, we observed a patient was sitting on a chair next to the nurse's station with no pyjama bottoms on. Staff told us it was the patient's decision not to wear pyjama bottoms. Staff had put a blanket over the patient's legs, but the patient kept standing up resulting in the blanket falling down exposing their legs and bottom areas in a public area of the ward. A disorientated patient in one of the side rooms repeatedly opened their door viewing the patient exposing themselves. On a second ward at night, two patients who were in bed did not have bedclothes fully covering them leaving them exposing the lower half of their body. There was no action by staff to replace the bedclothes to promote the patients' dignity. On the same ward, at night, all patients were dressed in hospital gowns, rather than their own night wear indicating no consideration of patient's individuality and wishes regarding their clothing. This was not the same on other wards where we saw some patients wore their own nightwear.
- On a third ward a patient was administered an injection without pulling curtains around them, the patient lifted their gown up for the injection in view of patients and staff.
- A patient on the Stroke Unit told us that they had not been dressed in clothes whilst a patient, they had always worn nightwear. This was in contrast to when they were at home where they would always get dressed during the day and would have liked to be supported to do that in the hospital. The same patient confirmed bedside curtains were always pulled round to promote their dignity.
- Patients told us about delays with staff answering call bells, which presented a risk to protecting their dignity. One patient on the Stroke Unit said they had to pass urine in a pad, rather than be supported to use the toilet, because staff took so long to answer call bells. The trust completed care audits monthly, where they sought the views of patients about the care they received. Between March 2015 and July 2015 there were

consistently low scores within medical and older persons medicines for the response to nurse call bells. This matched the experiences some patients described to us. The trust had identified a target of 95% response of yes or always to questions asked. For response rates to call bells, there was a range of 47% to 81% of patients saying call bells were answered in a timely manner. For the questions whether patients received assistance to use the toilet at the time they wanted it and whether patients always received assistance to prevent accidents such as 'wetting the bed', responses were below the 95% target with exception of once for older persons medicine for one of the questions and once for medical services for one of the questions.

- Before the inspection patients and relatives contacted the Commission to give feedback about their experiences at the hospital. Thirty two people expressed a view about the medical services. Overall opinions of the service provided were positive. However of the thirteen people who gave comment about the older persons medicine service, nine of them were dissatisfied with the service provided. All described some aspect of the service they felt did not demonstrate dignity of patients was respected and protected. One of the common themes was that patients on the older person's wards were not supported to mobilise, which resulted in them losing their mobility, not being able to access toilets and becoming incontinent. One relative told us that they felt staff viewed patients as being a nuisance.
- At meal times, patients were generally supported with sensitivity to have their meals. The trust operated a protected mealtime policy, where visiting was actively discouraged to promote a calm and undisturbed time for patients to eat their meals. However, when we spoke with staff, they said this did not always happen. We observed lunch times on the stroke unit, wards 21 and 22 and evening meals on the stroke unit and ward 25. We observed visitors were present during the meal times. Some visitors were actively supporting the patient they were visiting to have their meal.
- Across different wards there was a lack of consistency in the manner in which meals were served. In the evening, some patients had sandwiches for their meal. On some wards, sandwiches were removed from the packaging and given to patients on plates. On other wards sandwiches were given to patients in the packages and just placed on their bedside tables, which were not cleared in readiness for the meal.
- We observed staff supporting patients to take their meals. Most staff sat by the side of the patient. They checked and asked what the patient would like to eat and offered drinks between mouthfuls. However, not all staff sat next to the patient. We saw two members of staff on the stroke unit standing over the patient whilst they were supporting them to have their meal. Another member of staff had to be told by another member of staff to sit in a chair next to the patient they were supporting.
- Patients who attended the endoscopy unit were very complimentary about the service they received. Comments included "excellent service…made to feel at ease by all members of staff", "the staff bent over backwards in their efficiency, kindness and caring attitude demonstrated throughout the experience. You are amazing, all of you," and "Very kind and professional, I was dealt with dignity and respect."
- Patients on the haematology ward commented about the caring nature of all staff on the ward.
- We saw staff supporting patients who were confused and upset with kindness and compassion. On the stroke unit we saw a member of staff encouraging patient, who was very upset when transferring from a wheelchair to a sitting chair, with sensitivity, encouraging them to take little steps and being very patient in supporting the patient, "just take little steps". We saw staff noticing when patients were upset and offering them time to talk and had reassuring conversations with them.
- There were patients in the discharge lounge waiting to be discharged dressed in nightwear. Staff on the discharge lounge said this was not an uncommon experience that patients arrived from the wards for discharge with no outdoor clothing. Staff on the wards said they encouraged relatives to bring in suitable clothing for discharge however this was not always available.
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Understanding and involvement of patients and those close to them

- Most patients and relatives we spoke with stated they felt involved in their care. They had been given the opportunity to speak with their allocated consultant. However, of the 12 relatives spoken to for medical services some said they felt some nursing staff did not take into account their personal knowledge of their relative's needs, such as the support their relative

needed in making decisions and whether they needed support to take their medicines. One issue raised by patients and relatives before the inspection was that, on the older person's medical wards, staff did not listen to patient's carers or relatives regarding their needs and abilities and there was a lack of family involvement with discharge arrangements.

- Patients told us the doctors had explained their diagnosis and that they were aware of what was happening with their care. None of the patients we spoke with had any concerns in regards to the way they had been spoken to. All were very complimentary about the way in which they had been treated.
- On the stroke unit a patient told us they "see doctor every day – everything always explained well and in a way I can understand. I can ask questions." Patients on the Stroke Unit told us their discharge plans were fully discussed with them, their views and wishes were taken into consideration. .A relative of patient on the Stroke Unit poke about staff "they're busy, but friendly, they try and help. You can approach anyone and it's easy to get information. They get to know you."
- We observed nurses, doctors and therapists introduced themselves to patients at all times, and explained to patients and their relatives about the care and treatment options.

Emotional support

- During our inspection, we observed that staff were responsive to patient's needs, and we witnessed multiple episodes of kindness from motivated staff, towards patients and their relatives.
- The hospital chaplaincy had a visual presence abound the hospital and were happy to meet people to offer them support.
- A wide variety of specialist nurses provided emotional and practical support for patients with specific conditions. Specialist nurses were employed for diabetes, heart failure, cardiac arrhythmias, thoracic medicine, inflammatory bowel disease, haematological conditions, Parkinson's disease and dementia.
- We had positive comments from patients about the emotional support provided. This included for patients attending the endoscopy unit, "I felt welcomed, reassured and was given time to ask questions. I went in for my procedure understanding what to expect and felt confident I would be well cared for."
- During weekdays, specialist nurses were available to support patients receiving bad news following endoscopic procedures. However, the specialist nurses were not available at weekend to provide that service. The unit had identified this gap in the service and training was planned to give nursing staff appropriate knowledge and skills to support patients at the weekend if bad news had to be broken.
- In the discharge lounge some patients commented they felt their emotional needs were not met. One comment included that "staff don't seem to want to spend time with me. Don't realise they need to talk to us, not just kick us out."

Are medical care services responsive?

Good

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

We rated responsive as good.

- Medical services were responsive to patients' needs. The acute medical unit (AMU) and Treatment Investigation Unit (TIU) had contributed to the trust's ability to manage the increasing pressures on beds due to an increasing demand.
- There were 37medical outliers at the time of inspection (patients placed on wards other than one required by their medical condition).There patients were appropriately assessed and followed by a team of medical consultant and junior doctors.
- The trust was working with partners to improve the coordination, safety and timely discharge of patients.
- There was support for vulnerable people, such as people living with dementia and mental health problems. Three wards had been refurbished to improve the environment and appropriately support people living with dementia.
- Patients had access to information leaflets about different types of treatment and staff could request translation services or interpreters for people with communication or language difficulties.
- Staff took complaints seriously and responded in line with trust policy. There was evidence of learning from complaints on the wards.

However,

Medical care (including older people's care)

- There was a high number of delayed transfers of care. The main cause of delays was the provision of community services, especially care home places, to meet patients' on-going needs. The trust was engaged with partner organisations in managing these delays to minimise the impact on individual patients and the service overall.
- Not all wards had been refurbished to improve the environment for patients living with dementia, but this was planned.
- Some complaints took longer to respond to than the trust target of 25 days due to their complexity.

Service planning and delivery to meet the needs of local people

- The 52-bedded acute medical unit (AMU) was open 24 hours a day, seven days a week. Staff told us the unit was always busy and had alleviated pressures in the A&E department. The hospital also had a five-bedded GP AMU unit, designed to prevent avoidable inpatient admissions and manage the increasing numbers of patients requiring emergency admission with referrals directly from GPs.
- The trust had developed several services to meet the needs of patients in the community who required medical intervention without the need to be admitted to the hospital. This included the Treatment and Investigation Unit (TIU), which catered for patients undergoing infusion therapy and pre and post biopsy care.
- The Stroke Early Discharge Service enabled patients to return home at an earlier point in their recovery to continue their rehabilitation with support from the stroke therapy team. Comments from patients about this service included, "enabled me to return home. I did not want to be admitted and "I was able to sleep in my own bed."
- A GP led older person's ward had been established. This was used for patients who were medically fit for discharge, but there was delay in their discharge for reasons outside the control of the trust such as provision of community services. The ward was staffed and managed by the trust, but the medical input was from a GP as it would be for the patients if they were living at home. This released beds on the older person's wards for patients who were clinically unwell.
- All wards provided single sex accommodation.

Access and flow

- Bed occupancy in the hospital between April 2013 and March 2015 ranged from 90.5% to 95%. This was consistently above both the England average of 88%, and the 85% level at which it is generally accepted that bed occupancy can start to affect the quality of care provided to patients, and the orderly running of the hospital
- We found that bed pressures meant that the services admission pathways could not always be implemented. Emergency admissions to medical care services represented the majority of admissions. These were primarily via the Emergency Department or GPs. Patients were initially admitted to the AMU for assessment and diagnosis of their condition with a maximum stay of 72 hours. If a longer stay were required patients would be transferred to the relevant speciality ward. However, due to bed pressures patients were frequently cared for in the AMU for longer periods.
- Data provided by the trust showed that two thirds of inpatients admitted to the hospital did not move wards during their admission. However this data did not show how often patients moved bed spaces with in a single ward. Staff said that frequent bed moves occurred on the ward to cohort patients who required closer supervision or to enable single sex accommodation.
- There were 37 medical outliers at the time of our inspection (patients placed on wards other than one required by their medical condition).These patients were appropriately assessed and followed by a team of medical consultant and junior doctors. We visited wards which had medical outliers. The risk assessments and documentation for the medical patients were transferred and reviewed on the wards in a timely manner. Staff made all the attempts not to transfer these patients to a different ward unless clinically indicated.
- Bed pressures were compounded by high numbers of delayed transfers of care. Delayed transfer of care is when patients are in hospital, fit to be discharged but are unable to leave the hospital due to external factors. We were told that the main cause of delays was the provision of community services, especially care home places, to meet patients' on-going needs. On the care of elderly wards, staff told us there were delays in social

care assessments for patients who required on-going care. The trust was engaged with partner organisations in managing these delays to minimise the impact on individual patients and the service overall.

- The trust had a team of discharge coordinators and keyworkers who supported discharge planning at ward level. The keyworkers were based on wards, providing guidance and liaison with day to day discharges. The senior discharge coordinators were based centrally and case managed complex discharges with commissioners and partners, such as the local authority, CCG and the local community. Discharge arrangements and Estimated Dates of Discharge were discussed at the daily board rounds, and any issues escalated to the Manager for Discharge Services.
- The trust had processes and facilities to support effective and timely discharges. However, external providers and internal processes sometimes impacted on the trust's ability to deliver timely discharges.
- To release beds in the hospital and promote patient flow the trust had a discharge lounge where patients could wait for transport or final discharge arrangements such as medicines. Patients we spoke with in the discharge lounge had mixed views about their experience. One patient, who had been waiting nearly nine hours for transport, said, "This is bad – it's nearly six o'clock and I'm shattered. I've been awake since 6am and it's been a long day- this spoils the whole thing for me." Staff explained that although transport was booked to collect patients in a timely manner so they did not spend too long in the discharge lounge, the ambulance transport system did not always arrive within the timescale requested. The trust reported a good working relationship with the ambulance transport provider in trying to improve transport provision for patients being discharged. They told us data relating to transport services for October 2015 showed that 97% of patients were picked up within one hour of their appointment time.
- Pharmacy services had a key performance indicator (KPI) to complete discharge prescriptions within two hours. Data showed that between January 2015 to July 2015 an average 465 prescriptions per month breached this target by an average of 53 minutes. This was a slightly worse performance recorded for the same period in 2014. Staff said it was not unusual for patients to wait three to four hours for their medicines before they could be discharged. The pharmacy department were aware of this problem and were taking action to try to improve the timeless for completing discharge prescriptions. Improvements had been made ward 26, where two pharmacists embedded into the multidisciplinary team. There were effective processes for nurse triage of patients referred to Christchurch Day hospital to ensure patients were seen and treated in line with their clinical needs.
- Between April 2013 to February 2015, the 18 week referral to treatment times (RTT) target was consistently met.

Meeting people's individual needs

- The trust employed specialist dementia nurses that staff could access to provide support and guidance in caring for patients with dementia.
- The trust used the 'this is me' booklet for patients living with dementia, developed by the Alzheimer's Society to alert and inform staff to identify and meet the needs of these patients. On the care of elderly wards, we saw that patients living with dementia had the booklet and it was appropriately completed. A 'forget-me-not flower' symbol was used to identify people living with dementia on all the care of elderly and medical wards.
- All patients over 75 years were screened for dementia using a recognised methodology on their admission.
- Since the last inspection in August 2014, a second ward had been refurbished to make it easier for patients living with dementia to navigate. Refurbishment of the other wards was planned, although staff working on the wards did not know the timescale for this. However, the principles of bay based nursing had been introduced on all wards. This is where a member of nursing staff was based in a bay at all times to respond promptly to patient's needs. This could include responding to call bells promptly, improved observation of patients general wellbeing and recognition and action in response to nonverbal signs that a patient required assistance.
- The trust said they had adopted the Royal College of Nursing (RCN) principles of good dementia care in an acute hospital. One of those principles related to the environment of wards which included the provision of activities to improve and promote well-being. All wards had been supplied with a therapeutic

intervention kit. However, the only ward we saw where there was appropriate activity provision being provided for patients with dementia was ward 9, the GP led ward.

- At the previous inspections in August 2014 senior nurses in the older people's directorate said they were planning to train a cohort of health care assistants in the skills to provide meaningful care and support to dementia patients exhibiting challenging behaviours. They would be deployed to provide this support when needed to reduce the risk of patients being supported by agency or bank staff who did not have the specialist skills to support them. There was no evidence this practice had been implemented.
- The lead nurse of adult safeguarding monitored the provision of care for patients with a learning disability. The trust relied on service providers and the local learning disability community team to inform them of admissions of patients with a learning disability. Staff demonstrated an awareness of the "Care Passport" scheme where patients with a learning disability brought a document outlining their care needs and preferences and information about them for staff to reference. We had a conversation with a patient on one of the wards who had a learning disability. They told us "The doctor here is really nice, the nurses are kind too and they all tell me bits and bobs so I can understand it."
- Interpretation services were available and staff knew how to access the service when needed.
- A wide range of patient literature was displayed in clinical areas covering disease and procedure specific, information, health advice and general information relating to health and social care and services available locally. Patient information leaflets were also available on the hospital website. We saw patient literature leaflets in large print and on the website there were easy read leaflets suitable for patient with a learning difficulty. There was no information displayed in languages other than English. However, the trust informed us tis could be provided if required.
- During the unannounced inspection, we observed staff action that responded to the needs of patients. For example the evening, meal provision included a fish cake that the hospital kitchen provided with gravy to accompany it. Patients found the fish cakes too dry to eat without a sauce, but felt gravy was not the appropriate accompaniment. In response, nursing staff made up parsley sauced to go with the fishcakes.
- There were bathing facilities on all wards for patients. Staff on the stroke unit told us patients could not choose to have bath as there was only showering facilities available on the unit.

Learning from complaints and concerns

- The trust had identified a delay in responding to and closing complaints and action was in place to improve this. Data provided by the trust showed that between July 2014 to June 2015 there had been 94 formal complaints relating to medical services. Twelve of those complaints had no information detailed to indicate an investigation had taken place and that consideration had been made with regard to any learning points. There was one complaint that had taken seven months till completion of the investigation, and a second one that had taken eight months to complete investigation and close the complaint.
- On wards, senior nursing staff reviewed complaints and telephoned complainants directly and if appropriate, invited them to meetings.
- Staff were aware of the complaints process and how to support patients with a complaint or a concern. They could also recall changes and improvements made in response to complaints, for example in relation to checking pain assessments. Staff told us ward sisters investigated complaints and gave them feedback about complaints in which they were involved.
- Patients we spoke with felt they would know how to complain to the hospital if they needed to.
- Wards displayed results from patient feedback ,which included concerns as well as compliments. The displays detailed what action the wards had taken in response to comments. One example included the provision of eye masks and ear plugs for patients to reduce the level noise experienced at night.

Medical care (including older people's care)

Are medical care services well-led?

Good

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

We rated well-led as good.

- The trust had published its vision, values, mission statement and objectives, and had taken action to assess and improve staff understanding of these. The older person medicine, medical and cardiology departments had local strategic plans.
- Governance processes promoted reviews of the service provision and identified areas for improvement. Risk registers at department and trust level did not identify all risks posed to the service and patients. This meant these risks were not monitored effectively and no plan of action was followed to mitigate these risks.
- Staff felt valued by their immediate line management and well supported. They said they were comfortable reporting incidents and raising concerns.
- Systems were in place to gather patient feedback and use it to improve services.
- Christchurch Day Hospital and the endoscopy unit held patient focus groups where patients and their representatives could put forward suggestions for changes and improvements to the service.
- There were improvement projects to improve patient experience, safety and efficiency. An example was the heart failure service that was developed to provide a holistic and multidisciplinary service for patients resulting in improved outcomes and reduced length of stay in hospital for patients with heart failure

Vision and strategy for this service

- The trust had set up a new care group structure, with three main care groups made up of departmental specialties. Staff understood this structure and clinical leads felt this was now embedded within the trust. Progress was discussed at senior manager level.
- The strategic direction of services was open to review at the time of the inspection, as a result of the Dorset Clinical Commissioning review. The trust described its five-year strategic plan for patient care, underpinned by six strategic objectives.
- Not many staff were familiar with the trust's vision (to be the most improved hospital by 2017) but most recognised at least some of the four values (Communicate, improve, teamwork and pride), particularly if they had completed their appraisals or induction recently.
- The older person medicine, medical and cardiology departments had local strategic plans. In broadest terms, these were to focus on internal improvement programmes, integrate better with other services and develop 7-day services through the Dorset Clinical Services Review
- Progress had been made against departmental strategic objectives. For example, there had been a successful recruitment programme for medical services and staff monitored and responded to patient experience.
- Staff at all levels demonstrated a passion to provide a good service for patients.

Governance, risk management and quality measurement

- Wards visited had regular team meetings at which performance issues, concerns and complaints were discussed. Where staff were unable to attend ward meetings, steps were taken to communicate key messages to them.
- The medical services had a quality dashboard for each ward. It showed how the services performed against quality and performance targets. Members of staff told us that these were discussed at team meetings. The ward areas had visible information about the quality dashboard.
- Medical services had a governance structure that included monthly clinical governance meetings where the results from clinical audit, incidents complaints and patient feedback were shared with staff. Minutes of clinical governance meetings showed patient experience data was reviewed and monitored.
- Each department in the medical services had a risk register that included known areas of risk identified in their service. These risks were documented and a record of the action being taken to reduce the level of risk was maintained. The higher risks were also escalated on the

trust's risk register where they were presented to the trust's executive committee and were reviewed regularly. However, review of the medical services and trust risk register showed they did not fully reflect the risks we identified during the inspection process. This included risks to the health and wellbeing of patients as a result of risk assessments not being completed in a timely manner and risk associated with poor medicine management.

- The trust completed care audits monthly, where they sought the views of patients about the care they received. Wards displayed "Score cards" which included feedback from patients about positive and negative aspects of their experiences of receiving care and treatment at the hospital. We saw the findings in the monthly care audits and comments displayed on the 'score cards' were generally similar. The score cards detailed action the wards and trust were taking in response to the findings.

Leadership of service

- Clinical leads spoke positively about the leadership from the executive board. They told us, that following the last comprehensive inspection of the service, the executive team was much more focussed on patient experience and care, rather than just concentrating on cost improvements and profits. Two clinical directors who took on director role after the 2013 inspection said they told us they would not have taken on the role of directors if the attitude of the executive board had not changed to consider patient experience and care.
- Ward staff felt well supported by their ward sisters and matrons and told us they could raise concerns with them. Staff across medical wards told us matrons were visible and had a regular presence on their ward. However, ward staff told us the executive team were rarely seen on the ward.
- Junior doctors felt well supported by consultants and senior colleagues. Medical staff felt supported by the medical leadership in the division and the trust.
- The student nurses told us they felt supported on the ward and received supervision training from the senior staff. They told us consultants were accessible and approachable.
- Ward staff said the Director of Nursing (DoN) only attended the ward areas if there was a specific purpose, such as a meeting. They did not consider the DoN offered day to day support for staff and patients on the wards. However, senior nursing staff said that they could approach the DoN with any concerns and she would respond promptly.

Culture within the service

- Staff spoke positively about the high quality care and services they provided for patients and were proud to work for the trust. They described the trust as a good place to work and as having an open culture.
- Staff told us they were comfortable reporting incidents and raising concerns. They told us they were encouraged to learn from incidents.
- The trust's sickness absence rate was below the England average for all months from February 20011 to December 2014, with the exception of March 2013. Across the four years, it ranged from 3.0% to 4.7%. Between April 2014 to March 2015 the sickness absence rates for nursing staff on the older persons medical wards was 3.8%, which was the highest for the medical services. However, the 2014 NHS Staff survey showed the trust was rated worse than expected for the percentage of staff feeling pressure in last 3 months to attend work when feeling unwell.
- Staff survey results from the 2014 NHS Staff survey showed the trust's performance was rated as worse than expected for four out of 28 indicators. Areas in which staff did not feel the trust performed well included staff experiencing physical violence from staff, staff experiencing physical violence from patients, relatives or the public, staff experiencing harassment, bullying or abuse from patients, relatives or the public and the number of staff feeling pressurised to attend work when feeling unwell. When we spoke with staff on the wards, their experiences did not mirror these survey findings.
- The trust performed better than expected in two of the 28 indicators, which were regarding the trust using feedback from patients to make decisions about the running of the service and the level of work pressure felt by staff.

Public engagement

- Patients were engaged through feedback from surveys, such as the NHS Friends and Family Test and complaints and concerns. Other forms of engagement were not developed. Clinical governance meetings showed patient experience data was reviewed and monitored.

- The endoscopy unit held patient focus groups that gave patients opportunity to share their experiences and help staff identify areas for change and improvement.

Staff engagement

- Information was shared with the teams. Information was displayed in suitable areas of the wards about governance, risks, training, trust information and unit social activities.
- Staff meetings and handover periods provided opportunity to engage with staff and ensure information was passed on to staff. Records of staff meetings and discussions with staff confirmed this occurred.
- Junior doctors told us they were able to raise concerns.

Innovation, improvement and sustainability

- There were examples of innovative service delivery and clinical practice. Many of these were aimed at improving the patient experiences and outcomes which resulted in shorter lengths of stay in hospital
- Ward 9 was a GP led older persons ward. Older patients who were medically fit for discharge, but whose discharge was delayed usually due to social care delays, were cared for on this ward, releasing acute beds in the hospital for unwell patients to be admitted and treated by the hospital medical staff.
- The heart failure service provided a holistic and multidisciplinary service for patients with heart failure which had result in improved outcomes and reduced length of stay in hospital for patients with heart failure.
- Introduction of new pharmacy working practices on ward 26, which included two pharmacists embedded into the multidisciplinary team, resulted in improved effectiveness and outcomes for patients.
- Employment of an Acute Kidney Injury (AKI) nurse specialist, providing education, outreach bleep service Monday to Friday and development of care pathways resulted in reduced length of stay and reduced mortality rates for patients with AKI.
- Working in partnership with Dorset Adult Integrated Respiratory Service made improvements to care of patients with repository conditions in the community, including the administration of intravenous antibiotics for some patients, with specific respiratory conditions, at their home. This has reduced length of staff in hospital and improved patient experiences and wellbeing.

Surgery

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

Information about the service

Royal Bournemouth Hospital provides all the surgical services for The Royal Bournemouth Hospital NHS Foundation Trust. The majority of surgical activity is provided as day cases, with inpatients accounting for 31% of activity. The focus in on elective surgery, with the main specialities being ophthalmology, urology and orthopaedic surgery, which combined make up 75% of surgical treatments.

A surgical service in this report includes services provided by the surgery, anaesthetics, orthopaedics, interventional radiology (IR) and ophthalmology directorates. The first three directorates are within the trust's surgical care group A, IR is in the specialties care group B and ophthalmology in care group C.

There are 16 operating theatres located in the main theatre centre, in day units and the Derwent suite. We visited the day surgery unit, the day treatment centre referred to as the Sandbourne unit, the surgical assessment unit, the ambulatory care unit, the Derwent suite for elective orthopaedic procedures and the eye unit. We visited six surgical wards.

We spoke with 24 patients, eight relatives and 63 members of staff. These included nursing staff, healthcare assistants, ward clerks, junior and senior doctors, pharmacists, physiotherapists, occupational therapists, housekeeping staff, porters, personal assistants and managers. We looked at 24 care records. We observed care and treatment and received 14 feedback forms completed by patients. In addition we received feedback prior to the inspection visit, from listening events held in Bournemouth and via our website. Over 20 comments related to patients' experience of surgery.

This service was last inspected in August 2014, as a follow up inspection to review areas of concern previously identified in October 2013. At that follow up inspection we found that improvements had been implemented in all the areas where we had previously identified concerns.

Surgery

Summary of findings

This core service was rated as good. We rated safe as requires improvement and found effective, caring, responsive and well led were good.

We rated safe as requires improvement because of shortfalls in areas of medicines management, cleaning, the environment and equipment, surgical checklist compliance and staffing levels. For example, staff were not always monitoring medicine storage temperatures or following trust policy when destroying controlled drugs. We found dust and cobwebs in some theatre areas, although ward areas were visibly clean. The routes for patients to move from the main hospital wards to the Derwent unit were not suitable for patients, and some items of equipment were not stored safely or were not accessible. Although there had been recruitment of nursing staff, vacancy levels were still high in some areas, and there was evidence that requests for additional staff to provide cover were not always met. We found that in some theatres, staff did not follow the five steps for surgical safety accurately. There were systems in place to assess and respond to patient risks however, and records were generally legible and comprehensive. If they were completed electronically, they were automatically monitored for compliance.

Staff commented that access to information was not always effective. Patient information was held in a variety of formats which meant it could sometimes be difficult to use and time consuming to find.

Patients received care and treatment that followed national clinical guidelines and staff used care pathways based on evidence-based research. Staff audited patient treatment and care, and used the findings to improve outcomes for patients. Patients commented positively about the skills of staff, the quality of food and the provision of pain relief. Reports showed appraisal rates were improving following the introduction of a new system. Staff completed training relevant to their roles, but overall their compliance with mandatory training was below the trust target.

There was effective team working within and across different staff groups. This included multi-disciplinary working to provide person centred care. Staff commented that local leadership was good and there were opportunities for personal and professional development. Some staff, however, felt isolated and disconnected from the senior management team. This was mainly theatre staff.

Patients told us that staff provided care in a kind and compassionate manner and they were involved in decisions about their care. They were asked for their views and response rates were high, with a high proportion of patients recommending treatment. Results of patient feedback, as well as quality and safety data, were displayed for patients and visitors to view on ward areas.

There was an effective governance structure to review performance and there was evidence of formal reviews of risks, incidents, deaths, complaints and audits. Performance data showed the hospital was achieving the referral to treatment times and its cancellation rate for operations was below the England national average. Medical patients were frequently allocated beds on surgical wards however, and this presented a risk to patient experience and care. Staff worked hard to minimise this risk by working to admission criteria and re-allocating staff to reflect patient needs.

Surgery

Are surgery services safe?

Requires improvement

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

We rated safe as requires improvement.

- Theatre safety checklists had been improved, however we found staff were not consistently using the 'Five steps to safer surgery' to minimise risks of patient harm.
- There had been never events in the hospital, but not within the surgical department. Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.
- Staff in theatres were less confident about incident reporting and said feedback and learning was not shared consistently or accurately.
- Theatre areas were not always visibly clean. We saw dust on equipment, cobwebs in a recovery area and cleaning sign sheets were not consistently completed.
- The environment for patients moving to the Derwent unit from the main hospital and wards was not suitable. Staff had to take patients either outdoors or along a corridor in a non-patient area through a series of heavy fire doors. The route was not adequately lit, heated or served by a call system. This put staff and patients at risk.
- Some oxygen cylinders were found unsecured in theatre areas, presenting a hazard to patients and staff. Surgical ward staff were not able to access the blood gas analysis equipment outside normal working hours without going to the emergency department, which potentially put patients at risk.
- Medicines were not consistently managed in line with trust policies in regards to monitoring storage temperatures and destroying controlled drugs. Staff did not collect Medicine Reconciliation (MedRec) data to demonstrate that patients received the correct medicines when admitted.
- Requests for additional nursing and healthcare assistant staff, over the planned or 'templated' level were not always met. Staff made such requests to provide 1:1 care for specific patients or to staff additional beds. When additional nursing or care staff were not available, senior staff mitigated risks to patients by moving nurses and healthcare assistants between different ward areas, according to bed occupancy and patient needs. Data showed that on each week in a 31 week period, there were unfilled shifts. The trust recruitment campaign had been effective in filling vacancies, but there were still vacancies for nursing staff within the orthopaedic directorate. The impact of this varied depending on the local situation, but there was a risk that patients' needs might not be met.
- Surgical services staff were not yet achieving the trust target of 95% compliance with mandatory training

However,

- Most ward staff said they were encouraged to report incidents and received feedback. Incidents were investigated using root cause analysis and staff on the wards described shared learning from incidents.
- Staff used the safety thermometer and other data to monitor and report on patient safety. Action was taken when failings were identified.
- The wards areas were visibly clean and there were low infection rates.
- Equipment was serviced regularly.
- Patient records were created in electronic and paper formats. There were systems in place to check that staff monitored patients on a regular basis and recorded the findings. Signs of deterioration were monitored and responded to, to support patient welfare and safety.
- Staff understood how to safeguard adults and children and where to find additional support or advice if required.

Incidents

- Within surgical services there had been six serious incidents in the period September 2014 to April 2015. During this period, the trust reported 1041 surgical incidents, 249 orthopaedic incidents and 631 anaesthetic incidents. The majority of these were rated as minor or no-harm incidents, with two reported as major and 24 as moderate incidents.
- Detailed root cause analysis investigations were completed for serious incidents and never events which identified learning and any actions required. For example, following an investigation into a grade 3 pressure ulcer, the tissue viability nurse and head of

nursing had delivered training in wound care, nutrition and record keeping plus increased monitoring levels. Ward sisters reported a reduced level of avoidable pressure ulcers following this training.

- Staff completed hospital Adverse Incident Reporting System (AIRS) forms in the event of errors or incidents. Most staff said they understood how to report incidents and were encouraged to be honest and open in their approach to incidents. Ward staff who had reported incidents said they had received feedback. They could report examples of changes in practice and learning resulting from incidents. For example, in relation to patient falls.
- Four staff working in theatres were not clear what constituted a never event. Feedback from a review of a moderately severe incident had been confusing for staff, since contradictory guidance had been shared initially. Staff working in theatres reported they were not always listened to when raising concerns and feedback from incident reporting was inconsistent.
- At ward level, incidents were noted in monthly risk, governance and quality improvement reports. These summarised any trends and actions taken locally. There were opportunities for learning from these incidents, across surgical wards and theatres, as staff could access these summary reports on the departmental shared drive.
- Patient records showed evidence of incident reporting, for example a delay in obtaining medical advice was summarised within a patient's notes, with reference to the incident report.
- Audits of surgical site infections (SSI) showed the hospital rates were comparatively low in all areas except for knee surgery. The Surgical Site Infection Surveillance Service (SSISS) report showed the rate of SSI for knee surgery at 3.7% was significantly higher than the national average of 1.7%. The SSISS report for hip surgery, January –March 2015, indicated the rate of SSIs was comparable with the national rate, at 1.4%. The SSI rates for gastric surgery and large bowel surgery were lower than the national averages, as reported for the period July – September 2014.
- The trust had set up a quality improvement project to use the surgical safety checklist more consistently to reduce incidents and the risk of never events. The checklist had been adapted since it was first introduced, to include additional checks in response to recent incidents.
- NICE recommends that all patients are assessed for risk of developing thrombosis on a regular basis. The trust monitored the assessment of patients at risk of venous thromboembolism (VTE) and audited the inputting of VTE scores by speciality and by consultant each month. This highlighted specific areas and consultants where assessment scores were low.
- The medical director chaired the Mortality and Morbidity Group meetings, which were held approximately monthly. In addition, different speciality leads held mortality and morbidity meetings, for example in vascular services and urology. Minutes indicated that clinical leads discussed the causal factors for unexpected deaths, however it was not always clear what learning was taken forward. For example, the minutes did not record whether changes were made in response to identified trends or specific learning. Minutes showed the medical director planned to address this with improved liaison with clinical governance or the quality and risk committee as appropriate.
- Data showed the mortality rates were within the expected range for both weekdays and weekends. The hospital's standardised mortality ratio (HSMR) for April 2014 - March 2015 was 92.86 (better than expected). The Summary Hospital-level Mortality Indicator (SHMI) results for October 2013-September 2014 were 103. HSMR and SHMI figures were within the expected range for this financial year for weekdays and weekend admissions. The trust had undertaken its own mortality reviews in a range of clinical areas.
- The ophthalmology service had a mortality lead and there had been no deaths within ophthalmology in the past year.
- The trust's policy for adverse incidents, near miss reporting and management June 2015, included guidance on the statutory requirements, principles and concepts of Duty of Candour.
- The new regulation, Duty of Candour, states that providers should be open and transparent with people who use services. It sets out specific requirements when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, giving truthful information and an apology. Staff on wards and in theatres understood these principles of Duty of Candour. Incident monitoring reports showed staff were prompted to consider

whether incidents required the application of Duty of Candour. Both junior and senior nursing staff provided examples of when the Duty of Candour had been applied.

Safety thermometer

- The NHS safety thermometer is a monthly snap shot of the prevalence of avoidable harms, in particular new pressure ulcers, catheter-related urinary tract infections, venous thromboembolism (VTE) and falls. This information was displayed on ward notice boards, where patients, visitors and staff could view the results and trends.
- The safety thermometer data for surgical services showed 24 pressure ulcers (grade 2-4), three falls and eight catheter related urinary tract infections during the 13 months to July 2015. These results were in line with the English national average for similar sized hospitals. The prevalence rates for pressure ulcers were highest in February 2015, but the results did not indicate any particular trend.
- Ward sisters explained actions they took to minimise the risk of avoidable harms. They monitored risk assessments compliance and fluid charts. Where they found issues relating to care they raised them with staff directly. They also used the morning safety brief to reinforce messages relating to patient safety.

Cleanliness, infection control and hygiene

- We observed dust on a range of trolleys in the Derwent theatres, anaesthesia rooms 3, 4, 9 and 10. We also observed cobwebs in the windows of the Sandbourne unit recovery room. This indicated a lack of thorough cleaning in these areas.
- There were open waste bins in main theatres and in the Sandbourne recovery room, creating a risk of spreading infection.
- In the Derwent theatre there was no daily record of cleaning equipment, or pre-list checks. The cleaning record on display in the Sandbourne recovery room showed gaps in the weekly cleaning rota. For example, there were no signatures against 15 June 2015. There was no routine for nursing staff to sign for daily cleaning of clinical equipment.
- We observed the ward areas were visibly clean. These included patient bed spaces and the individual rooms on Derwent ward, corridors and equipment.
- Monthly cleaning audit reports showed high scores of over 98% in the majority of areas for most months. Scores dropped to 97%, below the target pass rate for high risk areas in three areas in March 2015: Sandbourne, the day treatment centre theatres and day surgery theatres. The day treatment centre scores dropped to 97% on four months between August 2014 and July 2015. These were flagged in the audit reports as 'amber'.
- Patients we spoke with found housekeeping standards were good.
- We observed staff using personal protective equipment appropriately in theatres and ward areas and patients with infections were isolated in single rooms to minimise the risk of spread of infections.
- The commodes we checked were clean, labelled as clean, and stored correctly.
- Clinical waste was labelled correctly in theatres and disposed of safely.
- Hospital acquired infection rates were low. The rolling 12-month trend to May 2015 for the surgical care group, showed zero MRSA bacteraemia and one incident of Clostridium difficile. Patients were screened for MRSA, in line with the trust's policy. This had been modified in March 2015, such that only patients assessed as at risk of MRSA infections were screened within 24 hours of admission.
- An audit of compliance with the MRSA policy had been undertaken in August 2015, and results showed a high rate of compliance with the revised screening protocols. Two percent of patients who should have been screened under the new policy had been missed. Ward managers were aware that outliers would only be accepted onto surgical wards if they had been screened for MRSA and showed a negative result.
- Hand hygiene and saving lives audits from July 2015 showed hand hygiene scores between 97% and 100%. Ongoing management of peripheral venous cannulas was given a low score in this audit of 75% in orthopaedics and 80% in surgery. Action plans had been submitted to improve cannula infection control and staff showed us practical steps that had been taken to improve procedures. These included providing targeted training, creating prompts on the drug trolleys and commending the staff showing vigilant assessments. The handover sheet had been amended to identify patients with cannulas, to prompt staff to carry out assessments.

- Infection control leads carried out regular audits within the surgical care group. These clearly outlined trends and areas for improvement. For example, there had been a focus on improving procedures for cannulation in surgical and orthopaedic wards, with additional training, closer scrutiny at handovers and revised handover sheets.

Environment and equipment

- Staff on surgical wards were not able to readily access blood gas analysing equipment outside working hours. This equipment could be accessed during working hours but staff had to take blood to the emergency department outside normal working hours, which also put additional staffing risks on the ward.
- The routes for transferring orthopaedic patients from ward 7 to the Derwent ward were not suitable for patient safety. The options were for staff to either take patients outside or via the pathology department and along a corridor in a non-patient area. The corridor option meant staff had to support patients, who could have limbs in plaster and be in wheelchairs, through eight sets of doors. The route entailed passing through, a waiting room, along a poorly lit corridor with right angle bends and past a section open to the outside. This put patients and staff at risk
- A room on ward 7, used by patients and physiotherapy staff, was overly congested with equipment and lacked suitable storage solutions. This could present a risk to patients and staff.
- Staff reported good access to equipment including beds to support patients at risk of developing pressure ulcers and mobility equipment. All the beds on ward 14 had mattresses which could be adjusted to support patients at risk of pressure ulcers.
- Staff checked defibrillator and resuscitation trolleys in line with guidance and the equipment was serviced.
- Equipment on wards was PAT tested. In some cases, the date of the last service had been rubbed off and this was raised with staff when observed.
- The trust had provided maintenance records for surgical wards. These showed maintenance of defibrillators and oxygen had been completed, but the records did not provide a comprehensive list of equipment and service dates. Records of other maintenance were held centrally by estates.
- Wards were generally tidy and organised. Staff positioned wheeled desks in bays to facilitate bay nursing and there were sufficient chairs for visitors.
- Consumables were stored in purpose built, locked cabinets in ward storage rooms. All those we checked were within their expiry dates. Staff told us there was a system for rotating stock to minimise the risk of it being used beyond its expiry date.
- Staff checked anaesthetic equipment in theatres to ensure they were safe.
- In anaesthetics, ophthalmology, orthopaedics and surgery, between 84% and 97% of nursing staff had completed level 2 infection control training.

Medicines

- Trust policy on the Management of Refrigerated Pharmaceuticals was not always followed in relation to safe medicine storage. Staff only recorded current medicines storage temperatures, not the external maximum and minimum temperature readings, to show the temperatures medicines had been exposed to.
- A maximum temperature of 14°C was observed in one fridge on ward 14. This meant there was a lack of assurance that refrigerated pharmaceuticals were safe to use.
- Fifteen out of 16 theatres were not recording the destruction of wasted controlled drugs (CDs). Staff were not following the trust policy that states that all CD wastage (including infusions started in theatre) should be recorded in the CD record book under the drug (not on a separate page) and witnessed by two people. This is recognised as good practice, although not a legal requirement.
- Wards were not aware of changes to the arrangements for anaphylaxis emergency medicines. Guidance had been issued to remove the blue boxes for anaphylaxis medicines, and add adrenaline syringes to the drug bundle in the emergency trolley. However this had not been completed when we visited. We raised this as a concern with senior managers who communicated this across the hospital for staff to address as a priority. By the end of our inspection, staff on the wards we visited were aware of the changes and new checklists were being distributed.
- The trust did not collect medicine reconciliation (MedRec) data, to check patients' medicines against their prescriptions. It was therefore not possible to say if patients were always receiving the correct medicines

when admitted to the hospital. NICE guidance (NG5) recommends that MedRec is completed within 24 hours in the acute setting to ensure patients' medicines are managed safely.

- Free standing oxygen cylinders were observed in anaesthesia rooms 3 and 4 and in recovery rooms for main theatres, the Derwent and Sandbourne ward/unit. They were not secured to minimise the risk of harm to staff or patients should they fall. However, we observed secured oxygen cylinders in other locations.
- Staff said there was an open culture for reporting medicine incidents. They said the online reporting system for this was easy to use. Medicine incidents were discussed at the Medicine Incident Risk Group.
- Ward staff reported medicine incidents including missed doses, on the ward risk, governance and quality improvement reports. Staff also displayed medicine incident rates for patients and visitors to view.
- Medicines and intravenous fluids were stored securely in locked cupboards.
- Patient records highlighted allergies to medicines, in both electronic and paper format.
- Pharmacists produced the summary of current medicines for patient's discharge letters. We saw these letters contained details of medicines started and stopped and any dose changes. Staff emailed or faxed letters to the patients' GP and community pharmacy.

Records

- Information about patients' assessments and care were held in different types of records. These included hard copy notes of medical and surgical records, fluid charts, handover notes and care plans. Staff electronically recorded risk assessments, surgical checklists, monitoring data and scanned records from previous hospital admissions.
- The records we reviewed were clear and sufficiently detailed. They included details of patients' admissions, risk assessments, monitoring charts, treatment plans and medical and therapy interventions. Records were generally well completed, legible and signed/dated.
- The trust had created pre-printed booklets for a range of purposes. For example, for pre-operative screening and operating department records of care. Staff used different care plans for short stay, day case and 7-day stays. The pre-assessment documents prompted staff to record important information relating to the safety of patients, including their medical history, allergies, current medicines and risk assessments. Records we reviewed were completed with the key information required.
- Staff completed electronic nursing assessments on hand held tablets, using a format designed in-house to prompt staff to report assessments in a timely way. The risk assessments related to malnutrition, skin integrity, dementia, mobility and frailty, falls, use of bedrails and venous thromboembolism. The system used Red, Amber and Green colour coding to flag when assessments were due or approaching their deadline for completion. This was a new system and staff were still adapting to its use. Data from the system was used for audit and monitoring purposes. When a patient transferred from one area to another, the 'clock' on the electronic nursing assessment tool was reset, and staff were prompted to review and update assessments. Staff explained they used their professional judgement at times to override this system, to avoid disturbing patients during the night if it was not necessary.
- Nursing staff carried out care rounding three times a day and this was noted in records. On Ward 17, we observed that the SKIN bundle, a tool designed to minimise the risk of patients developing a pressure ulcer, had not been used correctly for one patient. We highlighted this to the nurse in charge who took appropriate action.
- Staff handing over patients to theatre staff completed operating department records of care. These were generally completed in full.
- On wards, night staff created a recorded hand over for the day staff, which worked well, informing staff about changes and risks.
- Staff carrying out operations completed the operating department records of care, which included the pre-operative checklist, peri-operative care details, and recovery observations. We reviewed the records for one patient through their operation journey and their records were completed accurately.
- The paper records were legible and well maintained. Some records were loose in files, so at risk of being lost. They displayed patient identification details however, to reduce the risk of confusion or loss.
- Patient records also included dated entries from therapy staff, the pain team, pharmacists and dieticians.
- With the range of record keeping used, it was difficult to obtain an overview of a patient's treatment and care

needs. However staff we spoke with had a good understanding of the processes in use and could describe individual patient nursing and personal care needs.

Safeguarding

- All staff spoken with understood the term safeguarding, and knew how to raise a safeguarding concern. Most staff could name the adult and child safeguarding leads to whom they could go for advice and support..
- Most staff had completed mandatory training in safeguarding adults and children. In September 2015 the training compliance rates for orthopaedics, anaesthetic/theatres, surgery and ophthalmology directorates ranged between 85% and 96%. Compliance levels with safeguarding children, levels 1, 2 and 3 were between 50% (anaesthetics/theatres, for level 3) and 100% (ophthalmology for level 3).
- Patients we spoke with during the inspection told us they felt safe at the hospital. Feedback forms confirmed this, with comments such as, 'I felt safe' and, 'it felt like a safe environment'.
- The trust had not reported any safeguarding incidents relating to surgery at this hospital in the last 12 months.

Mandatory training

- In September 2015, 77% of staff in the surgical care group had completed mandatory training, compared with a trust overall average of 76% and a trust target of 95%. Over 80% of staff had completed face to face training on blood transfusions, and moving and handling. There was a similar level of compliance with infection control and safeguarding adults training. The surgical services directorates rarely achieved an overall compliance level of 95% with mandatory training, referred to as essential core skills.
- Most of the training was provided electronically, with 65% of courses only requiring refresher training every three years.
- There was an induction training programme for all staff, including agency staff. New staff from overseas were given a specific induction and all new staff were supernumerary on shifts until assessed as competent.
- Staff reported they were booked to attend face to face mandatory training and could access e-learning topics at home as well as at the hospital. Where available, ward personal assistants (PAs) assisted ward sisters in monitoring staff compliance with training and with booking staff onto courses.
- Ward staff reported they were usually able to access training, but were occasionally required to postpone attendance in order to cover staffing gaps on the wards. The ward PAs then prioritised them for the next available date. Theatre staff were less positive about access to training, commenting it was not easy to find time to complete it.
- Ward leads and staff could review training compliance on the intranet. Ward minutes and governance reports showed mandatory training compliance was monitored and reported each month.

Assessing and responding to patient risk

- The National Institute for Health and Care Excellence (NICE) recommends that all patients should be assessed for the risk of developing venous thromboembolism (VTE) on a regular basis. Records showed staff assessed surgical patients on admission for their VTE risks, and prophylactic measures were taken in line with their risk assessments.
- The trust had risk assessed 95.4% of patients for VTE in the first quarter of 2015/16, against a target of 95%. However, within the surgical directorate the percentage of patients risk assessed for VTE was lower than the trust average, below 95% each month for the six months to September 2015.
- Depending on their risks, patients were prescribed treatment for the prevention of thromboembolism, and this was observed in patient records. The admitting doctor or practitioner recorded the VTE risk assessment on the patient's drug chart.
- The staff undertaking surgery used a surgical safety checklist based on the World Health Organisation (WHO) surgical checklist and the Five Steps to Safer Surgery. The hospital used checklists tailored to their specific needs and adapted to include additional checks learnt from never events. For example, there was a specific checklist for eye surgery.
- An audit of the Five Steps, undertaken in July 2015, showed there were areas for improvement. A monthly review of the use of the checklist for the year to July 2015 showed variable levels of compliance. There was not a clear trend showing improved compliance over

the year; the compliance level in July 2015 was 92.2%. Monthly audit results by theatre and by specialty showed some specialties had taken longer to improve compliance, such as orthopaedics.

- Theatre staff identified the electronic checklists needed an update, to add the option of 'not applicable' to various entries, to avoid counting omissions as non-compliance.
- Our observations showed surgical teams did not use the five steps consistently in all theatres. For example, in the Derwent ward we observed staff did not complete a sign in nor debrief, and the consideration of 'human factors' in the checklist was not embedded. Staff omitted to undertake a visual and verbal confirmation check of instruments on the orthopaedic trays, against the tray contents checklist. The only items visually and verbally confirmed as correct were the instruments in the initial orthopaedic tray and the trial prosthesis. Similarly, we observed the surgical team in the main theatres omitted the sign-in step. The use of the Five Steps to Safer Surgery was improving but still not fully embedded in practice.
- Staff carried out interventional radiology in line with the Ionising Radiation (Medical Exposure) Regulations 2000 - IR(ME)R. Staff used a specific WHO checklist adapted for radiology to include the IR(ME)R procedures.
- Staff monitored patients' health during surgery, recovery and on the wards, and systems were in place to respond to any deterioration. The hospital used an electronic system to record patients' vital indicators on handheld devices. Analysis of these results indicated if a patient was deteriorating and alerted staff to take the appropriate action. This included alerting a doctor and, if necessary, the hospital's critical outreach team, to support the patient. The critical care outreach team observed the system remotely to track deteriorating patients and also liaised directly or attended the wards when necessary. Nursing and medical staff told us the system worked well.
- Staff assessed patients for their risk of developing pressure ulcers, VTE, for falls and malnutrition. They also reviewed risks relating to patients' medical history, medicines and lifestyle. The risk assessment process started at pre-assessment and staff monitored any changes throughout a patient's admission.
- Systems were in place to minimise the risk of patient harm. For example, if patients were at risk of dehydration staff monitored their fluid balance and provided pressure relieving equipment to help prevent skin damage.

Nursing staffing

- There are nationally defined minimum safe staffing levels of inpatient hospital wards. These include Safe Staffing: A guide to Care Contact Time (NHS England, November 2014), Direct Care Measurements (NHS England, January 2015) and NICE guidance.
- The staffing arrangements were not consistently planned and delivered to meet the needs of the patients on wards. This was exacerbated by the use of surgical wards to accommodate medical patients at short notice.
- The trust did not use an acuity tool to plan and adjust staffing levels. The trust's director of nursing, matrons and head of nursing reviewed surgical ward staffing levels and skill mix twice a year and devised a 'template', or planned staffing model for each ward. A range of statistics was used to inform this process. The template model reflected Royal College of Nursing (RCN) guidance and generally meant there was a trained nurse for seven patients during the day plus a coordinating nurse, and at night this ratio reduced to 2 trained staff to 21 patients. As part of the last staffing review, the trust assessed care contact time on the surgical upper gastric intestinal (GI) ward in May 2015. This showed care contact time for nurses, during the morning shift, ranged between 65% and 77% from 7am-1-pm, with nurse to patient ratios of 1:4 or 1:7 depending on the shift time.
- Each day the surgical and orthopaedic ward sisters took turns as 'bleep holders' to coordinate staffing across the wards to respond to changes in acuity. The bleep holders worked directly with the ward leads, matrons and bed management to check staff cover across the care group.
- The trust had recruited new nurses, and vacancy rates were relatively low in ophthalmology, anaesthetics/ theatres and surgical directorates (6.5%, 1% and 0.4% respectively) in March 2015. In orthopaedics however the vacancy rate was 10% with vacancies for 6.5 whole time equivalents. There were 11 band 5 theatre practitioner vacancies at the beginning of June 2015.

The trust had actively recruited to these posts, and six of these vacancies were filled by the end of June 2015. There was a full complement of band 5 nurses by the time of the inspection.

- Staff confirmed agency staff were employed on long term contracts to ensure there were sufficient theatre staff on duty a day to day basis.
- When we inspected in October 2015, ward staff commented on the ongoing success in recruitment, for example the urology ward had recruited to nine vacancies.
- Shifts were planned in advance, and the trust's electronic rostering system highlighted any gaps in the planned rotas. It also flagged the use of agency or bank staff, and any risks of staff working long hours in a month.
- Staff used an escalation process to request staff, to cover for sickness, respond to increasing acuity or to provide additional 1:1 support for patients with particular needs. The surgical directorate staff said the system was broadly effective, however if this occurred frequently it could be unsettling.
- Data showed that the surgery, anaesthetics/theatre and orthopaedic departments requested almost 3,000 duties to be covered by bank or agency nurses in the 31 weeks to 26 October 2015. These were mostly requested by the surgery department, with 1,875 duties filled by bank (47%) and agency (34%) and 20% left unfilled.
- In the 12 months to March 2015. The use of bank or agency nurses was highest in the surgical admissions unit at over 15% each month and over 25% for 6 months of the year.
- The use of agency in the colorectal ward was between 15% and 36% each month of the year, and above 15% in most months in wards 14, 17 (surgical) and 15 (urology).
- Bank or agency healthcare assistants (HCAs) were frequency requested by ward managers, as additional staff to provide patients with 1:1 care or to support ward staffing numbers. For example in surgery, during the 31 week period from 1 April 2015 to 26 October 2015, HCAs were requested to fill 1,179 duties. Of these 70% were filled with bank staff, but 12% went unfilled. In orthopaedics, 338 duties went to bank or agency, with 13% left unfilled.
- This data showed a high reliance on additional staff from bank or agency. The trust staffing templates were reviewed every six months and reflected the Royal College of Nursing guidelines. However, staff also made ad hoc requests for staff, when additional beds were opened or for 1:1 care. The data also showed a significant level of requested but unfilled additional shifts, which suggested a risk of patients' needs not being met.
- On the 21-bedded ward 7 the template was three nurses on early and late shifts, and a forth nurse on days Monday to Thursdays only. There were two nurses on night shifts.The template for healthcare assistants was two on early, two on late, one on a long day and one on night shifts. This 'U' shaped ward, with 10 separate rooms (two 2-bedded, three 4-bedded bays and five single rooms) meant oversight of the ward was difficult. Staff said they found night shifts difficult, particularly if they accompanied orthopaedic patients to move to the Derwent ward, which risked leaving the ward with one trained staff member. The ward also accommodated medical patients. When we visited, male and female medical patients were in two 4-bedded bays which put pressure on staff to maintain patient safety and dignity.
- The trust had closed bays on two surgical wards, because the beds were not required, and this had helped maintain safe staffing levels. If the bay was needed at short notice, for example for medical patients, additional HCAs were added to the allocation by request. A review of the staffing tool on ward 17 showed this happened on 50% of days in September. If agency staff were provided, then substantive staff moved to provide safe cover arrangements.
- In the month of October 2015 ward 16 had 12 unfilled shifts for HCAs and 12 unfilled shifts for nurses, against the template level.
- Ward 18, the surgical assessment ward, had a high turnover of surgical admission patients, including at night, when the template staffing was for two nurses and one HCA. It also had a bay set aside to accommodate up to five medical patients if required by site management, with the support of an additional HCA. A hostess was employed 9am-5pm on weekdays on the ward. The staffing template had recently been amended from three to four trained nurses on late shifts. The trust funded 12 beds on this ward, but had the ability increase staff to support 15 beds in times of high demand. The additional bay was not part of the staffing template.
- The trust was starting to allocate 'twilight' HCAs in evenings, for example on the urology ward for three nights a week. This had also been proposed for ward 7.

- In the year to April 2015, there had been a relatively low level of sickness amongst staff in the surgical directorate; between 3.9% and 4.4%.
- The interventional radiology service had recruited from overseas, but still had vacancies of 1.8 whole time equivalent (WTE), for an establishment of 8.2 WTE. The service was supported by staff taking additional shifts, and by bank staff on day shifts.
- Nursing staff reported good support from and access to therapists. Physiotherapy and occupational therapy staff were assigned to surgical wards on a rotational basis and were part of the ward team.

Surgical staffing

- The trust had slightly more consultants (44%) and middle career medical staff (16%) than the England national average of 41% and 11% respectively. The registrar group was significantly smaller in the hospital at 26% of medical staff, compared with 37% as an England national average. These results were for the ten-year period to September 2015.
- The proportion of locum doctors had varied in Royal Bournemouth Hospital over the past year. The hospital had employed a high proportion of locum doctors for vascular surgery until November 2014 (30-50%). Between November 2014 and March 2015, the use of locums in this specialty reduced to a low level, but peaked again in March 2015, to 22%. Between 10% and 12% of medical staff in general surgery were locums, in the year to March 2015.
- Vacancy rates for medical staff were as follows: 7.2% for anaesthetics and theatres (3 staff), 6.1% for ophthalmology (1 staff) and 5.8% for orthopaedics (2 staff). There were no vacancies in the surgical directorate.
- Theatre staffing was in line with The Association for Perioperative Practice (AfPP) recommendations. Recent recruitment drives had been successful and the department had over-recruited to vacancies.
- The hospital at night policy, 2015, outlined the medical cover arrangement, including contact details, specific roles, responsibilities and skills, handover guidance and night time pathways by specialty. This policy included weekend and bank holiday cover arrangements.
- Nursing staff reported good access to medical support. This included for medical patients, under consultants from the medicines care group

Major incident awareness and training

- The trust had a major incident and resilience plan. Staff knew the policy was available on the intranet and this had been discussed at a recent morning 'huddle' meeting in surgery.
- There were mixed views from staff about the content of the plan, and staff in theatres were not aware of any practice. Ward staff reported carrying out regular desk-top or walk-through exercises.

Are surgery services effective?

Good

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

We rated effective as good

- Patients received care and treatment that took account of national clinical guidelines and staff used care pathways based on evidence-based research.
- The services participated in national audits and carried out local audits to improve outcomes for patients. Results were used to improve outcomes for patients, for example a new pathway was introduced following the National Emergency Laparotomy Audit in 2014 and the hospital had implemented a quality improvement project based on findings from the 2015 audit. At ward level, staff carried out peer review audits.
- Staff monitored patients' pain levels and administered appropriate pain relief. Patients were complimentary about the food, and staff monitored those at risk of malnutrition and implemented appropriate care plans.
- Patients commented positively about the skills of staff. Reports showed appraisal rates were improving, following the introduction of a new system, and staff completed training relevant to their roles. The trust was addressing issues raised relating to the training of doctors by improving induction programmes and recruiting additional consultants to provide the training.
- There was effective multi-disciplinary working, with improved handovers and good support from therapists, pharmacists and dietitians.

- Patients were asked for their consent and staff understood the legal requirements of the Mental Capacity Act 2015 and the Deprivation of Liberty Safeguards

However,

- Staff commented that access to information was not always effective. Patient information was held in a variety of formats which meant it could sometimes be difficult to use and time consuming to find.

Evidence-based care and treatment

- Staff provided care and treatment to patients based on national guidance including that produced by the National Institute for Health and Care Excellence (NICE) and the Association of Anaesthetists of Great Britain and Ireland (AAGBI). The operating department's record of care was based on AAGBI and NICE guidance. The patient care plans for nursing care reflected Department of Health and NHS guidance.
- A review of minutes of meetings, including ward and clinical governance meetings, showed updates in NICE guidance was registered and reviewed to improve patient care. The monthly risk, governance and quality improvement forms included a section for highlighting any new NICE guidance.
- Staff used recognised tools for assessing and monitoring patients' care and welfare. For example, when risk assessing patients for pressure ulcers, malnutrition or deteriorating health. Staff used a tool recognised by NICE, the SKIN care bundle, to reduce the risk of pressure ulcer development and scorecards for venous infusion phlebitis (VIP) to check cannula sites.
- The hospital had implemented all day non-elective lists for emergency operations, based on the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) recommendations. Staff had started all-day 'CEPOD' lists in May 2014 which had improved theatre efficiency and reduced pre- and post-operative lengths of stay.
- Enhanced recovery pathways were used to improve outcomes for patients in orthopaedics, urology and colorectal surgery. Staff prepared patients for surgery and provided a structured post-operative recovery plan, including pain relief and early mobilisation. This involved therapists where appropriate, to help patients with recovery and discharge arrangements.
- The anaesthetic department had implemented a quality initiative to improve the pre-surgical assessment of patients with diabetes, following guidance from NHS Diabetes and the Joint British Diabetes Societies Inpatient Care Group. The service had set up a dedicated pre-assessment service in conjunction with the diabetes team. The Royal College of Anaesthetists had recognised this service nationally as an example of good practice.
- The trust had implemented a new care pathway for patients with acute abdominal conditions requiring emergency surgery, based on findings from the National Emergency Laparotomy Audit (NELA) in 2014. The audit had identified a range of areas for improvement, some of which the trust were still working on. These included making arrangements for review by medicine for the elderly and obtaining timely consultant review and cover.
- Surgeons provided data to national databases. For example, the urological surgeons contributed to the British Association of Urological Surgeons database.
- The departments undertook and monitored audit programmes effectively. The anaesthetics, ophthalmology, orthopaedics and surgical departments had started six audits in the first quarter of 2015/16, against an annual trust plan of 30. Progress against these audit plans was monitored. In the year to April 2015, the departments had reported on or completed 47 audits, and were collecting data still on 13 audits. Governance meetings showed that clinical leads discussed the outcomes of local audits, such as audits of hip dislocations, as well as national audits.

Pain relief

- Patients said their pain was controlled and they were offered pain relief regularly, including at night.
- Staff used patient assessment booklets to record pain care plans for patients. They used an electronic monitoring system to monitor and record pain. We were told this did not always trigger further action, and further work was planned to improve pain monitoring. For example, the trust did not use a recognised system for assessing pain in people living with dementia, but this had been identified for further action.
- Staff reported good access to guidance from the trust's pain team. We observed their guidance was included in patient records and staff said they could also telephone the team for advice at short notice.

- Training updates were provided monthly in pain management, and there were also resources available through the trust's e-learning system.
- During the inspection, two patients told us that staff had responded promptly when they started to feel discomfort.

Nutrition and hydration

- All inpatients reported a good choice of food, commenting that it was hot and tasty. They said they had enough to eat and drink. Comments included 'A lot of food is what I would choose' and 'Staff were very helpful making me drinks'.
- We observed patients could access their drinks easily.
- Staff used a recognised nutritional screening tool to identify patients at risk of malnutrition or dehydration. Patients at risk of malnutrition were referred to a dietician and their guidance was included in the patient's care plan. The use of this screening tool was audited in 2014, which showed year on year improvements in timeliness and accuracy of assessment. With the use of new electronic nursing assessments, ward staff were prompted to monitor completion of nutritional risk assessments in a timely way.
- Staff displayed the percentage of completed nutritional risk assessments on ward notice boards, using data produced by the electronic nursing assessments. These showed that the assessments were not always carried out within the agreed timescale.
- Patient's care plans included guidance on the administration of nutritional supplements where appropriate.
- The records we reviewed showed staff completed food and fluid charts when appropriate and regularly monitored patients at risk of malnutrition or dehydration. Data was collected on this and some wards performed better than others.
- Each ward operated protected mealtimes to promote a suitably calm environment to help patients enjoy their meals. Some wards employed hostesses during the week, for three or five days, to assist patients with meals and drinks.
- Staff reported good access to dietitian support, for example post bowel surgery

Patient outcomes

- The National Emergency Laparotomy Audit (NELA) in 2015 showed areas for improvement in patient care, to improve outcomes. The trust had set up an improvement project with the aim of reducing mortality rate from emergency laparotomy surgery from 11.4% to 9% by March 2016. As well as implementing a new care pathway to improve outcomes for patients, it had joined the Emergency Laparotomy Collaborative group of hospitals to share learning. The initial results from this improvement project were showing an improvement in the mortality rate.
- Patients on ward 16 were treated on the enhanced recovery programme, to enable them to spend less time in hospital. Patients received supporting pre-operative guidance on self-care and staff telephoned them after discharge to check on their recovery outcomes.
- Patient Reported Outcomes Measures (PROMs) is a national tool used to measure health gain in patients following hip replacement, knee replacement, varicose vein and groin hernia surgery in England. The measures are based on patients' responses to questionnaires before and after surgery. The PROMs data for this hospital were generally better than the England national average. Their PROMs data for April 2014-December 2014 showed patients treated for groin hernia said they had improved slightly more than patients nationally. For hip and knee replacements and varicose veins, improvement scores were similar to the England national average. In almost all cases, the proportion of patients who reported a worsening following treatment was lower than the national average. Results were on a par with the national average for patients reporting a worsening in outcome following varicose vein treatments.
- The hospital had participated in the national bowel cancer and lung cancer audits in 2014. For the bowel cancer audit, results showed the hospital was in line with the national average for most aspects of the audit, and better in areas such as 'seen by clinical nurse specialist' and 'CT scan reported'. Patient length of stay was less than the England average. The lung cancer audit showed improvements were required to meet the national target of 95% of patients receiving a CT scan before a bronchoscopy.

- Managers within the surgical department were reviewing high volume pathways, such as renal/ureteric stones to determine opportunities to reduce lengths of stay.
- The interventional radiology service had been awarded 'exemplar status' by the British Society of interventional radiology for continuous audit of their procedures, review and research. They had retained this status for over four years.
- An environmental audit report from June 2015 showed areas for improvement. The surgical wards scored poorly for dementia awareness and pictorial signs for bathrooms. The audit showed Ward 12 had a 'very poor score' for 15 aspects of the environment and actions were completed or planned.
- Surgical patients had a lower risk of needing to be readmitted to this hospital than the England average, based on data collected between December 2013 and February 2015.

Competent staff

- In the year to March 2015, appraisal rates varied between 60% and 100% for different staff groups within the orthopaedics, surgery, ophthalmology and anaesthetics and theatres directorates. Appraisal rates specifically for medical staff varied between 80% (anaesthetics and theatres) and 91% (orthopaedics). The trust's Medical Appraisal and Revalidation Annual Board Report 2014-15 included actions to improve appraisal and revalidation rates.
- A new appraisal system was introduced in April 2015. Ward managers monitored and reported on appraisal completion rates. Governance reports showed the overall rates were improving from a low base (less than 25% in May 2015), with appraisals booked for staff where needed. For example on Derwent ward 25% of staff had completed appraisals, whereas on ward 17 only one was outstanding and all staff on ward 16 had completed the new appraisal process. Some staff had requested a delay to their appraisals to align with nursing revalidation time-frames, and this was being discussed at the time of our inspection.
- We reviewed the induction programmes for new staff and it included competency assessments, for example for the administration of intravenous medicines. Staff said the induction was useful and they were supported to work in a supernumerary capacity for three weeks, or longer if necessary.
- New staff completed an induction and worked in a supernumerary capacity until they were assessed as competent and confident. Recently recruited nursing and therapy staff confirmed this was the procedure.
- Staff on the eye unit reported excellent opportunities for training and good consultant-led teaching.
- Data from junior doctor's GMC National Training Survey identified handover in general surgery and ophthalmology as below the national average. Induction in ophthalmology was above the national average, but was well below for orthopaedic surgery.
- A recent Deanery visit highlighted areas for improvement in doctor training. The trust had addressed the issues raised, and had recruited additional consultants and planned to provide knee training in orthopaedics. The surgical department had introduced improved induction programmes and changed shift patterns.
- Junior doctors on the wards were also positive about their training and the support they received from the consultant body. A surgical nurse practitioner provided training to F1s and F2s.
- Therapy staff confirmed they received an effective trust induction and shadowing opportunities, regular supervisions and group peer reviews. They also valued the mentor programme for new staff.
- Staff in interventional radiology said they received a focused training programme which they required for their roles.
- Ward staff said that access to training had improved and they felt well supported. Most wards had a personal assistant to help manage training and to book staff onto courses when necessary. Staff had access to the trust's training matrix, which was colour coded to highlight when training was due.
- 'Drop in' training sessions were organised during the week, for examples on 'teaching Tuesdays'. Staff told us they were able to access training in relevant topics such as pressure ulcer care and dementia. The annual orthopaedic study day was used to train new staff and to update those identified as needing additional guidance. One new nurse was pleased to have been encouraged to attend an enhanced recovery conference to improve their skills and to cascade learning to colleagues.

- Patients gave good feedback on staff skills, commenting on medical and nursing staff being knowledgeable and well informed. Patients also often praised the skills of the housekeeping staff.
- Nursing staff said the trust was facilitating training for their revalidation. They had set up roadshows and a trust 'task and finish' group to project manage the process. Staff told us they were aware of the work progressing with revalidation. Wards had set up revalidation focus groups, or champions and Band 6 nurses had started to identify training needs for confirmers.

Multidisciplinary working

- There was evidence of effective multidisciplinary working on the wards we visited. There were daily ward rounds involving nursing and medical staff. Pharmacists and therapists visited the wards on a regular basis and they had a good understanding of individual patient needs. On some surgical wards, a therapist commented that improvements could be made to the way they could contribute to patient care, and they were discussing these with the ward sister.
- Therapists, nurses and doctors on Derwent ward worked as a fully integrated team, with a daily handover each morning.
- Staff reported there was a good working relationship between different staff groups. Therapy staff worked across specific wards and this helped them build relationships with the nursing teams.
- Representatives from the 'leaving hospital support service', commissioned by social services, met with the therapists and nursing staff to support the discharge of patients with low-level needs. Their services were valued highly by the nursing team.
- Staff reported good support from the dietitian.
- The hospital transferred patients to neighbouring hospitals for certain treatments. For example, patients requiring surgery for fractured neck of femur were transferred to Poole hospital. There was a pathway for this, to ensure staff had made the necessary arrangements with the receiving hospital and prepared patient information with the handover checklist.

Seven-day services

- Within the surgical department, different specialties had their own consultant, middle grade and junior doctor cover arrangements. There were 24-hour consultants on call to cover surgical wards, seven days a week.
- For orthopedics, five consultants provided cover between 8am and 6pm Monday to Friday, with one consultant providing 24 hour cover based at Poole Hospital. Two junior doctors covered orthopedic wards between 8am and 10pm and middle grade doctors worked 8am to 6pm Monday to Friday.
- There was an emergency consultant anaesthetist Monday to Friday 8am to 6pm supported by a junior doctor. Outside these times, anaesthetics were covered by either two consultants or a consultant and an associate specialist.
- The ophthalmology service had an effective system for covering emergencies and providing out of hours cover.
- The wards received a clinical pharmacy service Monday to Friday and a pharmacist visited on Saturdays. A Sunday service was available from the pharmacy department if required. Staff knew how to access medicines outside of pharmacy working hours, for example, from other departments, the emergency cupboard or from the on-call pharmacist.
- Staff generally reported adequate access to imaging, as well as pharmacy and therapy services outside normal working hours. However, they had problems accessing blood gas analysis, and had to create work-arounds to share images from Salisbury and Dorchester hospitals.
- The interventional radiology service was available 24/7. The service had network links with radiology departments in other NHS hospitals which together provided an out of hours service. As part of this network, two radiologists from Dorchester NHS trust were training at Royal Bournemouth Hospital to assist with the on-call rota.
- Therapists were available seven days a week to support patients with mobilisation and recovery.

Access to information

- Patient records were stored electronically and in paper files. The electronic nursing assessments (ENA) and other information transferred with patients when they moved within the hospital. This information was available on the ward and staff could access it readily.

- Staff reported that access to patients' previous medical history was not always easy to access. Since electronic patient records had been introduced, handwritten notes were scanned after patient discharge, and the resulting record was hard to navigate. Staff said there was not a standard order to these notes, so it was hard to find information efficiently. Doctors reported this made it difficult to refer to previous records during patient consultations, as this weakness was apparent when they displayed patients' scanned records on the screen.
- The use of different electronic systems made collating patient information, for example for clinics, difficult and time consuming.
- Staff handed over key information about patients between shifts and when patients were moved within the hospital. We observed that handover information was noted effectively on handover sheets. Staff said having set handovers had improved information sharing and worked well.
- We observed informative and effective handovers between theatre and recovery staff.
- The sister on the surgical assessment unit had created a patient observation form for emergency department staff to complete for each patient transferred onto their ward. This summarised key information about the patient, including their reason for admission, risk scores and treatment given to support an effective handover. Staff from the ambulatory emergency care ward used a similar form to assist in prompt transfers.
- Patient discharge summaries were given to patients and posted to their GPs on discharge.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff ensured patients gave their consent prior to any interventions. Where there was a risk patients did not have capacity to consent, staff carried out mental capacity assessments in accordance with the Mental Capacity Act 2005 (MCA). If necessary, they carried out best interest decisions to agree treatment and care. Staff recorded patient consent in their records.
- Anaesthetists described the different types of consent and the procedures they followed to gain patient consent effectively.
- Staff were able to describe what was meant by mental capacity and the Deprivation of Liberty Safeguards (DoLS).
- Trust guidance on consent and the MCA was available for staff to refer to. On one ward, the ward sister described a recent experience of submitting two DoLS applications.

Are surgery services caring?

Good

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

We rated caring as good.

- Staff treated patients with compassion, dignity and respect. They interacted with patients in a kind, polite manner and explained their care clearly.
- Patients gave us positive feedback about the caring attitude of staff in different roles.
- The hospital staff asked for feedback from patients, using the Friends and Family Test, and results showed a high proportion of patients recommended the hospital.
- Overall, patients commented they were involved in decisions about their care.
- The chaplaincy service was available to provide additional emotional support above that offered by staff involved in direct patient care.

Compassionate care

- We observed staff treated patients with compassion, dignity and respect. Staff interacted with patients in a kind and polite manner. For example, we observed staff explaining what they were doing in a clear and concise way, which was well received by patients. This was observed in the theatre suites and on the wards. Staff used 'Care in progress signs' on wards, to advise others not to disturb patient privacy.
- We observed compassionate care from the theatres teams, who ensured patients' dignity was maintained and members of the teams made sure patients felt at ease.
- Most patients told us they were happy with their care, both when speaking with members of the inspection team directly, and via the feedback forms. We heard positive comments about staff in different roles, including consultants, nursing and care staff and housekeeping staff. For example, one person was

pleased the cleaners were chatty and friendly. One patient was particularly impressed with the reassurance provided by a member of staff who held their hand when they were going into theatre. Another patient recalled staff introducing themselves and was grateful when staff in recovery explained what was happening. Patients also told us they were asked for their preferred way of being addressed. Generally, patients said staff were attentive to affording them privacy wherever possible. We also received many compliments about the attitude of staff.

- We had negative feedback from three patients and their relatives. These comments related to patients who had been discharged from ward 18 in the last 12 months. Issues related to nursing care and the provision of drinks and pain relief.
- The wards reported results of the Friends and Family Test (FFT), which asked people if they would recommend the hospital or ward. The results were displayed for patients and their relatives to view. Overall FFT results for the hospital showed a higher average response rate than the national average (43.8% compared with 37.4%) between March 2014 and February 2015. Surgical wards showed a higher response rate than that of the hospital, of 46%. Across surgical wards 96% of people would recommend the ward they had visited. Generally, scores improved over the year, but this was not a consistent trend.
- Individual wards displayed their FFT scores as well as specific comments and 'you said/we did' feedback. For example, on ward 16, action had been taken in response to a comment relating to disturbances at night. Different wards chose their own style of sharing this information.
- The 2014 CQC inpatient survey found the trust overall scored similar to other trusts on all key areas relating to care and dignity.

Understanding and involvement of patients and those close to them

- Patients and relatives were generally positive about their involvement in care. A relative of a patient with dementia was impressed with the care shown by one nurse. They said the nurse had worked out how best to provide care before they had started to complete the 'This is Me' form together.
- A relative of a patient with communication difficulties said the pre-assessment nurse had been 'brilliant' and suggested overnight care due to their long term conditions. The relative said care overall was reassuring, supportive and well explained.
- A patient in the outpatients department appreciated that staff had called to advise them to attend slightly later than the original appointment time, and had given them the reason for this change. They were pleased that staff had considered them and wanted to lessen any inconvenience.
- Most patients said staff explained things carefully and checked their understanding. One patient said, "If I don't understand, I only have to ask". However, one patient commented, "Staff don't always give credit to a patient's understanding", and another said they had been "told off" for being a smoker, in a way they felt was not helpful. We also received feedback from a patient that an orthopaedic consultant spoke about their weight in an insensitive way.
- We observed staff explaining care and treatment to patients in a careful, considerate way. For example, the recovery staff described what they were doing and why, and checked patients understood what they had said. In theatres, staff demonstrated they understood patients' wider family context and took these into account when planning care and recovery for patients.
- The surgical directorate undertook an inpatient survey between April and June 2015. Results showed that although over 95% of patients said they felt welcomed onto the ward and their privacy and dignity was maintained, most patients had not discussed their discharge date. They gave low scores to the five questions relating to discharge. This indicated plans for patient discharge had not been discussed or shared fully with patients. The exception was patients attending the eye unit, who had a good understanding of the arrangements.

Emotional support

- Staff and patients praised the chaplaincy service, with staff commenting the chaplains were very accessible and highly appreciated.
- Staff reported that they could provide accommodation for relatives should patients need them for reassurance whilst at the hospital.

Surgery

- A visiting relative told us they found the presence of nurses on bays reassuring. They liked that they, 'Sat at the little desks and smiled'. It helped them feel that practical and emotional assistance was on hand if required.

Are surgery services responsive?

Good

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

We rated responsive as good.

- The hospital was subject to the Dorset clinical services review which would impact on aspects of surgical services. Most treatments at the hospital were elective day cases, in addition there was major elective surgery requiring in excess of one night's stay. There were lists set aside to provide 24 hour, seven day a week access to emergency surgery.
- The nurse-led ambulatory emergency care unit improved patients' access to advice and treatment and reduced the rate of admissions for surgery.
- The hospital had implemented an improvement programme to reduce patient length of stay in hospital, and had identified specific barriers which they were addressing.
- The hospital had performed above the England national average for the referral to treatment standards for patients to wait less than 18 weeks (May to July 2015). Previously, it had not met this standard on any of the 12 months to April 2015. Delays in the 62-day cancer referral to treatment time were below the trust-agreed 85% target in urology and colorectal surgical treatments. The trust had taken steps to reduce pathway delays and had set up 'robot weeks' to reduce waiting times for robotic prostatectomies.
- The hospital's cancellation rate for operations was below the England average for all quarters in 2014/15.
- There had been no mixed sex breaches for surgical services in the previous year. Medical patients were frequently allocated beds on surgical wards, and this presented a risk to patient experience and care. Staff worked hard to minimise this risk by working to admission criteria and re-allocating staff to reflect patient needs.
- Patients had access to information leaflets about different types of treatment and staff could request translation services or interpreters for people with communication or language difficulties.
- Staff took complaints seriously and responded in line with trust policy and there was evidence of learning from complaints on the wards

However,

- Not all wards had been refurbished to improve the environment for patients living with dementia, but this was planned.
- Complaints were not always managed in a timely way.

Service planning and delivery to meet the needs of local people

- At the time of the inspection the hospital's services, and those of other acute hospitals in Dorset, were subject to the Dorset Clinical Services Review to redesign and improve quality of care for people in the county.
- Commissioning of services across three of the NHS trusts serving Dorset, Bournemouth and Poole meant services were often planned in partnership. Some services were commissioned jointly with Poole and Dorchester NHS trusts, such as the vascular surgical network.
- Royal Bournemouth Hospital did not offer certain services, such as cardiac surgery or specialist trauma services, and these were provided at neighbouring hospitals.
- Patients and relatives told us they found travelling to the hospital difficult if they lived in the other side of the county, and the specialist service they required was only provided in Bournemouth. Access via public transport was not possible for many people. Patients also regretted this meant their relatives could not visit easily.
- The hospital had 16 theatres and their usage rates were generally above 75%, with a target of 85%. In June 2015, eight theatres had a usage rate greater than 90% of planned surgery. In April 2015, two theatres were used more than the planned available time. These were theatres 2 and the eye surgery.
- Surgical services were set up with a surgical assessment unit, to provide a centralised ward where staff could assess and monitor acutely ill surgical patients, a nurse-led ambulatory emergency care unit and a large day-case surgical facility. The majority of surgical procedures provided by the hospital were elective

day-case procedures. On the day of their surgery, patients for elective day surgery were admitted to the surgical admissions lounge. Post-operatively, staff took patients to the relevant ward.
- The Derwent ward provided acute rehabilitation services to promote safe, early discharge for patients following knee and hip treatments.
- Theatre lists were reorganised in May 2014 to provide dedicated lists for unplanned emergency sessions. This was in line with the Confidential Enquiry into Peri-Operative Death (CEPOD) recommendations to set time aside for emergencies. This arrangement reduced out of hours operating from over 20% to less than 6% which supported improved patient experience.
- An audit showed over 90% of emergency surgery took place during daytime shifts (8am-9pm) and the proportion of emergency procedures on the dedicated CEPOD list had increased over the previous year from less than 60% to over 75%.

Access and flow

- Patients were admitted for surgery through a number of routes. For example, following pre-planned day surgery, from a GP referral or via the hospitals' ambulatory care emergency unit or emergency department.
- The nurse-led ambulatory emergency care (AEC) had been in operation for two years and had moved to a purpose built area four weeks prior to the inspection. It had been set up as part of the quality initiative to reduce the proportion of avoidable emergency admissions to the hospital. The unit took referrals from GPs, the emergency department and the outpatient department and had three cubicles where staff assessed patients. Staff either referred them for a planned procedure the following day or discharged them if appropriate. Between 21 September 2015 and 2 November 2015, the AEC unit saw 311 patients, of which 64% were discharged home, 6% were asked to return the following day for theatre or further investigation, and 28% were admitted to hospital. Results showed the unit was effective in reducing admissions.
- Trust-wide, the average length of stay (LOS) was similar to the national average for elective admissions, and shorter for non-elective admissions, for the period January 2014 – December 2014. However, there were some exceptions. LOS was longer than the national average for elective orthopaedics, elective vascular surgery and non-elective general and colorectal surgery. For orthopaedic surgery, which made up 20% of elective surgery, the average length of stay was 3.7 days, as opposed to 3.1 days for the national average.
- The hospital's quality improvement programme, '5 Daily Actions' was set up to improve patient flow. Pharmacy and ward staff were aware of this programme and said there was a greater focus on improving the discharge process across the trust.
- Delays in giving patients medicines 'to take away' (TTA) on discharge were considered a cause of delayed discharges. The pharmacy had a Key Performance Indicator (KPI) to complete discharge prescriptions within 2 hours. An average of 465 prescriptions per month (Jan to Jul 2015) breached the 2 hour time by an average of 53 minutes. This also showed a worsening trend year on year. We were told by staff that it was not unusual for patients to wait three to four hours for their medicines before they could be discharged.
- As part of the '5 Daily Actions', the hospital planned to install an additional pharmacy 'hub' on the surgical assessment ward to promote faster dispensing.
- Staff on surgical wards told us they had also set up a system for forewarning pharmacy of TTA requirements. They advised pharmacy of potential discharges for the following day, as well as those for the same day, to improve availability of TTA medicines.
- The '5 Daily Actions' also promoted increased use of the discharge lounge. Ward staff were tasked with agreeing discharge arrangements earlier in the day. Ward sisters showed they had set up commendations for staff when they achieved this.
- Adult services commissioned support staff to set up basic domestic care needs for patients post discharge. They worked with nurses and therapy staff on the wards to plan domestic arrangements with patients prior to their discharge. For example, they could arrange meal deliveries at home for patients who otherwise would have difficulty looking after themselves. For more extensive packages of care, staff referred patients to adult services, which tended to take longer. Staff reported that patients from Poole and Hampshire were unable to secure short term re-ablement care packages from adult services, which meant patients from these areas tended to have longer stays in hospital.
- The hospital had not met the referral to treatment standards for any of the 12 months to April 2015, but had performed above the national average for May to

July 2015. Delays in the 62-day referral to treatment time were below the trust-agreed 85% target in urology and colorectal surgical treatments. This was due to pathway delays and the trust had taken steps to improve these timeframes.

- The trust was working to reduce the backlog of patients waiting for treatment shown by the incomplete pathway indicator. Again, urology continued to be the area most under pressure.
- The Sandbourne day suite carried out day cases and opened Saturdays if necessary in response to waiting times.
- The hospital's cancellation rate for operations was below the England average for all quarters in 2014/15. Staff on the Sandbourne suite commented they had few cancellations for day surgery, but when they occurred, they tended to be due to theatres over-running in urology.
- During the inspection we observed medical patients on some wards. Staff reported this sometimes impacted on the surgical lists, with elective lists occasionally cancelled due to a shortage of surgical beds.
- The percentage of patients, whose operations were cancelled and were not treated within 28 days, was also below the national average for all but four quarters in the 16 quarters between April 2011 and March 2015.

Meeting people's individual needs

- The trust reported there had been no mixed sex breaches for surgery services in the previous year. A mixed sex breach is when patients share sleeping areas and toilet facilities with members of the opposite sex, in situations defined by the Department of Health.
- Staff reported that surgical patients occasionally stayed on the ophthalmology unit.
- Bed managers frequently placed medical patients onto surgical wards. During our visits there were medical outliers on Wards 7, 15, and 17. Staff said there were criteria for admitting medical patients onto surgical wards, however this practice raised issues relating to meeting a patient's specific needs. Staff aimed to group outlying medical patients into bays to minimise the risk of infections, however this sometimes comprised their ability to provide suitable environments for patients. Staff reported they sometimes had to reverse the male and female toilets on ward 7, which could be confusing for patients.
- On Sandbourne, a wall had been extended to create a greater separation of the male and female waiting areas to help maintain privacy & dignity.
- Not all the surgical wards had been updated to improve the experience of patients with dementia. For example, on ward 16 and 18 there were no pictorial toilets or coloured bays to assist patients with orientation. Ward 18, as a surgical assessment ward, often had patients with dementia or learning disability. We were told that plans were in place to update the environment on this ward to make it more 'dementia friendly'. The ward had a dementia champion and directorates had representatives on the trust's 'dementia and learning disability steering group'.
- Staff identified patients with a disability at pre-assessment or on admission. Staff used a system to flag patients' specific disability needs onto the electronic records systems, to prompt them to check patients' individual needs. Staff on surgical wards told us they could make arrangements for relatives to stay with patients if requested. However, a relative of a patient with special needs told us they were not able to stay overnight on ward 18.
- The August information booklet for staff on ward 15 included the names of trust leads for dementia, learning disabilities and those with language difficulties, should they need to liaise with them for guidance. It also briefly outlined access to spiritual needs.
- The hospital had provision for religious worship for patients and visitors. There was a chapel or prayer room for Christian worship and Muslim prayers, with a facility for ritual washing. Christian services were held three days a week and Muslim prayers were held on Fridays. Most wards could also provide a quiet area for private consultations or quiet reflection. The chaplains held a list of local inter-faith representatives to support patients. The chaplains operated a 24/7 on-call service, and we were told the response time was under one hour.
- Staff could access sign language and interpreter services if necessary. If a surgical patient was unable to read and sign, the trust could offer an independent advocate or Braille translation services or the Dorset Blind Association for cassette translation. For severely deaf patients the hospital staff could access sign language services through the Patient Advice and Liaison Service (PALS).

- Staff in theatres confirmed they used translation services and outlined the process for involving them in patient care.
- The ward information leaflets provided patients with information to help them understand what would happen during their stay. The leaflet for ward 14 included visiting and meal times, how to access the multi-faith chaplains, the names of the consultants and phone numbers for the sister in charge of the hospital and the PALS office.
- There were a variety of leaflets for patients providing guidance on different surgical procedures. For example, the booklet for colorectal surgery included what to expect at pre-assessment, admission and post operatively. It also gave contact details for the ward and for relevant support services. These were written in English but were available in different formats via PALS.

Learning from complaints and concerns

- The trust had identified a delay in responding to and closing complaints and action was in place to improve this. In July 2015, there had been 13 complaints relating to surgery and orthopaedics. In June 2015, 95% of complaints to the trust had been responded to within 3 days, and 53% closed within 25 days.
- On wards, senior nursing staff reviewed complaints and telephoned complainants directly and if appropriate, invited them to meetings.
- Staff reviewed complaints at ward and governance meetings and were reported to the board. At a ward level, local concerns for example, raised through Friends and Family feedback was discussed for learning. Learning was shared in the style of 'you said, we did' and this information was often displayed on ward notice boards for patients and visitors to view. Staff completed 'Complaint Outcome' forms identifying evidence of change.
- Staff were aware of the complaints process and how to support patients with a complaint or a concern. They could also recall changes and improvements made in response to complaints, for example in relation to checking pain assessments.

Are surgery services well-led?

Good

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

We rated well led as good.

- The trust had published its vision, values, mission statement and objectives, and had taken action to assess and improve staff understanding of these. Staff had a better awareness of the trust values if they had recently completed their appraisal. Directorates within the care group structure had local strategic plans and were monitoring progress.
- Surgical services had effective governance arrangements. There was a committee structure to review all aspects of performance, quality and risk and high risks were escalated to the board. Whether this information was cascaded to front line staff depended on local management. This was effective on surgical wards.
- Staff felt valued by their immediate line management and well supported.
- Staff reported good access to personal and professional development and they commented positively on teamwork. They said they would raise concerns about patient care if they witnessed poor practices.
- Systems were in place to gather patient feedback and use it to improve services. Physiotherapists had used patient focus groups for example, to improve their services for orthopaedic patients.
- The trust had a programme of improvement projects underway to improve patient experience, safety and efficiency. The interventional radiology service was highlighted as an innovative service that had achieved awards.

However,

- It was not clear how local strategic plans linked specifically to the trust's strategic plans.

- Policy development and review was not accurate. The theatre policies lacked important details and there were duplicated versions on the intranet.
- Theatre staff were generally less aware of quality and performance trends.
- Staff in some departments staff felt isolated and theatre staff commented on a lack of connection between front line staff and senior managers.

Vision and strategy for this service

- The trust had set up a new care group structure, with three main care groups made up of departmental specialties. Staff understood this structure and clinical leads felt this was now embedded within the trust. Progress was discussed at senior manager level.
- The strategic direction of services was open to review at the time of the inspection, as a result of the Dorset Clinical Commissioning review. The trust described its five-year strategic plan for patient care, underpinned by six strategic objectives.
- A ward-based peer-review audit in March–May 2015 identified that staff awareness of the trust's vision and values required improvement. The audit action plan included using the trust's revised appraisal process to reinforce the vision and values. This had been rolled out in April 2015. The trust had also issued staff with lanyards showing the four values and there were various communications on the topic within the hospital.
- Not many staff were familiar with the trust's vision (to be the most improved hospital by 2017) but most recognised at least some of the four values (Communicate, improve, teamwork and pride), particularly if they had completed their appraisals or induction recently.
- The surgical, anaesthetics/theatres, orthopaedic and ophthalmology departments had local strategic plans. In broadest terms, these were to focus on internal improvement programmes, integrate better with other services and develop 7-day services through the Dorset Clinical Services Review. It was not clear how these were linked to the trust's overall strategic plans.
- Progress had been made against departmental strategic objectives. For example, there had been a successful recruitment programme for surgical services, staff monitored and responded to patient experience and staff had implemented quality improvement initiatives to improve access to services.
- Staff at all levels demonstrated a passion to provide a good service for patients.

Governance, risk management and quality measurement

- Surgical services had clinical governance arrangements in place. Departmental risk and governance meeting minutes showed evidence of discussions relating to incidents, complaints and staffing. Each surgical ward produced Risk, Governance and Quality Governance (RAGG) reports for the risk and governance group, reflecting key aspects of the safe and effective domains as well as staffing and patient experience. Team meetings were also held for staff in theatres, recovery and therapy services.
- Senior ward staff used the RAGG reports to share learning from incidents and complaints, describe audit trends and prompt staff with training and professional registration.
- The directorate clinical governance and risk meeting minutes showed senior clinical staff reviewed and discussed incidents and developed action plans. The meetings for the surgical and anaesthetic/theatre directorates followed a set agenda that ensured review of items on the risk register, complaints, workforce issues and patient experience.
- Care group leads attended the monthly quality and risk committees and presented reports from the directorate clinical governance meetings covering risks, mortality reviews and incidents. Monthly care group meetings covered issues relating to workforce, risks and performance. There were monthly morbidity and mortality meetings for each directorate and by speciality when relevant. Minutes demonstrated clear clinical discussion and reviews.
- The corporate risk register included significant risks relating to surgical services. The key risks were delays in finding records and past clinical details following the introduction of electronic records. This had been escalated to the board, with a high risk rating, in July 2015.
- Directorate risk registers, for example for surgery, orthopaedics and anaesthetics/theatres reflected known risks. Mitigating actions were generally included on the registers and there was evidence that risks were reviewed regularly and staff updated the registers accordingly.

Surgery

- We reviewed 27 policies and procedures for surgery and found they were not compiled in a systematic way to include clearly defined training and competency requirements (for example, the policy on anaesthetics and scavenging equipment), assessment guidelines (policies relating to laboratory specimens) and clear parameters (consent policy for theatres). There were also duplicate policies in the intranet following recent reviews (for example, the radiation exposure, controlled drugs and lab specimen policies). This indicated that the approach to policy development review was not robust.
- Matrons monitored nursing performance using the electronic systems, to check the timeliness of observations. The systems also enabled nursing leads to identify any trends amongst staff carrying out assessments or care interventions to enable them to target where staff needed additional training or support.
- Most staff below band 7 were not familiar with how the risk register system worked or what items were on the risk register and how these were being mitigated. Staff said they were kept informed of compliance relating to performance, rather than about progress against strategy. This was particularly evident from staff in theatres.
- Fifteen ward-based internal peer review inspections took place in March, April and May 2015. These were based on the five domains of safe, effective, caring, responsive and well led. The results showed areas of improvement as well as areas considered outstanding. For surgical wards results were good or requires improvement, with ward 14 awarded outstanding for infection control. Action plans were created in response to these reviews to improve patient outcomes and experiences.
- The monthly clinical audit and effectiveness group reviewed audits and the audit programmes. For example, committee members received 20 clinical audit reports for the September 2015 meeting, including ones related to surgical services. The trust advised they had not carried out audits of consent, or AAGBI audits, in the past year however.

Leadership of service

- Amongst staff there was mixed awareness of the trust leadership team, with theatre staff having the least knowledge of the executive team members. Theatre staff described poor links between the senior management and front line staff.
- We found a lack of band 7 staff providing day-to-day leadership within the day theatres and Derwent theatres. Staff in these areas reported a sense of isolation and also demonstrated a lower awareness of trust safety priorities.
- Staff on the eye unit said their unit was well organised and a good place to work, but they did not feel a strong connection with senior hospital management.
- Most staff spoke positively about their line managers and departmental leads. Staff were complimentary about the leadership in surgical and orthopaedic departments, commenting on the support and guidance they received.
- The surgical ward sisters undertook monthly spot-checks of the wards during the night, on a rotational basis and compiled reports on their findings. These visits helped them understand night pressures experienced by staff. Their reports highlighted areas of good practice as well as areas for improvement.
- Ward sisters received leadership training which they said was useful in developing management skills. They also said that having regular meetings with other sisters was useful for sharing good ideas and building relationships. They were well supported, could raise concerns and were listened to.
- Ward management were knowledgeable about the specific issues and priorities for their wards, and the wider context of the department. They had some protected time for management duties, however they all commented that this was often used to support their teams if there were pressures on the ward. They were supported by the nurse practitioners and had tailored personal training programmes for their own development.

Culture within the service

- Overall staff felt part of a team, locally in their place of work. For example, the Sandbourne staff considered they had a very cohesive team of part and full time staff, and staff on Derwent ward commented on the supportive working environment.

- On wards, staff commented they did not like being moved to work on other wards. We were not able to quantify this, however staff said this had a negative impact on their morale.
- Most staff said they would feel comfortable in reporting any concerns to their line manager or senior member of staff. However, staff working in theatres reported they were not always listened to when they raised concerns.
- Ward sisters were involved in staff recruitment and aimed to build strong teams.
- In the 2014 staff survey, a higher percentage of staff in the trust reported they had experienced harassment, bullying or abuse when compared with other acute trusts. This result had not improved significantly year on year. Staff did not report a bullying culture during our inspection of surgical services.

Public engagement

- Theatres and wards asked patients for their feedback and displayed the results, using the friends and family test (FFT). Overall, over 97% of patients said they would recommend care in the orthopaedics and surgery departments in the months of July, August and September 2015. In September, 100% recommended orthopaedics. This information was included in departmental dashboard reports for surgery and orthopaedics.
- The trust as a whole had a higher response rate to the FFT than the national average; between 39% and 48% for the 12 months to February 2015. On surgical wards, the average response rates were higher (46%) than those for the trust, and at ward level between 38% (ward 17) and 58% (ward 7). This showed staff gave a high priority to patient engagement within surgical services.
- On most wards, staff displayed the FFT results on electronic screens located above eye level at the ward entrances. On ward 7, the screen was located inside the ward near a nursing station. The screens displayed three-month FFT trends, as well as the ward staffing levels for the day and patients' comments. The screens toggled through this information, which also included guidance on visitor times and 'you said, we did' feedback. It would be difficult for visitors to take in all this information unless they stopped at the ward entrances for a few minutes to watch the screens.
- Most wards had additional notice boards with printed information displaying patient harm data, complaints, incidents, risk assessment and infection control compliance rates.
- Physiotherapy staff held a patient and carer focus group to find out about patient experience from those attending for orthopaedic procedures. For example, in April 2015 they asked patients from wards 7 and the Derwent ward for their views on the pre-operative information sessions, pain management and goal settings. Feedback was used to make improvements to care delivery.

Staff engagement

- The most recent staff survey for 2014, showed a response rate of 49%, compared to 42% nationally. The trust's 'staff engagement score' of 3.74 was average when compared with trusts of a similar type. This was based on three key questions in the survey.
- Staff valued the annual safety and quality conference, chaired by the medical director, as an opportunity to learn as well as meet up with colleagues.
- Senior staff on surgical wards and units developed their own ways for communicating with their teams. These included newsletters, notices on boards, and communication folders with sign sheets. Within directorates, staff could access information on a shared drive for different wards.
- Staff in surgical services were aware of a whistleblowing policy: 'speak out' and said they would be prepared to use it.

Innovation, improvement and sustainability

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Surgery

- Staff in surgical services were aware of a whistleblowing policy: 'speak out' and said they would be prepared to use it.

Critical care

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

Information about the service

The Royal Bournemouth & Christchurch Hospitals NHS Foundation Trust (RBCHFT) Critical Care Unit provides care and treatment for critically ill medical, surgical and emergency care patients. There are approximately 900 elective and emergency admissions per year, 85% of which are emergency admissions. The patient group is adults only, with no provision for paediatric or neonatal care. Regional neonate and paediatric intensive care services are provided at University Hospital Southampton NHS Foundation Trust or Poole Hospital NHS Foundation Trust.

There are 12 critical care beds. The bed configuration can be altered to provide treatment for patients requiring level 2 or level 3 care, Level 2 beds are for patients who require higher levels of care and more detailed observation and/or intervention than can be provided on a normal ward. These patients may have a single failing organ system or require post-operative care. Level 3 beds are for patients who require advanced respiratory support or basic respiratory support together with support of at least two organ systems. This level includes complex patients requiring support for multi organ failure. The service can accommodate a maximum of eight level 3 patients.

There is a critical care outreach service that provides advice, care and treatment to patients across the hospital, 24 hours a day, seven days a week.

During our inspection of critical care we talked with five patients, three relatives and nine members of staff. These included nursing staff, student nurses, junior and senior doctors, physiotherapists, pharmacists, dieticians, housekeeping staff, technicians and managers. We observed care and treatment and looked at eight care records. Before the inspection, we reviewed performance information from and about the hospital and the unit itself.

Critical care

Summary of findings

We rated critical care services as good overall, the service required improvement for responsiveness. There was a higher than average number of delayed discharges, which at times resulted in mixed sex breaches, sometimes across several days.

There was a culture of reporting and learning from incidents, the majority of staff received feedback from reported incidents. There was a low rate of hospital acquired infections, but infection control practices were not always adhered to.

The unit was built before specific building regulations, it was cramped and cluttered. There were safety systems for management of medicines, records and equipment. However, there was not always evidence that equipment was checked and ready to use.

There were processes for identifying and responding to risks and deteriorating patients on the unit.

The unit was consultant led and staffing levels met national guidelines, however the one doctor on duty at night was sometimes called away to the wards. The number of staff completing mandatory training was below trust target.

The critical outreach team was available 24 hours a day to respond to respond to requests to assess deteriorating patients across the hospital. The team followed up all patients discharged from the unit.

The treatment and care provided was evidence based. National and local audits and data showed there were good outcomes for patients. A number of critical care policies and clinical protocols were in the process of being reviewed.

There was access to multi-disciplinary services seven days a week. The wider multidisciplinary team did not attend the consultant led ward round the ward round. The allocation of multidisciplinary support to the unit, including pharmacy and physiotherapy, was lower that recommended.

Nurses were competent and trained in critical care nursing, with access university validated training. There was a low staff appraisal rate since introduction of a new process.

There was evidence of innovation and three research nurses undertook trials which aimed to improve patients care and outcomes. The critical care unit had won an award for developing a patient transfer course.

There was timely access to the unit and low rates of cancellation of operations due to lack of beds. The service was performing better than similar services in avoiding out of hours discharges.

Staff understood how to manage complaints and there was evidence of learning from concerns and complaints. Processes for formally obtaining patient and relative feedback were limited to the family and friends test on discharge.

Governance processes promoted reviews of the service quality and identified areas for improvement. Staff reported a strong consultant centred hierarchical culture on the unit and this was limiting delegation and multi-disciplinary team working.

Staff were caring and patients were treated with dignity and respect, staff tried to anticipate their needs and to enhance their experience on the unit. Patients and relatives gave positive feedback about the care they received and confirmed they had been informed and involved in the decision making regarding care and treatment. Staff offered ongoing emotional and psychological support to bereaved families.

The critical care unit was working to improve organ donation rate.

Critical care

Are critical care services safe?

Good

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

We rated safe as good.

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

We rated safe as good .

- Staff reported incidents, the majority received feedback and there was evidence of learning and improvement to reduce the risk of similar incidents occurring.
- Staff had awareness of the principles of Duty of Candour although its application was not documented in detail on incident investigations.
- There were medical and nursing handovers however the change of shift safety briefings were not included in handovers to all staff
- The unit was consultant led, and medical and nursing staffing levels were in line with national guidance.
- Appropriate equipment was available and there were checking procedures in place
- The unit had a low rate of hospital acquired infections.
- There was secure access to prevent entry by anyone unauthorised.
- There was secure storage and safe management of medicines
- Staff had awareness of safeguarding and followed procedures to protect vulnerable adults
- Medical and nursing staff were trained on the safe transfers of patients
- Records were securely stored and well completed, with patient assessment, care and treatment clearly documented.
- The critical outreach team was available 24 hours a day to respond to respond to requests to assess deteriorating patients across the hospital. Electronic data was used to prioritise referrals.

However,

- The unit was built before specific building regulations and the environment was cramped and cluttered.
- Documentarty evidence of equipment checks was were not always completed.
- The practice of nursing staff sometimes meant leaving patients unattended at the bedside created a risk. There was one doctor on duty after 11pm. They sometimes left the unit to review deteriorating patients across the hospital or attend emergency resuscitation calls.
- Infection control practices were not always appropriately followed.
- The service did not meet the trust target of 95% staff compliance with mandatory training.

Incidents

- Most of the staff in the critical care department that we spoke with knew how to escalate and report incidents. They knew they needed to report incidents such as patient falls, equipment errors, medicine errors, admissions and discharges to and from the unit out of hours (between the hours of 10pm and 7am).
- Incidents were reported using an electronic reporting system. Staff told us they did not always receive feedback that incident reports had been received or the outcome.
- Records showed there was a culture of reporting all incidents, reviewing and investigating incidents and taking action where required to reduce the risk of similar incidents occurring.
- We reviewed reported incidents from May 2014 to June 2015. There was one never event and no serious incidents reported. A never event took place in March 2015 where a central venous catheter was inserted and a guide wire was left in place, and not retracted, when the procedure was completed. A root cause analysis (RCA) was undertaken and lessons learned noted. Practice was changed and an insertion check list was re-introduced as well as an observation role in order to avoid reoccurrence. The incident was discussed at team meetings and information was shared regarding the investigation.
- Action was taken as a result of reported incidents. For example, between June 2014 to June 2015, the unit reported six pressure ulcers, one catheter urinary tract infection and no falls with harm. Two root cause analysis investigations were undertaken for pressure ulcers in June and August 2015, which resulted in care and treatment being changed to reduce the risk of similar occurrences. An example of this was patients were referred to the tissue viability nurse. Concerns were

also raised over failure of ambulance provision by local NHS and private ambulance services for critical care patient transfers. A meeting had been arranged with an external organisation to support improvements and reduce risks and incidents from the ambulance provider. Incident reporting forms had been logged by the clinical outreach team due to the failure of the emergency response phone number within the hospital. The cardiac arrest bleep had been unreliable and other communication devices had been purchased to reduce risks and the concern escalated.

- Records of nursing staff and critical care governance meetings showed that learning from incidents was shared within the critical care directorate, and the care group it sat in.
- Staff training records indicated there was no formal root cause analysis training for staff trust wide, and clinical leads were expected to investigate their own areas.
- Mortality and morbidity meetings were chaired by the critical care unit consultants. (Mortality and morbidity meetings are peer reviews of the care and treatment of patients with the objective to learn from complications and errors and to prevent repetition of any errors leading to complications). Quarterly meetings were held and attended by only the consultants, but occasionally nurses attended. Records of the last three mortality and morbidity meetings showed that the treatment and care practices for patients with low risk of death were critically reviewed, and where appropriate proposed changes of practices were identified. This included liaison with other departments such as the wards and the emergency department to improve care and treatment of patients. 10 to 15 patients in specific groups were discussed with three consultants reviewing all deaths based on the admitting consultant. However, records of the meetings lacked detail and did not show actions or set timescales. There was also no mention of post mortem reports.
- The 'Mortality Improvement through Clinical Engagement' quarterly reports for May and August 2015 discussed issues such as the deteriorating patient, sepsis, end of life care and hospital at night projects. We saw action points listed and completed with future objectives set by clinical leads. These supported the mortality and morbidity meetings.
- Staff understanding about the Duty of Candour legislation was variable. Most junior staff, both nursing and medical, understood Duty of Candour to mean they had to be open and honest with patients and their relatives. Senior nursing and medical staff understood their responsibilities with regard to the Duty of Candour legislation. A trainee doctor did not know what Duty of Candour was and their role within it.
- Root cause analysis documentation did not indicate if Duty of Candour principles had been applied. The never event RCA report recorded, 'the family were aware of treatment and plan of care throughout patient's stay'; but there were no other entries to confirm the event had been discussed with the patient or their relatives.

Safety thermometer

- The NHS safety thermometer is a monthly snapshot audit of the prevalence of avoidable harms including new pressure ulcers, catheter-related urinary tract infections, venous thromboembolism (VTE), and falls.
- The unit followed the trust wide process for reporting safety thermometer information. A monthly quality template was submitted to the trust's Health Assurance Committee by the Modern Matron of the unit.
- Safety thermometer information was displayed at the entrance to the unit. Risk assessments from May to September 2015 showed compliance with patient assessments for falls; mobility; bed rails; pressure ulcer , and Malnutrition Universal Screening Tool (MUST) were not consistently completed.
- The saving lives audit takes place across hospitals for monitoring delivery of safe care. The unit results were 92% in May 2015, 100% in June 2015, 94% in August 2015, 96.8% in September 2015 and 100% in October 2015.

Cleanliness, infection control and hygiene

- Data from the Intensive Care National Audit and Research Centre (ICNARC) detailed that rates of unit acquired Methicillin Resistant Staphylococcus Aureus (MRSA) and blood borne infections were less than those of similar critical care units. From 2007 to October 2015 there had been no unit acquired MRSA.
- The rate for Clostridium difficile (C Diff) infections was similar to that of other critical care units. (Clostridium difficile infection is a type of bacterial infection that can affect the digestive system. It most commonly affects people who have been treated with antibiotics). Unit

acquired infection rates for C Diff had reduced since 2013, with 12 reported in 2013, four in 2014 and one in 2015. There was a C Diff protocol pack in place to support staff in dealing with an outbreak.
- The hand hygiene audit for August 2015 was 80%; September 2015 was 100% and October 2015 100%.
- There was a trust wide MRSA policy change in March 2015, and further guidance was given to staff in August 2015 on the types of patients to be screened.
- Patients were screened for MRSA before admission to critical care and patients were screened on a weekly basis whilst in the unit.
- Patient records evidenced involvement of the microbiology team with entries on 'stickers.'
- The unit was visibly clean and cleaning staff were visible at the time of our inspection. The storage bay for chairs was cleaned weekly.
- The critical care unit policy stated patient's bedside curtains were changed three monthly, with the date of the next required change recorded on the curtain. We were told this process was the responsibility of the housekeeping staff and was regularly checked. Curtains were also changed after an infected patient was moved from the bed area.
- There was a checklist to complete when the patient left the unit to ensure the bed space and all equipment was cleaned.
- We were told were told equipment was cleaned between use and the unit did not use 'I am clean stickers' due to frequent use. Housekeeping staff undertook weekly environmental audits and results were positive. Most of the equipment we saw in critical care was clean, but we did not see 'I am clean' stickers being used. There was dry blood splatter on the blood gas machine, which increased the risk of spreading infection.
- Personal protective equipment, such as gloves, aprons and plastic glasses were available. All bed spaces were stocked the same coloured disposable aprons. We saw staff used this equipment when providing patient care and treatment. Staff disposed of the equipment after they had completed the episode of care. However, we also witnessed some staff walking through the unit wearing gloves and aprons, which increased risk of spread of infection.
- The hand gels were located at the end of beds rather than at the end of the bed space or outside the cubicle. This meant visitors or staff needed to cross the red line, a marker on the floor outside a patient's room or surrounding a bed space, before they could decontaminate their hands. Hand cleaning facilities, including hand gels were available at the entrance to the unit and throughout the unit.
- Unit staff complied with the trust's policy of bare below the elbows. However, at inspection we saw two clinical staff members wearing earrings and necklaces whilst in the clinical environment. This meant they were not bare below the elbow and could bring germs and bacteria into the unit that could put patients at risk of infection. We also saw a member of the IT team wearing a watch, however, although they did not provide direct patient care, this is not hygienic practice when entering the critical care environment.
- The junior doctors handbook that was given on induction for new staff made a statement called 'the ward round commandments'. This included advice on effective handwashing. It also told staff to clean the top of the ward round trolley between patients. However, we did not witness the trolley being cleaned between patients on the ward round.
- The unit had side rooms, one of which had a lobby and airflow system to help prevent the spread of air borne organisms. The air flow to this side room was identified as being below national standards in August 2015 as part of routine audit by the estates department. A report was sent to the head of estates and critical care and we were told work had been on-going to improve the ventilation plant. To mitigate risks, a positive pressure side room was available within the unit.

Environment and equipment

- The unit was secure with access by electronic swipe cards that were only issued to staff who had authority to enter. Visitors entered the unit via a door bell and intercom system. Unit staff welcomed each visitor individually.
- The unit was cramped and cluttered, and bed spaces did not comply with the HBN04-02 regulations. The hospital was built before the regulations were applied and so were not obliged to comply. This risk had not been listed on the risk register, however, we were told two bed spaces had been decommissioned to create a formal storage area to improve the use of space and reduce the risk of infection. We were told there had been no incidents related to lack of space within the unit.

- Resuscitation equipment, including equipment for the management of airways, was available on the unit. The trolley was checked daily and we saw completed checklists with signatures. There was no sign-posting on the resuscitation trolley to indicate the contents. This could pose a risk to patients if clinical staff were unable to locate a piece of equipment in an emergency. There was no intubation checklist, which meant clinical staff stocking up the trolley may miss essential pieces of equipment. The third drawer on the trolley contained a spare ventilator battery, stating it must be charged every three months, but the date seen showed it was last charged five months previously.
- Critical care had a bespoke patient transfer trolley for internal transfers as well as one for out of hospital transfers. This contained a checklist for the equipment.. However, Wwe did not see documented evidence the equipment on the trolley was checked to ensure it was available and in working order. However, we were told the co-ordinators on the unit used their own checklist to ensure this took place.
- Equipment was stored in three areas on the unit: the medical devices room; an open area, where the transfer trolley and blood gas machine were located: and in bed spaces behind the curtains. Medical equipment, including mechanical ventilators, renal replacement machines, infusion and feeding pumps were stored on the unit.
- All ultrasound machines in the equipment store room were unplugged and all batteries were found to be flat. This meant that if the machines were needed urgently the batteries would have no charge and would need to be plugged in to a mains socket before use.
- The nurse in charge of the shift was responsible for checking the equipment. We were told they completed a daily coordinators checklist, however, at the time of our inspection, were saw no written records to confirm these checks had been completed.
- Nurses completed a thorough bedside checklist to ensure patients were kept safe and all equipment was stocked and in order.
- There was a critical care asset register that showed the medical devices stocked, the serial numbers, manufacturer and asset numbers for all equipment in critical care.
- Equipment was PAT tested by an external contractor prior to use, the records were not held within the unit.
- Staff said that essential equipment was always well stocked, with individual patient bedside equipment replenished each shift. The hospital had an equipment library that the unit could access at all times.
- The nurses' training competence log for the equipment was incomplete and out of date, and we did not see an up to date training log for staff that indicated they had been trained and were competent in using the equipment. No induction equipment training documents were available. This had been identified by the lecturer practitioner, and training was planned.
- The unit had not had an equipment technician for six years. However, we were told the nursing staff were fully trained and responsible for the safe management of all the equipment including ventilators and haemofiltration machines.

Medicines

- Medicines were stored in secure areas. Medicine preparation rooms were secure, and members of the public were unable to access the rooms. Access was gained to these rooms via a numerical key code pad with the code only available to nursing, medical and pharmacy staff who worked on the unit. Controlled medicines were stored in a locked cupboard that complied with the trust's policies and stock was checked daily. The keys to access the controlled medicines were held by the shift team leader. Medicine fridges were kept within cold storage limits and a daily register of temperatures kept.
- Patient's individual medication was stored by the bedside that was secured by a numerical key pad.
- There was a locked cupboard in the middle of the unit that contained controlled drugs. The red warning light on the outside of the controlled drugs cabinet was not working. This would be to alert staff that the controlled drugs cupboard was in use.
- Two out of the three eye splash bottles we inspected in the store room were found to be opened but no date was recorded on them to indicate when they were opened. It was unclear to why they were located in the store room.
- Pre-printed critical care drug prescription charts were used which were adequately maintained with allergies recorded, dated and signed. Changes to prescriptions were routinely checked by the unit allocated pharmacist

to ensure the medicines were prescribed correctly and were appropriate for the patient. The pharmacy department regularly visited the unit to top up any medicines they needed.

- Medicines were administered in line with the trust's management of medicines policy and the Nursing and Midwifery Council guidelines. Nursing staff received training about the safe administration of medicines and only administered medicines after they had completed competency assessments. The medicines prescribing guidance document was out of date, and an electronic version was planned.
- The outreach team worked via two patient group directives (PGDs). These had been reviewed and were up to date.

Records

- The majority of patient records were paper records. However admission details and assessments for the risk of developing venous thromboembolism (VTE) were also recorded electronically. A new electronic nurse assessment tool was in use throughout the trust. Some staff told of us frustrations and difficulties with its use in the unit . Work was ongoing to adapt it and improve its performance and within critical care
- The outreach team told us there were issues with the trust using a variety of electronic patient recording assessment devices that did not communicate with each other. The risk meant there was a possibility of information being missed or duplicated.
- We looked at eight sets of records. Pre-admission notes were not always completed thoroughly, for example, to include the time the decision was made to admit. However, critical care notes were appropriately completed with organised and legible documentation. Microbiology and radiology stickers were seen in medical notes, with brief consultant discussion. Well completed nursing documentation was seen in critical care records and at the patient's bed side.
- Observation charts were located at the patient bedside and Information allergies or airway alerts was documented in the patient's notes.
- Patient records included detail of medical plans and instructions for the forthcoming 24 hours, plus multidisciplinary reviews, such as physiotherapy and dietetic input. They also contained brief detail of conversations had with patients and their family or relevant others.
- Most records were stored securely. However we saw a digital chest x-ray film that had been left in full view and visible to all in the unit which could breach information governance guidelines.
- We saw patient transfer forms with a checklist that clinical staff used as an aid memoire to ensure the patient was transferred safely and all risk assessments had been completed. The check list included clinical observations, medication and equipment checks.

Safeguarding

- Safeguarding children and safeguarding adult's information files were accessible in the unit and staff knew where to access them. Staff told us information about safeguarding both children and adults was also accessible on the trust's intranet. Both sources of information detailed who to contact if staff suspected a patient was at risk or had been exposed to abuse.
- Nursing staff in critical care reported there was a good support network from the safeguarding team, including any escalation to mental health liaison team. A 'how to' guide was available and visible to staff. In conversations, staff demonstrated an awareness of safeguarding procedures and how to recognise if a patient was at risk or had been exposed to abuse.
- We saw a safeguarding incident reported on the electronic reporting system for vulnerable children deemed at risk. This demonstrated critical care staff were aware of the process and had raised their concerns in an appropriate and timely manner.
- Training records provided by the trust showed compliance with mandatory training across the trust for safeguarding adults and children. The records demonstrate that only 56% of staff had completed safeguarding adult training and 76% of staff had completing children's safeguarding training. This was below the trust's 90% trust target.

Mandatory training

- The service was not meeting the trust compliance target of 95% for updating mandatory training. The shortfalls were in safeguarding training, conflict resolution, falls and equality. Trust records May 2015 and September 2015, showed a compliance rate of between 68% to 73% for all staff working in critical care.
- At the time of the inspection, 32/59 nurses were out of date for fire safety training, 23 for resuscitation, 17 for

moving and handling, 29 for equality and diversity, information governance, immediate life support (ILS) and 22 for medicines management. Good compliance was seen with infection control training.

- The modern matron told us low compliance with updates was due to the workload and some staff being absent on maternity leave. We were told nurses were sent to work on other wards in the hospital when short staffed which had an impact on completing their training in work hours.
- The critical care outreach team (CCOT) mandatory training compliance was between 84% to 90 % in August and September for most subjects.
- This gave an overall result for critical care being 69% compliant for national core skills competencies that included fire safety, infection control, moving and handling, safeguarding and resuscitation training, amongst others. CCOT were 86% compliant.
- Trust core skills training relevant to clinical staff's place of work was 76% compliance for critical care and 86% for CCOT at the time of inspection.

Assessing and responding to patient risk

- Nursing records included risk assessments for pressure ulcers, malnutrition, venous thromboembolism and specific risks that were associated with their clinical condition. These were uploaded onto a hospital database as part of a trust wide process which had a time scale so breaches were highlighted if timely assessments were not completed.
- Where risks were identified, detail was included in their care plan about the action required to reduce the risk to the patient. More detailed medical information was recorded in the medical notes; this included detailed information about discussions with patients, families and treatment decision making processes.
- Allergy or alert posters were not on display at the patient's bedside to flag up concerns to any clinical staff tending to them, although this was documented on the patients' medicines charts.
- Staff were trained in ALS or ILS. A simulation mannequin had been purchased to enable staff to train in advanced resuscitation skills for the critical care unit.
- All outreach nurses had completed advanced life support (ALS) training which meant they could manage simple airway problems. They followed up all critical care discharges, visiting deteriorating patients on wards, and escalating any concerns to the critical care doctors if necessary.
- The service used guidelines on acutely ill adults in hospital, recognising and responding to deteriorating patients.
- Electronic portable tablets were used across the hospital wards to record clinical observations. The National Early Warning System (NEWS) was used on the device to assess a patient's condition with algorithms and escalation categories. However, we found that escalation was not consistent or thorough from the ward staff. There was a step by step flow chart to follow, but ward staff escalation varied and some electronic devices did not automatically advise escalation of assessment or treatment
- The outreach nurses analysed the data collected by wards staff to prioritise their work load. Patients with a high NEWS score were seen first, and the outreach team were able to escalate any concerns directly to the critical care medical team.
- Safety briefs are used to communicate any concerns from patient care, medication or equipment. The safety brief happened between the nurse in charge to the nurse in charge at the time of patient handover, rather than to the whole team. Nursing coordinator checklists were in place for sharing of patient information. Clinical issues were raised and discussed during nursing handovers at the bed side
- This meant that key information, for example, highlighting a patient with a difficult airway, was not shared. We observed that the nurse in charge had to deal with frequent interruptions at the nurses station to respond to queries and the general running of the unit.
- There were patient transfer checklist in use, but this did not cover all patients. A head injury transfer checklist was seen which followed the critical care network guidelines but a transfer check list was not used before moving a ventilated patient to the digital imaging department. Transfer checklists were attached to the trolley for external transfers. Nurses were not allowed to transfer patients internally or externally unless they had attended a transfer course.

Critical care

Nursing staffing

- The unit had an establishment of 60 qualified nursing staff. At the time of inspection, there were 52 whole time equivalent (WTE) staff plus two administrative and support staff.
- We saw a critical care staffing tool dated October 2015 that described how many nurses were needed in relation to level two or level three patients. It demonstrated that critical care was resourced to provide treatment for eight level 3 patients or 16 level 2 patients. The maximum capacity for critical care was 12 patients in total. Beds were flexible and based on the staffing tool would need to reduce capacity by two level 2 patients for every level 3 patient admitted.
- Daily planned and actual staffing numbers were displayed on the unit. Staff reported that staffing numbers were sufficient to ensure they were in line with the recommended guidelines. Level 3 patients were nursed on a one to one ratio and level 2 patients were nursed on a two patients to one nurse ratio.
- Gaps in the duty rota caused due to staff absence or vacant posts were covered by staff 'in house'. There was overtime allocated to permanent staff instead of using bank or agency nurses to cover maternity leave and long term sick leave. There was a local agency check list and a request for an agency nurse had to go through the head of nursing for justification and authority. This meant the unit met the national guidance that no more than 20% of the work force on any shift should be agency nursing staff.
- Nurse staffing levels were: 102.2% for day shift and 98.7% for night shifts in April; just above 99% for days and nights in May and June 2015.
- The core standards of critical care nursing detail the number of supernumerary clinical coordinators required on each shift, depending on the number of beds in a unit. The unit did not meet the standard of having one clinical coordinator in charge of the shift if there were more than six patients on the unit. This was flagged on the risk register, and vacancies were being filled to resolve this.
- We saw evidence of two supernumerary nurses covering day shifts and none at night. Level 2 patients were regularly nursed with one nurse to one patient ratio, higher than one to two patients requirement.
- Staff expressed concerns that when the unit was quiet they were sometimes asked to help wards/departments elsewhere in the hospital. This was done on the understanding that if a critically ill patient needed to be admitted to the unit, the nurse would be released to return to the unit. However this did not always happen, leaving the critical care unit understaffed. All such incidents were raised and discussed at critical care group meetings. We were told staff could be summoned back immediately if required on the unit.
- One morning at 7.40am, we observed three level 3 patients and one level 2 patient, had no nurse visible at the bed side. There was only one band 5 staff nurse in the critical care area, and the nurse in charge was on the phone in the staff office.
- Patients and relatives we had conversations with expressed the opinion there were always sufficient numbers of staff available to attend to their needs.
- There was a critical care outreach team (CCOT) that consisted of six band 6 nurses and one band 7 clinical lead nurse. They worked 12 hour shifts, with one nurse on duty during the day and one at night. They supported the hospital at night team but were clinical and not bed managers.
- The critical care educational team consisted of two Band 7 nurses, including that included a part-time lecturer practitioner (whose time was shared between the unit and the local university), and a Band 5 staff nurse to provide clinical support at the bed side.
- Nurse sickness rates were elevated for the first quarter of 2015, but dropped to 3.3% in May; 2.6% in June; 1.4% in July; 2.3% in August and 3.4% in September 2015.
- There was a hand over between nurses in charge changing over shifts and a proforma was used. The nursing shift handover process was taped beforehand by each nurse to record their patient's status. This tape was used in the handover to save time. The nurses would be allocated a patient to look after and attend a 1:1 handover at the bed side. Handovers included patients waiting to be admitted or surgical cancellations, resuscitation status, family and any safeguarding issues. We observed a handover and found that the process did not offer staff the opportunity to seek clarification about a specific patient or issue which might contribute to inappropriate allocation or misinformation and there was no opportunity for all the team to hear confirmation or clarification .

Critical care

Medical staffing

- There were six consultant intensivist. The critical care unit was consultant led. The consultant intensivist worked in consecutive three to four day blocks with bedside handovers provided at each transmission of care. They were always immediately available 24 hours a day and when not on the unit, were able to attend within 30 minutes. When on call for critical care they did not have other clinical commitments, and this met the national recommended guidelines.
- Recruitment to the consultant intensivist rota met the national guidance, that consultant patient ratio must not exceed a range of 1:15.
- Critical care consultant had ward rounds occurred twice a day, seven days a week, in line with national guidelines. This was evidenced by conversations with nursing and medical staff and viewing patient records. Consultants reviewed all patients within 12 hours of admission.
- Medical staffing met Guidelines for the Provision of Intensive Care Services (GPICS) 2015 on behalf of the Faculty of Intensive Care Medicine for ensuring critical care units had appropriate numbers of medical staff on duty with appropriate qualifications and experience until 11pm. Numbers of resident medical staff meant the service met national guidelines that detail the critical care resident doctor / patient ratio should not exceed 1:8 during day hours. There were three junior doctors on duty during the day, and two on duty until 11pm. However, after 11pm there was only one doctor present which failed to meet the GPICS recommendation of trainees not looking after more than eight patients each.
- There was one doctor on duty after 11pm. They sometimes left the unit to review deteriorating patients across the hospital or attend emergency resuscitation calls. This left the unit without a doctor for prompt and urgent care. However, they were accessible should the unit require them and would be able to return in an emergency. The nurse in charge of critical care was made aware if the doctor left the unit, and if this was for a prolonged period of time, the on call Consultant would be called to provide cover.
- There was one resident doctor on duty overnight in critical care and they were part of the hospital wide cardiac arrest team, which meant they needed to leave the unit to provide support across the hospital in an emergency. On one occasion during our inspection, the cardiac arrest bleep went off whilst the doctor's round was underway, and all junior staff left to attend except for the consultant, which may have been unnecessary. This occurred during the day, but if it was at night, critical care patients could be left without a doctor on hand.
- At inspection, we visited the critical care unit at 9pm. There was no doctor available on the unit as both the junior doctor and specialist registrar were attending a ward to review a patient and the consultant was not present. By 9.35pm, no doctors had arrived and when we raised this with the nurse in charge we were told they would bleep them if they had any concerns. We were told a critical care registrar would respond promptly if bleeped by critical care staff and return if necessary. If required to be away from the unit for a longer period, a critical care consultant would be contacted to attend the unit promptly. We were told ITU consultants were frequently present on the ITU out of hours and at times overnight.
- Medical staff rotated to critical care for a four month block, and trainees were at a variety of stages in their career and from different specialities. Junior doctors working on the unit confirmed there were always sufficient senior medical staff on duty.
- We spoke with one trainee doctor who said they had no formal induction or paperwork completed for working on critical care. They were shown as they worked but lacked thorough preparation. We did however, see evidence of a 'Junior Doctor's Handbook', that was comprehensive and helpful for working on the unit. The doctor told us the rota meant they worked 12 days in a row at times with the longest day being 10 hours, which could have impacted on their health and well-being.
- There were three junior medical handovers every day. The hand overs were staggered due to doctor's different working hours. Consultants did not directly supervise trainee handovers. A consultant ward round followed the trainee handover and we were told this where trainee teaching and feedback occurred.
- The transfer of patients to other critical care units was undertaken by a consultant anaesthetist except when there was sufficient medical resource on the unit. In this case it would be a specialist registrar who had attended and completed transfer training.

Critical care

Major incident awareness and training

- A major incident policy and business continuity plan was accessible in paper format and on the intranet. We saw a major incident file in the critical care nursing office, and information was located on the computer desk tops.
- The clinical director explained to us the emergency plans in place for critical care. They knew which ventilators they had access to on the unit, and ones they could use that were spare and available for patient transfers. This was for internal or external transfers from the hospital, and equipment was accessible from theatres or the emergency department in an emergency. Patients could be treated in theatre recovery if the critical care unit was full and all beds were occupied. Bed spaces could also be flexed to increase capacity for level three patients, with risk assessments performed on making non-clinical transfer.

Are critical care services effective?

Good

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

We rated effective as good

- The treatment and care provided took account of evidence based guidance.
- The critical care service participated in national and local audits and data showed there were good outcomes for patients.
- Patient pain was well managed, supported by a pain resource nurse and nutritional needs met
- Nurses were competent and trained in critical care nursing, having access to the in-house course validated by the local university. Learning was facilitated by a lecturer practitioner who was implementing step 1 of the critical care network competencies. Some service specific competency training of senior nurses had expired. Junior doctors had access to appropriate training and support.
- There was access to seven day services.
- Appropriate transfer and discharge information supported consistency of care and the critical care outreach team followed up all patients discharged from the unit.
- Formal and informal consent was obtained as appropriate and staff had an effective understanding of the Mental Capacity Act 2005

However,

- A number of critical care policies and clinical protocols were out of date and in the process of being reviewed.
- There was multi-disciplinary team involvement was not in line with recommendations in the Guidelines for the Provision of Intensive Care Services, 2015. Physiotherapy staffing was below recommended levels and the wider multi-disciplinary team did not attend ward rounds.
- There was a low staff appraisal rate, following the introduction of a new appraisal system
- The critical care unit was working to improve organ donation rate.

Evidence-based care and treatment

- The critical care unit had guidelines and procedures that took account of national guidelines and evidence based guidelines. For example, the unit had produced a document explaining how the critical care unit met NICE CG 50 guidelines on acutely ill adults in hospital, recognising and responding to deteriorating patients. Nationally recognised care bundles that were in use, included care bundles to reduce the risk of ventilator acquired infections and central line infections and complications.
- The Critical Care Outreach Team (CCOT) operational policy, written in November 2007 (revised in August 2015) demonstrated the care and treatment also took account of National Institute for Health and Clinical Excellence (NICE), National Patient Safety Agency (NPSA) guidance and the United Kingdom Resuscitation Council 2010 Guidelines. It explained the referral process and described annual audits completed by the CCOT clinical lead to ensure effective service provision that was in line with organisational needs.
- The unit, however, had many guidelines and procedures that were no longer in date. Invasive procedure guidelines and protocols were available on the intranet but were out of date. Head injury guidelines expired in 2001; non-invasive ventilation expired in 2005; the

bereavement resource file was dated 2006; medical management expired in 2010; the chest drain policy in 2010; potassium supplements in 2010; and the transfer policy expired in 2012. The tracheotomy policy was in date.

- Ventilation care bundles were described on the intranet but only information was provided with no policy and date attached. Some bedside clinical checklists were due to be updated. Nasogastric tube insertion, expired 2013; tracheostomy inner tube cleaning guidelines, expired 2011; eye care guidelines, expired 2011 and weaning guidelines, expired 2010.
- A task and finish group had been set up to review and update the policies, but this was not completed and still in progress at the time of our inspection.
- The arterial line flush bags procedure met National Patient Safety Agency (NPSA) guidance 2008, and nasogastric tube practice met national recommendations for insertion, checks and documentation.
- We saw a clinical audit plan for 2015-2016 for Anaesthetics, which listed eight audits; three were assigned to various critical care doctors. The audit plan described the progress expected. After the inspection we were told of the mechanisms for audit feedback to the appropriate staffing group and areas of the trust.
- The unit monitored high impact interventions monthly, for example, insertion of central line and ventilation. Compliance in ITU/HDU was 100% in figures available for July 2015.

Pain relief

- Patients' pain and response to pain relief was monitored and recorded on their daily charts as part of their routine observations. Patients and their relatives said their pain was well controlled.
- During ward rounds, the pain-relieving needs of each patient were discussed and their pain-relieving medication adjusted accordingly.
- Patients who we could have conversations with, said their pain was well controlled and nurses gave them pain relieving medicines when they needed it.
- Conversations with staff evidenced they assessed patients' pain levels by observing non-verbal signs, such as facial expressions, as well as listening to patients who were able to express their level of pain.
- A deputy sister was the pain resource on the unit and attended updates four times a year. In addition to this, staff were able to access the trust wide pain team if necessary for guidance or support.

Nutrition and hydration

- Patient records demonstrated that their nutritional and hydration needs, and risk of malnutrition were assessed and appropriate. Protocols and policies were in place regarding enteral and parental feeding practice.
- In line with national guidance, the unit had a dedicated dietician to support patients with meeting their nutritional needs. Dieticians visited daily and reviewed all patients in critical care, although this was not part of the multi-disciplinary ward round.
- Speech and language therapists were available to check that patients were safe to swallow, and to offer advice accordingly if patients did not have a safe swallow reflex. Instructions from speech and language therapists were recorded in patients' records and care plans.
- Between July and September 2015, patients reported on the friends and family test cards they were happy with the food, and this was also confirmed to us at the time of our inspection.

Patient outcomes

- Critical care services took part in a number of national audits to measure the effectiveness of care and treatment provided. These included the Intensive Care National Audit and Research Centre (ICNARC) national case mix programme; the national cardiac arrest audit; the national emergency laparotomy audit; airway problems in the recovery ward; patient temperature in the peri-operative period; abdominal aortic aneurysm surgery; non-steroidal anti-inflammatory drugs and acute kidney injury.
- The unit submitted data to the Intensive Care National Audit and Research Centre (ICNARC) in order to monitor patient outcomes and compare performance to that of similar units. The most recently published report was for the period 1 April 2014 to 31 March 2015.
- The data showed that mortality rates were similar to those of comparable critical care units, approximately 86% of patients survived to discharge.
- Data for unplanned readmission to the unit within 48 hours showed the unit was performing at a similar rate to other similar critical care units. The average length of

stay for ventilated patients from June 2015 to September 2015 was between three and six days for ventilated patients, and two days for non-ventilated patients.
- ICNARC data showed the MRSA, and blood borne infections were lower (better) than those of similar units. There had been no reported cases of unit acquired MRSA since 2010.
- The critical care unit took part in The National Cardiac Arrest Audit from April to June 2015, which reported 28 individuals had a cardiac arrest, trust wide. The majority of these patients were aged 16-64 and male. Patients came from a variety of specialities and located on medical wards, the emergency department and the cardiac care unit. 10 of these patients died (35.7%); 18 survived (64.3%) and 11 (39.3%) were successfully discharged.
- The outreach team monitored outcomes of their intervention with patients, which showed 8% of patients referred to the team were treated in the critical care unit, 4% of patients died, with the remaining 88% being treated on the ward area.
- The critical care unit was working with the specialist nurses in organ donation (SNODs) to improve the donation rate. We were told referrals can be limited due to the unit's geographical location and the transplant coordinators base. Despite the higher than average age catchment population for Bournemouth (6-10 years older than national average), the most recent 6 month report of donation activity (April-Sept 2015) generated from the potential donor audit, showed referral rates were 72%.

Competent staff

- Many nurses had completed further specialist training in critical care nursing. This met the national guidelines that a minimum of 50% of nursing staff in a critical care setting should have a post registration qualification in critical care nursing.
- All nurses newly appointed to the critical care unit had a six week supernumerary induction programme. Staff confirmed they remained supernumerary throughout this period. The supernumerary period could be extended if both the nurse and their mentor felt it was needed. This was in line with the Standards for Nurse Staffing Adult Critical Care Consultation document (GPICS 2013).
- The National Competency Framework for Adult Critical Care Nurses (CC3N's 2013), was used to ensure staff were trained in becoming a competent and safe practitioner. The lecturer practitioner (LP) was in the process of renewing the 'critical care induction and clinical competences programme' for nurses incorporating the new step 1 competency guidance, as set by the critical care network 2015. The induction booklet contained clinical assessments and competencies for sign off as a competent critical care nurse. This pack included a unit orientation and a check list for induction. Steps 2 and 3 competency guidance had not been addressed or implemented.
- There was a new appraisal system in place, and staff were asked to be re-appraised even if done within 12 months so it could be reported on the new framework. The appraisal rate for November 2015 was low at 46%.
- Records showed some nurses and senior staff were not fully up to date with training on the existing critical care nurse's competence framework. Subjects included device training, blood administration, and intravenous updates.
- Junior doctors confirmed they received appropriate training and support at all times when working on the unit. At inspection we saw an junior doctor's handbook that was given to new starters. It contained all the information about the unit, plus contact phone numbers and an induction checklist at the back of the booklet.
- Junior doctors were able to attend weekly consultant teaching with the incoming consultant for that week. Teaching from tutors was protected, with e-portfolios monitored.
- There were no Ear, Nose and Throat (ENT) services on site . All tracheostomies performed in critical care were percutaneous. We were told consultant intensivists would be present for all procedures. Although doctors had been trained in the procedure, there was not a risk assessment to indicate how they would maintain their competency in performing the procedure. All tracheostomies were recorded in the trust operating record in line with NCEPOD guidance, "On the right Trach", June 2014. The lack of on-site ENT support meant any tracheostomies deemed as potentially difficult by the critical care consultant were transferred to another hospital.
- There was access to education and training such as the critical care nursing course, via the LP and the university.

An in-house course, 'principles of critical care' was accredited by the university. Four staff per year accessed this course and were given 100% study time to attend, with 50% for other courses.

- Some senior nursing staff had attended the history taking and physical assessment course and more junior staff were to undergo this training.
- The outreach team supported non-invasive ventilation within an 'acute lung unit' based on the respiratory ward. As part of this, they provided regular teaching sessions on non-invasive ventilation for ward staff.
- The LP told us they were working on the Nursing and Midwifery Council (NMC) revalidation requirement.

Multidisciplinary working

- Clinical staff in critical care did not work collaborate as much as they could as a multi-disciplinary team (MDT). Allied health care professionals such as the dieticians, pharmacists and physiotherapists did not attend ward rounds. The nurse in charge discussed patient issues with each professional on an individual basis. There were no formal meetings held with surgeons from other specialties
- There was an allocated pharmacist who provided support to the unit. There was 0.2 whole time equivalent (WTE) of pharmacy cover which was below Guidelines for the Provision of Intensive Care Services 2015 recommendations of 0.8 WTE. The pharmacists was able to review medications but was unable to attend the unit ward round.
- A clinical consultant microbiologist visited the ward every day to liaise with the medical staff, review the patients on antibiotics and make changes to treatment based on current microbiology results and the patient's condition.
- There were multiple junior medical handovers throughout the day and they did not involve the rest of the team, the nurse in charge or the consultant.
- Physiotherapists were attached to the unit and worked collaboratively with the nursing and medical staff. However the service was not following the recommendations for physiotherapy input in the Guidelines for the Provision of Intensive Care Services, 2015. There was limited physiotherapy cover, with one whole time equivalent (WTE) for the 12 bedded unit. The guidelines recommend one WTE physiotherapist to four level 3 beds. Physiotherapists did not attend the consultant led ward round for multi-disciplinary team working. They told us they prioritised critical care patients, and saw every patient each day, including weekends. However, they did not provide the recommended 45 minutes a day of rehabilitation, five days a week for each patient.
- There was good occupational therapy engagement, although they were not part of the MDT. 16 referrals were made by critical care in June 2015, and 24 in July, plus 10 patients were reviewed by therapy assistants.
- Dieticians and pharmacists attended the unit to review patients and provide advice, despite having stretched resources.
- Patients in critical care had access to the acute speech and language therapy (SALT) team that covered all the hospital. The team aimed to see all patients with swallowing problems within two days of referral, and patients with communication problems within five days of referral.
- Critical care staff reported delays in patients been assessed and receiving treatment from the tissue viability nurse.
- The minutes for the 'Trust Organ Donation Committee', dated September 2015 noted a change in trust policy to enable senior nurses to refer patients to NHS Blood and Transplant (NHSBT) rather than only consultants. This was hoped would speed up the process.
- The minutes recorded issues with NHSBT delay in response to referrals and attendance of Specialist Nurses in Organ Donation (SNOD) at the hospital. This appeared to be due to the SNODS covering a wide geographical area and not being located on site. The organ donation nurse was not employed by the trust, but worked with the unit. There was a low referral rate to the SNODs, and the clinical lead told us this was due to an elderly population. However, there was not effective multi-disciplinary working with the SNODS at point of withdrawing treatment of a patient. Data told us they were involved in only 16% of withdrawal of patient care discussion in critical care when the national network average was 30%. The meeting minutes recorded 'performing badly' on their collaborative approach to potential donor families for consent with the SNOD and consultant. This meant there could be a significant number of missed patient referrals.

Seven-day services

- The service had consultant intensivist presence on site and ward rounds seven days a week. Consultant

presence was from 8.30am to 5.30pm every weekday and 9am to 1pm at weekends. Out of hours, the on call intensivist was immediately available for telephone consultation and could access the hospital within 30 minutes
- A physiotherapy service was available 24 hours a day, with the service on call at night and the weekend. Staff said there was no delay in obtaining physiotherapy support and treatment for patients out of hours and at weekends.
- There were pharmacy and pathology services available seven days a week, with limited hours on Saturday and Sunday. An on call service was provided out of hours.
- Imaging (X-ray) services were available out of hours with a core team of staff on site 24 hours and an on call system overnight for CT.

Access to information

- Patient information and records were held at the patient's bedside so all staff had instant access to patient information.
- All staff had trust email accounts to access updates electronically.
- Communication files were kept for access to information.
- Staff meetings were held, during which information was cascaded and records were kept of these meetings for future reference.
- It was hard to locate critical care specific policies on the trust wide intranet as they were in different places and mostly out of date. This meant they were not easily accessible to staff or had up to date information.
- Medicines were administered in line with the trust's management of medicines policy and the Nursing and Midwifery Council guidelines. Nursing staff received training about the safe administration of medicines and only administered medicines after they had completed competency assessments. The medicines prescribing guidance document was out of date, and an electronic version was planned. This meant that clinical staff did not have quick access to up to date information on medicines
- Discharge and transfers were completed using both electronic written and verbal handovers.
- Patient transfer forms included a checklist that clinical staff used as an aid memoire to all risk assessments had been completed. The check list included clinical observations, medication and equipment checks.
- Discharge summaries were sent to the patient's General Practitioner (GP).

Consent and Mental Capacity Act (include Deprivation of Liberty Safeguards if appropriate)

- Staff were aware of the need to seek permission where possible from patients prior to providing any care or treatment. We observed informal verbal consent being obtained from conscious patients prior to provision of care.
- Appropriately completed consent forms were seen in critical care including consent for invasive clinical procedures such as tracheostomies. Patient records indicated consent was obtained prior to care and treatment being provided. This was confirmed in conversation we had with patients who could speak with us.
- Staff had an effective understanding of the Mental Capacity Act 2005. However, there was some uncertainty amongst staff about how Deprivation of Liberty Safeguards (DoLS) impacted on the treatment of patients in the critical care setting.
- There was trust guidance for staff on DoLS applications. We saw a one page handout containing a flow chart with processes on when there was a need to make an application and whom to contact for advice. The form was clear and concise, providing good information to staff on the DoLS pathway.
- DoLS assessment forms were visible, however the unit had not needed to complete any referrals so we could not evidence these were completed correctly and in a timely way.
- Staff reported that they would use Mitts to restrain patients if necessary. We were made aware following our inspection there was an in-date policy available on the unit, and staff were trained on how to use the Mitts and perform frequent checks on the patient's skin.
- A critical care complaint occurred in March 2015 relating to the recording of 'do not attempt cardio-pulmonary resuscitation' (DNACPR) in a patient's notes, without having discussed it with the patient first.

Critical care

Are critical care services caring?

Good

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

We rated caring as good.

- Staff were caring and provided compassionate patient centred care.
- Patients were treated with dignity and respect, staff tried to anticipate their needs and to enhance their experience on the unit. This caring approach promoted their recovery, and helped in their emotional well-being.
- Patients and relatives gave positive feedback about the care they received and confirmed they had been informed and involved in the decision making regarding care and treatment.
- Patient and family emotional needs were highly valued by staff and were embedded in their care and treatment. Staff offered ongoing emotional and psychological support to bereaved families.

Compassionate care

- We saw compassionate and empathetic care delivered to all patients on the unit.
- Patients were complimentary about the care and support they received. They were also positive about the staff approach to promoting their dignity. For example, a patient in the high dependency unit (HDU) we spoke with told us staff were attentive and caring to them and their relatives.
- We observed staff speaking to patients and their relatives in a caring and compassionate manner, providing reassurance and support.
- Patients said nurses took the time to wash their hair and listen to their anxieties. One patient said the care was faultless and gave an example of their hair being stroked to show how caring they were.
- We observed a patient sitting out of bed in a chair and looking out of the window. This demonstrated the nurses were considerate to the patient, aiming to improve their experience whilst in hospital.
- At the unannounced inspection we saw a HDU patient being escorted outside to the hospital grounds to visit the lake and get some fresh air.
- We observed staff supporting patients to eat in a sensitive manner. Patients, where able, sat out or sat up in bed to have their meals.
- Satisfaction surveys were used to seek the views of patients and their relatives about the care and support they received whilst in the critical care setting. The surveys consistently demonstrated a high degree of satisfaction from patients and their relatives. The critical care patient survey results from July to September 2015 reported patient experience cards as saying the unit was, 'an excellent and friendly department' and the staff were 'helpful, caring, friendly and professional'.
- There were also many thank you cards and compliments from patients and their relatives on display, although some of these were three years out of date.
- The NHS Friends and Family Test (FFT) results were 88% positive in May 2015 and 100% from June to August 2015 of patients saying they were 'extremely likely' to recommend critical care to friends and family if they needed similar care and treatment. Words were used to describe the staff as, caring, friendly and professional, as well as 'giving the best possible care'. Relatives said 'nothing was too much trouble' and one spoke about 'maintaining our father's dignity and preserved his personality until the end'. The responses for the FFT were lower than expected. The reasons for these were noted as most patients were transferred to another ward before going home and critical care results were often integrated with the cardiac care unit (CCU), and these could not be separated.

Understanding and involvement of patients and those close to them

- Patients, who we were able to have conversations with felt they were well informed and involved in the decision making process regarding their treatment.
- Relatives felt they were fully informed about their family member's treatment and care. They said staff checked whether they wanted to be contacted over night with any changes in their family member's condition and their wishes regarding this were respected.
- Both patients and their relatives commented that information was discussed in a manner they understood. They said there was always a member of

staff available to help them understand the explanations. Relatives said staff explained everything to the patient, even though their understanding might be limited or not known.
- We observed staff explaining to patients and their relatives the care and treatment that was being provided, in order to reduce any anxiety. Patients and relatives told us that staff on the unit were very supportive, and explanations about equipment and what was happening helped to reduce their anxiety.
- The nurses and doctors had good communication with patients. Patients told us staff planned for their discharge since being transferred from critical care to HDU, and their relatives were involved.
- Records of conversations were detailed on patient records. This meant staff always knew what explanations had been provided and reduced the risk of confusing or conflicting information being given to relatives and patients.
- A patient told us they and their family had been kept informed of issues with their health and the course of action. Another patient also told us their family was involved in their care.
- Patient survey results from July to September 2015 for critical care showed that 100% of patients were involved in decisions about their care and treatment.
- At inspection we noticed not all staff were wearing trust identification or badges stating their name and job role.

Emotional support

- Breaking bad news was always undertaken with a consultant intensivist, a member of the nursing team and other members of staff as appropriate. This meant there were staff who were known to the relatives and available during the breaking of news to provide emotional support.
- For patients whose medical condition meant there was an unlikely recovery from their illness, their families and / or friends were fully involved in decisions to withdraw treatment and commence palliative care. We saw that when possible, to support families in their grieving process, withdrawing treatment or ventilator support was delayed until the patients full family was able to visit and be with the patient during this process.
- Staff said emotional support for patients and their families was available from the trust chaplaincy team who provided support for patients of all faiths and those who did not have a faith.
- Relatives expressed they felt they were getting good support from all staff working in the unit.
- Patients who were able to speak with us expressed their gratitude about the emotional and practical support staff had provided to their relatives.
- A patient in HDU told us they were happy that staff introduced themselves and explained clinical aspects of their care, including limitations in treatment and reasons why.
- Staff said they always explained to patients and relatives that they could contact the unit at any time to discuss their critical care experience and ask any questions about their care and treatment. If required, appointments were made for the patient to return to the unit post discharge to discuss this.
- Staff spoke about how the specialist organ donation nurse provided support and relevant training to equip them with skills to provide emotional and practical support to relatives of patients of differing faiths who were considering organ donation.
- The patient survey for critical care from July to September 2015 showed that 100% of patients were able to talk to staff about their worries or fears. It also said that 100% of patients felt they were given enough privacy when discussing their condition or treatment.
- Patient's family and friends were offered a follow up appointment with the clinical team to discuss events around their loved ones death, as needed. This was available up to 12 months after the death so that they had time to grieve. They were then able to ask questions once they were ready, and find closure in understanding what happened to their loved one.

Are critical care services responsive?

Requires improvement

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

We rated responsive as 'requires improvement'.

- There was a higher than average number of delayed discharges, due to the lack of beds available across the hospital. This resulted in mixed sex breaches, sometimes across several days.
- Future planning for the critical care unit at the hospital was awaiting the outcome of a Dorset wide of clinical

services. The design of the current critical care unit although adequate, did not fully meet the needs of patients. The hospital was built before the current building regulations. The position of the entrance to the unit meant that sedated and intubated patients were transferred through the cardiac waiting area, although some were admitted via a different route from theatres.

- Follow-up clinics after discharge from hospital are recommended by the National Institute for Health and Care Excellence (NICE) for patients' ongoing treatment and emotional and psychological support. There were no rehabilitation follow-up clinics for patients at the hospital, a business case had been submitted and staff provided informal follow up in the interim
- There were low rates of surgery cancellation due to lack of critical care beds. Plans were being developed to ensure better coordination by the theatre staff to maximise critical care bed availability.
- There was limited information available to patients and relatives to take away and the information was not available in accessible formats or languages other than English.

However,

- There was adequate provision for bariatric patients and equipment was readily available for these patients within the trust.
- The service was performing better than similar comparable units in avoiding out of hours discharges.
- Access to critical care beds within four hours was similar to comparable units.
- There were low rates of surgery cancellation due to lack of critical care beds. Plans were being developed to ensure better coordination by the theatre staff to maximise critical care bed availability
- Clinical staff knew how to access information to support them in meeting the needs of patients with a learning disability or living with dementia. They demonstrated an understanding of adjustments that could be made to support patients. This included enabling family members and/or carers to stay to support the patient during their stay on the unit.
- Staff understood how to manage complaints and there was evidence of learning from concerns and complaints.

Service planning and delivery to meet the needs of local people

- The Dorset Clinical Commissioning Group's (CCG) had commissioned a Dorset wide review of clinical services. This was reviewing options for acute and emergency care for the population across the county. The clinical director expressed their wish to be the major acute hospital in Dorset for critical care within the next two to five years. Future service planning was awaiting the outcome of the service review.
- NICE CG 83 guidance which details patients discharged from critical care settings should have access to a critical care follow-up clinic. There was no critical care rehabilitation follow up service for patients at the hospital although this was under review. A business plan had been submitted, awaiting review. Although there was no formal opportunity for patients to be invited to return following discharge, patients or relatives were encouraged to make an appointment to see staff on the unit to provide support once they had been discharged from hospital. This service was also offered to family and friends up to 12 months after the death so they had time to grieve.
- The trust had identified issues around delays in the discharge of patients from critical care for patients returning to specialty-based wards. We were told there was ongoing work to mitigate this.
- A home ventilation service was available which linked in with respiratory physicians and managed from Addenbrooke's hospital, the Lane Fox unit at St. Thomas' hospital and the Royal Brompton Hospital.

Meeting people's individual needs

- The entrance to the critical care unit was through the cardiology out-patients clinic where patients waited for cardiac echocardiography during the day. This meant patient's waiting for appointments watched sedated and intubated patients being taken to and from the critical care unit.
- There was no visible receptionist to greet visiting relatives or visitors to critical care, however, a ward clerk and secretary where based in the unit itself and provided cover in office hours.
- The waiting room outside the critical care unit was small and unwelcoming. This was in the corridor outside the

unit. It did not provide a water fountain or vending machine. It was plainly decorated and there were no comfortable chairs. There were no facilities for visiting children with no toys and books.

- Staff told us space was sufficient in the unit so bariatric patients were accommodated in standard bed spaces with no need to close a neighbouring bed. However, the measurements did not comply with the critical care unit new build requirements, which meant space would be restricted. Hoists were available for moving and handling bariatric patients, and guidelines were available on the trust wide intranet.
- A relatives room was available for private and sensitive conversations with doctors and nurses, adjacent to the unit.
- The nearest public toilets were located some distance away in the downstairs atrium by the main entrance to the hospital, or by the canteen also located on the ground floor. We were told by staff that visitors could use neighbouring toilets close to the unit, but this information was not known to all relatives or visitors to the unit. This issue had been identified on FFT cards, with two feedback comments in August and September 2015 saying nearby public toilets were in need.
- Information about the critical care services was available on the trust website. However, the information was brief and not easily accessible to people who had difficulties with reading written literature. There was no process to change the background colour for people who had dyslexia and to translate the information. This meant that some people might not be able to fully access the information.
- Information leaflets and posters in the unit were not accessible in formats other than written English. We saw no offer of information in braille or large print. No information was seen in other languages, or offer of translation services. Staff told us there was 24 hour access to translation services.
- There was limited information available on support services for relatives in the critical care waiting room. There was information displayed on the walls, but no paper copies for visitors to take away with them. There was no information on chaplaincy services and spiritual support, but leaflets on organ donation and religious beliefs were displayed. Some of the spiritual information was small and hard to read. There was no information on translation services
- There was one copy of the critical care steps book available on a coffee table. This was a relative information booklet that explained the process for patients in the critical care unit.
- There was a television screen outside the unit showing a range of information including visiting times. The visiting times on display listed access as 24 hours and 2pm – 8pm; this related to the critical care and high dependency unit although it was not clear which related to each one. The information was displayed on a rolling screen and not full screen display which made it difficult to read the information.
- There was accommodation available for relatives visiting patients in critical care, and a two bedroom flat available in a nearby block which was shared with the oncology department.
- There were information files with support and advice for staff when treating and caring for patients who had a learning disability or were living with dementia. Staff demonstrated an understanding of adjustments that could be made to support patients. This included enabling family members and/or carers to stay to support the patient during their stay on the unit. Staff knew there were nurse specialists they could contact if they needed advice and support.
- There was trust wide dementia form that stated it must be completed to all patients over the age of 75 years old. It asked questions about the patient's cognitive abilities and went on to give an option for referral to the General Practitioner (GP), a psychiatrist, a dementia nurse specialist or other healthcare professionals. A band 5 nurse was a 'dementia' champion in critical care.
- Level 1 patients who were waiting for ward beds were encouraged to be as independent as possible, for example being enabled to wash independently and wearing own clothes where possible.

Access and flow

- ICNARC data showed the unit was similar in performance with regard to patients being admitted to critical care within the four hour target time.
- The medical team in critical care aimed to keep one level three bed available for emergencies, but there were pressures from the theatres department not to cancel operations, so the beds tended to get allocated and booked.

- Cancellation of surgery due to lack of critical care beds was infrequent. Records showed that the between 3 March 2015 to 16 October 2015 there were 11 cancellations of planned surgery due to the lack of critical care beds available.
- There was forward planning of elective surgical HDU requirements across the working week between theatres and critical care and work was underway to ensure better co-ordination by the surgeons and theatres to maximise the effective use of HDU beds.
- During the inspection a planned major surgical operation was unable to start on time. The critical care unit was full and the consultant was not available to make decisions about whether patients were able to be discharged to make space for planned post-operative patients. However, we were informed post-inspection that this was rare and we noted that the rate of cancelled surgery was lower than for comparable units.
- ICNARC data showed 60% of patients waited over four hours to be discharged once identified. This was higher than average.
- We saw three patients in the unit who were deemed safe and ready to be transferred to a ward bed, but were still in the unit due to the lack of beds available in the hospital. The decision had been made three days prior to our visit, and this situation resulted in mixed sex breaches. For example, a vulnerable female patient, with mental health needs had a delayed discharge although a mental health assessment had been completed. The patient was awake and was accommodated in close proximity to a male patient. This was recorded as a mixed sex breach.
- Nationally agreed standards for critical care detail patients should not be discharged out of hours for safety reasons and because patients perceive it as extremely unpleasant being moved from critical care areas to a general ward outside of normal working hours. ICNARC data showed discharges occurring out of hours (between 10pm and 7am) were lower to those of similar intensive care units in the country. 7% of discharges were out of hours, which was lower than the national average.
- The outreach team followed up critical care discharges within four hours of them leaving the unit.
- Occasionally, patients were discharged home directly from the unit. For some patients this was assessed as being the appropriate pathway. Processes were in place and followed to ensure patients were discharged home safely with the appropriate support and follow up where necessary.
- A fast track pilot system was being piloted where sick patients with a good prognosis were given critical care support for 24 hours only, on the understanding the patient would have a guaranteed bed saved on a ward for discharge the following day. Consultants identified suitable patients as part of the admission process. It was a six week trial that was in progress at the time of our inspection and the results and outcomes had not been analysed or interpreted. However, the medical director told us that early results showed most patients were not well enough to go to a ward after 24 hours, so remained in critical care.

Learning from complaints and concerns

- There were no Patient Advisory Liaison Service (PALS) or complaints leaflets on display in the waiting room.
- Patients and relatives said they would voice concerns or complaints directly to the nurse in charge of the shift or the nurse caring for them.
- Staff understood the hospital's complaints policy and knew how to manage any complaints they received. They all said they would try to resolve any concerns or complaint's that a patient might have before it escalated into a formal complaint.
- The clinical director gave us an example of a complaint that went through a legal team following a patient's death. Learning from this complaint resulted in the practice of appointments being offered with the consultant and nurse in charge. This would take place after a patient's death with representatives and family of the patient, in order to clarify any questions or queries about the patient's care and treatment.
- A complaint for critical care was received in April 2015 and the final response was completed in May 2015. It related to the recording of 'Do not attempt cardio-pulmonary resuscitation' (DNACPR) in a patient's notes, without having discussed it with the patient first. The patient themselves made the complaint via PALS. We were told the DNACPR discussion had occurred, which was documented in the patient's medical notes and that the decision had been discussed with the patient first. The matron sent an appropriate, professional reply within a suitable time frame.

- We saw a response letter from the modern matron to a patient's relatives complaining about poor clinical practice dated January 2015. This demonstrated the complaint was dealt with sensitively and provided explanations to the complainant.

Are critical care services well-led?

Good

By well led, we mean that the leadership, management and governance of the organisation assures the delivery of high-quality person-centred care

We rated this well led as 'requires improvement.'

- The vision and strategy for critical care services was to a large degree contingent on the outcome of the Dorset wide clinical services review. However, staff were positive about the possibility of extending the size and remit or the critical care service if the hospital became a major emergency centre.
- Governance processes promoted reviews of the service quality and identified areas for improvement.
- Staff were positive about the local leadership and the trust management focus on improving the hospital's culture.
- There was evidence of innovation and three research nurses undertook trials which aimed to improve patients care and outcomes. The critical care unit had won an award for developing a patient transfer course which was attended by allied healthcare professionals involved in caring for critically ill patients.

However,

- Some staff reported a strong consultant centred hierarchical culture on the unit and this was limiting delegation and multi-disciplinary team working
- Formal patient feedback was only provided through the family and friends test and this was limited to patients discharged from the unit and not those discharged to wards or transferred.

Vision and strategy for this service

- The clinical director for anaesthesia and critical care told us they felt the future strategy had faltered since the plans for merger with the neighbouring acute trust had stopped. They explained there would have been many benefits in merging both critical care units with a bed configuration of 30 and a workforce across two sites.
- The vision and strategy for critical care at the hospital, focused on the outcome of the Dorset wide clinical services review due in 2016. The Clinical Commissioning Group's (CCG) plan was to centralise acute care. The clinical director expressed their wish to be the major acute hospital in Dorset for critical care within the next two to five years. The trust strategy included high level plans for the two possible outcomes of the review; in the interim some developments in critical care were prevented or delayed. A larger critical care unit would be developed on the main emergency care site and there would be integration of existing teams working at Poole Hospital and the trust. Should the CCG decide to site the main emergency centre at the trust then there would need to be investment to expand facilities for the management of paediatric surgical emergencies, and the current out-of-hours provision will need to be strengthened to meet the increased acute work that will flow to the emergency centre. The trust would relocate critical care facilities to the Poole Hospital if it were to provide an elective surgical services as the planned care site.
- The service leads told us the trust had shifted from financial stability to being overspent due to investment in staff recruitment and safer staffing.
- Staff were positive about the possibility of extending the size and remit or the critical care service if the hospital became a major emergency centre. The trust had also increased staffing establishment within critical care services

Governance, risk management and quality measurement

- The clinical leads and deputy clinical leads attended monthly meetings. Records of these meetings which covered, operational and performance, education and human resources as well as quality and risk and governance were considered at this meeting. These included representation from medical, nursing and other allied healthcare professionals (AHPs). Information was then disseminated to the critical care staff. There were also quarterly clinical delivery group

meeting attended senior medical and nursing and managers, including staff from emergency care. Clinical audit and morbidity and mortality meetings were not multi-disciplinary and were attended by medical staff.

- Monthly dashboards demonstrated quality issues such as the prevalence of pressure ulcers, compliance with venous thromboembolism (VTE) assessments, delayed and out of hour's discharges, and compliance with hand hygiene practices.
- There was a separate risk register for critical care, there were four items listed as of the 21 August 2015. The first item was lack of compliance with NICE CG83, which was rehabilitation assessment within 24 hours and rehabilitation prescription on discharge. The risk register recorded there was a business case in progress and for follow up in August 2015, but we saw no update on this. This was placed as a low risk and no date was listed on when this entry was made.
- The second entry was listed as a risk to critical care capacity due to delayed discharges. The plan listed was to discuss high dependency beds on wards for vascular patients at meetings, but again no update was noted nor the date when it was entered. The lack of critical care pharmacy provision was also a listed item and graded as low risk, but again a note said a business case was in progress but no further information was listed.
- The lack of supernumerary coordinator on night shifts was the fourth item listed plus the lack of a 'runner' when over ten beds capacity. This was possibly due to their short term staffing issues. Records stated a business case was planned but again no further update since 21 August, only that it was 'in progress' as the other items listed.
- Risks identified from inspection, for example, with equipment and the environment were not recorded on the risk register.
- Clinical checklists had not gone through a governance process and been ratified, or processes reviewed. Documents did not contain version, author names or dates.

Leadership of service

- The critical care unit sat under care group A of the trust. There was a clinical director for theatres, anaesthesia and critical care. One of the consultant intensivists was the clinical director for critical care, and had overall responsibility for the provision of critical care services. The modern matron managed the critical care nursing staff and outreach team. A head of nursing and divisional manager overarched the nursing and medical team, and clinical leads reported a good working relationship with them.
- All staff spoke highly of the leadership of the unit and felt they had confidence in the leaders. Junior doctors told us senior staff were approachable and responsive, and they had good support from consultants.
- The directorate manager told us they had started providing 1:1 meetings with senior staff which were supportive. The clinical director told us they felt listened to when raising concerns to the board.
- Staff we spoke with at the time of our inspection reported that divisional managers, heads of nursing, and board members were not visible on the unit. However, we were made aware post inspection that they do visit the unit, and due to part-time staff being employed, they may have not encountered them on their working days.

Culture within the service

- Some staff told us that there was a hierarchical culture with consultant staff. There was a lack of delegated responsibility to other staff and effective multi-disciplinary team working.
- Nurses we spoke with were happy to work in critical care, saying they felt proud and part of a supportive team. We heard communication was good and they were informed of updates. Training was available with protected time allocated and they had the ability to visit another unit for a learning experience. However, a clinical lead told us they felt morale was low due to the staff being busy, with colleagues off work for various reasons.
- There was not an effective relationship with the Specialist Nurses in Organ Donation (SNODs). The clinical director stated they did not have a joint approach to managing patients for potential organ donation, and the communication needed improving.
- Staff felt the new care group structure had improved communication. We were told the trust was working on changing its culture since the feedback from the last inspection. The clinical leads told us the trust were focusing more on governance now and restructuring roles so information was disseminated effectively. It was

seen as a positive move to go from directorate to care groups. The service leads discussed the pros and cons of having a long standing Chief Executive Officer (CEO) running the trust, and they found the CEO supportive.

Public engagement

- Patient and family feedback was obtained by the use of the Friends and Family test cards, along with satisfaction surveys. Patients and relatives also sent in cards and letters showing appreciation of the care they received.
- Relatives were offered feedback appointments in order for them to come back and see a consultant following the death of their relative or friend.

Staff engagement

- Information was shared with the critical care team in the staff rest room and at team meetings.
- The Critical Care Unit had a 'What's App' information group in existence to advise all staff of the regular Unit teaching sessions and to aid cascade of critical care information, articles & research initiatives.
- An electronic communication tool was being launched in order to inform staff of hospital wide news as well as directorate specific information.

Innovation, improvement and sustainability

- The unit had a local quality improvement programme and projects were underway underway which would bring them in line with other critical care units of a similar size and skill mix. The unit used patient diaries and had a booklet children's booklet on visiting critical care. They were developing electronic records of all critical care referrals for local quality audit and feedback.
- In 2013, a patient transfer course which was run and managed by Bournemouth critical care unit won the Health Education Wessex Award for innovation in education at the intensive care society, 'state of the art' meeting. This was a multi-disciplinary course involving nurses, doctors and paramedics, using simulation training to give learners a real life experience on transferring critically unwell patients. It was a full day training, which was also presented at the British Association of Critical Care Nurses (BACCN) Conference in London in September 2015.
- The unit employed three research nurses who were funded by the National Institute for Health Research to carry out research activities. These were mainly ex-critical care unit nurses. The critical care research nurses undertook critical care specific trials and research as well as commercial trials from medical device or pharmaceutical companies. These included 'target temperature management', SPICE (Study of Protease inhibitor combination in Europe - sedation in ventilated patients) and completed projects on ProMISE and EuSOS (European surgical outcomes study – mortality after surgery. The next pending trial at the time of our inspection was on changing sedation protocols and had a worldwide participation with delegates from Australia and other countries. Only two trials at any one time were undertaken due to the work involved and possible impact for patients and staff
- The service leads told us they did not have a specific cost improvement programme for critical care, but were looking to make savings on drugs, including stores and stock levels.

Maternity and gynaecology

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

Information about the service

The maternity service provided by the Royal Bournemouth Hospital comprises of a three bedded, midwife led, birth centre, a community team for vulnerable women based in a GP surgery and community midwives. The birth centre had delivered 301 babies from April 2014 – March 2015, and there were 71 homebirths under the care of the community team.

There are dedicated midwives for the birth centre. In order to provide continuity of care the community midwives will attend the birth centre and it is also normal practice to ask community midwives to attend to act as a second midwife if there are two labouring women.

There is also an antenatal service that is provided by consultants at the Royal Bournemouth Hospital. Women assessed as having a high risk of complications during pregnancy are referred to Poole Hospital NHS Trust, even if their antenatal care is provided at The Royal Bournemouth Hospital.

The gynaecology service provides inpatient surgical treatment and outpatient consultations. Patients who were admitted to hospital were cared for on the urogynaecology ward 15, or the day surgical unit. Surgical termination of pregnancy was also performed by this service. Consultants were accessible to staff in the event of a patient deteriorating.

During the inspection we spoke with nine patients, 19 members of staff and three relatives. We also reviewed six sets of patient records.

Summary of findings

Maternity and gynaecology required improvement in the effectiveness and leadership of the service. The service was good for safety, caring and responsive.

Incidents were reported by staff, and these were investigated appropriately. However, learning from incidents was shared locally and not more widely. There were attempts to ensure governance processes were carried out robustly. However, the sharing of patients with Poole Hospital made this complex, it was not always clear who owned the actions around quality and risk from governance meetings.

There were appropriate numbers of appropriately trained staff on the maternity unit and gynaecology service. There was a high midwife to birth ratio in the maternity service. This was due to a higher proportion of women receiving antenatal and postnatal care compared with actual births at the trust.

The storage and management of medicines was mostly good. However, medicines that required to be stored in a refrigerator were not stored consistently at the correct temperature.

There was no up-to-date protocol to remove a collapsed woman from a birthing pool in the event of unforeseen complications during labour or birth.

Maternity and gynaecology

Staff participated in mandatory training, but the completion of some courses was low against the trust target. Good infection control and prevention measures were seen. Action was taken when audits showed that hand hygiene was not satisfactory at the birth centre.

The service provided a caring and supportive environment for women in pregnancy and those undergoing gynaecological surgery. Women were happy with the care they received from the services and this was consistently demonstrated by patient feedback.

The service did not collect outcomes from patients to allow them to monitor progress against targets and ensure that the service was providing effective care and treatment. There was a clinical dashboard for maternity that gave staff and patients information about performance against quality indicators for obstetrics. Although there was a programme of audits in place, no results from them were available. . The service was not collating sufficient assurance that evidence based care was being provided.

The service was responsive to the needs of women with access to the midwife led birth unit available across 24 hours. Community midwives provided antenatal care and support in GP surgeries and in children's centres. Community midwives were able to support women with a low risk of complications, to give birth at home if that was the woman's wish. Midwives provided effective coordination of a woman's care through pregnancy, birth and the post-natal period. There was a designated team of midwives to support women that were vulnerable.

Appointments for investigations required in gynaecology were available at times to suit patients. There was emotional support available for women and their families.

The trust had identified that there were potential risk associated with the changes to leadership for maternity service.

Are maternity and gynaecology services safe?

Good

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

We rated safe as good

- Staff reported incidents.
- Medicines were mostly stored and managed correctly in the birth centre.
- The birth unit, the gynaecology ward and day surgical wards were clean and well maintained. Infection control procedures were followed although there were variable results from hand hygiene audits in the birth centre.
- Midwives on the birth unit received training on children's safeguarding, and were aware of the issues that would affect mothers. There was a dedicated team that provided care for women assessed as being vulnerable. Midwives received a rolling programme of training in obstetric emergencies; this was provided in partnership with Poole Hospital.
- Comprehensive risk assessment was carried out when women were booked (their first appointment with a midwife). This was in place to ensure that only women assessed as having a low risk of complications in labour or birth would be suitable to have their baby at the birth centre. Women identified as having risks of complications in pregnancy or birth would be cared for jointly with midwives and doctors. It would be recommended that these women gave birth at Poole Hospital.
- Risk assessments were carried out and recorded for patients in gynaecology. We observed good use of the world health organisation (WHO) surgical safety checklist although this had not been audited by the trust.
- Tools to detect deterioration in patients were in use in the gynaecology ward. Patient observations were recorded using an electronic system that helped nurses to identify patients that may require review by doctors. A similar system that was on paper was in use by midwives with women in labour. This system was designed specifically for use with women in labour.

- There was appropriate and timely access to patient records that were stored securely
- There were adequate numbers of appropriately trained and supervised midwives in the maternity service. There was adequate nursing staff on the gynaecology ward.
- There were adequate numbers of medical staff on the gynaecology ward. There was appropriate emergency cover for gynaecology patients

However,

- Guidelines for the use of a birthing pool in labour and birth were not up-to-date. Staff were not confident in describing how the evacuation of a collapsed woman from a pool would be managed. Although emergency equipment was provided, there was no written protocol for the staff to refer to.
- Staff did not consistently received information or learning from incidents unless they had been involved in the incident or investigation. One action plan following an incidents was signed off before it was completed.
- Checks on the refrigerator needed to ensure that medicines were stored at the correct temperature. There was also an out of date patient group direction for a vaccine.
- Staff compliance with mandatory training was low against the trust target.

Incidents

- Incidents were reported on the trust wide electronic reporting system. All grades of staff we spoke with were aware of how to report incidents. Reported incidents were graded in severity by the reporter, the head of midwifery and risk lead then decided if a root cause analysis (RCA) was required. After the RCA was completed and reviewed, learning was shared across the department. However, this was inconsistent. We saw two examples of RCAs that had been well completed, with action plans. One RCA action plan we reviewed, had been signed off as completed. This was for women to be able to access written information about foetal movements in a variety of languages. When we asked staff at the birth centre if we could see the leaflets, we found they were not available.
- The maternity service had had three serious incidents from May 2014 – April 2015, this included two intrauterine deaths. These incidents had been investigated to ensure that any learning from them was shared. However, midwives told us that unless they were involved in a reported incident they could not confidently say that they would be informed about the issue.
- Mortality and morbidity meetings were facilitated at Poole Hospital NHS Trust as this was where women with high risk pregnancies were delivered. The meetings were attended by obstetric consultants from The Royal Bournemouth Hospital that provided antenatal care. The head of midwifery was not invited to attend these meetings.
- Midwives and maternity care assistants were aware of their responsibilities under the Duty of Candour.

Safety thermometer

- Maternity safety thermometer data was collected by the service, but this was not displayed in the birth centre. There was confusion about what figures to display as the care of women with pregnancies at high risk of complications were shared with Poole.

Cleanliness, infection control and hygiene

- Two rooms in the birth centre were equipped with birthing pools, these were visibly clean. There was a protocol for the cleaning of these after use. Trust policy on infection control procedures for cleaning the birthing rooms and pools was followed. The facilities at the birth centre were visibly clean. There was a weekly walk around led by the housekeeping team to identify any issues with the cleanliness of the environment.
- Monthly audits for hand hygiene were carried out in the birth centre and ward 15 (gynaecology), this was led by the infection control team. Results of audits were shared with the department. In the months January to June 2015 the birth centre had variable results between 60-100%. Staff had undertaken actions to improve this, as indicated by the 100% score on the most recent audit. Ward 15 achieved results between 90-100% over the same period. These results were displayed on the ward.
- On our inspection we observed good hand hygiene and use of gloves and aprons on ward 15 and the birth centre.
- At the birth centre MRSA screening was not completed for pregnant women unless they had previously had a colonisation or had been a hospital in-patient within the previous year. This was in line with hospital policy.

Maternity and gynaecology

Environment and equipment

- Resuscitation equipment for babies was available in both main birthing rooms. This equipment was clean and was checked daily to a checklist attached to the unit.
- There was adult resuscitation equipment that was checked daily, in the birth centre.
- Cardiotocograph (CTG) equipment was available for use in the birth centre to monitor the baby during labour. Midwives were given training on the interpretation of CTG data.
- There was appropriate equipment in the rooms for monitoring women in labour and during birth.
- Equipment was maintained regularly and was PAT tested annually.
- In order to ensure the security of the building, there was CCTV on all exits to the birth centre. There was also controlled access to the building via an intercom system, as the building was staffed 24 hours a day. For the security of new-born babies, they were tagged by midwives around the ankle. If an attempt was made to remove a baby from the unit an alarm would sound to alert the staff.

Medicines

- Medicines were stored securely in the birth centre. This included controlled medicines for strong pain relief. There was a daily reconciliation of controlled medicines.
- A medical gas used for pain relief (Entonox) in labour was piped to the birthing rooms. There was the appropriate equipment available to administer this to women in labour located in each room. Entonox for women having a baby at home was stored appropriately in the birth centre and community midwives had access to this across 24 hours.
- The medicines refrigerator was checked daily and the temperature recorded. However, on inspection we found the refrigerator temperature had been dropping too low for the medicines stored within it. Maximum and minimum temperatures were not being checked daily. This was highlighted to the midwife in charge of the unit. The refrigerator and all of the medicines stored were replaced immediately during the inspection.
- There was no procedure to follow if the refrigerator was found to be out of range of temperature.
- We checked medicines stored on the unit and found all were within date.
- There was a patient group direction for the administration of a vaccine, however this was found to be out of date. This was raised with the head of midwifery during the inspection to ensure it was updated.

Records

- Women in the maternity unit had their records stored using various systems. At booking appointment, a woman in early pregnancy would be given a set of records that she kept, and brought to her appointments. These were also used by community midwives at home or in clinics. The trust electronic record was also used and this was kept secure with passwords. The notes held by the woman herself had copies of laboratory results as well as documentation on the progression of the pregnancy. These notes also contained information on pregnancy and birth for the woman. The maternity record pack was used across both The Royal Bournemouth and Poole Hospitals.
- In gynaecology the patients records where kept using the electronic system, as well as some paper records and paper medical notes. Paper records contained risk assessments for falls, catheter infection, pressure ulcers and thrombo-venous embolism (blood clots that may form in the legs after surgery). We reviewed two gynaecology patients' records and these were fully completed to a high standard.
- Patient observations were also recorded on networked hand held devices. This highlighted to staff when patients needed their observations recording, and advised staff on the frequency. If the observations were abnormal the system would flag this in case it needed escalation to the medical team.
- We observed good use of a 'this is me' document for a patient living with dementia on the gynaecology ward. This helped to ensure that the patient's needs and preferences were taken into consideration, where she may not be able to explain them to staff.
- Patients' observations were recorded on an electronic recording system that helped staff to detect deterioration.
- Women attending the early pregnancy unit were provided with a copy of their ultrasound scan and a plan of care if this was their wish. Scans were reviewed remotely using a secure system by staff at Poole Hospital.

Maternity and gynaecology

Safeguarding

- Staff were aware of their responsibilities for safeguarding children and adults. Midwives attended level 3 children's safeguarding training. Midwives participation in level 3 children's safeguarding was 78% against a target of 100%. There was an awareness of specific aspects of safeguarding among midwives for example; domestic abuse and female genital mutilation.
- The "Sunshine Team" was a group of midwives that women would be referred to if there were any safeguarding concerns about them. This included women that were vulnerable, or had previously had children removed by social services.
- All women with active or previous concerns regarding adult or children's safeguarding would be referred to the Sunshine team.

Mandatory training

- Midwives attended trust mandatory training that included conflict resolution, equality and diversity, falls ,fire, medicines management and infection control. The trusts' own data showed there was low participation in fire (49%) and information governance (47%) training against the trust target of 100%.
- Staff told us that they were able to access their trust mandatory training, as well as midwifery specific mandatory training.
- All midwives were required to attend multidisciplinary training in obstetric emergencies (PROMT training) that was delivered at Poole Hospital NHS Trust. A rolling programme of training had recently been implemented in partnership with Poole.
- All midwives had received mandatory training in the resuscitation of babies. This was part of their essential competencies as registered midwives.

Assessing and responding to patient risk

- Guidelines for the use of the birthing pools to help manage pain during labour were not up-to-date. The trust's Water in Labour and Birth maternity guideline (August 2013) states that in the event of a maternal fit or collapse a hoist will be available to remove the woman from the water. However, there was no hoist in the birth centre, as this guideline was written before the service moved to new premises in November 2014. To mitigate this risk there was a sheet designed to assist in the removal a collapsed woman from the pool located in each room. Staff at the birth centre were not confident in describing to us the procedures for the use of this equipment. Not all staff had received training in the use of this equipment. There was no written protocol that described to staff how to remove a woman from the birthing pool in an emergency. However, detailed risk assessments were completed on booking (the pregnant woman's first contact with the midwife) to ensure that only women with a low risk of complications were offered birth at the midwife led unit.
- There had not been any incidents reported of emergencies occurring in the pools at the birth centre.
- At the booking appointment any risks to the woman or the unborn child were identified, a referral to an obstetrician was made by the midwife. At their first appointment the obstetrician would discuss the options for the place of birth.
- Women with high risk pregnancies could see community midwives, but would also attend consultant appointments at The Royal Bournemouth and Poole Hospitals. Women were made aware that labour and birth at the birth centre was only recommended for those with low risk of complications.
- The birth centre is a midwife led unit for women that are at low risk of complications in pregnancy and birth. If any complications occurred the woman would be transferred immediately to Poole Hospital. Antenatal screening was provided for mothers' at the Royal Bournemouth Hospital.
- All surgical patients and pregnant women were assessed for their risk of venous thromboembolism. Pregnant women were also screened for their risk of bleeding. If a high risk of VTE or bleeding was found the woman would be referred to a consultant clinic. If risks to the health of the woman were found at booking it would be recommended that they would give birth at Poole Hospital.
- Information about VTE prevention was given to women who had undergone surgery on discharge.
- We saw risk assessments for VTE, falls, nutrition and pressure ulcers completed in patient records on ward 15.
- In the operating theatre we observed good use of the five steps to safer surgery, this is a procedure to

minimise the risks of errors during surgery. This is a tool designed to be used in operating theatres to reduce the risk of surgical error. This had not been audited by the trust.

- The national early warning system was in use on the gynaecology ward to identify a patient that was deteriorating. There was a system that used handheld devices to record observations, this also reminded staff when observations were due and advised on frequency. Staff told us that this system helped them to ensure that observations were recorded correctly and that abnormal observations were appropriately escalated to the medical staff.
- Patients reported that when they had suffered with complications after surgery, they were reviewed rapidly by the medical team. The consultants were accessible to staff to discuss patient deterioration.
- In the case of the midwifery teams, staff completed the Modified Early Obstetric Warning Score (MEOWS) to record observations for women in labour. This system was used for women in the birth centre or at home. The MEOWS was recorded on a separate paper sheet.
- If a woman in labour developed complications, there was a protocol for escalating this to the obstetric team at Poole Hospital. The birth centre had an exit to a dedicated ambulance bay if a woman needed to be transferred to Poole Hospital. It was normal practice for the midwife to accompany them.
- The Royal Bournemouth Hospital website gave women information on the transfer time by emergency ambulance to Poole Hospital if this was required.
- In the event of needing to transfer a new-born baby to a neonatal unit, there were transfer facilities which were checked daily and ready for use at the birth centre.

Midwifery staffing

- The midwives told us that they held caseloads of between 110-140 pregnant women but this was variable. Midwifes could only estimate this figure.
- The funded midwife to birth ratio was 1:9 which, compared favourably with the average for England (October 2013 – May 2015) and was better than 1:28 required by The Royal College of Obstetrics and Gynaecology guidance (Safer Childbirth: Minimum standards for the organisation and delivery of care in labour, October 2007). This was due to staffing levels accommodating a higher proportion of women receiving antenatal and post natal care compared with actual births at the trust. Throughout antenatal care women with high risk pregnancies were given options on where to birth. The majority of women chose to birth at Poole Hospital.
- Staff reported to us that they provided one to one care in labour, though staff did not complete an acuity tool to be able to demonstrate this.
- The birth centre was staffed by a 'core' group of midwives. Other midwives that worked in the community provided ante and post-natal care, as well as homebirths. Community midwives were included on an on-call rota as cover acting as second midwife, for a home birth or if there were multiple deliveries at the birth centre. However, the rota showed that there were a significant proportion of days where there was no midwife available as a second on call. However, there had been no incidents reported where this affected one to one care .
- Staff had been engaged to participate in a working group to design a planned rota template that ensured on-call midwives did not work into days off. The new rota had been designed but was yet to be trialled before implementation.
- There were handovers of care in the birth centre, carried out for women in labour. Any sensitive issues would be discussed with the staff outside the suite, and clinical handover was carried out and involved the woman and her partner.
- Midwifery care for women in labour was always one to one in the birth centre or the community. A second midwife was called to assist with delivery.
- Each woman had a named midwife to coordinate her care.
- There was adequate nursing staff on the gynaecology ward.

Medical staffing

- The Royal Bournemouth Hospital employed five consultant obstetricians, who saw women with a high risk of complications in pregnancy in the antenatal clinic. They did not see women in the birth centre as this was a midwife led unit for women with a low risk of complications.
- The medical support for the birth unit in the event of a complication was provided by Poole Hospital.

Maternity and gynaecology

- Consultant obstetricians or their teams were always available at Poole Hospital. They could advise midwives at the birth centre or recommend an urgent transfer if there were complications during labour or birth
- The medical staffing in gynaecology at the hospital was in line with the average for England (September 2014).
- There were robust handovers between medical staff to ensure that women who had gynaecology operations received appropriate care.
- Out of hours there was a consultant gynaecologist on call that covered The Royal Bournemouth and Poole Hospitals. However, staff told us that the consultants of patients at the Royal Bournemouth Hospital were sometimes contacted out-of-hours to review their patients as they preferred to remain involved. There were no formal on-call arrangements in place for this practice.

Major incident awareness and training

- Staff were aware of the processes to follow in the event of a major incident. There was a trust wide major incident policy that was available to all staff on the intranet.
- In the event of the birth centre being closed (for example in full use) there were business continuity plans in place and women would be offered a homebirth or admission to the midwife led unit at Poole Hospital.

Are maternity and gynaecology services effective?

Requires improvement

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

We rated effective as 'requires improvement'

- There was not an effective audit programme in maternity or gynaecology services. The services were unable to demonstrate compliance with clinical standards based on policies and guidelines or review information on patient outcomes.
- The percentage of midwives who received appraisals was low against trust targets, but there was a plan to achieve this
- Midwives were not able to get experience of assisting with high risk births, within their employment by the trust. They accessed this training through temporary work contracts at another trust
- Specialist nurses on gynaecology had a high clinical workload such that they were not able to up-skill staff or complete work on protocols for the trust.

However,

- Policies and guidelines used in the maternity and gynaecology services were based on National guidance.
- Appropriate pain relief was available for women who were in labour. On the gynaecology ward pain was appropriately assessed and managed.
- There was appropriate access to food and drink for women using the services. Breast feeding was actively promoted to women.
- There were appropriate numbers of supervisors of midwives to monitor clinical practice. Junior doctors were satisfied with their learning experience on the gynaecology ward.
- There were examples of good multidisciplinary (MDT) working across the maternity service and with GPs and health visitors in the area. There was appropriate access to the multidisciplinary team across the gynaecology service. There were plans to increase the MDT for patients undergoing complex urogynaecological surgery.
- Maternity and gynaecology staff understood the Mental Capacity Act and Deprivation of Liberty Safeguards. Staff asked patients consent before carrying out examinations, observations or care.

Evidence-based care and treatment

- Care and treatment took account of current legislation and national evidence based guidance. For example, women identified as having a low risk of complications in pregnancy could choose to deliver their baby at the birth centre. A midwifery led unit is regarded as the safest option for low risk pregnancies (Maternity Matters, 2007, Birthplace, 2011, NICE Clinical guideline 190).
- Policies and guidelines were developed in line with both National Institute for Health and Care Excellence (NICE) and the Royal College of Obstetricians guidelines Safer Childbirth (2007). All trust policies and those for maternity were available for staff on the intranet. All policies were subject to a review and were up to date.

- We observed in the birth centre and in midwife clinics that processes and care adhered to local policies and procedures.
- There was a template for audit activity for the coming year, 2016, in maternity, but there was no data for the audits for the current year.
- The consultant nurse and specialist nurse in urogynaecology had a high clinical workload. This made it difficult to find time to develop protocols and guidelines for staff to follow. For example; the protocol to be followed after the removal of a urinary catheter was not yet available for staff to use.

Pain relief

- Two birthing pools were available to provide pain relief for women in labour.
- Midwives also told us that they used relaxation and breathing techniques to aid pain relief during labour. Women were taught these techniques in antenatal clinics and classes.
- Medicines for pain relief and assessment for pain was available for women in labour. Midwives do not require patient group directions to be able to administer pain relief and other medicines to women in labour. However, there were up to date midwives exemptions for dosages and when to administer medicines available for reference.
- There was Entonox available for women in labour via a piped supply into the two birthing rooms. Entonox is a mixture of gases which is inhaled during episodes of severe pain, such as contractions for example. There was a small store of portable Entonox gas cylinders for the use of women having a baby at home.
- Pain assessment was carried out for women that had undergone surgery on the gynaecology ward. This formed part of the observations and was also recorded on the electronic system to ensure that pain was managed or this was escalated. Pain assessment was carried out routinely after pain relief medicines had been administered. We observed the pain assessment tool in use, and the escalation of a patient whose pain was not controlled.

Nutrition and hydration

- Meals and snacks were available for women in labour, or that had recently delivered a baby. This was provided from the main hospital.
- Midwives held discussions with expectant mothers regarding options for infant feeding when the pregnancy was between 30 and 40 weeks. Breastfeeding information was given to mothers at their initial booking. There was proactive support available to mothers to enable and encourage them to breastfeed their babies. The maternity care assistants took the role of facilitating breastfeeding with mothers and babies. There was support available for women wanting to breastfeed their babies, provided in clinic, the birth centre or in the woman's home.
- On the gynaecology ward a variety of food was available to patients. There was always water available for patients if they had been assessed as able to eat and drink. We observed fluid charts that were maintained for post-operative patients, to monitor fluid intake.
- Nutritional assessments were carried out of pre and post operatively. If a risk of malnutrition was found, staff knew how to refer the patient to a dietician.
- Patients told us that they liked to food. One patient told us that they felt portion sizes were small.

Patient outcomes

- There were 301 births recorded at the Bournemouth birth centre and 71 home births.
- The delivery method reported at the birth centre and in patients' own homes was normal, this is appropriate for a midwifery led service. Any women with complications in labour or after delivery would be taken directly to the maternity service at Poole Hospital. This included third and fourth degree tears.
- The maternity service employed antenatal screening coordinators and contributed to the national antenatal screening programme.

Competent staff

- At the time of inspection 69% of maternity staff had received an appraisal, lower than the trust target. However, appraisals were planned and were on track for completion within the twelve month cycle.
- Supervisors of midwives (SoM) to midwives ratio 1:8,was better than the Nursing and Midwifery Councils' rules and standards which recommends a ratio of 1:13. A SoM is an experienced midwife that has undertaken a course in midwifery supervision. The role of the SoM is to provide advice and support for midwives, as well as monitoring care by an annual meeting with each midwife. In order to ensure that there is sufficient time

available for supervision and to guarantee that time is given for this, additional staff have been recruited to assist the supervisors of midwives already within the team.
- To remain competent midwives need on-going competency training, this includes having regular experience and exposure to intrapartum care. This regular experience was not available to the midwives. Some midwives had chosen to work extra shifts as bank staff at Poole Hospital or elsewhere to get this experience. The head of midwifery was working with her counterpart at Poole Hospital to ensure formal mechanisms for midwives to get all of the experience they needed.
- Junior doctors we spoke with were happy with the training they received.
- Specialist nurses in gynaecology had a high clinical workload; this meant that there was little opportunity to up skill staff on the gynaecology ward and day surgical unit.

Multidisciplinary working

- The Sunshine team midwives met with the health visitors once a month to ensure an effective handover of care between teams. Staff told us that these meetings worked effectively.
- The Sunshine team had good relationships and work closely with the social services department in Bournemouth. The effectiveness of liaison and working with social services in Christchurch was raised as an issue, this was going to be escalated. The team also had effective working and communication with GPs that were able to refer directly to the service.
- There were effective working between the service and with the maternity unit at Poole Hospital. This was improving as a number of midwives from Poole had been appointed to roles at Bournemouth.
- Women who had a high risk of complications would usually arrange to give birth at Poole Hospital; however their antenatal care would be delivered by the Bournemouth Maternity service. There were good working relationships between the teams at The Royal Bournemouth and Poole Hospital. Women were given all necessary information to ensure that they were aware of what to expect if they were booked to have their baby at Poole Hospital.
- There were good relationships and communication with community maternity team and the birth centre. The birth centre acts as a centre for coordination of midwives workload.
- There was good communication with GP's during antenatal care/discharge. There were also meetings with the health visitors to ensure a seamless transition of care between services.
- Multidisciplinary (MDT) meetings were held when women require advanced gynaecological procedures. These included specialist nurses, surgical team and specialist physiotherapist.
- We attended a MDT meeting for urogynaecology, this included consultant surgeons and a consultant nurse. These occurred weekly to discuss patients. The meeting was effective and demonstrated good communication between all disciplines. There were plans to include a women's health physiotherapist and consultant geriatrician in these meetings in the future. This would enable them to apply for accreditation through the British Society for Urogynaecology.

Seven-day services

- The birth centre was open 24 hours a day, seven days a week. The community midwives were able to see women in their own homes at weekends. There was an on-call rota to ensure that there were enough midwives to cover the community and the birth centre.
- Consultants for gynaecology had an on-call rota to cover for emergencies out-of-hours which covered The Royal Bournemouth Hospital and Poole Hospital

Access to information

- Electronic information systems made patients' records accessible to staff that needed to access them.
- Pregnant women also had their own care record that they kept at home and brought to all their appointments. Key information was also kept on the electronic information system.
- In gynaecology there was electronic recording of patient information. Paper records were also maintained that were stored close to the patient. This enabled records to be maintained and updated with the patient themselves. These records included fluid charts and information about the patients' care preferences.
- Access to the results of blood and other laboratory tests were available to staff via a computer system.

- Discharge summaries were available to the patient's GP and health visitors in a timely way.
- The early pregnancy unit completed ultrasound scans of women, these were viewed electronically and reports written by Poole Hospital. Women could have a copy of their scan to take home if they wished.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Midwives had a good understanding of the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards. They were aware of the process for getting specialist psychiatric help in the event of a woman exhibiting signs of puerperal psychosis (this is where a woman may become acutely mentally unwell after childbirth).
- We heard staff in the maternity and gynaecology services asking patients' consent to care and treatment. Staff asked a patients consent before carrying out examinations, observations or care tasks. Consent was documented in the patient record.
- In ward 15 the staff knew how to access advice from the trust safeguarding team about Deprivation of Liberty Safeguards. During our inspection there were no applications for a deprivation of liberty.

Are maternity and gynaecology services caring?

Good

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

We rated caring as good

- We observed patients were treated with dignity and respect by staff. Patients told us that the nursing and medical staff were approachable and caring.
- The friends and family test (FFT) survey results showed women were happy with the service provided.
- Patients were satisfied with the information given to them, and the way it was explained to them by midwives, nurses and doctors. Patients were involved in their care and treatment planning as much as they wanted to be.
- Midwife led antenatal clinics were provided in different community locations.
- There was a specialist team to support women assessed as vulnerable. There was support available to partners of a woman in labour.
- There was emotional support for women that needed it. The hospital had a chaplaincy service that could assist with the spiritual needs of women of different faiths.

Compassionate care

- We observed patients being treated with respect and compassion on ward 15 (gynaecology) and also in the day surgery unit.
- Patients in ward 15 told us that they were well cared for and described how all staff did their best to ensure their wellbeing. Patients also spoke highly of the kindness and care they had received from their consultant and gynaecology nurse specialist.
- Patients told us they had time to discuss planned surgery and admission procedures with staff.
- Feedback from the friends and family test (FFT) survey showed a higher than England average rating for all four maternity questions between March 2014 and February 2015. The response rate for the FFT had fallen from 50% in May 2014 to 13% in December 2014. This had now improved to 25% at the time of inspection which is above the average for England.
- Women in the birth centre told us they were happy with the care they received in the community and the birth centre. We heard positive comments about the caring staff at the birth centre from two women that had given birth there.
- Data from patient experience surveys from April 2015 – June 2015 found that 98-100% of women would recommend antenatal services to friends and family.

Understanding and involvement of patients and those close to them

- We saw that information and advice about labour and birth was communicated sensitively with women and their partners.
- Patients reported good communication from doctors and nurses in explaining procedures and involvement in decision making.
- The Sunshine team were based together at a GP surgery. They saw women who had been assessed as vulnerable. This included women with complex mental health, social problems or a learning disability. The team midwives provided care and advice that was tailored to

each individual's particular problems or disability. This included a high continuity of care, and also innovative ways of finding out information from women that they suspected were suffering domestic abuse.

Emotional support

- There was support given to partners of women in labour
- At the time of the inspection there was no bereavement midwife in the team, but a midwife had recently been redeployed for this role. Each named midwife would provide care and support for women who had miscarried or had a stillborn baby. Advice and support for named midwives was available from the bereavement midwife at Poole Hospital.
- Midwives were aware of screening mothers for signs of anxiety and depression during pregnancy and after the birth of a baby.
- Midwives were also sensitive to the emotional needs of women that might be carrying a child with a birth defect.
- The chaplaincy service was available, and an on call chaplain was available out of hours and at weekends/ bank holidays. Chaplains could administer the last rites or baptism if this was required.
- There was a clinical nurse specialist within the gynaecology service to provide clinical and emotional support, for example for a patient diagnosed with cancer.

Are maternity and gynaecology services responsive?

Good

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

We rated responsive as 'good'

- Services assessed and met the needs of people using them. There was a named midwife to support each pregnant woman. There was an understanding of the importance of good continuity of care.
- The birth centre was available 24 hours a day to offer advice by telephone or face to face. There were suitable facilities provided at the birth centre, that were organised around the needs of women and their partners. There was a dedicated team that supported women that were vulnerable or had complex social problems or mental health issues. There was an early pregnancy assessment unit that provided rapid care for women. Women were able to access antenatal care in various locations to suit them.
- Patients undergoing investigations in gynaecology were offered appointment times that were suitable to them.
- Written information was available to women.
- There was chaplaincy support available for women and their families. Patients living with dementia were given extra assessment to ensure that staff could understand their needs and preferences.
- Complaints were investigated and the results shared with staff. Complaints were responded to appropriately and in line with the trusts' procedures.

However,

- Women on the gynaecology ward had to walk past male patient bays to access toilet facilities.
- Written information was not always provided in different languages.

Service planning and delivery to meet the needs of local people

- There was an on-going Dorset wide review of clinical services which included obstetrics and gynaecology services. In the future plans a midwife led unit would sit alongside a consultant led maternity service in the major emergency hospital, at either Poole or Bournemouth . The outcome of the review was awaited
- The current service was midwifery led for low risk women to give birth in the birth centre or at home. The birth centre was staffed 24 hours per day, and a midwife was always available for women to speak to. Women in pregnancy were given a named midwife to coordinate their care. Continuity of care was recognised as being important by midwives. They tried to plan to ensure that they mostly saw the mothers allocated to them.
- Women could attend midwife appointments in their GP surgery, or a clinic provided in a children's centre.
- The "Sunshine team" provided community support for vulnerable women. They had smaller caseloads to enable them to spend more time with each expectant mother. They also ensured a greater continuity of care to mothers.
- After a consultation and advice at the early pregnancy unit, women could choose to self-administer medicines

to end a pregnancy. As the result of an audit, the service allows women to administer medicines at home at a time of their choice, rather than having the medicines administered by clinic staff.
- The antenatal day assessment unit had been closed, with women being asked to attend this service at Poole. The closure was in response to an incident and appeared on the risk register.

A business case had been made successfully to employ another obstetrician to allow the unit to reopen.

- The gynaecology service was based in the Jigsaw building, a newly opened part of the hospital part of which was specifically for women's health services. The changing facilities and clinical environment were designed around the needs of patients. The design of the changing facilities helped to ensure the privacy and dignity of women using the service.

Access and flow

- Women would be booked usually before the 12th week of pregnancy, this booking could be at a GP surgery or a children's centre depending on the woman's preference.
- Women with a low risk of complications who were booked to give birth at the birth centre (or could choose to have their baby at home) would be known to the service. Midwives would give women telephone advice about when to attend the unit. Women would be admitted to the unit and assessed to ensure they were in established labour. If this was not the case they could return home again. Community midwives would also examine women at home before attending the birth centre.
- There were three rooms available at the birth centre. If these were all in use women at a low risk of complications would be offered a home birth or transfer to the midwife led unit at Poole Hospital. The birthing centre had been closed on seven occasions in the last year.
- Women who thought that they were in labour would be assessed quickly by a midwife, and immediately on arrival at the birth centre.
- Patients were offered gynaecology appointments for tests at times that were suitable to them such as early morning and into the evening. There was also an emergency gynaecology clinic that ran from 8am-5pm on weekdays.
- Two births were recorded in the emergency department last year, midwives attended both. This was due to an error by ambulance staff taking the woman to the wrong location.
- The early pregnancy unit was open 8.30am-11.15am for booked appointments, and provided ultrasound scans and treatment until 3.30pm. There was not service provided at the weekend. Pre-admission assessment appointments were carried out to ensure that patients were suitable for surgery or anaesthesia.

Meeting people's individual needs

- The birth rooms were self-contained, and all three had en suite facilities. Equipment required in the rooms was kept discretely in cupboards until it was required. The birth centre had a pool for use by women in labour, in each of two of the rooms.
- We observed a clinic based in a children's centre where the midwife saw mothers and babies. This clinic was provided in an appropriate setting for the type of consultation that was provided. The use of children's centres as a venue for midwife clinics was arranged in partnership between them and the maternity service, and was designed to make clinics more accessible to women. It was also hoped that this partnership would encourage the use of children's centres. Women at the clinic gave good feedback about the care they had received at The Royal Bournemouth Hospital.
- Written information and advice was available to women. The booking process, where there was the first contact with the expectant mother, included leaflets about staying well in pregnancy, foetal movements and other maternity health information.
- Patients told us that they were given good quality written information and a treatment plan during an in-patient stay. The hospital website had information about the maternity and gynaecology services offered. This included some short videos covering what to expect in antenatal care, the birth unit and post-natal care.
- Leaflets and written information was not always available in other languages. Midwives told us that they recommended women find the NHS choices website information which could be translated automatically for users. There were translation services available by telephone if required. Staff knew how to access this service.

- Partners of women in labour were encouraged to stay and were provided with a fold down bed in the two main birthing rooms. In the third room a chair was available. There were plans to purchase a reclining chair.
- The Sunshine team was a dedicated team of midwives based in the community for women who were assessed as being vulnerable. A variety of issues and concerns would prompt a referral to this team such as, women who used drugs and alcohol, sex workers, women that had previously had babies or children taken into local authority care. Women with mental health problems or a learning disability could also be referred to this team. The Sunshine team had excellent working relationships with social services, education, the police and immigration service.
- Pregnant women with a learning disability had their antenatal care provided by the Sunshine team. This team had expertise in caring for women who were vulnerable.
- Pregnant women that had a history of mental health problems were also referral to the Sunshine team. The team had effective links to the community mental health team to support these women.
- As well as liaison with social services the Sunshine team had good links to police and substance misuse services. This team would also support women under 18 years and their families.
- The early pregnancy unit provided care for women who thought they might be pregnant needing advice, or those seeking a termination. Women in early pregnancy who were scanned were offered a copy of their scan and given information.
- We observed good use of a "this is me" document that described a patient's needs and preferences on the urogynaecology ward. The document was completed by the patient's family. It gave the staff additional information that the patient may not be able to express themselves. This helped staff to care for patients with special needs such as dementia or a learning disability. This document was kept with the patient so that it was accessible to staff.
- Ward 15 was a mixed Urogynaecology ward. Patients undergoing gynaecology surgery told us that they would prefer not to be on a ward with men. Although bays were separate for women and men, access to the toilet for women meant that women had to walk past the male patients' bay. Toilets in the ward to reallocated depending on the numbers of men and women, there were magnetic signs in use. At the time of inspection women had to walk past a bay of male patients.
- Chaplains were available to support women and families for religious and emotional support. They also offered access to elders or ministers of other faiths.

Learning from complaints and concerns

- The gynaecology ward had a white board for staff located in the ward office. This contained any ongoing incidents and complaints. This gave the ward manager and staff an overview of any outstanding incidents, concerns or complaints.
- Complaints were responded to appropriately and in line with the hospitals' complaints policy. Changes were made as a result of comments and complaints. For example, some women felt that there was a stigma attached to being referred to the Sunshine team. If this was the woman's wish, a community midwife would be her named midwife. This midwife was then closely supported by the Sunshine team.

Are maternity and gynaecology services well-led?

Requires improvement

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

We rated well led as requires improvement.

- Governance arrangements did not ensure that all quality issues and risks were identified. Staff were not confident, for example, that the learning from incidents was shared across all staff in maternity and gynaecology services. Risks were not always recorded or being managed in gynaecology.
- Clinical governance meetings were not always well attended by all relevant staff and information was not being disseminated effectively.

- Patients were shared with Poole Hospital and clinical governance meetings included staff from both trusts. Clinical governance meetings did not all have terms of reference. It was not always clear who was responsible for ensuring that actions were completed.
- Gynaecology did not have robust governance process. There was little time devoted to gynaecology governance issues. Quality dashboard information was not available for gynaecology services.
- Staff did not understand how the Dorset wide clinical services review and the Vanguard project would impact on their services.

However,

- Most staff knew about the local strategy for the maternity unit.
- Maternity staff had better governance process to manage risk and quality through a dashboard and risk registers.
- Staff were engaged with leaders so that improvements were possible. There was progress towards closer working with Poole Hospital to provide sustainable education and development for midwives.
- There was an open culture with in the service. Staff were confident to report concerns, and generally, felt that these would be escalated. The midwifery team were very supportive of each other and understood the needs of the women they looked after.

Vision and strategy for this service

- The strategy for the maternity service was for closer integration and working with Poole Hospital. This would ensure that midwives had access to training and experience of assisting with high risk births. The gynaecology service was also hoping to benefit from better cooperation with other hospitals as suggested by the developing One NHS in Dorset vanguard project. This is a government led initiative to integrate and improve patient care across the acute hospitals in Dorset.
- There were district wide discussions about the future configuration of maternity services across Bournemouth, Poole and Dorchester.
- There was an on-going Dorset wide clinical services review that looked at the role of the hospitals in the county, the impact of this was not yet fully understood. This led to strategic plans not being formulated until the high level outcomes of the review were understood by the trust.
- There had been a recent service review carried out by the Royal College of Obstetrics and Gynaecology, the service were waiting for recommendations from this.
- The strategy for the unit was known by most of the staff we spoke to. However, the impact of the Dorset wide clinical services review and the Vanguard project were not fully understood

Governance, risk management and quality measurement

- There were named clinicians that were responsible for reviewing departmental risks in maternity and gynaecology. There was a newly appointed full time midwife for risk for the maternity service. This was previously a part time role. There was also a senior manager and a consultant that were responsible for addressing risk in the gynaecology service.
- Clinical governance meetings were held, but these were not always attended by all relevant staff. The clinical governance meetings did not all have terms of reference. Senior doctors were given time to attend these meetings, but midwives would often not be able to attend. The information and actions from these meetings were shared sporadically.
- Staff were not confident that information from these meetings was disseminated effectively. There were governance meetings within the trust for the surgical directorate, and meetings for the maternity service were shared with Poole Hospital. This led to little time being devoted to gynaecology governance issues.
- Consultants met bi-monthly to discuss risk at Poole Hospital. Staff told us that most of the discussions were focused on maternity and less about gynaecology. There were also obstetrics and gynaecology meetings that were attended with Poole Hospital. It was not always clear from these meetings who was responsible for the actions to be completed.
- There were monthly consultant meetings in gynaecology to discuss operational issues It was difficult to see from minutes clear meeting objectives, actions and assurance from the governance meeting attended by staff.

- Clinical governance meetings were attended every three months. The consultants that attended governance meetings in gynaecology were not aware that there were any terms of reference.
- Risks registers did not always identify that timely and mitigations actions were taking place. There; Any risk identified for gynaecology would be included in the risk register for surgery but there were no gynaecology or urogynaecolgy risks identified.
- There was a separate risk register for the maternity service. There were identified risks and actions taken to mitigate risk. For example, The antenatal day assessment unit had been closed, in response to an incident and this appeared on the risk register with women being asked to attend this service at Poole. A business case had been put forward and a decision made, to employ another obstetrician to allow the unit to reopen.
- There was a clinical dashboard that gave staff and patient's information about performance against quality indicators for obstetrics, there was no separate dashboard for gynaecology.
- Women were asked for their feedback on the maternity service by comment cards. Results from comments cards were not displayed, by were collated and shared with staff.

Leadership of service

- The consultant clinical lead for gynaecology was an elected and unpaid role, with a term of three years. There was no job description for the role.
- The head of midwifery had been appointed in the last six months before our inspection. There had been some staff changes during this time, and also some recruitment to community team leader roles. There had also been successful recruitment of additional supervisors of midwives during this period.
- There was an increased emphasis on working in closer partnership and cooperation with Poole Hospital. Poole hospital was able to offer midwives joint training and also the experience of regularly attending births that are high and low risk.
- There was mixed feedback about the leadership of the service. Staff told us that they felt that management issues affecting the service were escalated to board level. Some staff did not feel that their concerns were listened to.
- Junior doctors working in gynaecology told us they were well supported and satisfied with the training they received.
- There were some problems with the relationships within the consultant team that were being resolved with the director of surgery. This did not impact on patient care, but was identified as a risk by staff.

Culture within the service

- There was an open culture in the birthing centre and in antenatal services, with staff generally confident to report incidents and concerns.
- Midwives told us they were proud to work for the service and felt they worked hard to get excellent feedback and recommendation from women.
- Midwives were supportive of each other, and wanted to give the best care they could to women. They planned their work carefully, with the support of their colleagues' in order to provide the best possible continuity of care for women.

Public engagement

- The Maternity Service Liaison Committee (MSLC) represented women that had used the maternity service. This group supported by Public Health England met 10 times per year and provided feedback to the hospital on its' services
- The public were engaged in the design of the new women's health unit, the Jigsaw building.
- Women were asked for their feedback having used the birth centre for a delivery or attending to see a midwife. Patients attending the women's health unit were also asked to provide feedback by completing confidential comment cards.
- Women who were assessed to give birth at the birth centre were invited to come in, to allow them and their partner to look at the facilities and talk to the staff.

Staff engagement

- Staff were engaged in the design and development of the new women's health building, Jigsaw building. This has meant that facilities and the design of the building were built around the needs of women.
- Midwives were engaged in designing a new rota template to better plan on-call work. A working party was formed to present proposals that could be tried across the birth centre and the community.

Maternity and gynaecology

Innovation, improvement and sustainability

- The gynaecology team were planning to include a specialist physiotherapist and an elderly care consultant in their multidisciplinary team meetings. This would allow them to apply for accreditation against standards set out by the British Society for Urogynaecology.
- Due to the high number of telephone calls to the birth centre an audit was being conducted to identify how much activity required the advice of a midwife. This data was being used to develop a 'Labour line' 24 hour telephone triage service in the future. This service has been successful for other nearby trusts.

Services for children and young people

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

Information about the service

We inspected services for children and young people at the Royal Bournemouth Hospital (RBH) and the Christchurch Hospital which are part of the Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust.

A very small number of services for children and young people are provided at the RBH and the Christchurch Hospital. These include ophthalmology and dermatology care for children and young people up to and including the age of 18.The Dorset Prosthetic Centre at the RBH also provides prosthetic limb fitting service for children and young people up to and including the age of 18. This report covers services across both sites.

The services in this report are within the ophthalmology directorate and speciality services directorate which are within the trust's specialties care group.

The ophthalmology services provided for children and young people include eye surgery for children and young people between age of one to 18 years, an orthoptist service and an acute referral eye unit. There is a three bedded children's eye ward where children are admitted for a day surgery. Between November 2014 to October 2015, a total of 95 children, between one and 18 years of age, underwent eye surgery at RBH.

The dermatology services provided for children and young people include a paediatric dermatology clinic and allergy clinic at the RBH and Christchurch Hospital and minor skin surgery at the dermatology unit at the Christchurch hospital. A very small number of children, between seven and 18 years of age, are operated on for minor skin surgery at the dermatology unit. These operating lists are held once in a month. Between November 2014 to October 2015, a total of 17 children, between seven and 18 years of age, underwent surgery at the dermatology unit.

There are no inpatient facilities for children and young people at the RBH and the Christchurch Hospital. The trust had a service level agreement to transfer children to Poole hospital if necessary. The Poole hospital has a full paediatric service including inpatient beds.

We inspected the children's eye surgery ward, outpatient areas, the acute referral eye unit, the dermatology unit and the Dorset prosthetic centre.

We spoke with approximately 11 patients, including their family members, 20 staff members including clinical leads, managers and matrons, ward staff, consultants, and other non-clinical staff. We observed interactions between patients and staff, considered the environment and looked at care records and attended the eye theatre. We reviewed other documentation from stakeholders and performance information from the trust.

Services for children and young people

Summary of findings

This core service was rated as 'good'. We found that children and young people's care was 'good' for safe, effective, responsive and well led and 'outstanding' for caring.

Children and young people received compassionate care that respected their privacy and dignity. They told us they felt involved in decision making about their care. We found staff were caring and compassionate. Without exception, parents of the children we spoke with praised staff for their empathy, kindness and caring. Children's emotional needs were highly valued by staff and were embedded in their care and treatment.

Process and procedure was followed to report incidents and monitor risks. Staff were encouraged to report incidents. The environment was clean and equipment was well maintained. The children's eye ward provided a 'child-friendly' environment with a variety of age appropriate toys and play equipment and access to play areas. Staff across all services described anticipated risks and how these were dealt with. Safeguarding protocols were in place and staff were familiar with these.

Infection control practices were followed. Staff regularly washed their hands in between patients, used personal protective equipment such as gloves and aprons, and adhered to the trust's 'bare below the elbow' policy.

Children whose condition deteriorated were appropriately escalated and action was taken to ensure harm-free care. The five steps to safer surgery checklists were completed for children and young people undergoing surgery.

Nursing staffing on the children's eye ward and outpatient clinics was adequate. There were three ophthalmology consultants with a paediatric specialist interest who operated on children for eye surgery. The trust employed two paediatric anaesthetic consultants to provide anaesthetic and analgesic advice in the eye theatre. The children in dermatology unit were seen by dermatology consultants with a paediatric specialist interest.

Staff provided care to patients based on national guidance, such as National Institute for Health and Care Excellence (NICE) guidelines.

Arrangements were in place to ensure that staff had the necessary skills and competence to look after patients. The acute referral eye unit at the Royal Bournemouth Hospital (RBH) offered a seven-day service for children and young people suffering with acute eye problems. The unit was open between 8am and 6pm every day of the week. Staff received statutory and mandatory training, and described good access to professional development opportunities.

Children and young people were consented appropriately and correctly. Young people were presumed to be able to give consent depending on their maturity and the nature of the decision. Staff undertook competency assessment and, when a patient was found not competent, only a person with parental responsibility was able to give consent.

There was clear guidance for staff on 'which patients to accept for eye surgery' at the eye unit at RBH. Children aged less than one year of age and those with multiple comorbidities and traumatic eye injury were referred to Poole hospital or Southampton hospital for treatment.

Complaints were handled appropriately in line with trust policy and these were reviewed to improve the service.

There was no documented vision or strategy for services provided for children and young people. Staff were aware of the trust's strategy and described high quality patient care as key components of the trust's vision. There were effective governance arrangements and staff felt supported by service and trust management.

The culture within children and young people services was caring and supportive. Staff were actively engaged and innovation and learning was supported. There was good local leadership at ward level.

Services for children and young people

Are services for children and young people safe?

Good

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

We rated safe as 'good'

- Processes and procedures were followed to report incidents and monitor risks. Staff were encouraged to report incidents. Trust data demonstrated there were no incidents reported in any of the children and young people services provided by the trust between October 2014 and October 2015. Staff described an ethos of openness and transparency in responding to incidents and were aware of the additional requirements of the Duty of Candour in handling incidents.
- The environment and equipment were well maintained. Equipment was mostly checked regularly to ensure it continued to be safe to use.
- Infection control practices were followed. Staff regularly washed their hands in between patients, used personal protective equipment such as gloves and aprons, and adhered to the trust's 'bare below the elbows' policy.
- Medicines including controlled drugs were managed and stored appropriately.
- Patient records were well maintained and completed with clear dates, times and designation of the person documenting.
- Observation charts, paediatric early warning scores (PEWS) and fluid charts were completed and totalled. The five steps to safer surgery checklists were completed for children and young people undergoing surgery.
- The children's eye ward had used national guidelines, and professional judgment to identify planned nursing staffing levels. We reviewed the rota for four months (April 2015 to July 2015) which demonstrated sufficient staffing levels. The trust did not employ any paediatric consultants as acute paediatric care was not delivered at the hospital. There were three ophthalmology consultants with a paediatric specialist interest who operated on children for eye surgery. The trust had employed two paediatric anaesthetic consultants to provide anaesthetic and analgesic advice in the eye theatre. The children in dermatology unit were seen by dermatology consultants with a paediatric specialist interest.
- Staff had good knowledge about safeguarding children and were aware of the procedure for managing major incidents, winter pressures and fire safety incidents.

Incidents

- Staff stated they were encouraged to report incidents. Staff we spoke with knew how to recognise and report incidents on the trust's electronic recording system.
- Staff told us they received feedback on the incidents they had reported in the past and learning was shared across the team.
- The data provided by the trust demonstrated that there were no serious incidents reported in any of the children and young people services provided by the trust between October 2014 and October 2015.
- Duty of Candour legislation requires an organisation to disclose and investigate mistakes and offer an apology if the mistake results in a severe or moderate level of harm. Nursing and medical staff across the children services we visited were familiar with the requirements of the Duty of Candour legislation. All staff who we spoke with understood the principles of openness and transparency that are encompassed by the Duty of Candour. Staff were aware of the importance of investigating incidents and potential mistakes and that the Duty of Candour now made meeting the patient/family and sharing the findings of investigations a legal requirement.

Cleanliness, infection control and hygiene

- There had been no cases of MRSA bacteraemia in the children's eye ward during January-June 2015.There was an information leaflet for parents explaining MRSA.
- All clinical environments and communal areas were visibly clean and tidy.
- The areas we visited had cleaning schedules and infection prevention measures in place, such as infection prevention and control guidance and wall mounted hand hygiene gels. There were signs reminding staff and visitors to use hand hygiene gel to sanitise hands at admission to the unit and ward.
- Staff had received infection prevention and control training as part of their annual essential training programme. Trust training statistics confirmed that

100% staff working with children and young people in dermatology and ophthalmology services had completed infection control training as of September 2015.
- We observed staff adhered to the infection control policies, including 'bare below the elbows', hand hygiene and appropriate use of personal protective equipment, such as disposable aprons and gloves.
- Standards of cleanliness were monitored. The eye ward, which also included the children's eye ward and eye theatre, participated in monthly infection control audit. The eye ward and eye theatre demonstrated 100% compliance with the infection control audits including hand hygiene audit (May 2015 - September 2015).

Environment and equipment

- There were weekly operating lists for children and young people, aged between 1 and 17 years, at the Royal Bournemouth hospital (RBH).There was a three bedded children's eye ward next to the adult eye ward where children and young people were admitted prior to the surgery and for recovery following their eye surgery. Children and young people did not stay overnight in this ward.
- The entrance to the paediatric eye ward was unlocked at the time of our inspection and was accessible to anyone from the outside. Staff told us that children in this ward were accompanied by their parents or relatives and there was always a paediatric nurse in the ward. Staff told us that any unauthorised persons would be challenged immediately by the staff.
- Emergency trolleys were found to be appropriately sited and stocked. They contained a range of paediatric appropriate equipment including cannulas, airways and defibrillator pads.
- Emergency equipment was regularly checked in the outpatient clinic areas. We found all equipment in date. The emergency trolley in the children's eye ward was not checked regularly. We were not able to locate any checks of the resuscitation equipment for the month of September 2015.We brought this to the notice of the ward matron at the time of our visit. We found during our unannounced inspection that the regular checks of emergency equipment had been put in place on the children's eye ward. Equipment was checked and serviced regularly in the eye theatre.

Medicines

- The trust policy for safe management of medicines was in line with National Institute for Health and Care Excellence (NICE) guidance.
- Medicines required for paediatric patients following their eye surgery were securely stored on the adult eye ward. For example, medicines were stored in locked cupboards. Controlled drugs were stored in accordance with NICE safe storage guidelines. Drug keys were kept separate from the ward keys.
- We reviewed three medication charts and no gaps were seen against entries. We noted that children's allergies and weights had been clearly added. Staff were trained to calculate and administer paediatric medicines. We did not observe medication being administered during the inspection.

Records

- We reviewed four sets of patient care records on the children's eye ward and the paediatric dermatology outpatient clinic. Patient care records were well maintained and completed with clear dates, times and designation of the person documenting. The records we reviewed were written legibly and assessments were comprehensive and complete, with associated action plans and dates.
- Children were weighed and their height measured. Observation charts, paediatric early warning scores (PEWS) and fluid charts were completed and totalled.
- The five steps to safer surgery checklists were completed for children and young people who had undergone surgery.
- Records were stored securely on the electronic recording system and hand-held notes were kept in a locked cabinet.
- An audit of electronic care records was conducted on a monthly basis at the eye ward to check for accuracy and completeness of records. However, we were not able to review the results of this audit.

Safeguarding

- All staff we spoke with showed an in depth understanding of safeguarding and what was required of them with regard to reporting concerns. There were clear policies and procedures in place which included working with external agencies.

- The clinical areas had allocated safeguarding leads who staff could access for support and advice.
- Staff told us they had received training in safeguarding vulnerable adults and children and were aware of the trust's safeguarding policy.
- Safeguarding governance reporting arrangements were in place to ensure that safeguarding processes were monitored trust wide.
- Staff told us they had effective working relations with the local children's safeguarding and child protection teams and demonstrated a knowledge of what to do and who to contact should a concern be raised. GP, community services and the safeguarding team were notified when there was concern that a child may be suffering neglect.
- NICE safeguarding guidance recommends that qualified staff should be trained to a level 3 in children's safeguarding. All staff on the on the paediatric eye ward, eye clinic and paediatric dermatology clinic had been trained to level 3 in children's safeguarding.
- There were policies around safeguarding and Female Genital Mutilation (FGM). Staff were aware of the reporting procedures for patients with FGM.

Mandatory training

- Mandatory training covered a range of topics including fire safety, health and safety, paediatric resuscitation, safeguarding, manual handling, infection control, conflict resolution, consent and information governance training. Most of the staff told us they were up to date with their mandatory training.
- The data provided by the trust showed us that the compliance with mandatory training varied across different children and young people services and ranged between 84% to 95% with some areas and teams demonstrating higher compliance in completing mandatory training than others. The trust's target for compliance with mandatory training was 95%.
- Ward leads and staff could review training compliance on the intranet. Ward minutes and governance reports showed mandatory training compliance was monitored and reported each month.

Assessing and responding to patient risk

- The paediatric eye unit, the acute referral eye unit and the paediatric dermatology unit had robust admission criteria for admitting children and young people for eye surgery or other treatment. Children with complex care needs or comorbidities were referred to Poole hospital or Southampton General Hospital for their eye surgery or treatment as there were no inpatient paediatric facilities available at RBH. These decisions were usually made at the initial consultation.
- Staff told us there had been incidences in the past where children with complex needs had undergone operations at the RBH, however this was very rare. We were given an example where a child with a learning disability was referred to the eye unit for a surgery. Multidisciplinary meetings were held at the unit to discuss the appropriateness of the referral and to establish the level of support needed for this patient.
- All staff understood the procedure to follow should a child collapse or become acutely unwell in the outpatient departments. Staff told us that they would look at a patient's vital signs and record them in their notes. We observed that assessments and observations, where necessary, were recorded in the notes. Paediatric early warning scores (PEWS) were used at the children's eye ward to identify patients whose condition might deteriorate.
- The trust had a service level agreement to transfer children to Poole Hospital if their condition deteriorated following the eye surgery. Staff told us they had developed good links with the paediatricians in Poole hospital and would contact the on call paediatrician for advice or if a child needed transferring.

Nursing staffing

- Royal college of nursing guidelines for paediatric wards state there should be a minimum of 70:30 registered to unregistered staff with a higher proportion of registered nurses in areas such as children's intensive care or specialist wards. There should be a minimum of two registered children's nurses at all times in all inpatient and day care areas and at least one nurse per shift trained in each clinical area trained in advanced or European paediatric life support.
- The children's eye ward had used national guidelines and professional judgment to identify planned staffing levels. The children's eye ward had two registered children's nurses who worked part time. The trust also used a trained children's agency nurse who helped if there were three children on the operating list, thus

ensuring that one to one care was provided when the children were recovering post-surgery. We reviewed the rota for four months (April 2015 to July 2015) which demonstrated sufficient staffing levels.

- The dermatology unit had a specialist dermatology paediatric nurse who covered outpatient clinics. The specialist dermatology paediatric nurse also assisted patients attending skin surgery as day cases at Christchurch hospital along with dermatology theatre nurses all of whom were trained in paediatric resuscitation.
- Parents of children told us the nursing staff looked after their children very well and they did not have to wait long for help or care. Parents of the children undergoing eye surgery were very complimentary of the nursing care and advice they received throughout the process.

Medical staffing

- The trust did not employ any paediatric consultants as acute paediatric care was not delivered at the hospital.
- There were three ophthalmology consultants with paediatric specialist interest who operated on children for eye surgery. The trust employed two paediatric anaesthetic consultants to provide anaesthetic and analgesic advice in the eye theatre.
- Children in the dermatology unit were seen by dermatology consultants with paediatric specialist interest. The dermatology consultants treated a number of young people who were in a transition to adult services. Young people were able to continue their treatment under the care of the same dermatology consultants when they reached adulthood, to maintain the continuity of care.
- All the medical staff involved in treating children and young people were trained in paediatric resuscitation.

Major incident awareness and training

- Staff we spoke to was aware of the procedures for managing major incidents, winter pressures and fire safety incidents.
- Emergency plans and evacuation procedures were in place which identified what measures would be put into place should a major incident require paediatric expertise. Staff were trained in how to respond to major incidents.

Are services for children and young people effective?

Good

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

We rated effective as 'good'

- Staff provided care to children that took account of national guidance. Local policies were written in line with these and had been kept up to date.
- The clinical outcomes related to children's eye surgeries were monitored against the performance of individual ophthalmic surgeons.
- Paediatric pain management guidelines were available to staff. There was access to paediatric anaesthetists for advice on paediatric pain relief.
- Staff offered children a wide selection of age appropriate snacks. The trust's food menu did not offer specific food choices for children and young people. Staff told us only on rare occasions the children would stay in the eye ward during the lunch time. Staff would offer them food choices from the adult menu on these occasions.
- Staff had access to specific training to ensure they were able to meet the needs of the patients they delivered care to. Staff commented positively about the training opportunities and we heard examples where the trust had supported staff to develop their skills and knowledge base. Staff worked effectively in multi-disciplinary teams and with external providers to provide a holistic approach to care.
- The acute referral eye unit at Royal Bournemouth Hospital (RBH) offered a seven-day service for children and young people suffering with acute eye problems. The unit was open between 8am and 6pm.The trust did not offer any other children services that were accessible seven days a week
- Children and young people were consented appropriately and correctly. Young people were presumed to be able to give consent depending on their

maturity and the nature of the decision. Staff undertook competency assessment and, when a patient was found not competent, only a person with parental responsibility was able to give consent.
- Discharge summaries were provided to GPs to inform them of their patient's medical condition and the treatment they had received.

Evidence-based care and treatment

- Staff provided care to children based on national guidance, such as 'National Institute for Health and Care Excellence' (NICE) guidelines and relevant Royal College of Paediatrics and Child Health (RCPCH) guidelines. Local policies were written in line with these and had been kept up to date.
- We saw examples of national guidance being followed including NICE guidance for 'atopic eczema in under 12s' and implementation of the 'eczema' pathway.
- Assessment and treatment given was in line with The Royal College of Ophthalmologists in the children's eye unit and care interventions were based on 'The British Society of Allergy and Clinical Immunology' in the allergy clinics.
- The paediatric dermatology unit was currently undertaking a national clinical audit of paediatric eczema management to measure its compliance against NICE guidelines. This audit was in progress at the time of the inspection.
- The children's eye ward participated in a few local audits such as infection control audits and orthoptic clinical case review audits. The service had developed action plans in response to these audit outcomes and these were being implemented and monitored.
- The eye unit was currently undertaking a school vision screening audit and an audit related to comparison of visual acuity found at school screening. These audits were in progress at the time of the inspection.

Pain relief

- Paediatric pain management guidelines were available to staff. There was access to paediatric anaesthetists for advice on paediatric pain relief.
- Paediatric pain assessment charts were in use in the nursing documentation we reviewed. Pain relief was reviewed for effectiveness and changed if necessary.
- Pain relief was discussed with parents after children's surgery. Medication records we reviewed showed clear prescribing of pain relief and the time, route and dose of the medication administered.
- Parents were positive about the pain management for children and commented that pain relief for their child had been highly effective.

Nutrition and hydration

- Staff offered children a wide selection of age appropriate snacks. The trust's food menu did not offer specific food choices for children and young people. Staff told us only on rare occasions the children would stay in the eye ward during the lunch time. Staff would offer them food choices from the adult menu on these occasions.
- There were no facilities available for parents to prepare their own food and beverages. Parents were offered tea and coffee on a regular basis. There were facilities available in the hospital for parents to buy snacks and drinks.

Patient outcomes

- The trust did not participate in any national audits related to children and young people as there were no listed national audits that met the eligibility criteria for participation.
- The senior nursing staff on the children's eye ward told us the clinical outcomes related to children's eye surgeries were monitored against the performance of individual ophthalmic surgeon. The trust was not able to provide us this performance data. However, the children's eye service did not record any untoward outcomes or incidents November 2014-October 2015.
- The results of the children's inpatient satisfaction survey (October 2015) of the children's eye ward was extremely positive with 100% of the children and parents rating the experience of care as 'excellent'.

Competent staff

- Staff told us they had regular annual appraisals. The data provided by the trust demonstrated that November 2014 to October 2015, appraisal completion rate for paediatric nurses was 100%.
- Staff had access to specific training to ensure they were able to meet the needs of the patients they delivered care to. For example; the staff on the children's eye ward

had access to the 'eye course' that was run by the eye unit. The orthoptist department conducted in-service training sessions which were accessible to all the staff in the children's eye ward and outpatient clinics.

- Staff commented positively about the training opportunities and we heard examples where the trust had supported staff to develop their skills and knowledge base. For example, the therapy staff from the Dorset prosthetic centre regularly participated in national prosthesis development meetings and attended the annual national conference. The children's specialist nurse in the dermatology unit was studying a masters module in child allergies.
- Paediatric nurses on the children's eye told us they occasionally met with paediatric nurses working in the emergency department which gave them opportunities to share practices and learn. However, there were no formal meetings or forums arranged to encourage shared learning

Multidisciplinary working

- There was an evidence of effective multidisciplinary working across various children and young people services within the trust. There was a range of multidisciplinary staff providing care and treatment to patients on the paediatric eye unit including orthoptists, optometrists, medical and nursing staff.
- The orthoptist service worked closely with community health visitors, school nurses and GPs and also provided outreach service at various community hospitals within Dorset.
- The staff at the Dorset prosthetic centre had close links with schools, community therapists and health visitors. The therapy staff often linked with school teachers to discuss the integration of a child with a prosthetic limb with other school children. The staff also did joint working with the child development centre at Poole.
- The Dorset prosthetic centre offered counselling service to provide psychological support for patients and parents of children who were referred for prosthetic limb fitting. The counselling service was provided by a trained counsellor.
- The paediatric dermatology service held dermatology and allergy clinics across Christchurch hospital and the Royal Bournemouth hospital (RBH).The staff had close working relationships with community services, health visitors, GPs and school nurses. The specialist nurse within this service participated in various networking events across Dorset for learning and sharing best practice.
- The children services had access to children and adolescent mental health services (CAMHS) which was offered by the local mental health trust for those children who needed psychological support. However, staff told us there was a long waiting time for the CAMHS service which often delayed assessments for children and young adults with mental health problems.

Seven-day services

- The acute referral eye unit at RBH offered a seven-day service for children and young people suffering with acute eye problems. The unit was open between 8am and 6pm every day of the week. This unit was run by ophthalmology consultants and ophthalmic nurses. Any children needing inpatient admissions were transferred to Poole Hospital as the hospital did not offer any inpatient paediatric facilities.
- The trust did not offer any other children services that were accessible seven days a week.

Access to information

- The trust had recently introduced electronic records system to store patient records. Staff on the eye unit had mixed views about the effectiveness of this system. The staff used paper notes for the pre-operative assessments of children undergoing eye surgery which were scanned onto the electronic system. However, staff told us there were often delays in the scanning process. The required information was not always available when a child came for surgery or for a follow up appointment. This had also led to delays in patient appointments. Staff had reported this as an incident and it was also reported as a risk on the departmental risk register.
- Discharge summaries were completed for GPs and the majority of these were done within 48 hours, with only a few delays. Discharge summaries for day cases were done on the same day.
- GPs and opticians had access to a referral and advice line run by acute referral eye unit seven days a week.

Services for children and young people

Consent

- We spoke with staff who confirmed that patient consent would be sought prior to any procedures or tests being undertaken. Children and parents we spoke with told us they had been involved in decisions relating to the treatment offered to them.
- Young people were presumed to be able to give consent depending on their maturity and the nature of the decision. Staff undertook competency assessment and if a patient was found not competent, they asked a person with parental responsibility to give consent.
- The patient records we viewed included a record of parental responsibility. We observed that parental responsibility was established and recorded at an early stage in assessment.
- Consent forms for surgical procedures that we reviewed were fully completed and signed, and included information about risks and benefits of the procedure.

Are services for children and young people caring?

Outstanding ☆

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

We rated caring as 'outstanding'.

- Children and young people were treated by staff with compassion, dignity and respect.
- Feedback from children and their parents was consistently positive about the way staff treated them.
- The results of the children's inpatient satisfaction survey (October 2015) of the children's eye ward was extremely positive with 100% of the children and parents rating the care as 'excellent'.
- Staff had developed a person-centred culture. Staff were motivated to offer care that was kind, supportive, and open. Staff were committed to work in partnership with children and their parents. Children and their parents were involved in their care and treatment and were encouraged to ask questions.
- Parents were able to accompany their children to theatre and recovery areas and were informed by ward staff when their children were out of theatre so they could re-join them to help lessen anxieties.
- Staff considered children's emotional needs and this aspect of their care was embedded in their treatment plans. During our inspection we observed that staff were responsive to children's needs.

Compassionate care

- We observed many examples of compassionate and understanding care being delivered by friendly, approachable and committed staff.
- We spoke with six parents and four children who all told us they had received empathetic and compassionate care. Parents told us the staff had developed trusting relationships with their children.
- We heard and saw written examples of positive comments from parents, relatives and children who used the service. Comments included staff being friendly and kind and creating a stress-free environment for children and parents. Others described the services and hospital as 'excellent'.
- The children's inpatient satisfaction survey (October 2015) was printed with pictures for ease of understanding at any age. The results of the survey of the children's eye ward were extremely positive with 100% of the children and parents rating the care as 'excellent'.

Understanding and involvement of patients and those close to them

- We observed clinicians communicating well with, and listening to, children and their parents. They were responsive to all questions and asked parents' views.
- Children and their parents told us they understood and were involved in their care and treatment and were kept updated. We observed children and their parents were encouraged to ask questions prior to treatments beginning.
- Parents were able to accompany their children to theatre and recovery areas and were informed by ward staff when their children were out of theatre so they could re-join them to help lessen anxieties.
- A parent of a child who had undergone an eye surgery commented in a feedback letter: "Full and clear discharge instructions were given together with several chances to ask any questions. A follow up call the

following day was very well received and very reassuring". They added, "Thank you all for your care and support-I have one very happy child who is currently extremely proud of himself for undergoing the surgery and very grateful for the outcome".

- Another stated, "From the initial assessment to the day of the operation to being discharged I always felt well informed. All very well organised and I liked it when staff chatted to my daughter too about what they were doing because this eased her nerves".
- Parents of children attending in the paediatric dermatology clinic made comments such as "The doctor kept us well informed at all times. I was told I was welcome to phone at any time for advice, this reassured me greatly".
- The care plans we reviewed were patient focused and showed clear evidence of parents and children being involved in decisions about their care.
- There were positive responses to questions about involvement in care in the children's inpatient satisfaction survey (October 2015).

Emotional support

- Psychology support service was available for children and young people and their parents attending the Dorset prosthetic centre. We were given an example of when staff offered a series of psychological counselling sessions to a young child whose parent had undergone an amputation of their limb.
- The paediatric dermatology specialist nurse offered 'exam support service' for teenagers who suffered with allergies to help them manage during their school exams. This support was offered through an exam support hotline once a week. The service offered advice, step up and step down plans and psychological support for exam going teenagers whose allergies usually flared up during this stressful period.
- Children, young people and their parents were positive about the emotional support provided by the staff. One parent told us, "The emotional support offered by the nursing and medical staff at time of my son's eye surgery was overwhelming". They added, "My son did not want to leave the hospital".

Are services for children and young people responsive?

Good

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

We rated responsive as 'good'

- There were good examples of staff and teams working responsively to meet service demands and responding to the needs and preference of children, young people and their families. There was good access to the service, with seven day access to the acute referral eye unit. GPs and opticians could refer a child to this unit by accessing a dedicated telephone referral line. Patients were also able to self-refer to this service.
- There was clear guidance for staff on 'which patients to accept for eye surgery' at the eye unit at the Royal Bournemouth Hospital (RBH).Children aged under one year old and those with multiple comorbidities and traumatic eye injury were referred to Poole or Southampton hospitals for treatment.
- Information leaflets were available on a number of health topics and treatments in both inpatient and outpatient settings. Health promotion information and access to local services was available for children and young people. Translation and interpreter services were available.
- There were good links with the paediatric community teams. Referrals were made and communicated with this team in a timely manner so that consistent and appropriate on-going care could be maintained.
- The paediatric dermatology service was consistently achieving the 18-week referral-to-treatment time target against the national target 90% (October 2014-October 2015).
- Extra support was offered to children who were reluctant or having problems wearing glasses. Parents of these children had an access to a direct telephone line to contact orthoptists and paediatric nurses for advice.
- Complaints were handled appropriately in line with trust policy and these were reviewed to improve the service.

However,

- The referral to treatment times for paediatric ophthalmology service inpatients was 88%.

Services for children and young people

Service planning and delivery to meet the needs of local people

- The services for children and young people at RBH and Christchurch hospital were planned in partnership with Poole Hospital who provided acute paediatric support and inpatient facilities for children.
- There was clear guidance for staff on 'which patients to accept for eye surgery' at the eye unit at the RBH. Children aged under one year old and those who weighed less than 10 kilograms were not accepted at the eye unit for surgery. These children were referred to other specialist eye centres in the local region.
- Children and young people with multiple comorbidities or those with traumatic eye injury were referred to Poole Hospital or Southampton General Hospital.
- Young people were offered a choice of either going to a paediatric or adult ward following their eye surgery. Ward staff told us that they always grouped patients by considering their age and sex. For example; male and female young patients were operated on separate days. There were no young people on any adult ward at the time of inspection.
- Age appropriate facilities were available on the ward and outpatient department for children and young people.
- Consultant paediatricians from Poole hospital conducted general paediatric satellite outpatient clinics at the RBH for patients who lived geographically closer to the hospital. The children who attended these clinics were able to access phlebotomy services at the hospital if they required blood tests.

Access and flow

- The acute referral eye unit was open seven days a week. GPs and opticians could refer a child to this unit by accessing a dedicated telephone referral line. Patients were also able to self-refer to this service. Parents of the children we spoke with found this service beneficial as it gave a rapid access to assessment and treatment.
- Patients were prioritised in the eye unit according to clinical need. Children were always prioritised on the theatre lists to be first in getting operated. The children's eye surgeries were scheduled for once a week with maximum of three children scheduled for the surgery on the day.
- Pre-operative assessment was undertaken one week before surgery. This was always a face to face appointment led by paediatric nurses. Children or their parents received a follow up call from paediatric nurses on the day after their surgery which was followed up by the doctor's appointment.
- Waiting times for appointments were monitored in paediatric dermatology outpatient clinics. Patients were given the choice of which hospital, either in Christchurch or RBH, they wished to attend for clinic. To ensure a responsive service, dermatology consultants and the specialist paediatric dermatology nurse offered telephone or face to face appointments for patients or parents needing urgent advice.
- The paediatric dermatology service was consistently achieving the 18-week referral-to-treatment time target against the national target 90% (October 2014-October 2015).The compliance rate for paediatric ophthalmology service for inpatients was 88%.
- There were good links with the paediatric community teams. Referrals were made and communicated with this team in a timely manner so that consistent and appropriate on-going care could be maintained.

Meeting people's individual needs

- Children were cared for and treated in bright child friendly wards and spaces. The children eye ward had a variety of age appropriate toys and play equipment and access to play area. The paediatric outpatient clinic areas at the RBH provided a 'child-friendly' environment with walls in the waiting area decorated with animal pictures. All areas were wheelchair accessible.
- Paediatric dermatology outpatient team could refer children with infected skin conditions to the dermatology unit at the Christchurch hospital. Children attended this unit for treatment on a daily basis, if necessary, until their condition was under control. The dermatology nurses worked closely with parents in making a management plan to treat the skin condition. They also liaised with school nurses and school staff if a child had to miss their school for a number of days.
- Paediatric nurses and orthoptists offered support to children who were reluctant to, or having problems with wearing glasses. The parents of these children had a direct telephone line to contact orthoptists and paediatric nurses for advice. Children were also offered a day therapy session by paediatric nurses to support them to wear glasses.

Services for children and young people

- Information leaflets were available on a number of health topics and treatments including squints, childhood eczema and skin conditions and eye patches. These were available in both inpatient and outpatient settings.
- There were child friendly versions of information leaflets to encourage children to understand the care and treatment. For example; the eye unit used 'Davy the detective' information booklet through which children could find out about the anaesthetics.
- Health promotion information and access to local services was available for children and young people.
- Information on how to access hospital services was available for people within clinical areas or on-line via the trust's web-page.
- Staff reported there was access to interpreters and a translation service should this be required.

Learning from complaints and concerns

- Complaints were handled in line with the trust complaints policy. We noted there was clear information available within the service to inform people how to make a compliant or how to contact the patient advice and liaison service (PALS).
- Complaints were discussed at the individual children service's clinical improvement and management team meetings. Outcomes and actions were disseminated to staff through formal and informal meetings.

Are services for children and young people well-led?

Good

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

We rated well led as 'good'

- Staff were aware of the trust's overall strategy and described high quality patient care as key components of the trust's vision.
- There was an effective governance structure to manage risk and quality.
- Staff felt supported by their managers. There was strong local leadership on the children's eye ward and dermatology unit.
- Children and young people were encouraged to feedback ideas to improve the service. Staff were passionate to deliver quality care and an excellent patient experience.
- The culture was caring and supportive. Staff were actively engaged and there was a culture of innovation and learning.
- There was a cost improvement transformation group for every directorate in the trust. The service leads considered 'safety and quality' as a priority in the cost improvement plans (CIPs).
- The speciality services directorate were committed to improving the children's speciality services and worked towards the sustainability of these services.

However,

- The directorate leads for ophthalmology and specialist services, which included the children and young people services, did not have a documented vision or strategy for children and young people.
- Staff on the eye ward did not feel a strong connection with senior hospital management.
- The service leads could not tell us about succession or sustainability plans for paediatric dermatology service. There was currently only one specialist paediatric dermatology nurse upon whom the service heavily relied.

Vision and strategy for this service

- The trust had set up a new care group structure, with three main care groups made up of departmental specialties. Staff understood this structure and clinical leads felt this was now embedded within the trust. Progress was discussed at senior manager level.
- The strategic direction of services was open to review at the time of the inspection, as a result of the Dorset Clinical Commissioning review. The trust described its five-year strategic plan for patient care, underpinned by six strategic objectives.
- The services provided for children and young people were under 'ophthalmology' and 'specialist services' directorates which were within the 'specialities care group'. The directorate leads for ophthalmology and specialist services did not have a documented vision or

strategy for children and young people. The leads told us that the children and young people's services were getting reviewed as a part of clinical service review plans across Dorset.
- Staff we spoke with were aware of the trust's strategy and described high quality patient care as key components of the trust's vision. The staff were passionate about improving services for children and young people and providing a high quality service.

Governance, risk management and quality measurement

- The specialist services and ophthalmology directorates, which included the children and young people services, had monthly clinical governance meetings where the results from clinical audits, incidents, complaints and patients' feedback were discussed. We reviewed minutes of clinical governance meetings which had minimal information about risks and quality measurements associated with children and young people. The patients' experience data were reviewed and monitored at these meetings.
- The specialist services and ophthalmology directorates did not have mortality and morbidity meetings in 2015 as there were no patient related deaths associated with these services. The trust informed us that any deaths related to children and young people would be discussed at the monthly quality and audit meetings if required.
- The children's eye ward we visited did not have regular team meetings. However, the staff on the children's eye ward could attend the team meeting on the adult eye ward at which performance issues, concerns and complaints were discussed. If staff were unable to attend ward meetings, steps were taken to communicate key messages to them.
- The specialist services and ophthalmology directorate had a risk register that included known areas of risk. These risks were documented and a record of the action being taken to reduce the level of risk was maintained. The risks were reviewed regularly in the clinical governance meetings and appropriately escalated. The higher risks were escalated to the trust's risk register where they were reviewed by the trust's executive committee. The risk register for the ophthalmology directorate identified the risk and issues around access to children's records using the electronic data monitoring system. No other risks related to children and young people were identified on the risk register.
- The trust produced a monthly newsletter which was shared with staff. This included patient stories and lessons learnt.

Leadership of service

- There was good local leadership at the children's eye ward, paediatric dermatology unit and the Dorset prosthetic centre. Clinical staff felt well supported by their immediate managers. Nursing staff told us of the many ways they had been supported locally by their ward managers and consultant colleagues.
- Staff on the eye unit said their unit was well organised and a good place to work, but they did not feel a strong connection with senior hospital management.

Culture within the service

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

Public engagement

- There were various initiatives in place to gain the feedback from children and young people and their families. These included patient survey feedback such as the NHS Friends and Family test and the 'children's inpatient satisfaction survey'. Children were encouraged to complete the form which included smiley faces and well-known cartoon characters to help communicate what they felt was good or bad about the service. The

results of the survey of the children's eye ward were positive with 100% of the children and parents rating the care as 'excellent'. This feedback was displayed throughout the children outpatient and ward areas.

Staff engagement

- Information was sent to staff regularly by email and the trust's monthly newsletter. Staff were encouraged to look at the staff intranet.

Innovation, improvement and sustainability

- There were examples of innovative service delivery and clinical practice. This included the use of 'exam support hotline' for teenagers who suffered with skin allergies which were worse at exam time.
- The service leads acknowledged there was a substantial financial challenge on the services and cost improvement was identified as one of the priorities. There was a cost improvement transformation group for every directorate in the trust. The service leads considered 'safety and quality' as a priority in the cost improvement plans (CIPs).
- The speciality services directorate were committed to improving the children's speciality services and worked towards the sustainability of these services. The ophthalmology service was sustainable as was a team based work, part of the wider ophthalmology surgery service. However, the leads could not tell us about succession or sustainability plans for paediatric dermatology service. There was currently only one specialist paediatric dermatology nurse upon whom the service heavily relied.

End of life care

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

Information about the service

Patients at the hospital with end of life needs at Royal Bournemouth Hospital are cared for on the general wards. They are supported by a consultant-led hospital palliative care (HPC) team. This team also included an end of life care nurse specialist.

The team provides specialist advice, support, training and education in palliative care across the trust. It comprises of three consultant (2.95 whole time equivalent) and 5.2 whole time equivalent palliative care clinical nurse specialists and one end of life care nurse specialist. In 2014, there were 1768 deaths across both hospitals: 1477 at the Royal Bournemouth and 298 at Christchurch Hospital.

There is also an end of life care team to support staff on the wards to care for patients who are at the end of their lives. This team comprises of one end of life clinical nurse specialist working with staff on the wards. Staff from both the palliative care team and the end of life care team care for people at the end of the life. Individual wards have palliative care link nurses who act as champions. They take on additional training for this role and are given time to attend meetings and training sessions. Both teams are well-supported by the trust support staff, the chaplaincy team and the mortuary staff.

During the inspection we visited three general medical wards, the oncology wards, two general surgery wards and one orthopaedic ward, the bereavement office, the mortuary, and the chapel. We spoke with 10 patients, five relatives, 15 nurses, eight consultants, 12 healthcare assistants, four ward sisters, four matrons, two managers, eight domestic staff and three volunteers. We also spoke with the mortuary staff and three members of the chaplaincy team. We observed interactions between patients, their relatives and staff, considered the environment and looked at 34 'Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR) orders and ten medical and nursing records.

Before our inspection, we reviewed performance information from and about the hospital.

End of life care

Summary of findings

We rated end of life care at the hospital as 'good' for safe, effective, caring, responsive, and well-led care.

There was a good track record and steady improvements in safety. Staff were aware of their responsibilities to report incidents and they received feedback on these incidents. Learning from incidents had taken place. Improvements to safety were made and the resulting changes monitored.

There were clearly defined and embedded systems to keep people safe. Arrangements to minimise risks to patients were in place including measures to prevent falls, and pressure ulcers. Patients had comprehensive assessments of their needs and were appropriately monitored. Staff demonstrated a good understanding of the early identification of a patients whose condition might deteriorate. The mortuary was appropriately clean. . All wards had documentation of the new care plan that the trust had introduced in August 2013 to replace the Liverpool Care Pathway

People's care and treatment was planned and delivered based on current national and evidence-based guidance. There were local guidelines for the management of the five key symptoms at the end of life. The end of life care steering group had successfully introduced personalised care plan for the last days of life (PCPLDL). Wards we visited were aware of this documentation which was a replacement following the national withdrawal of the Liverpool Care Pathway in July 2014. The trust was piloting AMBER Care Bundle on some wards. This was in response to an overarching vision and six ambitions identified in the National Framework of Ambition for Palliative and End of Life Care, 2015-2020.

There was participation in relevant local and national clinical audits. The trust participated in the National care of the dying audit for hospitals (NCDAH) 2013/14 and performed worse than average for six out of seven organisational indicators. However, a trust review in August 2015 demonstrated that the trust had achieved progress in five out of seven indicators and there were ongoing plans for improvement.

Feedback from people who use the service was consistently positive about the way staff treat people. Patients were cared for by compassionate and caring staff and we observed patients being treated with dignity and respect.

Patients told us they were well informed in their treatment and care. For example staff spent time talking to people to discuss and allay their fears.

There was a clear statement of vision of end of life care. This vision was based on promoting quality of care and a culture of patient safety. The trust, after our visit, produced a document with an overarching strategy for end of life care based on existing strategic objectives and actions to meet national guidance and standards. This had not been subject to consultation or consideration by the trust board.

A consultant in palliative medicine was the clinical lead who championed end of life care and palliative care, and the associate medical director provided leadership and support. There was a steering group to monitor performance against national standards. Strategic objectives were supported by quantifiable and measurable outcomes, which were cascaded throughout the organisation.

The end of life steering group met regularly and the quality of the service was monitored by an audit program. The end of life care team had developed their own performance dashboard based on national standards and local guidance. This was presented to the trust board on a monthly basis, for discussion.

End of life care

Are end of life care services safe?

Good

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

We rated safe as 'good'.

- Performance showed a good track record and steady improvements in safety.Staff were aware of their responsibilities to report incidents and they received feedback on these incidents. Learning from incidents had taken place. Improvements to safety were made and the resulting changes monitored.
- There were clearly defined and embedded systems to keep people safe.Arrangements to minimise risks to patients were in place including measures to prevent falls, and pressure ulcers.
- Patients had comprehensive assessments of their needs and were appropriately monitored. Staff demonstrated a good understanding of the early identification of a patients whose condition might deteriorate.
- Staff adhered to infection prevention and control practices, safe management of medicines and the secure management of patient records. The mortuary was appropriately clean.
- All wards had documentation of the new care plan that the trust had introduced in July 2014 to replace the Liverpool Care Pathway.
- Staff knew how to assess and respond to patient risks, including safeguarding.
- The majority of do not attempt cardio pulmonary resuscitation (DNACPR) forms had been appropriate completed.
- The trust had introduced mandatory end of life care training the uptake was being monitored.
- There were appropriate medical and nursing staffing to support end of life care.

However,

Some DNACPR forms needed to include the counter signature of a consultant within 48 hours of the form been signed by a registrar or junior doctor.

Incidents

- Staff reported incidents on the trust-wide electronic reporting system. In April 2015, the trust had moved from a paper system to an electronic system. This was available in all ward areas via the trust intranet home page. Staff we spoke with understood their responsibilities to raise concerns, to record safety incidents and near misses. The team delivering hospital palliative care and end of life care were aware of their responsibilities to report incidents and reported incidents using the hospital electronic system. Nurses on the wards were also aware of their responsibilities to report incidents.
- Between July 2014 and August 2015 there had been three serious incidents and one moderate incident relate to patients receiving end of life care. The serious incidents covered two patients where there was a deterioration in pressure areas to grade 3 and one patient fell and fractured his left hip. Learning resulted from the two pressure ulcer incidents, were found to be avoidable, with actions including the purchase of new pressure relieving equipment and a 'care board' to raise awareness regarding when re-positioning of a patient needed. There was also an introduction of a daily safety briefing as a result of these incidents.
- The new regulation, Duty of Candour, is concerned with openness and transparency and places a responsibility on NHS hospitals to inform patients when things have gone wrong when either severe or moderate harm has been caused.
- The Duty of Candour was discussed at an end of life care steering group meeting. The discussion was led by the lead of this steering group who outlined its origins and importance to patients and relatives. The trust monitored Duty of Candour through their online incident reporting system.
- Staff we spoke with had an understanding of the Duty of Candour. Staff had received guidance and information on the Duty of Candour. It was also available to them on the intranet. Two members of staff showed us where on the intranet they would find this information.

Cleanliness, infection control and hygiene

End of life care

- The mortuary was visibly clean and well-ventilated. It was cleaned every day at the end of the day by a specially trained cleaner. Records were kept that showed checks were undertaken on a daily basis. There was appropriate hand washing facilities.
- In the mortuary we observed a sharps bin which was sealed and safe.

Environment and equipment

- The National Patient Safety Agency recommended, during 2011, that all Graseby syringe drivers (a device for delivering medicines continuously under the skin) should be withdrawn by December 2015. During the inspection, we found that the Graseby syringe driver had not been withdrawn from the hospital, although there was a plan to do so by the deadline of December 2015. Staff training on replacement syringe drivers was planned to be completed by 2 November 2015During our unannounced visit to the hospital on 4 November, we visited six wards where patients were receiving end of life care, and spoke with one porter. All the wards we visited were aware of the new syringe driver launch that took place that week, and the Graseby syringe drivers had been withdrawn. We also saw the new syringe driver in use with two patients. Nurses using this new syringe drivers told us they were trained in it. We saw documentation that confirmed their training. They also had information packs regarding the new syringe driver. Fourteen staff had been trained across the six wards we visited. The policy for the new syringe drivers was on the trust intranet and there was a patient information leaflet that all patients had on this new equipment.
- The safety of other equipment was regularly maintained and checked to ensure it was safe to use.
- Equipment used in the mortuary was maintained and checked regularly.Records demonstrated that the trolleys and refrigeration system were checked daily by the mortuary staff and annually by the external contractors.
- There were contingency plans for safe management and moving of bariatric patients. Mortuary staff had received appropriate training to store deceased bariatric patients. Porters had received specialist training in moving a bariatric patient from the ward.

Medicines

- Staff followed the medicines policy and managed controlled drugs in accordance with the Controlled Drugs Regulation 2013.
- The trust had standard operating procedures for the prescribing of anticipatory medicines, medicines prescribed for the key symptoms in the dying phase (ie pain, agitation, excessive respiratory secretions, nausea, vomiting, and breathlessness). We reviewed three medical and nursing case notes of those patients identified as being in the last hours or days of life. We saw where the prescribing of anticipatory medications had been appropriate.
- When patients left the hospital, they were discharged with anticipatory medicines. However, no audit has been undertaken to confirm this was taking place.Nursing staff also received training on the use of anticipatory medicines.

Records

- The trust had introduced a new end of life care plan in August 2013.. This was known as 'personalised care plan for the last days of life.' This was in response to the national withdrawal of the Liverpool Care Pathway in July 2014. All the wards we visited were using this plan and they had all been completed and updated appropriately. The nursing section of this was with the patient, the medical section in the medical notes.
- During our inspection, we saw medical notes for end of life patients were stored in trolleys inside the nurses and/ or doctor's office. The doors of these rooms left closed and the trolleys were secured.
- The trust carried out audits of do not attempt cardio pulmonary resuscitation (DNACPR) forms and the data compared over two audit cycles, in July 2013 and the most recent audit March 2014. Both audits looked at 30 forms. Since the previous DNACPR audit in July 2013 there had been significant improvement in the number of forms where a senior clinician had signed/or endorsed the form within 48 hours, from 80% in 2013 to 90% in 2014.
- We inspected 34 do not attempt cardio pulmonary resuscitation (DNACPR) forms throughout the ward areas. Thirty forms were appropriately completed. However, four forms had not been completed in line with national guidance published by the General Medical Council (GMC). The areas of shortfall included the counter signature of a consultant within 48 hours of

the form been signed by a registrar or junior doctor. We highlighted these forms to the senior staff on the ward so that corrective actions could be taken. There was an action plan to improve this across the hospital.

Safeguarding

- There was a policy in place that outlined the processes for safeguarding children and vulnerable adults.
- Safeguarding training was mandatory. Staff from the team delivering hospital palliative care and end of life carehad undertaken safeguarding training. They were knowledgeable about their roles and responsibilities regarding the safeguarding of vulnerable adults and children.
- Staff were aware of the whistleblowing policy and felt they could report any concern. They were confident that concerns would be addressed.

Mandatory training

- The team delivering hospital palliative care and end of life care had completed mandatory training. This included training on fire safety, basic life support, moving and handling and safeguarding adults and children. This was confirmed by checking records held centrally.
- The trust followed national recommendations from the National Care of the Dying Audit-Hospital (NCDAH) (2013/14) for hospitals to have mandatory training in end of life care for doctors and nurses. As a result, the trust had introduced an advanced communication skills training, which had been made available to all consultants. At the time of inspection, 137 consultants had completed this training.. The trust was also introducing a new mandatory training programme in end of life care for all relevant staff in January 2016.

Assessing and responding to patient risk

- Nursing staff used an early warning system, based on the National Early Warning Score (NEWS), to record routine physiological observations such as blood pressure, temperature and heart rate. NEWS was used to monitor patients and initiated calls to the medical staff when required. We saw examples of care being escalated promptly when a patient's condition had deteriorated.
- Ward staff told us that the end of life care team were visible on the wards and supported the management of deteriorating patients. They would be involved in multidisciplinary review meetings.
- Patients at the end of their life were monitored appropriately. The personalised care plan for the last days of life (PCPLDL) provided nursing and medical staff with prompts to ensure, for example, mouth care, symptom control.
- Written safety briefings were in place that included staffing, patient allocation, bed availability, patients at increased risk of falling, and patients at risk of pressure damage. Some pressure damage was seen in end of life care patients and was unavoidable.
- Staff were aware of how to escalate changes in patient's condition to relevant clinical staff. In such instances, their first call would be to contact the end of life care team for advice and guidance.
- The results of the NCDAH 2013/14 showed that 73% of patients where health professionals had discussions with both the patient and their relatives/friends regarding their recognition that the patient was dying. The trust scored higher than the national average for review of the number of assessments undertaken in the patient's last 24 hours of life. Eighty-nine percent of RBCH patients were assessed five or more time (against the national average of 82%).
- The AMBER care bundle was being rolled out across the hospital and a recent audit (August 2015) showed it was being effectively used in the wards. The AMBER care bundle was an approach used in hospital when doctors were uncertain whether a patient may recover. Generally, it was initiated when patients had a few months to live. Staff we spoke with were aware of the AMBER care bundle and the end of life care nurses were raising awareness of this on the wards.

Nursing staffing

- The hospital palliative care team included 2.8 whole time equivalent (WTE) palliative care clinical nurse specialists. The trust also had one end of life care nurse specialist who reported to the palliative care clinical nurse specialist. Staff on the wards welcomed the recent appointment (August 2014) of the end of life care nurse specialist's hours making the role full-time.

End of life care

- The palliative care team were part of the cancer care directorate. They were supported by a directorate matron. Staff on the wards told us there were sufficient numbers of staff in this team to provide support for the caring of end of life care patients on the wards.
- As part of the end of life care link nurse programme, each ward had an end of life champion. The end of life champion shared relevant end of life information and enabled two-way communication between the specialist teams and nurses in the clinical area in order to increase awareness of end of life and palliative care. This further supported the ward in ensuring there were sufficient numbers of nursing staff on the ward to provide end of life care.
- There were safety briefings that included information on patients requiring end of life care. This ensured there was safe handover of care at the end of a ward shift.

Medical staffing

- There were three palliative care consultants who were employed by the trust. The number of palliative consultants within the trust, and for this hospital, complies with the Association for Palliative Medicine of Great Britain and Ireland guidelines which state that there should be a minimum of one palliative care consultant for every 250 beds.
- Junior doctors told us they received a high level of support from the palliative care consultant out of hours. One junior doctor told us there was high level of support and encouragement to develop skills, expertise and advanced learning in end of life care.
- Medical support out of hours was provided by a team including palliative care consultants and specialty doctors, organised using an on call rota.

Major incident awareness and training

- The trust had suitable major incident plans in place. A major incident policy was in place for all trust staff and outlined how The Royal Bournemouth and Christchurch NHS Foundation Trust would respond in the event of an emergency (major incident). Major incident training was included on the trust corporate induction and in the local induction for all new staff.
- Both the teams delivering hospital palliative care and end of life care and staff on wards were aware of the major incident plan and actions to take in the event of a major incident.
- There was a contingency plan in the event that the mortuary became full and arrangements with local undertakers. There was a business continuity plans which detailed how the mortuary would operate following any incident that interrupted the day to day running of the mortuary. Staff could not recall when the mortuary was last full.
- The staff in the mortuary had received major incident training and were aware of any actions to take.
- There were contingency plans to mitigate the disruption caused by major roadworks affecting access to and from the hospital.

Are end of life care services effective?

Good

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

We rated effective as "good".

- People's care and treatment was planned and delivered based on current national and evidence-based guidance.
- There were local guidelines for the management of the five key symptoms at the end of life. The end of life care team had successfully introduced personalised care plan for the last days of life (PCPLDL). Wards we visited were aware of this documentation which was a replacement following the national withdrawal of the Liverpool Care Pathway in July 2014.
- The trust was piloting AMBER Care Bundle on some wards. This was in response to an overarching vision and six ambitions identified in the National Framework of Ambition for Palliative and End of Life Care, 2015-2020.
- There was participation in relevant local and national clinical audits. The trust participated in the National care of the dying audit for hospitals (NCDAH) 2013/14 and performed worse than average for six out of seven organisational indicators. The trust had developed its clinical audit programme based on the national framework end of life care and has achieved progress in five out of seven indicators in August 2015. There were ongoing plans for improvement.

End of life care

- The majority of do not attempt cardiopulmonary resuscitation (DNACPR) forms were appropriately completed in terms of discussions with patients and their families and mental capacity assessment.

Evidence-based care and treatment

- The service took account of national guidance such as the National Institute for Health and Care Excellence (NICE) quality standard 13, which defines clinical best practice in end of life care for adults, and the Department of Health's National End of Life Care Strategy.
- The trust was piloting AMBER Care Bundle on some wards. This was in response to an overarching vision and six ambitions identified in the National Framework of Ambition for Palliative and End of Life Care, 2015-2020.
- Following the national withdrawal of the Liverpool Care Pathway in July 2013, the trust introduced 'personalised care plan for the last days of life' (PCPLDL). This document guided delivery of the priorities of care for patients recognised to be in their last few days or hours of life, for whom no potential reversibility was possible or appropriate. This was in response to the Leadership Alliance for the Care of Dying People (LACDP), 'One chance to get it right.' During our inspection we found patients identified at the end of life were receiving care based on this plan. For example, the end of life care nurse specialist actively promoted the use of AMBER care bundle and ensured wards used the PCPLDL for patients at the end of life.
- All staff reported having access to the Wessex Palliative Care Handbook of clinical guidelines (2014). These local guidelines were considered to be a good reference should they require guidance in end of life and palliative care delivery
- The trust had an audit programme in place to undertake an assessment of its end of life care. For example, following an opioid audit of 16 patients, one area of compliance was identified that needed to be addressed, and that was the prescription of a laxative with strong opioids. The specialist doctor in palliative medicine had designed a written leaflet for patients that includes frequently asked questions such as, 'what are opioids?' What are the side effects of opioids?
- The end of life steering group met regularly and the quality of the service was monitored by an audit program The end of life care team had also developed a service performance dashboard. This was discussed at the steering group and presented to the trust board on a monthly basis. The performance dashboard included information on audits undertaken, the results of the DNACPR audits and others. The board also received a report on the progress in meeting the objectives set out in the work plan.

Pain relief

- The trust's results from the NCDAH 2013/14 showed that, at the time of the patient's death, there was documented evidence that 'use when required' medication had been prescribed for 48% of patients; the England average was 50%. A follow up audit by the trust (June 2015) highlighted improvement in this. The monthly quality dashboard also highlighted sustained improvement in this.
- Ward staff told us they had appropriate medication to use for pain relief. They told us anticipatory prescribing was proactively managed. This was also confirmed by a senior consultant who visited on the wards.
- Staff used pain assessment tool to monitor the effectiveness of pain relief. The patient records we inspected showed patients received appropriate pain relief. Patient records provided instructions for staff on action to take to meet patient's individual needs.
- Patients told us their pain and comfort was well managed. Four relatives told us that staff ensured that their relative was pain free and kept comfortable. They told us they were involved in the discussions on the pain relief that was used
- Palliative care team told us pain management was a major part of their work on the wards. Their advice was sought and accepted.

Nutrition and hydration

- Patients told us the hospital food was nice. Snacks were available for patients outside of meal times.
- We found that most patients had a drink within their reach (18 out of 21 patients) which meant they could maintain hydration.
- Patients with special dietary requirements or who required assistance with eating were highlighted. We saw patients being assisted to eat. Patients who received special dietary requirements (including the provision of halal food) said the choice and variety was very good.

End of life care

- Recommendations for clinicians regarding artificial nutrition and hydration, and the legal and ethical guidelines for adult patients were available on the intranet. This included end of life care advice.

Patient outcomes

- The trust participated in the National Care of the Dying Audit-Hospitals (NCDAH) in 2013/2014. Of the 10 key performance indicators for clinical performance the trust scored worse than the England average for five. For the other five, the trust performance was similar to or slightly better than the England l average. For the organisational key performance indicators the trust did not achieve for six out of seven.
- The trust was monitoring progress against the indicators of the NCDAH through an action plan and monthly performance dashboard information. A recent action plan update (August2015) highlighted that the trust had made progress in all of the clinical performance and organisational key performance indicators where it had performed worse than the England average in the 2013/14 audit. For example, the trust had improved its documentation, appointed a third consultant in palliative medicine, appointed the end of life care nurse specialist rolled out the AMBER care bundle and recently launch of the seven day service.
- In the NCDAH 2013/14 the trust achieved a review of interventions during the dying phase in 57% of patients; this is better than the England average of 55%. The trust's follow up review demonstrated improved performance to 74%for the month of August 2015.

Competent staff

- The hospital palliative care team and end of life care nurse specialist were supported in various ways to develop their knowledge and competencies. These included continuing professional development days, team meetings and access to training and further qualifications.
- The hospital palliative care team and the end of life care nurse specialist had received clinical supervision and an annual appraisal.
- Specialist staff knew how to use the new syringe drivers effectively and safely. Training for this was provided and was rolled out to relevant staff across the hospital. As this was new equipment, only staff who had received this training were allowed to use it.
- Each ward had an end of life care link nurse who was supported with training to develop their skills and knowledge in palliative and end of life care. Link nurses we spoke with said their role was welcomed on the ward and valued by other staff.
- The hospital palliative care team visited wards and provided teaching sessions to doctors on ward rounds.
- The GMC junior doctors National Training Survey 2015 showed very high satisfaction with 100% scores for induction, adequate experience, clinical supervision and 96% for overall satisfaction. This was a positive compared to the national average.
- In July 2015, it was recognised by the trust that those patients at the end of life whilst in emergency department (ED) were not aware of as much information regarding end of life care as those patients on the wards. It was also recognised that families may have to deal with the death of a relative very suddenly. As a result a few staff from the ED had been trained on end of life care. This training was scheduled to be provided to all ED staff by the end of December 2015
- The mortuary technician has been trained to remove pacemakers and implantable cardioverter defibrillator (ICDs).An ICD is a device implanted into the body that treats people life –threatening cardiac arrhythmias. This procedure undertaken by the mortuary technician reduced the delay in releasing the body to the mortuary. .
- A new mouth care product has been introduced and training rolled out to all staff on the wards. Staff on 10 wards had been trained on its use by the end of October 2015 and a further 10 will be trained by the end of December 2015.

Multidisciplinary working

- The hospital palliative care team multidisciplinary meeting was held once a week. This team reviewed all cases of palliative care including the appropriateness of medicines and achievement of preferred place of care. Patients who were discharged or died were also discussed including on-going support to their families, where appropriate.
- The hospital palliative care team visited wards and attended ward rounds Staff throughout the hospital felt that the multidisciplinary team working was excellent. They felt the palliative team were very supportive

End of life care

- Staff told us they had good links in the community for example with coroner, hospice staff, funeral directors and religious community representatives.
- There were pathways in place for the discharge of patients to their homes. During our inspection we saw how quickly patients who wanted to move to their homes were able to do so. To enable patients to move home, staff linked with GPs and community services to help with this transition. Staff told us the links worked well.

Seven-day services

- The palliative care nurse specialists were available for urgent reviews and referrals between 8.30am to 4.30pm Monday to Friday. The palliative care nurse specialist had recently (November 2015) begun weekends and bank holiday service. The hospital palliative care team working hours provided telephone advice to acute hospital staff, community staff, patients and relatives in the evening, and overnight, 365 days a year.
- The consultants in palliative care were available 8.30am to 5.30pm Monday to Friday. They also provided out of hours telephone support and were on call at weekends, making visits where needed.
- Staff confirmed they could access advice and support from the team at any time.
- Chaplaincy support was available seven days a week. They were on call at the weekend.
- Pharmacy support was available on site Monday to Friday, and there was a pharmacist on-call for advice and any supply issues outside of normal working hours.
- The mortuary support at the Royal Bournemouth was available 24 hours seven days a week.

Access to information

- Staff had access to end of life information and guidance on the intranet. Staff found this resource valuable and easy to access.
- There was good access to the palliative care team for staff internal and external to the hospital.
- Records about patient care was shared with GPs through the discharge summaries. There was also a follow up regarding the care for end of life care patients through the district nursing support.
- There was a white board on each ward and staff could use symbols to identify patients on AMBER care bundle and the PCPLDL care plan. For example, patients following both the AMBER care bundle and PCPLDL, were allocated respective symbols. This meant that staff across the trust could identify how many patients there were on either the AMBER care bundle and PCPLDL care plan.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff told us they received training on consent and Mental Capacity Act.When patients did not have capacity to consent to care and treatment, staff were aware of what actions to take.
- We reviewed 34 DNACPR forms during inspection, only two forms did not show evidence that a discussion had taken place with the patient or any of their relatives before the form had been signed by medical staff. One form stated that the patient lacked capacity to understand the decision around the DNACPR but there was no evidence that a mental capacity assessment (MCA) had been undertaken. We highlighted these forms to the relevant clinical staff.
- There were consent arrangements in place for managing tissue removal after death.

Are end of life care services caring?

Good

By caring, we mean that staff involved and treated people with compassion, kindness, dignity and respect.

We rated caring as 'Good'

- Feedback from people who use the service was consistently positive about the way staff treat people. Patients were cared for by compassionate and caring staff and we observed patients being treated with dignity and respect.
- Patients told us they were well informed in their treatment and care. For example, improvements in communication were made.

End of life care

- Staff spent more time talking to people to discuss and allay their fears. Following the findings of national care of the dying audit the service had made improvements in the communication with patients and families about plans for care.
- Staff across the trust provided emotional support to patients and bereaved families. The bereavement support staff provided assistance to relatives after the death of a patient. They also guided relatives on how to register deaths.

Compassionate care

- We spoke with 10 patients who were receiving palliative care and they were highly complimentary of staff and the caring approach.
- During our inspection, we observed staff showed compassion and care and treated patients with dignity and respect.
- Clinical staff on wards told us they undertook comfort rounds regularly. Relatives we spoke with confirmed the regular checks undertaken by staff.
- A recent survey of wards undertaken by governors highlighted the compassionate care given to patients at the end of life and their relatives. There were numerous comments regarding the compassionate care provided.

Understanding and involvement of patients and those close to them

- Families and friends told us they were well informed about the condition of their relatives. They found the nurses and doctors shared with them information in a timely manner. For example, one family member told us: "I asked for information as and when I felt I could handle it. And they not only treat my husband but they care for me."
- The trust took part in the NCDAH (2013/14). The results showed that 73% of records reviewed provided evidence that discussions with patients and relatives had taken place. The national average was slightly higher at 74%. The trust performed significantly better with 68% communication regarding the patient's plan of care for the dying phase compared with the national average of 57%. However, the trust performed poorly in assessment of the spiritual needs of the patient and their nominated relatives or friends. The national average was 37% and the trust performed at 18%. Since that survey, the trust has undertaken its own spot checks to ensure the spiritual needs of the patients and their nominated relatives or friends was taking place. This improvement was as a result of the wards involving the chaplains earlier in the support and ward staff being extra vigilant of end of life care patients. Nurses told us the support to relatives had improved since the survey. A formal survey has been planned for roll out in January 2016.
- Patients and relatives told us doctors were good at communicating with them about the care patients were receiving. They did not feel rushed and their questions were answered in a detailed manner.

Emotional support

- Chaplains and nurses provided emotional support to patients and relatives who were experiencing difficulties in coming to terms with death and dying.The referrals to the chaplain were made by the ward staff.
- Chaplains told us they were planning a volunteer chaplaincy programme that would meet some of the needs for provision of emotional support.This programme had not yet been launched.
- There was a special viewing room in the mortuary where relatives could spend time with deceased patient. Mortuary staff also contacted the chaplaincy in cases where relatives required additional emotional support.
- There was a small multi-faith room next to the chapel that was used by Muslim patients and relatives for prayers. There were signs in this room on daily afternoon and evening congregational prayers and Friday prayers. Items for prayers were also made available. We spoke with a relative and two members of staff who told us they found the availability of this room helpful to meeting their needs.

Are end of life care services responsive?

Good

By responsive, we mean that services were organised so that they met people's needs.

We rated responsive as "good".

End of life care

- Services were planned and delivered in a way that met the needs of the local population.
- Most patients were seen by the hospital palliative care team within 24 hours and this enabled them to access the right care at the right time.
- The trust had a rapid discharge service for discharge to a preferred place of care and they performed well on this target.
- The needs of different people were taken into account when planning and delivering services. The service took account of individual needs and wishes, as well as cultural and spiritual needs.
- The specialist palliative care team had received no complaints from relatives regarding end of life care.
- There was a good process in place to receive and learn from complaints.

Service planning and delivery to meet the needs of local people

- The hospital palliative care team (HPCT) collected and analysed detailed information about the patients to provide a service according to people's needs. This included information such as the

  number of referrals, referrals seen within 24 hours, where were they seen and reviews undertaken The launch of the seven day service was a direct result of this needs assessment.

  The end of life care nurse specialist's hours increased to full time in February 2014, and there had been positive impact on the service provided to meet the needs of the local people.

- There were no dedicated end of life beds at this hospital. Patients identified as being in the last days or hours of life were mostly nursed on general medical and surgical wards. Nursing staff we spoke with told us those patients recognised as being in the last hours or days of life were nursed in a side room where possible, to protect their privacy and dignity,. This was not always possible as most staff, nursing and medical, told us there was a shortage of side rooms.

  The trust had access to 2.5 wte chaplaincy staff. Because of such low numbers, the wards used the services mostly in a reactive manners to meet the needs of the patients and not of staff. That meant wards called on chaplaincy services when needed. This narrow definition of the use of support services such as chaplaincy meant that chaplains were not proactively on the wards showing their presence and supporting staff and patients. Staff on the wards mentioned this lack of support and told us it would be welcomed.

- The new NHS Chaplaincy Guidelines 2015 launched in March 2015 by NHS England highlighted how trusts could deliver good quality pastoral, spiritual and religious care. Staff told us chaplaincy staffing was under review to ensure best practice in supporting the diversity of religions, beliefs, and cultures within the population that were growing. However, there were no plans in place as to how this was going to be delivered. The action log of the end of life steering group showed there had been no discussion of this document and how the trust would meet the chaplaincy in acute care.

Meeting people's individual needs

- Relatives of patients receiving end of life care were supported with free car parking facilities.
- Relatives told us that they were able to visit the ward at any time when their relatives were approaching the end of life.
- There were instances of poor environment for support services such as the chapel, which was used as an area for multifaith purpose. These instances of poor environment of support services highlighted long term neglect. We concluded ensuring the improvement in the décor of this service was not a priority for the trust. For example, the walls had paint peeling through. The carpet in the chapel was heavily stained due to long spillages and general wear and tear. We found chairs that had sponge showing through. A couple of these chairs were just patched up with duct tape and the overall general décor needed tidying up.
- The trust provided support to relatives after the death of a patient. This included bereavement care meetings where relatives were provided with information on post mortem, tissue donation, registration of death procedures, funeral arrangements and others. Relatives showed great appreciation for such services as evidenced from the letters of compliments received by the trust support staff.
- On the day of the inspection, we spoke with two relatives and they were both highly complimentary of the support provided by the bereavement services. The

bereavement services provided the relatives with the belongings of the deceased and these were given in a dignified manner. For example, jewellery items were placed in a jewellery box. One relative told us how comforting it was for her to receive her mother's jewellery in this manner.

- These meetings with relatives were pre-arranged to last one hour and staff told us they helped relatives to raise any concerns and get them addressed by the trust.
- The trust had identified there were insufficient comfortable facilities for relatives of patients although there was an overnight room available. There had been a suggestion that two rooms on West Wing and East Wing be used for this purpose. The action log for the end of life steering group mentioned it in 2014 and this matter was closed with no action after "investigate funding and logistics." However, during our inspection, we asked the trust if there was an update on this. The trust did not provide an update.
- We looked at 34 DNACPR forms and care plans. We found that doctors had a conversation with patients or their relatives and this was documented on the form and in the patient records. Feedback from doctors highlighted the need to improve communication between doctors and the patients and relatives regarding end of life.As a result, consultants in palliative medicine have run several workshops for consultants on Allow a Natural Death (also known as DNACPR)..A pilot programme had taken place in August 2014 and it was now being rolled out across the consultant body.
- Staff told us how they respected the families' cultural and religious requests and encouraged them to share their wishes with staff. For example, relatives from a local Muslim community had requested a special room for prayers, and arrangements were made accordingly with the chaplain to meet the needs of the family.
- There were various printed information leaflets available to patients and their relatives, including leaflets on what support to give patients and their relatives. Staff told us they valued the leaflets provided by the chaplaincy multi-faith team on how to support people from different faith. All information for patients was only available in English. Patients could request for information in another language but that request was also published in English making it highly unlikely that a patient who spoke another language could access the information in their own language. The trust had translation services for patients and relatives who did not speak English. Staff told us there were generally no delays in accessing this service when needed.
- The NCDAH 2013/14 found that 18% of patients had a spiritual needs assessment at the hospital. This was lower than the England average of 37%. This was recognised by the chaplaincy department.
- There was a chaplain who was part of the end of life steering group. The chaplain told us that they had good working relationships with other faiths to ensure the religious and spiritual needs of patients were met.

Access and flow

- The team delivering hospital palliative care and end of life care were visible on the wards. Nursing staff knew how to contact them.
- The NCDAH 2013/14 identified that access to specialist care in the last hours of life was better than the England average.
- We were told by service leads, 95% of the patients were seen by the hospital palliative care team within 24 hours of referral with only 2% waiting for more than 48 hours for a review. The number of patients with diseases other than cancer continued to increase. In the same audit, 20% of the patients referred to the service had conditions other than cancer.
- A recent audit (June 2015) highlighted that patients referred to the team delivering hospital palliative care and end of life care had a significantly reduced chance of dying in hospital, when compared with the average national for hospital deaths (33.9% nationally vs 65% for the trust) this meant patients at the end of life could die in their homes, if they chose to.
- There had been an issue of transferring end of life patients out of hospital to their own homes because the arrangements for patient transport could not be done in a timely manner. As a result, the trust allowed private ambulances for rapid discharge to people's homes.
- The team delivering hospital palliative care and end of life care routinely audited preferred place of care for all referrals. A monthly audit was undertaken (January to June 2015) and the resulted showed that on average 90% of patients referred to the team died in their preferred place of care.

End of life care

Learning from complaints and concerns

- Throughout the hospital, there was information for patients on how to raise concerns and complaints. Patients and relatives we spoke with knew how to raise any concerns and make complaints if they needed to.
- The hospital palliative care team had received no complaints from relatives regarding end of life care. However, staff were responsive to concerns raised informally and proactive in addressing any issues. There only had been one complaint regarding end of life care and that was in August 2014. The complaint had only recently (October 2015) been highlighted to the trust. At the time of the inspection we were unable to identify any learning from this complaint.

Are end of life care services well-led?

Good

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

We rated well led as "good".

- There was a clear vision statement for end of life care. This vision was based on promoting quality of care and a culture of patient safety.
- A consultant in palliative medicine was the clinical lead who championed end of life care and palliative care, and the associate medical director provided leadership and support.
- The medical director represented end of life care at board level and was regularly briefed by the associate medical director.
- There was a steering group to monitor performance against national standards. Strategic objectives were supported by quantifiable and measurable outcomes, which were cascaded throughout the organisation.
- The end of life steering group met regularly and had identified an audit programme to monitor the quality of the service. The quality of the end of life care service received assurance on the clinical quality provided to patient with end of life care. The end of life care team had developed their own performance dashboard based on national standards and local guidance. This was presented to the trust board on a monthly basis for discussion.
- There was an overall risk register that highlighted actions taken to improve patient care.
- The trust had a programme of improvement projects underway to improve end of life care.

However,

- The trust, after our visit, produced a document with an overarching strategy for end of life care based on existing strategic objectives and actions to meet national guidance and standards. This had not been subject to consultation or consideration by the trust board.
- There were no members of the public or relatives on the end of life steering group.

Vision and strategy for this service

- The trust's vision and values were displayed throughout the hospital. Staff we spoke with were aware of and committed to deliver the trust's visions, values and objectives. For example all staff we spoke with recalled the trust motto of "providing the excellent care we would expect for our own families. We found staff were aware of the four values of the trust: "communicate, improve, teamwork and pride."
- During the inspection, the trust provided us with a two page strategy document which was very brief and only comprised of list of priorities. We raised these issues in a follow up interview with the chair of the end of life steering group. After the inspection, the trust provided a new document entitled overarching strategy. This document aligned with the staff vision shared with CQC for improving end of life care. This document demonstrated how the trust four values, "communicate", "improve", "teamwork" and "pride", underpinned all its work. For example, during the inspection, we saw how the trust had improved communication with patients at the end of life care". However, because this document had only been recently compiled, it had not yet been subject to consultation or consideration to the trust board
- The trust had a well-established end of life steering group committee chaired by the associate medical director. The purpose of this group was to promote and

drive the end of life care agenda forward and advise the trust board on plans for end of life care. For example, they had advised on the education and training agenda for all appropriate staff on end of life care. They had also ensured the trust complied with the removal of the Graseby and funded the corresponding cost of this new equipment.

- Monthly end of life steering group meetings included representation from other services within the trust including a governor, therapy service, and medicine. A member of Dorset Clinical Commissioning group also attended. An action log was developed to address the gaps identified in NCDAH 2013/14.This was used to monitor progress and we could see where items had been actioned and closed. A review of the action log highlighted the progress made on end of life care at the trust.
- The medical director provided trust board representation, briefed by the associate medical director.

Governance, risk management and quality measurement

- The trust had developed end of life care quality indicators that were reported monthly to the board. The development of bespoke key performance indicators in 2015 included the indicators from the NCDAH and other information not included and identified as gaps in the NCDAH 2013 survey results. The indicators identified how well the trust the performing and identified improvements. Any audits undertaken were reported to the board and actions taken as a result highlighted. This gave the trust board the assurance that improvement to end of life care were taking place.
- The board also received a report on the progress the trust was making on end of life care.
- The end of life steering group had identified an audit programme to monitor the quality of the service. The end of life care team had also developed a service performance dashboard. This was discussed at the steering group and presented to the trust board on a monthly basis. The performance dashboard included information on audits undertaken, the results of the DNACPR audits and others. The board also received a report on the progress in meeting the objectives set out in the work plan.
- There was no end of life risk register, an overall risk register with end of life issues identified. Risks were identified and items placed on the risk register were dealt with effectively. For example, seven day a week working for palliative care nurses had been placed on the risk register and it was subsequently addressed by the trust. The seven day service started in November 2015.
- The trust was slow to respond to NPSA guidance on removal of Graseby syringe drivers, at Royal Bournemouth Hospital site, although likely to meet the December 2015 deadline this had not been seen as an urgent safety priority. Once identified as a priority, the roll out of the new syringe drivers was led by special project nurse whose work was closely monitored by the associate medical director and the consultant lead in palliative care.

Leadership of service

- The service was led by the consultant in palliative medicine who was a member of the end of life steering group. Doctors and nurses on wards told us the consultant was very visible and knowledgeable regarding palliative care in the organisation. The consultant had passion for this work and had engaged the clinical staff across the trust to get this embedded.
- The medical director was the board level lead for end of life care. The medical director was briefed by the associate medical director. The associate medical director provided the necessary push of this agenda in the trust. In discussion he evidenced an excellent grasp of what needed to be done and how it was going to be delivered. Staff told us that together with the palliative care lead consultant, they made a team to lead on improving end of life care .

Culture within the service

- The team delivering hospital palliative care and end of life care were passionate and dedicated to provide high quality end of life care for patients and their families.
- Staff on the wards felt that both the hospital palliative care team and the end of life care nurse

  specialist were helpful and approachable. Staff reported positive working relationships.

End of life care

- All the staff we spoke with told us they felt proud of working for the trust and enjoyed working within end of life care. We observed staff working well together and could see staff were supportive of each other.

Public engagement

- The end of life care steering group had engaged with two local community groups. However, there was no plan how further community engagement would take place.
- There were no members of the public or relatives on the end of life steering group. The associate medical director recognised this gap. This was going to be addressed in April 2016. However, the group had a governor who represented the public.

Staff engagement

- The specialist palliative care and end of life care team engaged with the link nurses on the wards to ensure end of life care issues were highlighted For example, a seven day a week working for palliative care nurses was welcomed by link nurses.
- There had not been any formal plans around engagement with the end of life care steering group or consultation on strategy. .

Innovation, improvement and sustainability

- The trust had recently (January 2015) embarked on quality improvement projects. This was a trust initiative as part of the overall improvement and change agenda. It was paid for centrally through investments in patient care. One of the quality improvement projects involved end of life care. Staff told us that through this project, improvements had been made to the quality of care for end of life care patients. For example, the trust bought reclining chairs for relatives to sleep at night whilst being with the patient.
- The trust used a palliative care handbook that was written by the Wessex palliative medicine physicians. This handbook was used across healthcare organisations in Dorset and Hampshire. This book contained guidelines on clinical management of palliative care. Doctors we spoke with found this handbook invaluable as a resource for treating patients effectively..
- The trust held a “Safety and Quality Conference” in September 2015 and the progress work to improve the communication skills for consultants on end of life care featured as a topic for good practice. Over 137 consultants had been trained in this communication programme.
- The end of life steering group welcomed the involvement of the commissioners, for example on the steering group. This enabled them to recognise implementation the work of the team and other departments such as mortuary, the chaplaincy department and bereavement services that supported relatives after the death of their family member.
- There was a statement in the end of life care strategy document regarding plans for the CCG to roll out the Electronic Palliative care Co-ordinating System (EPaCCS) which would help measure the effectiveness of palliative care services. There was clarity on how this was going to be done.

Outpatients and diagnostic imaging

Safe	Good
Effective	Not sufficient evidence to rate
Caring	Good
Responsive	Good
Well-led	Good
Overall	Good

Information about the service

The Royal Bournemouth Hospital is part of The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust and provides outpatient and diagnostic imaging services for a wide range of medical and surgical specialities.

Outpatient appointments are available from 8.30am to 5.30pm, Monday to Friday. In 2014, the trust provided 117,702 new adult's outpatient appointments and 194,662 follow up appointments

The diagnostic imaging department was open for appointments from 8.00am to 8.00pm and offered plain film radiography 08.30am –7.00pm , computerised tomography (CT), magnetic resonance imaging (MRI)(8am – 8pm), ultrasound (8am – 6pm), fluoroscopy, interventional radiology and breast imaging. The service was available 24 hours a day for urgent and emergency radiology.

During the inspection we visited the outpatient department, Jigsaw building, diagnostic imaging services, the eye unit, sexual health department and the prosthetic unit and workshop. We spoke with 46 patients and 38 members of staff including, nurses, consultants and other medical staff, physiotherapists, radiographers, occupational therapists, health care assistants, administrators, porters, receptionists and managers.

Throughout our inspection we reviewed trust policies and procedures, staff training records, audits and performance data. We looked at computerised records and online booking systems. We attended focus groups and listening events, looked at the environment and at equipment being used. We observed care being provided.

Outpatients and diagnostic imaging

Summary of findings

The outpatient and diagnostics imaging departments provided good safe, caring, responsive and well led services for patients.

Staff were encouraged to report incidents and the learning was shared to improve services. In diagnostic imaging, staff were confident in reporting ionised radiation medical exposure (IR(ME)R) incidents. They followed procedures to report incidents to the radiation protection team and the Care Quality Commission where necessary. The Duty of Candour was understood by senior staff, but it was not clear it was considered in all cases.

The environments were visibly clean and staff followed infection control procedures. Equipment was maintained regularly and medicines were appropriately managed and stored. However, in sexual health services the patient group directions for administration of medicines had expired.

Electronic patient records were used in outpatient clinics; this had been a recent implementation. Staff felt they were using the system well but there was concern about the increases in administrative time on clinic staff and the management of records information to reduce risk to patients.

Patients were assessed and observations were performed, where appropriate. However, there was no assessment tool available to identify patient's whose condition might deteriorate in outpatients.

Nurse staffing levels were appropriate and there were few vacancies. Radiographer vacancies were higher but recruitment was underway, some candidates had recently been appointed.

People's care and treatment was planned and delivered in line with current evidence-based guidance, standards, best practice and legislation. This was monitored to ensure consistency of practice. There were local audit programmes to monitor clinical standards. Staff had access to training and had annual appraisal but did not have formal clinical supervision.

Staff followed consent procedures and had a good understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards which ensures that decisions are made in patients' best interests.

Patients consistently told us that they had experienced a good standard of care from staff across outpatients and diagnostic imaging services. We observed compassionate, caring interactions from nursing, medical and radiography staff. Patients and relatives told us that they were included in the decision making process regarding their care and treatment. Staff recognised when a patient required extra support to be able to be included in understanding their treatment plans.

There was good evidence of service planning to meet people's needs.For example, the breast clinics within the Jigsaw building offered access to one stop clinics, patients were able to see a clinician and then a radiologist for imaging and have a biopsy if required. Ophthalmology patients had access to a one stop cataract clinic. National waiting times were met for outpatient appointments and cancer referrals. There were some clinics cancelled at short notice, but this was lower than the England average. The trust was meeting national waiting times for diagnostic imaging within six weeks. However in October 2015 the percentage of patients trust wide waiting over 6 weeks for all diagnostics was 6.2% compared to the England average of 2 – 2.5%. In diagnostic imaging no patients were waiting over 6 weeks in October 2015.

There was good support for patients with a learning disability or living with dementia. Clinicians had access to translation services and most staff knew how to access the service if required. The service received very few complaints and concerns were resolved locally. Staff were not aware of complaints across the trust or the learning from complaints.

The outpatient department had a strategy and were developing a plan to improve new patient referral waiting times. There were plans to deliver advice and guidance via telephone clinics, to assess where follow up care should be provided. There were various one stop and nurse led clinics already in place. Staff were not aware of how the strategy would develop for the

Outpatients and diagnostic imaging

future within their own departments. In diagnostic imaging they were working toward the '2020 strategy' with staff representatives who were assisting to move the strategy forward.

Governance processes to monitor risk and quality were well developed within the outpatient departments and in diagnostic imaging.

Some staff were clear about the overall vision and values of the trust. Nurses and radiographers spoke highly of their immediate line managers and told us they worked in caring, supportive teams which they valued.

There were good examples of local innovation and improvement to services. Particularly in ophthalmology, diabetes and endocrine services and in respiratory medicine.

Are outpatient and diagnostic imaging services safe?

Good

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

We rated safe as 'good'.

- Staff were encouraged to report incidents and the learning was shared to improve services.
- In diagnostic imaging, staff were confident in reporting ionised radiation medical exposure (IR(ME)R) incidents. They followed procedures to report incidents to the radiation protection team and the Care Quality Commission. Duty of Candour was understood by senior staff.
- The Duty of Candour was understood by senior staff
- Infection control processes had been followed. The environment was visibly clean and well maintained. Hand-washing facilities and hand gels for patients and staff were available in all clinical areas.
- Most equipment in use was well maintained and had been regularly serviced, although some hydraulic bed maintenance tests had lapsed. The resuscitation trolleys were checked daily and staff followed procedures to ensure that all equipment was in date.
- Medicines were secured and managed correctly. Staff compliance with mandatory training was good. Staff had a good understanding of safeguarding procedures. Patient group directions (PGD), which allow trained non-prescribers to administer medicines without prescription, were mostly in date,.
- Electronic patient records were available for clinics which included diagnostic results.
- Patients were monitored appropriately.
- Nurse staffing levels were appropriate and there were few vacancies. Radiographer vacancies were higher and there had been a recent successful recruitment event to fill some of these vacancies.

However,

- The Duty of Candour was not appropriately documented and considered in sexual health services However, there had not been a breach of the regulation.

- Patient group directions (PGD) had expired for sexual health.
- Some specialties identified that new records had increased administration and patient information could be missed.

Incidents

- In outpatient clinics and diagnostic imaging services, incidents were reported on the trust electronic reporting system. Staff felt confident with the process for reporting incidents and confirmed that feedback was disseminated during team meetings, to share learning and improve patient outcomes. The minutes of these minutes were seen during inspection.
- There were no serious incidents (SI) within the outpatient and diagnostic imaging departments at the hospital between May 2014 – April 2015.
- In diagnostic imaging, reportable incidents around ionising radiation medical exposure (IR(ME)R) was reported to the trust's radiation protection team and to the Care Quality Commission under IR(ME)R guidelines. Radiographers told us that there was an open reporting culture in relation to incident reporting and that their line managers encouraged staff to report incidents where applicable. The trust was not an outlier for diagnostic imaging. The number of reports was within the expected range and was similar to other trusts when compared with the same level of activity.
- The Duty of Candour requires healthcare providers to disclose safety incidents that result in moderate or severe harm, or death. Any reportable or suspected patient safety incident falling within these categories must be investigated and reported to the patient and any other 'relevant person' within ten days. Organisations have a duty to provide patients and their families with information and support when a reportable incident has, or may have occurred. The principle aim is to improve openness and transparency within the NHS.
- Staff demonstrated a good understanding of Duty of Candour and how to apply it in every day practice. However, in the sexual health unit there had been an issue in relation to patients receiving the results of cervical smear tests. The incident happened prior to the new legislation (November 2014). Patients with a negative smear result had not been informed of their result and a small number (seven) still needed to be contacted, which the service were doing. However, the service had not documented its considerations under the Duty of Candour in these circumstances and whilst still trying to contact the remaining women. There had, however, not been a breach of the regulation.

Cleanliness, infection control and hygiene

- Outpatient clinics and diagnostic imaging areas were visibly clean and well maintained.
- There was good evidence of trust infection control processes being adhered to. In the outpatient department there was an infection control link nurse who supported staff with infection control procedures. Audits were undertaken in relation to hand hygiene, with compliance across all departments being between 86% and 100% in the six month period prior to our inspection. There were notice boards in waiting areas to inform patients of the department infection control performance.
- The ophthalmology department participated in the H118 infection control audit for hand hygiene, of which the outcomes were good and represented the prevention of spreading infection.
- In all clinical areas there was good evidence of personal protective equipment (PPE), such as gloves and aprons being available and used appropriately by staff.
- Handwashing facilities were available in all clinical areas and hand gels were provided for staff and patients in all communal and clinical areas.

Environment and equipment

- Staff had access to resuscitation equipment in each clinical area.
- The resuscitation trolleys in outpatients and diagnostic imaging had been checked daily and all the equipment was in date. However, the trust had recently implemented trust wide changes to the drug supply held on the resuscitation trolleys. However, the staff that we spoke to who were undertaking daily checks of the trolleys were unaware of the changes. This was fed back to the trust during our inspection and was altered immediately by the production of a new trust wide check list secured to trolleys for staff who audited the equipment.
- The environment in outpatients and diagnostic imaging was well maintained and there was an equipment audit

in place to ensure that essential maintenance had been carried out in a timely manner. We looked at 24 pieces of equipment that received portable appliance testing (PAT). They had all been checked correctly.

- There were three hydraulic beds however, where annual maintenance checks had lapsed but they were still being used. There was no evidence seen of plans to address this issue.
- In diagnostic imaging there was signage to alert patients to potential radiation hazards in relevant areas. Personal protective equipment such as lead aprons were readily available for staff to use.
- Radiation protection checks on equipment had been completed every six months. Radiography staff signed documentation annually to confirm that they had read local rules and adhered to these within their working day.

Medicines

- Medicine cupboards were locked and secured and drug fridges were checked and in order. Fridge temperatures were recorded daily and were in line with guidance on drug storage.
- Prescription pads were stored securely in lockable drawers.
- There were no patient group directions in outpatients (PGD) other than sexual health where the PGD had expired in June 2014. Staff told us that the department had been given an extension from the Drugs and Therapeutic Committee to carry on with the existing PGD arrangements, but there was no evidence of this arrangement seen within the department. In Ophthalmology, eye drops were prescribed by the consultants and administered by nursing staff.
- In diagnostic imaging, all PGD's were in date and in accordance with trust guidelines.

Records

- All outpatient records were electronic. The system had recently been implemented and staff were using it effectively. Some staff told us it had slowed down record management in preparation for clinics and during clinics.
- Medical staff told us that everything they needed was on the system, including diagnostic results. However, some information was difficult to find because of how it was now accessed, particularly if you have patients that regularly attend clinics. Some medical staff identified that patient information could be missed and this was a risk when planning care and treatment. Nursing staff spent more administrative time on preparing records for clinic. The system was also slower than they would like due to dated IT equipment. The trust was responding to feedback and was developing ways in which the administrative support for the IT system could be improved.
- The electronic medical notes were available for all patients attending outpatient clinics. Clinic letters were scanned onto the Electronic Patient Records (EPR). Clinicians reported some disruption to clinics when the new EPR system had been implemented, but as staff got used to using the new system, they felt the disruption had minimised.
- In diagnostic imaging the picture archiving and communication (PACS) system was in place to view images that had been taken at other local hospitals. A further electronic system was in use that allowed radiology staff to review images generated within 98% of the hospitals within England.

Safeguarding

- All staff within outpatients and diagnostic imaging had completed their level 2 safeguarding training.
- Staff knew how to report safeguarding concerns. They knew how to access further advice from the trust safeguarding team and felt well supported by their line managers if they encountered more complex safeguarding issues.

Mandatory training

- Mandatory training included; infection control, basic life support, dementia awareness, health and safety, fire safety and safeguarding. Training was available as e-learning online and within a face to face classroom environment.
- Mandatory training was booked on the trust electronic system. Staff were able to book into available training slots and told us that generally they had no difficulty in being given time off to complete mandatory training.
- Line managers were alerted by email when a member of their team was imminently due to renew an element of their mandatory training. This enabled them to monitor staff compliance with their mandatory training requirements.
- In outpatients and diagnostic imaging, mandatory training was well attended.

Outpatients and diagnostic imaging

- Mandatory training across outpatients and diagnostic imaging was up to date with a 90% - 98% compliance rate, which exceeded the trust target of 85%.

Assessing and responding to patient risk

- All staff understood the procedure to follow should a patient collapse or become acutely unwell in the outpatient or diagnostic imaging departments.
- In the outpatient and diagnostic imaging departments, staff told us that they would measure a patient's vital signs and record them in their notes. We observed that assessments and observations, where necessary, were recorded in the electronic records. However, there is no national assessment tool available to identify patient's whose condition might deteriorate in outpatients.
- Within the imaging department, patients were alerted by signs and information in waiting areas where radiation exposure would be taking place. There was new national guidance in August 2015 which stated that radiographers no longer have to ask women about pregnancy unless it is a specific abdominal x-ray or CT scan. The trust made a decision with their radiation protection advisor to take their pregnancy notices down so as not to mislead patients.
- There was a team of Radiation Protection Supervisors and a Radiation Protection Advisor to provide advice and ensure the requesting of X-rays is in line with IR(ME)R guidelines.
- Staff referred to the Royal College of Radiologists standards for the administering of intravascular contrast.
- Diagnostic reference levels (DRL) and local rules guidelines were displayed in imaging rooms.

Nursing staffing

- In the outpatient department there were was a good skill mix of registered nurses (RN) and health care assistants (HCA). There is no available national acuity tool used within outpatient departments to plan staffing levels. There were few vacancies across the service. Recruitment was underway to fill the vacant posts.
- Bank staff were used to fill gaps in staffing. Bank staff told us that their induction had been thorough. New bank staff were initially supernumerary and had to complete a competency checklist before being able to work unsupported in clinical areas. Outpatients had a few members of bank staff who had worked for sometime within the department and these staff members generally filled most of the bank shifts. No agency staff were used.
- In diagnostic imaging, staffing was more of a concern. There were six radiographer vacancies across the trust. Recent recruitment had taken place and three of these vacancies had been filled. Overseas recruitment was being considered with HR to fill the other vacancies. New staff received a thorough induction. They received a pack containing a list of tasks to be completed within their first week and were assigned a mentor for support during the early stages of their employment.
- Diagnostic imaging services offered student radiographer placements, and they had previously recruited graduates who had been students within the department.

Medical staffing

- Senior nursing staff told us that there were adequate levels of consultant cover for all outpatient clinic specialities.
- Consultant appointment times were allied to clinic times. The outpatient department opened between 8am and 6pm with appointments from 8.30am to 5pm.
- There were 20 consultant radiologists working at the Royal Bournemouth Hospital.

Major incident awareness and training

- Major incident awareness training was provided to all new staff during the corporate induction programme. In the outpatient department the major incident plans were kept by the Matron. Staff knew that the major incident policy and details of the procedures to follow were kept in the Matron's office to access if and when required.
- There was evidence of business continuity plans in place in manager's offices which were to be referred to if a major incident was declared.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

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

We report on effectiveness for outpatients below. However, we are not currently confident that, overall, CQC is able to collect sufficient evidence to give a rating for effective in outpatients department.

- People's care and treatment was planned and delivered in line with current evidence-based guidance, standards, best practice and legislation. This was monitored to ensure consistency of practice. Radiography staff followed the Royal College of Radiology standards There was good evidence of local and national audit.
- Most staff had received an annual appraisal and felt able to access relevant training to update their clinical skills specific to their roles. Students were offered placements in diagnostic imaging teams. Staff, however, did not have formal clinical supervision.
- There was good evidence of multidisciplinary team (MDT) working practices, particularly within the one stop breast clinics and within diagnostic imaging teams.
- Seven day outpatient services were not available. Diagnostic imaging provided a 24 hour service for X-ray and CT scans overnight and at the weekends.
- Staff had a good understanding around consent procedures and there were clinical protocols and comprehensive consent documentation in place. In the outpatient department, there was good understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards which ensures that decisions are made in patients' best interests.

Evidence-based care and treatment

- Outpatient services took account of the relevant National Institute for Health and Care Excellence (NICE) guidelines to treat patients. We reviewed the clinical guidance for ophthalmology, diabetes and endocrine services and sexual health. They all referred to NICE guidance. Some examples of the guidance used: in ophthalmology, Glaucoma in adults QS7; in sexual health, Contraception services for under 25's PH51; and in diabetes and endocrine services, Diabetic foot problems: prevention and management NG19.
- Radiography staff told us that guidelines from the Royal College of Radiologists to obtain a renal function test prior to administering contrast had been adhered to. An audit was undertaken to monitor how well this was managed with 96% compliance.
- There was good evidence of adherence to local policies in diagnostic imaging. For example, the 'pause and check' system to ensure the correct identification of patients prior to imaging was observed to be used in everyday practice and performance audited to ensure compliance.

Patient outcomes

- The diabetes and endocrine service at The Royal Bournemouth Hospital participated in local and national audit, for example, the National Diabetes Audit which was ongoing, and locally an audit relating to insulin pump use. Outcome of these audits showed improving services for patients.
- The breast clinic provided clinical data for the Somerset Cancer Registry database which was linked to the two week wait clinic auditing. The trust were meeting this target.
- The ophthalmology department were participating in a national MERLOT study the outcomes of which were yet to be published.
- Diagnostic imaging services also participated in audit, for example, auditing images that located the positioning of nasogastric tubes, which ensured they were positioned correctly. As a result of this audit a change in practice was made to ensure all images were reported on.
- The follow up to new appointment rate for the trust was better than the England average for 2014.

Competent staff

- Most staff had completed an annual appraisal; 93% of outpatient staff had received their annual appraisal, 97% diagnostic imaging staff had completed their appraisal. Where appraisals had not been completed, line managers provided evidence as to why they were outstanding, for example; where staff had been on maternity or long term sickness absence.

Outpatients and diagnostic imaging

- There was no evidence that staff had formal clinical supervision.
- All staff across outpatients and diagnostic imaging services felt that there were good opportunities to develop professionally. They told us they were offered training to update their skills and knowledge relevant to their post. For example; training for staff nurses to develop knowledge to assist in the allergy clinic. Training was also available for staff who wanted to specialise, for example in diagnostic imaging, radiographers were offered training to cover MRI and CT scanning.
- Teaching sessions regularly took place within diagnostic imaging. The department had a learning file, which contained unusual clinical images. The images were discussed within the teaching sessions to offer staff the opportunity to learn from images that may not be seen again for some time within the department. This session was also used to look at any mistakes that had been made when taking images to ensure that the same errors were not made again.
- The service also provided training for junior doctors within the trust to offer them points to consider when requesting an x-ray, for example that there must be good clinical indicators for an image to be warranted.
- Nursing staff were aware of the requirements for revalidation and what their responsibilities were. They had received some information from the trust in relation to this.

Multidisciplinary working

- All nursing staff across the outpatients department told us that they had good working relationships with the consultants from each speciality. They felt that on-going communication with medical colleagues improved a patient's experience within the department.
- Multidisciplinary 'one stop' breast clinics were held. Staff told us that the multidisciplinary team (MDT) worked well. Nurses, radiographers, surgeons, radiologists and oncology specialists worked together to ensure that patients received the best possible care and treatment. Documentation confirmed well supported MDT meetings.
- In diagnostic imaging, staff told us they felt well supported by the radiologists. They felt part of a team where everyone recognised individual contributions to be important which ensured that patients were given the best possible treatment.
- Bi-monthly meetings were held with local clinical commissioning group (CCG's) to discuss protocols and guidelines, refer (the Royal College of Radiologists (RCR's) imaging referral guidelines) were used to inform discussions.

Seven-day services

- Outpatient appointments were offered Monday to Friday 8:30am – 5:30pm. In ophthalmology, waiting list initiative clinics were held on Saturday mornings.
- In diagnostic imaging, appointments were available Monday to Friday between 8:00am – 8.00pm. One radiographer and one radiography department assistant were available overnight and 2 radiographers at weekends for inpatients and emergency patients that required plain film X-rays. Emergency imaging facilities were available 24 hours a day, seven days a week.
- A radiologist was available on site between 9:00am – 10:00pm. Overnight, the radiology reporting service was outsourced. At 9:00am the following morning, the radiologist who was on site the previous evening would be responsible for reviewing the requests accepted and reviewed by the outsourced radiology service this ensured a quality service had been provided for patients overnight.

Access to information

- The electronic medical notes were available for all patients attending outpatient clinics. A copy of the initial referral letter was scanned onto the Electronic Patient Records (EPR). Any additional clinical letters were scanned into the EPR.
- Clinic letters were dictated by consultants at the end of the clinic. They were then typed, scanned on to the hospital electronic record system and a copy sent to the patient's GP. There was evidence that this was completed in a timely manner.
- Diagnostic test results were available online for clinicians to view during their consultations.
- There was an electronic, cross site imaging results facility with local trusts and another electronic imaging service that could expedite images from 98% of the trusts across England.

Outpatients and diagnostic imaging

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff demonstrated a good understanding around consent procedures and how patients should be supported in every day practice. There was good evidence of consent being sought and comprehensive consent documentation being used in radiology.
- Staff had a good understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards, to ensure decisions were taken in a person's best interest.

Are outpatient and diagnostic imaging services caring?

Good

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

We rated caring as 'good'.

Patients consistently provided examples of their experiences of a good standard of care from staff across outpatients and diagnostic imaging services. During our inspection, we observed compassionate, caring interactions from nursing, medical and radiography staff. There were examples of staff supporting patients and their relatives who were distressed.

Nurses greeted patients warmly in outpatient clinics and introduced themselves straight away.

There were no chaperone signs in waiting areas but staff were observed asking patients respectfully if they required a chaperone during their consultations, to protect their dignity. Staff knocked on doors and waited for a response before entering. In diagnostic imaging and in the breast clinic, there were privacy screens to separate patients who were undressed for examinations from other patients within the waiting room.

Patients told us that they were included in the decision making regarding their care and treatment and staff recognised when a patient required extra support to be able to be included in understanding their treatment plans

Staff demonstrated a real understanding of supporting patients who were in physical discomfort and took time to provide the additional care that these patients required. Staff demonstrated good communication skills and made patients feel welcome within the hospital.

Staff took patients to quiet rooms to provide emotional support when giving bad news.

Compassionate care

- We observed compassionate care was provided by nursing, medical and radiography staff. Throughout the outpatients and diagnostic imaging departments staff were friendly, warm and professional, which put patients and their relatives at ease.
- Overall patients spoke positively about the caring staff. One patient told us "the care here is absolutely top notch, I cannot say highly enough how lovely the staff are. They've always looked after my husband and me with real kindness". Another patient said "the staff here are so friendly, I trust my doctor and know that he has my best interests at heart. I ask as many questions as I like and am never made to feel that I'm inconveniencing them".
- In most clinical areas there was adequate provision to protect a patient's privacy and dignity. In diagnostic imaging and within the breast clinic in the Jigsaw building, there were areas for patients to change into gowns and to remain until their appointment. There were privacy screens separating patients who were undressed from other patients in the waiting room. However, once in gowns, patients waited for their x -rays or consultant appointments in a mixed sex waiting area. Patients did have the choice to remain in their changing cubicle if required, but there were no signs to communicate this to patients and we did not observe staff advising patients of this possibility when they attended for appointments.
- There was no signage which offered patients the opportunity to ask for a chaperone within any outpatient or diagnostic imaging area. However, staff were observed respectfully asking patients if they would like a chaperone.
- The friends and family test had been completed in outpatients. Between March 2014 and February 2015 the results showed that 97% of patients completing the survey agreed that they would recommend the hospital to family and friends.

Outpatients and diagnostic imaging

Understanding and involvement of patients and those close to them

- All the patients we spoke with felt well informed and involved in the decision making regarding their care and treatment from start to finish.
- We observed staff explain issues to patients and families in a way they could understand. Staff employed different techniques to ensure effective communication, such as sitting next to a patient or crouching down to speak to them. Staff recognised when patients required extra support to be able to become involved in their treatment plans.
- In the diabetes and endocrine service patients were given teaching sessions to enable them to understand and manage the use of their insulin pumps.

Emotional support

- Staff demonstrated a good understanding of supporting patients who were distressed or in physical discomfort and took time to provide the additional care that these patients required. During one interaction a health care assistant was observed spending time talking to an older patient who was upset and tearful. She engaged him in conversation about his previous employment and he immediately responded to her warm communication which settled his anxiety.
- Staff treated patients with dignity and respect, recognising individual patient's needs. For example, one patient told us, "my mother has dementia and I have been coming here with her for years because she gets very upset sometimes. Every time the nurses see us they remember us and say hello. I really appreciate that and I know my mum does too."
- Staff took patients to quiet rooms, away from other patients, to provide one to one emotional support to patients who were receiving bad news.

Are outpatient and diagnostic imaging services responsive?

Good

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

We rated responsive as 'good'.

- Services were planned and delivered to meet the needs of the local population. The environment was appropriately planned for the delivery of the service and to meet patients' needs. There were one stop breast, vascular and cataract clinics. There were fast track, nurse led clinics in ophthalmology. There were advice and guidance telephone clinics available for some follow up services.
- 'Did not attend' rates were lower (better) than the England average and phone calls and texts were used to remind patients of appointments.
- The national standard for referral to treatment for patients to wait less than 18 weeks was being met. Cancer waiting times for urgent referral appointments were being met.
- The trust short notice cancellation rate for appointments were lower (better) than the England average. 21% of patients waited over 30 minutes to see a clinician.
- There was good support for patients with a learning disability or living with dementia. Patients whose first language might not be English had access to interpreters although some staff were not aware of how to use this service.
- Some outpatient reception areas had self-service touch screen booking in facilities, but only a few of those offered a booking in facility in other languages. There were quiet rooms available for patients who had been given bad news and the trust chaplaincy service was available if required. Patient education sessions being held in ophthalmology and in the diabetes and endocrine service.
- There were privacy screens in waiting areas, once in gowns patients waited in mixed sex areas behind the privacy screens.
- The service received very few complaints and concerns were resolved locally, evidence was seen that changes were made as people raised concerns.

However,

- Staff were not aware of complaints across the trust or the learning from complaints.
- The waiting times for diagnostics within six weeks were variable and rose to higher than the England average in October 2015.

Outpatients and diagnostic imaging

- The overall length of time from scanning to report issued for outpatients exceeded the Royal College of Radiologists recommended 24 hour timeframe. However for in-patients the Trust was achieving this standard.

Service planning and delivery to meet the needs of local people

- The service was planned so each speciality managed their own clinic lists. Outpatients as a department provided the nursing staff and room capacity to meet the needs of the clinic.
- The breast unit provided a responsive service for patients who were anxious in relation to a potential cancer diagnosis. Appointments were offered to patients within two weeks following GP referral. The referrals were initially received into the central booking office and prioritised by consultants. Patients who attended the one stop clinics, saw a clinician, had a biopsy taken and saw a radiologist if required. If a cancer diagnosis was confirmed, patients were told before leaving the clinic and an appointment given to discuss the outcome and treatment options.
- One stop vascular and cataract clinics were also offered to patients as well as fast track age related macular degeneration (AMD) clinics which were nurse led. After initial referral onto the fast track clinic, patients were able to access the nurse led clinics directly.
- The service include telephone advice and guidance nurse led clinics for patients who were awaiting follow up and were assessed as not requiring further medical input at the hospital. These clinics were for certain specialities only.

Access and flow

- In outpatient services, some patients used choose and book to arrange appointments, but managers were not able to identify what percentage of patient's used this method.
- In diagnostic imaging, electronic booking same day appointment facilities were available, which decreased the waiting times for patients who required more urgent review.
- 'Did not attend' rates were consistently below (better than) the England average at 5% (January 2014 – December 2014); the England average was 7%. Phone calls and texts were used to remind patients of appointments.
- From April 2013 to February 2015, the trust achieved the referral-to-treatment (RTT) standard for non-admitted patients to be waiting less than 18 weeks (the incomplete pathways), in every month and was better than the England average during these months.
- Cancer waiting times for urgent referral appointments were below the national standard of two weeks (June 2014 – March 2015). However the trust was meeting the standard (. 96% of people had a first consultant appointment was within two weeks of a GP urgent referral (the operational standard is 93%). The trust was not meeting the standard for decision to treatment within 31 days (June 2014 – June 2015) 94% compared to the operational standard of 96%. The standard for 62-day cancer referral to treatment time was not met (June 2014 – March 2015) 80% compared to standard 85% . However the standard was met was (April – June 2015) although not specifically for urology and colorectal surgical treatments. The trust was taking steps to reduce delays in these pathways.
- There were some delays in clinics. 21% of patients waited over 30 minutes to see a clinician.
- In June 2015 3.6% of outpatient appointments across the trust were cancelled each month by the trust, this was lower (better) than the England average which was at 7%.
- In diagnostic imaging, between July 2013 and February 2015, overall less than 1.5% of patients experienced diagnostic waiting times of more than six weeks. In October 2015 6.2% of patients experienced diagnostic waiting times of more than six weeks which was higher than the England average 2-2.5%.
- The overall turn around time for CT and MRI scans was not within 24 hours.
- The waiting times for patients from arrival in the outpatient department until their consultation varied. In 2014/15, 21% of patients waited over 30 minutes to see a clinician.
- In all clinics, there were television information screens displaying the current waiting times for patients. Reception staff were also observed updating patients upon arrival of any expected delay.
- The outpatients department had recently undertaken an audit which assessed how many patients did not attend for their appointments. The audit was still ongoing during our inspection.

Outpatients and diagnostic imaging

Meeting people's individual needs

- The environment was designed to allow privacy and confidentiality. There were adequate seating arrangements for patients to sit and wait for appointments, X-rays and scans. However, in the breast unit and in diagnostic imaging once in gowns, patients sat in mixed sex waiting areas behind privacy screens.
- Waiting areas were large and signage was good. Patients told us they were able to find the department they were looking for with ease. However, there was no signage available for patients who did not speak English as their first language.
- There were information leaflets available for patients throughout outpatients and diagnostic imaging services, but nothing available in other languages or in easy read format.
- The waiting areas, consulting and imaging rooms were all wheelchair accessible.
- Some of the outpatient areas had self-service touch screen booking in facilities. Some of these units provided patients who did not speak English as their first language, with the option to book in for appointments in their own language. However, not all of these terminals had this facility.
- The trust had an interpreter service via language line. Interpreters were available over the telephone to support patients during their consultations. Staff we spoke with were not consistently aware of the translation services or how to access them.
- Staff gave good examples of where reasonable adjustments were made for patients who lived with dementia. Dementia awareness was part of the trust mandatory training. Nursing and radiography staff told us that if a patient living with dementia became distressed, they would often be prioritised in the clinic list.
- There was no information available in easy read format for patients with a learning disability. Where patients with a LD were flagged to any service, the trust LD specialist nurse came to assess the patient and advised the unit/department on helpful strategies.
- The ophthalmology service provided quarterly patient support groups on Saturday mornings, for patients who suffered from AMD and glaucoma. Guest speakers were invited and sessions usually attracted between 15 and 20 patients.
- The diabetes and endocrine service provided patient education clinics for a wide range of disciplines which included a, calcium clinic and an adrenal clinic.
- The bariatric clinic was located within the diabetes and endocrine department and was managed by a bariatric nurse specialist. They worked closely with the diabetes team and provided advice and treatment in relation to foot care, dietetics and diabetes as well as referral to the eye clinic and endocrine service.
- There were small café areas available in some outpatient areas to provide refreshments for patients. This was particularly helpful for patients with diabetes if there were long waits within the clinic during attendance.

Learning from complaints and concerns

- Information on how to make a complaint was displayed in waiting areas and leaflets were available for patients to take away.
- Across the trust the majority of speciality outpatient complaints were for the length of the waiting times once arriving at the hospital for clinic appointments. The outpatients staff were not aware of these complaints or the learning to improve the service. However, if a patient complained to nursing staff during clinics, the senior nurse in charge would resolve this issue by discussing the complaint with the patient prior to it escalating.
- Patient feedback was sought and welcomed across the trust. This feedback was obtained from patient surveys and comment cards. The comments were largely positive

Are outpatient and diagnostic imaging services well-led?

Good

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

We rated well-led as 'good'.

- The outpatient department had a strategy that was aligned to the values and vision of the trust. Staff were not aware of how the strategy would develop in their

departments but were generally aware of the vision and values of the trust. In diagnostic imaging the 2020 strategy was being planned with staff engagement in moving the strategy forward.

- Governance processes in the outpatient department were at divisional level and were well developed to manage risk and quality. Information about incidents and patient experience was shared among staff. Risks were collated at service and divisional level. Governance processes in diagnostic imaging were overall, well developed.
- Nurses and radiographers spoke highly of their immediate line managers. Medical staff told us the service worked very well in Radiology. They continually told us they felt well supported and valued. Staff told us that they enjoyed working for the trust due to the strong team support from colleagues.
- There was local innovation in relation to patient education within the diabetes and endocrine service.
- Public and patient engagement occurred through feedback such as surveys and comment cards.
- Staff engagement was also encouraged, particularly in diagnostic imaging, where 'seasonal sessions' were held quarterly to gain feedback from staff and to develop the service.

Vision and strategy for this service

- The strategic direction of services was not confirmed at the time of the inspection, as a result of the Dorset Clinical Commissioning review. The trust described its five-year strategic plan for patient care, underpinned by six strategic objectives.
- The outpatient department had a strategy, senior managers within the outpatient service were developing a plan to improve new patient referral waiting times. This was in line with the trust strategic objective of 'ensuring patients have rapid access to all of our services focusing on the provision of timely diagnosis and treatment with waiting times exceeding national standards'.
- Staff had no real understanding of the strategy for outpatients or how they could affect change within it. They did however, have a good understanding of the trust vision and values.
- Most staff told us that their main vision for the outpatient service was to provide a good standard of care for patients and to put patients at the centre of all decisions that were made.
- In diagnostic imaging there was the new 2020 strategy being developed. Staff representatives had been elected to bring forward ideas from the staff body to be involved in the new strategy development and to participate in moving this forward.

Governance, risk management and quality measurement

- The outpatient department held monthly performance review and risk management meetings attended by all senior staff. Individual specialities also held their own governance meetings, some weekly and others monthly. Governance issues were emailed out to all the outpatient staff, this included patient experience outcomes. Information on clinical risks was shared, but the outcomes from complaints both at local level and trust wide were not always made available to staff.
- Diagnostic imaging services held monthly governance meetings. During these meetings radiation protection issues were discussed. Quarterly radiation protection meetings were held and the minutes from both meetings were disseminated to all staff by email. Staff told us that they felt they were kept up-to-date in relation to governance issues.
- The results of the friends and family test FFT were regularly discussed at development meetings and all comments pertaining to outpatients or diagnostic imaging were monitored.
- The outpatients and diagnostic imaging departments had their own risk registers. Risks were identified and mitigating actions were being taken. Risks specific to specialities were on the speciality risk register.

Leadership of service

- Nurses and radiographers spoke highly of their immediate line managers. They repeatedly told us that they felt well supported and valued. Staff felt confident that they could go to their direct supervisors with any concerns or feedback they might have, and that it would be acted upon fairly and professionally. The staff in outpatients frequently saw the outpatient service lead and nurse manager.
- Medical staff told us the service worked very well in radiology.
- Staff felt their leadership was at a local level and that for them, there was a disconnect between their service managers and the board.

- Staff told us that the trust governors had visited outpatient and imaging departments and had made efforts to engage with staff.

Culture within the service

- Throughout outpatients and diagnostic imaging services we observed staff supported each other and there was an open and friendly culture.
- Staff told us that they were encouraged to be transparent and open, and the support they received from their service management and immediate supervisors was very good.
- Most staff that we spoke with had been in post for a significant number of years and really felt part of the outpatients or diagnostic imaging team as well as part of the trust as a whole.

Public engagement

- Engagement with patients was encouraged by the departments. Feedback was sought by survey, comments cards and the friends and family test results. 'You said, we did' boards were displayed in some patient waiting areas. Comments cards and patient satisfaction surveys had taken place within outpatients and diagnostic imaging.
- In the diabetes and endocrine service a patient satisfaction survey had been completed to establish if the patient education had been effective. The feedback had been received and had been wholly positive.
- Patient engagement meetings were held annually to encourage patients to have a voice in shaping their services.

Staff engagement

- In diagnostic imaging, all radiology staff were invited quarterly 'Seasonal Sessions'. Staff were asked to participate in discussion regarding the future plans for the service as well as educational topics. Staff told us that they felt engaged within the department and regularly asked for their opinions during team meetings to improve practice.
- In outpatient departments staff generally reported that they felt engaged. Staff attended ad hoc meetings where information was shared and discussions held about the service, what concerned staff and how the department could be improved.

Innovation, improvement and sustainability

- Outpatient department managers told us that to improve services in the future they would like to consider more nurse led telephone clinics offering advice and guidance to patients. New national guidance placed emphasis on the role of nurses in the management of patient care within an outpatient setting. The service managers were in discussion with local clinical commissioning groups to develop this service.
- In diagnostic imaging there were plans to enable reporting radiographers to further develop their skill set thus advancing their practice skills.

Outstanding practice and areas for improvement

Outstanding practice

- In Maternity and Gynaecology the Sunshine team offered support to women that were assessed as being vulnerable. They could be vulnerable due to mental illness or learning disability, but also from alcohol and substance misuse. The team worked with the local centre that cared for women who had been trafficked to Britain. The Sunshine team worked across health and social care and had excellent relationships with the police, education and the mental health. The service had been recognised by an all-party parliamentary group for its work with vulnerable women.
- The interventional radiology department had been awarded exemplar status by the British Society of Interventional Radiology for continuous audit, review and research in the unit, and improving patient experience. This award had been retained twice. The staff team were particularly proud of this achievement, particularly as they were not linked to a teaching hospital.

Areas for improvement

Action the hospital MUST take to improve

The hospital must ensure:

- At all times, emergency department patients are assessed and treated according to nationally agreed standards, particularly those for sepsis and fractured neck of femur
- Emergency department transfer equipment is checked regularly to ensure that it is always ready for use.
- all incidents are reported using the trusts incident reporting process and staff receive feedback.
- Pain relief, drinks and food are given in a timely manner .
- All staff comply with good hand hygiene and infection control practices
- Equipment is appropriately labelled, maintained, checked, cleaned and tested.
- Equipment that poses a risk of cross contamination is disposed ofpromptly
- That all premises and environments used by patients are clean, secure and safe for use including theatres and the corridor between Derwent suite and main hospital.
- The '5 steps to safer surgery' checklist is used consistently and effectively.
- All emergency equipment is checked and maintained in working order
- All medicines are stored securely, correctly and within a safe temperature range .
- Patient medicines are checked and recorded to ensure they receive the correct medicines when admitted to hospital
- Medicines are administered in a safe manner, following national guidance and trust procedures
- Patient risks are assessed and documented in a timely manner and escalated appropriately
- A policy, protocol and appropriate equipment is available to remove a collapsed woman from a birthing pool, and staff are trained in its use.
- Sufficient numbers of suitably qualified, competent, skilled and experienced persons are deployed at all times. Including sufficient numbers of permanent staff to provide guidance to the temporary staff about meeting patient individual needs in a safe manner.
- Staff receive appraisal annually in line with trust policy and procedures and access to clinical supervision improves .
- Privacy and dignity of patents is protected during care and treatment.
- The hospital escalation procedures are improved so that delays to ambulance patients are minimised
- Delays in discharge are reviewed to prevent patient stay in an inappropriate location and mixed sex breaches, particularly in critical care services.

Outstanding practice and areas for improvement

- There are effective systems to identify, assess, monitor and improve the quality and safety and mitigate risks across departments, in particular maternity and gynaecology services and the emergency department . This included clinical audit across the trust.

Action the hospital SHOULD take to improve

In addition the hospital should ensure:

- there is always a band 7 nurse in charge of each shift in the Emergency Department
- there is a consultant presence in Emergency Department for 16 hours each day.
- appropriate monitoring takes place check that changes in practice are effective
- there is a robust competency framework in place for nursing staff in Emergency Department
- Junior medical staffing levels on critical care are reviewed as there are at times when staff are called away from the unit to other wards.
- All PDGs are up-to-date and available for staff to use, in particular midwives and sexual health staff
- Oxygen cylinders are stored safely in theatre areas.
- Improvements in safety and communication around the critical care patient handover.
- Policies and procedures are comprehensive and up to date within theatres and critical care.
- Critical care clinical guidelines are up to date and appropriately approved and monitored.
- There is a checklist for all critical care patient transfers
- Multi-disciplinary team working improves in critical care services to ensure patients receive care according to recommendations and there is effective communication centred around the patient.
- Improved multi-disciplinary working with the SNODs to increase the organ donation rate
- Records are accessible in a timely way and there are improvements to the electronic patient record system
- Where relevant, mental capacity assessments are completed on DNACPR forms.
- Patients are offered the opportunity to wash their hands before meal times.
- There is consideration of the provision of eating utensils and how food is presented at meal times
- The environment on wards is suitable for people living with dementia
- Privacy is improved for patients in the major treatment area in the Emergency Department
- The accommodation of medical patients on surgical wards is minimised.
- Facilities for relatives of patients in critical care and end of life care are improved.
- There are separate toilet and washing facilities of the Urogynaecology ward, so that women do not have to walk past male patients to access these facilities.
- There is awareness of the interpreter service throughout the hospital
- Regular team meetings or forums are set up to encourage shared learning amongst paediatric staff; especially paediatric nurses across the trust.
- There is a sustainability/succession plan in place for paediatric dermatology service
- Feedback from patients improves in critical care services
- Staff engagement improves on critical care services .
- there is consultation on the overarching end of life strategy with internal and external stakeholders.
- Patient information is available in an easy to read format, and in other languages than English
- The general décor of the chapel is improved
- Chaplaincy provision review and timelines of delivery of good quality pastoral, spiritual and religious care
- Patient outcomes data is collected and used to improve services in maternity and gynaecology
- Duty of candour is appropriately considered in all cases where there is harm, a potential for harm, including psychological harm.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Regulation 9 (1) (3)(a)(b) · Patients in the emergency department did not always receive timely assessment, care and treatment to meet their needs. The provider must ensure all patients receive assessment, care and treatment to meet their needs or in line with evidence based guidance.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect Regulation 10 (1) (2)(a) How the regulation was not being met: · Patients did not consistently receive care in a way that respected their privacy and dignity. The provider must ensure patient privacy and dignity is maintained at all times.

Regulated activity	Regulation
Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 (1) (2)(a),(b),(c),(d),(e),(g) How the regulation was not being met:

This section is primarily information for the provider

Requirement notices

- Patients in the emergency department were not assessed and treated according to nationally agreed standards, particularly for sepsis and fractured neck of femur. The provider must ensure all patients are assessed and treated according to nationally agreed standards.
- The provider must ensure all patient risks assessments are completed and acted upon in a timely manner.
- The provider must ensure all incidents are reported and staff receive feedback.
- There was no up-to-date protocol on managing the removal of a collapsed woman from a birthing pool. All staff had not had training in the use of the equipment provided. The provider must ensure protocols are in place and staff trained in the safe evacuation of women from birthing pools.
- There was not a safe route for patients between main ward areas and the Derwent suite. The provider must ensure the premises are safe to use.
- Medicines were not stored at safe temperatures and staff did not follow trust policy when disposing of controlled drugs. Staff did not collect medicine reconciliation data to demonstrate that patients received the correct medicines when admitted. Medicines were not always administered correctly. The provider must ensure the proper and safe management of medicines.
- Not all theatre areas were clean. Contaminated equipment was not always disposed of safely. Staff did not always adhere to best practice in infection prevention and control. The provider must prevent and control the spread of infections.
- Transfer equipment in emergency department was not checked and ready for use. Internal audits showed that emergency trolleys were not consistently checked daily, equipment on some trolleys was missing and some equipment was not charged and ready to use. The provider must ensure all equipment is maintained, checked so safe and ready for use .

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Regulation 18(1)** How the regulation was not being met: · Staffing numbers were not consistently maintained at a safe level to meet the identified needs of patients. The provider must deploy sufficient numbers of suitably qualified, competent skilled and experienced staff

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17 (1), (2), (a), (b), (f)** How the regulation was not being met: · There were not effective identify, assess, monitor and improve the quality and safety of the maternity and gynaecology services · Hospital escalation procedures were not always effectively implemented to minimise delays to ambulance patients · Departmental risk registers did not always reflect all the risks identified by staff. The provider must ensure that all risks to quality and safety and health, safety and welfare of service users and others are assessed monitored and mitigated.