

Isle of Wight NHS Trust

St Mary's Hospital

Quality Report

Parkhurst Road
Newport
Isle of Wight
PO30 5TG
Tel: 01983 524081
Website: www.iow.nhs.uk

Date of inspection visit: 22-24 November 2016
Date of publication: 12/04/2017

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

Ratings

| | |
|--|---|
| Urgent and emergency services | Requires improvement  |
| Medical care (including older people's care) | Inadequate  |
| End of life care | Requires improvement  |

Summary of findings

Letter from the Chief Inspector of Hospitals

The Isle of Wight NHS Trust is an integrated trust. Services are provided to a population of approximately 140,000 people living on the Island, there is significant increase in population during holiday and festival seasons. St Mary's Hospital in Newport is the trust's main base for delivering acute services for the Island's population.

The hospital has 246 beds and handles 22,685 admissions each year. Services include urgent and emergency care, medicine and surgery, intensive care, maternity services, services for children and young people, neonatal intensive care unit and outpatient services, including planned care such as chemotherapy.

We carried out this short notice inspection of the Isle of Wight NHS Trust to follow up on some areas that we had previously identified as requiring improvement or where we had questions and concerns that we had identified from our ongoing monitoring of the service or if we had not inspected the service previously. We inspected three of the eight core services urgent and emergency care, medical care (including older people's care), and end of life care. We undertook site visits 22- 24 November 2016.

We did not inspect surgery, critical care, maternity& gynaecology, services for children and young people, or outpatients& diagnostic imaging. For information on these services please see the inspection report published in August 2014.

Overall we rated urgent and emergency care as requires improvement, medical care (including older people's care) as inadequate and end of life care as requires improvement. Services were caring but the safety of urgent and emergency care and medical care was inadequate as were responsive and well led services for medicine.

- The trust had a system in place for reporting and recording incidents. However, learning and action points were not disseminated to ward staff. Systems and processes were not always reliable and appropriate to keep patients safe. There were a significant number of open incidents which required investigating
- The hospital experienced difficulty meeting the demand for its medical services. Patient moves occurred frequently including at night. This can be confusing for patients and there is a risk of placing patients at risk. The use of escalation beds means single sex accommodation was not always being provided and neither was this being reported and monitored. End of life care patients were also moved for non-clinical reasons which resulted in lack of continuity of care for patients.
- Medical staffing levels did not meet national guidance. At less than 16 hours cover per day the medical consultant cover in the emergency department was below recommendations from the Royal College of Emergency Medicine. Consultant in the emergency department did not have sufficient time to supervise the education of junior medical staff. There was insufficient medical cover across medical services, particularly out of hours this included a shortage of older people medicine consultants and medical cover for the end of life care service was not as expected. A specialist palliative care service was not available seven days a week, telephone advice was available.
- The emergency department did not meet minimum registered nursing levels for safe care, with no evidence of how staffing was managed to meet fluctuations in demand. There was 16 hours of children nurse cover per week which did not meet the current recommendations of one children nurse per shift. In the medical service there was a significant shortage of nursing staff.
- The children's waiting room which was also used as a mental health assessment room but did not provide a safe environment.
- Medicines were not always stored safely and securely and good infection control practices were not consistently adhered to.

Summary of findings

- Ineffective systems of risk identification and management meant that opportunities to prevent or minimise harm were missed.
- It was not clear whether staff had completed mandatory training on end of life care and mandatory training data was not provided by the trust for all specialities. Where information was provided the up take was low. Therefore we were not assured regarding what training was provided or when staff attended. There was insufficient medical staff in the emergency department with child safeguarding level 3 training.
- Staff in some areas reported that they had received an appraisal, however we did not receive supporting information from the trust across all areas. Where we did receive information the appraisal rate was low, for one ward this was zero. Not all staff in the coronary care unit had the appropriate training and none had been competency assessed. Staff had limited awareness and a lack of knowledge in managing the process of deprivation of liberty safeguards.
- Medical records were not always secure and confidential patient information was compromised. A significant number of 'Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR) forms were not completed according to national guidelines.
- There were not robust processes to facilitate rapid discharge of patients at the end of their life and most patients were not transferred to their preferred place of death. Staff did not take extra care to ensure continued levels of privacy, dignity and compassionate care for the patients and families and friends when approaching the end of their life and a side was not available.
- Staff were not aware of how the trust was implementing the action plan as a result of the End of Life Care - Dying in Hospital Audit 2016 or how the end of life care strategy was to be implemented.
- The governance structure was not efficient. Meetings took place but outcomes and action plans were not joined up. The quality, risks and performance issues within end of life care were not monitored through the executive governance framework. In the medical service the governance processes were not effective at assessing or monitoring systems to improve the safety and quality of the services provided. There was not a robust local clinical audit plan in place in the emergency department to drive improvements to quality and performance. They also performed poorly in a number of the national audits they participated in.
- In the emergency department the governance structure did not provide a clear route to escalate issues of concern and there was no evidence that senior trust managers took account of the views of frontline staff. In the medicines service staff was discouraged from raising concerns and there was a blame culture. Staff did not feel engaged with and described the culture in the organisation as leading to integrated working.
- The trust did not have a robust system for handling, monitoring complaints and concerns. Response to formal complaints did not meet NHS Complaints Policy July 2016 standards. Learning was not consistently shared across the organisation.
- Staff had access to a wide range of clinical guidelines based on, for example, on the National Institute for Health and Care Excellence (NICE) and the Royal College of Emergency Medicine (RCEM) to ensure care and treatment was evidence based. However, we observed care did not consistently take account of evidence based practice and guidance, and clinical pathways were not always implemented fully. For example, priorities of care plans were not routinely completed for patients nearing the end of their life.
- In general staff treated people with compassion, kindness, dignity and respect. Feedback from patients and their families was positive.
- Staff felt supported and displayed resilience through team working and support from their department leaders.

Summary of findings

- The trust ran a 'carers are welcome here campaign'. This meant a carer was welcome to visit the hospital whenever they wanted to.
- The stroke lead nurse had developed same day access to scanning and Doppler tests to diagnose and treat patients promptly
- The trust had a protocol for the prescribing of anticipatory medicine for patients receiving end of life care and pain relief as available.

There were also areas of poor practice where the trust needs to make improvements.

Importantly, the trust must:

- There are 16 hours of cover by consultant grade staff in the emergency department daily.
- There is sufficient nursing staff on duty at all times in all areas calculated through use of a recognised staffing and acuity tool.
- Arrangements for staffing (nursing and medical) for the paediatric emergency department are urgently reviewed to ensure sufficient trained paediatric cover.
- All medical staff receive safeguarding children level 3 training.
- The medical rota supports junior medical staff receiving education as required by their training placements.
- There is a room available for ED staff to assess patients in mental health crisis that does not compromise the safety of the patients or staff.
- The environment to see and treat children, including the children's waiting area meets the requirements of the 'Standards for Children and Young People in Emergency Care Settings' by the Royal College of Paediatrics.
- Governance, risk management and quality measurement including the undertaking of audits is reviewed, improved and embedded across all departments ensuring all risks are identified and managed effectively.
- Nursing staff in the coronary care unit have competencies to care for patients on bi-level positive airway pressure (BiPAP).
- All incidents are investigated in a timely way and lessons from incidents are shared with all staff.
- There is a sufficient and safe number of doctors working on the coronary care unit (CCU) at all times.
- Single sex accommodation requirements for patients are maintained and any breaches are reported in a timely way.
- Staff identify patients who may need consideration of Deprivation of Liberty Safeguards (DoLS).
- Daily documented checks on each resuscitation trolley are complete.
- Intravenous fluids are stored in a locked room to prevent access to members of the public.
- Mandatory training rates for life support training and moving and handling improves to achieve the trust target.
- Complaints and concerns from patients are investigated and responded to in a timely way and lessons learnt shared across the organisation.
- All staff have yearly appraisals that are meaningful to their professional development.
- Review information governance protocols to ensure that patient identifiable or confidential information is kept secure at all times.
- All patients nearing end of life are assessed and have an individualised end of life care plan. There are monitoring mechanisms in place to ensure risks to patients were assessed.
- Medical staffing levels meet national guidance for end of life care.

Summary of findings

- Consultants undertake training in end of life care.
- Patient capacity is formally assessed and documented on the DNACPR form and the forms are completed in accordance with national guidelines.
- There are improved discussions with the family/friends regarding end of life care.
- End of life care patients are not moved for non clinical reasons.
- Patients are able to die in their preferred place of care. There is a robust rapid discharge system in place for end of life care patients and this is monitored.
- Suitable arrangements are in place to identify, assess and manage risk in end of life care services, through actively reviewed risk register.
- The quality, risk and performance issues within end of life care are monitored and improved through the executive governance framework.

In addition the trust should:

- Review the pathways and care for children in the emergency department to ensure that their needs are met.
- Reviewing the process of flow through the emergency department and develop a strategy to engage clinicians and teams across the trust to improve flow through ED and the hospital.
- Should find a safe area for patients with a mental health condition to wait for their assessment.
- Should consider the purchase of an additional drug dispensing machine for the minors area, or manage the risks to minimise delays to administering medicines for the patients when required.
- Should consider the development of a program of teaching sessions in-house to minimise long waits for phlebotomy, cannula insertion and IV drug administration training for nurses.
- Review protocols for the prescribing and administration of oxygen to patients. Ensuring the oxygen is prescribed prior to administration.
- Review the out of hours service provision at weekends for the medical service, ensuring that the risks of reduced services are managed.
- Review infection control practices for patients in isolation, ensuring that infection control protocols are adhered to.
- Reduce the number of bed moves after 10pm, and reduce the number of total moves per patient.
- The trust should provide training and access to the medicines systems for trust staff who work on the wards.
- Develop and implement an action plan for clear leadership to manage the frail, elderly patient pathway.
- Review the clinical hand wash basin provision in the sluice in Colwell ward to comply with infection prevention and control practices.
- Should assess and improve the discharge arrangements for patients from the hospital to the community or the patients home.
- Monitor the mandatory uptake of end of life care training across all specialities.
- Ensure staff are aware of how the trust is implementing the action plan as a result of the National End of Life Care Audit – Dying in Hospital, 2016, and their contribution to improvements.
- Ensure there is a review of how the trust meets the NHS Chaplaincy guidance.
- Further integrate the relationship between the trust and the hospice so it improves the planning of end of life care.
- Implement the AMBER care bundle across services.

Summary of findings

- Where possible, provide side room for end of life care patients, and ensure that staff maximise patient privacy and dignity and comfort when nursed in a bay.
- Train appropriate ward staff on rapid discharge forms and monitor their use.
- Raise awareness with staff on how the end of life care strategy is to be implemented.
- Improve access to specialist palliative care service seven days a week.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service

Urgent and emergency services

Requires improvement

Rating



Why have we given this rating?

Medical consultant cover in the emergency department was below 16 hours per day and therefore not in line with recommendations from the Royal College of Emergency Medicine. This impacted on the care and expertise available to the patients. Consultant staff did not have sufficient time to supervise the education of junior medical staff. The department did not use a safer nursing care tool for accident and emergency units. It was evident that the emergency department did not meet minimum registered nursing levels for safe care. There was insufficient nursing staff at night and in the emergency resuscitation department which meant that the safety and care of seriously ill patients attending the department was compromised.

The emergency department had 16 hours children nursing allocation per week. This did not meet the recommendations in “Standards for Children and Young People in Emergency Care Settings” developed by the Intercollegiate Committee for Standards for Children and Young People in Emergency Care Settings. (The recommendation is for one registered nurse [children] per shift to be available in emergency departments receiving children)

The responsibility for children, and the pathway for the care of children attending the emergency department, was not undertaken in a way that ensured safe and appropriate care as registered nurses (child branch) were not overseeing their care. We observed the paediatric team refused to accept children onto the ward or to come to the emergency department to see them. The children’s waiting room was not fit for purpose. The room was also used as a mental health assessment room but did not provide a safe environment for this purpose either.

Staff did not always follow safe infection prevention standards or medicines management.

There was no drug dispensing machine in minors which often caused delays due to staff queueing in the medicines room.

Summary of findings

No data on mandatory training rates was made available to us prior to the inspection, during the inspection or post inspection. Therefore we were not assured regarding what training was provided or when staff attended. There was insufficient medical staff in the emergency department with child safeguarding level 3 training.

The Department did not participate in all national audits, but had performed poorly in a number of those it did participate in. There was no robust local clinical audit plan in place to drive improvements to quality and performance. Patient flow was poor through the department due to poor access to medical beds.

The governance structure did not provide a clear route to escalate issues of concern and there was no evidence that senior trust managers took account of the views of frontline staff.

However we observed staff provided compassionate care and the department received many messages of thanks from patients for the care they received. Staff felt supported and displayed resilience through team working and support from their leaders. Staff worked closely with the medical assessment unit to try and improve patient flow through the department.

Medical care (including older people's care)

Inadequate



Summary of findings

Overall, we have rated medicine as inadequate because:

- Ineffective systems of risk identification and management meant that opportunities to prevent or minimise harm were missed.
- The trust had a system in place for reporting and recording incidents. However, learning and action points were not disseminated to ward staff. Systems and processes were not always reliable and appropriate to keep patients safe.
- There were a significant number of incidents that required investigation. Without investigating promptly and putting controls in place, the risk of further patient incidents could occur.
- Governance processes were not effective at assessing or monitoring systems to improve the safety and quality of the services provided.

Summary of findings

- The hospital experienced difficulty meeting the demand for its medical services. Patient moves were tracked by the trust. However, the frequency and reasons were not always appropriately monitored.
- From April to November 2016 between the hours of 10 pm and 7am, 958 patients were moved around the hospital. Repeated bed moves can be confusing for patients and vital patient care information could be lost.
- There were medical outliers across the hospital and in temporary wards. Patients stayed overnight in the surgical day care, ambulatory care unit or in the discharge lounge. The placements meant that the single sex requirement was not maintained, however the trust had not declared mixed sex breaches.
- Staff was discouraged from raising concerns and there was a blame culture.
- There was a significant shortage of nursing staff across all the medical services.
- There was insufficient medical cover across medical services, particularly out of hours. There was significant shortage of older people medicine consultants.
- The trust did not fully comply with infection prevention and control standards.
- There was a low staff appraisal rate. The trust appraisal rates for November 2016 showed Colwell ward 43% and Appley Ward 91.89%.
- Completion of mandatory training was low with 40% attending moving and handling training, and 42% trained in basic life support.
- Staff in the coronary care unit did not have the appropriate training to ensure they had the necessary skills and competence to look after patients.
- Medicines were not always managed safely or securely.
- Mental capacity act and deprivation of liberty safeguard training was not part of mandatory training. Staff had limited awareness and a lack of knowledge in managing the process of deprivation of liberty safeguards.

Summary of findings

- Medical records were not always secure and confidential patient information was compromised.
- The trust did not have a robust system for handling, monitoring complaints and concerns. Response to formal complaints did not meet NHS Complaints Policy July 2016 standards.
- From April 2015 to March 2016 the average length of stay for medical non elective patients was worse than the England average. The average length of stay for non-elective stroke medicine was more than 70% higher than the national average.

However:

- The new endoscopy suite was National Joint Advisory Group (JAG) accredited. World Health Organisation WHO checklists briefings took place in endoscopy theatres. Audits took place and results showed 100% compliance. The inadequate rating does not apply to this service.
- The chemotherapy day unit had processes in place to ensure safe care to patients. The inadequate rating does not apply to this service.
- The Friends and Family Test (FFT) response rate for medical care at the trust between August 2015 and July 2016 was better than the England average.
- The trust ran a 'carers are welcome here campaign'. This meant a carer was welcome to visit the hospital whenever they wanted to.
- The stroke lead nurse had developed same day access to scanning and Doppler tests to diagnose and treat patients promptly.
- The trust monitored implementation of policies to ensure they complied with NICE guidance.
- Mortality review committee meetings were held monthly and were chaired by the executive medical director.

End of life care

Requires improvement



There was limited learning from end of life care incidents across the organisation. Not all patients had end of life risks assessed and managed. There was no monitoring mechanism in place to ensure risks to patients were assessed. Medical staffing levels did not meet national guidance.

Summary of findings

It was not clear whether staff had completed mandatory training on end of life care and mandatory training data was not provided by the trust for all specialities.

A significant number of 'Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR) forms were not completed according to national guidelines.

Care did not consistently take account of evidence based practice and guidance, for example, priorities of care plans were not routinely completed for patients nearing the end of their life. The AMBER care bundle was not embedded in practice.

EOLC training was not mandatory for consultants.

A specialist palliative care service was not available seven days a week, telephone advice was available.

The trust performed worse than England average in the End of Life Care – Dying in Hospital Audit (2016) key performance indicator on health professionals' communication and discussion with relatives and friends, and consideration of their needs.

End of life care patients did not always receive care in a side room as these were prioritised for treating patients with infections. Staff did not take extra care to ensure continued levels of privacy, dignity and compassionate care for the patients and families and friends when this happened.

End of life care patients were moved from one ward to another or from one ward area to another for non-clinical reasons. This resulted in lack of continuity of care for patients and was not monitored. There were not robust processes to facilitate rapid discharge of patients and staff were not trained to use the rapid discharge forms. The trust was not monitoring the number of end of life patients who were discharged with fast track rapid discharge in place. Most patients were not transferred to their preferred place of death. There were complaints relating to end of life care but the learning was not shared across the organisation.

Staff were not aware of how the trust was implementing the action plan as a result of the End of Life Care - Dying in Hospital Audit 2016 or how the end of life care strategy was to be implemented. Staff did not feel engaged with and described the culture in the organisation did not lead to integrated working. The governance structure was not efficient. Meetings took place but outcomes and action plans

Summary of findings

were not joined up. The quality, risks and performance issues within end of life care were not monitored through the executive governance framework

However the trust had a protocol for the prescribing of anticipatory medicine. Patients had access to pain relief. The trust had implemented the ward accreditation programme across all wards. Staff treated people with compassion, kindness, dignity and respect. Feedback from patients and their families was positive. We saw good examples of staff providing care that maintained respect and dignity for individuals. There was good care for the relatives of dying patients, and staff showed sensitivity to their needs.

St Mary's Hospital

Detailed findings

Services we looked at

Urgent and emergency services; Medical care (including older people's care); End of life care.

Detailed findings

Contents

Detailed findings from this inspection

| | Page |
|--|------|
| Background to St Mary's Hospital | 14 |
| Our inspection team | 14 |
| How we carried out this inspection | 15 |
| Our ratings for this hospital | 15 |
| Findings by main service | 16 |
| Action we have told the provider to take | 74 |

Background to St Mary's Hospital

St Mary's Hospital in Newport is the trust's main base for delivering acute services for the island's population of approximately 140,000 people living on the Island. There is a significant increase in population during holiday and festival seasons.

The Isle of Wight ranks among the 40% most deprived local authorities in England with 20% children living in poverty. There are worse than average rates for smoking, alcohol consumption and obesity. The life expectancy gap between the most and least deprived areas on the island are 5.4 years for men and 3.8 years for women. There is an increasing population of older people, currently 26% aged over 65 years (17% England average) and 12% aged over 75 years (8% England average)

The hospital has 246 beds and there are approximately 22,685 admissions each year. Services include urgent and emergency care, medicine, surgery, intensive care, maternity, neonatal intensive care unit and services for children and young people

and outpatient services, including planned care such as chemotherapy.

St Mary's Hospital had a comprehensive inspection of all services in June 2014, the hospital was rated as 'requires improvement' overall.

We carried out this short notice inspection of the Isle of Wight NHS Trust to follow up on some areas that we had previously identified as requiring improvement or where we had questions and concerns that we had identified from our ongoing monitoring of the service or if we had not inspected the service previously. We undertook site visits 22- 24 November 2016.

We inspected three of the eight core services urgent and emergency care, medical care (including older people's care), and end of life care.

We did not inspect surgery, critical care, maternity & gynaecology, services for children and young people, or outpatients & diagnostic imaging. For information on these services please see the June 2014 inspection report, published in August 2014.

Our inspection team

Our inspection team was led by:

Head of Hospital Inspections: Joyce Frederick, Care Quality Commission

The team included CQC managers, inspectors, Mental Health Act reviewers, pharmacist specialist and a variety of specialists: , paediatric emergency nurse consultant, head of nursing emergency department, divisional director of medicine, consultant geriatrician/stroke

Detailed findings

physician, EOLC consultant, medical nurses, assistant director child safeguarding, school nurse, health visitor, community services manager, district nurse team leader,

occupational therapist, physiotherapist. Consultant psychiatrist, mental health nurses, Operational ambulance manager, paramedic, emergency call centre manager Director of nursing, and governance specialist.

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 used the findings of previous inspection plus on going monitoring information to decide which services to inspect

We carried out an unannounced responsive inspection of acute services and visited relevant wards and departments at St Mary's Hospital 22-24 November 2016

Before visiting we reviewed a range of information we held and asked other organisations to share what they knew about the hospital. This included clinical commissioning groups (CCG), NHS Improvement, and IOW Healthwatch. During the inspection we also spoke with the local Hospice

At the unannounced visits 22-24 November we spoke with in the region of 60 of staff in the departments we visited including nurses, junior doctors, consultants, therapists, pharmacists, administrative staff, and managers We also asked staff to share their staff 'drop in sessions every day, and invited them to share their views by email or online.

We talked with approximately 11 patients in the wards and departments, and reviewed comments left for us in boxes distributed around the hospital. We observed how people were being cared for, talked with carers and/or family members, and around 20 reviewed patients' records of personal care and treatment.







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 St Mary's Hospital.

Our ratings for this hospital

Our ratings for this hospital are:

| | Safe | Effective | Caring | Responsive | Well-led | Overall |
|--------------------------------------|----------------------|----------------------|--------|----------------------|----------------------|----------------------|
| Urgent and emergency services | Inadequate | Requires improvement | Good | Requires improvement | Requires improvement | Requires improvement |
| Medical care | Inadequate | Requires improvement | Good | Inadequate | Inadequate | Inadequate |
| End of life care | Requires improvement | Requires improvement | Good | Requires improvement | Requires improvement | Requires improvement |
| Overall | N/A | N/A | N/A | N/A | N/A | N/A |

Urgent and emergency services

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

Information about the service

The urgent and emergency services for the Isle of Wight were based at St. Mary's hospital in Newport. The urgent care service (UCS) is co-located with the emergency department (ED) but did not form part of our inspection.

The ED is the only one on the Island and serves a population of approximately 140,000 people. Its staff are responsible for the reception, triage, assessment and treatment of patients of all ages presenting with emergency health problems. Staff provided initial care for all patients conveyed by 999 ambulances and for patients who self-present to the department. The department was also a designated trauma unit and all patients were cared for at St Mary's Hospital except for those with major head injuries and those with some other highly specialist treatment requirements who are transferred to the mainland.

The ED treated 43,408 patients between August 2014 and July 2015; staff treated 120 patients per day of which approximately 19% were aged under 18. The number of attendances resulting in admission to hospital (13.1%) was lower than the England average (21.6%) in 2015/16.

The hospital had a helipad which was available to take severely injured patients to the mainland regional trauma centre.

Facilities in the department consisted of a resuscitation room with three adult bays, 10 cubicles for major injury, and six cubicles for minor injury. There was a separate

room for paediatric resuscitation purposes. In the minors area there were four trolley bays and two bays for patients who could sit. There was also a room for patients needing treatment for eye injuries and a plaster room.

The main waiting room was large and there was a small triage room just off it. There was also a small waiting room for children, but the receptionist told us that most families preferred to use the main waiting area.

The ED formed part of the Ambulance Urgent Care and Community Business Unit.

We inspected this core service as part of a short notice inspection to follow up on some areas that we had previously identified as requiring improvement and where we had questions and concerns that we had identified from our ongoing monitoring of the service.

During our inspection, we visited the department over two days including evening and early morning visits. We spoke with, two patients, two relatives and 27 staff including medical, nursing, administrative staff, and pharmacist. We spoke with senior ED staff including consultants, matron, directorate and divisional staff. We reviewed patient records and information about the service including policies, performance data and audit reports.

Urgent and emergency services

Summary of findings

We rated this service as requires improvement because:

- Medical consultant cover in the emergency department was below 16 hours per day and therefore not in line with recommendations from the Royal College of Emergency Medicine. This impacted on the care and expertise available to the patients.
- Consultant staff did not have sufficient time to supervise the education of junior medical staff.
- The department did not use a safer nursing care tool for accident and emergency units. It was evident that the emergency department did not meet minimum registered nursing levels for safe care. There was insufficient nursing staff at night and in the emergency resuscitation department which meant that the safety and care of seriously ill patients attending the department was compromised.
- The emergency department had 16 hours children nursing allocation per week. This did not meet the recommendations in “Standards for Children and Young People in Emergency Care Settings” developed by the Intercollegiate Committee for Standards for Children and Young People in Emergency Care Settings. (The recommendation is for one registered nurse [children] per shift to be available in emergency departments receiving children)
- The responsibility for children, and the pathway for the care of children attending the emergency department, was not undertaken in a way that ensured safe and appropriate care as registered nurses (child branch) were not overseeing their care. We observed the paediatric team refused to accept children onto the ward or to come to the emergency department to see them.
- The children’s waiting room was not fit for purpose. The room was also used as a mental health assessment room but did not provide a safe environment for this purpose either.
- Staff did not always follow safe infection prevention standards or medicines management.
- There was no drug dispensing machine in minors which often caused delays due to staff queuing in the medicines room.

- No data on mandatory training rates was made available to us prior to the inspection, during the inspection or post inspection. Therefore we were not assured regarding what training was provided or when staff attended. There was insufficient medical staff in the emergency department with child safeguarding level 3 training.
- The Department did not participate in all national audits, but had performed poorly in a number of those it did participate in. There was no robust local clinical audit plan in place to drive improvements to quality and performance.
- Patient flow was poor through the department due to poor access to medical beds.
- The governance structure did not provide a clear route to escalate issues of concern and there was no evidence that senior trust managers took account of the views of frontline staff.

However:

- We observed staff provided compassionate care and the department received many messages of thanks from patients for the care they received.
- Staff felt supported and displayed resilience through team working and support from their leaders.
- Staff worked closely with the medical assessment unit to try and improve patient flow through the department

Urgent and emergency services

Are urgent and emergency services safe?

Inadequate



We rated safe as Inadequate because:

- Medical consultant cover in the emergency department was below 16 hours per day and therefore not in line with recommendations from the Royal College of Emergency Medicine.
- The emergency department had 16 hours children nursing allocation per week. This was insufficient because there was no additional paediatric support to the department.
- The responsibility and pathway for the care of children attending the emergency department was not undertaken in a way that ensures safe and appropriate care as registered nurses (child branch) were not overseeing their care.
- We observed the paediatric team refused to accept children onto the ward (a designated place of safety) or to come to the emergency department to see them.
- There was insufficient medical staff in the emergency department with child safeguarding level 3 training.
- The room set aside for mental health assessment was not fit for purpose because there were ligature risks and none of the furniture was fixed which meant that there was potential for a patient in an unstable state of mind to barricade themselves into the room or use the furniture as missiles.
- Infection prevention audits showed poor results, such as the hand hygiene 5 moments and bare below the elbows audit dated July 2016, which showed compliance levels for nursing and medical staff was at 56.5 %. According to the trust infection prevention audit policy this required re-audit at compliance below 90%. Re- audit in September 2016 showed that staff achieved 83% compliance for hand hygiene, which was still below the hospital target of 90%.
- Medicines were not always stored safely and securely.

However:

- All staff we spoke with were aware how to report incidents and felt supported to use the trust electronic incident reporting system. We saw that learning was shared.
- Equipment was regularly maintained and faults were reported and acted upon promptly.
- Electronic records ensured that staff had access to the information they needed to treat patients safely.
- Staff told us that the mandatory training week in April was good.

Incidents

- All staff we spoke with were aware how to report incidents and felt supported to use the trust electronic incident reporting system.
- The trust had not reported any never events for the emergency department between September 2015 and August 2016. Never events are serious incidents that are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers. During the same period, in accordance with the Serious Incident Framework 2015, St Mary's Hospital's ED reported no serious incidents (SIs) in urgent and emergency care which met the reporting criteria set by NHS England. However there was one serious incident reported in September 2016
- Staff reported incidents in accordance with the trust policy. Staff were encouraged to report fully, appropriately and in a timely manner. Staff told us that they received feedback when they reported incidents on the electronic reporting system via email, and sometimes directly from the sister. Staff also told us they would receive a letter detailing the outcome if they reported an incident requiring an investigation
- Learning from incidents formed part of staff meetings an example given was that of a missed fracture on an x-ray image.
- Between July 2016 and October 2016, ED data showed staff reported 309 incidents: 235 were categorised as no harm, four as moderate, and 66 of minor injury. The highest category: 236 incidents were related to pressure

Urgent and emergency services

ulcers and skin integrity. The four incidents graded as moderate were related to patients coming into the emergency department from nursing homes with grade 3 and 4 pressure ulcers.

- We received data for September 2016 which showed that staff in the emergency department reported two major incidents which were under investigation.
- There was a process in place for the management of incidents that included the duty of candour. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person. Staff were aware of the duties required by the duty of candour; we spoke with 27 staff during the inspection and of those we spoke with two specifically discussed incident reporting and duty of candour. Six of the staff told us that incident reporting was covered during the two week mandatory training days in April each year.
- The hospital had a Mortality review group which met monthly and was attended by one of the emergency department consultants, who was lead for all mortality cases occurring in ED. The clinical lead held met weekly with the matron and the operational lead and told us that one week in four was devoted to governance mortality and morbidity.

Cleanliness, infection control and hygiene

- During the first day of our visit we observed that the main waiting area was visibly clean and tidy, and the clinical cubicles had aprons and gloves available for staff to use.
- Hand sanitiser gel was available. We observed staff took measures to reduce the risk of infection as they were bare below the elbow, used the gel and wore the personal protective equipment.
- We saw the results of an infection prevention audit undertaken in the department in July 2016 for nursing and medical staff was 56% compliant. A re-audit in September 2016 showed that staff achieved 83% compliance for hand hygiene, which was still below the hospital target of 90%.
- There was a compliance of 40% against a target of 90% for storage and use of items, for example segregation of

clinical and non-clinical items, and some sterile items were stored on the floor. The overall result for the audit showed that the department was 75% compliant against a target of 90%.

- We observed blood drops on a blood gas machine and a sharps bin that had not been cleaned.
- Staff were made aware of results and received reminders through a regular newsletter and the staff clinical information noticeboards, about their adherence to infection prevention best practice.
- We observed one registered nurse prepare intravenous medication with no gloves on and no adherence to aseptic technique, the expected standard parenteral drug preparation. However we did not observe any other poor practice with aseptic techniques during our inspection.
- Reception staff told us they would immediately alert cleaning staff if they were made aware of any blood or body fluid spillage in the waiting area. Reception staff had cleaning signs they could position to alert patients to the infection hazard.

Environment and equipment

- The ED had two areas: major receiving and treatment area (majors), and the minors or ambulatory reception and treatment area. These areas included a children's waiting room, which doubled up as a mental health assessment room. The resuscitation area was located in the majors area. There was also a plaster room and a room for treating eye injuries. There was good access to the radiology diagnostic imaging rooms and the computerised tomography (CT) room.
- The majors area consisted of 10 assessment cubicles, and three adult resuscitation bays.
- The minors area consisted of a large waiting area, one triage room located just off the waiting room and a treatment area with individual cubicles, four with beds and two with chairs.
- Staff told us that this room doubles up as a mental health assessment room. We observed that there were risks in the use of the room for this purpose; for example, there was a ceiling mounted examination lamp that presented ligature risks and the furniture was not fixed to the floor which meant that it could be used for barricading the door or for missiles. Staff told us that patients were never left alone in this room.

Urgent and emergency services

- The rooms that were used to assess and treat children and young people who attended the ED were not ideal for their purpose. They were located near the adult bays, which meant that conversations could be overheard. We were told about a child asking a staff member what certain words meant that a child should not hear.
- During the first day of our inspection visit we saw a number of issues of concern. For example, the children's waiting room was not equipped as a waiting room and we saw that there were open sockets and staff kept the sharps bin on a shelf above the child seat.
- Records for August September and October 2016 showed that staff checks of the paediatric airway trolley was inconsistent with 5 days in each month showing that the daily check was not undertaken. We saw similar inconsistencies in the records for checking of the paediatric resuscitation equipment trolley.
- The access to the paediatric resuscitation room was difficult as there was a bed in the room which did not easily allow room for another trolley to be wheeled in. Some of the equipment was not appropriate for paediatrics. For example a trolley which contained a diagnostic peritoneal lavage (DPL) kit was present, and would not be required for paediatric use.
- We observed that some of the clinical items were passed their expiry date, for example, an intravenous fluid bag had an expiry date September 2014, and a basic delivery pack had expired in May 2012.
- The hospital medical electronics department had a planned preventative maintenance (PPM) schedule designed to ensure that ED had a PPM visit on an annual basis. Staff told us that the team checked all patient applied equipment, in addition to any calls to attend to faulty equipment throughout the year.
- We were told that the defibrillators and portable suction devices in the resuscitation bays were checked every six months to ensure they were in good working order and we saw that maintenance dates on the items supported that.
- Ventilators, hoists and weighing scales were also regularly checked.
- We saw that staff had checked the resuscitation equipment in the adult bays consistently on a daily basis.
- There were daily checks recorded for the 'difficult airway trolley' but for September three days were omitted, in October four days were missed and in November we saw that checks were not recorded as completed for three days.
- There was a stack system with 16 trays for the emergency equipment which contained pictures for easy retrieval. We observed that the system was good but that there were some items missing and no indication of whether the item had been re-ordered, and we saw an open empty drawer without the pictorial guide to indicate what should be in there.
- The blood gas machine fluids which were incorrectly labelled, on the first day were removed and correctly labelled by the following day and we saw that the control of substances hazardous to health (COSHH) folder was updated.
- All the issues of concern were escalated to the matron and were all resolved when we returned the following day.

Medicines

- A trust wide medicines management policy with standard operating procedures was in place and monitored through audit by the pharmacy team. We saw the risk Identification and analysis checklist for ED used and completed by the pharmacist, but it was not clear how often these checks were undertaken.
- On the first day of our inspection we found a number of issues which we escalated to the matron. For example; the anaphylaxis bag in the drug room contained expired medicines – dexamethasone, paracetamol and lignocaine. In the paediatric resuscitation room we saw an intravenous fluids bag with an expiry date 09/2014 and lignocaine ampoules with an expiry date 07/2015. In the adult resuscitation room we saw that staff had left out some sodium chloride which we gave to the senior nurse dispose of. The matron took action to resolve this concerns immediately.
- We found tablets broken in half and scattered on a shelf in the medicines room, and the staff could not find the documentation relating to fridge checks.

Urgent and emergency services

- Staff had left a cardiac thrombolysis kit open and we saw a stroke thrombolysis kit left unsealed. There were several other bottles containing radiation contrast media on shelves with an expiry date of 28/7/16.
- On our return visit the next day staff had taken action to resolve the concerns in the resuscitation rooms. We saw that all emergency medicines, including oxygen, for adults and children were available and within their expiry date. The minors area was well stocked with no clutter or medicines left out.
- There was an electronic system in place for checking and dispensing of medicines and we saw that staff recorded, and handled controlled drugs (CD) appropriately. Spot checks on balances showed that contents of the cupboard matched the register.
- One staff member told us no key was available in the department to access medicines cupboards in the event of a power cut or other emergency. This did not appear on the department risk register and we did not see that any mitigating actions were developed in response to this potential risk.
- One consultant told us that no drug dispensing machine in minors was often the cause of delays due to staff queuing in the medicines room.
- Staff we spoke with understood the importance of medication error reporting and knew how to use the electronic system to do this.
- We saw that staff handled waste medicines properly and staff stored prescription forms securely.
- We reviewed 11 patient records and found that staff consistently recorded allergies.
- Staff put patients who remain in the ED for more than 4 hours on a bed and initiated a five point care plan; this care plan records pressure sores; standard observations; food and drink intake, medications and whether the relatives have been informed.
- Paediatric early warning (PEWs) charts were available in the department for a variety of ages
- We reviewed 11 sets of records, of which we found concerns with seven of them. There were inconsistencies in completion, for example seven of the 11 did not have pain scores recorded and three of the paediatric records did not have the PEWs scores documented for those presenting with medical issues.
- The observation charts we saw were paper based and at the time of our visit the trust outreach service was undertaking an audit of the medical early warning (MEWs) charts.

Safeguarding

- The department had systems in place to safeguard vulnerable adults. Staff were fully aware of their responsibilities and used safeguarding pathways in the department.
- Staff that had undergone safeguarding training identified vulnerable adults. Where concerns were identified, staff were aware of the correct escalation process, and provided examples of where this procedure had taken place.
- Staff we spoke with could describe occasions when a patient in the department required extra attention due to their vulnerable circumstances.
- Training in safeguarding was received annually during the mandatory training weeks in April but we did not receive data from the trust to show the levels of compliance with the training or the expected levels for staff groups.
- We saw there was a child protection policy in place which was reviewed in April 2016.
- A specialist children's nurse had recently undertaken training sessions with ED staff in female genital mutilation (FGM), domestic violence and child sex abuse so staff knew how to make appropriate referrals.

Records

- The trust used an electronic patient record (EPR) system. We observed the receptionists recorded patient details on the EPR at registration or staff handed details over to ED staff by ambulance crews.
- A receptionist told us that they had nine different electronic patient information systems in place including, for example one used for the out of hours service and one for the ambulance service

Urgent and emergency services

- According to the Standards for Children and Young People in Emergency Care Settings (Royal College of Paediatrics and Child health 2012) all staff should receive appropriate safeguarding training. We saw that at the time of our inspection compliance with the child safeguarding level 3 training was 45% for the medical staff in ED and 88% compliant for all other staff.
- We observed that the paediatric safeguarding pathway was not smooth due to tensions between staff in the ED and those on the ward. Staff told us that the children's ward was a "place of safety" but we witnessed the reluctance of the ward staff to accept referrals.
- The ED consultants were concerned about the lack of support from the paediatric inpatient team, particularly as they did not have specialist paediatric skills and frequently found it difficult to refer patients to the specialist team. Consequently children and young people who should have been seen by specialists left the department without proper and full assessment.
- We did meet a specialist children's nurse /health visitor who went to the department daily to check records of all the people under age 18 that attended the ED the day before. This worked as a safety net to capture any potential vulnerable children and young people who may slip through the net. This nurse reviewed the records and ensured that information was entered onto the electronic system used by the safeguarding teams, sent messages sent to school nurses, health visitors or CAMHS where appropriate. Sometimes staff made requests for home assessment. The records of any patient under age 18 who were admitted were also reviewed and the patients referred to specialist services if appropriate.
- The matron told us that all nursing staff received level 3 safeguarding training and a few of the staff we spoke with confirmed that they had received this training.
- We were told that mandatory training consisted of; fire safety, Ebola, chemical, biological, radiological and nuclear defence (CBRN), immediate life support (ILS), paediatric immediate life support (PILS) and major incident training. No data on mandatory training rates was made available to us prior to the inspection, during the inspection or post inspection. Therefore we were not assured regarding what training was provided or when staff attended.
- The matron told us that all the registered nurses undertook the PILS training but access to this training was limited and staff joining outside of the mandatory training weeks in April had to wait months for this training. No training data on PILS was provided.
- We saw notice boards in the staff corridor, which detailed some of the recent training available to staff; for example, conflict resolution, mask fitting.

Assessing and responding to patient risk

- The Royal College of Emergency Medicine recommends that patients should wait no more than 60 minutes from time of arrival to treatment. The trust consistently met the standard over a 12 month period. Between March and May 2016 performance against this standard showed a trend of decline. In June 2016 the median time to treatment was 35 minutes, compared to the England average of 61 minutes.
- All emergency departments in England are expected to receive and assess ambulance patients within 15 minutes of arrival. During our inspection we observed that this was the case in St Mary's Hospital ED. However data for the months of April to November 2016 showed that almost 53% of such handovers took longer than 15 minutes.
- We also learnt that during 2016 there were 35 "black breaches." A black breach occurs when the time taken from an ambulance arriving at the emergency department, and paramedics handing over the patient to the hospital staff, is greater than 60 minutes.
- All ambulatory patients who attended the ED were directed to the main reception desk in the waiting room. Reception staff we spoke with were clear their role was to register patients and ask for presenting information and not to triage. If they were concerned about a patient for example, in cases of chest pain they would alert the triage nurse to prioritise.

Mandatory training

- Staff told us that they received all mandatory training during two dedicated training weeks in April each year, half of the staff group attended for each week.

Urgent and emergency services

- Reception staff said they would “Watch the waiting room” to spot cases when a patient had collapsed and summon help if needed.
- The triage nurse was situated in a small room next to the waiting room and aimed to carry out a brief clinical assessment within 15 minutes of arrival. This nurse directed patients to the major treatment area if they felt this was clinically indicated. Otherwise patients were asked to return and wait in the minors waiting area until the nurse practitioners were ready to assess and treat them.
- Physiological track and trigger systems should be used to monitor all adult patients in acute hospital settings (National Institute for Health and Care Excellence, Clinical Guidance 50, 2007). We saw that staff consistently monitored and recorded adult MEWS scores.
- Staff put patients who remained in the ED for more than four hours on the ‘five point care plan’. This plan involves assessing and recording the pain score, pressure ulcers, standard observations, nutritional intake and whether relatives have been informed of the patient’s presence in ED.
- All staff we spoke with clearly understood the ‘The Sepsis Six Resuscitation bundle’ and the procedures associated with it. During our inspection we saw that medical staff did not always follow or document the full protocol. We saw two records where patients on this care pathway did not have the “must complete” information filled in.
- A 96 year old patient presented with symptoms that alerted staff to implement the sepsis action plan, but we observed that the sepsis screen integrated pathway tool was not fully completed. A risk assessment for acute kidney injury (AKI) was undertaken.
- During our evening visit we saw that there were six patients awaiting beds, all with initial medical assessments completed. These patients had been in the department from six to 14 hours.
- We observed that children attending the department were triaged quickly, but assessment by a paediatrician or children’s nurse was often delayed or not available.
- We reviewed records for paediatric patients. The paediatric early warning score (PEWS) and sepsis pathway was not recorded for all children.
- We did not see any evidence that the department used a recognised safe staffing tool to ensure staffing levels in the emergency department (ED).
- The trust did not provide us with any data on current staffing levels, vacancies or recruitment timelines for nursing and support staff.
- Planned staffing levels for the day shifts were six registered nurses (RNs) with four healthcare assistants (HCAs). At night the numbers reduced to three RNs with two HCAs. A registered nurse who worked a twilight shift from 6pm until 2am the following morning supported these shifts.
- An emergency nurse practitioner worked in the department from 10am until 10pm seven days per week.
- All of the staff we spoke with told us that the night shifts were often very challenging. There was a 1:5 ratio of trained staff to patients and we observed during one morning that one band 5 nurse and two student nurses were responsible for the resuscitation room. This level of staffing was not safe in the event of one patient clinically deteriorating. In such a situation a crash call would be initiated to enlist the support of the critical care response nurses and teams. We observed a similar situation during the evening when one band 5 nurse was responsible for three patients in the resuscitation room.
- During the same evening we saw that there was one band 5 nurse looking after five patients in the majors area. Four of the patients were waiting for beds.
- We were told that there was funding for a children’s nurse from the paediatric ward to support the ED for approximately 60% of full time hours, but this rarely happened. The ward team only made this support available in emergency situations.
- There was not always a band 7 nurse in charge of the department in accordance with national guidance. During our inspection there was an acting band 6 nurse in charge of the department for the night shift.
- According to “Standards for Children and Young People in Emergency Care Settings” (Royal College of Paediatrics and Child health 2012), sufficient RN [Children] nurses are employed to provide one per shift in emergency departments receiving children, this was not the case in the ED.
- At the time of our inspection, general nurse staffing levels did not appear on the department risk register; however a lack of paediatric nursing cover was included.

Nursing staffing

Urgent and emergency services

Medical staffing

- The trust did not provide us with any data on current staffing levels, vacancies or recruitment timelines for medical staff.
- There were four whole time equivalent (WTE) consultants working in the ED. They cover the department from 8am until 8pm during the week and 8am until 11am at weekends for one in two and 8am until 5pm one in two.
- The Consultant cover does not meet the required standard of 16 hours per day, seven days a week, as recommended by the Royal College of Emergency Medicine. This appears on the department risk register, graded as a low risk.
- None of the emergency department consultants have paediatric qualifications or special interest registration in paediatrics.
- There were six middle grade doctors in post however one was scheduled to leave. Whilst the individual informed us they would like to stay they were leaving due to a lack of opportunity in the department.
- The middle grades work a one in five night rota, prospective cover provided by the sixth. There were no training grades approved by Wessex.
- At night there was one middle grade on duty all night, two senior house officers (SHOs) until 2am and one SHO through the night.
- Five foundation year (FY2s) and three GP Vocational Training Scheme (GPVTS) junior doctors made up the junior rota.

Major incident awareness and training

- There was a hospital wide major incident plan in place, which included detail actions for the emergency department staff to take in the event of a major incident.
- All the staff we spoke with had received training for a major incident including the reception staff who explained how the practical exercises are undertaken and how useful they found the training. However, no training data was provided by the trust to corroborate this.
- Hospital business continuity plans were in place, including for the emergency department. Arrangements included a back- up generator in case of power failure.

Are urgent and emergency services effective?

(for example, treatment is effective)

Requires improvement



We rated effective as requires improvement because:

- The paediatric referral process did not work effectively.
- Participation in some of the Royal College of Emergency Medicine (RCEM) audits showed some poor outcomes and follow up re-audit programmes were not in place.
- Consultant staff did not have sufficient time to supervise the education of junior medical staff.
- Pain relief was not consistently documented in patients' records.
- Mental capacity assessments were not always carried out.

However:

- We saw some good audit outcomes and follow up actions.
- The 5 point care plan was a good initiative.
- Patients were offered food and drink appropriately.
- Nurses were supported with the re-validation process.
- Student nurse found the team supportive and knowledgeable.
- Access to radiology and pharmacy was good.

Evidence-based care and treatment

- The emergency department had access to a wide range of clinical guidelines based on, for example, on the National Institute for Health and Care Excellence (NICE) and the Royal College of Emergency Medicine (RCEM) to ensure care and treatment was evidence based. We observed that clinical pathways were not always implemented fully.
- The department did not participate in all required national audits. The ED took part in four RCEM audits in the years 2013 to 2016. There was limited local audit activity in the department, and nurses reportedly did not undertake any local clinical audits. There were no plans to commence these.

Urgent and emergency services

- The ED followed the trusts guidance on the 'Sepsis six' pathway. However, this was not yet working effectively as we identified some concerns with patients on the pathway. This has been detailed in the surgery section of the report.
- The recent changes to the organisational structure, forming business units did not take into account the views of front line clinical staff. The structure did not support natural clinical referral pathways and working relationships.
- For example there was no frailty care pathway and there were no specific healthcare for the elderly (HCE) wards which meant that elderly patients formed a high proportion of those waiting for long hours in the ED.

Pain relief

- In the CQC A&E Survey 2014, the trust scored 6.6 for the question "How many minutes after you requested pain relief medication did it take before you got it? This was "about the same" as other trusts. The trust scored 7.6 for the question "Do you think the hospital staff did everything they could to help control your pain?" This was "about the same" as other trusts.
- During our inspection we saw several adults and a child offered and administered timely pain relief.
- The department staff had not undertaken a pain relief audit during the previous 12 months.
- We reviewed 10 sets of paediatric notes and found that of the children attending with traumatic injuries no pain scores were recorded

Nutrition and hydration

- We saw that staff put patients who remained in the department for more than four hours onto the five point care plan which included the patients' nutritional intake. Staff offered food when appropriate.
- We observed following assessments, patients were prescribed and administered intravenous fluids for hydration when clinically indicated.

Patient outcomes

- Staff told us that all the RCEM audits for the current year had been undertaken in the emergency department. The ED is a designated major trauma centre and benchmarks itself against other trauma centres through

the trauma audit and research network (TARN). The most recent TARN report shows the ED in St Mary's Hospital performs well in most aspects against the England average.

- The results of this audit (October 2016) show for example that 90% of patients were meeting the NICE guidelines for receiving a CT scan within 20 minutes of arrival at the department. Against the England average of 57%.
- In the RCEM Audit: Asthma in children 2013/14 the ED department performed poorly on a number of measures. For example, GPS score taken within 15 minutes (6%) and peak flow taken within 15 minutes (0%) there were better results for oxygen saturation taken within 15 minutes (67%) and pulse taken within 15 minutes (67%)
- In the RCEM Audit: severe sepsis and septic shock 2013/14 the department was in the upper quartile compared to other hospitals for six of the 12 measures, and was between the upper and lower quartiles for five measures. The site was in the lower England quartile for one measure. Measures for which the hospital performed in the upper quartile were vital signs measured and recorded in the ED notes (98% compliant). Also high-flow O2 initiated in the ED (100% compliant). There was poor performance for evidence that urine output measurements were initiated in the ED with 42% compliance.
- The VTE risk in lower limb Immobilisation in plaster cast clinical audit 2015-16 the department performed poorly for documentation and patient information and an action plan to address the issues was in place. The VTE risk assessment was carried out 100% of the time.
- In the 'Vital signs in Children (care in emergency departments)' audit key findings were: 8/50 (16%) of the children attending the ED with a medical illness had a full set of obs within 15 minutes as recommended. None (0/25) of the children had a further complete set of vital signs recorded in notes within 60 minutes of first set.
- Between July 2015 and June 2016, the trust's unplanned re-attendance rate to the ED within seven days was consistently worse than the national standard of 5%. It was also worse than the England average in all but one of these 12 months. The rate was highest in May 2016, when 12.9% of patients re-attended within seven days. In June 2016, trust performance was 10.8% compared to an England average of 7.8%.

Urgent and emergency services

- We saw that action planning was in place to improve performance following audit. For example venous thromboembolism (VTE) risk in lower limb immobilisation in plaster cast clinical audit 2015-16. The ED team performed poorly on a number of aspects such as documentation and patient information and plan to re-audit this year.
- The Procedural Sedation in Adults Clinical Audit 2015-16 also showed that documentation is a weak area in St Mary's Hospital ED. We did not see evidence that there was a plan in place to improve this.
- A local audit undertaken in the ED between April and August 2016 was 'vital signs monitoring for children' within 15 minutes of arrival in emergency department. We did not see the results of this audit but we did observe that all children arriving in the department during our inspection were all assessed and triaged within 15 minutes.
- An ED newsletter was regularly produced which included the outcome data for local audits and reminded staff of their actions following results. For example, staff reminded to take and document a full set of observations to include PEWS appropriately. We saw that the department monthly audits for National Early Warning Score (NEWS) in October and November 2016 were 100% compliant

Competent staff

- Appraisals of both medical and nursing staff were undertaken and staff spoke positively about the process. However the trust did not provide us with any data that supported what we were told. No data for appraisals in any staff group were provided.
- We were told that the middle grade doctors had study leave built into their rota and that they were all up to date with their mandatory training, but that the clinical lead was not assured and did not have one to one interviews with them.
- One of the consultants is the educational lead for the middle grade doctors but the clinical rota restricts them from providing regular formal teaching sessions. This could create a future risk to the placement of trainees at the trust by the professional bodies that oversee these decisions.
- We were told that despite a busy department the consultant lead for education did spend the day in the post graduate centre fulfilling their clinical tutor role.

- ED is part of the trauma network and staff told us that they were able to attend study days.
- There were three emergency department nurse practitioners (ENPs) in the department. We spoke with two of them who told us that their scope of practice included all injuries and children of any age. They each have a consultant mentor for supervision.
- Staff told us that there were long waits for phlebotomy, cannula insertion and IV drug administration training for nurses, and independent departments such as ED were not allowed to arrange in-house training.
- Nursing staff told us that there was a revalidation guide nurse in the hospital who supports staff with this process.
- There was a notice board dedicated to the protocols and flow chart for sepsis management and the staff we spoke with were knowledgeable about the need for speed in diagnosis.
- We spoke with health care assistants (HCAs) who told us of their frustrations due to lack of progression and opportunities to develop their skills.
- The student nurses we spoke to found that the placements were satisfying their clinical training needs because the staff assigned to them were always able to explain procedures and were knowledgeable about all the areas of emergency department practice.

Multidisciplinary working

- We observed medical, 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.
- Staff spoke about an effective working relationship with the medical assessment unit. The staff in charge of each unit were supportive of each other in the daily task of trying to identify admissions for their patients.
- Senior ED staff including the ED lead consultant, informed us that their position in a different business unit from their medical colleagues, who had responsibility for the out of hours GP service meant that they felt isolated from the main hospital teams.
- We were told that lack of accountability by the medicine teams for the four hour target led to the high numbers of patients who remained in the ED for long hours waiting for beds.

Urgent and emergency services

- Referral pathways for children were not effective, and staff of all disciplines told us that there was a lack of support from the paediatric ward staff. We learnt that a rotational nursing post between the two areas was under consideration and due to commence in February 2017.

Seven-day services

- Emergency department consultant cover was not provided 24 hours a day, 7 days a week (24/7). The middle grade doctors provided overnight cover.
- Radiology service and support was available 24/7; x-ray and computerised tomography (CT) scanning was located adjacent to the ED with access to the radiographer.
- We were told that access to pharmacy was available 24/7. Pharmacist and pharmacy technician availability was good.

Access to information

- Information needed to deliver effective care and treatment was organised and accessible. This included test results. Treatment protocols and clinical guidelines were computer based and we observed staff referring to them when necessary.
- There were electronic information screens in the majors area which identified when patients were due to arrive in the department. This helped to allocate resources to ensure staff were available to receive patients.
- The electronic information system alerted staff when vulnerable children or adults arrived in the department. It also provided up-to-date information about patients' flow through the department, investigations and length of stay.
- We saw that computer systems in the department were protected by password to prevent unauthorised persons accessing patient information. We saw computers timed out after a short period and staff also logged out to reduce the risk of unauthorised access.
- We saw efficient and effective handovers between shifts in the ED.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We observed staff obtained patient consent where possible, before undertaking procedures. Where patients lacked the capacity to make decisions for themselves, such as those who were unconscious, we

observed staff making decisions which were considered to be in the best interest of the patient. We found any decisions made were appropriately recorded within the medical records.

- Consent forms were available for people with parental responsibility to consent on behalf of children.
- The staff we spoke with had sound knowledge about consent and mental capacity and knew when formal mental capacity assessments needed to be carried out.
- We asked to see training data for staff in respect of the Mental Capacity Act and DoLS however, no training data, for any staff group, was provided by the trust.
- We observed that a resuscitation decision form was completed for a 96 year old patient, but the assessment of mental capacity was ignored despite the clear instruction that this must be completed.

Are urgent and emergency services caring?

Good



We rated caring as good because:

- We observed ED staff provided compassionate care and were sensitive and empathetic in their interactions with patients.
- Patients spoke positively about the care they received and the attitude of caring and considerate staff.
- Privacy and dignity for the patients was maintained.
- We saw good use of the "My Life _a Full Life" document

However:

- Confidentiality for children and their families was difficult to maintain

Compassionate care

- We saw many examples of staff entering assessment cubicles following a polite "hello and can I come in" and always maintaining the patient's privacy.
- We spoke with two patients during the inspection. All the patients we spoke with described the care they received as good. Comments included, "Staff were fantastic" "kind" and "patient."

Urgent and emergency services

- We saw two patients come into the department following their attendance in the department the week before purposely to thank the staff they saw for their kindness and care.
- We saw staff treated patients with dignity and respect, where possible staff tried to maintain confidentiality of conversations by speaking discreetly.
- The A&E survey results from 2014 in response to the question about privacy and dignity, rated the department about the same as other trusts. The results of the CQC A&E survey 2014 showed that the trust scored about the same as other trusts in almost all of the 24 questions relevant to caring.
- We observed staff speak with patients in a calm and empathic manner to reduce patients' and relatives' anxiety and the results of the CQC A&E survey 2014 showed that the trust scored better for this than other trusts.
- The privacy score for St Mary's Hospital 2016 patient led assessments of the care environment (PLACE) was on average 86.7%. There was no clear understanding for the low rate provided by the trust, and there were no plans in place to assess or address any issues to improve outcomes.
- We did observe a lack of privacy for patients arriving in the emergency department from an ambulance. Crews had to wait with the patient, who was on a trolley, in the thoroughfare through the department. There were no receiving cubicles for patients to wait in prior to ambulance staff completing a handover. The area used for the handover meant other patients in cubicles close to this space could overhear
- The paediatric waiting room layout meant that staff were not able to preserve confidential information about individual patients as we observed patients and families could overhear conversations. Families preferred not to use this room.
- The trust's urgent and emergency care Friends and Family Test performance was consistently better than the England Average between August 2015 and July 2016. In the latest month, July 2016, trust performance was 86.9% compared to an England average of 85.4%.
- We observed staff conveyed information in a way that patients were able to understand and checked understanding. One patient's relative we spoke with said, "The staff have been great and we understand what's happening, but 13 hours in this department is not conducive to mother's health".
- Patients we spoke with were happy with the way they had been kept informed, but disappointed that staff were not able to tell them when a bed might become available.
- The CQC A&E survey 2014 showed that the trust performed better than other trusts for the question about how long it took for a patient to speak to a nurse or doctor.

Emotional support

- The results of the CQC A&E survey 2014 showed that the trust scored "better than" other trusts in two of the 24 questions relevant to caring. These included the question on whether patients were able to get reassurance from staff if they felt distressed while they were in the A&E department.
- The staff and patients in ED have access to the chaplaincy throughout the day. The team is of the Christian faith but have access to other denominations based on the island.
- A bereavement advisor was also available by appointment, Monday to Friday between 9am and 3.3 pm.
- One of the patients came to the department with a 'My Life a Full Life' Document (MLAFL). MLAFL is about healthcare and community organisations working together in partnership with the voluntary sector. This provides for people's individual needs to enable them to take control of their lives and plan for their future health and social care needs. The document contained all of the patient's likes and dislikes for activities of daily living as well as the care plan. For example the falls prevention measures and the tissue viability nursing plan. This ensured that the ED nurses could follow the agreed care plan, offering the support needed by the patient. Staff handed the care for this patient on to the end of life team at the earliest opportunity.

Understanding and involvement of patients and those close to them

Urgent and emergency services

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

Requires improvement



We rated responsive as requires improvement because:

- The trust consistently did not meet the requirement to transfer or discharge patients within four hours between August 2015 and July 2016. The trust's performance was worse than the overall England performance in nine of these 12 months.
- Patients frequently had long waits in the emergency department.
- Facilities for children were not fit for purpose.
- There was no frailty pathway in place, and no rapid assessment team to enable optimum flow.
- Specific training for nurses was not always available when required.

However:

- There was a good working relationship between the emergency team and the medical assessment unit, which helped improve the patient flow and gave some patients quicker access to a bed.
- Staff were aware of the needs of patients living with dementia.
- We observed handover between ambulance staff and ED staff took place efficiently.

Service planning and delivery to meet the needs of local people

- The St Mary's Hospital NHS Trust provided emergency department care for the local population, and is also a designated regional major trauma centre.
- There were discussions about the future of the service and how the service could be delivered, however nothing had been formalised.
- The acute medical unit team responded well to approaches from the ED team to accommodate patients and ease the flow, but the senior management within the hospital had not given support to the service attempts to create an ambulatory emergency care bay. This bay was almost always occupied by inpatients.

- The ED department had yet to introduce a frailty pathway, which would perhaps improve patient assessment and improve flow through the department.
- The CEO was a member of the island wide Systems Resilience Group, working with partners on the Island towards acute hospital avoidance and improving access and flow through ED.
- The trust was using the NHS England 'A&E rapid implementation guidance for local systems' to develop project plans, for example to improve patient flow through the hospital. There was little progress with implementation.

Meeting people's individual needs

- Ambulance staff transferred patients from the ambulance in wheelchairs, rather than trolleys, if it was appropriate to do so to encourage patients' independence.
- The trust's scored "better than" other trusts for one of the three A&E Survey questions relevant to this domain. This was the question on how long the patient's visit to the A&E department lasted. The trust scored "about the same" as other trusts for the remaining two questions.
- Staff were aware of the needs of patients living with dementia. If dementia was suspected in a patient this would be flagged. This ensured that patients were given a priority and that a small core of staff would look after the patient to increase continuity for them. Staff told us that in order to reduce exposure to noise patients living with dementia would be cared for in a cubicle.
- Confused patients or those living with dementia who liked freedom of movement requiring additional monitoring, were cared for in a bay near the nurse's station. This allowed closer observation of these patients by all staff.
- A member of staff would sit with a patient if they were very disorientated, distressed or frightened. Staff asked patients some screening questions to ensure that patients living with dementia were identified. Staff we spoke with had undergone training on caring for patients living with dementia.
- In the CQC A&E Survey, the trust scored 6.5 for the question "Were you able to get suitable food or drinks when you were in the A&E Department?" This was "about the same" as other trusts.

Urgent and emergency services

- Staff told us they offered food to patients cared for in the majors areas, including hot meals and drink during their stay. During our inspection we saw that this was the case
 - We were told that patients with a learning disability were given a priority; their attendance at the department was flagged. Patient's relatives would be asked for their help in the completion of a 'this is me' document. This provided staff with information of the needs and preferences of a patient that may not be able to willing to share this with staff they do not know.
 - Mental health staff told us there was an issue with inappropriate referrals from other wards. We were told of a recent example where a person had been admitted to A&E but then sent straight to Afton ward without any physical tests being carried out as it was assumed that mental health problems were the main reason for their presentation. They were not tested for a urinary tract infection (UTI), which should have been identified as a potential cause of their presentation. They were tested on the ward and it was found they did have a UTI, for which they then received the necessary treatment. There was no reason for them to have been admitted to a mental health ward, and they were then discharged back to their residential service once they had recovered.
 - The hospital staff could access "language line" to help patients whose first language was not English and patients who used British sign language could also be supported, but this usually needed to be by appointment which was rarely possible for patients attending ED.
 - We saw that there were racks in the waiting area with information leaflets for common clinical conditions in English. We did not see any such provision in languages other than English
 - Staff told us that support from the child and adolescent mental health services (CAMHS) was challenging as there is an expectation that patients stay in hospital overnight which was often not suitable for the patient's needs.
- Access and flow**
- We saw that patient flow through the department was often slow due to long waits for hospital beds, and we did not see any evidence that this was being addressed effectively. The urgent care centre was reconfigured a month before our visit. The out of hours contract had been withdrawn, and due to the lack of GPs on the island, the hospital had taken over out of hours management. The new service was accountable to the medical team which were in a different business unit from the ED. This was not discussed with the clinical lead in ED and this decision did not support an improved patient pathway through the hospital as the medical consultants did not cover the hours needed to support this pathway.
 - There was no effectual rapid assessment team and there was no agreed plan in place to expand the numbers or role of the emergency nurse practitioners (ENPs)
 - There were no advanced nurse practitioners (ANPs) who may be able to ease the congestion and overcrowding by improving links with clinical colleagues throughout the hospital and the community.
 - We witnessed reactionary responses from the trust wide clinical coordinators/ bed managers on the second day of our visit. Following 24 breaches in the ED during the first day they cleared the department during the night by placing eight patients in the day surgery unit and four patients on the surgical emergency ward. Resulting in the cancellation of the day surgery list.
 - The Department of Health's standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the A&E. The trust consistently did not achieve seeing more than 95% of patients within four hours between August 2015 and July 2016. The trust's performance was worse than the overall England performance in nine of these 12 months. Data for the six months leading up to our inspection showed that in May the service achieved 92.5%, all other months for the year to date were as follows: April 84.6%; June 85.4% (Quarter 1 87.5%) July 87.3%; August 87.5%; September 87% (Quarter 2 87%) and in October and November the service achieved 83.4% and 83.8% respectively.
 - Between August 2015 and July 2016 the monthly percentage of patients waiting between four and 12 hours from the decision to admit until admission for this trust was consistently worse than the England average. In July 2016 43.7% of patients waited between four and 12 hours. This was nearly four times the overall England performance of 10.4%.

Urgent and emergency services

- Over the same 12 months, 32 patients waited more than 12 hours from the decision to admit until actual admission. Most of these waits occurred in August and September 2015 (nine in August and 16 in September; 25 over the two months).
 - The percentage of patients that left the hospital urgent and emergency care services before being seen for treatment was better than the England average in nine of the 12 months between July 2015 and June 2016. However between April and June 2016 performance against this metric was worse than the England average. There was a marked deterioration in performance in May 2016, when 8.6% of patients left before they were seen for treatment. This coincided with increases in the percentages of patients re-attending within seven days.
 - Between July 2015 and June 2016 the hospital's monthly total time in the ED for admitted patients was consistently lower than the England average. Performance against this metric showed a trend of improvement over the 12 months.
 - During the inspection we observed handover between ambulance staff and ED staff took place efficiently.
 - We observed ambulance crews conveyed patients in wheelchairs or trolleys to the majors entrance where ambulance staff transferred patients to the ED nurse in charge. Patients waited in wheelchairs in the majors waiting area before being assessed in one of the majors assessment cubicles. Patients on trolleys would be transferred to an assessment bay if one was available or remain at the entrance to the majors area until a cubicle became available.
 - In the minors area a triage nurse carried out the initial assessment. The nurse sent patients for blood tests, x-rays or diverted them to the majors waiting area. The emergency nurse practitioners in the minors department said they monitored the waiting room and were able to expedite tests to improve the flow through the department.
 - Pathways were followed to reduce demand on ED. For example, GPs referred patients with acute medical needs to the medical assessment unit (MAU) and patients with surgical needs to the surgical emergency ward. ED staff also referred patients who required tests/investigations but did not need to be admitted, to the MAU.
 - The medical registrars responded well to calls to the ED to assess medical patients for admission but lack of beds does not allow good patient flow through to the wards. There was a less good response from the surgical registrars who were often busy in the operating theatre.
 - All the staff we spoke with told us that response from the paediatric team to review patients was very poor and often not available. Staff gave us an example of a young teenager found on the street in some distress, and when asked the paediatric team refused to see her.
- ## Learning from complaints and concerns
- There were 30 complaints received by the urgent and emergency care teams between November 2015 and October 2016. The majority of complaints received a response within 60 days. The most common subject was missed or incorrect diagnosis (20) and nine complaints referred to poor staff attitude.
 - Complaints were handled in line with the trust policy. Patients were advised to contact the patient advisory liaison service for support with their complaint. The hospital complaints team managed the complaints process and ensured complaints were sent to the correct team for response.
 - Information on how to complain was available in the main ED department and on the trust website.
 - A consultant or senior nurse investigated formal complaints and sent replies to the complainant within an agreed timeframe.
 - Staff told us that they were told about complaints at team meetings and learning was shared in the ED newsletter where appropriate.

Are urgent and emergency services well-led?

Requires improvement



We rated well-led as requires improvement because:

- The arrangements for governance did not operate effectively. There was a notable disconnect between the clinical department leadership and the hospital leadership.

Urgent and emergency services

- There were no clear plans in place to address failure to meet the four hour target and improve the patient pathway through the emergency department to appropriate admission
- There was no leadership for the management of children in the department.
- The approach to service delivery and improvement was reactive, with a lack of engagement between clinical leads and the hospital leadership.
- The risk register was not reflective of the department risks and there was no evidence that there were mitigating controls in place.
- Staff satisfaction was varied; and there was a notable low morale amongst the senior staff in the department. Staff reported they felt “beaten” by the system, and decisions taken at hospital level.
- The consultant lead told us that for some time he had felt isolated without a permanent nursing lead in post, but now he felt that the new leadership team would be able to make important decisions together to improve patient care.
- Staff were pleased that they had a new team in place. They told us that the team were visible and approachable.

However:

- Junior staff felt well supported by their clinical colleagues.
- Leaders only just in post needed time to develop as a team.

Leadership of service

- The emergency department formed part of the Ambulance Urgent Care and Community (AUCC) Business Unit. The business units were formed at the end of 2015.
- The leadership team of the emergency department consisted of the consultant clinical lead, the operational manager for ED and MAU, and the matron. There were no separate clinical leaders for the Children’s ED, the responsibility was with the main leadership team.
- At the time of our inspection the operations manager had been in post for a month and the matron had been in an interim role, which was made substantive very recently.
- Through our discussions with the ED consultant lead and the matron they demonstrated a clear understanding of the issues faced by the department, and acknowledged the concerns we had identified. We note that where our inspection team identified concerns, staff took action swiftly to resolve the issues.

Vision and strategy for this service

- The hospital has a vision statement “Quality Care for Everyone, Every time.
- The trust aspires to be an integrated care exemplar to the NHS – where patients experience excellent well-coordinated, holistic care and support to manage their physical and mental health needs at home, in the community and in hospital.
- At the time of our visit, the business unit structure was still less than a year old and the staff in the emergency department felt unsettled by the changes. It was unclear what the future strategy would be or how it would be taken forward by the emergency department.

Governance, risk management and quality measurement

- The department leads maintained a document titled ‘Risks and issues log’. This was a combination of concerns and the risk register. We reviewed the version from November 2016. There were 12 items recorded on the issues log, two of which were risk register items and 10 were logged as issues.
- The risk register entries did not identify a date for when the risk was added to the register, nor was there a date of when the risk was expected to be resolved.
- Of the eight risks identified on the risk register only one related specifically to the urgent and emergency service. The rest related to the trust wide risks such as pressure ulcer management, and improving compliance with embedding MCA and DoLS practices.
- We identified several areas of risk during our inspection, which had not been identified by the service. Out of date equipment, poor medicines practices, cleanliness concerns, inappropriate environment to see and treat children, and inconsistent practice around the deteriorating patient pathway. These risks were identified by the inspection, not by the service.
- The service had identified some risks as part of routine practice that had not been added to the risk register.

Urgent and emergency services

For example, audit outcomes on national audit data sets, local hand hygiene and infection control audits, or limited time to train and educate junior medical staff. However these were also not on the risk register, there were no mitigating control factors in place and no action plans to address the concerns or support improvement.

- Our conversations with the department leadership team revealed they had oversight of the challenges in their service. For the emergency department, patient flow was acknowledged as one of their biggest challenges.
- The clinical lead told us that now the leadership team were established they met weekly with one of the meetings per month focussing on governance and mortality and morbidity.
- The new operations manager told us that they had worked on an improvement plan which was in place and included all national emergency guidelines. The team accepted that the plan was challenging.
- The team acknowledged that the emergency department nurse practitioners should be undertaking more clinical audits based on the department areas requiring improvement.
- The matron was working with the consultants and nursing team leaders to establish continuity teams with a focus on different aspects of governance. For example, one of the four teams consisted of a consultant lead for pharmacy and department audits with the nursing team leading for infection control, observations and triage. There were also champions for end of life, oncology, arterial blood gas (ABG) training, and hand hygiene within that team. Each of the other teams had a similar make up.
- The matron put a learning lessons board in place for staff which details updates on outcomes from complaints or incidents.
- There was also a department newsletter published every two months which contained clinical updates and learning from audits, complaints and incidents.

Culture within the service

- Staff told us that they felt respected and valued by their colleagues and the leadership team within the ED. Senior ED staff described the ED team as, “A great team

who try to do their best every day for patients.” Staff we spoke with said they, “Loved working in the department” but there were times when work demands of the job made it stressful.

- Senior ED staff we spoke with said they felt the pressures faced by ED for example, the four hour requirement was considered by some parts of the trust to be, “Only ED’s responsibility as opposed to a hospital wide performance target.” This was made worse by the new business unit arrangements, which left ED, “Almost divorced from the rest of the hospital and part of the community.”
- The senior clinical team felt isolated from improving pathways due to a disconnect between them and other senior clinicians and managers in other departments. Staff we spoke with felt that the clinical pathways need more thought and planning, and the lack of engagement from other teams had resulted in them feeling demoralised.
- The staff reported that they felt supported by their managers, and that they would be happy to approach them with any concerns, they felt the culture between the ED team was an open one.

Public engagement

- The trust encouraged patients and their relatives to give feedback on their care using the NHS Friends and Family Test (FFT) but we did not see any data relating specifically to the emergency department.
- The trust had recently published information for the public to inform them about the changes made to the urgent care centre. The information explained the different services affected and encouraged the public to select the correct service for their needs if they wished to avoid potentially long waits in the emergency department.
- We were not made aware of other methods of gaining public feedback or encouraging engagement.

Staff engagement







- Staff showed high levels of engagement with the department. An ED newsletter contained a wide range of information on department topics, both operational and social. For example, the June /July 2016 newsletter contained sections on staff benefits, welcomed new staff to the department, and shared patient feedback.
- Medical and nursing staff said they had easy access to the senior staff in the department.

Urgent and emergency services

Innovation, improvement and sustainability

- There were no reported innovations or improvements shared with us for the emergency department.

Medical care (including older people's care)

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

Information about the service

The medical care service at St Mary's Hospital, Isle of Wight NHS Trust provides care and treatment for clinical haematology, diabetes, endocrinology, gastroenterology, general medicine, respiratory medicine and pain management.

There are 84 medical inpatient beds located across four wards: Appley Ward which specialises in gastroenterology and respiratory medicine, Colwell Ward which specialises in diabetes, endocrinology and care of the elderly. Whippingham ward and Luccombe ward are surgical wards where medical patients are also accommodated and treated, when medical wards are full.

The coronary care unit has seven acute beds and there is a step-down ward within the unit with eight beds available for non-acute cardiac patients. The stroke unit has a capacity for 30 beds, not all these were acute.

There is a discharge lounge where patients await medicines and transport to take them home. The medical assessment unit (MAU) is a 24 bedded unit which manages the flow of emergency medical admissions into the hospital. The unit takes referrals from the emergency department, general practice and from outpatient clinics.

Oncology services included an outpatient chemotherapy service to adult patients' with solid tumours and haematological malignancies in a chemotherapy suite for twelve patients. The chemotherapy day unit was open 9 am to 5pm on Monday to Friday. During April 2015 and March 2016 they treated 4691 patients.

The endoscopy suite opened in 2016 is accredited by the National Joint Advisory Group (JAG). The service offers investigatory type service such as gastroscopy, colonoscopy, bronchoscopy, cystoscopy and flexible sigmoidoscopy. The service also offers a bowel screening programme.

The trust had 7,463 medical spells between April 2015 and March 2016. A spell is counted when a patient is admitted under the care of a medical consultant. Emergency spells accounted for 83.3 %, 12.5 % were day case spells, and the remaining 4.2 % were elective. A total of 79.4 % of spells were general medicine, 9.2 % were pain management and 3.8% were gastroenterology.

We inspected this core service as part of a short notice inspection to follow up on some areas we had previously identified as requiring improvement and where we had questions and concerns we had identified from our ongoing monitoring of the service.

During our inspection, we inspected the endoscopy suite, the chemotherapy suite, the discharge lounge, four wards, the medical assessment unit (MAU) and coronary care unit. We spoke with nine patients, seven relatives and 31 members of staff, including consultants, nursing staff, porters, housekeeping staff, allied health professionals, medical staff and the divisional leads. We also reviewed 11 patient records, observed care on the wards, discharge lounge, coronary care, medical assessment unit, endoscopy and chemotherapy suite. We analysed data provided by the hospital after the inspection.

Medical care (including older people's care)

Summary of findings

Overall, we have rated medicine as inadequate because:

- Ineffective systems of risk identification and management meant that opportunities to prevent or minimise harm were missed.
- The trust had a system in place for reporting and recording incidents. However, learning and action points were not disseminated to ward staff. Systems and processes were not always reliable and appropriate to keep patients safe.
- There were a significant number of incidents that required investigation. Without investigating promptly and putting controls in place, the risk of further patient incidents could occur.
- Governance processes were not effective at assessing or monitoring systems to improve the safety and quality of the services provided.
- The hospital experienced difficulty meeting the demand for its medical services. Patient moves were tracked by the trust. However, the frequency and reasons were not always appropriately monitored.
- From April to November 2016 between the hours of 10 pm and 7am, 958 patients were moved around the hospital. Repeated bed moves can be confusing for patients and vital patient care information could be lost.
- There were medical outliers across the hospital and in temporary wards. Patients stayed overnight in the surgical day care, ambulatory care unit or in the discharge lounge. The placements meant that the single sex requirement was not maintained, however the trust had not declared mixed sex breaches.
- Staff was discouraged from raising concerns and there was a blame culture.
- There was a significant shortage of nursing staff across all the medical services.
- There was insufficient medical cover across medical services, particularly out of hours. There was significant shortage of older people medicine consultants.
- The trust did not fully comply with infection prevention and control standards.
- There was a low staff appraisal rate. The trust appraisal rates for November 2016 showed Colwell ward 43% and Appley Ward 91.89%.
- Completion of mandatory training was low with 40% attending moving and handling training, and 42% trained in basic life support.
- Staff in the coronary care unit did not have the appropriate training to ensure they had the necessary skills and competence to look after patients.
- Medicines were not always managed safely or securely.
- Mental capacity act and deprivation of liberty safeguard training was not part of mandatory training. Staff had limited awareness and a lack of knowledge in managing the process of deprivation of liberty safeguards.
- Medical records were not always secure and confidential patient information was compromised.
- The trust did not have a robust system for handling, monitoring complaints and concerns. Response to formal complaints did not meet NHS Complaints Policy July 2016 standards.
- From April 2015 to March 2016 the average length of stay for medical non elective patients was worse than the England average. The average length of stay for non-elective stroke medicine was more than 70% higher than the national average.

However:

- The new endoscopy suite was National Joint Advisory Group (JAG) accredited. World Health Organisation WHO checklists briefings took place in endoscopy theatres. Audits took place and results showed 100% compliance. The inadequate rating does not apply to this service.
- The chemotherapy day unit had processes in place to ensure safe care to patients. The inadequate rating does not apply to this service.

Medical care (including older people's care)

- The Friends and Family Test (FFT) response rate for medical care at the trust between August 2015 and July 2016 was better than the England average.
- The trust ran a 'carers are welcome here campaign'. This meant a carer was welcome to visit the hospital whenever they wanted to.
- The stroke lead nurse had developed same day access to scanning and Doppler tests to diagnose and treat patients promptly.
- The trust monitored implementation of policies to ensure they complied with NICE guidance.
- Mortality review committee meetings were held monthly and were chaired by the executive medical director.

Are medical care services safe?

Inadequate



We rated this service as inadequate for safe because:

- The service had 400 open incidents that had not been investigated. Without investigating promptly and putting controls in place, the risk of further patient incidents could occur.
- Learning and action points from incidents were not disseminated to ward staff. For example, staff told us incident forms for shortages of staff were only completed with approval from managers.
- There were significant delays in the investigation of incidents, over several months.
- The trust did not fully comply with infection prevention and control standards. For example, we saw clinical equipment such as commodes were not clean. Open sharps bins were placed on the floor and hand washing audits showed poor compliance.
- Resuscitation trolley checks were not all complete. Management of records did not always protect confidentiality of patient information. We observed poor practice for example patient details were displayed on a computer screen in full view of visitors with no staff in attendance, which compromised security of confidential information.
- On Whippingham and Colwell ward the medicine fridge temperatures were automatically recorded and logged electronically in pharmacy on a daily basis.. If the fridge goes out of range staff alerted and informed by pharmacy..
- Intravenous fluids were stored in an unlocked room in Luccombe ward. This room could be accessed by members of the public.
- There were no facilities for safe medicines storage in the discharge lounge and medicines were being kept on chairs beside beds.
- There were not the appropriate levels of nursing staff across medical wards. For example Appley ward and the coronary care unit (CCU) did not have sufficient safe staffing levels. This increased the risk of harm to patients.
- Staff were not suitably qualified or competent to care for the patients accommodated in escalation areas

Medical care (including older people's care)

- There was insufficient medical cover across medical services, particularly out of hours. There was significant shortage of older people medicine consultants, insufficient for the management of a frail, elderly patient pathway.
- Staff completion of statutory and mandatory training was variable and not in line with the trust's target.

However:

- The endoscopy suite was National Joint Advisory Group (JAG) accredited with new sterilisation machines and endoscope-drying cupboard installed in 2016. The unit had processes in place to ensure safe care to patients
- The chemotherapy day unit had processes in place to ensure safe care to patients.
- World Health Organisation (WHO) checklists briefings took place in endoscopy theatres. Audits took place and results showed 100% compliance.
- Mortality review committee meetings were held monthly and chaired by the executive medical director.
- The trust undertook joint major incident scenario based training with local emergency services.

Incidents

- From September 2015 to August 2016 the trust reported 11 open serious incidents (SI) requiring investigation. The most common SI reported was slips, trips and falls which accounted for seven incidents. One SI involved 42 patients who had not received an appointment in endoscopy when they should have.
- The service had 400 open incidents that had not been investigated. Without investigating promptly and putting controls in place, the risk of further patient incidents could occur.
- Staff we spoke with demonstrated an awareness of how to report incidents in accordance with the trust procedure using the electronic reporting system.
- Ward sisters told us they were responsible for reviewing incidents, investigating if appropriate, ensuring learning points were shared and implementing actions. However, one ward sister told us the delay in signing off and sharing incidents was due to managing staffing pressures.
- Oncology and endoscopy staff attended monthly incidents and complaints meetings. One incident in the endoscopy suite highlighted a patient was taken from

the ward without a wrist label and this caused a delay in correctly identifying the patient. This incident was shared at team meetings and a checklist was implemented.

- Monthly incident reports and trends were presented at the clinical governance committee meetings. All medicine incidents were reported to the pharmacy risk management meeting and further reported to the drugs advisory committee. We saw minutes of clinical governance meetings and senior staff told us that learning was discussed with action plans and timelines for completion. However, two clinical staff members said that they thought there was significant under reporting of medicines incidents. Ward staff told us there was limited learning and sharing of incidents.
- From September 2015 to August 2016 there was one never event for medical care. Never events are serious incidents that are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers. The never event involved a medication error. We saw evidence that an investigation was conducted and discussed at the clinical governance meeting. The patient was informed and changes were made to clinical practice.
- There was a process in place for the management of incidents that included the Duty of Candour. The Duty of Candour (DoC) is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person.
- Staff we spoke with were familiar with the concepts of openness and transparency and some could give examples of how they or their colleagues had applied the DoC. We saw evidence of two incidents, which were subject to the duty of candour discussed in the July 2016 serious incident forum minutes.
- Mortality review committee meetings were held monthly and were chaired by the executive medical director. Minutes showed that there was a set agenda and learning points and actions were discussed. Learning point presentations were given by clinicians and junior grade staff.

Safety thermometer

Medical care (including older people's care)

- 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. Ward staff displayed the information for falls, infections VTE and pressure ulcers on notice boards where patients, visitors and staff view the results and trends.
- Data collection took place one day each month. Between August 2015 and July 2016 trust data from the safety thermometer showed nine pressure ulcers, three falls with harm and six urinary tract infections in patients with a catheter in medical specialties. The trust did not collect or report any data for August to October 2016.

Cleanliness, infection control and hygiene

- The medical wards had single patient's rooms for the isolation of patients to minimise the spread of infections. Appropriate signs regarding infection control and use of personal protective equipment (PPE) were placed outside rooms. However, we saw three separate instances where clinical staff and housekeepers entered a side room without wearing gloves, apron or washing hands. The housekeeper then carried on serving foods to other patients.
- One relative told us staff entered his relative's room without using gloves or aprons and that this occurred on a daily basis. The senior member of staff was informed regarding these infection prevention and control concerns at time of inspection.
- We observed two members of staff on Colwell ward empty bedpans and commodes without wearing aprons. We also found two commodes were old and had signs of wear on the plastic seating and were visibly dirty.
- All of the medical wards we visited had toilet rolls, which were not in dispensers. They were found on top of toilet cisterns or on shelves. This meant the toilet roll was handled several times during use.
- We observed staff in clinical areas adhered to the bare below the elbows policy.
- All medical wards participated in monthly handwashing audits. In June 2016, hand hygiene audits showed 100% compliance for staff in the endoscopy and oncology department and the cardiac care unit was 94%. However, the intensive care unit (87%), Colwell ward (77%) and Whippingham ward (61%) were below the trust target of 90%. The infection control nurse had devised an action plan with the senior ward staff with monthly time lines for improvement and completion.
- The handwashing sink in the sluice in Colwell ward was not in accordance with 'Health Building Note 00-09: Infection control in the built environment', section 3.62, which requires all sluice areas to have a separate and accessible clinical hand wash basin.
- Staff valued having a housekeeper allocated to each ward. The housekeeper ensured the cleaning staff worked to a ward cleaning schedule for items like bedpan washers, mattresses and furniture. All records we checked were signed as complete.
- The resuscitation trolley on Colwell ward had a layer of dust on it.
- The trust scored similar results with the national average for cleanliness in the most recent patient-led assessments of the care environment (PLACE), in April 2016, scoring 97.9% against a national average of 98%.
- There was infection prevention and control (IPC) lead for the trust and most departments had a staff member who was an IPC link nurse. The trust IPC team produced monthly division reports, which included results for each ward and department.
- Hand sanitisers were available for staff and patient use at appropriate points throughout the ward. Hand wash basins were in working order and hand hygiene posters were on display to remind staff and visitors on effective hand washing technique.
- In the chemotherapy suite, we saw that staff washed their hands and wore gloves and aprons to administer chemotherapy. In the endoscopy suite we saw that staff wore long gloves and eye shields for endoscopy procedures.
- The trust required that all patients were screened for methicillin resistant staphylococcus aureus (MRSA) is a bacterium. Between July 2016 and September 2016 there were no cases of hospital acquired MRSA in medicine.
- There were two cases of Clostridium difficile and no cases hospital acquired Clostridium difficile.
- Monthly endoscopy audits were conducted to ensure cleaning of equipment was in line with 'Health Technical Memorandum (HTM) 01-06 management and decontamination of flexible endoscopes'. The audit for August 2016 showed there was 100% cleaning compliance.

Medical care (including older people's care)

- Nursing staff tested the endoscopy sterilisation machines every morning, to ensure they reached the correct temperature for the required amount of time to sterilise the used scopes.

Environment and equipment

- As part of the sustainability project for the trust, reusable sharps bins on wheels for disposing needles and syringes were used. However, we found bins were open and at floor level. There was a risk that the bins could be knocked over and the contents spill onto the floor and cause a needle stick injury to staff members of the public or patients.
- All areas we visited had emergency trolleys equipped with defibrillator and equipment required in the event of a cardiac arrest. On Colwell, Appley and Whippingham ward staff had not completed the daily checks on the resuscitation equipment in line with the trust policy, to ensure it was ready for use in an emergency. We reviewed the checklist record books over the last six weeks and found significant gaps in checking. On Colwell ward the suction machine was not plugged into the wall.
- The endoscopy suite was opened in 2016. It was purpose built and had received Joint Advisory Group (JAG) accreditation. The unit included high quality scope cleaning equipment and decontamination facilities. There were four treatment rooms, recovery areas, a large waiting area and staff facilities. The hospital had a service level agreement with an outside contractor to service the endoscopy sterilising machines twice yearly.
- Equipment such as commodes, bedpans and urinals were readily available on the wards we visited.
- Each ward had moving and handling equipment. Bariatric equipment was available and staff could order additional specialist beds and pressure relieving mattresses if required. Staff informed us specialist equipment arrived promptly once ordered.
- Equipment we observed on the ward was in working order and staff said they had sufficient equipment available to provide patient care. Systems were in place to request repairs and staff said repairs were dealt with efficiently. We saw records held by the maintenance department which identified the equipment on the wards we visited and that they were all 'in service' which included the electrical safety test.

Medicines

- We reviewed 11 medication and administration charts and found the majority were completed correctly and contained information about people's allergies. However, we found some gaps in medicine administration, for example, oxygen was administered but not prescribed.
- We also found one patient had not been given their morning medicines to prevent seizures. We informed staff and we found these medicine administration errors had not been reported through the incident reporting system to allow investigation and prevent reoccurrence.
- Treatment rooms on the general rehabilitation ward and stroke unit were unlocked and contained unlocked pharmacy returns boxes, which contained medicines.
- We saw in Luccombe ward that intravenous fluids were stored in an unlocked room. These rooms could be accessed by members of the public.
- There were no facilities for medicines storage in the discharge lounge and medicines were being kept on chairs beside beds..
- Staff told us there was an effective system of electronic prescribing across the medical wards. A record was maintained of medicines given to patients to take out (TTO's) when being discharged.
- Controlled drugs were stored, recorded and handled appropriately. Electronic medicines storage cabinets were available on the medical wards. The electronic cabinets kept a running total of medicines, including controlled drugs. Only registered staff accessed controlled medicines with fingerprint access.
- The trust medicine reconciliation targets for September 2016 were reported as over 80% completed at 24 hours of admission against the trust target of 60% to be completed within 24 hours.
- Chemotherapy was supplied pre-prepared to the hospital, and staff reported a timely service. The hospital pharmacists verified prescriptions and checked blood results before allowing any chemotherapy for administration. The oncology pharmacists at the hospital had completed specialist oncology training.
- All chemotherapy was prescribed through an electronic prescribing system; local cancer network protocols were used. Oncology nurses used the electronic prescribing system to perform checks and record administration.

Medical care (including older people's care)

- Oncology nurses told us they had received training, achieved medicine management competencies and adhered to the hospitals policy. We saw two nurses correctly checked a patients chemotherapy drugs before they were administered.

Records

- The trust used a combination of paper and an electronic system for patients' records. All wards used the trusts comprehensive personalised nursing needs assessments and care plans. Access for electronic records was password protected and staff said this was secure.
- We saw limited evidence of medical records being audited. There was no evidence of sharing or learning from medical audits. We found paper records were not stored securely in clinical areas. We found sets of patient's notes in open trolleys, behind the ward reception desk in three wards and on top of patient's bedside lockers. There was a risk the records could be accessed by unauthorised personnel.
- We observed some poor practice, which compromised security of confidential information. For example, on Colwell ward we saw a computer was left on with patient test results visible. The unsupervised nurse station contained records of patients' personal details which included their medical history.
- We reviewed 11 patient risk assessments such as pressure risks, falls and venous thromboembolism (VTE) completed by nursing staff. Nine out of 11 risk assessments were completed. However, we saw one patient required their fluid intake and output monitored and intake only was recorded not the total balance. The patients risk assessment had been completed but not followed.
- A review of 11 VTE records showed eight were completed except for those patients admitted within the last 24 to 48 hours. Where risks were identified preventative treatment was prescribed.
- Patients had a comprehensive endoscopy pre-assessment which was recorded in the pre-assessment care pathway document and placed in the patient's main hospital notes once completed

Safeguarding

- All staff we spoke with understood the term safeguarding, and knew how to raise a safeguarding concern. Staff were aware of the actions to take to keep people safe from abuse. Staff gave us examples of when they had intervened if they suspected abuse.
- The trust employed a safeguarding lead who devised a safeguarding training programme, which included mental capacity act training and deprivation of liberty safeguards for all clinical staff. However, mental capacity act training and deprivation of liberty safeguards this was not part of statutory and mandatory training.
- Our review of patient records showed that safeguarding issues were identified and recorded.
- All staff was required to undertake safeguarding vulnerable adults and children training annually. This training included awareness of female genital mutilation (FGM) and the duty to report.
- Training records for September 2016 showed 80.1% medical staff and 91.8% of nursing staff had completed adult safeguarding training against the trust target of 90%. For safeguarding children level 1 training 91.8% of nursing staff and 93.1% of medical staff had been trained against a trust target of 90%. However, only 66% nurses had completed safeguarding children level two training against a trust target of 90%. We did not see an action plan to address this concern.

Mandatory training

- Each ward and department had a member of the nursing staff responsible for monitoring compliance with mandatory training. Mandatory training was a mix of eLearning and face to face training. Staff said the mix of styles of training met the varied learning styles of staff.
- The mandatory training target of 95% had not been met across the medicine service. Data provided by the trust showed 40% attended moving and handling training, and 42% on basic life support training.
- Two members of medical staff we spoke with said that they had not received a formal induction since joining the hospital six months ago. They had not completed basic life support training, safeguarding training or mental capacity act or deprivation of liberty safeguard training. Neither of these medical staff could describe how to report a safeguarding incident or how to complete a mental capacity act or deprivation of liberty safeguards incident. However, they both confirmed that they had received fire training.

Medical care (including older people's care)

- Clinical staff told us they booked onto training courses but when the wards were short staffed the training was cancelled, they had to work on the wards as patients care was the priority.

Assessing and responding to patient risk

- There were medical outliers across the hospital. Patients with high acuity needs staying overnight in surgical day care unit or the discharge lounge were not risk assessed or had medical reviews prior to being moved.
- All oncology staff had received one-to-one training in assessing patients using the United Kingdom Oncology Nursing Society's (UKONS) 'Oncology/Haematology 24 Hour Triage Rapid Assessment and Access Tool Kit'.
- There were processes in place for identifying and managing neutropenic sepsis in chemotherapy patients. Patients were given instructions on recognising symptoms and when to contact the team, when at home or in hospital. The trust monitored compliance with all aspects of the sepsis pathway. Staff was aware of who to contact if they needed to arrange an urgent review for a patient with sepsis.
- The trust's sepsis group had developed a sepsis screening and treatment pathway based on the National Clinical Guideline No. 6. Sepsis Management. Doctors and nurses used this tool which assessed the risk of sepsis in patients and gave clear guidance on what actions to take and when. However, we saw two patients on Appley ward and one patient in the stroke unit had not had a sepsis screen on admission.
- Nursing staff told us when they transferred patients between wards or teams, staff received a brief handover of the patient's medical condition and on-going care information was shared. This helped to ensure the transfer was safe and the patient's care continued with minimal interruption and risk. However, the night staff said some patients were moved to the ward late at night and it was difficult to get to know the patients individual care needs.
- We saw a patient with a nasogastric tube that should be checked for correct position every day. This check was not documented on seven out of eight days. Daily checks should be completed every day to ensure the feeding tube is in the correct place in the patient's body.
- The trust used the nationally recognised National Early Warning Score (NEWS), a scoring system that identified patients at risk of deterioration or needing urgent review. The electronic scoring system alerted staff to

take the appropriate action if a patient was identified at risk of deterioration. This included alerting a doctor to support the patient. Nursing and medical staff told us the system worked well.

- We saw clinical staff in the endoscopy theatre consistently followed the World Health Organisation (WHO) safety checklist 'Five Steps to Safer Surgery', to reduce harm by consistent use of best practice, which included team brief, sign in, time out, sign out. Audits took place from August to October 2016 and results showed 100% compliance.
- Staff assessed patients for their risk of developing pressure ulcers, venous thromboembolism (VTE) falls and malnutrition. They also reviewed risks relating to patients' medical history, medicines and lifestyle. The risk assessment process started at admission and staff monitored any changes throughout a patient's admission.
- The trust employed a falls prevention nurse following a risk review of the number of patient falls. Patients identified of being at risk of falling were given non-slip slipper socks to wear and simple instructions to "call the nurse don't fall."
- Patients booked for endoscopy procedures completed a medical questionnaire, reviewed by nurses on arrival at the hospital to identify risks such as allergies prior to the procedure.
- Staff scheduled complex chemotherapy regimens so that patient treatment times did not overlap, enabled staff to spend the required time responded to increased risks if presented
- Patients who required chemotherapy had a wallet-sized medical alert card to carry which advised them about the risks of developing an infection and told them what symptoms to act on and the hospital's contact numbers.

Nursing staffing

- In November 2016, medical services reported there were 225.14 nursing whole time equivalents (WTE) allocated for medicines. The trust reported a 50% vacancy rate of nurses across all clinical services. The trust reported a 12.8% vacancy rate for medicine.
- Staffing levels were adjusted depending on the acuity of patients. Daily staffing was reported on the ward's safety board under the headings as planned, actual and safe.
- There were not the appropriate levels of nursing staff across all wards caring for medical patients, for example Appley ward, had four nursing staff and not eight staff

Medical care (including older people's care)

- There was low staffing in the coronary care unit (CCU) we saw two registered general nurses for seven patients. Staff had raised concerns about the levels of care and the staffing ratios. There was a risk that some patients may not be cared for if there was a medical emergency.
- We reviewed the staffing level data for Appley ward for four weeks. We saw three shifts below expected staffing levels where there had been one registered nurse less than planned. This meant there were two registered nurses to care for 21 patients, and two healthcare assistants. Staff told us the impact of working on or below minimum staffing levels meant sometimes antibiotics were delayed and paperwork was not always completed.
- Staff said below minimum staffing levels were not reported as an incident unless it was 'not safe' and this would be determined by the nurse in charge.
- Staff who were moved to wards to provide care, had not always received the required training. For example, intensive care nurses were moved to work on ward areas but could not administer medicines as were not trained on the electronic system.
- Endoscopy and chemotherapy nursing staff told us they worked flexibly to meet any extra demands of the service. If the permanent staff were unable to cover any extra work, bank staff filled the shift. Ward managers told us they filled outstanding shifts with their own ward staff first, then offered bank shifts and as a last resort requested agency staff.
- Patients observed staff were busy but also said when they used the call bell staff attended within a reasonable time frame.
- We observed six medical patient care handovers and these showed staff responded to patient risks. For example, specialists were requested in a timely way and by obtaining specific equipment and aids.
- The trust did not have a cardiologist at night. If there was a clinical concern, staff phoned the consultant from two NHS hospitals based on the mainland. Staff told us this could cause a significant delay in treatment for patients.
- There were 3.35 WTE vacancies for care of the elderly consultant. The consultant in post only worked three days a week. The trust did not have sufficient care of the elderly consultant to manage the frail, elderly patient pathway. Senior managers discussed that they had advertised several times for this post. Staff reported patients who were fit for discharge would wait the hospital for a final consultant review for an additional six or seven day before going home.
- Each ward had an allocated number of junior doctors and consultants. There was a medical assessment unit (MAU) on-call team working 7 days per week. The on-call team were responsible for the medical wards out of hours, and did not include consultants.
- As of June 2016, the proportion of consultants reported to be working at the trust was similar to the England average. The proportion of junior doctors was reported to be higher than the England average.
- There was a dedicated medical outliers team and we saw from medical records patients were reviewed daily.
- When junior doctors are on-call or on nights they are not included in the numbers during the day on their allocated ward to allow them sufficient rest breaks.
- Not all medical wards were fully established and clinical staff reported a number of vacancies. However, the trust did not provide us with any data on current staffing levels, vacancies or recruitment timelines for medical staff.
- Nursing and junior medical staff told us it was easy to contact a consultant if they needed advice. The consultant had overall responsibility for a patient's care.
- The medical team consultant rota was divided into two shifts 8am-6pm and 1pm-9pm. The consultants we spoke with told us they spend 8-10 hours in the medical department at weekends. The consultant cover provided was therefore compliant with the recommendation from the College of Emergency Medicine 2011 of 16 hours per day.

Medical staffing

- In November 2016 in medical services there were 41.02 medical staff whole time equivalents (WTE) allocated for medicines.
- There were 9 WTE medical consultant vacancies, a 31.4% vacancy rate. Consultant resources were particularly limited between Friday evening and Monday mornings.
- The trust was reliant on agency locums to cover consultant and Specialist Registrar posts, these were not always available.

Major incident awareness and training

- The trust had an emergency escalation plan dated 2015/16, which was drafted in partnership with the clinical commissioning group, the independent sector,

Medical care (including older people's care)

local area team, primary care providers and the council. The plan outlines what local providers would do in the event of an incident or an emergency to make best use of all locally available resources. All the staff we spoke with had received training for a major incident.

- Hospital business continuity plans were in place. Arrangements included a back-up generator in case of power failure.
- The trust undertook joint major incident scenario based training with local emergency services. An event was carried out during the inspection and although the outcome was not known, initial feedback was from the contributors was positive.

Are medical care services effective?

Requires improvement



We rated effective as requires improvement because:

- From April 2015 to March 2016, the average length of stay for medical non elective patients was worse than the England average. The average length of stay for non-elective stroke medicine was more than 70% higher than the national average. The trust did not have a plan for improvement.
- In the case of elective clinical haematology the risk of readmission was more than twice the England average. Non-elective gastroenterology, elective gastroenterology and clinical haematology patients at the trust had a higher than expected rates of readmission.
- Nursing staff in the coronary care unit had not all had appropriate training, for example, bi-level positive airway pressure (BiPAP) training. Staff had not been competency assessed.
- Nursing staff had limited access to appraisals. From April 2015 to March 2016, the trust data showed no (0%) staff on Appley ward had received an appraisal and only 17% on Colwell ward. The appraisal rates for November 2016 showed Colwell ward 43% and Appley Ward 91.89%

- Staff did not fully understand their roles and responsibilities regarding the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards. Staff did not always recognise patients who may need consideration of deprivation of liberty safeguards.
- There were no physiotherapy staff available at weekends for on-going patient care rehabilitation needs.

However:

- The trust monitored implementation of policies to ensure they complied with NICE guidance.
- The trust took part in the 2015 National diabetes inpatient audit and scored 100% for staff awareness of diabetes.
- The falls audit plan 2015 identified a number of areas for improvement which the trust had acted upon which included the appointment of a falls co-ordinator
- Patients at risk of venous thromboembolism (VTE) received VTE prophylaxis in line with NICE guidance. The trust monitored this to check compliance
- Throughout the inspection, our observations of practice, review of records and discussions with staff confirmed multidisciplinary working between the different teams involved in a patient's care and

Evidence-based care and treatment

- Medical services had pathways and protocols for a range of conditions, which took account of national guidance such as the National Institute for Health and Care Excellence (NICE) guidelines. For example, for heart failure, stroke, diabetes, respiratory conditions, falls prevention, pressure ulcer prevention and sepsis. The trust monitored implementation of the policies to ensure they complied with NICE guidance.
- The endoscopy nurse manager was part of the British society of gastroenterology group, they ensured that all endoscopy staff worked in line with British Society of Gastroenterology (BSG) guidance.
- The hospital used the national cancer intelligence network chemotherapy protocols, based on National Institute of Clinical Excellence Guidelines (NICE) 2014.

Medical care (including older people's care)

- We reviewed the trust clinical audit programme. The division of integrated elderly and community care had participated in four audits in 2015, which included the national audit of inpatient falls. The falls audit plan 2015 identified a number of areas for improvement which the trust had acted upon which included the appointment of a falls co-ordinator.
- The division of integrated medicine had participated in twelve national audits, which included chronic obstructive pulmonary disease and diabetes. Staff we spoke with on the respiratory wards were familiar with the outcomes of the audits and actions that had been taken in response.
- Actions were put in place following the chronic obstructive pulmonary audit (COPD) audit, which provided additional support for patients to reduce admissions and facilitate early discharge. The audit also found the trust needed to make improvements in the smoking cessation advice provided to patients. Actions were taken to identify patients on admission and ensure advice was provided. A re-audit had shown improvements had been made.
- The trust used a scale recognised by NICE which assessed the risk of pressure ulcers. This enabled staff to categorise the risk of skin breakdown and prompted them to take the right action. The trust used skin bundles for both preventative care and treatment of pressure ulcers.
- Patients at risk of venous thromboembolism (VTE) received VTE prophylaxis in line with NICE guidance. The trust monitored this to check compliance.
- The trust had a 2016 medicines policy in place to ensure the safe handling of medicines in accordance with national guidance such as nursing and midwifery standards for medicine management (NMC) 2015.
- Staff we spoke with on the respiratory ward confirmed they had undertaken pain management training; they were also supported by the trust pain team and were aware of what action to take if patients reported unresolved or escalating pain.
- Patients we spoke with described that their pain had been managed well. One patient told us how they were now able to get out of bed whereas as before they could not due to the pain.
- Staff on the cardiac ward explained how chest drains were very painful for patients. There was an acute pain specialist nurse who visited the ward and assisted with pain management for patients with a chest drain.
- Staff told us they attended study days which included topics such as pain, where they received training on infusion devices.
- Records showed staff completed the malnutrition universal screening tool (MUST) as part of the patient's risk assessments. The MUST was used to identify patients at risk of malnutrition. Staff contacted a dietitian for additional advice if needed.

Nutrition and hydration

- Records showed staff completed the malnutrition universal screening tool (MUST) as part of the patient's risk assessments. The MUST was used to identify patients at risk of malnutrition. Staff contacted a dietitian for additional advice if needed
- There was a clinical nurse specialist for nutrition to support patients requiring additional nutritional support such as percutaneous endoscopic gastrostomy (PEG), feeding tube into the stomach.
- Patients were weighed weekly to monitor weight. Food charts were maintained for patients who were risk assessed for malnutrition.
- Speech and language therapists assessed patients' ability to swallow safely and left clear guidance for ward staff on how to prepare their food and drink to the right consistency.

Patient outcomes

- The trust participated in the quarterly sentinel stroke national audit programme. (SSNAP) On a scale of A-E, where A is best, the trust achieved grade D for SSNAP

Pain relief

- Most patients were provided regular pain relief and when needed. The records we reviewed showed staff monitored and recorded patients' pain levels on a score of 1-10 and used the electronic assessment system. However, one patient was observed as having pain on a scale of seven out of 10 and was not offered pain relief. The inspection team reported this concern to the staff nurse and the patient was given pain relief.

Medical care (including older people's care)

level for all four quarters from quarter 1 to quarter 4 of 2015/16. However, the trust achieved grade A for the patient- and team-centred scanning indicators for all four quarters.

- The stroke lead nurse was aware of the SSNAP results and had devised an action plan. Clinical staff told us an example of the action plan was they were working to improve the SSNAP four hour target admission to the unit. The action plan had been discussed at the clinical governance meeting with named leads and time frames for completion.
- The stroke lead nurse had developed same day access to scanning and Doppler tests to diagnose and treat patients promptly. This service was currently Monday to Friday with a view to extend to cover weekends. However, we did not see any data to show there had been improvement.
- The Endoscopy service was inspected during September 2016 by the Joint Advisory Group on Endoscopy (JAG) a clinical accreditation process that is overseen by the Royal College of Physicians. The outcome of the inspection was pending though the trust were confident in receiving accreditation.
- From April 2015 to March 2016, the average length of stay for medical elective patients at the trust was 1.5 days, which was better than the England average of 3.9 days. For medical non-elective patients, the average length of stay was nine days, which was worse than the England average of 6.6 days. The average length of stay for elective clinical haematology was only 0.1 days.
- The average length of stay for non-elective stroke medicine was more than 70% higher than the national average. We saw no evidence of how the trust planned to improve.
- The 2013/14 myocardial ischaemia national audit project (MINAP) audit scored better than the England average for two of the three metrics. Patients seen by a cardiologist or member of the team scored 100% against a national figure of 93.7%. Patients admitted to a cardiac unit or a ward scored 85.4%, against a national figure 52.6%. However, the trust scored 69.2% for patients who had been referred or had undergone angioplasty against a national figure of 72.6%.
- The trust's results in the 2015 heart failure audit were better than the England and Wales averages for two of the four standards, which related relating to in-hospital care. The trust's results were better than the England and Wales average for three of the seven standards relating to discharge. These include beta-blocker medicine on discharge 93%, nationally 83%.
- The trust took part in the 2015 national diabetes inpatient audit. They scored better than the England average in 11 metrics and worse than the England average in six metrics. The trust's scores for patients having a foot risk assessment during their stay (and within 24 hours), choice and timing of meals and medication errors were all better than the England average. There were no management errors reported (compared to 23.9% nationally), all patients were seen by the multi-disciplinary team within 24 hours and the trust scored 100% for staff awareness of diabetes insulin errors and prescription errors were more prevalent at the trust than nationally.
- From March 2015 to February 2016, non-elective gastroenterology, elective gastroenterology and clinical haematology patients at the trust had a higher than expected rates of readmission. In the case of elective clinical haematology the risk of readmission was more than twice the England average. The risk of readmission for elective admissions was higher than expected.
- The stroke lead nurse audited the patient care plans in the stroke unit on a weekly basis and discusses improvements with individual members of staff to ensure compliance.

Competent staff

- Nursing staff in the cardiac care unit told us they did not receive a specific competency training programme. For example, not all had bi-level positive airway pressure (BiPAP) training. None of the staff had been competency assessed to ensure they had knowledge and skills to care for the patients in their area.
- Two members of staff in the endoscopy suite took the lead for decontamination of clinical equipment. Both members of staff had undertaken a training and competency assessment programme to City and

Medical care (including older people's care)

Guilds level in decontamination. These same staff members completed and documented daily endoscopy equipment cleaning and sterility checks. Two other staff members completed this task at all other times, having received in-house training and competency checks.

- Staff did not receive formal clinical supervision, however, staff told us their managers did observe them when working and issues around performance were discussed with them. We saw evidence in meeting minutes showing the trust had taken action when staff performance was not as expected or in line with trust's policy.
- Nursing staff had limited access to appraisals. From April 2015 to March 2016, the trust data showed no staff (0%) on Appley ward received an appraisal and only 17% on Colwell ward. The appraisal rates for November 2017 showed Colwell ward 43% and Appley Ward 91.89%. No data for appraisals in any other medical staff group were provided.
- The nurse in charge told us when agency staff were used, they had worked on the ward before and underwent a short orientation to the ward at the start of the shift. We observed the nurse in charge provided support and supervision to junior staff when they were on duty.
- New nursing staff completed induction training and they were not included in staffing numbers for their first three weeks. This allowed them to carry out additional training with supervision when they provided medicines to patients.
- Two members of the medical team confirmed they attended clinical supervision every three months.
- Five new members of nursing staff we spoke to said they were supported on joining the hospital. They had all completed a trust wide induction programme and had all received mandatory training.

Multidisciplinary working

- Our observations of practice, review of records and discussions with staff confirmed good multidisciplinary working between the different teams involved in a patient's care and treatment.

- We observed daily focus meetings on Colwell, Appley ward, cardiac care unit and stroke unit. This was a one hour multidisciplinary meeting which included medical, nursing and allied health professional staff. There was clear communication between staff from different teams. Participants demonstrated a thorough knowledge of patients' needs and care plans, which resulted in an agreed ongoing progress to facilitate patients discharge.
- Patient records showed that care planning for patients with complex needs included assessments by different professionals.
- Staff referred patients to specialist teams including diabetic specialist nurse team, palliative care team, pain team and speech and language therapists when required.
- Colwell and Appley ward staff described a good relationship with the pharmacy department. The pharmacist was part of multi-disciplinary team (MDT) meetings and provided prompt advice to prescribers.
- If a patient required transfer to another hospital medical staff were responsible for liaising with the hospital and arranged for the transfer, after discussion with the patient and family.

Seven-day services

- All specialities had medical doctors on-site seven days a week. A specialist registrar was on duty to support more junior medical staff. Staff told us there was limited medical consultant cover on site seven days per week. Following the inspection, the trust provided evidence to explain the first on-call medical consultant does ward rounds twice daily over weekends and is available as required at other times although not necessarily on-site. A second medical consultant is on-site Saturday and Sunday to review highlighted ward patients and potential discharges.
- Nursing staff on the ward and in endoscopy theatres told us there was good access to support and advice from medical staff, during the day, night and at weekends.
- The medical team held daily ward rounds for all patients and had daily handover meetings which

Medical care (including older people's care)

discussed new admissions, complex patients and patients fit for discharge. There were rotas in place which provided medical cover to the wards out of hours and at weekends.

- New and patients at risk of deterioration were seen at the weekend by the consultant. However, there was no cardiologist available at the weekends and staff accessed advice from two NHS hospitals based on the mainland which staff told us could cause a delay in treatment options for the patient.
- The ambulatory emergency care (AEC) service was not available during the evenings or weekends. The service is located within the medical assessment unit (MAU). Patients attended the unit for nursing and medical assessments of their physical and healthcare needs. The service was open Monday to Friday (except Bank Holidays) between 9am and 5pm. We were told the service closed at 7pm. However, we saw medical outpatients waiting for a bed on a ward outside of these times.
- Patients seen in AEC were transferred to re-enablement team for ongoing care in the community. Staff in AEC told us that there were delays to accept patient care as the re-enablement team were busy looking after patients in the community, awaiting care agency packages of care.
- There were no physiotherapy staff available at weekends for any clinical service. The nurses told us that they did not have the time to continue the patient's therapy over the weekend. This could affect patient care and their rehabilitation needs.
- Staff reported they did not have concerns in accessing support at night and there were no issues with tests, such as scans or x-rays, at the weekend if required.
- Pharmacy staff was accessible seven days a week to dispense medicines and provide discharge medication. Staff we spoke with told us support from pharmacy services was effective. Medical wards had support from pharmacy technicians to assess and maintain patients own medicines.
- Patients received out of hour's telephone numbers on discharge from the hospital, in case they became

unwell after their endoscopy, or chemotherapy treatment. Oncologists provided an on call service for patients who felt unwell and needed to contact the hospital out of hours.

Access to information

- The nurse in charge updated summary medical and care handover information at the end of their shift. We saw necessary information such as if the patient had a do not attempt cardiopulmonary resuscitation order or deprivation of liberty authorisation was in place.
- A discharge letter was sent to the patients' GP for information. The information contained details on the patient's diagnoses, medicines; treatment and plans for follow up. We saw an example of this in the patients notes.
- Staff had access to diagnostics imaging and pathology results and were able to access these through electronic identity cards.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Frontline staff we spoke with did not fully understood their roles and responsibilities regarding the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS). They told us they received a basic on-line training course for Mental Capacity Act and deprivation of liberty safeguard training and this was not part of mandatory training for the trust employees. We requested but have not received the trust data to state how many clinical staff completed this training
- On Colwell ward and the stroke unit we reviewed three DoLS forms. We found there were application that had not been processed. We raised this with senior staff who reported they had been in communication with the local authority who recognised there was a backlog processing DoLS forms. The issue had not been identified as a risk on the service risk register. Senior nursing staff told us the trust maintained a weekly DoLS audit spreadsheet of which was reviewed by the by the lead for MCA/DoLS. However, we did not see this spreadsheet.
- On Whippingham ward there were at least two patients who required consideration of DoLS, nothing

Medical care (including older people's care)

was recorded in patient notes and no application had been made. The CCG informed us there was a lower than expected number of DoLS applications from the trust overall.

- We reviewed patient records on different wards and they included evidence of informed consent. Where appropriate, staff had completed MCAs and DoLS referrals. We did see effective mental capacity act documentation within the stroke unit patient notes.
- Ward sisters highlighted those patients with a DoLS on the ward safety brief and the handover forms made reference to any DoLS due to expire or which required renewal.
- We observed an endoscopy procedure from admission to discharge and saw written and verbal consent obtained by the consultant.
- We observed staff asked patients for their consent before they provided care or treatment. The inpatient assessment form prompted staff to carry out mental capacity assessments if they felt patients might not have the capacity to make decisions or provide informed consent.

Are medical care services caring?

Good



We rated caring as good because:

- The Friends and Family Test (FFT) response rate for medical care at the trust between August 2015 and July 2016 was 33%. This was better than the England average of 26%
 - We observed staff treated patients with dignity and respect. Overall patients were complimentary about the care they received.
 - The trust employed a memory service liaison nurse to speak with patients and families, which staff told us were helpful for planning safe discharge home.
 - All patients were given a "going home" information leaflet. Staff told us and we saw they were individually tailored to suit the patient and family needs.
- Patients told us the cancer specialist nurse rang them to ask how they were after their treatments.

Compassionate care

- The Friends and Family Test (FFT) response rate for medical care at the trust between August 2015 and July 2016 was 33%. This was better than the England average of 26%.
- The FFT score for the coronary care unit was higher than 90% for 11 of the 12 months from August 2015 to July 2016. For the medical assessment unit it was 90% or higher every month (except July 2016 where there was no figure available).
- Appley and Colwell wards both had fewer than 100 responses over the 12 months and were therefore excluded from the data.
- We saw staff responded to call bells promptly and treated patients with dignity and respect. Patients had access to single room if required and available.
- Patient room doors were closed when care was provided and confidentiality maintained.

Understanding and involvement of patients and those close to them

- Patients we spoke with on the chemotherapy and endoscopy wards discussed being involved in their care. For example one patient need to complete treatment in order to collect a child from school, and staff made sure this was possible. Patients' relatives told us they appreciated they could stay as long as they liked on the wards.
- Patients told us that they received constant reassurance from the staff. One patient told us, "The staff makes sure you understand information".
- Two patients on separate wards told us that the doctor had understood they had been smoking since a young age and offered them both patches to stop the craving.
- We saw endoscopy and chemotherapy staff explain procedures prior to treatment.
- We saw in medical notes a patient had treatment options explained and how the treatment may have affected relationships with young family members.
- Family members were involved where possible in discussions about care and treatment. Staff acknowledged chemotherapy affected all family members and included relatives in care planning.

Medical care (including older people's care)

- Staff considered the needs of the patients loved ones when cancer treatment was planned. An example was explaining the possible effects of nausea and vomiting prior to treatment and management of tiredness.

Emotional support

- After endoscopy, we saw that if a diagnosis of cancer was suspected, nurses took the patient to a private room to discuss the findings, and then called the oncology clinical nurse specialist to speak with them.
- Patients told us the cancer specialist nurse rang them to ask how they were after their treatments.
- One chemotherapy patient told us, "The best support is the team here at the hospital, everyone from the consultant, the fabulous nursing team to the smiling cleaners find time for you to say how you feel". Another patient said, "If I am anxious about anything at all, I just phone and they always put you right".
- Patients accessed a clinical psychologist if clinical staff assessed this was required, and staff requested on their behalf for a hospital chaplain to visit.
- Counselling services were available upon request via the oncology service.
- We saw a board full of letters and cards to thank the consultant and nurses for their care in the oncology unit. Patients were positive about the care they received. One patient told us, "the nurses are professional, polite and respectful", "they explain everything all the way along". Another patient told us, "all of them are cheerful and most importantly kind".

Understanding and involvement of patients and those close to them

- Patients we spoke with on the chemotherapy and endoscopy wards discussed being involved in their care. For example one patient need to complete treatment in order to collect a child from school, and staff made sure this was possible. Patients' relatives told us they appreciated they could stay as long as they liked on the wards.
- Patients told us that they received constant reassurance from the staff. One patient told us, "The staff makes sure you understand information".
- Two patients on separate wards told us that the doctor had understood they had been smoking since a young age and offered them both patches to stop the craving.

- We saw endoscopy and chemotherapy staff explain procedures prior to treatment.
- We saw in medical notes a patient had treatment options explained and how the treatment may have affected relationships with young family members.
- Family members were involved where possible in discussions about care and treatment. Staff acknowledged chemotherapy affected all family members and included relatives in care planning.
- Staff considered the needs of the patients loved ones when cancer treatment was planned. An example was explaining the possible effects of nausea and vomiting prior to treatment and management of tiredness.

Emotional support

- After endoscopy, we saw that if a diagnosis of cancer was suspected, nurses took the patient to a private room to discuss the findings, and then called the oncology clinical nurse specialist to speak with them.
- Patients told us the cancer specialist nurse rang them to ask how they were after their treatments.
- One chemotherapy patient told us, "The best support is the team here at the hospital, everyone from the consultant, the fabulous nursing team to the smiling cleaners find time for you to say how you feel". Another patient said, "If I am anxious about anything at all, I just phone and they always put you right".
- Patients accessed a clinical psychologist if clinical staff assessed this was required, and staff requested on their behalf for a hospital chaplain to visit.
- Counselling services were available upon request via the oncology service.

Are medical care services responsive?

Inadequate



We rated responsive as inadequate because:

- The trust data for bed moves between April and November 2016 highlighted that 958 patients were moved between the hours of 10pm and 7am. The trust did not collect data for bed moves during the day. We did not see a plan of action to improve this concern.

Medical care (including older people's care)

- Complaints were not responded to in line with the NHS Complaints Policy July 2016 national standards in dealing with complaints.
- There were breaches of the single sex accommodation requirement on the surgical day unit and discharge lounge, where medical outliers were cared for. The trust had not considered these as mixed sex breaches.
- From April 2015 to March 2016, the average length of stay for medical non elective patients was worse than the England average. The average length of stay for non-elective stroke medicine was more than 70% higher than the national average.
- Staff told us that there was a problem with delayed transfers, and we saw little evidence or innovative plans, for example no hospital at home service.
- The trust worked in partnership with local commissioners to plan and deliver services, to meet the needs of local people, but with limited success.
- We were provided with poor discharge information by Health watch, clinical commissioning groups and care homes. We saw no evidence of how the trust planned to improve.

However:

- Staff took account of the needs of different people, including those with complex needs when planning and delivering services. Staff showed good understanding and made reasonable adjustments to meet patients' individual needs including those living with a dementia or a learning disability.
- The new endoscopy suite colour and signage especially assisted patients with dementia and learning disabilities.

Service planning and delivery to meet the needs of local people

- There was a rising population of older people on the Island and inpatient geriatric medicine was not commissioned or provided by the trust. The activity for inpatient geriatrics was included in general medicine activity.
- There was no frail elderly care pathway in place, this had been discussed but no progress had been made in implementing

- Senior staff told us they worked with the commissioners of local services such as GPs, the local authority, other providers and patient groups to plan and co-ordinate services to meet the needs of local people. However we found this work was limited.
- Arrangements with the local commissioners were discussed regarding service admissions and discharge, as well as community placements.
- No hospital at home service had been developed.

Access and flow

- The service was not planned to meet the needs of medical patients. The trust data for bed moves between April and November 2016 highlighted that 958 patients were moved between the hours of 10pm and 7am. Vital patient care information could be lost between staff during these moves. In addition 379 patients were moved three times and one patient moved 11 times. The trust did not collect data for bed moves during the day. We saw the impact of these bed moves with patients visibly distressed. We did not see a plan of action to improve this concern.
- From April 2015 to March 2016, the average length of stay for medical non elective patients was worse than the England average. The average length of stay for non-elective stroke medicine was more than 70% higher than the national average.
- We were provided with poor discharge information by Health watch, clinical commissioning groups and care homes. We saw no evidence of how the trust planned to improve.
- There were medical outliers across the hospital and in temporary wards. We saw seven medical patients who stayed overnight in surgical day care unit, discharge lounge or in ambulatory care unit, were in unsuitable environments. The trust did not provide data to show the bed usage for patients who were medical outliers, or how this flow was managed.
- We were provided evidence of three poor discharge arrangements which involved two elderly patients. Both patients were discharged home without adequate clothing in cold weather, or adequate transport arrangements.

Medical care (including older people's care)

- A care home manager informed us of a further poor discharge. The patient transferred to the care home was non weight bearing and was moved using a hoist. This information was not communicated to the staff and the care home did not have the correct moving and handling equipment to care for this patient.
- We attended the multidisciplinary bed management meeting and heard that there were 40 patients in the hospital medically fit for discharge. The delays were discussed for each patient and an action plan with timelines and a named lead allocated to speed up the process. Staff told us this happened at least twice a day, every day depending on patient flow.
- The patient pathway team met weekly with community representation with the aim of preventing unnecessary hospital admission and planning safe discharge. The team highlighted lack of carers, nursing and residential, homes on the island to care for patients.
- Ward staff told us that a patient was fit for discharge from hospital who required a care package had an 8-10 day wait.
- The trust had noted for many years an acute shortage of doctors, however had not considered alternative posts such as nurse consultants for safe medical care.
- Staff told us patients who were fit for discharge were waiting in the hospital for final consultant discharge for a further six or seven days before going home.
- The trust had developed a patient flow and length of stay project plan, dated September 2016. This included initiatives such as The Patient Flow Bundle -SAFER . We found very limited evidence of implementation across medicine services.
- Staff told us there was a lack of paramedic staff. If a patient required heart treatment on the mainland this could delay the patient transfer. Some patients went with a nurse from the ward, potentially leaving the cardiology unit short staffed.
- The trust's referral to treatment time (RTT) performance for admitted pathways for medical services was worse than the England overall performance for seven out of 12 months between August 2015 and July 2016. Cardiology performed worse than the England average for admitted RTT

(percentage within 18 weeks) over the 12 months from August 2015 to July 2016, at 70.4% compared to the England performance of 86.1%. Trust data provided following the inspection for April 2016 to June 2016 showed improvement in most medical specialities and all patients in cardiology were treated within 18 weeks..

Meeting people's individual needs

- Healthwatch told us that patients living with dementia, and their families had experienced lack of support in the wards, the trust was responding to this but it had taken time to embed. They told us of concerns about unsafe discharge, raised by patients' families and local care homes. Examples included late night discharges, poor or incorrect information to care homes pre discharge and delays in discharge summaries to GPs.
- The discharge lounge had a mix of beds and reclining chairs. Male and female patients were dressed in nightwear. One male patient had his legs open with a catheter on show and was not sufficiently covered to protect their privacy and dignity.
- We also noted breaches of mixed sex accommodation on the surgical day unit where medical outliers were. The trust had not considered these as mixed sex breaches.
- One patient told us that they were being moved to a private provider and the reason given was capacity issues in the hospital. The patient said this would make visiting very difficult for family and friends as they live some distance away.
- The endoscopy team for the new build design requested specialised advice regarding the use of bold colour and signage to assist patients with dementia and learning disabilities. Staff told us patients remarked how the colour and signage indicates where toilet facilities were without having to ask staff and this helped them remain independent.
- The hospital introduced a carer's passport in February 2016, which was written in six different languages. The passport recognised the carer as a partner in the planning and delivery of care by the trusts staff. This meant that that the carer was able to have access to the person they cared for at any time during the day or

Medical care (including older people's care)

night. . We spoke to two carers who told us this had made a positive difference to them. "I come in early mornings to help staff wash my wife and get her up in the chair as I know the best way to do it", "I can stay in the evening to feed my husband as he gets very restless without me there"

- Endoscopy staff gave an example of how they made reasonable adjustments for a patient living with dementia. To help ease anxiety for the patient, relatives were invited into the endoscopy suite.
- The endoscopy staff had requested specialised advice regarding the use of bold colour and signage to support patients with living with dementia or a learning disability for the endoscopy suite. Patients told us that the unit looked "welcoming, fresh and bright".
- Patients and families received an information leaflet explaining different endoscopy and chemotherapy procedures. Clinical staff reported that the National Cancer Care Centre produced leaflets in whatever language was required for the patient, however staff reported minimal need on the island.
- Staff we spoke with said they accessed telephone translation services for patients whose first language was not English. This meant that these patients were able to hold detailed discussions about their care and treatment.
- Staff told us that occasionally patients who received chemotherapy stayed overnight in the hospital if they were frail or nauseous and had no support at home.
- We observed many examples of support for patients living with dementia. For example, reminiscence boards for patients to look at and twiddle muffs were provided, to patients to occupy their hands and to provide comfort.
- The trust employed a memory service liaison nurse to speak with patients and families with dementia which staff told us were helpful for planning safe discharge home.
- All patients were given a 'going home' information leaflet. Staff told us and we saw they were individually tailored to suit the patient and family needs and gave information such as managing wounds, mobility and

pain relief and whom to contact if concerned. Patients said this information was useful so they knew what to expect and did not become anxious on discharge from the hospital.

- We observed patients who requested porridge for breakfast and was informed; they could not have this choice. We also observed patients who did not get their choice of food on two occasions.
- Patients in all other wards told us that the food was, "tasty, there was a good choice" and the cottage pie and chocolate pudding was just perfect" another patient said the vegetarian option was, "local fresh produce and very nice".
- We saw a volunteer who assisted a patient with their meal. The volunteer informed us this was a new initiative the trust had trialled in the stroke unit. These involved volunteers trained and signed off as competent to assist patients with their meals. After the patient had eaten the meal they said "smashing, no waiting!" However, one patient informed us that, "some days there was no tea brought round due to not enough staff".
- Patients we spoke with said their water jug was replenished at least daily.
- Patient-lead assessments of the care environment (PLACE) 2016, scored ward food 80% which was lower than the England average of 88%.

Learning from complaints and concerns

- The trust response to formal complaints did not meet NHS Complaints Policy July 2016 standards. From November 2015 to October 2016, the trust received 216 formal complaints. There were 58 complaints relating to medical care (26.9% of all complaints) The trust took more than 30 days to respond to the majority (56%) of complaints. Nearly one in five complaints (19.9%) took more than 60 days to close.
- The hospital had a complaint, concerns and compliments' policy (2016), which provided staff with a clear process to investigate report and learn from complaints.
- The chief executive had overall accountability for formal complaints. The medical director, chief nurse and director of patient care standards had

Medical care (including older people's care)

responsibility for ensuring complaints were processed and responded to in a timely fashion. They also ensured the medical service took action because of a complaint to improve the quality of care. An investigating officer was assigned complete a full investigation of any formal complaints.

- Staff recognised that early resolution of patients' concerns prevented the concern from escalating into a formal complaint. When a concern was first raised, it was highlighted to a senior nurse. If the senior nurse was unable to deal with the concern directly, they directed the patient to the Patient Advice and Liaison Service (PALS) to formalise the complaint.
- Information for patients on how to leave feedback or make a complaint was provided throughout the hospital. We saw feedback boxes in use on the wards. Patients told us they would speak to a member of staff if they had any concerns. All of the patients we spoke with said they had no reason to complain, as their care had been good.
- The most common complaint in the medical directorate was poor communication between staff and patients or their relatives and staff attitude. Thirteen of the 58 complaints mentioned poor communication. Three complaints concerned poor clinical treatment. We saw a complaint made by a patient on Appley ward. The complaint stated staffing levels at night were poor which meant their observations were not recorded and action was not taken when their pulse rate was high.
- There were five complaints about lack of attention to patients' nutrition or hydration needs. There were five complaints about medication. These included cases of patients who were not given their regular medications or discharged without their regular medication. We saw an action plan and the top priority was to address patient's timely medication regimes and a training programme to improve communication amongst staff.
- Governance processes were not effective at assessing or monitoring systems to improve the safety and quality of the services provided. There was limited process in place to review key items such as the strategy, values, objectives, plans or the governance framework.
- There was a limited programme of audits in the medical units. This meant staff could not assess and improve quality care delivery and patient experience for example to reduce infection rates and safer medicine management
- There was no leadership strategy in place. The care of the elderly consultant only worked three days a week for the trust. This meant that there was an overall lack of leadership for the management of the frail, elderly patient pathway.
- There was lack of clarity about authority to make decisions and how individuals are held to account. The trust had noted for many years an acute shortage of doctors, however had not considered alternative posts such as nurse consultants for safe medical care. We did not see a plan to improve.
- The cardiology team told us that they are not part of the clinical business unit (CBU) but sit within intensive therapy unit (ITU), day surgery and endoscopy theatres which staff said may hinder the development of advanced nurse practitioner (ANP) roles for the future.
- There were no effective arrangements for the systematic provision of assurance to the Board that risks are being adequately identified or managed. Staff recruitment, retention and patient flow was listed as the main risk for the trust. However, did not include risk of transferring patients, mandatory training, and medication errors from missed doses or escalation provision. Risks associated with mixed sex breaches were also not identified as a concern. These risks were identified by inspectors during the inspection, and no action had been taken to address these concerns.
- There were low levels of staff satisfaction, high levels of stress, work overload, and conflict within the organisation. Staff said that there was limited

Are medical care services well-led?

Inadequate



We rated well-led as inadequate because:

Medical care (including older people's care)

understanding of their concerns and they felt, "not listened to". Sickness was higher than the England average of 4.2% in all clinical areas for all but two months.

- Staff did not feel valued, supported, appreciated and cared for. The culture was top down and directive. Staff we spoke with shared their concerns about a lack of human resource leadership in the trust. Ward staff were not encouraged to complete incident forms for low staffing unless approved by a manager.

However:

- The trust had developed a corporate strategy called 'Beyond boundaries'. This strategy aimed to develop a model of health and social care delivery on the island through partnerships with the local authority called my life a full life (MLFL) programme.
- The trust ran a, 'carers are welcome here campaign'. This meant patients who relied on a carer to understand their individual needs and could not speak for themselves were welcome to visit the hospital whenever they wanted to.
- Staff and patients welcomed the trust initiative of volunteers being trained and signed off a competent to assist feeding patients.
- Both the lead nurse in oncology and the lead nurse manager in endoscopy clearly described the vision in their units, to give patients the best experience possible at a difficult time. The culture of the endoscopy and oncology team was nurturing and professionally supportive of each other.
- We saw effective partnerships with volunteers in all parts of the hospital. Volunteers told us that they felt valued by clinical staff.

Leadership of service

- The clinical director and operations manager, key leadership posts, in the medicine clinical business unit had recently been appointed. The CBU leadership team was at early stages of development.
- The trust did not have a full time care of the elderly consultant this post was advertised several times.

There was a care of the elderly consultant who only worked three days for the trust. This meant that there was a lack of overall leadership for the frail, elderly patient pathway.

- The trust had started early discussions which explored different options including employing additional middle grade doctors and nurse consultants. However, without a leader there was no cohesive plan. The effect was staff reported patients who were fit for discharge who were waiting in the hospital for a consultant final review for a further six or seven days before discharge home.
- The cardiology team told us that they were not part of the clinical business unit (CBU) but sat within intensive therapy unit (ITU), day surgery and endoscopy theatres, which may hinder the development of advanced nurse practitioner (ANP) roles for the future.
- Medical teams told us of their positive relationships with nursing leadership. Some of the leadership within the nurse's teams was new and were working well.
- Ward staff told us of very supportive senior staff and ward sisters. Some wards had experienced staffing pressures, which meant some staff had not received breaks or time off.
- Trainee doctors reported consultants were responsive they provided support and training. They said that consultants listened to their concerns.

Vision and strategy for this service

- The trust corporate strategy called beyond boundaries aimed to break down boundaries between the trust, primary care and the council and to develop an integrated model of health and social care delivery on the island. Trust strategic priorities included: align services to the needs of our patients and carers, become a centre of excellence for care of older people, become excellent in the provision of dementia services.
- The trusts 2014-2019 clinical vision was to 'deliver, quality care for everyone every time'.
- The trust aimed to join health and social care delivery through partnerships with the local authority. The life a full life (MLFL) programme aimed to deliver new

Medical care (including older people's care)

health and social care support for people of the Isle of Wight. Three identified priority areas were, self-care, crisis response and re-enablement and locality working. Some medicine CBU leads expressed confusion about national and regional changes and how their work was part of My Life a Full Life integration project.

- The CBU had developed an 'operating plan FY2017' for medicine, dated 2 November 2016. This considered the context and risks for the service and a five year vision. There were 13 objectives over the next couple of years, including further development of services. A lot of these were contingent on approval of business cases and recruitment. There was limited detail and lack of action plan for implementation
- The trust had its own vision and values. The vision was 'quality care, for everyone every time'. The trust's values were 'we care, we are a team, we innovate and improve'. All staff we spoke to knew about them, and had been consulted about these. Staff descriptions and observations of the care and support they gave patients indicated they incorporated the values into their work.
- Clinical leaders told us their vision was to identify common patient pathways through their service. To evaluate and re-evaluate progress within the service and to embed key decision points for individual pathways for example with ambulatory pathways for stroke patients.
- Both the lead nurse in oncology and the lead nurse manager in endoscopy clearly described the vision in their units, to give patients the best experience possible at a difficult time.

Governance, risk management and quality measurement

- We found the trusts risk management process was not effective at identification of risks to the service. Staff recruitment, retention and patient flow around the hospital were identified as the main trust and ward risks. However, the risk management process did not identify risks that were found during the inspection including out of hours bed moves, discharge arrangements, low mandatory training or appraisal

rates. Risks associated with mixed sex breaches were also not identified as a concern. These risks were identified by inspectors during the inspection, and no action had been taken to address these concerns.

- Senior clinical staff maintained quality measurement and performance dashboards for each service. Outcomes were discussed at the clinical governance meetings. However, this was not disseminated down to ward level. Nor was learning from incidents or complaints fully disseminated to staff. This meant that board to ward governance was not assured.
- There was a limited rolling programme of audits in the medical units. We found action plans and re-audits showed improvements in the stroke services. For example, the stroke lead nurse had audited 20 sets of clinical care notes and found that the doctor had not documented each time they were called to the ward to treat a patient or give advice. Actions included highlighting to all staff to remind doctors to document every time they review a patient.
- The documentation audit results were discussed at clinical governance and medical advisory meetings. A date for re-audit was set for the following quarter to check if improvements occurred.
- The trust had devised the ward accreditation programme, which the trust intends to use in the future. Staff told us that the aim of the programme was to drive improvements of quality care delivery and improve patient experience for example to reduce infection rates and safer medicine management.

Culture within the service

- Three staff members in different parts of the trust told us that there was a, "culture of bullying".
- Staff were told that if they spoke up about grievance concerns, they were told to complete an incident form. Once an incident form was completed, there was limited feedback to resolve the concern.
- The trust had a dignity at work policy and procedure (2014) which detailed action for bullying. However, staff told us there was no dedicated human resources lead for the trust and that there was limited understanding of their concerns and they felt, "not listened to".

Medical care (including older people's care)

- Endoscopy theatre and staff in the oncology suite staff told us about the culture around reporting incidents had improved and there was now more transparency in reporting. Both oncology and theatre staff confirmed they had no hesitation in reporting incidents. Staff said there was an open and honest culture where they were prepared to ask questions.
- Sickness rates for the stroke ward were the highest in the medical division 11.27% whole time equivalent (WTE) for April 2015 to March 2016. The trust average was 4.2%, which was also higher than the England average.
- Teams were supportive of each other and aware of the emotional stress of working with shortages of staff and bed pressures. The handover meeting were seen as a time to check on team wellbeing.
- Staff told us that everyone felt part of a team. Housekeepers told us that they felt included by the ward staff, that they had a varied role and that they were happy undertake additional duties if requested by ward management, for example if the ward clerk was absent.
- A health care assistant said the trust were very helpful in finding hours to suit looking after young child and this made her feel valued.

Public engagement

- Wards displayed feedback from patients, including any comments for improvement and the action they had taken in response.
- The ward manager on Appley ward made a change to extending ward opening times following a face to face family meeting, which was well received by staff and patients.
- Matron reported she held a weekly surgery for patients and relatives to raise issues.
- Patients and visitors could easily identify members of staff from the ward team photo board.

- The trust valued and supported a large number of volunteers. Staff and patients welcomed the trust initiative of volunteers being trained and signed off a competent to assist feeding patients.







Staff engagement

- A bimonthly staff news magazine was available for everyone in the trust. The news magazine contained a wide range of information on department topics, both operational and social to keep staff and volunteers up to date with latest developments.
- The November 2016 newsletter highlighted news from the executive medical director, the future of the catering service, the need for staff to have a flu jab and also recognised staff achievements.
- Patient feedback was shared with staff in a variety of ways. These included electronically via newsletter or team feedback. If a staff member was mentioned by name then they would get personal feedback.

Innovation, improvement and sustainability

- The stroke lead nurse demonstrated an innovative solution in that the team had developed same day access to scanning and Doppler tests to diagnose and treat patients promptly.
- The trust ran a 'carers are welcome here campaign'. This meant patients who relied on a carer to understand their individual needs and could not speak for themselves were welcome to visit the hospital whenever they wanted to. The carer was given a 'pass' to park their vehicle and for subsidised meals at the hospitals canteen.
- Staff and patients welcomed the trust initiative of volunteers being trained and signed off a competent to assist feeding patients.
- Medicine services were finding it difficult to find recurring cost improvement programmes and were financially challenged, mostly due to the spends on locum agency medical staff.

End of life care

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

Information about the service

End of life care at St Mary's Hospital is provided on all general wards in the hospital and across the community. The hospital palliative care team is led by a consultant and includes clinical nurse specialists. Between April 2015 and March 2016 there were 531 deaths reported, this was 2.1% of all in patient discharges.

This inspection focussed on the provision of end of life care services at St Mary's Hospital. The provision of end of life care by district nursing teams was reviewed during the inspection of community services of adults, the findings are also referenced in this report.

We inspected this core service as part of a short notice inspection to follow up on some areas we had previously identified as requiring improvement and where we had questions and concerns we had identified from our ongoing monitoring of the service.

We observed interactions between staff and patients, and their relatives. We looked at 23 'Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR) orders and ten medical and nursing care records. We reviewed service performance information provided by the trust.

Summary of findings

We rated this service as requires improvement because:

- There was limited learning from end of life care incidents across the organisation.
- Not all patients had end of life risks assessed and managed. There was no monitoring mechanism in place to ensure risks to patients were assessed.
- Medical staffing levels did not meet national guidance.
- It was not clear whether staff had completed mandatory training on end of life care and mandatory training data was not provided by the trust for all specialities.
- A significant number of 'Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR) forms were not completed according to national guidelines.
- Care did not consistently take account of evidence based practice and guidance, for example, priorities of care plans were not routinely completed for patients nearing the end of their life. The AMBER care bundle was not embedded in practice.
- EOLC training was not mandatory for consultants.
- A specialist palliative care service was not available seven days a week, telephone advice was available.
- There were three areas where the trust performed worse than the England average in the End of life

End of life care

Care-Dying in Hospital Audit (2016). The first area was whether there was documented evidence that the patient was given an opportunity to have concerns listened to. The second area was whether there was documented evidence that the needs of the person(s) important to the patient were asked about. The final area was whether the trust sought bereaved relatives or friends views in the last two financial years (2013 to 2014 and 2015 to 2016).

- End of life care patients did not always receive care in a side room as these were prioritised for treating patients with infections. Staff did not take extra care to ensure continued levels of privacy, dignity and compassionate care for the patients and families and friends when this happened
- End of life care patients were moved from one ward to another or from one ward area to another for non-clinical reasons. This resulted in lack of continuity of care for patients and was not monitored.
- There were not robust processes to facilitate rapid discharge of patients and staff were not trained to use the rapid discharge forms. The trust was not monitoring the number of end of life patients who were discharged with fast track rapid discharge in place.
- Most patients were not transferred to their preferred place of death.
- There were complaints relating to end of life care but the learning was not shared across the organisation.
- Staff were not aware of how the trust was implementing the action plan as a result of the End of Life Care - Dying in Hospital Audit 2016 or how the end of life care strategy was to be implemented. Staff did not feel engaged with and described the culture in the organisation did not lead to integrated working.
- The governance structure was not efficient. Meetings took place but outcomes and action plans were not joined up. The quality, risks and performance issues within end of life care were not monitored through the executive governance framework

However:

- The trust had a protocol for the prescribing of anticipatory medicine.
- Patients had access to pain relief.
- The trust had implemented the ward accreditation programme across all wards.
- Staff treated people with compassion, kindness, dignity and respect. Feedback from patients and their families was positive.
- We saw good examples of staff providing care that maintained respect and dignity for individuals. There was good care for the relatives of dying patients, and staff showed sensitivity to their needs.

End of life care

Are end of life care services safe?

Requires improvement



We rated safe as requires improvement because:

- There was limited learning from end of life care incidents across the organisation.
- Not all patients had end of life risks assessed and managed as they did not have priorities of care assessment or an individualised care plan.
- There was no monitoring mechanism in place to ensure risks to patients were assessed.
- Medical staffing levels did not meet national guidance.
- It was not clear whether staff had completed mandatory training on end of life care and mandatory training data was not provided by the trust for all specialities.
- A significant number of 'Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR) forms were not completed according to national guidelines.

However:

- The trust had a protocol for the palliative care prescribing including anticipatory medicine.
- Equipment was appropriate and fit for use.
- Antibiotic prescribing took place according to local antibiotic guidelines.

Incidents

- The trust had an up-to-date incident reporting policy for staff to follow. The specialist palliative care team were familiar with the process for reporting incidents, near misses and accidents using the trust electronic incident reporting system. The trust process for managing serious incidents involved investigation through the use of root cause analysis and actions taken in response such as staff retraining if necessary.
- Data provided by the trust showed staff reported 90 incidents end of life care/ palliative and mortuary between December 2015 and November 2016. Thirty five of the incidents related to care of patients on inpatient wards. A log of incidents recorded the investigation carried out and actions taken in response to the incident. However, learning from incidents was not shared across the organisation.

- Members of the hospital palliative care team (HPCT) we spoke with said there were very few reported incidents relating to end of life care.
- Between May 2015 and April 2016, there were no serious incidents or never events reported in the end of life care services at the trust. Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. Although a never event, incident has the potential to cause serious patient harm or death, harm is not required to have occurred for an incident to be categorised as a never event.
- All staff we spoke with were knowledgeable about the duty of candour. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.

Medicines

- The trust had a protocol for the prescribing of anticipatory medication. Anticipatory medicines are prescribed to control key symptoms such as agitation, excessive respiratory secretions, nausea, vomiting and breathlessness, which may occur as a patient reaches the end of their life. We reviewed the medicines administration records of two patients who were receiving anticipatory medicines. We found these medicines had been appropriately prescribed and administered.
- End of life care services at this hospital followed the National Institute for Health and Care Excellence (NICE) Quality Standard QS61. This quality standard defines clinical best practice about how people are prescribed antibiotics in accordance with local antibiotic formularies. Additionally, nurses followed the standards set out in the nursing and midwifery council (NMC) standards for medicine management.
- There was an Island wide approach to anticipatory prescribing. The guidelines for 'Palliative Care Prescribing' were developed by the palliative care consultants jointly employed by the trust and the hospice.
- Medical staff we spoke with said the electronic prescribing system was easy to use and information on anticipatory prescribing was accessible.

End of life care

- Syringe drivers were available and used for end of life patients or for as required medications. These were small powered syringes, which administered high-risk medicines to patients in a controlled rate to prevent overdose or side effects.
- All community matrons were independent prescribers, which meant they could respond to patients' needs and prescribe appropriate medication in a timely way; they told us they received regular prescribing updates. They managed and prescribed medicines for patients on their caseload, with the input of the GP, patient and carer. They also prescribed 'rescue' medicines if the patient deteriorated or had increased pain.

Environment and equipment

- Most wards had side rooms which could be used for patients who were dying. During our inspection we observed some patients who were actively dying being treated on main wards, as the side rooms were in use for other patients such as those who were infectious.
- Common equipment used for palliative care patients were syringe drivers. One syringe driver model was used throughout the hospital in line with hospital policy. Staff told us there were adequate numbers of syringe drivers to meet the needs of patients.
- We observed patients who were in the last few days of life were all cared for on pressure relieving mattresses.
- Systems were in place to ensure equipment had been maintained and electrical safety tested to ensure it was safe for use.

Records

- The trust had implemented individualised care plans for patients requiring end of life care. The individualised care plans replaced the Liverpool Care Pathway documentation, which was phased out in July 2014.
- We looked at 10 sets of patient records throughout our inspection; all of them were clear, legible and up-to-date. Patient records for patients receiving end of life care were kept in secure trolleys at the end of each bay or near the nurses' station.
- The trust's policy on do not attempt cardiopulmonary resuscitation (DNACPR) included a new 'ceiling of treatment and resuscitation decision record' (CoTRDR) for recording these decisions on. The new policy was

ratified in February 2016, and the CoTRDR form introduced in April 2016. The CoTRDR form combined the DNACPR and ceiling of treatment decisions into one form.

- The trust resuscitation officer informed us DNACPR audits were conducted to confirm the validity of forms. If forms were incomplete, they are raised with the medical staff. If consistent errors were identified this would be addressed in medical staff training. Between April 2016 and October 2016 data showed approximately 88% inpatient deaths had a DNACPR in place.
- Our review of 23 DNACPR forms showed 11 were fully completed. In the medicine service we found 75% of 'Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR) forms we reviewed were not completed according to national guidelines.

Safeguarding

- There were up-to-date trust wide safeguarding policies and procedures in place, which were accessible to staff via the trust's intranet site.
- All the staff we spoke with in the hospital palliative care team were knowledgeable about their role and responsibilities regarding the safeguarding of vulnerable adults and children and of the referral process to the safeguarding team. Although none of the staff we spoke with could recall a recent safeguarding incident regarding patients receiving end of life care.

Mandatory training

- The trust's mandatory training programme for staff included information governance, moving and handling and infection control. Training modules were a mix of online e-learning or practical sessions.
- Although data was requested no data on mandatory training uptake on end of life care was requested, it was not provided by the trust for all specialities.
- Some staff we spoke with said they had attended training on end of life care, but no data on uptake was provided.

Assessing and responding to patient risk

- The results from the End of Life Care- Dying in Hospital Audit (2016) showed on the key performance indicator (KP1): 'Is there documented evidence within the last

End of life care

episode of care that it was recognised that the patient would probably die in the coming hours or days?' the trust performed better than the England average, 92% compared with 83%.

- We reviewed the nursing documentation for five patients receiving end of life care. Risks such as falls, malnutrition and pressure damage were assessed. For example, we saw the Malnutrition Universal Screening Tool (MUST) used to assess malnutrition risk and the Waterlow tool was used to assess patients' risk of pressure ulcers. We found the risk assessments were completed appropriately.
- Nursing staff used the Early Warning Score (EWS), to record routine physiological observations such as blood pressure, temperature and heart rate. EWS was used to monitor patients and prompt staff to follow appropriate procedures, should a patient's vital signs fall out of expected parameters. This meant that there was a system in place to monitor patient risk, including those patients receiving end of life care.
- Between April 2016 and October 2016 data showed approximately 19% of patients identified as end of life had a priority of care plan in place and 82% of patients had a priority of care plan applicable. The priority of care plan included risk assessments of end of life including mouth care needs and pain relief. The trust were working to improve the low uptake and aimed to achieve compliance of 65% by March 2017.
- Intentional rounding took place for all patients receiving end of life care. Dependent on the individual patient risk, these checks were undertaken between one to four hourly intervals. Intentional rounding is an organised process where nurses carry out regular checks with individual patients at set times, normally one to four hourly.
- We saw a patient record for a patient who died overnight during the course of the inspection. The patient's notes showed an elevated EWS but it had not been escalated according to procedure. However, there were no clear guidance on whether the EWS should be monitored for patients at the end of life care.
- Advice and support from the specialist palliative care team concerning deteriorating patients was available on all wards by telephone or by visit request. Staff on the wards were clear that the specialist palliative care team responded quickly to requests for advice and support.

Nursing staffing

- The hospital palliative care team (HPCT) staff were provided by the hospice. The team consisted of three clinical nurse specialists (2.3 whole time equivalent staff).
- The end of life care facilitator had recently left the trust and the post had not yet been filled, a band 6 nurse was due start February 2017, there was no interim cover.
- General nursing staff provided care and treatment for patients requiring end of life care (EOLC) with support from the HPCT.

Medical staffing

- Medical staffing in the HPCT included one full time consultant from the hospice. In addition there was a speciality doctor (16 hours per week) for the community only. This did not meet recommendations by The Association for Palliative Medicine of Great Britain and Ireland, and the National Council for Palliative Care, which states there should be a minimum of one consultant per 250 beds, as the consultant covered hospital and community patients.
- Patients receiving end of life care were reviewed on the wards on a daily basis and sometimes more than once a day as needed.
- Medical staff we spoke with all told us they had good access to and support from the consultant within the HPCT.

Major incident awareness and training

- The trust had a major incident plan, which was readily available to staff via the trust's intranet. The plan detailed the role of the mortuary in arranging to receive and manage the deceased, liaising with the police and the Coroner in the event of a major incident.
- The mortuary manager was knowledgeable about the role of the mortuary if there was a major incident. They told us about the local facilities that they could use if there was an increase in the requirement for extra storage facilities. For example, transferring the deceased between hospital sites.
- Staff were aware of the trust's major incident plan but could not recall undertaking major incident training.
- Porters stated they were aware of a major incident plan were aware of their responsibilities in the event of a major incident.

Are end of life care services effective?

End of life care

Requires improvement



We rated effective as requires improvement because:

- Care did not consistently take account of evidence based practice and guidance, for example, priorities of care plans were not routinely completed for patients nearing the end of their life.
- Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) forms were not all completed according to national guidelines. In some cases patients' capacity was not formally assessed and documented on the DNACPR form, and there was no evidence of discussion with the patient or families.
- Staff were not aware of how the trust was implementing the action plan as a result of the National Care of the Dying in Hospital Audit 2016
- End of life care training was not mandatory for consultants.
- A specialist palliative care service was not available seven days a week, telephone advice was available.
- The AMBER (Assessment, Management, Best practice, Engagement, Recovery uncertain) care bundle was not embedded in practice.

However:

- Patients had access to pain relief.
- The trust had implemented the ward accreditation programme across all wards.

Evidence-based care and treatment

- Between April 2016 and October 2016, the trust recorded 314 inpatient deaths this figure represented approximately 2% of all discharges. Data provided by the trust showed the number of referrals to HPCT increased year on year since 2012/13; for example, referrals in 2015/16 were 543 and this represented an increase of 18% compared to the previous year.
- The service had introduced priorities of care nursing care plan to take account of the Priorities for Care of the Dying Person set out by the Leadership Alliance for the Care of Dying People.

- Between April 2016 and October 2016 data showed approximately 19% of patients identified as end of life had a priority of care plan in place and 82% of patients had a priority of care plan applicable. The trust aimed to achieve compliance of 65% by March 2017.
- Staff we spoke with were familiar with the priorities of care document and we saw examples of its use in practice.
- The trust had produced an action plan in response to the findings of the End of Life Care Audit - Dying in Hospital (March 2016). However, staff we spoke with in hospital palliative care team (HPCT) said they were not fully informed as to how improvements were being implemented.
- Staff in the hospital palliative care team (HPCT) we spoke with said they had worked to improve education and inform staff to ensure appropriate and timely referrals.
- The trust's self-assessment of achievement against the End of Life Care Audit: Dying in Hospital 2016, in the last days of life was 99%; assessed as 71 out of 72 recommendations were met.
- The trust had implemented the ward accreditation programme (WAP). This included assessment on provision of end of life care against eight key areas aligned with Care Quality Commission standards. We reviewed the reports for wards which had been assessed in October/ November 2016: Alverstone, Appley, Colwell, Mottistone, rehabilitation unit and the stroke unit. Some of the reports were still in draft stage. All the wards reported compliance in seven out of eight areas for end of life care except for the stroke ward which reported requires improvement and compliance with only two out of eight areas.
- The trust end of life care audit programme 2016 included an audit of weekly mortality review and bereaved relative's survey.
- The hospital had taken no action as a result of the NHS Chaplaincy Guidelines 2015, Promoting Excellence in Pastoral, Spiritual and Religious Care. There was no formal response to this neither was discussed at the board level seminar on end of life care.

Pain relief

End of life care

- We observed patients were provided pain relief.
- Anticipatory end of life care medicines were prescribed to manage symptom and pain relief.
- A pain assessment tool scoring 0-3 was used in conjunction with an oral morphine pain chart.
- A flow chart highlighted management of pain in accordance with Faculty of Pain Medicine's Core Standards for Pain Management (2015) and when to contact the pain team for advice.
- We saw a newly referred palliative patient visited by the community nurses and had care planned within four hours. This included appropriate referrals made and equipment requested. The nurses discussed and arranged access to Macmillan nurses.
- There were two Macmillan nurses in each locality; there were end of life champions who had monthly meetings to talk through patients and their risks. The whole team was trained in palliative care, syringe drivers and medicines. They discussed the patient's priorities of care and individualised their care plans.

Nutrition and hydration

- Eating and assisted nutrition was included in the daily assessment in the Priorities of Care Nursing Care Plan.
- Our review of 10 records showed patients' nutrition and hydration needs were met.
- Medical staff we spoke with were aware of the GMC guidance for doctors in supporting nutrition and hydration in end of life care (EOLC).

Patient outcomes

- The service did not contribute data to the National Minimum Data Set (MDS). The MDS for Specialist Palliative Care Services is collected by the National Council for Palliative Care on an annual basis, to provide an overview of specialist palliative care service activity.
- We saw an example of how an end of life care patient was referred to speech and language therapist (for swallowing difficulties) and a dietitian.
- The trust participated in the National End of Life Care Audit – Dying in Hospital 2016. There were three areas where the trust performed worse than the England average. The first area was whether there was documented evidence that the patient was given an opportunity to have concerns listened to. The national

average was 82% and the trust performed at 42%. As a result, clearer question has been included in the priorities of care nursing care plan to establish the patients concerns and their goals. The second area was whether there was documented evidence that the needs of the person(s) important to the patient were asked about. The national average was 56% and the trust performed at 46%. a question has been included in the priorities of care nursing care plan to establish the needs of those close to the patient. This was also audited in the bereaved relatives survey. This was also cross referenced to the current programme charter 'Delivering and embedding High Quality End of Life Care.' The third area was whether the trust sought bereaved relatives or friends views during the last two financial years (i.e. from 1 April 2013 to 31 March 2015). The national average was 80% and the trust had not implemented it by the 31 March 2015 deadline. The trust implemented the bereavement survey in April 2015.

- Staff we spoke with said they were aware of the AMBER care bundle approach to manage the care of patients who were at risk of dying in the next few months but it was not 'embedded' in practice. (AMBER- Assessment, Management, Best practice, Engagement, Recovery uncertain).
- On the stroke unit staff we spoke with told us they did not think there was problem recognising patients who were dying but more patients were choosing to continue treatment therefore medical staff were not completing the documents and active treatment was continued. On the stroke unit staff said consultants were slow to identify dying patients and doctors had "Difficulty letting go."
- The human tissue authority audit (November 2016) did not identify any areas of non-compliance with the standards measured.

Competent staff

- Data provided by the trust showed no member of the palliative care team had received an appraisal in 2015/16.
- Data for November 2016 showed 25 medical staff had undertaken advanced communication skills training, it was not clear what proportion still needed to complete the training and when this would be achieved.

End of life care

- Junior doctors received training in end of life care through grand rounds. There were no mandatory training programmes for consultants.
- Champions had training on end of life care and were supported by the end of life care facilitator. It was intended the champions support staff in their ward areas and cascade learning but some staff said this was not always the case. On the stroke unit staff said the EOLC champions cascaded information to staff.
- There were end of life champions in community services who had monthly meetings to talk through patients and their risks. The team was trained in palliative care, syringe drivers and medicines. They discussed the patient's priorities of care and individualised their care plans.
- EOLC training included completion of priorities of care documentation. Discussions with staff indicated EOLC training compliance of, for example, MAU 75% MAU, ED reported 84% compliance. However, no overall figure for uptake of end of life care training was provided by the trust.
- Hospital volunteers were provided with EOLC training.
- Staff had received syringe driver training and staff told us there were competency assessment undertaken to assess whether a member of staff was able to safely administer the syringe driver. One member of nursing staff said they set up syringe drivers but had never completed competency training on syringe drivers. They added "Competencies do not seem to be a priority for this hospital." No data on uptake of syringe driver competency training was provided by the trust.
- Staff we spoke with told us there was a lack of coordinated working between the hospice and the HPCT.
- A psychologist was part of the MDT and provided advice and support to staff to meet patients' needs.
- There was effective team working between the specialist palliative care team the bereavement service and the chaplaincy service. There was good team working between mortuary and the ward staff.
- GPs received discharge letters informing them of their patient who was at the end of life.
- Community teams drew up a checklist of essential actions for example, just in case drugs, checking and signing of the DNACPR form by the GP to avoid gaps and upsets in the final days of a patient's life.

Seven-day services

- One of the recommendations of National End of Life Care Audit – Dying in Hospital, is provision of specialist palliative care 9am to 5pm seven days a week, to support the care of dying patients and their families, carers or advocates. The HPCT provided a service between 8.30am to 4.30pm Monday to Friday and there was an on call service out of hours by phone.
- Mortuary services were available 8.30am to 4pm Monday to Friday with on-call cover out of hours
- Bereavement service was available to assist families with viewing between 9am to 3.30pm.
- The chaplaincy service provided a 24 hour seven days a week on call service.
- The trust had an agreement with the hospice to ensure end of life care phone support was available 24 hours a day.

Access to information

- Staff had access to the electronic patient record system. There was not a single electronic palliative care coordination system for access by hospital and community palliative care teams.
- There was no electronic flag on the electronic patient record system to indicate to staff a patient was identified as the end of life.

Multidisciplinary working

- Ward staff we spoke with said HPCT were very supportive; they provided advice around symptom control.
- We spoke with physiotherapy staff who said they felt communication with the multidisciplinary team (MDT) had improved to meet patients' needs.
- We observed effective communication and discussion during the weekly palliative care team multidisciplinary meeting.

End of life care

- Staff told us plans were in place to introduce an electronic information system across the island for GPs, district nurses and community staff to have access to. However, the same system was not planned to include the hospital.
- Discharge letters were sent to GPs for end of life care patients.
- Staff told us they had access to sufficient information including policies and procedures relating to palliative care via the trust intranet.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff had an awareness about their roles and responsibilities regarding the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (DoLS). The trust did not provide data on uptake of The Mental Capacity Act (MCA) training
- Our review of 23 patient records which included DNACPR forms showed 11 were fully completed. Four did not have MCA completed and in six records, the medical notes did not show, if a discussion had taken place with the patient or relatives.
- Advance care planning is a process of discussing and/or formally documenting wishes for future care. It enables health and care professionals to understand how patients want to be cared for if they become too ill to make decisions or speak for them. Members of palliative care team said they were confident discussions regarding advanced care planning took place with patients. However, they were not confident evidence of discussion was recorded in notes. They told us the introduction of the ceilings of care and decision record documentation would improve record keeping.
- The trust reported they developed their own DNACPR Policy, along with a new 'ceiling of treatment and resuscitation decision record' (CoTRDR) for recording these decisions on. The new policy was ratified in February 2016, and the CoTRDR form introduced in April 2016. The CoTRDR form combined the DNACPR and ceiling of treatment decisions into one form, it identified the escalation status of patients who were not for resuscitation. The board assurance report (2 November 2016) showed a monthly audit of wards with a return rate of 26%. It included a plan to address the areas for

improvement such as: poor audit return rates from wards/departments, consultant sign-off within the 72 hour timeframe, clear patient details on forms and documentation of patient capacity to participate and understand decisions.

Are end of life care services caring?

Good



We rated caring as good because:

- We witnessed staff provided compassionate care to patients at end of life.
- Patients and carers we spoke with described the staff as caring, sensitive and empathetic.
- The results of the trust's previous two quarterly bereavement surveys most respondents agreed their relative/ friend was treated with dignity and respect was given pastoral/ spiritual care.

However:

- The trust performed worse than England average in the National End of Life Care Audit – Dying in Hospital, 2016 key performance indicator on health professionals' communication and discussion with relatives and friends, and consideration of their needs.

Compassionate care

- All staff we spoke with talked about the patients they cared for with compassion, dignity and respect.
- We saw examples of care that was compassionate, caring and focused on supporting patients as much as possible during difficult times. We saw staff using the skills of empathy when speaking to patients and using good eye contact.
- During our inspection, we observed patients were treated with compassion, dignity and respect.
- Porters told us they observed that deceased patients were treated respectfully by ward staff
- The trust's quarterly bereavement survey results October 2016 and July 2016 showed approximately 78% of respondents agreed with the statement 'Was their relative/friend treated with dignity and respect'.

End of life care

- Mortuary staff told us that when the deceased was brought to the mortuary, they were prepared with utmost care. They told us they never had any concerns regarding this.

Understanding and involvement of patients and those close to them

- All of the staff we spoke with showed an awareness of the importance of treating patients and their representatives in a sensitive manner.
- The trust had a chaplaincy service which offered support for relatives, following the death of a patient.
- The hospital scored 69% in the National End of Life Care Audit – Dying in Hospital, 2016 key performance indicator two (KP2) for documented evidence that health professionals had discussed the patient would probably die in the coming hours or days with families. This was worse than the England average of 79%. The hospital also did not meet key performance indicator 7 which assessed ‘Did your trust seek bereaved relatives’ or friends’ views during the last 2 financial years’.
- The hospital scored the same as the England average in the ‘patient led assessment of the care environment’ (PLACE), ‘privacy, dignity and wellbeing’ category in 2015.
- Services provided in the mortuary demonstrated respect and understanding of a patient’s cultural or religious needs an example of this was the trust’s urgent release policy, this was when the deceased was released within 24 hours of death and was used regularly with regard to cultural and religious beliefs.

Emotional support

- Hospital palliative care team assessments documented patients psychological and spiritual support needs as part of their holistic needs assessment.
- Cancer Patient Experience Survey (CPES) 2014/15 the trust performed in bottom 20% of trusts for 19 out of 34 questions, and in top 20% of trusts for two out of 34 questions and scored in middle of 60% of trusts for remaining 13 questions.
- The results of the previous two quarterly bereavement surveys undertaken by the trust (July 2016 and October 2016) showed approximately 66% of respondent agreed their relative/ friend was given pastoral/ spiritual care.

- The trust achievement in National End of Life Care Audit – Dying in Hospital, 2016 key performance indicator 4: ‘Is there documented evidence that the needs of the person(s) important to the patient were asked about?’ was worse than the England average; 46% compared to 56%.
- The chaplaincy service provided a 24 hour seven days a week on call service for patients in the hospital, as well as their relatives, and aimed to see people within the hour.
- The chaplaincy service held communion at the patient’s bedside if patients were too ill to attend the chapel. The chaplain told us they conducted last rites and blessed the deceased in the mortuary if this was requested.
- The chaplain supported patients, their families and staff. We saw there were a number of thank you cards in the multi-faith chapel.

Are end of life care services responsive?

Requires improvement



We rated responsive as requires improvement because:

- The partnership working and relationships between the trust and the hospice were not as integrated as they could be and this affected the planning of end of life care.
- End of life care patients did not always receive care in a side room as these were prioritised for treating patients with infections.
- End of life care patients were moved from one ward to another or from one ward area to another for non-clinical reasons. This resulted in lack of continuity of care for patients and was not monitored.
- There were not robust processes to facilitate rapid discharge of patients and staff were not trained to use the rapid discharge forms. The trust was not monitoring the number of end of life patients who were discharged with fast track rapid discharge in place.
- Most patients receiving end of life care were not transferred to their preferred place of death.

End of life care

- There were complaints relating to end of life care but the learning was not shared across the organisation.

However:

- There was open access for relatives visiting patients who were dying.
- There were adequate facilities to meet individual's spiritual and cultural needs.

Service planning and delivery to meet the needs of local people

- There were no dedicated end of life care beds at the trust. Patients who required end of life care were nursed on general medical and surgical wards or were offered a hospice bed if appropriate and available.
- Staff we spoke with told us the palliative care service was not integrated. At a strategic level, the relationships between the trust and the hospice that provided some of the services to the trust were fragile. Only recently (August 2016) had the trust lead on end of life care and the hospice management team started to meet formally to discuss the provision of the end of life care at the trust. There were, for example, no action points from these meetings that would highlight progress being made. The head of the local hospice described working "in silos."
- The trust board seminar (October 2016) highlighted progress with End of Life Care in the trust and concerns particularly around care planning that meets people's wishes and links in with work partners have done especially GPs. Actions included for the Deputy Director of Nursing and Quality and the Executive Medical Director to working more closely with primary care and hospice partners to provide more care and support in home settings.

Meeting people's individual needs

- Staff we spoke with informed us EOLC patients were moved out of side rooms if the room was needed for a patient to reduce the risks of spread of infection. The trust informed us data on movement of patients at end of life care was not captured. However, we found a number of instances where end of life care patients were cared for in a bay instead of a side room and staff had not made adjustments to ensure the same degree

of compassionate care. For example, relatives did not have access to comfortable chairs. Staff did not explain to relatives as to why they could not get a side room for the patient.

- Information was available in other languages if needed, however staff interpreters or translation services were rarely needed.
- The results of the previous two quarterly bereavement surveys (July 2016 and October 2016) showed approximately 47% of respondents agreed their relative/ friend was given spiritual emotional support.

Access and flow

- Data provided by the trust showed on average between April 2016 and September 2016 patients were seen within one day of referral to the hospital palliative care team. Staff said the HPCT were responsive and the referral process was efficient.
- End of life patients were being moved within wards and staff were receiving requests to move end of life patients from one ward to another for non-clinical reasons. Staff on Appley ward gave an example of where they were "Pushed" to move a patient from ward to hospice bed or non acute bed elsewhere in the hospital, although the patient wanted to stay on Appley ward. We asked for the data but the trust did not provide this. The trust had a policy in place not to move patients at the end of life care but this policy was not monitored to make sure it was adhered to. We saw instances where end of life care patients were being moved.
- In our review of 10 records of patients known to be in the last days or hours of life, we saw the patient's preferred place of death was recorded. Data provided by the trust for April 2016 to August 2016 showed approximately 25% patients died in their preferred place of death each month.
- The National Framework for NHS Continuing Healthcare and NHS Funded Nursing Care was published in 2007, and revised in 2012. The framework set out that patients with a rapidly deteriorating condition should be 'fast tracked' to receive NHS funded care in a place of their choice at the end of their life.

End of life care

- We found rapid discharge of patients took on average one week, Staff were not yet trained on the use of fast track forms and approval took one to two days. There were delays to equipment provision from the central store and transport home was slow.
- Although it was requested the trust did not provide data on the number of end of life patients who were discharged with fast track in place.
- Staff we spoke with said it was “Not easy” to arrange discharge of patients at end of life to the hospice.
- Palliative care consultant told us three pathways that had been developed for critically ill patients at end of life in the emergency department. Pathways involved transfer home, in to hospital for palliative care or to the hospice. A community paramedic was deployed to the emergency department at night. They facilitated patient discharge home including for patients at end of life
- Staff on the stroke unit said they were able to coordinate a rapid discharge for patients if needed.
- In the community we saw a newly referred palliative patient visited by the community nurses and had care planned within four hours. This included appropriate referrals made and equipment requested. The nurses discussed and arranged access to hospice Macmillan nurses.

Learning from complaints and concerns

- Between November 2015 and October 2016 the trust received six complaints across different wards, relating to end of life care. The issues identified were concerns about communication and completion of DNACPR forms.

Are end of life care services well-led?

Requires improvement



We rated well-led as requires improvement because:

- Staff were not aware how the end of life care strategy was to be implemented. Staff did not feel engaged with and described the culture in the organisation did not lead to integrated working.
- There was no end of life specific risk register.

- The governance structure was not effective. Meetings took place but outcomes and action plans were not joined up. The quality, risks and performance issues within end of life care were not monitored through the executive governance framework

However:

- The trust had recently appointed a non-executive director for end of life care on the trust board.
- There was an Island wide end of life strategy.

Leadership of service

- Leadership of the end of life care service at the trust was provided by the trust executive lead, the medical director. The end of life care service was led by the end of life clinical lead, end of life care lead nurse and end of life care nurse facilitator. The end of life care nurse facilitator (band 7) had recently left (early November) and the post had been filled by a band 6 staff who was due to commence in February 2017. There was no front line leadership of the service in the interim period.
- There was a recently appointed (August 2016) non-executive director for end of life care on the trust board.
- The hospital palliative care team said they were aware of the leadership structures and received good leadership and support from their immediate line managers at the hospice.
- The Island wide end of life strategy group chaired by a GP and the hospital group was chaired by the medical director.
- Staff we spoke with told us the palliative care service was not integrated. At a strategic level, the relationships between the trust and the hospice that provided some of the services to the trust were fragile. Only recently (August 2016) had the trust lead on end of life care and the hospice management team started to meet formally to discuss the provision of the end of life care at the trust. There were, for example, no action points from these meetings that would highlight progress being made. The head of the local hospice called this way of working as working “in silos.”

Vision and strategy for this service

- A trust strategic priority was ‘to provide excellent end of life care’ Palliative care staff we spoke with said they were not clear how the end of life care strategy or action

End of life care

plan of the national care of the dying audit 2016 were being implemented. There was no mention of plans for end of life care in the CBU plans within the trust operating plan.

- The trust's end of life care policy (June 2015) provided a framework for end of life care service provision in accordance with the End of Life Strategy for England (2008). The policy aimed to encourage early recognition of people entering the last phase of their life with open, sensitive discussion of their preferences for the care they received and the place in which they received their care. The policy was aimed at all professionals who work in the Isle of Wight NHS Trust and who have the responsibility for providing end of life care. Senior staff at the hospice has been consulted in the development of this policy as the Hospice adopts the NHS Trust's policies

Governance, risk management and quality measurement

- The palliative care team was managed by the hospice. The trust reported there had been changes to the governance and reporting arrangements with regards to end of life care. There were two groups that oversaw delivery of end of life care for the Isle of Wight. These were the end of life care strategic group, which looked at end of life care island wide, and the end of life care strategic hospital sub group, which concentrated on delivering developments within the acute setting of the hospital.
- We reviewed the notes of the end of life care strategy hospital sub group meeting which was held quarterly, (April 2016 and July 2016), the role of the group was to lead and monitor delivery of the island end of life care strategy in the hospital.
- The end of life care strategic group membership was multidisciplinary. Meetings were held every two weeks. Notes of meetings held in June and September 2016 highlighted discussion of issues and recommendations for improvement, for example regarding advanced care planning and improved IT systems.
- A report on the results and actions following the national care of the dying audit 2016 was reported to the trust board in October 2016, this highlighted actions taken and further recommendations.

- We saw the report of the ward survey of discharging patients, education and end of life champions. It highlighted the need for further education for staff on, for example, syringe drivers and initiation of the priorities of care nursing care plan.
- We reviewed the last three notes of the bimonthly mortality review committee, this was led by the medical director. The committee received regular updates from the weekly mortality review group and a bereavement report.
- Evidence showed the trust board were informed of issues relating to provision of end of life care. In April 2016, presentation to the board by the chief executive of the hospice on the end of life care strategy, in July 2016, they received a report of mortality update, and in October 2016 the results and action plan of the national care of the dying audit 2016.
- Members of the palliative care team were involved in local networks Wessex Palliative Care Group, Macmillan Network and Earl Mountbatten Hospice.
- There were no corresponding action plans to identify actions to be taken as a result of the bereavement surveys undertaken by the trust.

Culture within the service

- Staff said the organisational culture did not encourage integrated team working across different parts of the palliative care service. The hospice, the community and the acute services that provided end of life care were seen as separate entities rather than cohesively working to improve patient outcomes for end of life care patients.
- Staff within the hospital palliative care team spoke positively about the service they provided for patients and were passionate about their work.
- Ward staff were positive about the support provided by the specialist palliative care team
- Staff reported positive working relationships, and we observed that staff were respectful towards each other, not only in their specialities, but across all disciplines.
- Most staff we spoke with said they felt confident to whistleblow or raise concerns with their managers.

Public engagement

End of life care

- The trust undertook a quarterly bereavement survey. The response rate for the July 2016 survey was 40% and for October 2016 the response rate was 17%. The trust provided the survey results but there was no report of recommendations or actions following the surveys.

Innovation, improvement and sustainability

- The trust reported a number of initiatives to improve the end of life care services including widening access to the pre- bereavement and bereavement services. The

service is available to all patients and all those close to patients. All bereaved families/carers are given an information leaflet and staff made aware of the referral process.

- A project was undertaken to identify patients who were in the emergency department and medical assessment unit and to establish whether patients could be identified earlier and care provided in their preferred place of care. Plans were in place to continue the project in 2017.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital **MUST** take to improve

The hospital must take action to ensure that:

- There are 16 hours of cover by consultant grade staff in the emergency department daily.
- There is sufficient nursing staff on duty at all times in all areas calculated through use of a recognised staffing and acuity tool.
- Arrangements for staffing (nursing and medical) for the paediatric emergency department are urgently reviewed to ensure sufficient trained paediatric cover.
- All medical staff receive safeguarding children level 3 training.
- The medical rota supports junior medical staff receiving education as required by their training placements.
- There is a room in available for ED staff to assess patients in mental health crisis that does not compromise the safety of the patients or staff.
- The environment to see and treat children, including the children's waiting area meets the requirements of the 'Standards for Children and Young People in Emergency Care Settings' by the Royal College of Paediatrics.
- Governance, risk management and quality measurement including the undertaking of audits is reviewed, improved and embedded across all departments ensuring all risks are identified and managed effectively.
- Nursing staff in the coronary care unit have competencies to care for patients on bi-level positive airway pressure (BiPAP).
- All incidents are investigated in a timely way and lessons from incidents are shared with all staff.
- There is a sufficient and safe number of doctors working on the coronary care unit (CCU) at all times.
- Single sex accommodation requirements for patients are maintained and any breaches are reported in a timely way.
- Staff identify patients who may need consideration of Deprivation of Liberty Safeguards (DoLS).
- Daily documented checks on each resuscitation trolley are complete.
- Intravenous fluids are stored in a locked room to prevent access to members of the public.
- Mandatory training rates for life support training and moving and handling improves to achieve the trust target.
- Complaints and concerns from patients are investigated and responded to in a timely way and lessons learnt shared across the organisation.
- All staff have yearly appraisals that are meaningful to their professional development.
- Review information governance protocols to ensure that patient identifiable or confidential information is kept secure at all times.
- All patients nearing end of life are assessed and have an individualised end of life care plan. There are monitoring mechanisms in place to ensure risks to patients were assessed.
- Medical staffing levels meet national guidance for end of life care.
- Consultants undertake training in end of life care.
- Patient capacity is formally assessed and documented on the DNACPR form and the forms are completed in accordance with national guidelines.
- There are improved discussions with the family/friends regarding end of life care.
- End of life care patients are not moved for non clinical reasons.
- Patients are able to die in their preferred place of care. There is a robust rapid discharge system in place for end of life care patients and this is monitored
- Suitable arrangements are in place to identify, assess and manage risk in end of life care services, through actively reviewed risk register.
- The quality, risk and performance issues within end of life care are monitored and improved through the executive governance framework.

Action the hospital **SHOULD** take to improve

The hospital should ensure that:

- Review the pathways and care for children in the emergency department to ensure that their needs are met.

Outstanding practice and areas for improvement

- Reviewing the process of flow through the emergency department and develop a strategy to engage clinicians and teams across the trust to improve flow through ED and the hospital.
- Should find a safe area for patients with a mental health condition to wait for their assessment.
- Should consider the purchase of an additional drug dispensing machine for the minors area, or manage the risks to minimise delays to administering medicines for the patients when required.
- Should consider the development of a program of teaching sessions in-house to minimise long waits for phlebotomy, cannula insertion and IV drug administration training for nurses.
- Review protocols for the prescribing and administration of oxygen to patients. Ensuring the oxygen is prescribed prior to administration.
- Review the out of hours service provision at weekends for the medical service, ensuring that the risks of reduced services are managed.
- Review infection control practices for patients in isolation, ensuring that infection control protocols are adhered to.
- Reduce the number of bed moves after 10pm, and reduce the number of total moves per patient.
- The trust should provide training and access to the medicines systems for trust staff who work on the wards.
- Develop and implement an action plan for clear leadership to manage the frail, elderly patient pathway.
- Should assess and improve the discharge arrangements for patients from the hospital to the community or the patients home.
- Monitor the mandatory uptake of end of life care training across all specialities.
- Ensure staff are aware of how the trust is implementing the action plan as a result of the National End of Life Care Audit – Dying in Hospital, 2016, and their contribution to improvements.
- Ensure there is a review of how the trust meets the NHS Chaplaincy guidance.
- Further integrate the relationship between the trust and the hospice so it improves the planning of end of life care.
- Implement the AMBER care bundle across services.
- Where possible, provide side room for end of life care patients, and ensure that staff maximise patient privacy and dignity and comfort when nursed in a bay.
- Train appropriate ward staff on rapid discharge forms and monitor their use.
- Raise awareness with staff on how the end of life care strategy is to be implemented.
- Improve access to specialist palliative care service seven days a week.

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 |
|--------------------|---|
| | <p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <p>How the regulation was not being met:</p> <ul style="list-style-type: none">• The room used for mental health assessment was not safe for staff or patients due to ligature risks and the potential for furniture to be used as missiles.• The children's waiting room did not provide adequate safety measures for children.• Arrangements were not in place to respond quickly to changes in patients' needs; referral pathways were not embedded.• Staff in the coronary care unit had not completed a specific competency programme for the use of bi-level positive airway pressure (BiPAP) to maintain patient safety.• Daily checks on each resuscitation trolley were not documented to ensure the equipment was safe for use.• Intravenous fluids were stored in an unlocked cupboard accessible to the public.• Mandatory training rates for life support training and moving and handling training were significantly below the trust target.• There was not timely coordination and planning of care for facilitate rapid discharge/ transfer of patients to preferred place of death• End of life care training was not mandatory for consultants. There was insufficient palliative care consultant cover for the hospital and community. There was no interim end of life care facilitator in post. <p>Regulation 12(1) (2)(a)(b)(c)(d)</p> |

Requirement notices

Regulated activity

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

How the regulation was not being met:

- The emergency department had not ensured that nurse staffing levels were calculated using a recognised acuity tool.
- The medical consultant cover in the emergency department did not provide cover for the required minimum of 16 hours per day.
- Medical and nursing had not received training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. This included safeguarding adults and children training, medical education, appraisal and supervision.
- Medical staffing levels for doctors and nurses were insufficient in clinical areas across medicine

Regulation 18 (1)(2)(a)

Regulated activity

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

How the regulation was not being met:

- The provider had not ensured that the emergency department had assessed, monitored or improved the quality and safety of the services provided in the carrying on of the regulated activity. This was because the service participated in a limited number of national and local clinical audits.
- The service did not participate in all required national audits.
- The service risk register did not fully reflect all identified risks.
- There was no local strategy or vision for the emergency department.

Requirement notices

- The trust had not assessed, monitored or mitigated the risks of service users and others who may be at risk from a disconnected culture between the main hospital and the ED. Staff felt demoralised and not linked to the main service of the hospital.
- Incidents were not being investigated in a timely way and lessons from incidents were not being shared with staff.
- The governance, quality assurance and risk management processes were not effective. Risks to services and patients were not identified or being managed.
- There were not suitable arrangements in place to identify, assess and manage risk in end of life care services, there was no risk register in place.
- There was insufficient monitoring of the quality and performance of services for end of life care patients. Where improvements had been identified the action plans were limited in scope and detail and staff were not involved in implementation.

Regulation 17 (1)(2)(a)(b)

Regulated activity

Regulation

Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints

How the regulation was not being met:

Complaints and concerns from patients were not always investigated or responded to in a timely way

Regulation 16 (1) and (2)

Regulated activity

Regulation

Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

How the regulation was not being met:

This section is primarily information for the provider

Requirement notices

- Staff were not sufficiently involving family/friends in discussions about end of life care or considering their needs.
- Staff did not take extra care to ensure privacy and dignity and comfort for end of life care patients, and their families/friends, when moved into a ward bay
- Individualised care plans were not completed for all patients nearing the end of their life.

Regulated activity

Regulation

Regulation 11 HSCA (RA) Regulations 2014 Need for consent

How the regulation was not being met:

Do Not Attempt Cardiopulmonary Resuscitation orders (DNACPR) were not completed as directed in the Mental Capacity Act 2005.