Care Quality Commission

Poole Hospital NHS Foundation Trust

Poole Hospital

Quality Report

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Poole Hospital is the hospital provided by Poole Hospital NHS Foundation Trust. The trust gained foundation status in 2007 and provides services to a local population of around 500,000 people, although this figure rises significantly between May and September each year, as Dorset is a popular holiday destination.

Poole Hospital has approximately 638 inpatient beds. The hospital provides the following services: urgent and emergency care, medical and older people's care, surgery, critical care, maternity and gynaecology care, care of the young person, end of life care, and outpatient and diagnostic services. We inspected each of these eight core services at the hospital.

Poole Hospital is the trauma unit for East Dorset and the designated Cancer Centre for Dorset, providing medical and oncology services for the whole of the county, serving an approximate population of 750,000.

The Trust has an unusual case-mix, undertaking a very high proportion of non-elective work, with only 15 acute trusts across the country delivering a higher percentage of non-elective activity. Given the distribution of acute services within east Dorset, the Trust does not provide the usual range of elective services, with orthopaedics, urology, ophthalmology and interventional cardiology being largely provided by the neighbouring trust in Bournemouth.

We inspected this hospital as part of our planned, comprehensive inspection programme. We carried out an announced inspection visit to the hospital from 26-28 January 2016, and additional unannounced inspection visits from 8 -10 February 2016. The inspection team included a Chair, a CQC Head of Hospital Inspection, managers, inspectors, planners and analysts. Doctors, nurses, allied healthcare professionals, senior NHS managers and an 'expert by experience' were also part of the team.

We inspected the following core services at Poole Hospital: Urgent and emergency care, medical care, surgery, critical care, maternity and gynaecology, children and young people, end of life care, outpatient and diagnostic services.

Overall, we rated this trust as 'requires improvement'. We rated it 'good' for providing effective, caring and well-led services and 'requires improvement' for safe and responsive services.

Our key findings were as follows:

Are services safe?

- Staff were encouraged to report incidents. The Trust overall had a culture of safety where incidents were mainly appropriately reported and followed up. Learning was shared and changes made as a result of this to improve the safety of services. However, clinical safety incidents were not consistently reported in the maternity service where midwives told us that they were not always able to report incidents due to staffing pressures. The children and young person's service had also not always ensured learning from incidents was embedded in practice.
- The rate of NRLS reported incidents per 100 admissions is 45% higher than the England average: 12.2 per 100 admissions, against an England average of 8.4 per 100 admissions. There was one never event reported in the trust and 88 serious incidents between August 2014 and July 2015.
- Patients arriving to the emergency department by ambulance were assessed and treated within national standard times. The trust time to treatment had been better than the England average since October 2013.
- Staff carried out risk assessments and management plans for patients in a timely way although this was not entirely robust within the care of the elderly wards. Some patient risk assessments and fluid charts on these wards were incomplete.
- The early warning score system needed to be used more reliably for the escalation of patients whose condition might deteriorate.

Summary of findings

- In some operating theatres, staff did not follow the five steps for surgical safety reliably or accurately in order to minimise the risks to patients.
- 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. At the trust, from July to September 2015, 97% of care was harm free.
- Medicines were not consistently managed in some areas across the hospital. Medicines were not always kept safe at the correct temperature, or stored securely in line with current legislation, in the ED, critical care and surgery departments.
- Staff generally adhered to infection control procedures, but systems and processes for monitoring infection control standards in some services were not always reliable or appropriate to keep people safe. Premises and equipment were not always kept clean and cleaning was not always done in line with current legislation and guidance. Most wards and clinical areas were clean. However, areas in the delivery suite and ANDA were visibly dirty.
- In the Emergency Department, patients were sometimes at risk of harm as they did not always receive name-bands within an appropriate time; this meant they could have had the wrong treatment or care if they were unable to tell staff their name.
- Equipment was checked and stored appropriately in most clinical areas. However some of the equipment remained unchecked and unsuitable for immediate use in a post maternity clinic. Within the theatre complex, there was an insufficiently robust system for calling for emergency assistance. There were sufficient amounts of specialist equipment on, for example, the stroke unit, where adaptive cutlery and crockery was used.
- Staff understood their safeguarding responsibilities towards vulnerable adults and children, but in the ED, there was low take up of training for reception staff.
- Mandatory training compliance was sometimes below the trust target, and this was often as a result of staffing levels, as staff could not always be released to attend.
- There were not consistent numbers of staff in terms of staffing levels and skill mix as planned by the trust on medical and older people's wards and in paediatrics. The Trust had tried to mitigate this risk by having on-going nurse recruitment which was successful in some areas. Midwives said they were regularly short-staffed and were not able to consistently provide one to one care to women during labour.
- Medical staffing levels were mainly appropriate. There were areas where further recruitment was necessary.
- In diagnostic imaging, staffing was a concern. There were five radiographer vacancies (25% of the workforce) affecting MR and CT scanning. Staff reported heavy workloads and concerns with the demands on the on-call rotas.
- Senior clinical staff were aware of the Duty of Candour regulation and the importance of being open and transparent with patients and families.

Are services effective?

- The treatment and care provided in most services took account of current evidence-based guidelines. However, although evidence-based guidelines for the care and treatment of sepsis patients in the emergency department were followed, although some records had important pre-sepsis checks omitted.
- Services participated in national and local audits. There was appropriate monitoring of performance against national targets although this needed to improve medical services and for end of life care.
- Pain relief was given in a timely manner. Pain scores were used as part of the normal observations to record patients' pain and to ensure that medicines for pain were effective. However, the use of pain tools designed for children were not being used within ED.
- Patients nutrition and hydration needs were met appropriately. Patients who required intravenous fluids had these prescribed, administered and recorded appropriately.
- Patients received drinks and food in a timely manner. There were protected mealtimes and staff to support patients who required extra help.

Summary of findings

- Care and treatment for people following a stroke was below the national average and the trust had been slow to implement improvements.
- Patients were cared for by a multi-disciplinary teams working in a co-ordinated way. Staff reported good working relationships and clear lines of clinical responsibility with specialist teams who were called to review patients.
- Many services had developed across seven days a week. However, there were reported delays for patients who required mental health assessment out of hours and over the weekends: these services were supplied by a local mental health trust. Stroke inpatients also received significantly less physiotherapy than patients' nationally.
- Many staff had access to specific training to ensure they were able to meet the needs of the patients they delivered care to and there were educational opportunities available for all grades of medical and nursing staff.
- Staff had clinical supervision and appraisal, although appraisal rates for medical staff in the Emergency department were low.
- Staff had immediate access to patient information. There were robust systems and processes to ensure that information was kept secure, but was available to all clinical staff that needed access to them.
- Most staff followed consent procedures and had overall good understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards which ensures that decisions are made in patients' best interests.

Are services caring?

- All staff made a concerted and sustained effort to ensure that patients, carers and relatives were treated with kindness and support. We observed that staff were consistently kind and compassionate, putting the patient at the centre of care. Receptionists at the front door made a concerted effort to put any visitors or patients at ease, and this level of high support and regard continued throughout the hospital. Staff told us they were encouraged, no matter how busy, to stop to take time to help or reassure anyone in the hospital and this sometimes involved escorting people to unfamiliar areas, rather than just telling them how to get there.
- However, on the medical and care of the elderly wards, some concerns were expressed about personal care prior to our inspection, and staff understanding of people living with dementia. Further feedback from some patients and relatives on medical wards indicated they did not (always) feel informed or involved in decisions about their care. This inconsistency was also reflected in feedback we received at our listening /public engagement event immediately prior to our inspection.
- Many other patients, relatives and families told us they were kept informed of plans for on-going care and treatment. They said they had been given personalised support, adapted to their ability to take on complex or emotional information.
- Patients and their families were supported by staff to reduce anxiety and concern. They felt involved in the decision-making process and had been given clear information about treatment options: they then felt enabled to ask questions of senior medical and nursing staff and be supported to make the decision that was right for them or for their loved one. There was further emotional care from the chaplaincy and bereavement services, and counselling support where required for patients and families.
- Dignity and respect for patients was maintained at all times during treatment or examination. There were signs on curtains to remind staff and relatives that they needed to ask permission before entering.
- Overall, the trust consistently scored better than the England average for the Friends and Family test.

Are services responsive?

- At the time of the inspection the hospital's services, and those of other acute hospitals in Dorset, were subject to the Dorset Clinical Services Review to redesign and improve quality of care for people in the county.
- Bed occupancy in the hospital ranged between 86-98%. This was consistently above the England average. It is generally accepted that at 85% level, bed occupancy can start to affect the quality of care provided to patients, and the orderly running of the hospital.

Summary of findings

- Performance in meeting national emergency access target for 95% of patients to be admitted, transferred or discharged from ED within 4 hours had varied through the year. The target was met between May 2015 and August 2015, and again in September 2015. Overall the trust performance had been in line of better than the England average but the average was approximately 91%.
- The trust reported 72 black breaches between November 2014 and October 2015. This is when ambulances are not able to hand over patients within one hour. A lack of physical capacity in the hospital was the main reported reason for this. The ambulance median time to treatment was around the standard of 60 minutes.
- The percentage of patients waiting 4 -12 hours in the department for a bed in the hospital had been decreasing since October 2014. However, the trust still remained below the England average.
- The acute medical admissions ward, rapid assessment consultant evaluation unit (RACE), and medical investigations unit had contributed to the trust's ability to support older patients and manage the increasing pressures on beds.
- There were 32 medical outliers at the time of inspection. These patients were appropriately assessed, and there was a robust process to ensure junior and senior medical staff from the relevant speciality reviewed medical outliers regularly.
- In November 2015, 93% of patients with fractured neck of femur had surgery with 36 hours of being medically fit, 96% within 48 hours and 89% within 24 hours of being medically fit.
- The trust had identified patient flow through the hospital as a significant concern. In the period October to December 2015, the trust had mixed achievements in meeting the 18 week incomplete pathway for referral to treatment (RTT) standard. National standards detail that 92% of patients should start treatment within 18 weeks of referral for treatment. This data was for patients who were having elective surgical procedures carried out at the hospital. General surgery and trauma and orthopaedic service met this target. However, ENT and oral surgery services did not meet this target, with compliance rates ranging from 87% to 91%.
- The hospital's cancellation rate for operations was similar to the England average. The percentage of patients whose operation was cancelled and were not treated within 28 days was lower (better) than the England average.
- The critical care unit had a low rate of elective surgical operations being cancelled because a critical care bed was not available. However, patients fit for wards were not always transferred out of critical care within 24 hours. Thames-Valley and Wessex networks leads carried out a review in July 2015. The trust was identified as an outlier on the NHSE national dashboard. A further review was planned for January 2016.
- In critical care, there were 39% of delayed discharges over 12 hours to wards due to lack of bed availability in the rest of the hospital, which meant patients could not be discharged to a ward at the earliest opportunity. This had resulted in patients that should be deemed as mixed sex breaches. There was an action plan in place which included meeting with director of operations to discuss this issue and identify solutions. This would be fed into the Best Practice Organisational Flow Group. The trust had recognised this was an on-going problem and was not meeting the NHS England key performance indicator.
- Maternity senior managers had not completed an assessment of needs to analyse how the service should be planned and delivered to local people. This meant the managers could not be assured the service provided appropriate care to meet the needs of the local population. The trust wide bed occupancy rates for maternity and gynaecology were higher than the England average and fluctuated between 65% and 83%. For example, from April 2015 to June 2016 the trust reported a bed occupancy rate of 82.8% compared with the England average of just over 60%.
- Pregnant women had prompt access to maternity services. The national and trust target for booking women for ante natal care by 12 weeks and 6 days gestation was 90%. The hospital consistently exceeded the trust and national targets for April 2015 to September 2015 with an average of 96.2% of women booked within the timeframe.
- Staff told us the 24 hour paediatric assessment unit improved patient flow. They felt having a facility whereby patients could be observed for longer than four hours allowed the paediatric team to reduce their admission rate to inpatient areas. GPs could refer children to the assessment unit, and following triage children were then admitted or they could return home. There was a system for recording waiting time within the assessment unit.

Summary of findings

- The trust short notice cancellation rate for outpatient appointments was lower (better) than the England average. 'Did not attend' rates were also lower (better) than the England average and phone calls and texts were used to remind patients of appointments.
- The trust was meeting cancer waiting times for patients to see a specialist within 2 weeks and from decision to treat to first definitive treatment within 31 days. The trust also met the waiting times target for from 2 Week Wait referral to first definitive treatment within 62 days (April 2014 to October 2015) in 14 out of the 19 months. Overall performance for this period was 86.6% (target ≥85%).
- The hospital delivered patient centred end of life assessments in a timely way. The hospital specialist palliative care teams assessed newly referred patients within 24 hours as outlined in the Operational Policy for the Poole Palliative Care Service. The community specialist palliative care nurses assessed patients within three days of the referral.
- The trust operated a Rapid Discharge Home to Die (RDHD) pathway which served to discharge a dying patient who expressed wanting to die at home within 24 hours.. However, the trust had recognised through audit that patients were not always appropriately highlighted as suitable for fast track Continuing Health Care funding and there was a widespread deficit in knowledge about the CHC funding process.
- The trust was working in partnership with social care services to effectively support the discharge or patients, particularly patients with complex needs.
- Clinical staff did not always know how to access information to support them in meeting the needs of patients with a learning disability. There was not a specialist nurse, team or link nurse scheme to support where staff could receive advice and support to enable them to support these patients effectively.
- There was a clear and comprehensive complaints process. Staff understood how to manage complaints and there was evidence of learning from concerns and complaints. Patient feedback was sought and welcomed across the trust. This feedback was obtained from patient surveys and comment cards. The comments were largely positive.

Are services well led?

- The trust had published its vision, values, mission statement and objectives, and had taken action to assess and improve staff understanding of these. Staff used "The Poole Approach" (a delivery method of ensuring patients and relatives were at the heart of their care) as a daily strategy for internal and external communications.
- Staff felt that the executive team provided a strong, visible and supportive presence within the trust. Staff were positive about all the directors in the trust. However, many staff identified that some senior staff who attended bed meetings were viewed as obstructive and unsupportive. They also described difficulties in accessing these staff. For example, some senior nurses described having to wait in a corridor for up to an hour for requests for extra staff to be signed and agreed.
- The Director of Nursing provides end of life care leadership at trust board level and had good oversight of end of life care issues across both specialist palliative care and the acute medical wards.
- The trust was part of the on-going Dorset wide clinical service review and the Developing One Dorset vanguard to integrate acute care. Most services had developed interim strategic plans within this context. However, there was not a service-wide strategy or vision for paediatric services or for maternity services. The paediatric service had lacked leadership at a senior nursing level until an acting matron was appointed in January 2016. Senior managers did not consistently demonstrate an understanding of current service risks.
- Some services had effective clinical governance arrangements to monitor quality, risk and performance, but some local risk registers did not always reflect all of the concerns described to us by staff, or provide sufficient detail on actions being taken. The risk registers did not include key issues such lack of staffing on the paediatric wards or the maternity concerns regarding delays to care and the inability to consistently provide one to one care in labour. A few issues, such as lack of paediatric staffing, had not been formally raised to the executive team.
- Staff told us they were proud to work for their trust and some had done so for many years.
- Patient feedback was mainly through surveys and there was less evidence of other engagement opportunities.
- There was active participation in research and quality improvement projects, and the Outpatient and Diagnostics departments had highlighted much innovative practice.

Summary of findings

We saw areas of outstanding practice including:

- The trust had developed a set of values called "The Poole Approach". The Poole Approach was established in the early 1990s as a philosophy of care. It pledges that staff at Poole Hospital will strive at all times to provide friendly, professional, patient-centred care with dignity and respect for all. These values were well embedded with staff working in the hospital. Staff were consistently kind and compassionate, putting the patient at the centre of care. Receptionists at the front door made a concerted effort to put any visitors or patients at ease, and this level of high support and regard continued throughout the hospital. Staff told us they were encouraged, no matter how busy, to stop to take time to help or reassure anyone in the hospital.
- The rapid assessment consultant evaluation (RACE) unit provided a high multi-disciplinary quality of care specifically for older patients, over the age of 80. The unit provided a seven day service and was reducing the number of elderly patient admissions and the length of stay for elderly patients that were admitted.
- For neonates, children and young people receiving palliative care, the trust had designed a special unit called the Gully's Place Suite. This was a purpose-designed space which provided privacy and dignity for parents and families of babies, children and young people who required palliative and end-of-life care.
- Nuclear medicine was an exceptionally well led multidisciplinary service, despite an increasing workload, with no breaches of waiting times. Patients interviewed confirmed an outstanding level of care, information provided to patients, and concerns responded to appropriately. The department has also safely introduced two new radio pharmaceuticals based on scientific evidence. Medical physics have developed a new dental phantom; a commercial product.
- Non-invasive cardiology in CT and MRI imaging have reduced the need for invasive tests on patients with low and medium risk of coronary disease whilst ensuring high risk patients are transferred quickly to the neighbouring NHS hospital. There is excellent team working between cardiology and radiology to provide this service.

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

Importantly, the trust **must** ensure:

- Action is taken to improve the cleanliness of clinical areas at St. Marys hospital and this is monitored to ensure good infection control practices.
- Delivery rooms meet with Department of Health regulations
- A review of the midwifery staffing to ensure sufficient staff are available to provide one to one care in labour.
- Medicines are stored at the appropriate fridge temperature and are recorded daily.
- Medicines are stored safely and securely including intravenous fluids. This should be in line with current legislations, trust's policies and standard operating procedures.
- Appropriate dates are placed on medicines once opened.
- Patient group directions are correctly completed and in-date for staff to use.
- Flooring is accessible for cleaning purposes and equipment is clean and protected from dust.
- There is a robust process for calling for emergency assistance in the theatre complex.
- There is appropriate support for patients with a learning disability including better flagging and referral for patients to specialist
- Equipment on the wards is in date and stored in a safe manner.
- The five steps to safer surgery checklist is appropriately completed.
- Review the emergency theatre arrangements to ensure patient safety and wellbeing is not adversely affected.
- The staffing levels and skills mix is assessed in all areas and staffing is delivered as planned.
- Patient records are secure stored so as not to breech patient confidentiality and to prevent unauthorised access, particularly in medicine and maternity departments.
- All staff participate in mandatory training.
- Risk register includes all factors that may adversely affect patient safety.

Summary of findings

- Learning from incidents are embedded in practice.
- Implement a flagging alert system to identify Looked After Children within the trust
- Ensure secure access arrangements to the paediatric unit are in place out of hours.
- Implement policies and protocols for children and young people for absconding or for restraint.
- Patients and members of the public are informed of the safety thermometer results.
- Where relevant, DNA CPR forms must be endorsed by a consultant grade doctor.
- There is a clear and measurable action plan which details how they will improve patient outcomes with regard to the organisational targets and key performance indicators as measured in the National Care of the Dying Audit.
- Service leads review how they use data to improve patient outcomes.
- An end-of-life care policy is developed that addresses the withdrawal and withholding of life-sustaining treatment for critical care patients.
- That end of life care patients are given sufficient opportunity to identify their preferred place of care.
- There are no mixed sex breaches in critical care.

Action the hospital SHOULD take to improve

- Consultant presence in the delivery suite meets the Royal College of Gynaecologists and Obstetricians guidelines.
- Clear guidelines for staff regarding the maximum numbers of women accepted the induction of labour.
- Conduct a needs analysis to ensure the service is meeting the needs of the local population.
- Develop clear plans to deliver the maternity service strategy.
- Encourage improved working relationships between senior midwives and their managers.
- Patients in the department are correctly identified with name bands in a timely way.
- Review necessary improvements to achieve referral to treatment time targets.
- There is a robust process used for monitoring requests for agency and bank nurses and whether they are fulfilled or not.
- A patient is given the opportunity to wash or clean their hands before meals.
- Staff check equipment regularly, and equipment is maintained or replaced in line with trust policy.
- Staff complete risk assessments and actions required to reduce risks to a patient, in a timely way.
- Appropriate arrangements happen with the local mental health trust to improve patient assessment and out of hours support.
- Staff are offered regular supervisions and appraisals to promote staff development.
- Training provision should ensure all staff have an accurate understanding of the trust's deprivation of liberty safeguards policy.
- Improvements in the care pathways for stroke and heart failure are embedded and sustained.
- A decrease in the number of bed moves, and patients moved overnight.
- An increase in the number of complaints responded to within 25 working days.
- Delayed discharges from CCU should be improved including out of hours discharges from the unit.
- Resuscitation trolleys in the critical care unit should be tamper-evident.
- Mandatory training updates for critical care staff should meet trust targets ensuring staff complete updates in essential and core training.
- Development of a safety checklist for patients undergoing invasive procedures such as insertion of central venous catheters.
- Access to a follow-up clinic for patients discharged from the critical care unit should be further developed and to include better access for psychological and other support.
- The hospital improves the access and flow of patients in order to reduce delays from critical care for patients being discharged to wards.
- There is dedicated dietetics support for patient in critical care.
- Policies and procedures should be regularly reviewed to provide up to date guidance for staff including withdrawal of treatment policy.

Summary of findings

- Support and develop the paediatric service so it can deliver service-wide strategy and vision.
- Outpatient clinics are planned to meet the specific needs of children.
- Play therapists are used by the outpatient department to help children cope during outpatient procedures.
- Documents within electronic records for patients are filed appropriately once scanned to enable clinicians to find relevant information effectively.
- Departmental and team meetings are held at an agreed frequency to enable good communication between managers and staff.
- Seven day service provision in diagnostic imaging is reviewed and monitored to ensure stability of staffing.
- Managers in diagnostic imaging provide forums for staff engagement.
- All staff within outpatients and diagnostic imaging are aware of the department strategy.
- There is an agreed set of performance indicators for end of life care to measure service quality in a timely manner.
- There is a process for monitoring whether patients who express a wish to die at home are able to do so and that any delays in discharge are recorded and reviewed.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services	Good	We rated the service in the emergency department (ED) as good for safe, effective, caring, responsive and well-led. We saw a high standard of care and treatment delivered by competent, caring and compassionate staff. The department had a culture of safety where incidents were reported. Learning was shared and changes made as a result of this. The department was visibly clean. Staff adhered to infection control procedures. Equipment was available, fit for purpose and clean. However, medicines were not always appropriately managed and stored. The department had appropriate medical staffing levels that included a consultant present for 12 hours a day and senior medical cover for 24 hours per day. There was an appropriate number of suitable trained and skilled nurses in the department. There was a lead nurse for the unit, as well as skill mix of emergency nurse practitioners, advanced nurse practitioners and children's nurses. There were a low number of nursing vacancies within the department. Agency staff were seldom used as staff worked flexibly to provide appropriate skill mix and staffing levels. Recruitment to a small number of vacancies was ongoing. The safeguarding requirements for children, young people and vulnerable adults were understood, and there were appropriate checks and monitoring in place. However, there was no flagging system to identify patients with a learning disability. The department provided effective care that followed national guidance and this was delivered to a high standard. Pain relief was offered appropriately and the effectiveness of this was checked. Multi-disciplinary work was in evidence and the department ran its services seven days a week. Patients gave positive comments about the care they received, the attitude of the staff. Patients and relatives told us they were treated with

Summary of findings

compassion, dignity and respect, and staff were observed treating them with kindness and courtesy. Patients' were kept informed of treatment options and were involved in decisions about their care.
The service had some improvement to make in consistently meeting the 4 hour emergency access target of 95%. The hospital was not consistently meeting the national emergency access target of 95% of patients who required hospital admission to be transferred to a ward or discharged from ED within four hours. However, this target was achieved in 5 months in the last year, and was above 90% for a further 5 months.. Patients were however, assessed and treated within standard times. There was good support provided for patients with a mental health condition and patients living with dementia.
The ED was well led by senior nurses and doctors, and the departmental strategy and vision was recognised by staff. The culture within the department was one of accessible leadership with mutual trust and respect, leading to the maintenance of an effective team. There was appropriate monitoring of incidents, quality and performance by senior staff.

Medical care (including older people's care)

Good

Overall we rated medical care as 'good'.
We found that medical care (including older people's care) was good, for effective, caring, responsive and well led and 'required improvement' for safe.
Processes and procedures were followed to report incidents. Themes from incidents were discussed at ward meetings and staff were able to give examples where practices had changed as a result of incident reporting. Staff adhered to the trust policy of bare below the elbows and the use of personal protective equipment. Nurses and healthcare assistants spoken with had a good knowledge of safeguarding and their responsibilities in raising concerns.
There was sometimes a shortage of staff on the medical and older people's wards and safer staffing levels were not always met. The trust set a target of

Summary of findings

90% compliance for all staff with mandatory training. This target was not achieved, this meant patients were at risk of being cared for and treated by staff who lacked updated knowledge and skills.
A never event occurred in August 2015 involving the wrong site procedure in the dermatology department. Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. When we inspected in January 2016, the trust had not yet agreed and implemented a key action; to implement a new dermatology surgical checklist.
Medical care services used specific pathways and protocols for a range of conditions, based on national guidance such as National Institute for Health and Care Excellence (NICE) guidelines.
Hospital standardised mortality ratio was within the expected range. The trust performed above the England average on all three measures of the Myocardial Ischemia National Audit Project (MINAP) audit 2013 t0 2014. Outcomes for people who use services were below expectations in relation to heart failure treatment and care following a stroke. The trust had been slow to implement improvements in stroke care, but action plans were in place to drive improvements.
Multidisciplinary working was widespread and effective. There were arrangements for ensuring patients received timely pain relief. Patients at risk of malnutrition or dehydration were risk assessed by appropriately trained and competent staff. Staff made referrals to dieticians or speech and language therapists as required.
Feedback from patients and their relatives was nearly always positive about the way staff treated them. The culture we observed amongst all staff groups was caring and supportive. Staff encouraged patients and relatives to be partners in their care and make decisions. There was some inconsistency in interactions which caused distress.
Medical services were responsive to patients' needs. The acute medical admissions ward, the rapid assessment consultant evaluation unit (RACE) for patients over 80 years of age, and the medical investigations unit had contributed to the trust's ability to support older patients and manage the

increasing demands for beds. The trust was working with partners to improve the coordination, safety and timely discharge of patients. However, there was a high number of delayed transfers of care.
Staff took complaints seriously and responded in line with trust policy.
There was support for vulnerable people, such as people living with dementia and a learning disability. Staff applied the Mental Capacity Act appropriately, and the associated Deprivation of Liberty Safeguards.
Senior staff outlined the vision and strategy for their department. The leadership was strong and supportive, and staff worked well together. Staff felt valued by their immediate line management and said they were comfortable reporting incidents and raising concerns.
Quality and risk was assessed and monitored through audit. The matrons discussed actions to be taken forward at clinical leads meetings and risk meetings held for general medicine and department of medicine for elderly people. Risks, such as workforce, had been taken to the trust board. The senior team met with the executive team quarterly to present quality reports for medical wards and specialties, and department of medicine for the elderly.
Systems were in place to gain patient feedback and use it to improve services. The trust was involved in the 'After Francis Research Project', which involved gathering patients' experiences. Where required, action plans had been developed to improve patient experiences.

Surgery **Good**

We rated safe as requires improvement because of shortfalls in areas of medicines management, cleaning, storage of patient records, the environment and equipment and surgical checklist compliance. Staff did not consistently complete the 'Five steps to safer surgery' check list to minimise risks of patient harm. In theatres, there was no emergency call system for staff to call for assistance in an emergency. Patient records were stored in unsecured areas, presenting a risk of breaching patient confidentiality.
However, staff were encouraged to report incidents and generally received feedback about reported

Summary of findings

incidents. A recognised acuity tool was used and was continually developed to determine required nurse staffing levels. There were systems in place to assess and respond to patient risks and records were generally legible and comprehensive.
Patients received care and treatment that followed national clinical guidelines and staff used care pathways based on evidence-based research. Staff audited patient treatment and care, and used the findings to improve outcomes for patients. Patients commented positively about the skills of staff, the quality of food and the provision of pain relief. Staff completed training relevant to their roles. Most staff had a good understanding about their responsibilities towards the Mental Capacity Act and associated Deprivation of Liberty Safeguards
There was effective team working within and across different staff groups. This included multi-disciplinary working to provide person centred care. Staff commented that local leadership within the service was good and there were opportunities for personal and professional development.
Patients told us that staff provided care in a kind and compassionate manner and they were involved in decisions about their care. Results of patient feedback, as well as quality and safety data, were displayed for patients and visitors to view on ward areas.
Performance data showed, with the exception of trauma and orthopaedic surgery, the hospital was not achieving the referral to treatment times for 92% of patients to be on a waiting list for less than 18 weeks for surgery. Cancellation rate for operations was similar to the England national average. The percentage of patients whose operation was cancelled and were not treated within 28 days was lower (better) than the England average. Trauma and orthopaedic patients were frequently allocated beds on general surgical and medical wards. The trust mitigated risks to these patients with a trauma and orthopaedic outlier medical team that provided the medical care and treatment for trauma and orthopaedic patients on non-speciality wards.

Summary of findings

There was an effective governance structure to review performance and there was evidence of formal reviews of risks, incidents, deaths, complaints and audits.

Critical care

Requires improvement

We rated critical care services as requires improvement overall with elements of innovative and outstanding care. We rated safety and responsiveness as requires improvement. Caring is rated as outstanding, effective and well led are 'good'.

There were generally safe systems for the management of infection control, medical records and equipment. Infection control procedures were followed for the prevention and control of infection. Equipment in CCU was standardised to minimise the risks of errors as all staff were familiar with these.

However, not all medicines were consistently stored safely and securely which may impact on patients' health and safety.

Patients received care and treatment in line with national guidance and best practice. There was a process for assessing risks such as pressure ulcers falls and venous thromboembolism (VTE) and care plans were developed to help manage these effectively. However the unit was not fully compliant with two National Institute for Health and Care Excellence (NICE) guidelines which pertained to critical care patients.

There was a holistic and multidisciplinary approach to assessing and planning care and treatment for patients. The CCU was using critical care bundles to ensure compliance with national best practice. Care bundles ensure key aspects in the general care of a critically ill patient were regularly identified and checked.

They used recognised critical care pathway for assessments and treatment of patients. All staff were engaged in monitoring and improving outcomes for patients.

The multi- disciplinary team worked collaboratively and provided care tailored to patients' individual needs. Patients and their families were involved in their care as much as possible.

Summary of findings

There were adequate numbers of skilled nursing and medical staff to provide safe and effective care. The unit was consultant led and medical staffing met the recommended standards and consultants were available at all times for advice and support. Feedback from patients and their relatives was overwhelmingly positive. Staff ensured patients experienced compassionate care which promoted privacy and dignity. People's cultural, religious and personal needs were respected. Although support and links for patients with a learning difficulty were not well developed.
The vision and strategy for the service was known by staff. There was monitoring of performance and quality which fed into the trust wide dashboard. Innovative support for patients, such as the development of patients' diaries, was encouraged and valued.
There was evidence of strong local leadership in the unit. Leadership, governance and culture within the service were used to drive and improve patients' care.

Maternity and gynaecology

Good

Maternity and gynaecology services were rated good for effective, caring, responsive and well led-services However we rated safe as requires improvement.
Clinical safety incidents were not consistently reported. Midwives told us that they were unable to report incidents due to staffing pressures.
Systems and processes for monitoring infection control standards were not always reliable or appropriate to keep people safe. The delivery suite environment was difficult to keep clean. We noted emergency obstetric equipment and equipment required to remedy a tongue tie in the antenatal clinic was dirty and also sterile equipment had expired**. There was a risk of a hospital acquired infection if the equipment had been used..**
Staffing levels and skill mix were not always planned, implemented and reviewed. Midwives told us the last staffing assessment had taken place in 2012 and this had not been updated to reflect the increase in activity in the service. The midwife to birth ratio did not meet national guidelines. The funded midwife to birth ratio was 1:31. Between April to September 2015 the midwife to birth ratio

Summary of findings

was 1:32-33. The Royal College of Obstetrics and Gynaecology guidance (Safer Childbirth: Minimum standards for the Organisation and Delivery of Care in Labour, October 2007) states there should on average be a midwife to birth ratio of 1:28. The England average was 1:29. Midwives were unable to consistently provide one to one care for women during labour.

Consultant presence on the ward was 60 hours per week compared to the Royal College of Obstetricians and Gynaecologists good practice recommendation of 98 hours per week. The consultants provided a further 108 hours per week on call.

Overall attendance at mandatory training updates was below the trust's 95% target. There was a risk that not enough staff had attended updates to ensure they had suitable training to care for women safely.

Midwives followed comprehensive risk assessment processes from the initial booking appointment through to post-natal care. Identified risks were recorded and acted upon across maternity and gynaecology services.

The gynaecology ward participated in the NHS Safety Thermometer**.** That is a local improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care. The ward conducted monthly audits in respect to patient falls, pressure ulcers, catheters and urinary tract infections. However, information about the audits was not displayed. It is considered to be best practice to display the results of the Safety Thermometer audits to allow staff, patients and their relatives to assess how the ward has performed.

Care and treatment was delivered in line with current legislation and nationally recognised evidence based guidance. Women had access to a variety of methods for pain relief throughout the service. Feedback from women and relatives about their care and treatment was consistently positive. We observed women were treated with kindness, compassion and dignity throughout our visit.

Summary of findings

Women had prompt access to gynaecological treatment. For the period January 2015 to December 2015 the hospital exceeded the target of 92% of patients waiting less than 18 weeks for treatment following referral (incomplete pathway). Translation services were available, and some midwives had undergone further specialist training to support women with additional needs such as learning disabilities and drug and alcohol addictions.

There were comprehensive risk, quality and governance structures and systems to share information and learning. Junior staff across the service described an open culture and felt well supported by their managers.

There was no clear strategy for maternity services. Managers told us they had produced a strategy which had not yet been presented to the board. However, the strategy did not have a plan of how its aims would be met. Senior managers did not consistently demonstrate an understanding of current service risks. The concerns regarding delays to care and the inability to consistently provide one to one care in labour had not been documented on the maternity risk register. Senior midwives described a disconnect between themselves and senior managers. They felt unable to speak freely and said they were not listened to.

There were comprehensive risk, quality and governance structures and systems to share information and learning. Junior staff across the service described an open culture and felt well supported by their managers.

Services for children and young people

Requires improvement

We rated the services for children and young people as requires improvement for safety and well led We rated effective, caring and responsive as good.

Our key findings are:

There were not sufficient number of nurses on the paediatric ward based on the Royal College of Nursing guidance. There was not a flagging alert system to identify Looked After Children within the trust. The trust did not have policies such as an absconding protocol and a restraint policy for children and young people. Learning from incidents was not always embedded in practice.

Summary of findings

However, there was openness and transparency about safety, and continual learning was encouraged. Staff were supported to report incidents, including near misses. There were secure access systems in place, however these were not consistently robust on the paediatric wards at night.

Staff were clear about their responsibilities if there were concerns about a child's safety. Safeguarding procedures were understood and followed, and staff had completed the appropriate level of training in safeguarding and other mandatory training. A paediatric early warning system was used for early detection of any deterioration in a child's condition.

Care and treatment was planned and delivered in line with evidence-based guidance, standards and best practice. The individual needs of children and young people were assessed and care and treatment was planned to meet those needs. Care pathways and multidisciplinary records were used to support practice. Staff assessed patients' pain effectively and obtained consent to treatment appropriately and in line with legal guidance.

Staff were trained and had the skills and knowledge required to undertake their role. Staff undertook appropriate competence assessments. Appraisals and supervision took place and this helped staff to maintain and further develop their skills and experience. Services, including access to consultant paediatricians, were provided seven days a week. However, concerns were raised regarding attendance for training for junior doctors.

Feedback from children, young people and parents about the care and kindness received from staff was positive. All the children and families we spoke with were happy with the care and support provided by staff. Staff treated children, young people and their families with compassion, kindness, dignity and respect. Staff worked in partnership with parents, children and young people in their care.

Inpatient services were tailored to meet the needs of individual children and young people. There were good facilities on wards for babies, children and young people and their families. A 24 hour paediatric assessment unit improved patient access and flow through the hospital. There were no

barriers for those making a complaint. Staff listened to the feedback given to them by parents. Play therapy staff ensured children were supported during their hospital stay. Parents told us how they provided a much needed break sometime for them. Play therapists were not engaged by the outpatient department to help children cope during outpatient procedures. There was a risk children would be distressed in the outpatients clinics, as they were treated with adult patients who were treated at the fracture clinic.

There was not a service-wide strategy and vision for paediatric services. The paediatric service had lacked effective leadership until the recent appointment of an acting new matron. This had an impact on nursing staffing as the lack of nurses was not formally highlighted neither on the risk register nor on the quality reports submitted to the executive team.

Staff at all levels of the organisation were proud to work in this department and were familiar with the Poole approach of being compassionate, open, respectful, accountable and safe.

End of life care

Good

End of life care at this hospital was rated as 'good'. We rated the service as requiring improvement for responsive care. We rated the service good for safe, effective, caring and well-led care.

The trust had taken part in the National Care of the Dying Audit (NCDA) between 2013 - 2014 and at that time had not achieved six out of the seven key organisational targets and scored below the national average for six of the ten clinical key performance indicators. In the 2014 – 2015 NCDA the trust performed better than the national average in 10 out 12 measured indicators of performance. The data could not be directly compared as it did not measure against exactly the same performance indicators. However, it did suggest improvement when compared nationally with other end of life services.

Patients were protected from avoidable harm and abuse. There were reliable systems and processes in place to ensure that safe care was being delivered. Staffing levels were sufficient to provide safe care.

Summary of findings

Staff at this hospital delivered person-centred care and treated people with compassion, dignity, kindness and respect. Feedback from patients and relatives was consistently positive.

There was good multidisciplinary working and staff were effectively trained. End of life care formed part of the mandatory training and staff induction programme at this trust. Staff received training in advanced communication which equipped them well when having sensitive discussions with patients and their relatives.

Staff across the trust reported timely access to advice and support from the specialist palliative care team and who were able to meet response times as outlined in the Operational Policy for Poole Palliative Care Service. The end of life care facilitator supported the care of dying patients across the hospital.

Patients were offered a range of pain relief interventions including medication and complementary therapies and pain was assessed, monitored and managed effectively. Staff had good working knowledge of end of life pain medicines to include anticipatory prescribing.

The leadership for end of life care was good. Service leads have produced a five year strategy which includes seven day working for the specialist palliative care team. The overalls aims and vision for end of life care were well understood by staff working in specialist palliative care and the trust had an awareness of the need to embed the strategy with staff working across the whole hospital. The Director of Nursing provided end of life care leadership at trust board level and had good oversight of end of life care issues across both the hospice and the main hospital.

The trust were undertaking regular audits to assess some patient outcomes in specific areas. However, the trust did not have an agreed set of performance indicators in order to measure the quality of the service on a continuous basis. The trust were collecting a variety of patient data at a local and national level but were not effectively using the data to improve patient outcomes.

Summary of findings

DNA CPR orders were not always recorded by, or endorsed, by a consultant which meant decisions being made a patients resuscitation status may not have been shared by the consultant in charge of the person's care.
The trust operated a Rapid Discharge Home to Die (RDHD) pathway which served to discharge patients who were diagnosed as dying with 24-48 hours if they expressed a wish to die at home. Local audit results from March to April 2015 showed that patients were not being discharged within 24 – 48 hours and the trust could not demonstrate improvement following this audit. Patients who were dying and had expressed a wish to die at home were not routinely discharged in a timely way. The trust were not routinely monitoring discharge delays for patients on the RDHD.

Outpatients and diagnostic imaging

Good

We found the outpatients and diagnostic departments at Poole Hospital were good for safe, caring, responsive and well-led services.
Staff were encouraged to report incidents and the learning was shared to improve services.
Staff compliance with mandatory training was good in outpatients and diagnostic imaging.
Two radiographers worked overnight and were responsible for plain film X-rays for the main hospital and the emergency department. One on-call radiographer carried out computerised tomography (CT) scans and worked alone if called in. Radiographers reported a heavy workload and raised issues regarding manual handling. Between 10.00pm and 8am, radiology was supported by an overnight, outsourced radiologist service. Staff confirmed that this service worked well and did not compromise patient care.
In diagnostic imaging, staff were confident in reporting ionised radiation medical exposure (IR(ME)R) incidents. Staff followed procedures to report incidents to the radiation protection team and the care quality commission.
The environments were visibly clean and staff followed infection control procedures. There were monthly environmental audits carried out by the infection prevention team. There was appropriate management and storage of medicines. Records were available for clinics using an electronic

document management system. Patients were assessed and observations were performed, where appropriate. However, there was not a tool in use to help identify a deteriorating patient.
Nurse staffing levels in the department were appropriate to patient needs, and there were few vacancies (approximately 8% at November 2015). Radiographer staffing levels were five vacancies (25%) across the service. Staff reported this affected the on-call rota and was placing a strain on their workloads. However, there was an ongoing recruitment plan for nurses and radiographers.
There was evidence that care was being provided according to National Institute for Health and Care Excellence (NICE) guidelines.
Staff had access to training and had annual appraisal but did not have formal clinical supervision.
Staff provided compassionate care, and ensured patients and relatives were well supported whilst in the department. Patients were well informed and routinely involved in the planning of their care and treatment. Staff recognised when a patient required extra support to be able to be included in understanding their treatment plans. Patients and relatives we spoke with gave us positive feedback about the department.
There was evidence of service planning to meet people's needs. For example, with there had been changes to seven day working in radiology, and a re-design of the therapies directorate. National waiting times were consistently met for outpatient appointments, cancer referrals and treatment and diagnostic imaging. There was good support provided for patients with a mental health condition and patients living with dementia.
Patients whose first language was not English had access an interpreter although some staff were not aware of how to access this service. The self-service checking in system, located in outpatients, presented multiple languages on screen. The service received very few complaints that were upheld and, where possible, concerns were resolved locally.
Governance processes to monitor risks and quality required further development in the outpatient and diagnostic department.

Summary of findings

Staff were not clear about the overall vision and values of the trust but told us that the departmental patient experience and the provision of high quality care was their main concern. All staff spoke of the 'Poole Approach', which is a culture, embedded across the whole trust.

Nursing staff in the outpatient department felt well supported by their immediate line managers. They told us that they felt well supported and valued. However, some staff in diagnostic imaging did not identify a strong leadership presence and did not feel well supported. All staff said they enjoyed working for the trust due to the strong team support from colleagues.

Public and patient engagement occurred through feedback such as surveys and comment cards.

Poole Hospital

Detailed findings

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

Detailed findings

Contents

Background to Poole Hospital

Poole Hospital is the hospital provided by Poole Hospital NHS Foundation Trust. The trust gained foundation status in 2007 and provides services to a local population of around 500,000 people, although this figure rises significantly between May and September each year, as Dorset is a popular holiday destination.

Poole Hospital has approximately 638 inpatient beds. The hospital provides the following services: urgent and emergency care, medical and older people's care, surgery, critical care, maternity and gynaecology care, care of the young person, end of life care, and outpatient and diagnostic services. Poole Hospital is the trauma unit for East Dorset and the designated Cancer Centre for Dorset, providing medical and oncology services for the whole of the county, serving an approximate population of 750,000.

The Trust has an unusual case-mix, undertaking a very high proportion of non-elective work, with only 15 acute trusts across the country delivering a higher percentage of non-elective activity. Given the distribution of acute services within east Dorset, the Trust does not provide the usual range of elective services, with orthopaedics, urology, ophthalmology and interventional cardiology being largely provided by the neighbouring trust in Bournemouth.

We inspected this hospital as part of our planned, comprehensive inspection programme. We carried out an announced inspection visit to the hospital from 26-28 January 2016, and additional unannounced inspection visits from 8 -10 February 2016.

We inspected this hospital as part of our planned, comprehensive inspection programme. We inspected each of the eight core services.

Our inspection team

Our inspection team was led by:

Chair: Dr Nick Bishop

Head of Hospital Inspections: Joyce Frederick , Care Quality Commission

The team of 49 included CQC managers, inspectors and analysts, and a variety of specialists including a consultant in intensive care medicine, consultant gynaecologist and obstetrician; consultant surgeon; consultant geriatrician, consultant radiologist; consultant paediatrician, specialist registrar doctor with experience in emergency medicine, emergency care consultant nurse, midwife, theatre nurse, paediatric nurse, neonatal

nurse, palliative and end of life care nurse; critical care nurse; board-level clinicians and managers, a governance lead; two safeguarding leads, a junior doctor and one expert by experience.

How we carried out this inspection

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

We carried out an announced inspection visit to Poole Hospital during 26-28 January 2016. We visited unannounced during the period 8-10 February 2016.

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

We held listening events at a local library and shopping centre on 14 January 2016. This enabled local people to tell us about their views and experiences of Poole Hospital NHS Foundation Trust.

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

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

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

Facts and data about Poole Hospital

Key facts and figures

Context and activity.

- This organisation has one location: Poole Hospital, which provides services to a local population of 280,000 in Poole, East Dorset and Purbeck. This rises between May and September to approximately 500,000 as it is a popular holiday destination.
- There are 638 inpatient beds. In 2014-2015 , there were 36,682 inpatient admissions, 346,384 outpatient attendances, and 66,118 ED attendances.
- The Clinical Commissioning Group (CCG) for this trust is Dorset CCG.
- In January 2016, the trust employed 3180 (Whole Time Equivalents) staff, of which 420 were medical, 898 nursing and 1862 'other'.
- The trust has an annual turnover of £215,321,000, and in 2014/15 the deficit was (-) £4,940,000.
- Bed occupancy overall was higher than the England average.

Safety (trust wide).

- There was one never event reported in the trust and 88 serious incidents between August 2014 and July 2015.
- There were 8,884 events reported to the National Reporting and Learning System (NRLS) in August 2014 –

July 2015. The rate of NRLS reported incidents per 100 admissions is 45% higher than the England average: 12.2 per 100 admissions, against an England average of 8.4 per 100 admissions.

Number of incidents - % (E**ngland average)**

Deaths 1 - 0.01% (0.1%)

Severe harm 1 - 0.01% (0.4%)

Moderate harm 182 - 2.0% (4.0%)

Low harm 3124 - 35.1% (21.8%)

No harm 5576 - 62.7% (73.7%)

- There were 19 cases of C Diff in this trust between August 2014 and July 2015, and one case of MRSA.

Effective (trust wide)

- There were no mortality risks identified for the trust in the May 2015 Intelligent Monitoring report.

Caring (trust wide)

- This trust performed similarly to other trusts in the CQC 2015 in-patient survey. It had consistently better scores than the England average for both the PLACE indicators and the Friends and Family test.
- The trust has had a steady number of complaints between 2011 and 2015 with no discernible trends. There has been a 10% increase in complaints over this period.

Responsive (trust wide)

- A&E four hour standard – not met; Overall above the England average. 95% target met for five months from April to September 2015. 90% was achieved for a further 5 months from January 2015-16.
- Performance data showed, overall, the hospital was achieving the referral to treatment times for 92% of patients to be on a waiting list for less than 18 weeks for surgery.
- 46% of delayed transfers of care in the trust are due to "waiting for further NHS non-acute care" or "awaiting care package in own home" (both higher than the England average. Compared to the England average, the number of patients delayed due to "completion of assessment" is relatively low. (see figures below).
- There were 3142 patients awaiting residential home placement or availability; that equates to a percentage of 17.1% which is higher than the England average of 10.9%
- There were 2639 patients awaiting nursing home placement or availability; that equates to a percentage of 14.3% which is higher than the England average of 12.6%
- 1564 patients were awaiting completion of assessment; that is 8.5% which is much lower than the England average of 18.1%
- The trust was meeting cancer waiting times for patients to see a specialist within 2 weeks and from decision to treat to first definitive treatment within 31 days. The trust also met the waiting times target for from 2 Week Wait referral to first definitive treatment within 62 days (April 2014 to October 2015) in 14 out of the 19 months. Overall performance for this period was 86.6% (target ≥85%).

Well led (trust wide)

There are 3180 (WTE) staff working in this trust. The numbers of staff by staff type are given below.

Staff type FTE (% BME figures not available)

Nurses 898

Doctors 420

Other 1862

Total 3180

(NB: 'Other' includes AHPs, other clinical staff including healthcare and maternity care assistants, and non-clinical staff.)

- Staff sickness absence rate has varied across time, but the rate has been lower than the England average.
- As at March 2015, the contracted WTE medical headcount was approximately 418, and the skill mix percentage for each grade of doctor is: Consultants 39.37%, Middle Career 11.58%, Registrar group 33.17% and Juniors 15.88% (total 100%).
- Performed similar to the England average for the majority of indicators in the NHS Staff Survey, but also achieved 5 positive findings and 6 negative findings (out of 31 indicators).

Detailed findings

- Performed as expected to the England average for all indicators in the GMC National Training Scheme Survey.

CQC intelligent monitoring

- In the latest Intelligent Monitoring report (November 2015), this trust had two risks and no elevated risks.
- The priority banding for inspection for this trust was six (the lowest priority band), and their percentage risk score was 1.6 %. The risks identified were potential under-reporting of patient safety incidents resulting in death or severe harm and composite of Central Alerting System (CAS) safety alerts indicators.

Our ratings for this hospital

Our ratings for this hospital are:

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

Notes

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

Urgent and emergency services

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

Information about the service

The emergency department at Poole Hospital serves a population of around 500,000 people in Poole, East Dorset and the Purbecks. The trust gained foundation status in 2007. The emergency department provides a service 24 hours a day, seven days a week. Last year the emergency department last year saw 66,118 patients, of these 24% were children.

Although the emergency department designated as a trauma unit, it does not provide specialist major trauma support as there is a major trauma centre located at Southampton General Hospital. The hospital trauma service treats patients with hip fractures from the neighbouring NHS hospital. There is a higher than average number of elderly people in the area, with 30% of the population being over 65 years of age.

The department was purpose built and had a refurbished majors area re-opened in December 2015. The department consists of a waiting room for walk in patients, with a reception area. There is a triage room off of the main waiting area as well as a separate waiting room for children. There are four minors' cubicles and a treatment room for children. The majors' area had access for ambulances to a three bedded resuscitation room. The majors' area within the department had 14 bays as well as four cubicles that can be used for children. There was a minor illness service provided within the ED. However, this service was provided by South West Ambulance Service and was therefore not inspected.

During the inspection we observed the care and treatment of patients, and looked at 24 treatment records. We spoke with approximately 24 staff, 13 patients, and 7 relatives.

Urgent and emergency services

Summary of findings

We rated the service in the emergency department (ED) as good for safe, effective, caring, responsive and well-led. We saw a high standard of care and treatment delivered by competent, caring and compassionate staff.

The department had a culture of safety where incidents were reported. Learning was shared and changes made as a result of this. The department was visibly clean. Staff adhered to infection control procedures. Equipment was available, fit for purpose and clean. However, medicines were not always appropriately managed and stored.

The department had appropriate medical staffing levels that included a consultant present for 12 hours a day and senior medical cover for 24 hours per day. There was an appropriate number of suitable trained and skilled nurses in the department. There was a lead nurse for the unit, as well as skill mix of emergency nurse practitioners, advanced nurse practitioners and children's nurses. There were a low number of nursing vacancies within the department. Agency staff were seldom used as staff worked flexibly to provide appropriate skill mix and staffing levels. Recruitment to a small number of vacancies was ongoing.

The safeguarding requirements for children, young people and vulnerable adults were understood, and there were appropriate checks and monitoring in place. However, there was no flagging system to identify patients with a learning disability.

The department provided effective care that followed national guidance and this was delivered to a high standard. Pain relief was offered appropriately and the effectiveness of this was checked. Multi-disciplinary work was in evidence and the department ran its services seven days a week.

Patients gave positive comments about the care they received, the attitude of the staff. Patients and relatives told us they were treated with compassion, dignity and respect, and staff were observed treating them with kindness and courtesy. Patients' were kept informed of treatment options and were involved in decisions about their care.

The service had some improvement to make in consistently meeting the 4 hour emergency access target of 95%. The hospital was not consistently meeting the national emergency access target of 95% of patients who required hospital admission to be transferred to a ward or discharged from ED within four hours. However, this target was achieved in 5 months in the last year, and was above 90% for a further 5 months. Patients were however, assessed and treated within standard times. There was good support provided for patients with a mental health condition and patients living with dementia.

The ED was well led by senior nurses and doctors, and the departmental strategy and vision was recognised by staff. The culture within the department was one of accessible leadership with mutual trust and respect, leading to the maintenance of an effective team. There was appropriate monitoring of incidents, quality and performance by senior staff.

Urgent and emergency services

Are urgent and emergency services safe?

Good

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

We rated safe as good.

- Incidents were reported by staff, these were investigated appropriately and the learning shared across the department. There was evidence that changes had been made to processes and clinical practice as a result of incidents.
- Staff knew about their responsibilities under the Duty of Candour, and gave an apology and feedback to patients and relatives after an incident. Senior staff regularly attended mortality and morbidity meetings and shared the learning from these.
- The department was visibly clean and well maintained. There was compliance against infection control standards. There was an agreed cleaning rota for the department, and protocols for cleaning areas where there was deemed to be a risk of infection.
- Patients attending the department with a gastrointestinal problem were isolated from other patients in cubicles to reduce the risk of spreading infection.
- There was an open reception desk and a separate suitably-equipped waiting area for adults and children. There were appropriate arrangements to maintain the security of staff and other patients such as CCTV and panic buttons.
- There was a safe system of triage in the department, provided for the prompt initial assessment of patients with minor injuries. There were robust systems in place for the transfer of critically ill children.
- The majors area consisted of 14 beds and three cubicles, and an appropriately equipped three bedded resuscitation room for adults and children. There was a suitable room provided for the relatives of critically ill patients in majors.
- The minor injuries area was staffed primarily by emergency/advanced nurse practitioners to provide a service for children and adults. This service had good access to X-rays that provided a responsive service. There was an additional minor illness service run by the ambulance service to increase patient turnaround.
- Staff received appropriate mandatory training, and used recognised tools to detect deterioration in adults and children. Staff were aware of the safeguarding of vulnerable adults and children. Children's safeguarding checks were always undertaken, and processes were in place to escalate concerns to the appropriate authority.
- Medicines were generally stored and managed correctly.
- Records were available to clinical staff when they needed them, and were kept secure to ensure the privacy of patient's information.
- There were an appropriate number of suitably trained and qualified nursing and medical staff in the department across 24 hours.
- There were plans for a major incident, and the department had access to appropriate equipment if required. The staff were aware of the major incident plan and had received training.

However,

- The reception desk did not allow a patient to discuss their health problems without the risk of being overheard by other patients booking in or waiting patients.
- Although the department provided separate waiting room and assessment room for children. It was difficult for staff to have a view of the children's waiting area and treatment room. Staff preferred to use more observable cubicles for children. This however, was the closest cubicle in the minors adult area.
- Patients' were not given identification bands in a timely way to ensure they could be accurately identified, especially in the event of transfer to another department in the hospital. This had caused delays in patients' diagnostic tests being carried out.
- The drug fridge in the resuscitation room was kept unlocked, no risk assessment had been carried out for this.
- Patient group directions that allowed nursing staff to administer patients certain medicines were found to be out of date.
- Staff participation in mandatory training was significantly below the trusts' target of 95%.

Incidents

- Medical, nursing and support staff were aware of their responsibilities to report incidents and we saw examples that had been submitted.
- Incidents were reported using a trust wide electronic system, all staff had access to this, and could describe what defined an incident. Staff understood the value of reporting "near misses", and we saw evidence of this. Managers responded to the reporter of submitted electronic incident reports within 48 hours. Feedback from minor reported incidents was shared with staff at handover, team meetings and staff training days.
- Thorough investigations of serious incidents were carried out and a report produced by the nominated investigator. We saw examples of root cause analysis that were detailed and ensured that staff and patients involved in the incident had been appropriately supported.
- There were systems in place to ensure that learning from incidents was shared throughout the emergency department (ED). For example, after a particular incident had been investigated, a checklist had been devised to ensure that a nerve block was given in the correct place.
- Staff told us that there were governance and staff meetings which included learning from incidents. The matron for the urgent care group produced a monthly newsletter that was shared across the department, staff told us that this was useful.
- Staff were aware of the requirements of Duty of Candour when giving feedback about incidents to patients and relatives. 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.
- The senior sister was the departmental lead for the Duty of Candour requirements. Duty of Candour actions, including the apology, were recorded on the root cause analysis of an incident. We found evidence of this being used.
- Mortality and morbidity meetings were held every two months, these were also attended by doctors and nurses of Anstey Ward (the assessment unit), to ensure that any learning was shared. These meetings were minuted and the outcomes were shared widely through staff meetings.

Cleanliness, infection control and hygiene

- The department was visibly clean. There were hand sanitising gels in use around the department, and notices reminding visitors to use this. We saw that people entering the department complied with this request.
- There were sufficient facilities for hand washing around the department.
- Hand hygiene audits were carried out on a monthly basis: any results with below a 95% compliance rate were escalated by the infection control team. The department met the 100% hand hygiene audit target for five months. However, this target was 80% or below in four of the months between February and October 2015.
- Staff complied with the 'bare below the elbows' policy in clinical areas, and monthly audit demonstrated compliance. Gloves and aprons were available for staff to use when they needed them.
- Monthly audits were carried out by the infection control team, to ensure the cleanliness of facilities and equipment. We saw equipment that had been cleaned and was labelled as ready for use.
- Chemicals required for cleaning a blood spill (or other body fluid) were stored appropriately and were available for staff to use.
- There were no reported incidences of MRSA or Clostridium difficile in the department. Patients admitted with a suspected gastrointestinal infection were isolated from other patients in a cubicle and infection control precautions taken. The cubicles would be "deep cleaned" after the patient had been discharged from the department, and before use by another patient.

Environment and equipment

- There were two reception desks, and receptionists had a good view of the waiting room. In the event of an incident in the waiting area there was a "panic button", this alarm would summon security and the police. A receptionist was on duty 24 hours a day.
- There was no barrier between the reception staff to maintain patients privacy when book-in, however, there were plans in progress to provide one. It was difficult for staff to provide privacy at the reception desk when booking in. However, receptionists' were concerned that physical barriers would impede communication.

- A triage room led directly off the waiting room, where patients with minor injuries could have an initial assessment by the triage nurse or emergency nurse practitioner (ENP).
- There was also a second assessment room, where patients with a minor illness would be streamed from the list of waiting patients. The patients were seen by an advanced nurse practitioner that was provided by Primary Care. This service ran seven days a week between the hours of 1pm to 8pm Monday – Friday, and 10am-10pm at weekends.
- There was a separate waiting area for children. However, there was no staff oversight of the children's' waiting area and no CCTV. There was also a suitably decorated cubicle in minors in which children could be treated. However, due to the inability of staff to see patients, ENPs told us that they often preferred to use the first cubicle in minors for children as this was larger and could be more easily observed.
- There was a relative's room for use when patients were admitted by ambulance directly into the majors' area of the department or the resuscitation room. This room was also used for assessment of patients presenting with a mental health problem. The relatives room had been risk assessed for psychiatric liaison network accreditation in October 2015. Although the room had two exits and an alarm system, the new chairs were not floor fixed. Staff told us that this work had been requested. A potential ligature risk identified from a blind cord, was not replaced as it was a type that would break if it was misused.
- The resuscitation room was divided into three bays, one of which was equipped for infants and children. Resuscitation equipment was checked daily, and a record of this signed by staff every day.
- Suitable equipment was provided for the transfer of critically ill adults around the hospital, and this was regularly checked. There was also transfer equipment for children Medications for the transfer of these patients were appropriately stored and checked.
- There were appropriate waste management processes in place that ensured segregation and secure disposal. Bins for the disposal of sharps (needles and other sharp medical devices) were available for use in the resuscitation room.
- The department was tidy and fit for purpose, with equipment maintained in good order. Electrical devices we checked had been tested. There was a record of equipment kept, this had due dates for planned preventative maintenance of devices. The list showed that the schedule of equipment maintenance was up to date.
- There was good access to x-ray and the CT scanner. X-rays and CT scans were ordered electronically and were available 24 hours a day. Out of hours' an external provider reported on radiological images and advised medical staff.
- We saw there was spare equipment stored in the ambulance access corridor. The department's blood gas analysis machine was on a trolley in the main ambulance corridor, and there was a risk that this essential piece of diagnostic equipment was vulnerable if bumped by a patient trolley. If this equipment was damaged it would affect patient care, and another machine would have to be used elsewhere in the hospital. There was a plan to build storage for this equipment.
- The main waiting room was equipped with accessible toilets; these had facilities for changing babies. There was a vending machine available for snacks, and water was available for patients and relatives in the waiting room. There were posters advising patients not to eat and drink unless they have been told they can by a member of staff.

Medicines

- The storage of medicines within the department was mostly appropriate and safe. This included the storage of controlled drugs (CDs). These were checked regularly and reconciled against stock levels. There was a process in place for the disposal of CDs. Medicines used in emergencies were checked daily
- Medicines were stored correctly in the department, including medicines that were used to transfer critically ill patients around the hospital. Medicines and intravenous fluids were stored in a locked room.
- Refrigerators for temperature controlled storage of medicines were kept locked and the temperatures were checked. However, the refrigerator in the resuscitation room was not locked. This refrigerator was freely accessible to staff and patients and was on view. We raised this as a concern during the inspection and another lockable refrigerator was found.
- The department used patient group directions that allow some medicines to be dispensed by nurses. These were found to be out of date, this was escalated to

senior staff during the inspection. Many of the senior nursing staff such as emergency nurse practitioners were able to prescribe medicines themselves and did not require the use of patient group directions.

Records

- Records for patients attending the ED were paper based during their stay in the department. These paper records were scanned onto the computer system before discharge or admission, to allow good access to the records of patients who have attended the department. This computer system was protected by passwords. Paper records were held in the department for a month in case of a patient returning, these were destroyed securely after this period. Administrative staff checked patient records to see if there were any follow up appointments that were required.
- There were different coloured notes held in the department for frequent attenders. There were copies of care plans available for clinical staff to refer to for these patients. Care plans for these patients were also available to view by staff from a secure shared electronic file.
- Patient flow through the department was recorded on a dedicated computer system. This system allowed staff to see when patients arrived, and when they were approaching the four hour target. The system allowed investigations to be ordered. There was a risk identified with this as scans and X-rays had been ordered for the wrong patient previously. Pop-up warning messages on the electronic system, designed to provide extra checks were put in place and this had not reoccurred.
- Access to electronic records was protected by passwords, and data was backed up safely.
- The records we reviewed during our inspection included pain scores and the use of the early warning systems but this was inconsistent. For example, the sepsis screening questions on patient records were not always ticked.
- Ten sets of children's records we reviewed included comprehensive safeguarding checks.
- Nursing records also included informal risk assessments for pressure ulcers, falls and infection control. Nursing staff completed a check list to assist them to identify patients who were vulnerable or at risk of mental health problems. Observations and transfer plans were recorded.
- Patients' in the majors area had their national early warning scores (NEWS) recorded in their record. The patients' NEWS was displayed on a whiteboard and included details of when their physical observations needed to be repeated, blood tests and investigations. Patients were only referred to by their surname. Although this did not protect the patient's identity, errors had occurred in documenting interventions and NEWS on the white board when using initials. Therefore, a decision was taken to use the patient's surname instead.
- The COAST early warning system was used for children that attended the department.

Safeguarding

- There was a safeguarding policy and procedure in place and this was understood by staff.
- Receptionists knew how to escalate any concerns they had if the system flagged any child attending the department repeatedly. Staff conducted safeguarding checks on all children that attended the department. Documentation verified that this was always carried out for children. There was a pathway in place to guide staff with the safeguarding and treatment of women and girls that were at risk of female genital mutilation.
- Adult safeguarding training had been completed by 76% of nursing staff, this was below the trust target of 80%.
- Children's safeguarding mandatory training had been completed by 72% of nursing and 40% of medical staff.
- In the minor treatment area of the department there was a pathway on display to assist staff in the management of suspected domestic violence.
- There was a lead ENP for children in the department that delivered the safeguarding level 1 and level 2 mandatory training.

Mandatory training

- The trust submitted data about staff attendance at mandatory training. This indicated that records were kept of training, and training opportunities were available for staff.
- Participation in mandatory training was above 82% but the trust's target was 95%. The infection control training was attended by 79% of doctors and 71% of nurses; Manual handling training by 100% of doctors and 70% of nurses.
- The trust data on mandatory training showed that attendance on other training modules such as, conflict resolution, health and safety and fire was 85% for doctors and nurses, this was below the trust target.

Urgent and emergency services

Assessing and responding to patient risk

- There was inconsistent use of patient identification bands in the department. We found that less than 50% of the 11 patients in the department when we checked had an identification name band. This does not comply with the National Patient Safety Agency guidance on the Standard for Patient Identifiers for Identity Bands (2009) and WHO guidance (2007). This had impacted on patient care when investigations were delayed while identification name bands were sought from the department.
- Incorrect labelling of patient blood samples was the highest low harm incident in the department. We did not see a plan to reduce incorrect labelling of blood samples.
- Data provided by the trust (July 2013 – August 2015) showed that the trust performed consistently better than the national average with an immediate initial assessment. The trust median time to initial assessment was 2-3 minutes, compared to the England average of 4-6 minutes, and the national standard of 15 minutes. The trust time to treatment was better than the England average since October 2013.
- Patients who were critically ill or required resuscitation were brought by the ambulance crew directly into the resuscitation room. This facility was appropriately equipped for the resuscitation of adults, children and babies. The ambulance service would phone to ahead to allow the department to prepare to receive such a patient if the situation allowed. A kit of equipment and medicines was available to support clinical staff in transferring critically ill patients around the hospital. This equipment was checked monthly and after use. The contents were checked and found to be in date. There was an appropriate store of controlled drugs located in the resuscitation room.
- There were dedicated staff allocated to care for patients in the resuscitation room.
- Staff monitoring a patient's condition used the National Early Warning Score (NEWS) to ensure that deterioration was detected and escalated appropriately. For children the COAST Paediatric Early Warning Score was used.
- In the event of a critically ill child attending the department there were processes in place for immediate referral to a paediatrician. There was a protocol in place that critically ill children requiring transfer to a specialist facility elsewhere would be collected directly from the hospital by the Southampton and Oxford retrieval team (SORT). The SORT team would provide specialist staff to support the child during the transfer.
- There were four cubicles in the minors' area that was managed by emergency nurse practitioners (ENPs) who offered a service between 7.30am and midnight. This service was in the process of being extended to ensure quick treatment times for walk in patients.
- The majors' area had fourteen bays and four cubicles. There was a separate room that was equipped for suturing and was only used for this purpose.
- Patient flow issues meant that corridors were sometimes used to accommodate patients on trolleys who were awaiting treatment. Staff understood the potential risks posed by this, and ensured that patients were moved as soon as possible depending on their clinical needs. If patients need privacy for assessment or toileting, a cubicle would be used for this.
- Patients with fractured neck of femur that had been diagnosed at the neighbouring NHS hospital and would be transferred to Poole when a bed became available. Sometimes these transfers happened with little warning. Consultants were in the department for at least 12 hours per day, but there was a suitably experienced doctor in the department across 24 hours.

Nursing staffing

- The department had a low vacancy rate for nursing staff. The department was able to cover a shortfall in staffing with bank nurses. There was a global text system and a Facebook page to help get bank staff if they were needed. There was minimal use of agency nurses across the department for this reason. Shifts were planned ahead against agreed numbers of staff required for each shift. There was a plan in place to increase the number of trained nurses at night. Any shifts that could not be adequately staffed on the rota would be escalated against this.
- The unit had a number of ENPs who were managed and supervised separately from the departments nursing staff. The ENPs' led the minor injuries service and provided a 'see and treat' service.
- The co-ordinator did the immediate first assessment of the patient and decided on the acuity of the patient. Along with the NEWS score this helped them make the decision where the most suitable place of care was within the department.

- Handovers for nursing staff were conducted in front of a centrally located screen that displayed the ED electronic patient system. This area was screened off by a glass partition to ensure that it would be difficult for patients to overhear confidential information.
- The department did not use a specific handover tool, to help with communication.
- There were separate handovers for medical and nursing staff, as their shift times differed. Although we discussed this best practice with senior staff there were no immediate plans to alter this.
- Two trained children's' nurses were employed in the department. There were good links to the paediatric wards, and adult nurses had development option to rotate to the wards. The department had a lead advanced nurse practitioner as recommended by the Royal College of Paediatrics and Child Health recommendations (2012).
- There were staff that maintained the department's supplies and housekeeping staff.
- The department had its own porter to assist with ward transfers. The porter would help out the general portering service, but would treat ED requests as first priority.

Medical staffing

- There were 5.75 consultants on the medical rota: this accounted for 23% of medical staffing. The consultants we spoke to told us they spend 6 ½ hours in the department at weekends. The consultant cover provided is therefore not compliant with the requirement of 16 hours per day. The department was however, actively recruiting more consultants.
- Middle grade doctors (registrar group) were in the department 24 hours per day. There was a higher than average number of registrars employed by the trust (52%), the average for England is 39%. Middle grade doctors told us that they were able to access education and training. The trust did not employ any middle career doctors, but this was compensated for by the higher number of registrars.
- Junior doctors had an organised programme of learning, and told us that they were well supported by senior medical staff. Junior doctors rated their experience in the department highly.
- Departmental consultant-led reviews occurred daily at 8am, 1pm and 5pm and were attended by the nurse in charge, junior doctors and ENPs. The purpose of these handovers was to ensure everyone had an overview of how the department was running. Handovers also had a significant educational element, particularly for junior doctors and were observed being used well. Additionally information from these meetings would inform the bed meeting which looked at capacity across the hospital.
- There was no specific handover tool used, this was identified as a risk on the departments risk register. A suitable tool was being adapted for use in the department, it was not clear when this was to be implemented.
- The department were trialling the use of two ENPs as majors' practitioners (MAPs) to support critically ill patients in the majors' area. These staff were already ENPs developing the MAPs role and if successful would see an increase in ENP numbers.

Major incident awareness and training

- There was a major incident response plan for the ED. Staff were given training on how this plan would be implemented, there was a training compliance rate of 88% for nurses and 90% for doctors. The major incident response plan had been last reviewed in March 2015.
- Materials and supplies for dealing with hazardous materials that may be required in the event of an incident were available and stored securely in dedicated storage area outside the department.
- Security for the department was poor, with free public access to the majors' area. There was CCTV in use 24 hours a day, this was recorded. There were security officers on site that were trained in de-escalation and restraint techniques. A panic button at the main desk and another in the main office would summon police to the department. This was infrequently used however.

Are urgent and emergency services effective?

(for example, treatment is effective)

Good

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

We rated effective as good.

- Evidence based and up to date guidance was used across the department. Local audits were undertaken to measure the department against national standards. There was appropriate monitoring of performance against national targets. The results of audits were used to improve treatment.
- Food and drinks were always available for patients that were able to eat and drink. Pain relief was given in a timely way and its effectiveness checked by staff.
- Patient outcomes were collected and monitored by staff in line with the clinical standards. Staff understood and followed critical pathways for sepsis, asthma and paracetamol overdose. There was a stroke pathway in place.
- Staff were trained and supervised appropriately. There were educational opportunities available for all grades of medical and nursing staff. There were suitable arrangements in place for the supervision and appraisal of staff.
- Patients were cared for by a multidisciplinary staff team to assist with assessment, diagnosis and treatment. Staff worked effectively together to provide patient care in a coordinated way.
- The department had 24 hours access to scans and X-rays seven days a week. This included the use of MRI scans and endoscopy. There was also timely access to other services such as critical care, emergency surgery, and physiotherapists.
- Staff had immediate access to patient information. There were robust systems and processes to ensure that information was kept secure, but was available to all clinical staff that needed access to them.
- Patients consent for treatment, observation or examination was always sought by staff treating them. When people lacked mental capacity to make decisions, staff understood their responsibilities around making best interest decisions. Staff were aware of the impact of the Mental Health Act (2005) and the Deprivation of Liberty Safeguards.

However,

- There was a low appraisal rate for medical staff in the department. This was a known problem across the trust and more appraisers were being employed.

Evidence-based care and treatment

- Policies based on National Institute of Health and Care Excellence (NICE) and College of Emergency Medicine (CEM) guidelines were used in the department, some were accessed via the intranet. Posters were displayed in discreet clinical areas to highlight changes to clinical guidance and to raise awareness. Guidance was discussed at risk and governance meetings, disseminated and acted upon as appropriate.
- A range of clinical care pathways was used that aligned with national guidelines, such as the Sepsis Six and the Golden Hour.
- Care was provided in line with 'Clinical Standards for Emergency Departments' guidelines. The department fully participated in Royal College of Emergency Medicine audits that were facilitated by a consultant.
- The 'Sepsis Six' had been implemented across the department, to prioritise timely diagnosis of patients admitted with infections. Early treatment of sepsis reduces complications and improves outcomes for patients. The sepsis pathway was available for staff on the coordinators station in the majors' area. We saw that the departments new system for immediate escalation of potential septic patients was been used in line with CEM guidance. However, in six patient records we reviewed the sepsis screening flag questions were not completed.
- Staff had access to databases that provided information on the treatment of patients that had ingested poisonous substances. They also had access to local policies and procedures via the staff intranet.
- Medical staff told us that there were no barriers to providing timely access to CT scans for patients attending the department with suspected stroke. This included out of hours' services.
- The department was re-auditing its compliance against the CEM standards on the treatment of sepsis, as it was aware of the poor performance in the previous audit and needed to evaluate the changes that had been put into place.
- The ED undertook a range of audit activities, these related to clinical issues as well as flow through the department. Audits were carried out on clinical issues such as subarachnoid haemorrhage pathways, acute kidney injury and management of sepsis, as well as the CEM. These audits were in addition to those required by commissioners. There were also audits on flow such as time from X-ray request to completion, major trauma deaths and trauma call audit.
- Internal audits took place regularly on infection control and environmental checks.

Urgent and emergency services

Pain relief

- Pain scores were used as part of the normal observations to record patients' pain and to ensure that medicines for pain were effective. However, the use of pain tools was inconsistent.
- We did not find any evidence that pain scoring tools specifically designed for children were being used in the department.
- Records demonstrated that a patient's pain was assessed as part of the initial triage to allow early access to pain relief for patients. This was in both minors and majors.
- Patient group directions were in use to enable pain relief medicines to be administered by nursing staff without a prescription. However, these were found to be out of date, and this was escalated during the inspection. The department told us this would be rectified as quickly as possible.
- The 2014 A&E survey reports that the department is better than other trust in England for the speed of patients receiving pain relief when they requested it. The survey also reports that the department was better than other trusts' for the question, "Do you think the hospital staff did everything they could to help control your pain?"

Nutrition and hydration

- Patients who required intravenous fluids had these prescribed, administered and recorded appropriately.
- Patients who were assessed as able to eat and had been in the department over a meal time were offered food and drinks. Relatives attending with critically ill patients were also offered refreshments.
- If a patient had to wait in the department, a meal could be ordered for them.
- There was a vending machine for snacks located in the waiting area, and water was available.
- The 2014 A&E survey reported that patient's ability to get suitable food and drinks whilst in the department was about the same as other trusts in England.

Patient outcomes

- The department took part in national audit schemes such as the College of Emergency Medicine audit for the measurement of vital signs and repeat checks during the attendance at ED. Junior doctors were encouraged to participate in these audits.
- The department had implemented a range of measures to ensure that patients who had infections were screened for sepsis and treated quickly. Data from the severe sepsis and shock audit 2013/14 showed that the department performed below the standard of similar departments in England. Vital signs for Sepsis were recorded within 15 minutes of arrival in 43% of cases. Intravenous fluids were given within an hour in 38% of cases, the CEM audit (2013/14) identified this as key indicator. Antibiotics were administered in the department in 93% of cases, and 28% within 1 hour. Since the audit a sepsis pathway had been introduced where the initial assessment identifies any flags for sepsis, and the pathway is added to the patient's record. Figures provided by the trust for antibiotic administration within 1 hour were 81% in November 2015 and 76% in January 2016.
- In the Asthma in children audit 2013/14 the ED were in lower – middle range against the clinical indicators.
- The Paracetamol overdose audit results for 2013/14 showed that the ED was better compared with other trusts for giving treatment compliant with the medicines and healthcare products regulatory agency guidelines.
- The department performed similarly to other trusts in England in the mental health in ED audit 2014/15.
- The department performed similar to other trusts for the initial management of the fitting child 2014/15.
- The computer system ensured that patients' with certain potentially serious conditions were seen by a consultant before being discharged.
- The unplanned re-attendance rate within seven days (July 2013 – August 2015) had been consistently better than the England average.

Competent staff

- The trust data showed that 42% of medical staff had received an appraisal between April and October 2015. The trust were aware that a higher number of appraisals were completed in the last quarter of the year, and they were looking at ways that this could be spread more evenly throughout the year.
- Nursing staff completed a competency based training folder to complement practice based learning. Trust data reports the ED nursing staff compliance with appraisals averaged 85% from February 2015 to January 2016. The majority of experienced staff had completed immediate life support training, in addition 19 had completed paediatric life support.

- The department used a computer system linked to the roster to record mandatory training. If mandatory training needed to be completed or revisited this was flagged by the system.
- The General Medical Council national survey (2015) indicates that junior doctors rate their learning in the ED highly. The workload indicator in the survey showed that the ED is significantly better than the England average.

Multidisciplinary working

- There was effective multidisciplinary working within the ED. We observed positive team relationships between doctors, nurses and other staff, this was a notable feature of this department.
- Staff reported good working relationships and clear lines of clinical responsibility with specialist teams who were called to review patients in the department.
- The emergency department had access to a therapy service to facilitate discharge for patients with complex needs. This was hosted by the rapid assessment consultant evaluation (RACE) unit, but was accessible to ED.
- There was a minor illness service provided by the trust that was located near the department. Some patients attending the emergency department were seen by this service if they attend with a minor illness.
- There was a trust alcohol care and treatment service for staff to refer patients to. This service provided advice for staff and patients. Patients that frequently attended the ED with alcohol related problems would be seen by an outreach team.
- A substance misuse liaison team was available for doctors to refer to. Patients would be seen on the ward or as outpatients. However, there was no specific ED liaison available. Consultants told us that there is not a large substance misuse problem in the area, so a dedicated liaison team was not necessary.
- Access to mental health assessment was through a local Dorset University Healthcare NHS Foundation Trust. The staff reported to us that there were sometimes delays to timely mental health assessment. There were long delays for the assessment of young people with mental health problems.

Seven-day services

- The department was in operation seven days a week, 24 hours per day.
- Consultants were not present in the department 24 hours a day. However they did provide senior clinical advice 24 hours per day, seven days per week, either directly within the department or on-call from home. A consultant on-call would always attend a trauma call.
- Emergency nurse practitioners provided a nurse led treatment service in minors between 7.30am and 12pm every day
- There was access to pathology and diagnostic tests within the across 24 hours.
- There was access across 24 hours to x-ray and CT scans. Reporting on x-rays and scans was done out of normal hours by an external provider. Although there had been some feedback about early problems in getting CT scans authorised, these had now been rectified and the system was reported as working well. Whilst we were there, we observed this process in action where a CT was ordered and swiftly carried out.

Access to information

- All paper patient records generated during an episode of care were scanned onto an electronic record when the patient was discharged or transferred out of the department. This meant that there was immediate access to records for any patients re-attending ED.
- Paper records were held in the department for patients that frequently attended the department. These contained agreed care plans for these patients.
- Access to all electronic records was protected with passwords.
- Discharge summaries were completed for patients efficiently within 48 hours, and these were sent to GPs electronically where possible.
- Although, the Joint Children's Protection Register (a system for checking if children have been at risk of abuse) was not used for all paediatric attendances a series of safeguarding questions were asked of adults that accompanied any child to the department. The ED electronic system would flag to staff if the child had re-attended the department.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Nurses and doctors asked patient's consent before carrying out observations and examinations. Consent was requested verbally and documented in patient notes.

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- Consent forms were available for people with parental responsibility to consent on behalf of children they were responsible for.
- We did not see anyone who required a Mental Capacity Act assessment during inspection and were only able to ask staff about this.
- Patients that required mental health support received this service from Dorset HealthCare University NHS Foundation Trust (DHUFT).
- Staff also received assistance from DHUFT with regards to the assessment of mental capacity to consent to treatment.
- Staff had awareness of the requirements of the Mental Capacity Act, and could demonstrate knowledge of processes around the Deprivation of Liberty Safeguards (DoLS).
- The trust safeguarding team were available to advise and support staff if there was a patient that required an application for a DoLS. There was guidance information available for staff on the trust intranet.

Are urgent and emergency services caring?

Good

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

We rated caring as good.

- The emergency department (ED) staff were welcoming, and did all they could to provide patients with privacy when booking in. We witnessed staff treating distressed patients with kindness and compassion.
- Staff in the department treated patients and their relatives with dignity and respect. Staff met the needs of patients promptly, including pain relief.
- Emotional support was provided for patients and their relatives in the department. There was a room that could be used to accommodate the relatives of critically ill patients brought into the majors' area. Whilst in the room, staff ensured that families were given regular updated information.
- The chaplaincy team were available over 24 hours, and were able to provide additional support for patients and their relatives.

Compassionate care

- The reception desk was open and welcoming, but if two patients were speaking to receptionists there was no partition to enable privacy for the conversation. It was possible to hear a patient giving their personal information to the receptionist from the waiting room seating. Receptionists told us that they had tried various approaches to enhance patient privacy, and a new screen was being fitted to divide the reception desk.
- We observed nurses and doctors providing care in the department. Staff demonstrated respect for the individual's personal, cultural and social needs of patients. Staff spoke to patients in a respectful and considerate manner. Consent was sought from patients before undertaking treatment, observation or examinations. Staff took time to ensure that children and their parents were fully informed about care and treatments.
- We observed that dignity and respect for patients was maintained at all times during treatment or examination. There were signs on curtains to remind staff and relatives that they needed to ask permission before entering. We saw these used consistently across all areas of the department.
- Staff responded promptly to the needs of patient's in the department, including responding to requests for pain relief. Staff introduced themselves to the patients that they would be responsible for while they were in the department.
- Medical staff dealt carefully with the psychological needs of patients, and understood its impact on the patient's condition.
- Staff respected the confidentiality of patient's information and care records at all times.
- The NHS Friends and Family test results (July – September 2015) showed that the 87% of patients would recommend the department, this had been consistently similar to the England average. The A&E survey 2015 showed that the ED performed better than the England average in the specific areas of the explanation of the patient's condition, tests and treatment in a way that they could understand.

Understanding and involvement of patients and those close to them

- There was a relative's room in the majors' area that was used to accommodate relatives of critically ill patients in the resuscitation room. Staff told us that relatives using this room were regularly updated on the condition of the patient.
- The department had links to help patient's carers access a support group.
- We observed that relatives of patients being treated in majors were kept informed of plans for investigations and treatments. There was proactive support available for the parents of sick children attending the department.

Emotional support

- The Senior Sister in ED was leading on a liaison scheme with chaplaincy service, where recently bereaved relatives can receive follow-up, following a death in the department.
- There were trust chaplaincy services available 24 hours a day for patients or relatives who needed them. This included access to religious and emotional support through periods of distress. The department staff told us that they felt this service was underutilised however. The chaplaincy service also offered patients access to multi faith support.
- Most relatives and patients we spoke to were very happy with the service, as they were kept informed and assessed promptly.
- The department was not busy when we inspected, and the patients attending were happy with the care and treatment they received. Relatives commented that staff were caring and maintained the patient's privacy and dignity during assessment and treatment.
- Patients and relatives using the department were informed partners in their care. Medical and nursing staff described tests, investigations and treatment options in simple English and checked patients understanding.

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

(for example, to feedback?)

Good

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

We rated responsive as good.

- Although the trust was not consistently meeting the national emergency access target for 95% patients to be admitted, transferred or discharged within 4 hours, overall the trust performance had been in line or better than the England average.
- An additional service for minor illnesses was provided by primary care. Emergency nurse practitioner availability was increased during periods of predicted high attendance, to increase capacity in the minors' area. Senior staff provided a rapid assessment and treatment service, this included a consultant clinic follow up.
- There was adequate and suitable seating in the waiting area. The department was fully accessible to people with physical disabilities.
- There were translation services available for patients whose first language was not English. Sign language interpreters could also be made available for patients that needed them. Patient information was available for patients to take away, and could be provided in other languages on request.
- The needs of patients living with dementia were assessed by staff. The ED provided assessment services for patients with a mental health problem.
- Information was available for patients or relatives that wished to raise a complaint about the department. Complaints were dealt with appropriately by the trust. Changes were made in response to complaints from patients and relatives.

However,

- The trust reported 72 black breaches between November 2014 and October 2015. This is when ambulances are not able to hand over patients within one hour. A lack of physical capacity in the hospital was the main reported reason for this.

- The percentage of patients waiting 4 -12 hours in the department for a bed in the hospital had been decreasing since October 2014. However, the trust still remains below the England average.
- There was no mechanism for the prompt identification of a person with a learning disability attending the department.

Service planning and delivery to meet the needs of local people

- The ED served the community of Poole, East Dorset and the Purbecks. The ED provided a service 24 hours a day for adults and children. It was the lead receiving unit in the area for trauma patients. This included a high number of elderly patients that had fractured a hip. Patients that attended the ED at the neighbouring NHS hospital. Hospital would be transferred to Poole Hospital for surgery. The ED provided facilities for resuscitation, major injury or illness as well as minor injuries. The service was appropriately staffed by doctors and nurses with additional skills and training. The nearest major trauma centre was at Southampton General Hospital.
- The triage room was adjacent to the waiting room to allow for rapid assessment of patients.
- A minor illness service for GP patients operated by South West Ambulance Service was available for patients attending with minor illnesses. The advanced nurse practitioner would screen the patients attending the department to see if any required treatment for minor illness. This service was not inspected as it was not provided by the trust.
- The ENP service hours were increased during periods of anticipated high attendance such as over bank holidays and during local public events, to increase capacity.
- The trust liaised with Dorset University Healthcare NHS Foundation trust to provide psychiatric assessment services. This link assisted the department with patients who were needed to have their mental health status assessed, or detained under the Mental Health Act.

Meeting people's individual needs

- The waiting room had sufficient suitable seating for patients and relatives. There was a separate waiting area for children. However, this was under-used and we noticed children sharing the main waiting room with adult patients. The children's waiting room was decorated and equipped with toys suitable for younger children. However, there was no specific provision aimed at young people.
- We observed a young person with a learning disability waiting in the majors area as there was no available space on the children's ward. This young person was nursed next to adult patients.
- There was a flagging system in place for children and young people with long term conditions to ensure that they were prioritised. The patients had open access to the paediatric service.
- Translation services were available over the telephone for patients who were unable to communicate in English. This service could be accessed by staff 24 hours a day and was provided by an external contractor.
- There was no passport system in use that helped identify patients with a learning disability. There was no formal mechanism for ensuring that patients with a learning disability were given a priority. There was no mechanism for the trust to be able to identify numbers of patients with a learning disability attending the ED or those admitted to wards.
- The department had a 'memory box' for patients living with dementia. We observed this being used very effectively. There was also a Forget-me-not flower symbol attached to the notes to discreetly communicate to other staff that the patient was living with dementia.
- There was a box of resources for use with patients who were at end of life in the department. If there was a patient at end of life in the department, a butterfly symbol was placed on the cubicle door to let staff know this in a discreet way.
- Children up to the age of 18 years could have a 'green card' completed that identified an early need to the triage nurse.
- The ED was designed so that there were separate facilities for adults and children. The children's waiting room was separate from the main waiting area, with toys and appropriate seating.
- A patient brought to the department close to the end of life (with a known condition) would be given end of life care in a specific cubicle. This cubicle had discrete access from the resuscitation room so that deceased patients could be seen by their families and friends in a less acute environment.

- There were advice leaflets available for patients in the ED minors' area. These were provided for adults and children. Advice leaflets in different languages could be provided for patients via the Patient liaison and advice service.
- Basic equipment suitable for patients with a high body weight could be provided to the department from within the hospital.

Access and flow

- Black breaches occur when an ambulance has arrived with a patient but it is not possible to handover the patient to ED staff within one hour. The trust reported 72 black breaches between November 2014 and October 2015. There was a spike in occurrences in December 2014. A lack of bed capacity within the hospital was the main reported reason for this. In December 2014 the hospital reported a bed occupancy rate of 99% indicating that there would have been a difficulty in accommodating patients.
- Ambulance handovers delayed over 30 minutes occurred on 1153 occasions (November 2014 – March 2015). However, this had improved significantly since the opening of majors B area in December 2015.
- The ambulance median time to treatment was around the standard of 60 minutes (and the England average) between July 2013 and August 2015. The most recent data in August 2015 shows a median time to treatment of 64 minutes.
- The trust was not consistently meeting the national emergency access target for 95% patients to be admitted, transferred or discharged within 4 hours. The 95% target was met between May 2015 and August 2015, and again in September 2015. Overall the trust performance had been in line or better than the England average but averaged 91% (April 2015 – November 2015).
- The percentage of patients waiting 4 -12 hours in the department for a bed in the hospital had been decreasing since October 2014. However, the trust still remains below the England average.
- The approximate time patients could expect to wait was displayed in the waiting room.
- Patients leaving without being seen were on average 3% between July 2013 and September 2015 this was above the England average.
- The nurse in charge attended a trust bed meeting twice a day to share the capacity of the emergency department and understand bed availability across the hospital. In the event of there being poor availability of beds across the hospital, these meetings were held three times a day.
- Ambulance transport for patient requiring discharge home on a stretcher was provided by an external contractor. This external provider was responsible for delays that stopped the department reaching its four hour target for discharge on 15 occasions (January – December 2015).
- The ED used performance dashboards to check and share performance information with staff and the ambulance service.

Learning from complaints and concerns

- There was information in the waiting room to inform patients how to make a complaint. Staff advised us that they gave patients who expressed a concern a PALS leaflet. There was also a leaflet that explained why patients were waiting in the ED.
- Complaints were managed effectively by the trust. Although the numbers of complaints had risen slightly, the number of complaints upheld had remained the same. Formal complaints were handled by the senior sister in ED and the matron in charge of emergency care.
- A complaint about the cleanliness of the waiting room had been received by the department. In response, the waiting room cleaning was increased to three times a day.

Are urgent and emergency services well-led?

Good

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

We rated well-led as good.

- Governance and quality monitoring processes were effective across the department. There was a weekly meeting to discuss quality and outcomes. There were also governance meetings that included mortality and morbidity reviews, this was shared with Ansty Ward, and clinical staff attended these

- The staff in the department spoke highly of senior nursing and medical staff who promoted an open culture, and learning from incidents. Staff felt safe to raise concerns. Staff commented on the strong team focus that cut across all disciplines and grades.
- The leadership and staff actively looked for improvement to services from evidence of incidents, complaints and near misses.
- Staff were highly engaged with their department and expressed their pride in the service they provided to local people.

Vision and strategy for this service

- The service had a clear vision for the near future. This included continued primary healthcare provision for the management of patient attending ED with minor illness. It also included an expansion of emergency nurse practitioner service to increase capacity in majors by the development of majors' practitioners within ED.
- The longer term strategic planning of the service had been held until the outcome of the Dorset clinical services review. This however had not halted developments within the department.
- Staff were aware of the departmental strategy and quality priorities. They were also aware of the importance of the outcome of the clinical services review.

Governance, risk management and quality measurement

- Departmental governance processes were robust, with learning shared across the team.
- The risk register clearly identified risks within the department such as patient flow and the impact on quality and finance from four hour breaches. The risk register also identified mitigations and gaps and was shared with the board of directors.
- Governance meetings were held regularly and were attended by medical and nursing staff. Mortality and morbidity meetings took place to ensure that learning and if necessary, change of practice occurred.
- The ED used performance dashboards to check and share performance information with staff and the ambulance service.

Leadership of service

- Nursing leadership was effective: the senior nurse was supported by the matron for medicine and urgent care. Staff told us that they felt the nursing leadership in the department to be experienced and knowledgeable, as well visible and approachable. There was also strong medical leadership from the lead consultant (clinical director) and his team. Junior and middle grade doctors told us that they felt well supported by the consultants in the department. They recommended the department as a place to work.
- The leadership team were proud of the warm and friendly atmosphere in the department. All staff we spoke with identified a strong team ethos as being one of the unique features of the department.
- Staff reported to us that they were listened to, and felt safe to raise concerns to senior staff.
- The senior team at the trust such as the director of nursing, chief operating officer and Chief Executive were approachable, and contactable if needed.

Culture within the service

- We found the culture in the emergency department to be open to new ideas and learning from incidents. The team were supportive of each other and staff were happy to report concerns. Staff told us that they felt that they were respected and valued by managers.
- There was a culture of openness in discussing and reporting incidents. The service was focused on the needs of patients and the need to make changes based on risk.
- Junior doctors told us that the consultants worked well with their counterparts in medicine and surgery. Medical staff reported good relationships with speciality doctors that attended the department to see patients that had been referred to them. There were agreements in place about the pathway for certain conditions, this ensured there were no delays to referrals being accepted by speciality doctors.

Public engagement

- The senior sister of the department kept copies of patient feedback and letters of comment or complaint.
- Patients that we spoke to were very supportive of the department and felt that it existence in Poole was under threat due to the clinical services review. They were keen to tell us of good experience in the department.
- The matron was often accompanied on walk arounds by a member of the public.

- Patients and their relatives were encouraged to complete the friends and family survey, we saw evidence that changes had been made on response to comments.

Staff engagement

- The staff across the department were actively engaged and proud of the service they delivered. They were particularly proud of the caring ethos of the department that was facilitated by excellent teamwork.
- Staff engagement was high despite the pressures on the service and changes to nursing leadership. Senior staff met regularly with departmental staff both clinical and managerial to discuss any issues of concern or update. The senior team had an 'open door' policy and was easily contactable, the trust had promoted this.

Innovation, improvement and sustainability

- The department team supported the culture of continuous improvements to practice. All roles of staff actively participated in local and national audits.
- The ED participated in research projects and trials such as CRASH3. A research nurse was employed by the department to coordinate the research activity.
- There was a consultant led review clinic for scaphoid (wrist) injuries and limping child. Scaphoid injuries could have an MRI scan performed in order to detect hidden injuries.

Medical care (including older people's care)

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

Information about the service

Poole Hospital provides medical services for Poole and East Dorset and cancer services for Dorset. Between July 2014 and June 2015, 48% of the medicine care group activity was day case medicine and 50% was treatment of emergency inpatients. The main specialties were general medicine (39%), geriatric medicines (20%) and dermatology (11%).

Poole hospital's medicine care group provides general and speciality medical care including, cardiology, gastroenterology, endocrinology, rheumatology, neurology, endoscopy and dermatology, care for the elderly, acute stroke care and stroke rehabilitation. In addition, the hospital runs the Dorset Cancer Centre, with inpatient and day-case facilities for oncology and haematology. We inspected; Ansty (acute medical admissions), Coronary Care Unit, Arne Ward (respiratory), Avonbourne ward (gastroenterology, diabetes and endocrine), Cranbourne 4 (Medical Investigations Unit and medical elective and escalation ward),Rapid Assessment Consultant Evaluation unit (acute assessment unit for people over 80), Lytchette ward (older people's care), Lilliput ward (older people's care), Lulworth ward (older people's care, with focus on cognitively impaired patients), Kimmeridge Ward (older people's short stay care with 14 winter escalation beds), Rockley Ward (acute stroke care, older people's care and stroke rehabilitation, the discharge unit, Studland Outpatients (rheumatology and dermatology), Portland Ward (acute brain injury and neurology), Endoscopy, Durlston ward (medical oncology –haematology), Sandbanks ward (clinical and medical oncology) and the oncology day unit.

During the inspection we visited 16 ward or day-case units during the day time and in an evening and attended shift handovers. We spoke with 20 patients, five relatives and 72 members of staff. These included nursing staff, healthcare assistants, ward clerks, junior and senior doctors, volunteers, pharmacists, physiotherapists, occupational therapists, housekeeping staff, porters, personal assistants and managers. We looked at 23 care records. We observed care and treatment. In addition we received feedback prior to the inspection visit, from listening events held in Poole and via our website. Over 27 comments related to patients' experience of medicine and cancer care. We observed interactions between patients and staff, considered the environment and reviewed a range of management documentation and feedback from other agencies involved with the trust.

Medical care (including older people's care)

Summary of findings

Overall we rated medical care as 'good because;

We found that medical care (including older people's care) was good, for effective, caring, responsive and well led and 'required improvement' for safe.

Processes and procedures were followed to report incidents. Themes from incidents were discussed at ward meetings and staff were able to give examples where practices had changed as a result of incident reporting. Staff adhered to the trust policy of bare below the elbows and the use of personal protective equipment. Nurses and healthcare assistants spoken with had a good knowledge of safeguarding and their responsibilities in raising concerns.

There was sometimes a shortage of staff on the medical and older people's wards and safer staffing levels were not always met. The trust set a target of 90% compliance for all staff with mandatory training. This target was not achieved, this meant patients were at risk of being cared for and treated by staff who lacked updated knowledge and skills.

A never event occurred in August 2015 involving wrong site procedure in the dermatology department. Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. When we inspected in January 2016, the trust had not yet agreed and implemented a key action; to implement a new dermatology surgical checklist.

Medical care services used specific pathways and protocols for a range of conditions, based on national guidance such as National Institute for Health and Care Excellence (NICE) guidelines. Hospital standardised mortality ratio was within the expected range. The trust performed above the England average on all three measures of the Myocardial Ischemia National Audit Project (MINAP) audit 2013 t0 2014. Outcomes for people who use services were below expectations in relation to heart failure treatment and care following a stroke. The trust had been slow to implement improvements in stroke care, but action plans were in place to drive improvements.

Multidisciplinary working was widespread and effective. There were arrangements for ensuring patients received timely pain relief. Patients at risk of malnutrition or dehydration were risk assessed by appropriately trained and competent staff. Staff made referrals to dieticians or speech and language therapists as required.

Feedback from patients and their relatives was nearly always positive about the way staff treated them. The culture we observed amongst all staff groups was caring and supportive. Staff encouraged patients and relatives to be partners in their care and make decisions. There was some inconsistency in interactions which caused distress.

Medical services were responsive to patients' needs. The acute medical admissions ward, the rapid assessment consultant evaluation unit (RACE) for patients over 80 years of age, and the medical investigations unit had contributed to the trust's ability to support older patients and manage the increasing demands for beds. The trust was working with partners to improve the coordination, safety and timely discharge of patients. However, there was a high number of delayed transfers of care. Staff took complaints seriously and responded in line with trust policy.

There was support for vulnerable people, such as people living with dementia and a learning disability. Staff applied the Mental Capacity Act appropriately, and the associated Deprivation of Liberty Safeguards.

Senior staff outlined the vision and strategy for their department. The leadership was strong and supportive, and staff worked well together. Staff felt valued by their immediate line management and said they were comfortable reporting incidents and raising concerns.

Quality and risk was assessed and monitored through audit. The matrons discussed actions to be taken forward at clinical leads meetings and risk meetings held for general medicine and department of medicine for elderly people. Risks, such as workforce, had been taken to the trust board. The senior team met with the executive team quarterly to present quality reports for medical wards and specialties, and department of medicine for the elderly.

Medical care (including older people's care)

Systems were in place to gain patient feedback and use it to improve services. The trust was involved in the 'After Francis Research Project', which involved gathering patients' experiences. Where required, action plans had been developed to improve patient experiences.

Are medical care services safe?

Requires improvement

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

We rated safe as 'requires improvement' because;

- There was a shortage of nursing staffing on the medical and older people's wards. Staff provided cover whenever possible and the service used bank and agency staff, but some gaps remained. Safer staffing levels were not being met consistently particularly in the medicine for older people's department. An impact of unfilled shifts was incomplete fluid charts, and insufficient detail in planning actions to minimise risks to patients.
- A never event occurred in August 2015 in dermatology where the wrong lesion was excised. Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. When we inspected in January 2016, the trust had not agreed and implemented a key action to implement a new dermatology surgical checklist.
- Staff compliance with hand hygiene in medicine was inconsistent.
- Patients were not offered the opportunity to wash their hands prior to meals.
- Staff did not always check emergency equipment in clinical areas, which meant in the event of an emergency staff could not be assured the equipment was available and in working order.
- Medicine fridge temperatures were not monitored appropriately so staff could not be assured medicines were stored at the correct temperatures.
- Patient records were not stored in a way that prevented unauthorised access.
- Compliance with mandatory training was at 83% against a target of 90%. This meant patients were at risk of being cared and treated by staff who lacked updated knowledge and skills.
- Some patient risk assessments and fluid charts were incomplete.

However

- Processes and procedures were followed to report incidents and staff were aware of the Duty of Candour legislation.
- Staff adhered to the trust policy of bare below the elbows and the use of personal protective equipment.
- Compliance with hand hygiene in the oncology wards was consistently greater than 95%.
- The patient-led assessment of the care environment (PLACE) scores were consistently better than the England average for cleanliness.
- Nurses and healthcare assistants spoken with had a good knowledge of safeguarding and their responsibilities in raising concerns.
- Staff knew where to access major incident plans.

Incidents

- There were 46 serious incidents reported in the medicine care group in the 12 months January to December 2015. The largest number of reported serious incidents was for slips/trips/falls which accounted for 44% of all incidents and data showed staff reported these incidents consistently throughout the year.
- There had been one never event relating to medical services. Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. The event occurred in August 2015 and involved a wrong site procedure in the dermatology department. A root cause analysis (RCA) was undertaken following the event and recommendations made. These included implementing a revised dermatology surgical safety checklist. At the time of our inspection in January 2016, the trust had not implemented the new checklist. This meant the risk of similar incidents occurring had not been fully lessened.
- Staff used the trust's electronic recording system to record incidents. These included accidents, pressure ulcers, medicine errors and falls.
- Themes from incidents were discussed at ward meetings and staff were able to give examples where practices had changed as a result of incident reporting. One example was the use of a different nasal cannula with foam on the tubing to minimise the risk of patients developing sores.
- Incidents reviews showed staff investigated and carried out root cause analysis (RCA). They developed action plans to reduce the risk of a similar incidents reoccurring. Ward sisters placed the RCA reports in staff rooms, for staff to read and learn from the recommendations.
- 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 we spoke with were familiar with the concepts of openness and transparency and could give us examples of how they applied these when managing safety incidents.
- The trust had systems and processes for receiving and responding to the Central Alerting System (CAS) alerts. CAS is a web-based system for issuing patient safety alerts, important public health messages and other safety critical information and guidance to the NHS and other providers.
- The minutes of the mortality steering group included national mortality trends and noted that patient deaths at Poole Hospital were within the expected range. The steering group had set up a new weekly meeting for a group of staff, to review regularly the notes of deceased patients to check for any learning.

Safety thermometer

- The NHS safety thermometer is a monthly snap shot of the prevalence of avoidable harms, in particular new pressure ulcers, catheter-related urinary tract infections, venous thromboembolism (VTE) and falls. At the trust, from July to September 2015 97% of care was harm free.
- Information relating to new pressure ulcers was displayed on wards, but not the other elements of the NHS safety thermometer. The trust displayed data relating to falls and 'harm free care'. An explanation of what harm free care meant was only observed in Ansty (acute medical admissions) ward. However, staff on Ansty had not updated this information since June 2015. The sister said she had not received any updated information to display.
- The matrons had identified a trend of an increasing number of pressure ulcers. A health care assistant who had worked with the pressure ulcer prevention team had been seconded to the rapid assessment consultant evaluation unit (RACE) (acute assessment unit for people over 80) unit to educate staff on minimising pressure ulcers.

- The trust's version of safety thermometer information were on public display. However there was no narrative to explain the data or any action staff were taking improve patient safety results.

Cleanliness, infection control and hygiene

- Most of the wards we visited were visibly clean and cleaning schedules were clearly displayed on the wards. The trust scored higher than the national average in the patient-led assessments of the care environment for cleanliness (PLACE) assessments.
- Patients told us the wards and bathrooms were kept clean.
- Ward cleaners used a bespoke cleaning trolley system. They used clean cloths and mops for cleaning different parts of wards, to minimise the spread of infection. If a patient had an infection, cleaning staff cleaned their rooms last, to help control infection risks.
- Staff marked equipment with 'I am clean' labels after cleaning, to show it was ready for use.
- Staff compliance with the trust's 'bare below the elbows' policy ranged from 98% to 100% between January 2015 and September 2015.
- Staff had access to adequate supplies of protective equipment, such as aprons and gloves in varying sizes. We observed staff using this equipment and discarding it between each patient contact.
- Hand hygiene gel was available at the entrance to every ward, along corridors, and at the bottom of each patient's bed.
- Hand hygiene audit compliance between July 2015 and December 2015 was inconsistent, with nine out of the 16 areas in the medicine directorate scoring less than 95% on one occasion or more. The control of infection link nurses had been active in presenting information to highlight the importance of good infection practice to staff. In November 2015, five wards did not submit an audit. The matron discussed this with staff and in December 2015 and audit compliance improved. In the oncology wards compliance was consistently over 95%.
- In November 2015, 74% of staff had completed infection prevention and infection control training. Health and safety training compliance in November 2015 was at 83%. Between July 2015 and December 2015 there no cases of meticillin-resistant staphylococcus aureus (MRSA) bacteraemia, and two cases of meticillin susceptible staphylococcus aureus (MSSA) bacteraemia. Trust-wide, cases of MSSA had fluctuated over the period but had been mainly above the England average. There were ten cases of hospital acquired C. difficile. The number of C. difficile cases remained below the England average between November 2014 and August 2015. The matron in older people wards had identified some concerns with the completion of the C. difficile pathway, and was working with teams to improve compliance.
- When we visited in January 2016, Kimmeridge ward (older people's care short stay ward and 14 winter escalation beds) was closed with norovirus (winter vomiting virus). At the unannounced inspection in February 2016 the charge nurse explained the outbreak had lasted about 10 days with approximately eight patients affected and a small number of staff. The infection had been contained within the ward and the infection control team had started to review the outbreak to see if they could learn any lessons. The trust had placed a sign at the entrance to the hospital, highlighting to relatives the importance of considering their health before visiting. This helped minimise the spread of infections.
- There was a risk patients ate their meals with dirty hands as patients told us they were not offered the opportunity to wash or clean their hands prior to meal times. This was confirmed during our observations, including on Kimmeridge (older people's care short stay ward and 14 winter escalation beds) Ward. Patients' health was at risk from eating with dirty hands.

Environment and equipment

- The medicine care group had completed health and safety work place assessments throughout 2015. These included an assessment of washing facilities, flooring and compliance with manual handling regulations. Many identified issues with the fabric of the wards. Action plans were developed but these had not always been updated.
- The risk register included a risk relating to a lack of space between beds in bays on Lytchett, Lilliput (older people's care) and Lulworth (an older people's care ward with a focus on cognitively impaired patients) wards. There was limited space to use free standing hoists to manoeuvre patients safely and there was no electronic ceiling hoist system. Staff were concerned

about being able to maintain a patient's dignity within the limited space. If a patient fell, and was suspected to have a fracture, staff told us they used a special piece of equipment to raise the patient off the floor.

- Staff knew how to report faulty equipment and said maintenance staff attended to this promptly or provided replacement equipment in a timely manner. This meant they had the equipment needed to provide safe care and treatment. However a broken drug fridge on Lilliput (older people's care) ward had taken a long time to repair or replace. It was still broken when we returned in February 2016 although this issue had been chased by the ward staff. This meant nursing staff had to use a medicine fridge on the ward on the floor below.
- Equipment was maintained and checked regularly to ensure it continued to be safe to use. Clearly labelled equipment showed the date when the next service was due.
- Labels on equipment indicated portable appliance testing (PAT) was up to date.
- On Lytchett (older people's care), Lilliput (older people's care) and Lulworth (older people's care, with focus on cognitively impaired patients) wards staff could not take patients in beds down to the hospital exit except through other ward areas. Staff would have to go through Kimmeridge (older people's care short stay ward and 14 winter escalation beds) ward,Studland Outpatients(rheumatology and dermatology) or the Stroke Care rehabilitation unit. The lifts were only large enough to take patients in chairs or trolleys. In January 2016, Kimmeridge (older people's care short stay ward and 14 winter escalation beds) ward was closed with norovirus, which meant patients were at risk of infection if staff transported them through this ward. Nursing staff risk assessed the need to take a patient through another ward on a case-by-case basis. This risk was not on the risk register.
- Staff did not always carry out daily checks of resuscitation equipment. For example, RACE (acute assessment unit for people over 80) unit had failed two recent audits, through gaps in signing the daily checklist. The resuscitation team undertook audits and reported results to the ward sisters to take appropriate action. During our inspection we found staff had not checked equipment on one day in January 2016, following seven days missed in December 2015.
- On Arne ward (respiratory) a sharps bin was not securely located to minimise the risk of unauthorised access. When we visited again in February 2016, the sharps bins were not two thirds closed on Ansty (acute medical admissions) ward. Staff immediately closed the bins in line with policy when we alerted them to the risk.

Medicines

- The trust were not assured that refrigerated medicines were safe to use or were fully effective because staff did not follow policy to monitor drug fridge temperatures each day. The non-compliance had been discussed at a monthly harm free care group meeting in September 2015. On the acute stroke ward there were gaps in the records for three days in January 2016.
- On RACE (acute assessment unit for people over 80) unit a medicine trolley was closed, but left unlocked and not secured to the wall. The staff nurse immediately locked the trolley when we highlighted this, and secured it to the wall. On the unannounced visit in February 2016, there were two medicine trolleys that were both locked, but only one was secured to the wall. Nursing staff tethered the second medicine trolley to the wall when we pointed this out.
- We reviewed six prescription records and over all these were completed accurately. On Lilliput ward (older people's care) we noticed that staff had not signed a record to show they had given a patient an injection to thin the blood the previous day. The nurse undertaking the early morning drug round had also not identified this omission. We spoke to the ward sister, who agreed an error had been made, and they would raise an incident report.
- Staff in both the RACE (acute assessment unit for people over 80) unit and the discharge lounge explained the medicines patients took home before they left the hospital, to ensure they understood how to take them safely.

Records

- Medical consultants and junior doctors reviewed medical records regularly. We reviewed records for patients treated on wards other than medical wards (outliers) and these also showed their care was regularly reviewed by an appropriate doctor.
- Nursing staff did not complete records consistently. We found incomplete fluid charts in the stroke unit and Lytchett (older people's care) ward. There were incomplete risk assessments in RACE (acute assessment unit for people over 80), Ansty (acute medical

admissions), Lytchett (older people's care) and Lilliput (older people's care) wards. Nursing staff on Lilliput (older people's care) ward had noted on moving and handling care plan that a patient required two staff when being assisted to move. The records did not describe what technique or equipment to use to enable staff to assist the patient safely.

- Staff consistently did not lock the medical records trolleys, although there was a locking system on most wards. The trust submitted a risk assessment about this subsequent to our planned inspection. The clinical risk manager identified trolleys should be locked if they had the provision to be locked. The charge nurse on Kimmeridge (older people's care short stay ward and 14 winter escalation beds) explained the medical notes on the ward had been held in cupboard with a key pad lock, however, they had moved the notes trolleys out of this room to store equipment.
- Staff were using printed handover sheets. We looked at a range of these from different wards and found the patient medical records matched the handover sheet.

Safeguarding

- Nurses and healthcare assistants had a good knowledge of safeguarding and understood their responsibilities in raising concerns. Nurses were aware of signs to look for, procedures to follow and how to make a safeguarding referral.
- Staff were aware of the safeguarding policy and procedures in place.
- Trust-wide, staff training in safeguarding children was meeting compliance targets, with 95% of staff trained to level 1, 92% to level 2 and 90% to level 3. This level of compliance was not achieved for training in adult safeguarding although this was recognised by the trust and the compliance level was improving. The trust had increased the mandated frequency for safeguarding training from three yearly to two. In the departments of medicine, medicine for older people (DME) and specialist medicine compliance was at 70%, against a target of 90%.
- The trust had created a new safeguarding web page for both adult and children safeguarding and a screensaver. Each care group had a champion for safeguarding. The deputy director or nursing had reviewed safeguarding arrangements in the trust and was updating information and guidance.
- Ward staff did not receive regular safeguarding supervision, but this was arranged on an ad hoc basis following a safeguarding report.

Mandatory training

- Mandatory training included basic life support, manual handling, information governance, fire training, care of blood transfusions and conflict resolution. Overall, staff compliance with mandatory training was 83% against a target of 90%.
- Sisters reported difficulty with accessing face to face training, due to a shortage of places available. Face to face training included basic life support and safeguarding. Ward sisters told us they had discussed their concerns with the lack of places available and the flexibility required when staff needed to cover shifts and postpone their training with the human resources department.

Assessing and responding to patient risk

- We looked at 10 records in relation to risk assessments. Individual patient risk assessments were not always completed in sufficient detail. Overall actions were not clear in relation to pressure also prevention, nutrition and hydration and manual handling. For example, nursing staff on Lilliput (older people's care) ward had completed a pressure relief chart for a patient, which showed in a 36 hour period the patient had been repositioned after four hours, five hours, three hours, two hours, five hours, seven hours and then at five hours. The patient's pressure ulcer prevention risk assessment did not state the planned personalised safe repositioning frequency. The patient, who was at risk of developing pressure ulcers, was also on an unsuitable mattress. The patient had been put at risk by the lack of safe risk assessment.
- Staff had been reminded to complete falls assessments and to provide falls prevention aids without delay. Staff in the rapid assessment consultant evaluation (RACE) (acute assessment unit for people over 80) unit and Lytchett (older people's care) ward started a 'safety cross initiative' in November 2015, to reduce falls incidents. Part of the plan meant staff changed the layout of rooms and bays to enable patient to access the bathroom more safely. Staff also aimed to place patients at risk of falling where they could observe them more frequently.

- Staff told us the falls team were very supportive and had issued a useful falls protocol. We tracked a fall in patient notes and saw timely medical assessment and advice was given from the falls team.
- The medical wards used the Early Warning Score (EWS), a scoring system that identifies patients at risk of deterioration or needing urgent review. These scores were recorded on an electronic device. Medical and nursing staff were aware of the appropriate action to take if patients' risks escalated, and this was confirmed in the records we viewed. Staff carried out repeat observations within the necessary time frames. There was a trust procedure and flow chart to guide staff to call the critical care outreach team to support a deteriorating patient. The trust's electronic monitoring system meant that the outreach team were automatically alerted when a patient's risk levels increased to a critical level.
- Nursing staff felt well supported by doctors when a patient's deterioration was severe and resulted in an emergency.
- The discharge lounge had access to oxygen for a patient including a mask and tubing, a blood glucose monitor and medications in case of an allergic reaction.

Nursing staffing

- All staff we spoke with from the management team to health care assistants recognised nursing recruitment as a major safety risk to the service. An impact of unfilled shifts was incomplete fluid charts, and insufficient detail in planning actions to minimise risks to patients.
- Insufficient nursing workforce for the demands of the service was on the hospital risk register. The management team told of various recruitment initiatives they had put in, such as open days and overseas recruitment. All ward staff were aware of these initiatives and were supportive of them. There was general agreement that recruitment and retention of nursing staff was seen as a priority by the trust.
- Nurse staffing levels were planned using the Safer Nursing Care tool and professional assessment of the needs of each clinical area.
- The sister on Lilliput (older people's care) ward said the Safer Care initiative meant they had increased the number of trained staff on duty. Nursing staff on Lilliput (older people's care) had also carried out assessments of patient dependency, and this had showed a need for an extra health care assistant on each shift, which was due to be implemented in April 2016.
- The trust displayed planned and actual numbers of nursing and healthcare assistants on electronic screens near the entrance to most of the wards. However, two wards we visited only displayed the actual numbers of staff, not the establishment or planned level. This meant the public were not shown any short fall in staffing.
- Dependency scoring took place twice daily on some wards, which meant staff recorded the specific staffing needs of the patient group on the ward. This was more embedded in some wards than others.
- We reviewed staffing rotas for December 2015 in detail on Ansty (acute medical admissions), Kimmeridge (older people's care short stay ward and 14 winter escalation beds) and the acute stroke unit. On Ansty (acute medical admissions), there were eight unfilled registered nurse shifts and 20 unfilled healthcare assistant shifts. The trust used bank staff or asked their own staff to work extra hours when there was a need for additional staff. Nursing cover was sometimes achieved by moving staff from a less busy area or by using a non-ward-based nurse. Agency nurses were used only if the ward was short of two nurses. If agency nurses were requested, the ward would compensate with only one healthcare assistant. This meant that on Antsy (acute medical admissions) ward there had been 16 shifts in December 2015 which were short of healthcare assistants.
- On the stroke unit, 20 shifts had unfilled registered nurse gaps and thirty nine healthcare assistant gaps. In addition, three requests for 'specials', to provide 1;1 care, were unfilled. The gaps in registered nurses represented shifts requested in case a patient required thrombolysis. (Thrombolysis is a specialist treatment that is used for patients whose stroke is caused by a blood clot). If this patient need subsequently arose, a nurse would be requested from another directorate. This registered nurse from another directorate would work on the ward, and the registered nurse trained in thrombolysis would look after the patient requiring thrombolysis.
- A member of staff at the listening event told us that the shortage in the healthcare assistants could lead to delays with giving people personal care and with timely

access to therapies. Healthcare assistants we spoke with confirmed this. They said if they were short staffed there were delays in supporting patients with fluids, having a wash or with their meals.

- On Kimmeridge (older people's care short stay ward and 14 winter escalation beds) ward there were 20 unfilled registered nurse shifts, and nineteen unfilled healthcare assistant shifts. The charge nurse explained the nurse shifts would have been filled by a co-ordinating nurse on the ward. The co-ordinator would then not be able to support discharge planning. The healthcare assistant shifts remained unfilled.
- The coronary care unit was short staffed. This unit had a central observation area with monitors showing patients' cardiac rhythms, but staff were not able to observe these directly. However, if an audible alert sounded, a nurse or doctor responded promptly. Recruitment of nurses on the unit was taking place, with two new starters due to start in March 2016 and further interviews scheduled.
- The senior sister on Sandbanks Ward (clinical and medical oncology) reported that when beds increased from 16-20, the trust had not increased staffing levels. This has resulted in delays in staff completing risk assessments. A full time registered nurse and healthcare assistant have now been added to the ward establishment.
- The nurse in charge requested extra staff when patients required 1:1 care. This included when patients needed extra support if they were agitated or distressed. We observed evidence of this on Lulworth Ward (older people's care with focus on cognitively impaired patients). The sister also described how the staff member providing this care was rotated due to the intensity of the role.
- Patient support workers (PSWs) in Ansty (acute medical admissions) worked alongside the nursing team and escorted patients for investigations or to other wards and obtained equipment. The ward employed three PSWs each day and these roles were considered very valuable in supporting patient care and movement on the ward.
- Advanced Nurse Practitioners supported the medicine for older people wards.
- Nursing handovers we observed were detailed. The nurse in charge of RACE (acute assessment unit for people over 80) handover included information about all the patients to the whole team coming on, including a patient's resuscitation status. The team then went around in pairs, to meet the smaller team of patients they would be caring for directly on their shift. The oncoming pair accompanied by a trained nurse from the previous shift.

Medical staffing

- There was a consultant on call 24 hours a day who also reviewed any new patients on a ward round every morning from 08:00 to 11:00 and a daily evening ward round. Consultants provided cover in the acute medical unit 8am to 8pm during week days and 8am to 6pm at weekends. Registrars covered the night times.
- Respiratory and gastroenterology departments had 24 hour access to consultant cover.
- Junior doctors said there were enough junior medical staff out of hours. They felt able to approach their clinical tutor or supervisor as needed.
- The stroke service was short of consultant cover. There were two part time stroke consultants in post. At the time of our inspection the Geriatricians were covering leave of one of the stroke consultants. The service also+ trained stroke fellows.
- Consultant geriatricians were ward based on the older people's wards. They also provided a service to RACE (acute assessment unit for people over 80) and reviewed surgical patients admitted at weekends.
- We observed a medical handover on RACE (acute assessment unit for people over 80). Nursing staff and junior doctors discussed in detail those patients who had been unwell and any patients who had been transferred to other wards. Nurse practitioners who had triaged patients contributed to the discussions.
- A Specialist Registrar (SpR) led the 'Hospital at Night' team between 8.30pm to 9am. The SpR clerked patients, covered wards and took referrals for general and elderly medicine. A middle grade doctor clerked patients and provided ward cover, with a junior doctor. Two nurse practitioners were also in the team, one for medicine and the other for surgery. A consultant from medicine was on call between 9pm and 8.30am from home.

Major incident awareness and training

- A major incident policy was available on the trust intranet. Major incident files were available on wards.
- A bleep system was in place, with bleep holders aware of their role in the event of a major incident.

Medical care (including older people's care)

- We spoke with staff who explained escalations beds were in use, in response to winter pressure, during our inspection in January 2016.

Are medical care services effective?

Good

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

We rated effective as 'good' because;

- Hospital standardised mortality ratio was within the expected range.
- The service used specific pathways and protocols for a range of conditions based on national guidance such as National Institute for Health and Care Excellence (NICE) guidelines.
- Clinical audit was being undertaken and there was good participation in national audit.
- The trust performed above the England average on all three measures of the Myocardial Ischemia National Audit Project (MINAP) audit 2013 t0 2014.
- The Endoscopy unit had been assessed by the Joint Advisory Group for Gastrointestinal endoscopy, and has been awarded full accreditation
- There were arrangements to ensure patients received timely pain relief.
- Patients at risk of malnutrition or dehydration were risk assessed by appropriately trained and competent staff and dieticians or speech and language therapists were involved in their care when required.
- Multidisciplinary working was widespread and effective.
- The service was making progress towards seven day working.
- Staff had an understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards

However

- Outcomes for people who use services were below expectations in relation to care following a stroke and heart failure treatment. Action plans were in place to drive improvements, although the trust had been slow to implement some improvements.
- Annual appraisal rates for staff in the departments of medicine, medicine for older people and specialist medicine was 86.5%, which was below the trust target of 95%.
- Food and nutrition charts were not always fully completed.

Evidence-based care and treatment

- The trust had specific pathways and protocols for a range of conditions. These included for heart failure, stroke, diabetes, respiratory conditions, melanoma, blood transfusions, and pressure ulcer prevention. The pathways were based on national guidance such as National Institute for Health and Care Excellence (NICE) guidelines. For patients who had heart failure or had suffered a stroke the care pathways were integrated, promoting effective care and treatment from the full multidisciplinary health team.
- In Ansty (acute medical admissions), staff had developed guidelines based on NICE guidelines for identification of possible sepsis. Doctors and nurses had clear information on recognising sepsis and action they should take. Patients identified as possibly having sepsis followed a care pathway which included administration of oxygen, blood tests, antibiotics and fluids management. This enabled early recognition, prompt treatment and clinical stabilisation. We reviewed records in relation to use of the sepsis pathway, which confirmed staff followed the pathway effectively.
- Policies were developed in line with national guidelines, such as the pressure ulcer prevention and management policy. Staff we spoke with were aware of these policies. We saw a practice educator on Kimmeridge (older people's care short stay ward and 14 winter escalation beds) ward that supported staff to understanding their responsibility to complete risk assessments and action plans.
- The medical services participated in national clinical audits, to measure the effectiveness of care and treatment provided. These included a heart failure audit, the Myocardial Ischaemia National Audit Project and the Sentinel Stroke National Audit Programme.
- Medical staff conducted local clinical audits, including on the treatment of patients with liver disease and effective treatment of older patients with a suspected urinary tract infection.

- The aim of the audit with older patients was to improve the efficiency with which patients are started on appropriate antibiotics in the presence of urinary tract infection (UTI), thus enabling quicker clinical recovery and faster discharge from hospital. It was also aimed at avoiding unnecessary treatment in those without a UTI, minimising the risk of medication side-effects and saving the hospital the costs of unnecessary prescriptions. In summary, between two rounds of data collection cycles, a 9% decrease in the number of patients with a urine culture sent within 24 hours of admission was noted, whilst there was a 12% increase in the number of patients who had their urine microscopy/ culture result checked within 24 hours of admission. An action from this was to provide education for doctors working with older people on incontinence and diagnosing UTI.
- Local audits by nursing staff included a weekly audit called 'Ward Watch'. This included assessing compliance with the Malnutrition Universal Screening Tool (MUST), completion of patient risk assessments and recording temperatures of medicine fridges. The results were discussed by the matrons with ward sisters. The assistant director of nursing also discussed results of the 'Ward Watch' with the sisters at the harm free group.

Pain relief

- Nurses and doctors monitored and recorded patients' pain levels. Pain levels were scored using the National Early Warning Score (NEWS) chart.
- For patients who had a cognitive impairment, such as dementia or a learning difficulty, staff used the 'Abbey Pain Scale' to assess pain. This scale was developed for patients with communication difficulties who were unable to verbalise how much pain relief they required. Staff on the elderly care wards said they would also contact the pain team and/or the dementia nurse specialist for support in assessing pain needs.
- Patients we spoke with told us they were given pain relief when they needed it and nursing staff checked if it had been effective.

Nutrition and hydration

- The 'Malnutrition Universal Screening Tool' (MUST) was used in all the wards and medical units. Patients who were nutritionally at risk were referred to a dietitian.
- Speech and language therapists were available on the stroke ward to check that patients could swallow safely and to offer advice if patients did not have a safe swallow reflex.
- Nursing staff on the stroke unit had received training to equip them with skills to assess whether patients could swallow safely. Stroke patients, on admission, were screened to find out if they could swallow safely. When required, staff made prompt referrals to therapists or clinicians to provide appropriate support in meeting patients' nutritional and hydration needs.
- A system of protected meal times was in place, to support a patient having time to eat and enjoy their meals.
- We visited medical and care of elderly wards at mealtime. We observed that nursing staff were giving assistance to feed the patients who needed support. The staff assisting did not always sit down, which may have given the patient a feeling of needing to rush. Adapted crockery was in use on the stroke ward, supporting a patient to be independent.
- We looked at 11 records in relation to food and fluids, and nine were incomplete. This would make it difficult to assess a patient's fluid and nutrition status. However, patients who required intravenous infusions in order to maintain hydration, had these fluids prescribed and signed as given on appropriate charts.
- Patients were positive about the quality of food and range of options.

Patient outcomes

- Hospital standardised mortality ratio was within the expected range**.**
- The hospital participated in the 2013-2014 Myocardial Ischemia National Audit Project (MINAP), a national clinical audit of the management of heart attack. The trust performed above the England average in all three measures of the MINAP audit. The trust scored particularly highly on the number of patients admitted to a cardiac ward or unit.
- Care and treatment for people following a stroke were below the national average and although action plans were in place, the trust had been slow to implement improvements. The trust contributed to the Sentinel Stroke National Audit Programme (SSNAP). This audit is based on 10 domains of both patient centred and team

centred (organisational) indicators. These included, for example, indicators for assessment, multidisciplinary treatment and discharge, which are scored at levels A (best performing) to E.

- The combined indicator for Poole was level E for the quarter January 2015 to March 2015, then level D in April to June 2015 and July to September 2015. The trust performance in this audit had worsened for patients being admitted to a stroke unit, and for patients receiving thrombolysis. (Thrombolysis is a specialist treatment for patients whose stroke is caused by a blood clot). The trust also performed worse for discharge standards and was in the lowest 4% of trusts and for specialist assessment placing it in the bottom 16% of trusts. The timeliness of patients receiving a scan had improved, but was still below the national average.
- The SSNAP audit also demonstrated that inpatients also received significantly less physiotherapy than patients' nationally.
- The trust's action plan detailed actions to improve stroke patient outcomes. We spoke with a stroke nurse practitioner who explained work had already resulted in improvements. For example the number of patients having a CT scan within one hour had improved, from 31.9% in April to June 2015, to 40.4% in the quarter July to September 2015. There was still work to embed improvements in stroke care at the hospital.
- The trust performed worse than the England average in 10 of the 11 measures in the heart failure audit 2013/2014. There were particularly large variances in patients who received input from a consultant cardiologist, where the England average was 57% compared with 37% for the trust. The trust performed worse than the England average for input from a specialist (50% compared with 78% nationally) and receiving an echocardiogram (67% compared with 91%). The 2014/2015 heat failure audit was not published at the time of the inspection. The service produced an action plan in December 2015 to address poor performance in these areas, which did seem slow. A part time heart failure nurse specialist had been put in post in 2012. However this post had been made full time in March 2015. The service had also produced a business plan proposing further expansion of staff in the heart failure team.
- The National Diabetes Mortality and Morbidity (M&M) project organised by NaDIA, encouraged and supported hospitals to undertake an analysis of serious diabetes harms within their hospital, using a Root Cause Analysis (RCA) approach. The trust took part in this national audit with 65 other trusts, in Autumn 2014. Actions completed included closer working with orthopaedic team and increased teaching including on a Sunday. Teaching included the introduction of a 10 point training in diabetes across the trust for both medical and nursing staff. It followed the 2013 NaDIA audit when the trust performed better than the England average for 14 of the 19 indicators with full data. It performed worse than the England average in regard to medicines management, staff knowledge about diabetes and foot disease for people with diabetes. The trust participated in the NaDIA audit in 2015, results not yet published.
- The Endoscopy unit had been assessed by the Joint Advisory Group for Gastrointestinal endoscopy, and has been awarded full accreditation. The accreditation process assesses the unit infrastructure policies, operating procedures and audit arrangements to ensure they meet best practice guidelines. This meant the endoscopy department was operating within this guidance. One area of improvement was required, in relation to developing a patient experience questionnaire, and was being addressed.
- The standardised risk of readmission compared to the England ratio was slightly higher than expected for elective patients and slightly lower for non-elective patients. The rate for clinical oncology for both elective and non-elective pathways was higher. Elective general medicine and clinical haematology were also higher.
- The average length of stay for elective patients was slightly higher than expected in general medicine, and much higher for clinical haematology. The average length of stay of non-elective patients was slightly shorter than expected.

Competent staff

- There was an induction programme for all new staff and staff who had attended this programme felt it met their needs.
- The new starters from other countries had a longer induction, and language support/peer support from established oversees staff. Feedback from the public during the course of the inspection included some concerns with communication with foreign nurses.
- Staff told us they had regular annual appraisals. Appraisal rates were 86.5% which was lower than the trust target compliance level of 95%.

- Appraisal documents showed evidence that staff performance was assessed and monitored.
- Nursing staff told us they did not receive formal supervision. Staff however were supervised clinically and felt that handovers, ward rounds and board rounds provided them with learning opportunities.
- Staff had access to specific training to ensure they were able to meet the needs of the patients they delivered care to. For example, in cardiology nursing staff completed competencies that included echocardiogram training and a health and physical assessment examination course.
- Ward sisters used a system of link roles on the ward to support best practice. The roles included infection prevention, pressure ulcer prevention and dementia.
- Agency and bank staff signed a log on a ward when they went to work, which also contained information to support their induction to a ward.
- Nurse specialists in the medical investigations unit had undertaken specialist training including peripherally inserted central catheter line training and nurse prescribing.
- Specialist older person's advanced older nurse practitioners were supported in maintaining competency with clinical supervision from a designated consultant geriatrician and daily on hand training, advice and support.
- The therapist became aware that in the oncology department nursing staff were not always promoting independence. New staff and health care assistants had a training day, to help them understand how to work effectively with therapy staff. There is now better liaison between nursing and therapy staff, with nursing staff seeking advice on how best to help patients with their mobility.
- The trust performed as expected to the England average for all indicators in the GMC National Training Scheme Survey.
- Healthcare assistants had started to complete the national Care Certificate launched in March 2015. The Care Certificate aims to equip health and social care support workers with the knowledge and skills which they need to provide safe, compassionate care. We saw evidence of healthcare assistants who had completed and were undertaking the Care Certificate on Avonbourne (gastroenterology, diabetes and endocrine) and Kimmeridge (older people's care short stay ward and 14 winter escalation beds) wards.
- Nursing staff were aware of the need to revalidate their registration.

Multidisciplinary working

- Staff told us that multidisciplinary team (MDT) working across the trust was good. Junior doctors and nursing staff told us nurses and doctors worked well together within the medical speciality. We saw evidence of this on medical wards. There were clear lines of accountability that contributed to the effective planning and delivery of patient care.
- On the Rapid Assessment Consultant evaluation (RACE) (acute assessment for people over 80) unit, medical, nursing, therapy, social services and the voluntary sector attended an MDT daily, Monday to Friday. Social services attended from Poole, Dorset, Bournemouth and Hampshire. A nurse from the short stay older persons Kimmeridge (older people's care short stay ward and 14 winter escalation beds) ward also attended to facilitate discharge of patients. There was also support from the end of life team and psychiatry. On the day we attended 10 discharges were planned from the RACE (acute assessment for people over 80) unit. On Saturdays a board round took place with the consultant on call and therapy staff, and they also saw the new admissions from the Friday night.
- On the stroke rehabilitation ward, staff held a multidisciplinary meeting twice a week.
- Within the acute older people's wards, staff held weekly MDT meetings that which included the doctor, social services, the nurse in charge, therapists and the dementia nurse specialist. On a daily basis staff summarised patients' progress and discharge needs with therapy staff.
- Cancer MDT's included teleconferencing with NHS hospitals in Dorset and Southampton. Some of the specialities involved were gynaecology, gastroenterology, thyroid, lung and central nervous system.
- Psychiatric support was in place, and accessible. However for 16-18 year olds Ansty (acute medical admissions) reported delays in assessment, and delays in discharge. The sister told us a new link for adolescent psychiatry service has just commenced, aimed at improving psychiatric liaison for adolescent patients.

Seven-day services

Medical care (including older people's care)

- The medicine care group provided acute medicine consultant presence 8am to 9pm Monday to Friday, and 8am to 6pm on Saturdays and Sundays. Consultants provided on-call services overnight from home.
- On all the medical and care of elderly wards we visited, consultant ward rounds took place twice a week. Over the weekend, the consultant on call saw all new and deteriorating patients.
- Respiratory, gastroenterology and diabetic patients had 24 hour access to consultant support.
- There was a seven-day endoscopy service available for therapeutic upper and lower gastrointestinal endoscopy.
- The medical services had access to radiology support seven days a week, with rapid access to CT scanning and MRI scanning. Echocardiography was only available Monday to Friday. A consultant radiologist was on call seven days a week, and frequently attended the department outside normal working hours.
- Biochemistry, pathology, haematology, microbiology and radiology were available seven days a week.
- In medicine, consultant-directed diagnostic tests and reports were offered seven days a week. These were carried out within one hour for critical patients or 24 hours if non-critical, in general and respiratory medicine. This was not available 7 days a week in cardiology and geriatric medicine.
- Advanced nurse practitioners worked 7am to 8pm Monday to Friday and 7am to 1.30pm Saturday and Sunday to support acute medical patients care.
- Cardiac pacing, thrombolysis and percutaneous coronary intervention were available seven days a week.
- The trust had made arrangements with Bournemouth and Dorset hospitals that enabled them to provided transient ischaemic attack (TIA) clinic services seven days a week. Clinics were held at Poole, Bournemouth and Dorset on a rotational basis at weekends. This meant the clinic was held at Poole every third week.
- A diabetic nurse specialist was available six days a week (Sunday to Friday).
- The medical investigations unit was open five days a week from 7.30am to 7.30pm and at the weekends 7.30am to 3.30pm.
- Pharmacy services were available seven days a week. The pharmacy was open 10am to 6pm on Saturdays and 10am to 4pm on Sundays. A service was provided for new patients, patients for discharge and newly prescribed items for inpatients. An on call pharmacy service was provided when the pharmacy was closed. The clinical management team were able to access the emergency medicines room.
- The alcohol and treatment service became a seven day service in January 2016.
- A seven day service therapy service is provided to the medical directorate. In addition there was a dedicated therapy team 08:30-16:30 on RACE (acute care for older people over 80) and the care of older people wards). The trust also has an on call respiratory physiotherapy service every evening, overnight and at weekends.

Access to information

- Staff told us they had good access to patient-related information and records. The hospital had planned to move to electronic patient records. Staff reported that sometimes specific scanned notes were difficult to find electronically in a patient's record, and this caused delays.
- The bank staff also had access to the information in care records to enable them to care for patients appropriately. All areas used electronic handover sheets to ensure staff had up-to-date information about patients on their ward.
- Discharge summaries were provided to GPs to inform them of their patient's medical condition and the treatment they had received.
- Staff told us when the patient was transferred from Ansty (acute medical admissions) or RACE (acute assessment for people over 80) to a ward, information about the patient's condition and needs was included in a transfer handover form. The handover forms we reviewed were not all fully completed, however nursing staff explained there was also a verbal handover when a patient transferred.
- Medical staff accessed patient early warning vital signs (EWS) scores from any computer terminal or hospital hand held device, which meant they could access patient's vital information promptly and remotely if needed.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Medical and nursing staff were prompted by a screen saver displayed on computers to consider the Mental Capacity Act and Deprivation of Liberty Standards (DoLS).

Medical care (including older people's care)

- Patients were consented appropriately and correctly. Where patients did not have capacity to consent, staff carried out formal best interest meetings. Nursing staff assessed a patient's capacity routinely within care of the elderly wards, particularly for those patients diagnosed as living with dementia.
- A nurse on the discharge unit obtained consent from a patient before telling their relative how to support the patient with their medicines at home.
- Nursing staff on Durlston ward (for oncology patients), discussed how they had used the Independent Mental Capacity Advocacy Service recently. This was for a person living with a learning disability. This helped staff support decision-making in line with the Mental Capacity Act.
- Staff understood the procedures to follow when restriction or restraint might become a deprivation of a patient's liberty. Most of the staff were aware of the trust's policy if any activities, such as physical or pharmaceutical restraint, met the threshold to make an application to the local authority to temporarily deprive a patient of their liberty. For example, four patients on Lulworth ward (older people's care with focus on cognitively impaired patients) and four patients on Lilliput (older people's care) ward had Deprivation of Liberty Safeguards (DoLS) in place.

Are medical care services caring?

Good

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

We rated caring as 'good' because;

- The trust's Friends and Family Test was better than the England average. Within the medical directorate people recommending the care was 91% or above.
- Feedback from patients and their relatives was nearly always positive about the way staff treated them. The culture we observed amongst all staff groups was caring and supportive.
- Staff encouraged patients and relatives to be partners in their care and make decisions.
- Staff helped patients to cope emotionally with their care.

However

- In stroke rehabilitation the FFT was for people that recommend the ward was 87% in November 2015, and 79% in December 2015.
- Some concerns were expressed prior to our inspection about personal care, and staff understanding of people living with dementia
- Feedback from patients and relatives indicated they did not always feel informed or involved in decisions about their care.

Compassionate care

- Ward sisters displayed results of the Friends and Family Tests (FFT) where the public could see them. Overall results from October to December 2015 showed patients were satisfied with the service provided. The trust FFT was better than the England average. Lilliput ward, for older persons consistently scored 100% for participation and 100% said their experience was good or excellent.
- Lulworth (older persons care with focus on cognitively impaired patients) FFT ranged from 91% to 96% that recommended the ward. The concerns about a patient's experience was in relation to call bell response times, which the matron was investigating.
- The FFT for Stroke rehabilitation ranged from 79% to 100% in the period October to December 2015. The matron had reminded staff about the importance of good communication
- For the FFT completed in the medical wards the range was 92% to 100% from May to October 2015.
- For the FFT undertaken In Durlston (medical oncology –haematology) and Sandbanks between May to October 2015, 96% to 100% people recommended these wards.
- The 2014 CQC Inpatient Survey found the trust scored similar to other trusts on all the indicators.
- In the 2013/14 Cancer Patient Experience Survey, the trust scored in the middle 60% of trusts for 24 of the 34 indicators. The trust scored in the top 20% of trusts for seven of the indicators and in the bottom 20% for four of the indicators.
- When staff interacted with patients, they almost always crouched down to the patient's level which showed respect.

Medical care (including older people's care)

- In the discharge lounge an older person became distressed whilst waiting for transport to take him to his usual place of residence. Staff were very attentive and reassuring with him, and we saw him visibly relax.
- Patients commented that they found staff kind, responsive and considerate. This was all staff, from housekeeping staff to consultants. A patient commented they were 'in the best place to get better'.
- Twenty seven people via our website and attending our listening events provided feedback prior to our inspection. Some of the feedback from people contained both positive and negative comments. Almost two thirds of peoples' feedback was positive. The concerns included a delay with responding to a request for the toilet, promoting self-care and staff understanding the needs of a person living with dementia.

Understanding and involvement of patients and those close to them

- We observed nurses, doctors and therapists introduced themselves to patients at all times.
- There were examples where staff helped relatives to find further information and encouraged them to ask questions about care and treatment. On Lulworth ward for older persons the sister organised 'Meet the Team' meetings within the first 72 hours of admission. These included the patient, their relative and staff involved in their care such as a therapist, doctor and discharge facilitator. The meeting had been introduced in response to complaints.
- Staff did not always involve patients in their care, by explaining next steps and involving them in decisions about their care. Some patients and relatives we spoke with felt involved and informed in decisions about their care, and others did not. This inconsistency was also reflected in feedback we received immediately prior to our inspection.

Emotional support

- During our inspection, we observed that staff were responsive to a patient's emotional needs. We witnessed many examples of kindness and emotional support from staff towards patients and their relatives.
- A wide variety of specialist nurses provided emotional and practical support for patients with specific conditions. The specialist nurses included diabetes, heart failure, acute brain injury, cancer, cardiac, respiratory, epilepsy, Parkinson's disease and dementia.
- The charge nurse on Portland ward (acute brain injury) had reintroduced 'caring canines'. The matron explained suitably trained dogs and their owners visited the ward and the dogs had a positive impact patients' emotional wellbeing.
- A matron explained how the service had set up diagnostic tests for one patient in their nursing home, as they would have suffered particular emotional stress if they had to attend the hospital.

Are medical care services responsive?

Good

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

We rated responsive as 'good' because;

- Medical services were responsive to patients' needs. The acute medical admissions ward, rapid assessment consultant evaluation unit (RACE), and medical investigations unit had contributed to the trust's ability to support older patients and manage the increasing pressures on beds.
- There were 32 medical outliers at the time of inspection (patients placed on wards other than one required by their medical condition). These patients were appropriately assessed, and there was a robust process to ensure junior and senior medical staff from the relevant speciality reviewed medical outliers regularly.
- The trust was working with partners to improve the coordination, safety and timely discharge of patients. However, there were a high number of delayed transfers of care.
- The main cause of delays was the provision of packages of care and community rehabilitation. The trust was engaged with partner organisations in managing these delays to minimise the impact on individual patients and the service overall.

Medical care (including older people's care)

- There was support for vulnerable people, such as people living with dementia and a learning disability. This support included changes to the environment in some wards, and use of information to support staff understanding a person's needs.
- Patients had access to information leaflets about different types of treatment and staff could request translation services or interpreters for people with communication or language difficulties.
- Staff took complaints seriously and followed trust policy. There was evidence of learning from complaints on the wards. A sister told us an example had been raising awareness with staff about the importance of timely communication with relatives.
- Lulworth ward had been refurbished to improve the environment for patients living with dementia.
- Most wards had not been refurbished or re-organised to improve the environment for patients living with dementia; this was planned if financial support was available.

However;

- A third of patients experienced at least one bed move. A significant number of patients were also moved from Ansty (acute medical admissions) and Race (acute care for people over 80) at night.
- There was not a robust flagging and referral system for people with a learning disability in place.

Service planning and delivery to meet the needs of local people

- The trust serves a population of over 500,000 in East Dorset. Almost 30% of the population are aged 65 and over.
- The East Dorset area profile shows the population has a higher rate of malignant melanoma and diabetes than the England average.
- The Dorset cancer centre, located at Poole hospital, is a major specialist cancer treatment centre. It provides treatments for both common and rare cancers, including radiotherapy, chemotherapy and a range of associated support services.
- The trust had developed specific services for older people. These included RACE for people over 80, which had 25 beds. There was also an older persons' ambulatory emergency clinic (AEC), which became operational in April 2015. The AEC was staffed by advanced nurse practitioners and was open Monday to Friday 7am-7.30pm, and a reduced service at weekends, to avoid unnecessary admissions.
- The trust increased the capacity of Kimmeridge ward (acute older people's care short stay), in the winter by 14 beds to help meet increased demand.
- In addition, the trust's acute medical admissions ward (Ansty) was set up to assess and discharge or admit patients within 24-48 hours, to minimise unnecessary admissions. This ward took eight patients from GP referrals.
- There was an ambulatory (medical care run on an outpatient basis) clinic run by medical staff, and a deep vein thrombosis clinic which was led by nurse specialists.
- The trust had developed services to meet the needs of patients in the community who could receive medical intervention without admission. The nurse-led medical investigations unit had eight bed spaces, which included bays and cubicles. The staff were able to provide different services including blood transfusions, which they also prescribed, and bone marrow aspirations.
- The trust had opened a low dependency and elective inpatient area to improve flow (Cranbourne 4 ward) across the medicine directorates. The area had six beds that were permanently staffed, and could flex to another five if needed, with additional staff. The unit provided resilience during winter pressures, and reduced the risk of elective operations being cancelled due to inpatient pressures.
- There was a seven day a week early support discharge team for stroke. This provided early stroke specialist multidisciplinary rehabilitation and support for those patients meeting specified eligibility criteria.

Access and flow

- Bed occupancy in the trust was above the England average between September 2014 and June 2015. In the period July to September 2015 it was below the England average. It is generally accepted that at 85% level, bed occupancy can start to affect the quality of care provided to patients, and the orderly running of the hospital.
- To release beds in the hospital and promote patient flow the trust had a discharge lounge where patients

could wait for transport or final discharge arrangements such as their medicines. A patient in the discharge lounge was distressed by the length of time he had waited to go back to his nursing home. This had been over five hours. The person was out of area, which had made transport arrangements more complicated. However staff said it was not unusual for a patient to wait several hours in the discharge lounge.

- Staff held twice-daily bed meetings. Additional meetings were held when demand increased. Staff maintained a dashboard which displayed closed beds, discharges, planned discharges and current capacity. This helped heads of department, matrons and ward leaders make decisions about patient flow.
- Admission to Ansty (acute medical admissions) ward or RACE (acute assessment for people over 80) wards was though the emergency department or GP referral.
- The average length of stay was about two days in Ansty (acute medical admissions) ward. On the day of inspection there were three patients who had been in Ansty (acute medical admissions ward) over three days. This was due to demand on beds within specialities. The average length of stay between April and September 2015 in RACE (acute assessment for people over 80) had been zero to two days for 87% of patients. The discharge destination for patients from RACE (acute assessment for people over 80) was 53% moved to another ward in the trust and 47% discharged from the trust.
- Admission to the older people's ambulatory emergency clinic was through the emergency department or GP. This was run by an advanced nurse practitioner. At the time of our planned inspection, due to capacity issues, the older people's ambulatory clinic had moved up to the medical investigations unit, reducing its capacity. At our unannounced inspection ambulatory care had moved back to RACE (acute assessment for people over 80).
- Data provided by the trust showed that 31% of patients experienced one bed move and 5% two bed moves during their stay. From the data supplied by the trust, it was not clear if these were clinical or non- clinical bed moves. Almost two thirds of inpatients admitted to the hospital did not move wards during their admission. Staff moved patients at night mostly when it was necessary to make beds available in the assessment units. During the period May 2015 to October 2015, an average of 75 patients moved from Ansty (acute medical admissions ward) and 41 patients from RACE (acute assessment for people over 80) at night (between 10pm and 7am) each month.
- There were a high number of delayed transfers of care, which imposed bed pressures on the hospital. Delayed transfer of care is when patients are in hospital, fit for discharge but are unable to leave the hospital due to external factors. From data we received the greatest number of delays were for people requiring packages of care and community rehabilitation. The trust was engaged with partner organisations in managing these delays to minimise the impact on individual patients and the service overall. A model the trust had developed was to keep care packages open for 48 hours on RACE (acute assessment for people over 80) and up to seven days on Kimmeridge (short stay older people's ward with 14 winter escalation beds). Staff said this was a great help in coordinating discharge arrangements for patients. Volunteer drivers also helped to take people home, if this met their needs.
- The trust had a team of discharge facilitators who coordinated support for patients and their families, liaising with community services. These were often healthcare assistants who were supported by registered nurses for more complex discharge planning. For example, registered nurses supported a discharge involving assessments for NHS funded care and best interests decisions. Staff discussed discharge arrangements at the daily board rounds and used a discharge tool to initiate and plan discharge arrangements. Most patients had an estimated date of discharge, planned on admission.
- All medical specialties between July and December 2015 met the standard for the incomplete referral to treatment pathway, which is above 92%. This indicated that patients waited for less than 18 weeks from referral to treatment.
- The trust had met the 31-day waiting time from diagnosis of cancer to treatment, between October 2014 and November 2015. The 62-day waiting time target for referral to treatment within medical specialities was generally met. For the period October 2014 and November 2015 in haematology, 87.2% (based on quarterly reports on Open Exeter and the monthly report for October & November) met the target, for sarcoma the result was at 84.6% (based on quarterly reports on Open Exeter and the monthly report for

October & November) but referrals for this are very small in numbers. (Sarcomas are rare cancers that develop in the muscle, bone, nerves, cartilage, tendons, blood vessels and the fatty and fibrous tissues).

Meeting people's individual needs

- The trust used the 'this is me' booklet developed by the Alzheimer's Society for patients living with dementia alert and inform staff to identify and meet the needs of these patients. Nurses on Lilliput (older people's care) and Lulworth (older people's care with focus on cognitively impaired patients) wards confirmed the booklets were in use, and said they were helpful. A forget-me-not flower symbol was used to identify people living with dementia on the care of older people and medical wards.
- All patients over 75 years were screened for dementia using a recognised methodology on their admission.
- The trust employed specialist dementia nurses that staff could request to provide support and guidance in caring for patients living with dementia.
- The trust had received funding to upgrade Lulworth (older people's care with focus on cognitively impaired patients) ward in 2012 to make more suitable for people living with dementia. The four bedded bays had been changed to three beds, with the fourth bed space converted to a wash room and toilet. This supported patient privacy and way-finding. Different areas on the ward were also colour coded to help patients find their way. The matron said they hoped to make other areas of medicine more dementia friendly.
- The older person wards enjoyed the support of an art and music project before Christmas 2015. The patients particularly liked the music. Staff were working with Poole Alzheimer's Society to create a hospital dementia community.
- We spoke with a patient and their carer who had a learning disability. The patient had a 'care passport', to support staff in meeting his needs. However the trust did not have a dedicated lead nurse for patients with a learning disability, or a robust flagging and referral system for these patients.
- The matron was leading a transitional care group meeting for 16-18 years olds to increase staff awareness of their particular needs. For example, the matron had noted a pattern of 16-18 year olds presenting with a similar health issue and planned to develop a lead physician on Ansty (acute medical admissions ward) ward to support this group.
- A wide range of patient literature was displayed in clinical areas covering different diseases and specific procedures. Printed information included health advice and guidance on local health and social care services. Patient information leaflets were also available on the hospital website. This included four easy read leaflets; 'going into hospital', 'about your operation', 'my medication book' and 'leaving hospital.
- On Portland ward, for people with an acute brain injury, the trust had planned a 'safe room' with soft surfaces to meet the needs of patients. The charge nurse also planned admissions so people with acute brain injury were located on one side, and those with neurological conditions the other. This was because patients with neurological conditions benefited from being in a quieter area.
- Staff organised activity groups on inpatient wards, including on Lulworth ward older people's care with a focus on cognitively impaired patients) and Portland ward (acute brain injury and neurology). For example, on Portland ward staff and patients were preparing celebrations for the Chinese new year.
- Patients on Portland ward had access to a secure garden, with raised beds. This provided them an opportunity to spend time outside in a safe environment.

Learning from complaints and concerns

- Complaints were handled in line with trust policy, and staff gave patients information on how to complain. Staff directed patients to the 'Patient Advisory Liaison Service (PALS)' if they were unable to deal with their concerns directly and advised them to make a formal complaint.
- Literature and posters were displayed advising patients and their supporters how they could raise a concern or complaint, formally or informally.
- Between March 2015 and February 2016 there were 27 complaints in medicine, 49 in medicine for older people, four in specialist medicine and one in the endoscopy service.
- On wards, senior nursing staff reviewed complaints and telephoned complainants directly and if appropriate, invited them to meetings.

Medical care (including older people's care)

- The main themes from complaints were medical and nursing care, property loss and communication.
- A trust should formally respond to a complaint within 25 working days. The trust between the period October to December 2015, responded to approximately 50% of complaints within 25 working days.
- Where patient experiences were identified as being poor, action was taken to improve their experiences. Staff told us that any learning from complaint investigations was shared with the team. A sister told us an example had been raising awareness with staff about the importance of timely communication with relatives.

Are medical care services well-led?

Good

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

We rated well-led as ' good' because;

- Leaders had the experience, knowledge and capability they required for these posts.
- Quality and risk was assessed and monitored through audit. The matrons discussed actions to be taken forward at clinical leads meetings and risk meetings held for general medicine and department of medicine for elderly people. Risks, such as workforce, had been taken to the trust board. The senior team met with the executive team quarterly to present quality reports for medical wards and specialties, and department of medicine for the elderly.
- Staff felt valued by their immediate line management, and well-supported. They said they were comfortable reporting incidents and raising concerns.
- There were robust systems to gain patient feedback and use it to improve services. The trust was involved in the 'After Francis Research Project', which involved gathering patients' experiences. Where required, action plans had been developed to improve patient experience.
- There were improvement projects to improve patient experience, safety and efficiency. An example was the Dorset Adult Integrated Respiratory Service formed in 2015 to provide a consistent and equitable service for particular respiratory conditions.
- The leads were able to outline their vision and strategy. This had been completed within their business plan dated 2014-2017, which they were due to share with the hospital executive team. Some individual objectives had been achieved and business plans had been prepared where required. The strategy had not shared with internal and external stakeholders, as a whole. The strategic direction of services at the hospital was open to review at the time of the inspection, as a result of the Dorset Clinical Commissioning review.

However;

- The capacity of ward lead on stoke and elderly care wards was a concern. Ward Sisters were filling in staffing gaps and this meant they had less time to fulfil their leadership roles. The matron in department of medicine for the elderly had identified this had impacted on audit completion during the period October to December 2015.
- Some ward level risks identified by staff were not on the risk register.

Vision and strategy for this service

- A medical director, general manager, deputy general manager, two matrons and clinical leads led the medicines directorate, covering the departments of medicine, medicine for the elderly (DME) and specialist medicine. The medicine directorate business plan for 2014-2017 outlined the service vision and strategy. The strategic direction of services at the hospital were part of the Dorset Clinical Commissioning review. The leads were due to present their business plan to the executive team in February 2016.
- The leaders were clear about service priorities which included continued progress towards seven day service, increasing ambulatory care, continuing to work with partners to reduce delayed transfers of care and work to support staff retention.
- The leads were realistic about challenges within their business plan. These included staff recruitment, particularly to older people's care, and the increasing elderly population.

- Staff at all levels demonstrated a passion to provide a good service for patients.

Governance, risk management and quality measurement

- The matrons produced a quarterly governance report. This included patient safety events, clinical effectiveness and patient experience. They submitted the reports to the hospital executive team to inform trust quarterly performance reviews.
- The medicine risk register contained risks relating to transfer of echo images electronically from Poole to other hospitals. The IT solution needed required investment meanwhile these images were being copied and taken by courier. There had been no incidents with this system, which was due for review in January 2016. The matron had two other risks on medicine risk register which were also being managed appropriately. The matron on the medicine for elderly people risk register had a risk that identified limited storage impacted on infection control management. This was to be raised at the executive walk arounds. A further risk in relation to manual handling equipment was on the risk register, and being managed appropriately. As nursing workforce was an issue across the hospital this risk was on the trust wide risk register.
- Ward sisters said risk registers did not necessarily include individual ward risks and new risks were added as a result of a unit decision. On the stroke ward, the staff expressed concerns that a lack of specialist seating was a risk as this could cause delays in a patient's rehabilitation. This was not on the risk register for medicine for older people.
- The medical service and medicine for older people held bi-monthly risk meetings. At the meetings the staff discussed issues such as risks, incidents, complaints, actions and learning to share with teams and staffing.
- In medicine the matrons held meetings with the clinical leads. Minutes showed these were used to discuss issues such as patient flow, staffing and incidents and any actions required. These meetings ranged in frequency from weekly to monthly.
- Within medical services, each medical speciality also had monthly governance meetings, speciality performance meetings and mortality and morbidity meetings. The frequency of these meetings ranged from monthly to three monthly. In dermatology the meetings were three monthly the cancellation of the October 2015 meeting meant a delay in completing actions relating to a never event.
- Ward meetings were held inconsistently due to staffing pressures. One matron planned to set up regular monthly meetings from January 2016. The ward leads created information and learning in staff rooms, to share learning from incidents and complaints.
- In Ansty the sister did not have a formal department meeting but held a 'closed Facebook' meeting for share information. This format worked well for Ansty (acute medical admissions unit), had the approval of the information technology department and was compliant with information governance requirements.

Leadership of service

- There was tripartite leadership for each directorate with a clinical director, a directorate manager and a manager. The matron advised the clinical director, who took the main lead was open and approachable.
- The clinical lead also supported the stroke service, due to long term sickness of a stroke consultant.
- The matron for older people's wards had two roles; matron and discharge lead for the trust. This meant she had less time to spend on wards.
- Staff said the director of nursing had been very visible on the older people's wards and the stroke unit, and helped to raise staff morale. The matron also said she had regular one to one meetings with her which she found very helpful. In other areas such as Ansty, nursing staff told us that members of the executive team were rarely seen.
- Junior doctors felt well supported by consultants and senior colleagues.
- Medical staff felt supported by the medical leadership in the division and the trust.
- In the medicine for older people's wards, staff told us there had been challenges due to sickness of senior ward staff and senior staff had been moved to cover gaps. Senior ward staff told us at times their leadership time was lost, to cover gaps in staffing. In the period October to December 2015 this had affected the completion of audits, and so monitoring of care.

Medical care (including older people's care)

- Ward staff felt well supported by their ward sisters and matrons and told us they could raise concerns with them. Staff across medical wards told us matrons were visible and had a regular presence on their ward.

Culture within the service

- The matrons felt the trust was striving to improve staff retention in response to a nursing staff turnover rate of over ten percent.
- There was an open culture in raising patient safety concerns, and these were taken seriously. For example, a sister in the coronary unit said there had been an incident in the medical wards with use of heart rhythm recording equipment in use. The matron had taken this forward to discuss with relevant members of staff to develop actions to prevent reoccurrence of the incident.
- Front-line staff worked well together, and there was respect between staff within the specialities, across disciplines and with partners.

Public engagement

- The trust was one of six trusts involved in an 'After Francis Research Project'. It involved asking patients 18 questions about the quality of care in hospital. Areas in medicine surveyed included acute stroke, the Rapid Assessment Consultant Evaluation (RACE) (acute assessment for people over 80) unit and Ansty (acute medical admissions) ward. The trust had drawn up an action plan in September 2015 for Ansty and older people's medicine. One action reported as completed was to ensure overseas nurses conducted all their communication in English where appropriate.
- A matron undertook a monthly medical walk around with a member of the Public Patient Involvement Group and gave immediate feedback or took action in response to people's comments.
- The rheumatology department participated in a patient experience survey with 10 other rheumatology units in October 2015. When Poole Hospital's satisfaction results were benchmarked they exceed the national data set in six areas and matched on coordination of care, at 89%. The only area where the trust scored lower was with patients feeling they could take family members with them to outpatients, to become involved in decisions about care if they wanted.
- Nursing staff from Arne (respiratory) had attended a local school in June 2015, to teach young people about resuscitation. This encouraged engagement as eight students wanted to visit and learn about the hospital as a result, and some students expressed an interest in working with older people.

Staff engagement

- The trust published a matron's newsletter. The November 2015 edition contained useful, brief articles to update staff about staff achievements and service developments.
- Information was shared with the teams. For example, governance, risks, training, and trust information was displayed in suitable areas of the wards for staff to refer to, as well as posters about unit social activities.
- At the handovers we observed, there was an opportunity to ensure important, relevant information was passed on to staff promptly.
- The charge nurse on Portland (acute brain injury and neurology) had begun a neurological book club, which involved most of the ward staff. It was an on line club where staff read and developed their knowledge about neurological conditions, and discussed their learning with colleagues.

Innovation, improvement and sustainability

- The trust provided various examples of innovative service delivery and clinical practice. Many of these were aimed at improving patient experiences and outcomes that resulted in admission avoidance, or shorter lengths of stay in hospital.
- The RACE (acute assessment for people over 80 years) unit ambulatory emergency clinic had been set up in April 2015 to improve outcomes for frail older patients. This also was developed to support strategies to meet an increase in emergency activity and relieve acute hospital beds. The Dorset Adult Integrated Respiratory Service, formed in 2015, provided a consistent and equitable service for particular respiratory conditions. For example it offered oxygen service and intravenous antibiotics at home. This service facilitated early discharge through integrated working.
- In May 2015 consultants and skin cancer nurse specialists offered skin and mole checks to members of the public on a local beach. The take-up was very successful with over 100 people receiving checks. The staff also provided safety advice and information about skin cancer.

Medical care (including older people's care)

- In collaboration with a diabetes specialist nurse at the neighbouring NHS hospital. The lead diabetes nurse at Poole, who is also the clinical champion for Diabetes UK, led three interactive patient workshops on managing diabetes.
- In gastroenterology there was a unique, nurse-led iron deficiency clinic supported by a consultant gastroenterologist. The clinic accepted referrals from primary and secondary care. Referrals were seen and vetted swiftly, and those meeting the criteria, scheduled for appropriate investigations in a timely way. A patient requiring bi-directional endoscopy, would have their investigations on the same day. The clinic then monitored appropriate referrals for those with identified pathology, and those without.
- On Lytchett ward (older people's care), as a result of a journal group, the physiotherapy team had set up an exercise gym trial.
- A physiotherapist was collecting evidence to support oncology outpatients with self -management. The physiotherapist reviewed evidence to determine if there was a role in them supporting outpatients with spinal cord compression to minimise pain.
- The stroke lead had tested a new model of care, trialling the new role of assistant practitioner in stroke. They said the test model was successful, and they had submitted a business case to progress to substantive recruitment.

Surgery

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

Information about the service

Poole Hospital provides all the surgical services for The Poole Hospital NHS Foundation Trust. The hospital is a trauma unit and consequently carries out a significant amount of emergency surgery. In the period July 2014 to June 2015 45% of the surgical activity was emergency surgery, 44% elective surgery and 11% day surgery. General surgery and trauma and orthopaedic surgery made up 72% of all surgical treatments carried out. The hospital also carried out ENT, maxillo- facial and breast surgery.

There are 11 operating theatres located in the main theatre centre and the day theatre suite. We visited the day surgery ward, the surgical assessment unit and all surgical wards. We visited all theatre areas and the recovery area.

We spoke with 15 patients, four relatives and 58 members of staff. These included nursing staff, healthcare assistants, ward clerks, junior and senior doctors, pharmacists, physiotherapists, occupational therapists, housekeeping staff, porters, volunteers and managers. We looked at 14 care records. We observed care and treatment. In addition, we received feedback prior to the inspection visit, from listening events held in Poole and via our website.

Summary of findings

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

- We rated safe as requires improvement because of shortfalls in areas of medicines management, cleaning, storage of patient records, the environment and equipment and surgical checklist compliance. Staff did not consistently complete the 'Five steps to safer surgery' check list to minimise risks of patient harm. In theatres, there was no emergency call system for staff to call for assistance in an emergency. Patient records were stored in unsecured areas, presenting a risk of breaching patient confidentiality.
- However, staff were encouraged to report incidents and generally received feedback about reported incidents. A recognised acuity tool was used and was continually developed to determine required nurse staffing levels. There were systems in place to assess and respond to patient risks and records were generally legible and comprehensive.
- Patients received care and treatment that followed national clinical guidelines and staff used care pathways based on evidence-based research. Staff audited patient treatment and care, and used the findings to improve outcomes for patients. Patients commented positively about the skills of staff, the quality of food and the provision of pain relief. Staff

completed training relevant to their roles. Most staff had a good understanding about their responsibilities towards the Mental Capacity Act and associated Deprivation of Liberty Safeguards.

- There was effective team working within and across different staff groups. This included multi-disciplinary working to provide person centred care. Staff commented that local leadership within the service was good and there were opportunities for personal and professional development.
- Patients told us that staff provided care in a kind and compassionate manner and they were involved in decisions about their care. Results of patient feedback, as well as quality and safety data, were displayed for patients and visitors to view on ward areas.
- Performance data showed, with the exception of trauma and orthopaedic surgery, the hospital was not achieving the referral to treatment times for 92% of patients to be on a waiting list for less than 18 weeks for surgery. Cancellation rate for operations was similar to the England national average. The percentage of patients whose operation was cancelled and were not treated within 28 days was lower (better) than the England average. Trauma and orthopaedic patients were frequently allocated beds on general surgical and medical wards. The trust mitigated risks to these patients with a trauma and orthopaedic outlier medical team that provided the medical care and treatment for trauma and orthopaedic patients on non-speciality wards.
- There was an effective governance structure to review performance and there was evidence of formal reviews of risks, incidents, deaths, complaints and audits

Are surgery services safe?

Requires improvement

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

We rated safe as requires improvement.

- Staff were not consistently completing the 'Five steps to safer surgery' check list to minimise risks of patient harm.
- In theatres, there was no emergency call system for staff to call for assistance in an emergency.
- Staff did not consistently manage medicines in line with trust policies in regards to monitoring storage temperatures and destroying controlled drugs.
- Some oxygen cylinders were found unsecured in theatre areas, presenting a hazard to patients and staff.
- The storage of boxes and fans on some ward areas meant that cleanliness could not be effectively maintained.
- Some equipment on B4 ward was out of date which meant the trust did not have assurance this equipment would be fully effective if it had to be used to treat a patient.
- Staff reported incidents when the number of staff on duty resulted in delays in administering medicines, delays in recording patient observations and delays in delivering personal care to patients.

Patient records were stored in unsecured areas, presenting a risk of breaching patient confidentiality.

- On the TAU wards, patient records did not detail locked door practices were explained to patients' or that staff completed assessments of patients' suitably to have the code key to leave the wards.

However,

- Staff said they were encouraged to report incidents and received feedback.
- Staff used the safety thermometer and other data to monitor and report on patient safety.
- Equipment was serviced regularly.
- A recognised acuity tool was used and was continually developed to determine required nurse staffing levels. Staff said generally there were sufficient numbers of staff to meet the needs of patients

- Patient records were created in electronic and paper formats. There were systems in place to check that staff monitored patients on a regular basis and recorded the findings.
- Staff used a nationally recognised scoring system to identify patients whose condition was at risk of deteriorating. This prompted them to seek appropriate medical support for the patient.
- Staff understood how to safeguard adults and children and where to find additional support or advice if required.

Incidents

- The trust reported 18 serious incidents between January 2015 to December 2015 within surgical services, of which one was a Never Event that occurred in December 2015. 'Never Events' are serious, largely preventable patient safety incidents, which should not occur if the available preventative measures have been implemented. The never event related to a retained swab in a patients wound. Clinical leads from surgical services described the actions that had been implemented following the never event to reduce the risk of similar occurrences happening.
- The highest number of serious incidents reported were pressure ulcers meeting the serious incident criteria (total of five) followed by slips or trips or falls meeting the serious incident criteria (total of four.)
- Staff reported incidents using an electronic reporting system. Most staff we spoke with knew how to report incidents using the electronic system. Staff who said they were not sure how to report incidents said they would cascade the incident to a more senior member of staff to ensure it was reported.
- Staff were clear about the requirement to report patient safety incidents and any harm to patients or staff.
- Staff of all grades and disciplines had mixed opinions about receiving feedback from reported incidents. Some reported good feedback from reported incidents, which included email feedback, feedback at ward or team meetings, in handover periods and from newsletters. However, some staff said they rarely or did not receive feedback from incidents reported.
- NICE recommends that all patients are assessed for risk of developing thrombosis on a regular basis. We looked at a sample of patient record. They all had assessments of the patients' risk of developing venous thromboembolism (VTE). Staff prescribed and carried out appropriate treatment when risk were identified.
- Each clinical speciality had clinical governance meetings in which they reviewed morbidity and mortality issues. Records from the meetings indicated clinical leads discussed the causal factors for unexpected deaths and learning shared and acted on. One example included recognition of the need to involve the full multidisciplinary team in the management of patients with neck injuries. There was evidence in the records of shared learning for trauma and orthopaedic services across Poole hospital and a nearby acute NHS hospital. There was no evidence that the multidisciplinary team was involved in mortality and morbidity meetings and therefore it was unclear how learning from the meeting was shared with the wider care team.
- The trust had a policy titled Being Open/ Duty of Candour Policy dated April 2014 that gave the guidance on the statutory requirements, principles and concepts of 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. We saw detail in the incident reporting records that staff considered duty of candour and the process followed where appropriate.

Safety thermometer

- The NHS safety thermometer is a monthly snap shot of the prevalence of avoidable harms, in particular new pressure ulcers, catheter-related urinary tract infections, venous thromboembolism (VTE) and falls. This information was displayed on ward notice boards, where patients, visitors and staff could view the results and trends.
- The safety thermometer data for surgical services showed 16 pressure ulcers (grade 2-4), three falls and eight catheter related urinary tract infections between September 2014 and September 2015. There were no identified trends in the data although there was a consistently low number of pressure ulcers reported each month. These results were in line with the English national average for similar sized hospitals. However,

staff had identified there was an increasing number of pressure ulcers developing on the wards. They were considering the reasons for this and trying to identify actions to further reduce development of pressure ulcers.

Cleanliness, infection control and hygiene

- The trust provided data about surgical site infections for patients who had total hip replacement surgery. The data showed surgical site infection rate for these cases were similar to those of other trusts.
- Most areas we viewed were visibly clean and tidy. However, the practices of storing boxes on the floor in TAU Red ward and B4 ward meant staff could not clean the floor effectively. On TAU Red ward there were fans stored in the sluice area that were dusty and had no covering to protect them from getting dusty and dirty. On the same ward, we saw mobile computers were dusty. This meant risk of contamination of patient's wounds with dust particles was not fully mitigated.
- Equipment had "I am clean" tags on them to identify they were clean and the date they were cleaned.
- The trust subcontracted cleaning of the environment to another service provider. Each ward and department had cleaning schedules displayed for cleaning staff to follow. This schedule was colour coded to give guidance to staff about which cleaning equipment to use to reduce risks of cross infection between areas. For example, blue mops for general areas and red mops for toilets and bathrooms.
- Ward staff cleaned clinical equipment. Staff were clear of their individual roles to ensure cleanliness of the environment and equipment.
- Monthly cleaning audit reports showed all areas met cleanliness targets set by the trust.
- Hand hygiene audits completed monthly showed that for the period March 2015 to December 2015 there were only three months when surgical services achieved the trust target of over 95% compliance with hand washing techniques. However, for compliance with bare below the elbow practice, all areas for the same time achieved the trust target of over 95% compliance.
- There were hand cleansing facilities, including hand sanitizers, at the entrance to all wards and departments and at the entrance to all patient accommodation areas. Personal protective equipment (PPE) that included gloves and aprons for ward staff and gloves, eye shield and masks were available in relevant clinical areas. We observed staff using this equipment and discarding them between each patient contact. Information was displayed advising visitors about hand hygiene.
- During our announced inspection, the trust had an outbreak of Norovirus. As a response to reduce risk of cross infection, the trust closed some of the bays on wards and one of the surgical wards to all but essential staff and close family of patients in these areas. To reduce risk of cross infection, staff working in these areas did not help staff or patients in areas that did not have suspected norovirus.
- We saw that when closed bays became empty cleaning staff completed a deep clean of the area before the area or ward was reopened to other patients.
- We observed an infection controls round, where the infection control lead nurse for the trust and a microbiologist reviewed patient's antimicrobial treatment to ensure it was appropriate for their condition. Pharmacists allocated to ward areas also monitored and advised medical staff about the appropriate use of antimicrobial treatment.
- In all theatre areas there was clear segregation between clean and dirty equipment, reducing the risk of cross infection.
- Between August 2014 and August 2015 the trust had only one reported case of MRSA, which was agreed by NHS England to be non-trajectory. The trust explained this meant NHS England agreed the case of MRSA was not caused by the treatment and care provided by the hospital. For the same period the rate of cases of clostridium difficile were below the England average.

Environment and equipment

- In theatres there was no appropriate call system for staff to call for assistance in an emergency.
- Equipment on most wards was in date. However, on B4 ward there was a chest drain kit dated 2014 and some nasal cannulas dated 2013. This meant the provider did not have assurance this equipment would be fully effective if it had to be used to treat a patient.
- Each ward and clinical area had sufficient moving and handling equipment to enable patients to be cared for safely.

- Equipment was maintained and checked regularly to ensure it continued to be safe to use. Clearly labelled equipment showed the date when the next service was due.
- Labels on equipment indicated portable appliance testing (PAT) was up to date.
- Staff completed and documented daily checks of resuscitation equipment. We reviewed the records for the checks on wards and theatre departments and found staff completed them daily.
- Equipment such as commodes, bedpans and urinals were readily available on the wards we visited.
- Staff knew how to report faulty equipment and said the equipment maintenance team attended to faulty equipment promptly. Staff said if required, replacement equipment was provided in a timely manner. This meant they had the equipment needed to provide safe care and treatment.
- Equipment maintenance records showed servicing and maintenance of equipment was planned and monitored.
- Records evidenced anaesthetic equipment was checked daily and circuits were changed weekly. This met the Association of Anaesthetists of Great Britain and Ireland guidelines.
- Clinical sterile services department provided an effective service with a one and half hour turn round for sterilising equipment. This meant instruments and equipment were always available for routine surgical procedures.

Medicines

- Staff were not assured medicines requiring refrigeration were stored at temperatures that ensured their effectiveness. Medicine fridges were fitted with thermometers that recorded maximum and minimum temperatures. Staff recorded the temperature of medicine fridges daily. However, on some wards (day of surgery, B4, TAU Red ward) the maximum and minimum temperatures for the day were not checked and recorded. The trust's Medicines Management Policy for the safe and secure handling of medicines dated February 2015 stated "Refrigerators must be fitted with maximum-minimum thermometers, which should be monitored and the daily temperature recorded on a log to ensure a constant temperature between 2-8 °C." This did not provide clear guidance to staff about the need to measure and record maximum and minimum temperatures.
- On B4 ward a maximum temperature of 18°C was recorded for the medicine fridge. There was no detail to evidence action was taken to correct the fridge temperature. This meant there was a lack of assurance that refrigerated pharmaceuticals were safe to use.
- Oxygen was piped to patient areas and where cylinders were used, for example on emergency trolleys; they were generally stored in a secure manner. However, on B4 ward we observed three oxygen cylinders that were not stored securely and were free standing. This posed a potential hazard to staff and patients.
- Medicines and intravenous fluids were stored securely in all areas. However, we saw in some wards a high volume of medicines that needed returning to pharmacy meant they were not able to be stored in a locked cupboard. They were however, stored in a locked clinical room that only health care staff had access to.
- Staff detailed patients' medicine allergies on medicine administration and prescription charts and in their medical and nursing records.
- Medicine administration and prescription charts clearly detailed the name, dosage route of administration and time that medicine needed to be administered and was administered. Staff recorded reasons any medicines not administered.
- Patients told us staff usually gave them their medicines on time. They also said staff explained the medicine to them and they were told about risks associated with taking medication.
- Staff working on Cornelia suite (private ward) said there were sometimes difficulties in administering some medicines in a timely manner at night. This was because there was only one trained nurse and a health care assistant on duty at night. For medicines such as intravenous and controlled medicines, that hospital policy required two members of staff to check, this meant they had to request for a nurse from another ward to attend the ward to check the medicine. This also had an adverse impact on the ward's ability to complete weekly stock checks of controlled medicines. It was identified by looking at the controlled medicine register that weekly checks as required by hospital policy and best practice guidelines were not being carried out.

- Staff working on Cornelia ward said they had escalated their concerns about checking medicines and completing weekly stock checks on controlled medicines. In response, the pharmacy service had arranged for health care assistants to receive training and complete competency assessments so they could check medicines with the trained nurses, including controlled medicines.

Records

- Storage of patient notes on wards did not fully protect their confidential details. Staff stored notes in open topped note trolleys, with some notes stored on a shelf underneath the note sling holders. Notes trolleys were not locked. This meant notes were potentially accessible to people who did not have professional need to look at notes. The trust had not completed an assessment of the risk this posed to protecting patient's confidentiality. The trust completed a risk assessment of this practice on 28 January 2016 after we had raised the concern to the trust. At the unannounced inspection we saw note trolleys that had lids had the lids closed and notes that had been stored under the trolley were now kept in a lockable room. However, we saw on B2 this room was not always locked.
- Records were in both paper and electronic formats. Patient paper records that we looked at were well maintained and completed with clear dates, times and designation of the person documenting. The records we examined were written legibly and assessments were generally comprehensive and complete, with associated action plans and dates. However, on B4 ward on 27January 2016 staff had not fully completed risk assessments for patients admitted overnight. Staff explained this was due to staffing shortages overnight and they would complete the assessments during the day shift.
- The trust was transferring all patient documents to electronic records. Once the patient was discharged from the hospital, records were sent to a central scanning team, who scanned the records onto the electronic recording system. Staff said patient's scanned records were not organised in a logical order, for example chronologically. This potentially posed delays in accessing relevant patient records if a patient contacted the ward or department for advice after they were discharged.
- Medical records of patients demonstrated medical consultants and junior doctors reviewed them regularly; this included medical treated on wards other than medical wards (outliers).
- Staff carrying out operations completed the operating department records of care, which included the pre-operative checklist, peri-operative care details, and recovery observations. We reviewed the records for two patients through their operation journey and saw their records were completed accurately.
- The trust carried out audits of clinical notes. The last, carried out on 16 November 2015, identified areas of not meeting trust policies for completion of clinical records. This included patient's names and identification not clearly recorded on each page, recording of patients symptoms or diagnosis not recorded, prescription charts not signed in an identifiable manned and medicine allergy box not completed on all prescription charts. The action plan from this audit detailed results were being cascaded to all medical staff and a repeat audit was planned for June 2016 to monitor progress.
- We saw patient records had details of their capacity to make decisions, records of best interest decisions and consent to treatment. However, for patients on the TAU wards where the doors were locked to prevent confused wandering patient's accessing the main hospital, we did not see details of this practice in patient records. We did not see any documentary evidence to indicate staff assessed patients for their suitability to have the code key to leave the wards.

Safeguarding

- All staff spoken with understood the term safeguarding, and knew how to raise a safeguarding concern.
- However, not all had received safeguarding training. Staff presented a confused picture as to whether safeguarding training was part of their mandatory training.
- Most staff knew who the safeguarding lead for the trust was. Those that did not ,knew they could find the lead's detail on the intranet and knew they could contact them by the hospital bleep system.

Mandatory training

- Each ward and department had a member of the nursing staff responsible for monitoring staff

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.
- Staff expressed concerns that due to staff shortages some staff found they could not attend their booked mandatory training because they were required to work clinically. However, on some wards senior staff ensured staff booked for mandatory training had that time protected and did not work clinically.
- Data provided by the trust showed there was a range between 75.5% to 100% of staff meeting the target of 95% compliance with mandatory training.
- New members of staff said they were supported on joining the hospital. They had completed a trust wide induction programme. When on the ward they had opportunity to understand processes and procedures. Agency and bank staff completed a local induction to the area they were working on.

Assessing and responding to patient risk

- The National Institute for Health and Care Excellence (NICE) recommends that all patients are assessed for the risk of developing venous thromboembolism (VTE) on a regular basis. Records showed staff assessed surgical patients on admission for their VTE risks. Where risk of a patient developing a VTE was identified, treatment was prescribed and administered to reduce the risk of the patient developing a VTE.
- Staff carrying out surgical procedures used a surgical safety checklist based on the World Health Organisation (WHO) surgical checklist and the Five Steps to Safer Surgery. A monthly review of the use of the checklist from October 2014 to November 2015 showed consistent poor compliance with completing two areas of the check list. These were 'Time out in Theatre' completed & signed by surgeon or anaesthetist with compliance rates of 67% to 70% and 'Post List Debrief' completed with compliance rates of 49% to 67%. This showed surgical services had not made effective improvements in their use of the safety check list. Governance meeting records showed compliance with the safety check list was reviewed at the meetings.
- The trust told us they were working to achieve 95% compliance with completing the safety check list by the end of March 2016. We observed during the inspection staff using the safety check lists in full and appropriately.
- Staff carried out interventional radiology in line with the Ionising Radiation (Medical Exposure) Regulations 2000 - IR(ME)R. Staff used a specific WHO checklist adapted for radiology to include the IR(ME)R procedures.
- Staff monitored patient's health during surgery, recovery and on the wards, and systems were in place to respond to any deterioration. The hospital used an electronic system to record patients' vital indicators on handheld devices. The surgical wards and recovery areas used the nationally recognised Early Warning Score (EWS), a scoring system that identified patients at risk of deterioration or needing urgent review. The scoring system alerted staff to take the appropriate action if a patient was identified at risk of deterioration. This included alerting a doctor and, if necessary, the hospital's critical outreach team, to support the patient. Nursing and medical staff told us the system worked well.
- Staff assessed patients for their risk of developing pressure ulcers, VTE, for falls and malnutrition. They also reviewed risks relating to patients' medical history, medicines and lifestyle. The risk assessment process started at pre-assessment and staff monitored any changes throughout a patient's admission.
- Systems were in place to minimise the risk of patient harm. For example, if patients were at risk of dehydration staff monitored their fluid balance.
- To protect confused and disorientated patients leaving the ward, the hospital and into potential dangers from nearby roads and traffic the trust had installed locked doors to the access corridor to the TAU wards. The door was locked with code key access. The trust told us patients and their relatives were informed of the reasons for the locked door policy. Staff said patients could have the code to exit the wards if assessments concluded it was safe for them.
- Information received from the trust before the inspection indicated a practice of daily safety briefings was being introduced in the surgical ward areas. There was no time scale for this, and there was no evidence at the time of inspection that it was occurring.
- We observed nursing staff protected the safety of patients by ensuring medical staff attended to the correct patients. An example was on one ward an anaesthetist asked to see a patient planned for surgery. The anaesthetist did not know the patient's name, only

the procedure they were having done. The anaesthetist asked the nurse to find the patient for them. The nurse refused and insisted the anaesthetist went back to theatres to find the name of the patient.

Nursing staffing

- Data provided by the trust showed that most ward and clinical areas within surgery services did not have a full complement of nursing staff. However, data provided indicated successful recruitment drives meant actual staffing levels were improving. For example in, September 2015 B2 ward, who had a planned staffing level of 41.41 whole time equivalent (WTE) staff, had 30.92 whole time equivalent (WTE) staff in post. In October 2015, the number of staff in post had increased to 33.36 WTE.
- Information received from the trust before the inspection indicated they were evaluating staff to patient rations using a recognised safer nursing care tool, which included guidance for determining the acuity of patients. At inspection, the trust was implementing the tool across all wards in the hospital, with some ward areas more advanced in the use of the tool. The aim of the tool was to determine whether wards and departments had appropriate staffing numbers and skill mix on duty to safely meet the needs of patients. Staff recorded the information electronically on an iPad. The clinical management team in overall charge of the hospital could access all ward's results to identify wards that needed extra staff to ensure patient needs were met.
- Staff explained this was a new process and hoped the data collected would result in a better understanding of the acuity of patients and required staffing numbers, eventually resulting in improved staffing on the wards. One charge nurse described how ward staff were able to influence the development of the safer nursing care tool. He identified that scoring patient acuity at 7am and 7pm, as requested by the trust, did not accurately reflect the level of patient acuity on the ward. Patient acuity was greatest in the afternoon when patients were returning from surgery. This meant the identified numbers and skill mix were potentially insufficient to meet the needs of patients post operatively. In response, the trust had started collecting the data at 3pm as well as 7am and 7pm, so an accurate description of patient acuity was recorded.
- The trust had recently introduced an electronic rostering system that highlighted any gaps in the planned rotas. It also flagged the use of agency or bank staff, and any risks of staff working long hours in a month. Some staff told us they found the electronic rostering system inflexible.
- However, other staff told us changes to the system were being made and work around processes enabled them to use the system to flexibly meet the individual needs of each clinical area and staff group. Staff commented on the positive aspects of the system. These included monitoring of staff annual leave to ensure there were not too many staff on leave at one time and ensuring staff did not take all their leave at the end of the financial year which would result in reduced staff numbers.
- Staff on the wards and in theatres said there were generally sufficient staff detailed on the rota to meet the usual needs of patients. However, when staff were on sick leave or the acuity of patients was greater than normal, replacement staff were not always available leaving the areas short staffed and unable to fully meet the needs of patients. The trust collected data on the use of agency and bank staff. However, the trust did not collect this data at ward level so it was not possible to determine how frequently shifts were not filled by the bank or agency services.
- Staff told us they were often requested to attend other wards where there were shortages in staffing level. They found it this very unsettling as their perception was that it made the ward they were moved from less safe for patients. Some staff we spoke with told us about incidents when they were asked to work in clinical areas they did not have the skills for. The electronic incident reporting system showed staff had reported 13 incidents of unsafe staffing during December 2015 and January 2016. Incidents were reported across all the surgical wards. Reported themes included low staffing numbers due to staff sickness with bank or agency staff not available to cover shifts. Reported impact on patient safety included delays in administration of oral and intravenous medicines, delay in recording patient observations, delay in providing personal care, including care to prevent development of pressure ulcers. There were also recorded incidents of staff not able to take breaks, due to workload. In escalation situations, the trust opened beds on the day of surgery ward for inpatients. In these circumstances the night

shifts were staffed by agency or bank nurses. Staff on the day of surgery ward said it was not unusual to have stay beyond their shift time, whilst waiting for agency or bank staff to arrive. Staff did not keep any record to monitor the frequency this occurred.

Surgical staffing

- The hospital was the trauma unit for the local population. This meant there was a high volume of emergency and urgent surgery carried out in comparison to most district general hospitals. The majority of elective surgery for the local population was carried out at by a neighbouring acute NHS trust. Medical staffing was planned to meet the needs of the nature of emergency and urgent surgical work.
- The trust had slightly more middle career medical staff (19%) and junior medical staff (13%) than the England national average of 11% and 12% respectively. The registrar group was slightly smaller in the hospital at 36% of medical staff, compared with 37% as an England national average. The consultant staff group was smaller at 32% compared to the England average of 41%. These results were for the ten-year period to September 2015.
- The trust provided data that showed the proportion of locum doctors who had worked at the hospital for the period April 2014 to March 2015. The number of locum doctors working for the trust varied over the year and for different specialties. In trauma and orthopaedic services, the number of kokum doctors working at the hospital was between 24% to 15% for the first part of the year, but reduced to between 7.4% and 0% between November 2014 to March 2015. For the same period, the use of locum doctors' in general surgical services was consistently low, at a rate of between 2.7% and 0%.
- Data provided by the trust detailed vacancy rates for medical staffing. This showed that in October 2015 there was a vacancy rate of 17% for oral surgery staff, 8% for ENT staff and 10% for anaesthetic staff. At the same date, there were no vacancies for trauma and orthopaedic medical staff and for general surgery medical staff.
- Medical working patterns ensured consultant, middle grade and junior doctor availability for all surgical specialities were available to attend to patients when needed. This included carrying our urgent and emergency surgical work in and out of hours.
- The hospital at night policy, 2015, outlined the medical cover arrangement, including contact details, specific roles, responsibilities and skills, handover guidance and night time pathways by specialty. This policy included weekend and bank holiday cover arrangements. The junior doctor's working patterns meant they were rostered into the hospital at night working practices. There was a combined ENT and general surgery junior doctor on call role and a combined maxilla facial and trauma and orthopaedic junior doctor on call role in the hospital at night team.
- Theatre staffing was in line with The Association for Perioperative Practice (AfPP) recommendations.
- Nursing staff on the wards and in theatres reported good access to medical support, both during the day, at night and at weekends.

Major incident awareness and training

- There was a trust wide Emergency Preparedness Resilience and Response Policy dated December 2014. Staff understood the processes followed in response to increased demands in beds and response to outbreaks of infections. This was demonstrated at the time of our inspection by staff acting in accordance with processes for containment and management of an outbreak of norovirus.
- Most staff were not aware of the action they needed to take in the event of a major incident occurring. However, they all said they would refer to guidance on the intranet and would be led by the Clinical Site Management team.
- A bed management system aimed to ensure patients' needs were met when there was an increased demand on beds. At the time of the inspection, due to increased numbers of patients, some trauma and orthopaedic patients were placed and cared for on the general surgical and medical wards.
- The trust followed a defined process for deferring elective activity to prioritise unscheduled emergency procedures.

Surgery

Are surgery services effective?

Good

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

We rated effective as good.

- Patients received care and treatment that took account of national clinical guidelines and staff used care pathways based on evidence-based research.
- Overall, outcomes for patients were similar or better than England average.
- Services participated in national audits and carried out local audits to improve outcomes for patients. The trust was taking action to make improvements in response to the findings of the 2015 National Emergency Laparotomy Audit, where although they performed similar to other trusts, they performed significantly below two of the nationally required standards.
- Staff monitored patients' pain levels and administered appropriate pain relief. Patients were complimentary about the food, and staff monitored those at risk of malnutrition and implemented appropriate care plans.
- Patients commented positively about the skills of staff. Staff completed a comprehensive trust induction. Agency and bank staff completed a local induction to the area they were working. Staff completed competency assessments relevant to their area of work.
- There was effective multi-disciplinary working, with good support from therapists, pharmacists and dietitians.

However,

- It was unclear whether the trust's training programmes fully ensured all staff understood the trust's policy about MCA and DoLS.

Evidence-based care and treatment

- Surgical staff managed emergency laparotomy surgery in accordance with National Confidential Enquiry into Patient Outcome and Death (NCEPOD) recommendations. We found the Royal College of Surgeons' standards for emergency surgery/surgery out of hours were consultant led and delivered.
- Local policies such as the pressure ulcer prevention and management policies were written in line with national guidelines and staff we spoke with were aware of these policies.
- To improve outcomes for patients undergoing colorectal surgery and gynaecological surgery staff used enhanced recovery pathways following recognised professional guidance. This focused on thorough pre-assessment, less invasive surgical techniques, pain relief and the management of fluids and diet, which helped patients to recover quickly post-operatively. We reviewed the enhanced recovery pathway documentation for colorectal surgery and gynaecological surgery. There was clear guidance for staff regarding the recording of pre-operative and post-operative care and treatment.
- Surgical services participated in national clinical audits, for example, the National Joint Registry. This registry collects information on all hip, knee, ankle, elbow and shoulder replacement operations, and monitors the performance of joint replacement implants.
- Surgical services had an annual audit programme. This included repeated audits for known risks, audits of clinical practices, patient outcomes and compliance with trust policies such as record keeping, the surgical safety checklist and the use of tools for assessing risks such as pressure ulcers and malnutrition.

Pain relief

- Staff assessed patients pre-operatively for their preferred pain relief.
- Patient records showed that patient's pain was assessed using numerical scoring system. However, it was not evident, from patient records we looked at, that staff recorded the effectiveness of pain relieving medicines. Staff used a recognised tool to assess pain in patients with dementia or who had a cognitive impairment. There was no specific pain assessment tool to use for patients with a learning disability.
- Patients told us staff gave them pain relief when they needed it and that their pain was well managed. Patients told us they did not have to wait for pain relieving medicine. One relative said it was "marvellous" that their family member has their pain so well controlled.

- Staff could access specialist advice from the pain management team when required. Patient records showed that advice and support was provided by the pain management team.
- We saw audits for the pain management of patients who had a fractured neck of femur. This showed that since 2012 trust had made steady improvements with the management of pain for this group of patients.

Nutrition and hydration

- Staff used a recognised tool to assess patient's risk of malnutrition. The tool gave guidance about when a patient needed closer monitoring of their food and fluid intake and when staff needed to refer patients to dieticians. Records, conversations with staff and a dietician evidenced staff made referrals to dieticians in an appropriate and timely manner.
- The trust carried out six monthly audits of compliance with the use of the malnutrition assessment tool. The most recent audit in June 2015 showed that both the surgical wards and trauma and orthopaedic wards were failing to meet the trust target of 90% compliance with the completion of these assessments. There was an ongoing rolling education programme to staff about the carrying out of MUST assessments.
- Where identified as required, we observed staff used fluid balance charts to monitor patients' hydration status. Records recorded ongoing fluid balance and staff used them to support clinical decision making.
- Patients had access to drinks by their bedside. Care support staff checked that regular drinks were taken where required.
- The patients said they had choices for food and snacks. Most commented highly about the quality and varied choice of food.
- The trust had extended visiting hours on the wards, which meant meal times were not fully protected. Staff told us the positive outcomes of visitors being able to support their relative in hospital at meal times, outweighed the distraction of visitors being on the wards. There was no clinical activity at meals times, with the exception of clinical emergencies.
- Volunteer workers called 'meal time companions' supported patients to have their meals. A 'meal time companion 'told us they received regular training to equip them with the skills to support patients at meal times.
- Staff monitored all patients who displayed nausea and/or vomiting post-surgery within recovery. Where applicable suitable analgesic and anti-emetic regimes were prescribed and administered.

Patient outcomes

- The 2015 National Emergency Laparotomy Audit looked at structure, process and outcome measures for the quality of care received by patients undergoing emergency laparotomy. NELA compared against standards of care such as those detailed in NCEPOD reports, and the Department of Health/Royal College of Surgeons of England's "Higher Risk General Surgical Patient (2011)". The trust had a mixed performance in this audit. The trust scored significantly below the required standards for patients having a consultant surgeon review within 12 hours of emergency admission and for patients over the age of 70 being seen by an older person physician. Although many trusts had similar results in these areas, this did not distract form the audit findings that these were areas the trust need to make improvements. The senior clinical leads said they were monitoring their performance against the audit criteria. The trust told us a number of improvement measures had been implemented, which included the new surgical assessment unit. Senior clinical leads said monitoring had identified improvement in the two areas they had performing less well in. However, the trust performed very well on patients having a CT scan reported on before surgery, patient's arrival in theatres within a time scale appropriate to the urgency of their clinical condition, consultant presence in theatres and final case ascertainment. The trust preformed within nationally acceptable levels for the remaining five outcome areas of the audit.
- Surgical services took part in national audits, for example, the elective surgery Patient Reported Outcome measures (PROM) programme, national hip fracture database and national joint registry. Performance in the national audits was reviewed at clinical governance meetings.
- Patient Reported Outcomes Measures (PROMs) is a national tool used to measure health gain in patients following hip replacement, knee replacement, varicose vein and groin hernia surgery in England. The measures are based on patients' responses to questionnaires

before and after surgery. The hospital only collected data for groin hernia surgery, as hip replacements, knee replacements and varicose veins surgery were all carried out at a neighbouring acute NHS trust. The hospital had better patient reported outcomes (PROMS) for groin hernia than the England average.

- The trust performed well in the 2015 Hip Fracture Audit, performing better than the England average on all comparable measures. Data provided by the trust showed that in November 2015 the percentage of patients who had surgery for a hip fracture within 36 hours of being admitted to the hospital was 76%. The trust also measured how long it took patients to have their surgery for hip fractures once they were medically fit to undergo surgery. In November 2015 93% of patients had surgery with 36 hours of being medically fit, 96% within 48 hours and 89% within 24 hours of being medically fit.
- In the bowel cancer audit, the trust scored better than the England average on all comparable measures
- The overall risk of readmission for both elective and non-elective patients at the trust was comparable to or lower than the England average. The only exception to this was elective trauma and orthopaedics which was 41% higher than the national average.

Competent staff

- Annual appraisals were completed. Staff said they had annual appraisals where development goals were set and adhered to. Data provide by the trust showed that between April 2014 to March 2015, compliance with appraisals for nursing staff on the general surgical wards was 84% and trauma and for orthopaedic wards was93%. For medical staff in the same time, they were 74% compliant on general surgery and 75% compliant in trauma and orthopaedics. The data demonstrated an improvement from the previous year for all staff groups.
- Staff did not receive formal supervision. Staff, however, were supervised clinically and felt that handovers, ward rounds and board rounds provided them with learning opportunities.
- All staff undertook competency tests, relevant to their area of work, to ensure they had the necessary skills to carry out their role. Examples included care of patients with a tracheostomy.
- Overall, patients expressed the view that staff were skilled in their work.
- Nursing staff were aware of the need to revalidate their registration. The appraisal process was used to support them with their revalidation process.
- In the General Medical Council (GMC) National Training Scheme Survey 2015, the trainee doctors within surgical specialities rated their overall satisfaction with training as within expectations.

Multidisciplinary working

- Staff described the multidisciplinary team as being supportive of each other. Health professionals told us they felt supported, and that their contribution to overall patient care was valued. Staff told us they worked hard as a team to ensure patient care was safe and effective.
- Daily ward rounds were undertaken seven days a week on all surgical wards. Medical and nursing staff were involved in these together with any physiotherapists, occupational therapists, gastroenterologists, oncologists and specialist nurses as required.
- The therapy team, including physiotherapists, therapy technicians and occupational therapists worked together to promote patients rehabilitation and safe discharge from hospital.
- Staff said that they could access medical staff when needed to support patients' medical needs.
- Junior doctors and nursing staff told us they worked well together within the surgical specialities. We saw evidence of this on the surgical wards and the day care unit.
- A trauma and orthopaedic outlier team, which consisted of medical and therapy staff, worked together with staff on general surgical and medical wards to ensure outlying trauma and orthopaedic patients received the care and treatment they required.
- An ortho-geriatrician doctor saw all trauma and orthopaedic patients that were ever the age of 75 ensuring treatment was appropriate to meet the sometimes-complex needs of the elderly patient.
- The TACT team supported the orthopaedic medical team to ensure theatre lists were managed effectively.
- Patients' records showed they were referred, assessed and reviewed by dieticians and the pain management team when required.
- There was pharmacy support on all the wards we visited which helped to speed up patient discharges with take home medicines.

- The records viewed identified family involvement at admission to encourage effective discharge.
- Staff described the multidisciplinary team as being supportive of each other. Health professionals told us they felt supported, and that their contribution to overall patient care was valued. Staff told us they worked hard as a team to ensure patient care was safe and effective

Seven-day services

- Surgical services had a consultant presence over the weekend.
- Consultants worked throughout the week within the surgical services.
- Access to medical advice at night came from the hospital at night team which was made up of nurse practitioners and junior medical staff. Nurses told us they were very responsive.
- Pharmacy services were available seven days a week. The pharmacy was open 10am to 6pm on Saturdays and 10am to 4pm on Sundays. An on call pharmacy service was provided when the pharmacy was closed. An emergency medicines room was available which was accessed by the clinical management team.
- The trust provided a seven day diagnostic service that included, for example endoscopy.
- Therapy services were provided at the weekend, enabling patients to continue with their rehabilitation.

Access to information

- Staff told us they had good access to patient related information and records whenever required. The agency and locum staff also had access to the information in care records to enable them to care for patients appropriately.
- Nursing staff told us when patients were transferred between wards or teams, staff received a handover of the patient's medical condition and ongoing care information was shared appropriately in a timely way.
- Nursing handover in some wards was recorded on a hand held recording device. This meant staff, such as agency or bank staff, who did not commence work at the beginning of a shift, had immediate access to patient information in the nurse handover. However, this did not give them opportunity to ask questions for clarification at the time of the handover.
- Medical staff accessed patient monitoring records from any computer terminal or hospital hand held device, which meant they could access patient's vital information promptly and remotely if needed.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Most staff, in conversations, demonstrated a good understanding of the Mental Capacity Act and associated Deprivation of Liberty Safeguards.
- The legal requirement of the Mental Capacity Act 2005 requires organisations such as hospitals to consider patients' mental capacity and assess their ability to make decisions about care and treatment, if there is any doubt. Within this legislation, the Deprivation of Liberty Safeguards (DoLS) relate to patients who lack mental capacity. When a patient lacks mental capacity to consent to care or treatment, it is sometimes necessary to deprive them of their liberty in their best interests, to protect them from harm. The hospital must apply to the local authority to request a DoLS, giving reasons.
- The trust had a detailed Deprivation of Liberty Safeguards (DoLS) policy dated January 2016 that set out the legal requirements for DoLS applications. The trust told us that a "How to" Deprivation of Liberty guide was completed in 2014 in order to ensure a Trust wide response. Training about the Mental Capacity Act and associated DoLS was included in the trust induction programme and one of the ward sisters form the surgical wards was tasked with developing this and rolling out training to all staff about MCA and DoLS.
- However, it was unclear whether these training programmes fully ensured all staff understood the trust's policy about MCA and DoLS. A member of staff on one ward who had recently completed the trust's induction programme understood the trust's policy required them to make a DoLS application for all patients diagnosed with a dementia in order to prevent them leaving the ward. They understood from the training they had received that the trust considered all patients with a dementia lacked capacity to understand and consent to their care and treatment.
- Staff asked patients for their consent to surgical procedures appropriately and correctly. We saw

examples of patients who did not have capacity to consent and the Mental Capacity Act 2005 was adhered to appropriately with documented capacity assessments.
- The records, where applicable, showed clear evidence of informed consent, which identified the possible risks and benefits of surgery.
- Patients confirmed they had received clear explanations and guidance about the surgery and said they understood what they were consenting to.
- The last audit of clinical notes completed in November 2015 showed 93% compliance with trust policies with regard to obtaining formal written consent from patients. This met the trust target of 80% compliance.
- Patient records evidenced informal consent was sought prior to care or treatment such as physiotherapy. Where a patient did not have capacity to give informal consent to the care or treatment, best interest decisions were detailed.

Are surgery services caring?

Good

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

We rated caring as good.

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

Compassionate care

- Throughout our inspection, we witnessed staff treating patients treated with compassion, dignity and respect.
- Patients said the nursing staff were kind and caring. One patient said that if they needed care again they would "get the best care possible in this hospital."
- Thank you cards displayed on the wards included comments such as "" big thanks to all the staff for helping though operation and recovery", "the most helpful friendly and caring staff I have ever experienced, nothing was too much trouble" and "Thank you so much for all your kindness, care and compassion, you have bee unfailingly wonderful and kind."
- We observed and patients told us all staff always introduced themselves to them, including their name and their clinical role.
- The NHS Friends and Family Test results were displayed within the wards. We saw posters encouraging patients to feedback so they could improve the care provided. Between August 2015 and December 2015 results showed that showed that over 90% of patients were "extremely likely" to recommend the trust to friends and family, which is better than the national average.
- With permission of the patients, we followed two patients through their surgical experiences. At all times staff acted in a compassionate and caring manner. Staff introduced themselves to the patient, and gave explanations to the patients so they knew what was happening. After surgery, we observed staff removing medical devices from patients, gently explaining to them what was happening.

Understanding and involvement of patients and those close to them

- Patients said they felt involved in their care. They had the opportunity to speak with the consultant looking after them. Patients and relatives were involved in their discharge planning. We saw a patient, their relative, nursing and therapy staff working together, making discharge arrangements that would meet the needs of the patient and their relative.
- Patients said the doctors had explained their diagnosis and that they were fully aware of what was happening, including their discharge plans. None of the patients had any concerns regarding the way staff spoke to them. All were very complimentary about the way they had been treated.
- We observed nurses, doctors and therapists introducing themselves to patients at all times, and explaining to patients and their relatives about the care and treatment options.

Surgery

Emotional support

- During our inspection, we observed that staff were responsive to patient's needs, and we witnessed friendly and supportive interactions from staff to patients.
- Patients spoke positively about the emotional support that staff provided. Comments included "excellent, professional and friendly service - most reassuring when feeling 'low'"
- The hospital chaplaincy had a visual presence abound the hospital and were happy to meet people to offer them support.
- A wide variety of specialist nurses provided emotional and practical support for patients with specific conditions.

Are surgery services responsive?

Good

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

We rated responsive as good.

- The current Dorset Clinical Services Review would affect surgical services at the hospital.
- The hospital was a trauma unit. Approximately half the surgical work was urgent or emergency surgery, with other half being elective day case or inpatient surgery. There were lists set aside to provide, seven day a week access to emergency surgery.
- The hospital had implemented an improvement programme to reduce patient length of stay in hospital, and had identified specific barriers that they were addressing.
- The hospital's cancellation rate for operations was similar to the England average. The percentage of patients whose operation was cancelled and were not treated within 28 days was lower (better) than the England average.
- In November 2015 93% of patients with fractured neck of femur had surgery with 36 hours of being medically fit, 96% within 48 hours and 89% within 24 hours of being medically fit.
- Length of stay in hospital for patients with fractured neck of femur was better than the England average.
- General surgery and orthopaedic service met the national referral to treatment targets for elective surgery.
- There had been no mixed sex breaches for surgical services in the previous year.
- Trauma and orthopaedic patients were frequently allocated beds on general surgical and medical wards. There was a trauma and orthopaedic outlier medical team who provided the medical care and treatment these patients.
- Patients had access to information leaflets about different types of treatment and staff could request translation services or interpreters for people with communication or language difficulties.
- Staff took complaints seriously and responded in line with trust policy.

However,

- Staff were unclear whether there was any support available for patients admitted to hospital who had a learning disability.
- ENT and oral surgery services did not meet the national referral to treatment targets for elective surgery.
- An emergency theatre was not available in the morning, which posed a potential risk for patients requiring emergency surgery

Service planning and delivery to meet the needs of local people

- At the time of the inspection the hospital's services, and those of other acute hospitals in Dorset, were subject to the Dorset Clinical Services Review to redesign and improve quality of care for people in the county.
- Commissioning of services across three of the NHS trusts serving Dorset, Bournemouth and Poole meant services were often planned in partnership.
- Poole Hospital did not offer certain services, such as ophthalmic and urology surgery and these were provided at the neighbouring NHS hospital.
- The hospital was a trauma unit, which meant a significant amount of surgical work was emergency or urgent procedures. However, there was an elective service for oral maxillofacial surgery, ENT and colorectal surgery. In the period June 2014 to July 2015 45% of the surgical work was emergency procedures, 44% day case procedures and 11% inpatient elective procedures.
- Theatre lists were organised to release a theatre for dedicated lists for unplanned emergency sessions. This

was in line with the Confidential Enquiry into Peri Operative Death (CEPOD) recommendations to set time aside for emergencies. However, the CEPOD theatre did not run in the morning, which posed a potential risk for patients requiring emergency surgery. Records of theatre management meetings showed staff monitored the use and effectiveness of the emergency theatre to ensure the facility was responsive to the needs of patients admitted to the hospital. Records from the meetings showed that 66% of emergency abdominal surgery was carried out within 2 hours of the decision to operate. The same records showed less than 5% of emergency general surgical cases were carried out after midnight, which met national standards.

- The hospital had eight main theatres, three day theatres and two maternity theatres. Theatre usage rates were generally above 75%. In September 2015, two theatres had a usage rate greater than 90% and seven a usage rate of greater than 85%.

Access and flow

- The trust had identified patient flow through the hospital as a significant concern. In the period October to December 2015, the trust had mixed achievements in meeting the 18 week incomplete pathway for referral to treatment (RTT) standard. National standards detail that 92% of patients should start treatment within 18 weeks of referral for treatment. This data was for patients who were having elective surgical procedures carried out at the hospital. General surgery and trauma and orthopaedic service met this target. However, ENT and oral surgery services did not meet this target, with compliance rates ranging from 87% to 91%.
- Due to the large numbers of orthopaedic trauma patients admitted to the hospital the trust struggled to meet the target for timeliness of patients with a fractured neck of femur being operated on. In November 2015 93% of patients had surgery with 36 hours of being medically fit, 96% within 48 hours and 89% within 24 hours of being medically fit. However, data showed length of stay in hospital for these patients was steadily decreasing with the most recent data showing length of stay being just under 8 days.
- The average length of stay for both elective and non-elective general surgical patients was similar or better than the English average, with the exception of elective oral surgery which was slightly higher (worse then)than the English average.
- The number of cancelled operations for the period March 2013 to April 2015 was similar to the England average. The number of patients who had surgery cancelled and not treated within 18 days had increased in the period March 2014 to March 2015. However, the numbers during this period remained lower than the England average.
- At the time of the inspection there was a significant increase in elderly orthopaedic trauma patients which resulted in elective and urgent operations being cancelled to enable patients with fractured neck of femurs to be treated. Over the three days of our announced inspection, 31 elective operations were cancelled and three urgent operations were cancelled. There was a clear decision making process for deciding which operations to cancel which included clinical need, likelihood to breach RTT, patients who had surgery cancelled previously and availability of critical care and same sex accommodation.
- Surgical and trauma and orthopaedic services had a 'Reducing length of stay and improving patient flow' plan. This included monitoring of patient length of stay, patient flow, assessment of the risk to the service in relation to patient flow and length of stay and an action plan to address the identified risks and bring about improvements. We saw the action plan was being followed with some of the actions completed including the opening of the Surgical assessment unit, appointment of two Poole based trauma orthopaedic surgeons, with time built in their job plan for daily decision making regarding moving the patients on in their pathway.
- To support patient flow and provide rapid inpatient assessment of acute surgical, gynaecological and maxilla facial patients a Surgical Assessment Unit was opened in October 2015. Priority access to CT and ultrasound investigations was agreed for this group of patients, which led to more rapid diagnosis and treatment. As part of this initiative, the trust employed a nurse practitioner to support the pre and post-operative pathways for patients, to ensure patients were effectively prepared for theatres and minimise pre-operative delays.
- Staff told us, due to the demand for trauma and orthopaedic beds; it was normal practice for orthopaedic patients to be cared and treated on general surgical and medical wards. At the time of our announced inspection, there was an unusually high

number of trauma and orthopaedic patients outlying in general surgical and medical wards. .A trauma and orthopaedic outlier medical team was tasked with providing the medical care and treatment for trauma and orthopaedic patients on non-speciality wards. We saw trauma and orthopaedic patients on non-speciality wards were seen by this team. This ensured patients received the appropriate medical care and treatment.

Meeting people's individual needs

- The trust reported there had been no mixed sex breaches in surgical services in the last 12 months. This meant female and male patients were not nursed in the same ward area and had separate toilet facilities.
- In the day of surgery ward there were separate female and male waiting areas where patients waited for their surgery. Several of the surgical wards had mainly side rooms, which helped to prevent single sex breaches.
- In discussion, staff on the wards demonstrated a good understanding of providing care, support and accommodating patient's individual needs. This could be of patients living with dementia, who had a learning disability or any other specific need or disability. Staff and the local community knitted twiddle muffs for patients living with dementia. These are a hand muff with bits and bobs attached inside and are designed to provide a stimulation activity for restless hands for patients living with dementia. We saw patients using these.
- Elective patients who had specific needs such as a learning disability were identified during the pre-admission process. This meant wards and departments were alerted and could arrange to meet the patient's needs before the patient was admitted.
- The role of dementia champions was being developed on all ward areas. Staff told us there was a team of three dementia specialist nurses they could access for support and advice. Dementia awareness was part of all staff mandatory training. The trust had recently introduced a forget me not scheme. Staff placed a sticker of a forget-me-not next to the patients name board to identify to all hospital staff that the patient was living with dementia or had a cognitive impairment.
- Staff were less clear on the support available in the hospital for patients with a learning disability. Staff did not know whether there was a specialist learning disability nurse for the trust. However, conversations with staff demonstrated their understanding of accommodating patients individual needs meant they would do what they could to make reasonable adjustments if a patient with a learning disability was admitted to their area. This included providing a side room for the patients and enabling carers or relatives to stay with the patient to support them with their care and emotional needs.
- For patients whose first language was not English an interpreting service was available. Staff reported no problems with accessing this service when needed.
- Patient information leaflets were only printed in English. We were told the information could be made available in alternative languages or in other formats such as pictorial, large print or braille.
- Staff on some of the wards said the environment of the wards sometimes posed a challenge in ensuring patient's privacy and dignity was maintained and that safe care was carried out. The size and layout of patient bays meant there was minimal space between beds. Staff explained this posed a challenge when using moving and handling equipment. They sometimes had to move patient's beds to accommodate equipment. There had been no reported incidents of staff injuring themselves whilst working in the confined bed space, but managers in the relevant wards were concerned about such risks. They said they were going to complete an assessment to identify risks to staff and patients in relation to the confined spaces on the ward.

Learning from complaints and concerns

- Complaints were responded to in line with the trust's policy. The Director of Nursing had responsibility for overseeing the management of complaints with the individual ward sisters and department leads carrying out complaint investigations that were relevant to their area of work.
- Staff on all ward and department areas said they would attempt to resolve issues with patients and relatives, so they did not escalate to a formal complaint.
- Staff spoke about changes made in practices in response to complaints.
- Patients expressed confidence they could voice concerns and complaints and were confident staff would respond appropriately.
- Records of clinical governance meetings showed learning from complaints was shared amongst clinicians.

Surgery

Are surgery services well-led?

Good

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

We rated well led as good

- Surgical and trauma and orthopaedic services had business plans for the period 2014 to 2016 that included the vision for the separate. Goals for the services included becoming one of the south coast's head and neck cancer centres, development of nurse practitioners and development and embedding of an early facilitated discharge model to improve discharge of orthogeriatric patients. Staff were aware of these goals and could describe progress made in achieving these goals
- Staff were engaged with the trusts values and spoke positively about living the values of the "Poole Approach."
- Surgical services had effective governance arrangements. There was a structure to review aspects of performance, quality and risk. There were processes to escalate risks to the executive board.
- Staff felt valued by their immediate line management and well supported.
- Systems were in place to gather patient feedback and use it to improve services.
- The trust supported staff to innovate and enabled staff to influence the development of new processes.

However,

- Some ward managers said the morale of some staff was falling. They said this was because staff were worried quality of care would deteriorate because vacant shifts were not always filled by bank or agency staff.
- Individual departments owned and managed risks but these were not always detailed on the risk register and there was sometimes no oversight and coordination of the management of these risks.

Vision and strategy for this service

- At the time of the inspection, a Dorset clinical commissioning review was in progress to identify where certain acute hospital services should be located. This meant the trust did not know what services they would be providing in the future, making it difficult to develop a long term strategy for the service.
- However, the surgical and the trauma and orthopaedic services still looked to continually improve and develop their services. Both had business plans for the period 2014 to 2016 that included the vision for the separate services, key issues and challenges, identified goals for the service and the plans to achieve those goals. Goals included becoming one of the south coast's head and neck cancer centres, development of nurse practitioners and development and embedding of an early facilitated discharge model to improve discharge of orthogeriatric patients. Staff were aware of these goals and could describe progress made in achieving these goals.
- The trust was very proud of their values, which they labelled the "Poole Approach". The "Poole Approach" was an approach to care and treatment of patients that was followed by all staff at the trust. The aim of the approach was to provide" friendly, professional, person centred care with dignity and respect for all." All staff spoke with pride about working with the values of the "Poole Approach", which were compassionate, open, respectful, accountable and safe.

Governance, risk management and quality measurement

- There were structured governance processes for the surgical services.
- Records from clinical governance meetings showed there were structured processes followed for monitoring outcomes, risks, staffing including sickness rates, vacancies, compliance with mandatory training and compliance with policies, procedures and national guidance.
- Surgical services held their own risk register. Surgical leads said they had recently been reviewed and where appropriate items had been taken off the risk register as they no longer presented as a significant risk. At the time of inspection there were four risks identified on the surgical service's risk register. The risk register detailed reviews of the risks, action already taken to mitigate risks and actions to be taken and by whom to further

mitigate risks. Most of the risks related to risk identified in theatre services. Theatre staff were aware of the risks and understood what actions were being taken to reduce the risk of harm to themselves and patients.

- The surgical, trauma and critical care directorates risk management group met monthly. Records of these meetings showed they reviewed items on the risk register, including whether staff took appropriate actions to reduce the impact of identified risk and when appropriate removed items from the risk register.
- As part of the inspection we identified risks that included the lack of an appropriate emergency call system in theatres and failure to fully comply with the WHO surgical check list and Five Steps to Safer Surgery that were not detailed on the risk register. Although individual departments owned and managed these risks, without them detailed on the risk register there was no oversight and coordination of the management of these risks.
- Wards and departments did not hold their own risk registers. However, each area completed an annual health and safety audit to identify risks. We saw where risk was identified, an action plan was followed to reduce the level of risk. Areas assessed included the environment, moving and handing and security of the environment and records.
- Staff said any new identified risks were escalated using the electronic incident reporting system.
- Records of sisters, and surgical heads meeting showed findings from the health and safety audits were discussed. Where needed staff escalated identified risks through the trusts clinical governance processes to the executive board.

Leadership of service

- Staff felt supported by the director of nursing within the hospital whom they said was visible and approachable.
- Each ward had a manager who provided day to day leadership to members of staff on the ward. Members of staff told us the manager was visible and approachable and that they felt valued.
- The surgical matron and deputy matron supported ward managers. Ward managers said they were generally well supported by the matron. However, they recognised the matron had a large portfolio of services to manage, which had an impact on their ability to provide effective support to all at all times.
- The trust did not collect data on the use of agency or bank staff so it was not possible to determine how frequently shifts were not filled by the bank or agency services.
- Most staff know who the executive team were. They said the Director of Nursing (DoN) and associate directors of nursing were approachable and supportive. They described occasions when the DoN worked shifts on the wards to ensure they shared the experiences of patients and staff.

Culture within the service

- All staff spoke positively about the high quality care and services they provided for patients, and were proud to work for the trust. They described the trust as a good place to work and as having an open culture. They spoke proudly about being part of the organisation and working within the values of the "Poole Approach."
- Staff told us they were comfortable reporting incidents and raising concerns. They told us they were encouraged to learn from incidents.
- Data showed the trust's sickness absence rate was below the England average. .
- Some ward managers said the morale of some staff was falling. They said this was because staff were worried quality of care would deteriorate because vacant shifts were not always filled by bank or agency staff.

Public engagement

- Patients were engaged through feedback from surveys, such as the NHS Friends and Family Test, and through complaints, concerns and compliments received from patients and their families.
- A trust wide initiative that was implemented following comments from patients and relatives, was to introduce extended visiting hours to enable relatives visit round their working hours and other commitments.

Staff engagement

- Information was shared with the teams. Information was displayed in suitable areas of the wards about governance, risks, training and trust information. Information was shared by email correspondence and information was available om the trust's intranet.
- Staff meetings and handover periods provided opportunity to engage with staff and ensure information was passed on to staff. Records of staff meetings and discussions with staff confirmed this occurred.

- Junior doctors told us they were able to raise concerns.

Innovation, improvement and sustainability

- Staff said the trust supported innovative and new ideas. This meant wards and departments developed care planning processes that met the speciality needs of the patient's on that ward, rather than having to use a trust wide care plan that might not meet the needs of the type of patient being cared for.
- Staff influenced the implementation of new tools and practices. An example was on one of the surgical wards staff influenced the development of the safer nursing care tool to give a more accurate picture of the acuity of patient's on the ward.
- The trust opened a surgical assessment unit in October 2015 to improve patient flow and provide rapid inpatient assessment of acute surgical, gynaecological and maxilla facial patients.
- The trust employed an orthopaedic nurse practitioner. They worked with the junior medical staff to ensure patients were efficiently prepared for theatre and to minimise pre-op delays.
- Surgical services were working to a cost improvement plan. Records from the surgical executive performance review in November 2015 showed the cost.

Critical care

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

Information about the service

Poole Hospital NHS Trust provides care and treatment for critically ill medical, surgical and emergency care patients. The patient group provided for is adults, children and young people. The Critical Care Unit (CCU) is in a separate and self -contained area of the hospital and provides special expertise and skills of medical, nursing and other personnel experienced in the management of these patients.

There are 12 critical care beds. Level 2 beds are for patients who require higher levels of care and more detailed observation and/or intervention than can be provided on a normal ward. These patients may have a single failing organ system or require post-operative care. Level 3 beds are for patients who require advanced respiratory support or basic respiratory support together with support of at least two organ systems.

As part of our inspection we visited the CCU on 26, 27 and 28 January 2016. We also carried out an unannounced inspection on 8 February 2016. The CCU consisted of 11 fully funded beds and one step up bed to accommodate emergencies. The unit also provided emergency care and support to children who are stabilised in the unit and transferred out to other hospitals. There are five single room facilities to enable them to isolate patients as required, as part of their infection control procedures.

Patients were admitted to the critical care unit following traumatic injuries and complex and/or following serious surgical procedures, also medical and surgical emergencies. There is a critical care outreach service that provides advice, care and treatment to patients across the hospital twenty four hours a day and seven days a week.

We observed care and spoke with seven patients who were able to talk with us, seven relatives and visitors. As part of our inspection we spoke with approximately 22 staff including consultant intensivists, doctors, nurses, matron, healthcare assistants, physiotherapists, technician, pharmacist, administrative support and the housekeeping team.

We checked the clinical environment and equipment, observed care and we reviewed trust policies and procedures, staff training records, audits and performance data. We looked at computerised records and reviewed data provided by the trust.

The critical care unit (CCU) contributed data to the Intensive Care National Audit and Research Centre (ICNARC) an organisation reporting on performance and outcomes for around 95% of intensive care units in England, Wales and Northern Ireland. This is reflected in some of the statistical data used in this report.

Critical care

Summary of findings

We rated critical care services as requires improvement. We rated safe and responsive as requires improvement. Caring is rated as outstanding, and effective and well led were rated as good.

There were safe systems for the management of infection control, medical records and equipment. Infection control procedures were followed for the prevention and control of infection. Equipment in CCU was standardised to minimise the risks of errors as all staff were familiar with these. However, not all medicines were consistently stored safely and securely which may impact on patients' health and safety.

There were adequate numbers of skilled nursing and medical staff to provide safe and effective care. The unit was consultant led and medical staffing met the recommended standards and consultants were available at all times for advice and support

Patients received care and treatment in line with national guidance and best practice. However the unit was not fully compliant with National Institute for Health and Care Excellence (NICE) guidelines for rehabilitation for critical care patients. The provider told us patients could access this service through their GP.

There was a holistic and multidisciplinary approach to assessing and planning care and treatment for patients. The CCU used recognised critical care pathways for assessments and treatment of patients. The multi-disciplinary team worked collaboratively and provided care tailored to patients' individual needs. All staff were engaged in monitoring and improving outcomes for patients.

Patients and their families were involved in their care as much as possible. Feedback from patients and their relatives was overwhelmingly positive. Staff ensured patients experienced compassionate care which promoted privacy and dignity. People's cultural, religious and personal needs were respected. Although support and links for patients with a learning difficulty were not well developed.

Leadership, governance and culture within the service promoted improvements patients' care. The vision and strategy for the service was known by staff. The quality, safety and performance of the CCU was monitored appropriately and there was innovation and support to improve the service for patients.

Critical care

Are critical care services safe?

Requires improvement

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

We have rated safe as requires improvement.

- Medicines were not managed safely. In particular the storage of medicines did not comply with best practice guidelines and this put patients at risk of harm. Intravenous fluids and other drugs were not stored safely and securely.
- Mandatory training completion rates were low for medical and anaesthetic staff.

However

- Staff were confident in reporting incidents and trust procedures were followed to report incidents and monitor patients' risks.
- The unit was clean and well maintained. Staff followed infection control practices for the prevention and control of infection. They adhered to trust policy of bare below the elbows and the use of personal protective equipment. Numbers of unit-acquired infections were in line with the national average.
- The majority of staff had mandatory training that was up to date.
- There were good levels of nursing staff meeting the Core Standards for Intensive Care Units (2013) to keep patients safe. A consultant intensivist was responsible for patients' care on a daily basis and available out of hours.
- Staff demonstrated a good understanding of safeguarding procedures and to raise alerts as needed to protect patients in vulnerable situations. .
- The environment was modern and the equipment was well maintained. There was one type of ventilator and all infusion pumps were standardised to minimise the risks of errors.

Incidents

- The critical care unit (CCU) had a strong focus on patients' safety and incident reporting. There was a positive culture amongst all staffing groups to report incidents, including near misses and low harm incidents. Managers and staff recognised the importance of incident reporting as a learning tool to maintain and improve safety, and were aware of their responsibilities to ensure incidents were reported.
- Serious Incidents were reviewed by the team and a root cause analysis (RCA) completed and learning shared across teams. The unit's safety performance over time compared favourable against similar services. There had been no serious incidents reported between August 2014 and July 2015.
- The trust used an electronic incident reporting system which was available throughout the CCU and staff were able to access this easily. Staff said they were confident to use the reporting system and had training and guidance on how to use the system.
- Learning opportunities were recognised and shared with staff. Once an investigation had been completed, the investigator provided the reporter with individual feedback where this had been requested. All incident reports were discussed at the unit's governance meetings and minutes of these were shared with all staff. Specific learning points were communicated to all staff by email and during daily handovers.
- The practice and culture of mortality and morbidity meetings was embedded in CCU. mortality and morbidity meetings are peer reviews of the care and treatment of patients with the objective to learn from them. Monthly mortality and morbidity meetings were consultant-led and identified those patients from the previous month to review and identify any areas of learning. The unit's matron participated in these meetings. Minutes were circulated to ensure all staff had access to the cases discussed and learning shared.
- 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 we spoke with had an understanding of the Duty of Candour and actions they should take to report incidents.

Safety thermometer

- The NHS Safety Thermometer is a national tool used for measuring and monitoring and analysing common causes of harm to patients, such as new pressure ulcers, catheter and urinary tract infections (CUTI and UTIs),

falls with harm and venous thromboembolism (VTE). This information provides a means of checking performance and is used alongside other measures to direct improvement in patients' care.
- The Safety Thermometer data for the unit showed better results than the national average. There were no catheter related urine infections (CUTIs) reported between July and December 2015. There were two falls with no harm recorded during that same period. There were four pressure ulcers reported to the patient safety thermometer between October to December 2015. One patient who developed a pressure ulcer in CCU was critically ill and was receiving palliative care. However three patients were admitted to CCU with existing pressure ulcers.

Cleanliness, infection control and hygiene

- Equipment and the whole unit were clean and well maintained. We checked three empty bed spaces at different times during the inspection and found the bed space and equipment was clean.
- We observed staff stringently adhered to the 'bare below the elbows' policy, washed their hands between patients and used personal protective equipment (PPE), such as disposable aprons and gloves. This included different coloured aprons for bed spaces to minimise the risks of cross infection.
- The CCU undertook regular infection prevention and control audits which included hand hygiene. Results showed there was 100% compliance and areas of concern were raised appropriately and rectified promptly.
- The unit had isolation facilities available. Within the CCU there were a number of side rooms used for patents' isolation if required. These rooms did not have negative pressure isolation facilities. Negative room pressure allows air to flow into the isolation room but not escape from the room, preventing contaminated air from circulating amongst other patients in the unit.
- Adjacent bed spaces were separated by disposable curtains which were changed at regular intervals and these were clean.
- The CCU had a consistently low rate of unit-acquired infections. There had been no case of unit-acquired methicillin-resistant Staphylococcus aureus in the unit between July 2014 and December 2015, and no cases of Clostridium difficile or bloodstream infections during the same period.
- The CCU also monitored and reported on ventilator acquired pneumonia (VAP). CCU undertook a monthly audit of patients with tracheostomy tubes of which all if not most were ventilated.
- Staff told us they relied on communication between themselves and the cleaning staff to identify when a bed space needed cleaning. This could potentially lead to confusion and / or failure to ensure that a bed space and the equipment in it were clean for a new admission. We observed matron cleaning the bed space for an emergency admission and staff said they had a team approach and it was everyone's responsibility to ensure the place was clean and fit for purpose. However the trust has since provided evidence of checklist and other measures they used to ensure there was a process for checking bed spaces.
- There were clear waste and clinical specimen disposal arrangements and these were followed by staff. The unit had separate dedicated areas for clean and dirty equipment, linen and specimens, with clearly marked standard waste and clinical waste bins. Sluice facilities were contained in the dirty utility where items were cleaned and sanitised. Waste was regularly removed from the unit.

Environment and equipment

- The critical care unit (CCU) was secure and safe area for patients. The staff had access cards which they used and an intercom system allowing them to monitor entry / exit and facilitating access to the unit.
- The nurses' stations had monitors displaying live observations from the patients' monitors, allowing remote monitoring which the medical and nursing staff used effectively for their handovers.
- Resuscitation and difficult airway equipment was readily available, but these were not tamper-evident. There were two emergency trolleys, a paediatric and an adult trolley in the unit, both of which contained equipment needed to manage a difficult airway. These contained emergency resuscitation equipment, including resuscitation drugs. Both trolleys were checked daily in line with their policy, and records were maintained. However the trolley contained some potent drugs which were not on the list and matron told us these should not be in the trolley and were removed.
- All the required equipment was available and in date. Neither trolley had a means of identifying if it had been used or tampered with or equipment removed, and

these could be accessed by others. We were told the trolleys were not sealed because they were regularly used for difficult airways management and resealing them every time was time consuming.

- The unit had immediate access to regularly used specialist equipment, and could request other equipment not held locally. Equipment in the unit included machines capable of haemofiltration (a process where a patient's blood is passed through a machine where waste products and water are removed. Replacement fluid is then added and the blood is returned to the patient). Syringe drivers and non-invasive breathing equipment. Staff told us additional equipment, for example bariatric commodes and hoists, were available centrally if required.
- Equipment in the CCU was regularly maintained. Once they had been serviced, the records were updated. A random sample of equipment showed these were in date.

Medicines

- Medicines in CCU were not all kept safely and securely. There were a number of medicines which included intravenous antibiotics and sedatives which were kept in unlocked cupboards and a fridge containing emergency medicines and neuromuscular blocking drugs which were accessible to unauthorised staff and visitors to the unit. This did not ensure that all aspects of the management of medicines complied with the trust policy and current legislation.
- Intravenous fluids were stored in a separate room and was unlocked which meant there were risks of unauthorised access to these fluids. There are strict guidelines for the storage of intravenous fluids following recent national cases of misappropriation. The risk of this type of storage had not been assessed and was not on the unit's risk register.
- Medicines were not always stored safely as we found calibration fluids for a blood gas analyser which was alongside injectable medicines. This was not a safe practice and posed risk of harm. We raised this with Matron who agreed it should not be kept in this fridge.
- There were some medicines such as oral antibiotics and insulin which did not contain the date of opening. There were two lots of oral antibiotics which had been opened in September 2015. One bottle of oral antibiotic was still in the fridge for a patient who had been discharged from the unit some time previously. There was a risk that patients could receive medicines which had expired as these medicines should be used within a set timescale once opened as recommended.
- Staff told us they had not had a dedicated unit pharmacist for a number of months which meant there was no medicines reconciliation carried out. The deputy pharmacist provided cover during that period. Although the unit did now have a replacement pharmacist, they had relatively little critical care experience, although were being supported in this role by the previous unit pharmacist. Also, their workload meant that they were not dedicated to the unit on a full time basis and were required to cover other clinical areas. The drug fridge temperatures had been checked daily in January 2016. However, there were numerous dates in December 2015 such as on 7, 8, 9, 18, 27 and 28 where the records were blank. During August to December 2015 there were no records available to indicate the fridge temperatures and been checked and recorded. This meant staff could not be assured the medicines had been stored according to the manufacturer's guidance. Medicines stored at the wrong temperature and not according to the manufacturer's recommendations could reduce the efficacy of medicines given to patients.
- There was a fridge located in the treatment room that contained calibration fluid, and we saw no records that indicated the temperature had been checked and recorded in this fridge.
- In another part of the unit, medicines were kept in a locked room with keypad entrance ensuring restricted access.
- Controlled drugs (CDs) were stored safely and managed in accordance with legislation and policy. Keys to the CD cupboards were held by nominated nurses, identified to all staff at the beginning of each shift. All CDs were audited regularly, with evidence of these checks being recorded in the CD registers.
- The unit was using an electronic prescribing system, which staff told us worked well. When a patient was transferred from the wards, the paper copy of their drug charts was transferred onto the computer on admission. We reviewed both the paper and electronic records and found they were accurate. On discharge, the prescriptions were printed for handover to the wards.

- Antibiotics were administered in accordance with the trust's microbiology protocols which staff had access and microbiologist who were actively involved and provided advice on antibiotics as needed.
- Records of medicines administered were maintained. We carried out a random check of seven electronic prescription records and found they were all fully completed.
- Oxygen cylinders were mainly stored appropriately in racks and in a designated area. All oxygen cylinders were seen to be in date. We observed two cylinders which were out of the rack and a staff member said was empty. There was no separate area for storage of empty cylinders and posed a risk of staff picking up the empty cylinder in an emergency.

Records

- In the CCU, innovative electronic recording systems supported the effective assessment and monitoring of patients. The electronic system was password protected and provided secure access.
- Risk assessments were completed and reviewed. We looked at a sample of eight records and found they all contained appropriate risk assessments and care plans, including for falls, venous thromboembolism and pressure ulcers.
- The electronic patients' records were detailed, completed and legible. These were updated on a regular basis and some hourly depending on the level of intensive care patients received.
- The paper records such as the patients' diary were not always legible and some of these were not securely bound with a risk of information within these getting mislaid.
- The CCU used e- prescribing and the pharmacist told us staff had restrictions on their log in with a different level of access. Only doctors or pharmacists had prescribing rights. Therefore other staff could not alter the drugs prescribed, including infusions, IV or oral drugs.

Safeguarding

- There were processes and guidance documents available to support staff in managing safeguarding concerns. Policies and procedures relating to safeguarding were easily accessible on the trust's intranet system. Staff showed us how they would access these and explained they would inform matron or the shift co-ordinator who would then complete a safeguarding referral.
- Staff were aware of their responsibilities with regard to safeguarding. They were able to tell us what would constitute a safeguarding concern and the process they followed to raise an alert.
- Staff gave us an example following a recent incident where a safeguarding alert was raised with Poole safeguarding team to protect children in the community.
- Following feedback from Care Quality Commission the trust had developed a strategy in order to raise awareness about safeguarding. The Safeguarding Champions Development Programme commenced on 28th October 2015 and was planned to run until June 2016.
- Staff training in safeguarding was one element of core training. The latest data for the critical unit in November 2015 showed 88% of staff had completed mandatory adult level one safeguarding training. For Level 2 children safeguarding training staff achieved 95% and 100% completed child protection training at level three with a trust target of over 95%.

Mandatory training

- The trust had an induction programme for all newly appointed staff that included health and safety, safeguarding, fire procedures, basic life support and information governance awareness. Staff had access to and undertook e-learning training modules and face to face training.
- Overall compliance with mandatory training on the CCU was 94%. This was just below the trust target of 95%. However mandatory training rates for medical and anaesthetic staff were lower and averaged 75% and 50% respectively.

Assessing and responding to patient risk

- All patients admitted to CCU had a risk assessment. These were available in the patients' records seen and used in the development of care plans. The risk assessments included pressure ulcer, venous thromboembolism (VTE) and falls.
- The National Institute for Health and Care Excellence (NICE, 2010) recommends that all patients should be **assessed** for the **risk** of developing thrombosis (blood

clots) on a regular basis. The unit's performance for completing pressure ulcer and VTE risk assessments the months from July –December 2015 was 100% compliance for VTE and pressure ulcer assessments. Patients were prescribed prophylactic (preventive) drugs and other measures such as stockings for the prevention of thrombosis.

- Staff followed guidelines for the prevention and management of pressure injury. Patients had their pressure risk assessed using a standardised assessment tool which was completed on admission. Pressure relieving equipment such as pressure relieving mattresses were on all the beds. However a patient complained about having a sore sacral area and told us they were "very uncomfortable" sitting in the wheelchair provided, with no pressure relieving cushion on the chair. The tissue viability nurses had assessed this patient two days previously and they were receiving treatment for "moisture lesion" which was causing the discomfort and staff agreed they would benefit from a pressure relieving cushion when sitting out. The physiotherapy team was contacted to provide appropriate pressure relieving equipment.
- A hospital-wide electronic national early warning system (eNEWS) was used to identify deteriorating patients, as part of their escalation process. Although the eNEWS system was not used in the CCU, it helped identify when a patient may be escalated for critical care review from the wards and appropriate care and support provided.
- The CCU worked closely with the anaesthetic team who led the EWS process together with the outreach team who provided the response and advisory function of a traditional 'outreach' team to ensure critically ill patients on wards outside of the CCU were provided with early critical care input.
- The World Health Organization (WHO) has produced guidance to increase safety for patients undergoing surgical procedures. The guidance sets out Five Steps to Safer Surgery that should be undertaken during every procedure to help prevent errors. Patients in CCU underwent some surgical procedures such as insertion of central venous catheters. A senior doctor told us they did not have a checklist for such a procedure and this was being developed.

Nursing staffing

- The unit had a band seven senior nurse on each shift who was supernumerary and supported staff in running the unit. A review of nursing ratio based on national guidance was completed regularly during the shifts to ensure there were adequate staff to meet the needs of patients.
- The unit has a total of 11 funded beds of which 5 are level 3 and 6 are level 2 and the duty roster was planned to provide cover for this. Staff told us on average there were fewer level three patients as the unit also supported level two patients. Level three patients required one to one care, whereas level two patients required one nurse to two patients. Therefore, by regularly providing 11 nurses the department was able to adequately support all the patients given the variations in dependency and a mixture of level two (high dependency) patients.
- The nursing handover took place daily at 7.30am and 7.30pm and followed a structured format. The shift leader for day and night handed over to each other in the office. Each patient was reviewed and any changes were clearly communicated including any new treatment and investigations. Staffing numbers were confirmed and staff allocated ensuring continuity of care and staff were able to request change of patients.
- Staff said there were always enough staff on duty and they worked well supporting each other as a team. We observed that where patients who were designated level 2, but who required one to one care due to their confusion, this was provided.
- The unit did not have a full establishment of nursing staff. In December 2015, the unit had 7 whole time equivalent vacancies, equating to a 14% vacancy rate for nursing staff. Staff confirmed they used bank and agency to fill the gaps. Matron said they were planning for some expected leavers and some staff returning from maternity leave on reduced hours and recruitment was ongoing.
- The unit had introduced an e-rostering system which ensured the right skill mix to keep patients safe. A senior staff said this was positive change. Staff were able to swap their shifts with another staff member of the same grade.
- Staff had raised concerns about the e-rostering system which only allowed them to have two requests and the 12 hour shift patterns which did not allow for flexibility and which they said impacted on staff's morale and retention of staff.

Medical staffing

Critical care

- There were six consultants covering a "week about" rota in CCU. Analysis of UK Intensive Care Medicine Consultants, demonstrated that the majority of consultant intensivists work consecutive blocks of days at a time to improve continuity of care. In CCU the consultants worked a 7 day daytime rota with another consultant covering the night shift for four of the seven days. Arrangements were in place to cover planned and unplanned absences and leave. The consultant rota was in line with recommended practice.
- The Consultant saw all patients under their care at least twice daily which included weekends. This was in the form of a structured bedside round where management plan was discussed and reviewed with the critical care team.
- Consultant Intensivists were available at all times to offer consultant level care to patients as necessary. Once admitted to critical care, a Consultant Intensivist led the patient's care as defined by the Faculty of Intensive Care Medicine.
- We observed a morning medical handover and observed a multi-disciplinary ward round: there was appropriate information sharing and decision making. We observed positive communication between doctors and the nursing team. However there were no therapy staff present at handover, as their shift did not start till 08:30 which meant a valuable opportunity for participation in patient management was missed.
- The Core Standards for Intensive Care Units (2013) recommend a resident doctor to patient ratio of one to eight, and a consultant to patient ratio of one to 15. During the day there was sufficient medical cover to achieve this, with at least one consultant and two doctors on duty.
- The overnight resident doctor was based in the unit and did not have to support other services which meant there was always a doctor immediately available on the unit.
- The consultant intensivist was available out of hours including weekends and could attend the hospital within 30 minutes. Staff said they were confident in calling out the consultants as needed and they were very supportive. There were sufficient numbers of trainees and middle grade doctors to safely cover the workload on the unit. Junior doctors did not cover nights and only occasional weekends.

Major incident awareness and training

- The trust had a major incident plan, which included specific plan for critical care staff to follow. This included emergency grab bags to use in the event of a major incident. The matron was also part of the emergency prevention, preparedness and response group.
- The unit was involved in major incident training exercises. We were told of a recent table top major incident exercise, which the CCU had participated in. Staff were aware of their responsibilities should a major incident occur.
- Following recommendations and in line with NHS England emergency preparedness, response and resilience (EPRR) documents, the trust incident response plan, which replaces the major incident plan, has been revised. The plan has gone through a period of implementation which included table-top exercises for the executive team in March 2015.

Are critical care services effective?

Good

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

We rated effective as Good.

- The treatment and care provided took account of evidence based guidance. Patients received effective treatment from therapists, doctors and nurses, which was delivered in accordance with best practice and recognised national guidelines and critical care pathways.
- There was an holistic and multidisciplinary approach to assessing and planning care and treatment for patients.
- The unit participated in monitoring and improving outcomes for patients. They achieved consistently good results with patients who were critically ill and with complex problems and multiple needs.
- There was a robust process in place for organ donation with the involvement of the specialist nurse.
- There was a collaborative approach with a multidisciplinary attitude to patient care. All staff were treated with respect and their views and opinions heard and valued.

- Patients received appropriate support with nutrition. Staff followed the trust's standard feeding protocols to ensure ventilated patients received adequate nutritional intake.
- The CCU had sufficient numbers of nurses who held a post-registration critical care award to enable them to support patients in their care.
- There were individualised care plans and support provided to both patients and those close to them. Patients and families understood what was happening and were fully involved in decisions and plans of care.
- Effective arrangements were in place from the multi-disciplinary team including Consultant Intensivists to provide care and support 24 hour, seven days a week.
- Critical care career pathways were developed to promote the development of the nursing team

However

- The unit was not fully compliant with NICE guidance for a rehabilitation service after a critical illness.
- Policies and procedures were not all up to date and required reviews.
- There was no recognised pain assessment tool used for patients who may not be able to verbalise their needs for pain control.

Evidence-based care and treatment

- The CCU was using national best practice guidelines and research from relevant groups to ensure care and treatment was effective. Policies and practices were based on guidance from the royal colleges, National Institute for Health and Care Excellence (NICE). The unit reported they were compliant with the majority of NICE guidance in CCU. The references included National Institute for Health and Care Excellence (NICE), Royal College guidelines and Intensive Care Society recommendations. The CCU also used a nationally recognised Feeding, Analgesia, Sedation, Thromboembolic Prophylaxis (for the prevention of blood clots), Head of bed elevation, Stress Ulcer prevention and Glucose control (FAST HUG) care bundle.
- Intensive care specific policies and procedures were mostly up to date and referenced to current best practice from a combination of national and international guidance. There were a number of policies which were under review at the time of the inspection.
- The CCU was using critical care bundles to ensure compliance with national best practice. Care bundles ensure key aspects in the general care of a critically ill patient were regularly identified and checked.
- All patients had a Feeding, Analgesia, Sedation, Thromboembolic Prophylaxis (for the prevention of blood clots), Head of bed elevation, Stress Ulcer prevention and Glucose control (FAST HUG). This was used as an aide memoire when reviewing patients. It has been suggested that the use of such checklists in critical care may be effective in improving patient's care and safety.
- Patients who had acute respiratory distress syndrome (ARDS) were treated in accordance with national guidelines from the ARDS committee. There was a policy in place which included an algorithm to calculate the patients' body weight. There was no care bundle available for the management of patients with ARDS. Protocols for the management of controlled ventilation was available and followed which included ARDS algorithms and took account the predicted weight of patients.
- Patients were safely ventilated using specialist equipment and techniques in accordance with national best practice. This included mechanical invasive ventilation to assist or replace the patient's breathing using endotracheal tubes (through the mouth or nose into the trachea) or tracheostomies (through the windpipe). The unit also used non-invasive ventilation to help patients with their breathing, using masks or similar devices. All ventilated patients were constantly reviewed and checks made were recorded hourly.
- The Core Standards for Intensive Care Units (2013) recommend all patients are screened for delirium. Patients in a critical care setting are at high risk of psychological effects resulting primarily from the drugs used to treat patients such as sedatives. Patients were screened for delirium using a nationally-recognised risk assessment tool. The confusion assessment method for intensive care units was used in this unit to assess patients for delirium.
- Critical care unit should develop a written end-of-life care management policy that addresses the withdrawal and withholding of life-sustaining treatment. Consideration of organ donation should be included in

this policy, particularly the timely identification and referral of potential organ donors. The trust had declared they were partially compliant with it and they were working towards developing this.

- The unit was not fully compliant with NICE CG 83 guidance for Rehabilitation after critical illness. The assessments of patients rehabilitation needs were completed within 24 hours of admission. Rehabilitation treatment plans were developed on discharge. However, the critical care team provided one outpatient follow up clinic a month and only a small proportion of patients were seen. In order to comply fully with NICE guidance CG83, the trust had identified the frequency of these clinics need to be increased. Also clinical psychology input was required to meet the psychological needs of patients with post- traumatic stress disorder (PTSD), anxiety and depression. We did not see an action plan about how this would be achieved.
- All patients should also be assessed for non- physical sequelae (a pathological condition resulting from a prior disease or injury) during and after CCU and receive treatment as required. Although this is carried out by CCU nurses on an ad hoc basic, only a small proportion of patients were seen due to staffing constraints .. There was a need for more therapists input so that patients who are deemed as "at risk" could start their rehabilitation as early as clinically possible.

Pain relief

- Patients who were ventilated had their pain managed appropriately and the FASTHUG care bundle was used. Pain control was reviewed and discussed during handovers and ward rounds.
- Patients told us their pain was well managed and they received pain control as needed. Records showed regular pain control was administered which included as required pain relief.
- Staff had access to the acute pain team who were responsive and provided guidance and support to review patients' pain effectively, including daily visits to the unit. A patient whose pain had not been well controlled had been referred to the pain team and was awaiting a review. The acute pain team also managed epidurals in CCU.
- A pain assessment tool was available as part of the care bundle. Three of five records seen did not have their pain assessment completed. This was discussed with a senior nurse who confirmed these should be completed when pain control was administered. Patients should also be reviewed following administration of pain control to assess their efficacy. Staff said although they monitored the patients, this was not recorded. Pain assessment records could provide valuable information to the acute pain team such as which combination of pain tablets were effective.
- Staff confirmed there were no pain score tool such as the Abbey pain score used in CCU which would be appropriate for patients with a learning difficulty and those living with dementia. The Abbey Pain Scale is a nationally recognised tool for assessing patients' pain such as those who are unable to verbalise. This could impact on the delivery of effective pain control at the right time to meet the needs of these patients.

Nutrition and hydration

- Patients' nutrition and hydration needs were being met. Staff followed the trust's standard feeding protocols to ensure ventilated patients received adequate nutritional intake. This included the target rates for feeding according to the patient's weight. Staff were advised to gradually increase the feeding rate according to tolerance. This was monitored and reviewed on the consultant round and formed part of the FAST HUG care bundle.
- Patients' nutritional intake was recorded and monitored, daily fluid balance charts were maintained. We reviewed seven care records and found the fluid balance charts were completed appropriately.
- The nutrition protocol had clear guidance regarding dietitians being asked to review patients where specialist input was required.
- Patients were offered choices and they were able to choose from a varied menu. Patients were complimentary about the food and choices offered. Comments included "the food is fantastic".
- Staff provided support with food and drinks in a respectful manner. Patients who were able to feed themselves were given the time and opportunity to do so. Hot and cold drinks were available and we observed staff ensured these were placed within the patients' reach.

Patient outcomes

Critical care

- The CCU participated in the Intensive Care National Audit and Research Centre (ICNARC) which was part of national and regional benchmarking. There was no data for 2013-2014 as the trust did not take part due to lack of staff to collate data.
- The ICNARC data for the period of April –June 2015 showed the mortality ratio was in line with similar units when compared nationally. Data from the directorate dashboards, the unit reported mortality for June –December 2015 fluctuated between 9 and 15%.
- The unit was better than the national average for non –clinical transfer which was at 0%. This meant patients were appropriately discharged to other trusts when required.
- The unit had completed a self-audit against the NCEPOD 'On the right trach' recommendations, all of which showed positive results for patients' outcomes.
- The CCU took part in the International Multicentre Prevalence Study on Sepsis (IMPRESS). Local audits, including central line audit and phlebitis cannula audit were also being completed. These were completed on a monthly basis and recorded and progressed against any learning actions that had been identified.
- The unit had participated in a self-review against the recommendations of the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) 'On the right trach' report. This study looked at the pathway of tracheostomy care for patients beginning with a surgical or percutaneous insertion, followed in most by a stay on critical care and/or up to 30 days on a hospital ward. The unit was compliant with the majority of the recommendations and an action plan was in place to address areas identified in the survey to meet the standards. This showed the majority of the action plan had been achieved. The report was last presented to the clinical governance group in June 2015.
- The critical care unit adhered to NICE guidance CG135 by promoting and participating in a programme of organ donation led nationally by NHS Blood and Transplant. A specialist team facilitated the organ donation programme and worked closely with the unit. Between April 2014 and September 2014, the trust achieved 100% on testing, consent, referral and their approach for donor after brain death (DBD activity. The trust performed better than the UK average for 3 of the 5 measures and the same for referral and approach.
- The trust performed better than the UK average for specialist nurses also known as (SN-OD) involvement. Evidence shows there is a higher success rate for organ donation if a specialist nurse is involved with discussions with the family.
- The trust also performed better than UK average for DCD (Donor after cardiac death) donor activity and comparably in consent, approach and referral. Although there was a 50% decrease to their performance in 2013.
- In 2014-2015 the trust had three actual DBD donors and 2 DCD donors. They performed 9 DBD transplants and 5 DCD transplants. There were 16 organs retrieved for transplant which included liver, kidney and heart valve transplants.
- The number of organs transplanted at the trust has fluctuated over the last 10 years between 4 and 24 with an average of 15 organs donated per year. The number of donors at the trust has remained relatively steady at around 5 each year. The trust also looked at the reasons for refusal to transplant included family refusal, medically unsuitable and did not proceed to asystole (no cardiac output).
- The percentage of discharges readmitted to critical care within 48 hours of discharge was monitored. Between April and December 2015, there were five readmissions. For 2015-2016 this was 0.97% compared with national average of 1%.
- ICNARC data for 2014-15 showed early readmissions to the unit was better than expected and late readmissions were similar to other trusts.

Competent staff

- There were specific mandatory training for CCU staff which was a mix of theory and simulated scenarios which staff said was very useful and "challenged their thinking ".
- The trust data on appraisal rates in CCU showed from October 2015- January 2016 the appraisal rates varied between 81-84% which was below their target of 95%.
- Apart from consultants, the medical staff covering the unit were a mixture of experienced middle grades (non-training grade), anaesthetic SpR's and other junior doctors (training grades). Training was provided by a mixture of bedside teaching and specific topic teaching plus supported practical experience e.g. central line insertion, as appropriate for the level of experience and in line with Royal college / **Faculty of Intensive Care Medicine (**FICM) guidance.

- The CCU had sufficient numbers of nurses who held a post-registration critical care award. The Core Standards for Intensive Care Units (2013) recommend at least 50% of the nurses working in intensive care hold a post-registration award in critical care. In this unit 78% of staff had achieved this award as of December 2015.
- Staff confirmed they had regular appraisals and arrangements were in place to support the staff with revalidation.
- There was a development plan for new nurses joining the unit without any critical care experience. They followed a six weeks preceptorship course and allocated a mentor to support them and their competencies were assessed. Staff were positive about the support and training opportunities available to them.
- The NCEPOD report 2014 showed medical and nursing staff of the Critical Care Unit were adequately trained to manage blocked or displaced tracheostomy/ endotracheal tubes
- Nursing staff were encouraged to undertake the critical care qualification; however some staff told us they were happy to remain in their current role and grade until they felt they had enough experience and move to the next level.
- Junior doctors told us they had good support from consultants and nursing staff. They were able to access regular training including weekly training sessions delivered by consultants. Junior doctors were able to develop their skills and gained clinical experience such as insertion of lines.
- The activity of trials in the unit meant that clinical staff had received additional training. There were 13 training dates seen planned between January and March 2016 following a recent trial on sepsis. In turn, this meant they were more alert for signs of sepsis in the patients they managed

Multidisciplinary working

- The staff described multidisciplinary working as “very good”. Physiotherapists and assistants were based on the unit and completed patients’ assessments and treatment plan to support nursing and medical staff.
- There were clear discharge procedures which the staff followed. Discharge arrangements included a formal handover and follow up of patients. The outreach team followed up patients once discharged from the unit within two hours. The outreach team visited the unit regularly and had a close working relationship with the unit.
- Pharmacy staff visited the unit daily and the lead pharmacist told us a designated pharmacist was now allocated to the unit. Microbiologists attended ward rounds and were available to offer advice and support at other time.
- There were good support from clinicians across other directorates and we saw neurology and Care of the Elderly physicians were present in the unit and carried out reviews of patients. Surgical review of patients was also observed.
- The unit did not have a dedicated dietician or any formal agreement for dietician’s review. However staff told us dietetics input was available and they were responsive when patients were referred to them.
- There were good links with the end of life care team and staff worked closely with them to strengthen support to patients and their families at the end of a patient’s life.
- There was a multidisciplinary team approach for the planning and discussing organ donation with the patient and those close to them.
- We observed the multi- disciplinary team in CCU had developed excellent working relationships and were respectful and supportive of each other. Staff told us communication was “very good” and put patients “at the centre of our care”.
- There was a critical care network agreement for transfers between services such as the local trust in Bournemouth and staff said they had developed close and supportive working relationships with the trust.

Seven-day services

- Effective arrangements were in place to provide Consultants Intensivists support 24 hour, seven days a week. The unit’s consultant when not on site provided a 30 minute response on an on-call basis and would be available on site as required.
- There was good access to other services seven days a week. Physiotherapy, radiology, pharmacy and microbiology were all available seven days a week; with out of hours’ access available where required through the trust’s on-call system. The physiotherapy team provided cover in the unit seven days a week, although

at weekends this was a reduced service, but they were responsive to patients' needs and assessments were completed to identify those patients requiring additional input.

Access to information

- The unit had a fully developed electronic record system which meant all patients' records were accessible at all times. Every bed space had a dedicated computer for accessing patients' care records. Relevant sections of paper care records were copied onto the electronic system when a patient was admitted to the unit. There were multiple sections within the electronic care records for different specialties to record relevant information. This made it easy to find information about a patient's care and treatment.
- At the medical handover we observed the consultant was able to access patients' investigation results which facilitated discussion about plan of care and discharge planning.
- When a patient was discharged to another ward from the unit, all relevant notes and records required to support their ongoing care were printed from the electronic system and were sent with the patient to the ward. The CCU staff also completed a detailed paper transfer form to ensure all relevant information was available to promote continuity of care.
- Test results, for example X-rays, scans and blood tests were available on the electronic system.
- During the bedside round, the nursing co coordinator completed a 'critical care daily plan sheet' for each patient which communicated any changes in the patient's care such as weaning from ventilation, sedation hold, and any tests to ensure effective communication from the bed patient's round.
- Policies, procedures and other supporting information were available on the trust's intranet to support and guide staff's practices. There were a number of policies which were under review. However we identified some policies which were out of date including one relating to withdrawal of treatment. Matron confirmed this would be addressed as it had been missed.

Consent and Mental Capacity Act.

- Staff we spoke with had an effective understanding of the Mental Capacity Act (MCA 2005) and Deprivation Liberty Safeguards (DoLS). They were aware of the impact of DoLs when providing care and treatment to patients in CCU environment.
- The matron told us they had completed training and carried out DoLS assessments and application for authorisation to deprive the patient of their liberty. Matron gave an example such as use of mittens in CCU to stop patients pulling out their breathing tubes. This was carried out in conjunction with the consultants and reviewed daily to ensure the least restrictive measures were adopted and patients were not subjected to unnecessary restriction. Although we were told patients' relatives were consulted as part of best interest's process, this was not recorded. The record for a patient who had been subject to DoLS showed this was not in line with the trust policy and best practice as it contained only one signature and had not been signed by the consultant responsible for the patient's care and as part of the decision making process.
- The trust had developed a strategy following the Care Quality Commission (2015) which highlighted an ongoing deficit in the knowledge of providers in relation to the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).
- The trust had received additional funding and launched a project in November 2015. This included a trust wide on-line survey of staff knowledge regarding MCA and DoLS. This survey will inform the next targeted education and support provided to staff to enhance knowledge and skills relating to MCA and DoLS application in care setting.

Are critical care services caring?

Outstanding ☆

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

We rated caring as Outstanding.

- Patients were treated with respect care and compassion by all the staff. Throughout the inspection staff went

above and beyond their usual duties to ensure patients experienced compassionate care. This included making special arrangements and training carers to provide support for a child with diverse needs.
- Care was provided with an infusion of humour in difficult circumstances.
- Patients and relatives were overwhelmingly positive about the care and treatment they had received and the promotion of patients' dignity.
- Staff had developed good relationships with patients and their relatives and patients felt valued as individuals.
- People's cultural and religious, social and personal needs were respected. Support for patients, such as the development of patient's diaries, was encouraged and valued.
- Medical and nursing staff took the time to ensure patients and their families understood treatment plans and were involved with their care as much as possible.
- Patients received positive emotional support, including counselling support from nurses and a community psychologist at their follow up one month after discharge

Compassionate care

- Care was provided in a caring and compassionate way. Staff took the time to talk with patients, even when they were sedated and explaining what they were doing.
- Patients received compassionate and care where patients were treated as individuals. We observed the multi- disciplinary staff treating patients and their relatives with kindness and respect. Patients' relatives gave overwhelmingly positive feedback about the care and treatment they had received
- Staff also told us of the steps taken above and beyond their usual duties to provide support for a child with a learning difficulty and communication problem. They had sourced and facilitated training in infection control and moving and handling to enable the carers to remain in the unit and support the child's care. This ensured compassionate care to minimise disruption in their care and safeguarding the welfare of the child. A decision was also taken for the child to remain in the unit and discharged from the unit back to the community
- Visitors were welcomed into the department and staff made sure they took the time to talk with all visitors in a caring and compassionate manner. For example, a relative told us the compassion shown to them was "second to none "and they felt staff just "could not do enough for you". Another relative said, "The care was magic".
- The friend and family test data from October 2014-September 2015, there were 12 respondents and this showed 100% of patients surveyed said they would recommend the hospital.
- Privacy and dignity was maintained at all times. There were two areas in the unit which had open bed spaces. At all times we saw curtains were drawn and single rooms' doors were closed to maintain privacy and dignity. Staff told us they moved patients in the side rooms so that patients of opposite sex were not accommodated in the open bays and ensured privacy and dignity were maintained at all times.
- We saw at all times staff positively interacting with patients and sometimes in difficult situations and yet remained patients' focussed and caring We observed, for example, two different patients who were agitated and confused. At all times staff provided care and support in a calm and compassionate way by speaking with them calmly and providing constant reassurance. A patient who was confused and was trying to bite a staff member's hand and they responded to the patient in a joking manner which made the patient smile.

Understanding and involvement of patients and those close to them

- Patients, who we were able to speak with us, said they were provided with information and involved in the care and decision regarding their treatment.
- The unit had developed the use of patient's diaries. The diary was a summary of events of the time when the patient was admitted critically ill, likely to have been sedated from which they had only fragmented or no memories at all. The diaries were also seen as an important support for a long time after their stay in the CCU. All staff and patients' relatives were encouraged to contribute to the diary. One relative told us they did not want a diary for their relative and the staff had respected their decision.
- Relatives felt they were fully informed about their family member's treatment and care. They said staff checked whether they wanted to be contacted over night with any changes in their family member's condition and their wishes regarding this were respected.

Critical care

- Both patients and their relatives commented that information was discussed in a manner they understood. They said there was always a member of staff available to help them understand the explanations. Relatives said staff explained everything to the patient, even though their understanding might be limited or not known. This was particularly evident for patients suffering from delirium following sedation.
- We saw a consultant talking to some relatives in a calm and unhurried way. The relatives were given time to ask questions and provided reassurance about the patient's current condition. Relatives told us the consultants were available if they needed to ask "any questions" and "put your mind at ease".
- The unit participated in organ donation programmes. Matron explained the process for making contact with a specialist nurse for organ donation to facilitate discussions with relatives around organ donation. We were told this was initiated as early as possible to allow time for relatives to make an informed decision about organ donation and were supported by the staff throughout.

Emotional support

- Patients and their relatives told us the staff went above and beyond and provided "reassurance every step of the way".
- A patient told us they were "extremely frightened" when they were admitted to the unit. However the staff took time to explain things "a little at a time" and also supported their family which they said helped them
- The end of life clinical nurse specialist worked collaboratively with the staff in the unit in providing end of life care and support to a patients' family and also to staff caring for the patient. .
- Patients were screened for delirium using a nationally-recognised risk assessment tool. The confusion assessment method for intensive care units was used in the unit to assess patients.
- Patients who were followed up post discharge from critical care at monthly follow up clinics had access to nursing staff had completed counselling courses to be able to support. Patients were also referred to clinical psychologist in the community and other support such as occupational therapy, as needed.
- Spiritual support was available from the multi-faith chaplaincy. The chaplain visited the unit at least once a week, and more often if a patient or their family requested. Staff told us they were able to access support for people from different faith and information was available on the trust's website.
- The unit provided support and training for a group of carers to enable them to continue to assist in caring for a young adult with diverse needs in critical care setting.
- There was a support group for patients and their families called ICUStep. This provided drop in support for people recovering from intensive care treatment.

Are critical care services responsive?

Requires improvement

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

We rated responsive as requires improvement

- There were 39% of delayed discharges over 12 hours to wards due to beds' availability in the rest of the hospital. These patients should be deemed to be mixed sex breaches.
- The unit had a higher rate of patients who were discharged out of hours for non- clinical reasons.
- The follow up clinic for patients post critical care only saw a small number of patients.
- The environment was not suitable for patients who were fit for discharge but remained in the unit and there was inadequate provision such as washing facilities to promote and maintain patients' privacy and dignity.

However

- The critical care service was responsive to patients' needs.
- Staff at the unit were responsive to emergency admissions and provision of critical care beds to accommodate unwell patients.
- There was a good response from consultants and nurses when new patients were admitted. Patients were treated as individuals, and there were strong link nurse roles for all aspects of patient need, including dementia and end of life care.
- The critical care unit had a low rate of elective surgical operations being cancelled because a critical care bed was not available

- Communication aids, including translation services, were available for patients who could not otherwise communicate easily or effectively.
- The number of complaints received was low. Patients and relatives felt they were able to raise any concerns with staff and they would be dealt with satisfactorily. Information on how to complain was readily available.

Service planning and delivery to meet the needs of local people

- The CCU was well designed to meet the needs of patients requiring intensive care. The unit was located within the hospital to enable staff to respond to emergencies from other core services at the trust. Staff recognised the difficulty with access and flow due to bed capacity both within the unit and in the rest of the Trust. However staff at the unit were responsive to emergency admissions and to timely provision of a critical bed to accommodate unwell patients.
- The unit provided care and support to children under the age of 16 requiring level 3 (intensive) care while in other parts of the hospital. Children were admitted for ongoing resuscitation and stabilisation before they were transferred to other units. The CCU did not have any paediatric trained nurse; staff said a nurse from the paediatric unit supported them in this situation. Emergency equipment was available; although there was no dedicated area to treat children in CCU, a side room was identified if at all possible.
- The CCU had equipment to meet patient's health needs that could be unrelated to their critical illness or condition. This included, for example, haemofiltration and dialysis machines to provide treatment for patients with kidney failure which may not be related to their critical illness. During the inspection we observed two patients receiving this treatment.

Meeting people's individual needs

- It was recognised that the CCU was a 'mixed sex' environment and did not meet all the gender separation rules. However, the Department of Health guidance recognised that gender separation was difficult to fully manage in the critical care environment and staff made best use of the available space and equipment to ensure privacy and dignity with this regard. Like many intensive care units nationally the CCU had no provision of separate gender toilets or washing facilities to meet the element of the same-sex rules. However, once a patient should be discharged form CCU then the patient becomes a justified breach. Patients who have more than 12 hour delays from the CCU should be identified as a mixed sex breach. The trust had only recorded one mixed sex breach in the last 12 months.
- The Core Standards for Intensive Care Units (2013) recommend that patients discharged from intensive care should have access to a follow-up clinic. The lead consultant ran a monthly follow up clinic for patients which staff said had a positive impact on patients. Two nursing staff had completed counselling courses to enable them to provide support to patients post CCU care. However this was being supported by the staff and the clinic only saw a small number of patients.
- Staff had raised concerns about the access to ambulance services and delays for time critical transfers. The arrangements were not coordinated effectively with the ambulance service. This had impacted on patients' care as they were not able to be transfer patients out in a timely way and there were potential delays in access to specialist intervention which is not provided on site that could result in an emergency call out.
- Staff told us they felt confident to deal with people who were confused or disorientated as this was often an after effect of sedation or the patients' underlying critical illness.
- The unit had good links with the dementia team who were available to provide advice and support for patients living with dementia. As with all critical care units, the environment was not dementia friendly. A senior staff said they always tried to transfer the patient out to a more suitable environment as soon as possible.
- Staff were able to access translation services and information was available on the trust's internet.
- None of the staff were able to tell us of the flagging system to identify patients with a learning difficulty. Although staff were able to tell us about how they had supported patients with learning difficulty. For example some patients were admitted with "this is me "document and they would ensure their carers were able to stay with the patients. There was no link learning disability team where staff could receive advice and support to enable them to support these patients effectively in the critical care environment.

Access and flow

Critical care

- The Critical care unit (CCU) had a clear admission policy and guidance which staff followed. All patients were admitted under a consultant. Admissions to the unit included elective admissions (post- operative patients), and emergency admissions from all other specialities within the trust, as the hospital was a designated trauma unit. Other admissions were requests and transfers in from other hospitals.
- Emergency admissions to CCU remain the main pathway to the unit. This had shown a gradual increase from 76% in 2013-14 to 80% in 2014-15. There were two elective surgical admissions cancelled between July and September 2015 due to the lack of critical care beds. The unit was already in escalation mode with all 12 beds filled (including the escalation bed).
- Matron confirmed there had been no "serious delays " during escalation periods due to the turnaround time for bed spaces and this caused only short delays in getting patients admitted from theatre to CCU. This was being closely monitored.
- All admissions were discussed with the CCU first and the outreach team also kept the CCU staff informed of deteriorating patients around the hospital who may require intensive care. Matron told us in the event of a CCU bed not being available; a senior staff from the unit would support the patient in the recovery area in theatres until a bed became available.
- Patients fit for wards were not always transferred out of Critical Care within 24 hours. Thames-Valley and Wessex networks leads carried out a review in July 2015. The trust was identified as an outlier on the NHSE national dashboard. A further review was planned for January 2016.
- The Intensive Care National Audit and Research Centre (ICNARC) data showed 39% of discharges from critical care to a ward were delayed over 12 hours. This meant the unit often breached the same-sex rules as they related to providing washing facilities and toilets which were inadequate. We were told the main impact on this was bed availability in other areas of the hospital, which meant patients could not be discharged to a ward at the earliest opportunity. The action plan included meeting with director of operations to discuss this issue and identify solutions. This would be fed into the Best Practice Organisational Flow Group. The trust had recognised this was an ongoing problem and was not meeting NHS England KPI
- ICNARC data showed out of hours discharges were worse than expected.
- There were a number of patients who were discharged home from the unit. From April 2014- September 2015, this varied between 5-22% of patients being discharged home from CCU. Staff said some patients had remained in the unit for up to 10 days due to the lack of beds on the wards. This clearly affected the ability to plan for and deliver effective discharge planning for patients ongoing care needs.
- The proportion of elective surgical critical care bed bookings cancelled due to lack of availability of a post -operative critical care bed was low compared to national average
- The percentage of critical care bed days lost also fluctuated between 2 and 11% from April – December 2015. In August 2015, there was a marked improvement of 1% bed days lost, and in December this was at 6%.
- The Royal College of Anaesthetists recommend maximum critical care bed occupancy of 80%. The monthly bed occupancy figures for April – December 2015 showed occupancy levels were above 80% for five of the nine months. In December this was reported at 86% which was an improvement to December 2014 where this peaked at 100%. Bed occupancy levels increased due to a lack of a ward bed into which to discharge the patient
- The standard was for 93% of patients to be discharged from CCU between07:00 and 21:59 hrs. There were15 out of hours discharges (22:00-06:59), between June and December 2015 and this was worse than the national average. It is recognised that patients discharged overnight are at increased risk of deteriorating and best practice suggests limiting the number of overnight discharges.
- The environment was not suitable for patients who were fit for discharge but remained in the unit. There was no provision for those patients to have a shower in the unit which meant patients were taken to another ward. There was only one toilet which was outside the unit in close proximity to the visitor's room.

Learning from complaints and concerns

- The CCU had not received any complaints in the last 12 months. We reviewed the last complaint they had

received and found good multidisciplinary involvement in the investigation and good communication with the complainant. Records were clear and lessons learned recorded and shared.
- Information about how to raise a complaint including the Patient Advice and Liaison Service (PALS) was available to the patients and their relatives.
- Staff followed the trust's complaint policy and said they reported complaints from patients or their relatives to the manager or matron.
- Patients said they were confident to raise their concerns and said they would speak to the ward sister or would tell their relatives.
- A staff told us that should a patient or their relative wished to make a complaint they would try and address any concerns at local level. A senior staff commented they did rarely receive complaints and it was "always listen to what patients and relatives are telling you".
- The unit audited all complaints received and this was formed part of the quarterly governance report. Matron confirmed following an investigation, action plan would be developed as needed and learning shared with the team.

Are critical care services well-led?

Good

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

We rated well led as good.

- The leadership, governance and culture on the unit promoted improvements in the delivery of high-quality person-centred care. All the senior staff were committed to their patients, staff and the unit with an inspiring shared purpose in providing care centred around the patients.
- The critical care unit had governance arrangements in place to monitor and act on aspects of performance, quality and risks; high risks were escalated to the board.
- Staff felt valued by their immediate line management and well supported.
- There was strong evidence and data to from national studies and research to drive the service forward in providing evidence based care.
- Innovation and improvement were celebrated and encouraged, with a proactive approach to achieving best practice and sustainable models of care.
- Systems were in place to gather patient and staff feedback and use it to improve services.

However

- Some staff group felt arrangements could be more robust such as feedback from learning and incidents and cascaded to all staff.
- Not all risks had been identified on the risk register. This included the risks related to medicines management and inter hospital transfers.

Vision and strategy for this service

- The CCU had a local vision to increase its capacity of the unit in order to provide effective care to meet the demands for CCU beds. The vision had not yet been put into a strategy due to the current constraints and the wider Dorset Clinical Services Review. Senior staff and managers were passionate about improving the delivery of critical care services to meet with increasing demand.
- The vision for the unit from the staff's perspective was "to be the very best" in delivering care tailored to patients' individual needs.
- Managers were aware they needed to improve the timeliness of critical care patients' discharges to the appropriate wards and to achieve new national KPI.
- New software development to facilitate effective reporting system and contributing to the development of patients' care.

Governance, risk management and quality measurement

A consultant lead was responsible for the audit programme. This focussed in ensuring participation in relevant audit such as Intensive Care National Audit and Research Centre (ICNARC) data returns. Other audits included the International Multicentre Prevalence Study on Sepsis, the National Confidential Enquiry into Patient Outcome and Death (NCEPOD).

- There were monthly local audits which included infection control, ventilator acquired infection, central lines and early readmissions to the critical care unit. The

audit results were discussed at governance meetings to ensure appropriate actions were recorded and monitored. Learnings from these audits were shared with the team as appropriate. Following an investigation of early readmission of a patient; staff were reminded to look at specific clinical requests to ensure patients were discharged to the appropriate directorate for continuing care.

- There were monthly departmental governance, audit, mortality and morbidity meetings with representation from all staffing groups.
- The unit had a risk register which was linked to the trust risk registers. There was one item on the risk register related to CCU which was rated red. This was delayed discharges from the unit which was recognised and understood by the clinical lead, matrons and staff. The unit to continue auditing this and action included monthly meeting to discuss discharge from CCU and review any queries from audit. However monthly meetings had not occurred as planned and this was being addressed.
- Not all risks had been appropriately identified on the risk register, specifically, the risk pertaining to medicines management and inter hospital transfer. Staff were aware of risks around inter hospital transfers and a pharmacist had recently been allocated to support critical care but these risks had had not been appropriately identified.
- The CCU had developed an "in house quality dashboard" in order for critical care staff to access reports, audits and action plans which was relevant to their core service.
- The unit participated in the monthly divisional performance review meeting. The meeting was regularly attended by the CCU's lead consultant and senior nurses. Items including safety performance, finance and staffing were reviewed. Details and actions from the meeting were minuted and shared with staff in the unit.
- Senior medical staff felt that governance arrangements could be more robust. Incidents and learning from these could be improved particularly by better sharing of information across directorates.

Leadership of service

- There was strong and dedicated leadership from senior clinicians and senior nurses to provide a culture of high quality care underpinned by teamwork, teaching, training, learning and support for all staff.
- The unit had a lead consultant and an experienced staff team. They communicated a strong passion and commitment in delivering a service which was patient centred. This was supported by good clinical governance helping to deliver consistently effective and well led care.
- The nursing leadership was visible and involved in the day to day management of the unit. Staff were complimentary about the matron and senior nursing colleagues who they described as "extremely supportive" and genuinely committed to provide support to staff.
- The consultants we spoke with had a high regard and respect for the nursing team, and the allied health professionals. Staff told us the consultants and medical staff were "supportive and very approachable", and they felt their input was respected.
- Managers recognised emerging issues and responded to them before a problem arose. This included ensuring that skill mix in the unit was reviewed to provide safe care. Three further staff were supported to complete the critical care course in Quarter 2 at the local university to maintain the correct levels of skills in providing safe and effective care.
- There was a shift co-ordinator who was supernumerary to the nursing numbers allowing them to oversee the running of the unit and providing support to staff and relatives.
- The unit benefitted from highly flexible staff in critical care working extra hours and ensuring the right skill mix to provide safe care.

Culture within the service

- Staff worked collaboratively in a culture that promoted effective patient care. All staff were encouraged to contribute on issues raised and given the opportunity to talk openly with each other, and felt safe doing so. We saw doctors asking nurses for their input on patient treatments, and saw nurses asking questions of doctors for advice.
- Staff were confident in raising concerns regarding patients' care such as reporting any errors and two staff told us they felt they would receive management support.

- Patients and relatives felt the unit was well run and committed to putting patients first. Staff member told us they valued the team work and support they received from all staff grades. A staff commented the culture here is “learning from each other”.
- The unit’s ethos was to continue the culture of continuous quality improvement underpinned by reliable information and audit.
- There was good team work and support from the matrons and the clinical lead, so the morale was high with professional respect evident between team members.
- Staff worked well together, and there was obvious respect across various disciplines. Staff said they felt valued team members.
- The matron and senior staff took an interest in the staff’s wellbeing in the unit with opportunity for debrief. A staff member commented that it was a stressful environment to work in and they “always look out for each other”.

Public engagement

- The trust has good links with the local community and volunteers were active at the trust. Relatives and friends were encouraged to give feedback to help identify improvements. Staff told us overall patients were “highly satisfied” with the care and support they received. Comment cards were available to encourage feedback.

Staff engagement

- Following the last staff survey an action plan had been developed for 2014 results. An action plan had been developed and staff encouraged reporting potentially harmful errors and needle stick injuries. Noticeboards and yellow posters were in place regarding compliance with personal; protective equipment (PPE). Alternative needle stick product was sourced and this was changed in September 2015.
- The NHS staff survey 2014 showed 21% of staff had experienced physical violence from patients/ relatives or members of the public. The trust had responded and additional Care First posters and leaflets had been introduced advising all service users of zero tolerance to abuse towards staff. Also raised staff awareness that inappropriate behaviour would not be tolerated. Other initiatives to improve communication included staff survey focus with managers and HR to identify improvement. A new communication board had been developed in the critical care unit with information updated at least monthly.
- The staff survey was also an agenda item at the quarterly head of department meetings. This had been cascaded to team leads to engage with staff and feedback on ideas for improvement. The actions were reviewed regularly and communicated to teams.

Innovation, improvement and sustainability

- The unit was research orientated. The research team was based in the critical care unit and led by a lead critical care research Consultant and two nurses. They worked closely with the critical unit with staff seconded to take part in research projects. Some of the recent research projects included trial of the route of early nutritional support in critically ill adults. This looked at two different methods of supporting patients’ nutritional needs such as those who were not able to receive their feeds orally. Staff said the result of the survey had been used to support changes in their practice for patients requiring nutritional support.
- They had participated in the BREATHE trial which is a randomised, controlled, open, multi-centre, effectiveness trial to determine if the use of Non-Invasive Ventilation (NIV) as an intermediate step in weaning patients off mechanical ventilation . This had changed their management of certain ventilated patients.
- The trust had recognised that the ability of critical care team to discharge patients was pivotal in enabling the unit to manage admissions.
- Action required included they continued to raise awareness of lack of capacity along with consequences at trust level. Measures in places included continued monitoring, internal audits and aligning these to ICNARC and NHSE data.

Maternity and gynaecology

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

Information about the service

Poole Hospital NHS Foundation Trust provides maternity and gynaecological services to the population of East Dorset. Between July 2014 and June 2015 there were 4,285 births at Poole hospital.

Maternity services are based at St. Marys Hospital which is situated a short way from the main hospital site. Obstetrician and midwife led services are provided for early pregnancy, antenatal, delivery and postnatal care.

Inpatient maternity care is provided on an 12 bed combined antenatal and induction of labour ward.. The delivery suite contains eight labour rooms and two high dependency beds where care is provided by midwives, obstetricians, operating department assistants and anaesthetists. There are two dedicated operating theatres for women who require an assisted delivery or emergency or booked caesarean section. There is a three bed recovery area where women are cared for immediately after operative delivery.

The Haven Birthing Suite is available for women who have been identified as low risk and for whom a midwife led delivery is suitable. The suite contains five rooms, three of which have birthing pools.

The Spring Suite comprises of two rooms and is used for women who require a medical termination of pregnancy or who have had a bereavement. On the postnatal ward there are eight transitional care beds (an area where babies are cared for, after discharge from neonatal intensive care) and 25 postnatal beds

Gynaecological services are also provided on the main Poole hospital site. These comprise 15 gynaecological beds on a ward shared with other surgical specialities. Gynaecology and some early pregnancy outpatients' services are offered in the Harbourside gynaecology centre, based on the main hospital site.

During our inspection we spoke with 12 patients, four relatives and 34 staff. These included midwives, nurses, maternity support workers, senior managers and doctors. We observed a shift handover and held focus groups attended by a total of 29 members of staff. We reviewed nine patients' healthcare records. Before and during our inspection we reviewed the trust's performance information.

Maternity and gynaecology

Summary of findings

Maternity and gynaecology services were rated good for effective, caring responsive and well-led services. However we rated safe as requires improvement.

Clinical safety incidents were not consistently reported. Midwives told us that they were unable to report all incidents due to staffing pressures.

Systems and processes for monitoring infection control standards were not always reliable or appropriate to keep people safe. The delivery suite environment was difficult to keep clean. We noted emergency obstetric equipment and equipment required to remedy a tongue tie in the antenatal clinic was dirty and also sterile equipment had expired**. There was a risk of a hospital acquired infection if the equipment had been used..**

Staffing levels and skill mix were not always planned, implemented and reviewed. Midwives told us the last birthrate plus staffing assessment had taken place in 2012. A further trust review had been conducted in 2013 and had concluded there was no indication to increase the planned maternity staffing establishment for the year 2014/15. Midwives felt the staffing review had not been updated to reflect the increase in activity in the service. The midwife to birth ratio did not meet national guidelines. The funded midwife to birth ratio was 1:31. Between April to September 2015 the midwife to birth ratio was 1:32-33. The Royal College of Obstetrics and Gynaecology guidance (Safer Childbirth: Minimum standards for the Organisation and Delivery of Care in Labour, October 2007) states there should on average be a midwife to birth ratio of 1:28. The England average was 1:29. Midwives were unable to consistently provide one to one care for women during labour.

Consultant presence on the ward was 60 hours per week compared to the Royal College of Obstetricians and Gynaecologists good practice recommendation of 98 hours per week. The consultants provided a further 108 hours per week on call.

Overall attendance at mandatory training updates was below the trust's 95% target. There was a risk that not enough staff had attended updates to ensure they had suitable training to care for women safely.

Midwives followed comprehensive risk assessment processes from the initial booking appointment through to post-natal care. Identified risks were recorded and acted upon across maternity and gynaecology services.

The gynaecology ward participated in the NHS Safety Thermometer**.** That is a local improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care. The ward conducted monthly audits in respect to patient falls, pressure ulcers, catheters and urinary tract infections. However, information about the audits was not displayed. It is considered to be best practice to display the results of the Safety Thermometer audits to allow staff, patients and their relatives to assess how the ward has performed.

Care and treatment was delivered in line with current legislation and nationally recognised evidence based guidance. Women had access to a variety of methods for pain relief throughout the service. Feedback from women and relatives about their care and treatment was consistently positive. We observed women were treated with kindness, compassion and dignity throughout our visit.

Women had prompt access to gynaecological treatment. For the period January 2015 to December 2015 the hospital exceeded the target of 92% of patients waiting less than 18 weeks for treatment following referral (incomplete pathway).

Translation services were available, and some midwives had undergone further specialist training to support women with additional needs such as learning disabilities and drug and alcohol addictions.

There was a clear strategy for maternity services. Managers told us they had produced a strategy which had not yet been presented to the board. However, the strategy included plans for future development of the services and how those aims would be met. Senior managers did not consistently demonstrate an understanding of current service risks. The concerns regarding delays to care and the inability to consistently provide one to one care in labour had not been documented on the maternity risk register. However, an action plan had been developed which addressed concerns regarding delays for women undergoing an

induction of labour. Senior midwives described a dis-connect between themselves and senior managers. They felt unable to speak freely and said they were not always listened to.

There were comprehensive risk, quality and governance structures and systems to share information and learning. Junior staff across the service described an open culture and felt well supported by their managers.

Are maternity and gynaecology services safe?

Requires improvement

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

We rated safe as 'requires improvement'

- Not all incidents were reported. Midwives told us they did not have time to report all incidents. Midwives were unsure whose responsibility it was to report delays to care when women were unable to access the delivery suite from the antenatal ward in a timely manner.
- Systems and processes for monitoring infection control standards were not always reliable or appropriate to keep people safe. The delivery suite environment was difficult to keep clean. We noted
- Equipment, including emergency equipment, was not sterile. **There was a risk of a hospital acquired infection if the equipment had been used.**
- Staffing levels and skill mix were not appropriately planned, implemented and reviewed. Midwives told us the last staffing assessment had taken place in 2012. Staff felt this assessment had not been updated to reflect the increase in activity within the service and as a consequence they were not able to consistently provide one to one care for women in labour across the service.
- The midwife to birth ratio did not meet national guidelines. The funded midwife to birth ratio was 1:31. The funding had been adjusted to account for antenatal and post natal care provided at another site. However, between April to September 2015 the midwife to birth ratio was 1:32-33.The Royal College of Obstetrics and Gynaecology guidance (Safer Childbirth: Minimum standards for the Organisation and Delivery of Care in Labour, October 2007) states there should on average be a midwife to birth ratio of 1:28. The England average was 1:29. Midwives were unable to consistently provide one to one care for women during labour.
- Overall attendance at mandatory training updates was below the trust's 95% target. There was a risk that not enough staff had attended updates to ensure they had suitable training to care for women safely.

However,

- Incidents were reported and learning shared in gynaecology.
- Staff we spoke with were knowledgeable about the trusts safeguarding procedures.

Safeguarding vulnerable adults, children and young people was given sufficient priority.

- Risk assessments were completed at the initial booking and continually evaluated throughout antenatal, perinatal and postnatal care. These included signs of deteriorating health or clinical emergencies.
- Staff recognized and responded appropriately to changes in risks to people who use services.
- Plans were in place to respond to emergencies and major situations. All relevant parties understood their role.

Incidents

- There were seven serious incidents in maternity during the reporting period of October 2014 to December 2015. Senior medical staff and midwives had investigated why the incidents had occurred and the results of the investigations were shared in meetings and via email. One midwife told us as a result of the investigations, there was an ongoing audit to ensure **Gestation Related Optimal Weight** (GROW) charts had been completed and interpreted correctly.
- All grades of staff we spoke with were aware of the recently introduced incident reporting system and told us they were encouraged to report incidents. Staff told us the system was simple to use, and most of the staff had access to the reporting system. We spoke with one member of the domestic staff who did not have access to the system. They were clear about their responsibilities to alert the senior member of staff on duty to any areas of concern which may affect the safety of patients.
- Midwives told us they reported incidents when they had enough time. They told us there were often times when they were too busy to complete the incident report forms. Some midwives told us they did not have individual feedback about the incidents they had reported. However, midwives were able to request feedback through the incident reporting system if required.
- The risk manager allocated band 7 midwives incidents to investigate. However, they reported they were unable to meet the 48 hour target to start investigating the incidents as they did not have time. They had escalated this issue to senior managers. In response a new band 7 'risk leader' had recently been appointed.
- Reported incidents and subsequent investigations were presented at regular risk management meetings. Senior managers told us this was to ensure trends were identified and learning was shared. Band 7 midwives told us they did not have time to regularly attend the risk meetings. We saw from documents sent to us by the trust that Band 7 midwives had been able to attend some meetings. If they were unable to attend they received minutes from the meetings which outlined any serious incidents, audit results and best practice. They shared this information with junior staff at a '60 seconds meeting'. This was a briefing held at the beginning of each shift to disseminate information to staff. Band 7 midwives told us the frequent movement of staff to cover other areas made information sharing problematic. They had instigated a communication diary to ensure all staff had access to the information.
- Delays in treatment were reported as incidents through the electronic incident reporting system. Two midwives told us there was confusion as to who was responsible for reporting delays. They told us prior to the electronic system, the midwives completed a yellow incident form which they attached to the patient notes and when the patient was transferred to labour ward the form was completed and sent off. With the electronic system neither the midwife on the antenatal ward nor the labour ward midwife took responsibility for completing the online form. This meant delays in treatment may not have been accurately recorded to allow further investigation into the cause and prevent recurrence.
- Nurses on ward B2 (gynaecological ward) told us they received information via email about the outcome of the incident they had reported. Incidents were discussed at monthly team meetings. Senior staff told us this was to ensure learning was shared. For example there had been a controlled drug incident which resulted in the loss of some medication. Further controlled drug checks were implemented. The checks were regularly monitored to ensure compliance.
- All reported incidents in gynaecology and maternity were documented in the services' quarterly quality report. We saw that trends had been identified and plans developed to address incidents that occurred

regularly. For example, in response to frequent incident reporting about an inconsistency between sample details and request forms, all samples were to be double checked to reduce the risk for error.
- Regular mortality and morbidity meetings were held. Investigations and case histories were presented and learning shared.

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. All grades of staff we spoke with were aware of the principles of Duty of Candour. Staff explained how women were informed about investigations into any incidents which related to the care they had received. We saw in the records of investigations for serious incidents that members of staff had identified that the duty of candour legislation should be applied.
- Information was displayed in the maternity staff office to remind staff of their responsibilities with regards to duty of candour.
- Senior midwives told us they were unsure if there been any trust wide training. However, they planned to include information about duty of candour on the midwives' update day.

Safety thermometer

- Staff on ward B2 participated in the NHS Safety Thermometer**.** The NHS Safety Thermometer is a local improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care. The ward conducted monthly audits in respect to patient falls, pressure ulcers, catheters and urinary tract infections. However, the only information about the audits displayed was with regards to hand hygiene, cleaning standards and trust wide infection control. It is considered to be best practice to display all the results of the Safety Thermometer audits to allow staff, patients and their relatives to assess how the ward has performed.
- Safety thermometer information was displayed on the doors of both the antenatal ward and Haven Birthing Suite. Information displayed included wound infections, post-partum haemorrhage and hygiene audits. The postnatal ward did not display their audits. Staff told us they had started to use the maternity specific safety thermometer four months before our inspection. They felt they did not have sufficient information to display trends. However, they intended to display the information in the near future.

Cleanliness, infection control and hygiene

- There were inconsistencies in cleanliness within the maternity service.
- In the antenatal day assessment area (ANDA) an emergency trolley was kept in a cupboard close to the waiting area. The trolley contained medication and equipment that were used in an obstetric emergency. The trolley was visibly dirty and some sterile equipment was out of date. The cupboard also contained a box which contained equipment for babies who required treatment for a tongue tie **(a problemaffecting somebabies with a tight piece of skin between the underside of their tongue and the floor of their mouth). The box was cracked and dirty and the sterile scissors (required to rectify the tongue tie) were kept in an open packet and were not sterile. There was a risk of a hospital acquired infection if the equipment had been used. We alerted the midwife in charge of our concerns. We re-visited the area on the second day of our inspection. The emergency trolley had been cleaned and re stocked with sterile equipment. The box which contained equipment for tongue ties had been replaced.**
- **We noticed the toys in the waiting area were dirty. Maternity and cleaning staff were unsure about whose responsibility it was to clean them. We raised our concerns about the toys with a member of staff during our unannounced inspection.**
- In the delivery suite we saw that some window sills were dirty and in one room we saw the wallpaper border was peeling which made the walls difficult to clean. Senior staff told us they had initiated cleaning checklists for each delivery room in response to concerns about cleanliness. We visited five rooms (the remaining delivery rooms were occupied) we noted three of the rooms contained cleaning and equipment checklists. The checklists had last been completed in December 2015. Senior members of staff told us they trusted the maternity support workers to ensure the rooms were

clean, however, there were no up to date checklists to ensure cleaning was monitored. All clinical areas in the postnatal ward and Haven Birthing Suite were visibly clean.

- Across both services we saw staff adhered to the trust's infection control policy. Information was clearly displayed above sinks in most areas to remind staff about correct hand washing procedures. Staff were seen washing their hands and using hand gel appropriately. However staff in the ultrasound department told us access to handwashing facilities was difficult in two out of the three scanning rooms. This was due to the increase of technical equipment used. They told us they used hand gel in between each woman.
- Hand hygiene gel was available at the entrances to wards and departments. Gel was also present in the delivery and examination rooms. One woman told us, "Midwives and doctors washed their hands before touching my tummy".
- We observed the majority of staff were bare below the elbows. We noted that maintenance and blood transfusion staff were not bare below the elbow on the labour ward.
- Personal protective equipment was available and staff were seen changing gloves and aprons in between patients to prevent the risk of cross infection.
- Regular infection control audits were performed across the maternity service. These audits observed a variety of infection control practices such as hand washing and bare below the elbow. The target for correct hand hygiene was above 95%. We saw from the results sent to us for November 2014 to October 2015 the service scored 100% for the majority of the audits.
- B2 ward and the Harbourside unit were visibly clean. On ward B2 green "I am clean" stickers were displayed on commodes to indicate they were clean and available for use. Cleaning schedules were displayed and regular cleaning audits were conducted to ensure the ward was clean.
- Infection control audits for the gynaecological service included monitoring of compliance for hand hygiene and bare below the elbows. The results for April to June 2015 showed low compliance in April for hand hygiene in both B2 and Harbourside, 70% and 80% respectively. Senior ward staff developed an action plan to ensure all ward staff met the standards of hand hygiene. The compliance with the action plan was monitored and audited and was consistently 100%.
- There had not been any reported incidents of Methicillin resistant Staphylococcus aureus (MRSA) or Clostridium difficile infections between August 2014 and August 2015.

Environment and equipment

- The size of the birth rooms in the delivery suite were documented on the trust risk register. The trust acknowledged the birthing rooms did not meet Department of Health (DH) regulations. The DH document Children, young people and maternity services: Health building note 09-02 Maternity care facilities point 2.25 states. All birthing rooms should include an area designated and equipped for resuscitation of a new born baby'.
- Most of the rooms were small and they were unable to accommodate a baby resuscitaire if required. There was a central area for babies who required the use of a resuscitaire and a portable resuscitaire that could be used outside of the delivery room. Staff were aware of where emergency equipment was located. Training had occurred to ensure staff followed standard procedures to make sure the appropriate equipment was located in the event of an emergency. Midwives told us they ensured two midwives were present when women delivered their babies. This was to make sure a woman was not left alone in the room if their baby required resuscitation.
- The baby resuscitaires had lists attached to them to ensure the equipment had been checked on a daily basis. A signature was required to document the checks had been completed. We noted the equipment had been regularly checked to ensure it was safe to use.
- There was an emergency trolley in the delivery suite which contained equipment used in the event of a post-partum haemorrhage (PPH). A primary PPH is defined as the loss of more than 500 ml of blood within the first 24 hours following childbirth. The trolley also contained equipment required to treat women with pre-eclampsia (a condition in pregnancy characterised by high blood pressure and swelling). We noted the equipment had been checked and the trolley was clearly labelled to ensure it was located promptly.
- Within the Haven Birthing Suite, clinical equipment was stored out of site in cupboards and corridors were kept uncluttered. The birth rooms were spacious and each room had a pull down resuscitaire.

- A range of equipment to aid labour was available across both areas. These included birthing pools, birth stools and birthing balls.
- Equipment was available to evacuate a women from the birthing pools in the event of collapse.
- Other equipment was available in the maternity services, for example fetal cardiotocography (CTG) equipment. We noted stickers were attached to show the equipment had been serviced and checked.
- The call bell system was documented on the trust risk register as a potential safety concern. Midwives carried pagers so that they could tell which woman required assistance. We were told that the pagers were often broken and the display panels could only display emergency calls. The trust had ordered new pagers and had contacted the external contractor to upgrade the system.
- Babies were labelled at birth but not security tagged until they reached the post-natal ward. This was because the alarms went off incorrectly in the labour rooms near the exit door.
- Midwives who worked on the post-natal ward described their difficulties with the security system used for tagging the babies. They told us the system often alarmed up to 40 times a day or failed to alarm when tested. Staff were unable to respond to every false alarm and were concerned that they may miss a baby taken out of the ward without permission. They had raised these concerns with the supplier of the alarm; however, midwives told us the faults were not being rectified in a timely manner.
- Within B2 ward equipment used to support the delivery of care for example hoists and portable monitoring equipment was stored appropriately. The equipment was clean and fit for purpose. All equipment displayed a sticker which gave information which detailed when it had been serviced and tested. We noted that all equipment had been checked within the last 12 months.
- The early pregnancy service was located in the Harbourside gynaecology centre which was situated in the main hospital. Women who were up to12 weeks pregnant were able to attend this service. The Harbourside gynaecology centre also contained appropriate equipment to cater for a wide range of gynaecological treatments. Women over 12 weeks of pregnancy attended the day assessment unit based in the maternity hospital, where further equipment such as cardio-tocographs (CTG) were available to support them.
- All of the wards and clinical areas we visited had portable resuscitation trolleys. The trolleys contained medication which was to be used in the event of a cardiac arrest. We saw check sheets which documented all trolleys had been checked to ensure equipment was available and in date.

Medicines

- The medicine trolley on B2 was not secured to the wall to prevent unauthorised removal. We alerted a member of staff who ensured the trolley was secured.
- In all other areas medication was stored correctly within locked cupboards and resuscitation trolleys.
- Medication that required storage at low temperatures was kept in dedicated fridges. Fridge temperatures were checked daily to ensure the medication was stored at the correct temperature.
- Midwives told us they felt there had been an increase in medication incidents, due to low staffing levels. Between July 2015 and September 2015 there were five controlled drugs medication incidents and 17 medication incidents not related to controlled drugs. These included missing and delayed medication. Each incident was reviewed and shared with the supervisor of midwives if a practice issue was identified. Further training was implemented for any midwife involved in a medication error.

Records

- Records were not consistently stored securely.
- On B2 ward the records were stored in an open trolley in front of the nurse's station. The records trolley was not lockable.
- We observed during a ward round, notes were left unattended on a trolley in the corridor on the delivery suite. There was a risk that notes could be accessed by unauthorised personnel**.**
- Pregnant women carried their own records. These were completed at their initial antenatal booking and were maintained throughout their pregnancy through to the completion of their care by community midwives and obstetric staff. The records contained clear plans of care for midwives and obstetricians to follow.

- All the records we reviewed contained relevant risk assessments, for example pressure ulcer risk and venous thromboembolism (VTE) assessments.
- Women were given a child health 'red book' by community midwives when they were 36 weeks pregnant. Midwives told us if a baby had been born prior to 36 weeks, the mother would not have a red book and they did not have access to the books at St. Mary's Hospital. Women were given computerised printouts of the treatment their baby had received to ensure accurate records were kept.
- Pre- printed stickers were used to assess fetal wellbeing during labour. The stickers included information which enabled midwives to identify when fetal cardiotocography (CTG) recordings deviated from the norm.
- Documentation was completed correctly when an abortion had been carried out for fetal abnormality. The HSA1 (grounds for carrying out an abortion) had been completed but the process for ensuring that the HSA4 (abortion notification) had been completed and submitted to the Department of Health as required was not robust and relied upon the return of the patients notes to a specific member of staff.

Safeguarding

- All of the staff we spoke with were clear about their roles and responsibilities and the processes and practices that were in place to keep women safe and safeguarded from abuse.
- The midwifery service employed a lead midwife for safeguarding who reported to the named midwife for safeguarding. Their role was to assess and monitor safeguarding concerns across the service. Women and babies who were considered at risk were flagged on the computer system and in their hand held notes. Care pathways were in place to enable all midwives to care for them appropriately. Information was disseminated to community midwives and health visitors to enable them to support women and babies in the community.
- In each community midwifery team a 'partnership' midwife took the lead for safeguarding children and vulnerable women within the community team. Joint working had been established with external agencies in primary and social care. This ensured women and babies considered at risk were supported by all the relevant agencies.
- Maternity and gynaecology staff had attended mandatory safeguarding training updates to ensure their knowledge was up to date. The trust target for attendance for maternity staff was 95%. We saw that 70% to 72% of maternity staff had attended level one and level two 'safeguarding adults' updates. 89% to 92% of staff had attended safeguarding children levels two and three updates. There was a risk that not enough staff had attended safeguarding adults updates to ensure their knowledge was up to date.
- Within gynaecology between 90% to 100% of staff had attended levels one and two safeguarding adults updates. 100% of staff had attended training for safeguarding children.
- The target for attendance at child protection level two training was 95%. We saw that 91.54% of staff had attended training to ensure they were up to date with child protection requirements.

Mandatory training

- For the maternity service, overall attendance at mandatory training updates was below the target of 95%. Figures for April 2015 to November 2015 showed that staff attendance for various training days such as adult basic life support, fire safety, health and safety and equality and diversity varied between 74% and 79%. Overall the figures as at November 2015, which included attendance at safeguarding training,(where training attendance was higher) showed that 86.17% of staff had attended mandatory training. There was a risk that not enough staff had attended updates to ensure they had suitable training to care for women safely. Midwives told us they were booked to attend mandatory training sessions, however they were often unable to attend or asked to leave the training session if the maternity unit was short of staff. Mandatory training attendance was documented in the service quality report for July to September 2015.The non-compliance with training attendance had been identified with an expectation that attendance would improve. However, there were no clear plans documented to ensure staff attendance at training sessions improved.
- Midwives and obstetricians undertook further role specific training, practical emergency obstetric training (PROMPT) which included neonatal life support and fetal monitoring.

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Maternity and gynaecology

Assessing and responding to patient risk

- Risk assessments were completed at the initial maternity booking and continually evaluated throughout a woman's pregnancy.
- Between April 2015 and December 2015 the maternity service met the trust target of 96% for women assessed for the risk of venous thromboembolism (VTE) seven times.
- Monthly audits were completed by senior staff on B2 which evaluated whether VTE assessments had been completed. Between April 2015 and December 2015 the service had exceeded the target for eight out of the nine months. However, because the ward was shared with another surgical speciality there was no breakdown of figures to allow us to assess the compliance for VTE assessments for gynaecology.
- Midwifery staff completed the modified early obstetric warning score (MEOWS) to assess women's observations. This was a system that enabled midwives to record observations and gave protocols for staff to follow if the observations deviated from the woman's norm.
- Midwives who worked in the delivery unit used the 'fresh eyes' approach which assessed fetal monitoring. Different midwives regularly checked recordings from the CTG machine to ensure any anomalies in the fetal heart trace had not been missed by the midwife responsible for the woman's care. Midwives had attended training and updates to enable them to monitor the recordings effectively.
- Women who required an unexpected admission to ICU were transferred to the main hospital by the local ambulance service.
- Midwives and obstetricians had received appropriate training and were aware of the signs symptoms and treatment for sepsis (a blood infection, although rare, is now the leading cause of maternal death in the UK).
- Nursing staff completed the early warning scoring system (EWS) on B2 ward. The scoring system enabled nurses to assess patient's observations and provided protocols to follow if the observations varied from the patient's norm.
- Senior nurses on B2 ward completed monthly audits to assess risks to patient care had been identified, this was known as the 'Wednesday ward watch'. Ten patients' notes per month were audited to ensure they had been accurately completed and risks had been identified and plans developed to minimise the risk. Areas covered included pain, manual handling and oral hygiene risk assessments. The results of the audits were discussed at team meetings and presented on the quarterly performance report. Areas for improvement had been identified and we saw plans had been put in place which addressed areas for improvement.
- We observed the five steps to safer surgery check list was not consistently completed for a gynecology day surgery procedure. This is a nationally recognised system of checks designed to prevent avoidable harm and mistakes during surgical procedures. These checks include a team brief at the beginning of each theatre list, sign out and the World Health Organisation (WHO) surgical safety checklist (a tool for the relevant clinical teams to improve the safety of surgery by reducing deaths and complications).Whilst the team brief and checklist were completed, the recommended sign out was not performed for one procedure. The sign out would have enabled confirmation from staff that instruments and swabs were correct and post-operative management was discussed and handed over. Compliance of the gynaecology WHO surgical checklist was monitored and reported through the quarterly quality report. For July to September 2015 the audits were fully completed.
- We observed the checks were fully completed in the maternity theatre.

Midwifery staffing

- We spoke with four patients on the postnatal ward. All the patients told us staff answered their call bells very quickly. Patients told us staff were always very busy and two patients told us, "there doesn't seem to be enough staff".
- Midwives told us that overall assessment of the service provision had been calculated by the Birthrate Plus acuity tool (Birthrate Plus is an assessment tool that provides a comprehensive assessment of the staffing needed to provide the care required by a woman in the maternity services). The assessment had taken place in 2012. A further trust review had been conducted in 2013 and had concluded there was no indication to increase the planned maternity staffing establishment for the year 2014/15. Staff felt this assessment had not been updated to reflect the increase in activity within the service. Senior midwives told us they "couldn't remember the last time it had been used". Senior staff

told us the current midwifery staffing levels were not planned by the use of an acuity tool (a tool used to assess the level of staffing required related to the dependency of women and babies). They had recently introduced the electronic rostering of staff and there were plans to include an acuity tool in the electronic system. There was a risk that women may not be cared for effectively because staffing may not have been planned to meet their individual requirements.

- All of the 29 registered and unregistered staff who attended our focus groups told us there was not enough staff in the maternity service. Midwives told us they were regularly required to work through one of their breaks and were often moved around the unit to "plug the gaps".
- Midwifery staff told us they were frequently moved between wards. Senior midwives told us, "Every day we have to move staff around, the midwives feel unsettled so we try not to move the same people."
- The funded midwife to birth ratio was 1:31. The funding had been adjusted to recognise whilst the trust provided 100% of intrapartum care only 50% of postnatal and antenatal care was provided. The remaining 50% was provided at another hospital. Between April to September 2015 the midwife to birth ratio was 1:32-33.The Royal College of Obstetrics and Gynaecology guidance (Safer Childbirth: Minimum standards for the Organisation and Delivery of Care in Labour, October 2007) states there should on average be a midwife to birth ratio of 1:28. The England average was 1:29. One midwife told us "there are definitely times when there are not sufficient midwives to look after the women".
- Midwives were not consistently able to provide one to one care for women in labour. Data recorded on the maternity dashboard showed that between April 2015 to September 2015 between 95.3% and 98% of women received one to one care. Midwives told us this was due to women who commenced labour in the induction suite and were unable to be transferred to the delivery suite because of lack of capacity. There were not sufficient midwives to provide one to one care for women in established labour in the induction suite. The Royal College of Obstetrics and Gynaecology guidance (Safer Childbirth: Minimum standards for the Organisation and Delivery of Care in Labour, October 2007) states the midwife to woman in established labour ratio should be one midwife to one woman.
- The current midwife sickness rate was 8% which was above the trust target of 3.5%. Senior managers told us this had increased over the past year. They felt the increase in sickness was associated with the introduction of longer shifts. Midwives worked 13 hour shifts which included two thirty minute breaks. There were plans to consult with midwifery staff to change the current shift pattern. Staff shortages created by sickness were filled by existing staff.
- Midwives used Situation, Background, Assessment, Recommendation (SBAR) forms to facilitate a structured written handover when they were about to finish caring for a woman.
- Nursing staffing on ward B2 was planned and assessed using a recognised safer nursing care tool, which included guidance for determining the acuity of patients. The tool was used to ensure the ward had the right staff, with the right skills in the right place and the ward was staffed appropriately. Staff told us there was enough staff to care for patients effectively.

Medical staffing

- The Royal College of Obstetricians and Gynaecologists Good Practice Guidelines 2010 state the recommended consultant cover for a maternity unit which delivers between 4000 to 5000 births should be 98 hours a week. The consultants on the maternity unit provided 60 hours per week on site and a further 108 hours per week on call.
- Consultants were present on the ward for 10 hours a day during the week.
- There were nine consultants in total for both services.
- A specialist registrar (a doctor who has received advanced training in a specialist field in order to eventually become a consultant) was present in the maternity unit overnight.
- There were 12 senior house officers and a further nine registrars.
- Doctors from another trust provided registrar and consultant cover for labour ward each Wednesday between 8.30am and 9pm. This was to ensure they kept their skills updated because midwives led the care at their trust.
- A consultant anaesthetist was present on the delivery suite between the hours of 9am to 5pm Monday to Friday. An additional anaesthetist was present on the delivery suite between 9am to 1pm when elective caesareans were in progress.

- There was a further middle grade anaesthetist (a doctor who worked under the guidance of a consultant and had six years' experience in a specialty) who worked between 9am to 7pm Monday to Friday.

Major incident awareness and training

- Staff were aware of their roles and responsibilities in the event of a major incident.
- Midwives followed escalation plans, which were available on the trusts intranet, in the event of a major incident.
- Business continuity plans were available for staff to follow to ensure routine care was delivered in the event of a major incident.

Are maternity and gynaecology services effective?

Good

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

- Care and treatment took account of current legislation and nationally recognised evidence based guidance. Policies and guidelines were developed to reflect national guidance. They were monitored and audited to ensure consistency of practice.
- A range of equipment and medicines were available to provide pain relief in labour and for patients on the gynaecological ward. Women were able to self-administer pain relief if required.
- Women had comprehensive assessments of their needs, which included consideration of clinical needs, mental health, physical health and wellbeing, and nutrition and hydration needs.
- Breast feeding was encouraged and the maternity services were working towards accreditation with UNICEF's UK Baby Friendly Initiative's breast feeding standards.
- When people received care from a range of different staff, teams or services, this was coordinated. All relevant staff, teams and services worked together and assessed, planned and delivered peoples care and treatment collaboratively.
- Staff were clear about their roles and responsibilities regarding the Mental Capacity Act (2005). Consent guidelines were followed appropriately.
- Staff had access to training to develop and maintain their competencies.

However,

- The supervisor to midwife ratio was between 1:17-1:18 which was higher than the recommended ratio of 1:15 for supervisors to midwives

Evidence-based care and treatment

- Overall we found care and treatment took account of current nationally recognised evidence based guidelines within the maternity service. Policies and guidelines were developed in line with the Royal College of Obstetricians and Gynaecologists (RCOG), safer childbirth (2007) and National Institute for Health and Care Excellence (NICE) guidelines. However we found with regards to NICECG 190: women in established labour have one to one care and support from an assigned midwife, the service was unable to continuously provide one to one care. During our unannounced inspection senior managers told us they had commenced an audit in response to our highlighting the lack of one to one care for some women.
- Patients on B2 had access to enhanced recovery protocols to facilitate a shortened length of stay on the ward.
- Gynaecological services took account of current legislation and nationally recognised evidence based guidance. For example the trust adhered to guidelines provided by the Human Tissue Authority (HTA) for matters relating to fetal loss and termination of pregnancy for fetal abnormality.
- There was an on-going audit programme to evaluate care and change practice if required. For example a retrospective audit suggested the modified early obstetric warning score (MEOWS) charts had not been used appropriately. Further training and education had been implemented to ensure all staff were aware of the correct completion of the charts.
- Rolling audits were performed to continually assess the delivery of care. These included the management of perineal tears and gynaecology and maternity record keeping.

Maternity and gynaecology

- The hospital elective caesarean rate for January 2014 to December 2014 was 13% which was above the England average of 11%. However figures recorded on the service dashboard for April 2015 to September 2015 showed there had been a decrease to 11% against the England average of 10.7% for the same timescale. Midwives told us they discussed birth options with women in line with NICE quality standard 22.
- Data for January 2014 to December 2014 showed 56 % of women had normal deliveries which was slightly lower than the England average of 60%. Figures on the service dashboard for April 2015 to September 2015 showed that 63.2% of women had normal deliveries.
- Midwives encouraged normal childbirth. Posters were displayed around the delivery suite which explained various birthing positions to aid normal childbirth.

Pain relief

- Patients on B2 ward reported they received pain relief in a timely manner. One patient told us, "Whenever I ask for painkillers they always come very quickly". Another patient told us, "They ask me regularly if I have any pain and whether I need any pain medicine". Patients on B2 ward had pre-operative and on-going assessments for pain during their stay.
- Patients on B2 had access to a variety of pain reliving medication which included patient controlled analgesia (PCA).
- Midwives assessed women's pain throughout labour and there was guidance to follow for the administration of analgesia.
- Women in labour had access to birth pools, and equipment to enable different positions to alleviate pain.
- Women were able to have epidural medication on the delivery suite. The hospital episode statistics (HES) maternity statistics for 2013/2014 showed the England average for women receiving an epidural as 16.4%. Data from the trust for August 2015 to January 2016 showed that 24.21%% of women received an epidural.
- The delivery suite had two patient controlled analgesia pumps (PCA) for Remifentanil (a morphine like pain reliever) which gave women who did not want, or weren't suitable for an epidural, another option for strong pain relief. Anaesthetists were in the process of auditing the use of remifentanil to ensure it was effective as pain relief.
- Aromatherapy was provided to aid pain relief and relaxation. Most midwives on The Haven Birthing Suite had attended further training to provide aromatherapy.

Nutrition and hydration

- One patient told us the food was good and there was plenty of choice. However, two patients told us, "there is not much choice" and "it is always cold". Patients on the ward had their nutritional status assessed using the Malnutrition Universal Screening Tool (MUST). Referrals were made to the dieticians if a patient required further support with their nutrition.
- Intravenous fluids were prescribed and administered for women post-operatively. Fluid balance charts were fully completed to ensure women were adequately hydrated.
- The maternity service was working towards full accreditation with the UNICEF Baby Friendly Initiative. This meant staff were implementing breast feeding standards which would be externally assessed by UNICEF.
- The trust target for breastfeeding initiation was 80%. Between April 2015 and September 2015 the hospital service had achieved 80.9%.

Patient outcomes

- The maternity and gynaecology services provided effective care, treatment and support to pregnant women living in the locality before, during and after birth.
- Outcomes of care were measured on the maternity dashboard, such as delivery methods maternal admissions to the intensive care unit and post-partum haemorrhages (PPH). We saw the service did not consistently meet national and local targets for outcomes of care. For example for April to September 2015 the target for PPH was less than 1% the service achieved 1.3%. For the same timescale the target for the incidence of shoulder dystocia was less than 0.5% the service achieved 1.4%. However the service met the targets for maternal admissions to intensive care and emergency readmissions within 28 days. Between April and September 2015, rates of third and fourth degree tears were 2.8% to 3.5%, within the target of less than 5%. The stillbirth rate was one to two a month which was within expected limits. Areas of concern were discussed at the obstetric risk meeting and plans put in place which addressed areas for improvement.

- The National Neonatal Audit Programme (NNAP) 2013 reported a mixed performance in the audit. They fell below the standard for 85% of mothers receiving any dose of ante-natal steroids. The hospital scored 79%.
- The service had identified an increase in women who chose to deliver their babies by caesarean section. An action plan had been developed which addressed the factors which contributed to the increase. The effectiveness of the action plan was monitored through the maternity dashboard. However it was not clear as to how widely disseminated the action plan was and how effective it would be in the medium and long-term.
- The outpatient induction of labour service had been audited in line with NICE CG70. This was to ensure outcomes for women were measured and best practice guidelines adhered to. The outcomes showed that women were positive about the experience and there had been a decrease in the amount of instrumental deliveries.
- The service benchmarked their caesarean section rates against the rates for five London trusts. This was to ensure they monitored their outcomes of care and developed improvement plans if required. Results were presented as red, amber and green ratings (RAG). Poole maternity service measured amber for the period July to August 2015. This meant their rates were similar as the London trusts. However the comparison of these rates may have given false reassurance as they did not take into account the different demographics of the patients cared for in Poole compared to those delivered in London.

Competent staff

- Staff across both services had the necessary skills and experience to provide effective care and treatment.
- Appropriately trained midwives were allocated to look after high dependency women. Senior midwives had identified all midwives should have additional training to meet the care requirements for high dependency women. They were working with an anaesthetist to develop a training package to ensure all staff were suitably trained.
- Staff on B2 told us they had us they had access to further training to ensure they were competent to care for the patients on their ward. For example specialist gynaecological training which enabled then to care for women effectively.
- Some midwives had undertaken further training and development to support their role. For example, midwives had received training to be able to conduct the NHS Newborn and Physical Examination Programme. These checks were completed to detect and promptly treat a number of congenital medical conditions.
- Midwives and obstetricians took part in annual skills and drills training for obstetric emergencies such as post-partum haemorrhage and shoulder dystocia.
- All midwives were assigned a Supervisor of Midwives (SoM). The regulation of midwives includes an additional layer of investigative and supervisory responsibilities provided by a supervisor of midwives. The supervisor of midwives is someone who has been qualified for at least three years and has undergone further training to enable them to fulfil the role. (rule 8, Nursing and Midwifery Council (NMC) 2012) .The supervisor of midwives provides advice and support, audits midwives' record keeping and investigates any areas of concern relating to practice. The supervisor to midwife ratio was between 1:17-1:18 which was higher than the recommended ratio of 1:15. To improve the midwife to supervisor ratio three further midwives were undergoing training to enable them to become supervisors.
- The local supervising authority midwifery officer (LSAMO) had recently conducted an audit of the supervision of midwives across the trust. The role of the LSAMO is to ensure that the requirements of the nursing and midwifery council are met. The audit for 2014/2015 showed that the SoMs across the trust achieved the standards for the statutory supervision of midwives as set out by the Nursing and Midwifery Council and cited in The Midwives Rules and Regulations (NMC, 2012). However, some areas required improvement such as the secure storage of records and additional or specialist training. The supervisors of midwives had written action plans to address these areas.

Multidisciplinary working

- Staff consistently told us they worked well as a team.
- Our observation of practice, review of records and discussion with staff confirmed there were effective multidisciplinary team (MDT) working practices.Staff worked collaboratively to understand and meet the range and complexity of people's needs. For example, the handover and ward rounds on the maternity unit

were well attended by the multidisciplinary team such as doctors, midwives, and anaesthetists. This promoted effective communication and gave the opportunity for shared decision making.
- We observed effective multidisciplinary working during a uro-gynaecology, colorectal, radiology and physiotherapy review of complex pelvic floor care.
- Radiographers described a positive relationship with the screening midwife, who they spoke with frequently when a woman's results showed a high risk of a fetal abnormality.
- Midwives in the hospital worked closely with the community midwives to ensure the effective exchange of information.
- Midwives reported good support from the staff who worked in the neonatal unit.
- The safeguarding lead nurse and community midwives worked closely with external agencies such as social services to ensure women and babies were safeguarded.

Seven-day services

- Consultants were present on the delivery suite between 9am to 2pm at weekends. They were available for advice and support by telephone during the rest of the day and overnight.
- One registrar covered both maternity and gynaecology overnight. Midwives reported the registrar was present at the maternity hospital unless he was required to visit a gynaecology patient in the main hospital. The midwives reported there were occasions when the registrar was not able to attend the delivery suite in a timely manner. This was due to urgent gynaecological patients on the main hospital site. In this instance, midwives told us they would usually call the consultant on call. They reported variable responses from consultants. They told us some arrived very quickly and others took a considerable time to arrive. However, they told us other consultants would attend even if they were not on call.
- If an anaesthetist was required out of hours they were contacted via the bleep system. Out of hours cover was provided by an anaesthetist who was usually a consultant during the day (at weekends) and a middle grade or registrar anaesthetist at night.
- Haematology services were available out of hours.
- A midwife was available in the day assessment unit until 2am every day. They offered a triage service for pregnant women. Women were able to call for advice and support and could be admitted to the antenatal ward for further investigations if required.
- A portable ultrasound machine was available for use out of hours on the ante natal ward.. Doctors were able to scan women out of hours, on the ward if required.
- Women with hyperemesis (severe and prolonged vomiting in pregnancy) were able to access treatment out of hours. If a woman was referred by her GP or attended via the emergency department they could be treated in the medical investigations unit (MIU). The nurses had received further training and followed strict procedures which ensured the correct medication was administered.
- The early pregnancy unit in the Harbourside gynaecology centre was open from 9am to 1pm at weekends. If women were less than 12 weeks pregnant they were able to attend for advice and ultrasound scans if required. Out of those hours they attended the emergency department or contacted the maternity hospital.

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Access to information

- Pregnant women carried their own records**.** These were used by all clinicians involved with the woman's care during the pregnancy. After delivery, additional records were developed which included relevant information regarding the pregnancy, birth and baby. These records were carried by women and used for their postnatal care.
- Midwives told us it was difficult to obtain women's hospital notes out of hours, if they had received their antenatal care at another hospital. They told us if a woman had forgotten her hand held notes and they were unable to access her notes from the other hospital they were able to obtain some information from the shared computer system.
- A midwife told us, the computerised system used for maternity notes, had recently improved the way information was flagged. For example, whether there was a child protection plan in place or a woman was experiencing domestic abuse.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients on B2 told us they were asked for their consent prior to any medical/surgical/nursing intervention. One woman told us, "I know everything that's going on" and another patient told us, "they always ask me before they do anything".
- Throughout our visit staff we spoke with were clear about their roles and responsibilities regarding the Mental Capacity Act (2005). They understood the processes to follow if they thought a patient lacked capacity to make decisions about their care.
- We saw obstetricians discussed the likelihood of caesarean sections in advance of the procedure if possible. We observed a consultant explaining to a woman why they had taken consent well in advance of a caesarean. They explained they had decided to "do it now, as it would not be true consent if it had to be done in an emergency."

Are maternity and gynaecology services caring?

Good

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

We rated caring as 'good'.

- Feedback from women and relatives about their care and treatment was consistently positive. We observed women were treated with kindness, compassion and dignity throughout our visit.
- Women told us they felt involved with their care, had their wishes respected and understood
- Staff helped people and those close to them to cope emotionally with their care and treatment.

However,

- Some women felt their privacy was compromised on the post-natal ward because there was unlimited visiting for partners.
- The CQC Maternity survey showed the trust performed the same as or worse than other trusts.

Compassionate care

- Overall women were positive about the care and treatment they received in the maternity service. For example, one woman's partner told us, "People have been kind and treated us with dignity and privacy, the doctors and midwives are lovely people." Another woman commented, "The scan staff make you feel comfortable."
- Women and their partners spoke highly about the care they had received on the postnatal ward. For example, one woman told us "they have been outstanding" and another woman and her partner told us "We really couldn't have asked for any better".
- All of the women on ward B2 spoke highly of the care they had received. For example, one told us " they are very kind and caring".
- We observed throughout our visit that women were treated with respect and dignity. Curtains were drawn around patients on B2 ward when personal care was delivered.
- Some women felt their privacy was compromised by allowing partners to stay on the postnatal ward. Midwives told us because the curtains were consistently drawn around beds to provide privacy, some partners had mistakenly opened the wrong curtains. Midwives told us some partners were at times semi clothed and they showed us how little space there was between a woman and their neighbour's partner, with only a curtain between them. Midwives told us they had raised these concerns numerous times with senior managers and the situation was still not fully resolved. Midwives told us some women had complained. However, the women we spoke with during our inspection told us they did not have any concerns about privacy on the post-natal ward.
- During handovers in the delivery suite doors were closed to prevent other staff and relatives from hearing sensitive information. However during the ward round women were discussed in the narrow corridors with people passing by, albeit in quiet voices. However, the handover was professional and respectful.
- The trust participated in the Friends and Family Test. Results were mainly good and consistent with England averages. The exception to this was the percentage of women recommending antenatal care. The ANDA ward was recommended by a lower than average 83.9% of 62 women during the latest survey in September 2015. It had fallen from a peak of 97% in January 2015.
- The CQC's 2015 Survey of Women's Experiences of Maternity Services showed around the same percentage of women as the England average reported being treated with kindness, dignity and respect. However the

trust scored less favourably than the England average for 6 out of 16 questions., Scores were worse than the England average for women feeling their concerns in labour were taken seriously, staff treating and examining them, not introducing themselves and being spoken to in a way they could understand.

Understanding and involvement of patients and those close to them

- Women across both services told us they were given sufficient time to ask questions and had enough information about their care. However in CQC's 2015 Survey of Women's Experiences of Maternity Care, less women than the England average felt they were given all the information and explanations they needed.
- We witnessed theatre staff took time to explain care to a woman with a learning disability. The staff remained patient and respectful and tried different ways to explain the care to ensure she understood what was happening.
- We saw from women's records that discussions had taken place with regards to choices in pregnancy care and information was given to enable women to make informed decisions about where they would like to deliver their baby.
- Overall the women we spoke with said they understood and were involved in the plans for their care. For example, one woman told us, "They were really good at minimal intervention. They had obviously read my plan [for labour] and they respected what I wanted."
- Women who had experienced a traumatic birth could discuss what had happened and why at debrief consultations. Clinic staff told us that these were arranged for the end of clinic times and women were directed to "the quiet room", away from the main waiting area in order to minimise women having to chat to others about why they were there.

Emotional support

- Women had access to specialist perinatal midwives to enable them to discuss any anxieties about giving birth.
- Assessments were undertaken to detect if women required further support for mental health needs.
- Women were able to access further support and counselling if they had undergone a termination of pregnancy for fetal abnormality.
- The service employed specialist bereavement midwives. In the event of a stillbirth or unexpected death, women and their families were cared for sensitively away from areas where women had delivered their babies.
- All of the women we spoke with were positive about the emotional support they had received. For example, one woman told us, "Everyone I meet is supportive." Another woman said, "I stayed on the antenatal ward for a week, the care was really good and the staff were reassuring and friendly." Another woman reported, "The labour ward staff are really nice. I got upset earlier and they were really reassuring."

Are maternity and gynaecology services responsive?

Good

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

We rated responsive as 'good'.

- Women were able to choose the most appropriate place to receive their antenatal care. This included their GP practice, another hospital or at Poole.
- Women had access to sufficient information to support them with their pregnancy options and gynaecological diagnosis. Women had access to telephone translation services and staff told us information could be sourced in other languages if required.
- Women had prompt access to maternity services. The national and trust target for booking women for antenatal care by 12 weeks and 6 days gestation was 90%. The hospital consistently exceeded the trust and national targets for April 2015 to September 2015 with an average of 96.2% of women booked within the timeframe.
- Women who received gynaecological services were able to access treatment in a timely manner. For the period January 2015 to December 2015 the hospital exceeded the target of 92% of patients waiting less than 18 weeks for treatment following referral (incomplete pathway).
- Information was displayed which enabled women to make complaints. Complaints were taken seriously, investigated. Improvements were made to the quality of care as a result of complaints and concerns.

However,

- There had been no recent overall needs analysis to enable managers to assess how the maternity service should be planned and delivered to people.
- There was poor communication with regards to the daily numbers of women who were booked for induction of labour. On the second day of our inspection both the antenatal ward and the delivery suite were full. This meant if a woman being induced had gone in to established labour this would have occurred in the antenatal ward rather than the delivery suite. There were not sufficient staff in the antenatal ward to provide one to one care to a woman in labour.

Service planning and delivery to meet the needs of local people

- Senior managers told us they had not completed an assessment of needs to analyse how the service should be planned and delivered to local people. This meant the managers could not be assured the service provided appropriate care to meet their needs. However, views and feedback were encouraged via the Maternity Voices. For example, the service had recently asked for feedback about the quality of the antenatal classes via the Maternity Voices' social media page. Members of maternity voices included Dorset Clinical Commissioners Group (CCG), service users and service providers.
- Most routine antenatal and post-natal care was carried out by community midwives. The community midwives (employed by the trust) provided care in community venues to suit individual women. Women told us they were able to choose where they would like to have their antenatal care. If women had more complex health needs they attended multi-disciplinary clinics held at the hospital.
- The consultant anaesthetist ran a weekly anaesthetic clinic to assess women prior to labour. The consultant saw women who had chosen to have a caesarean section to assess if women had any underlying conditions that may create a risk. For example, women with long term back conditions, medical problems or women that had a body mass index (BMI) greater than 40. The clinic was held to facilitate the discussion of plans prior to their planned delivery date.
- The staff on B2 told us there were times when they had non-gynaecological patients on the ward and this could impact on their ability to perform the booked gynaecological operations. Figures for April 2015 to October 2015 showed 82 patients had their operations cancelled due to bed shortages or 'theatre issues'. During our inspection there were three gynaecology patients on Ward B2. The remaining 12 gynaecological beds contained patients from other surgical specialities. Ward staff told us patients were visited and reviewed by their appropriate surgical teams. We witnessed the surgical team reviewing patients on the ward.

Access and flow

- There was lack of clarity with regards to the number of women who could attend for induction of labour each day. Midwives told us, "there doesn't seem to be a limit". On the second day of inspection we noted there were 11 women who were undergoing induction of labour and the delivery suite was full. This meant if a woman had gone in to established labour this would have occurred in the antenatal ward rather than the delivery suite. However, senior managers told us there was a limit to daily inductions. This was a maximum of six a day and a maximum of three outpatient inductions. Inductions were booked via a computer system and were checked daily by ante-natal midwives to ensure the correct numbers were booked. We were told induction of labour appointments were re-scheduled if the antenatal ward was at full capacity.
- There had been high level of delays in treatment due to lack of capacity on the labour ward or increased workload. Between July 2015 to September 2015, 49 delays in treatment had been recorded. Senior managers had devised an action plan to address the issues which affected the flow of women through the department. Daily bed meetings were attended by staff from all areas in the maternity hospital to assess the number of women who required beds and women who were ready for discharge. Figures for December 2015 showed there were eight recorded incidents of a delay in care. However, midwives told us they were not reporting all the delays in care due to the new incident reporting system and it was therefore difficult for them to accurately assess whether the action plan was working.
- Induction of labour was offered as an outpatient service. Women assessed as being suitable attended the antenatal department, received their medication and

were able to go home. Midwives reported women were "much happier" with this service because they were able to go home rather than stay in hospital until their labour started or they needed to be reassessed.

- Women with hyperemesis were able to self-refer to the medical investigations unit (MIU) up to ten days after discharge if their symptoms had not been alleviated. This was to enable them to receive further day case treatment. Nurses in the MIU told us this service had prevented 176 women from being admitted to hospital. Treatment for hyperemesis was also available on the antenatal ward.
- Early pregnancy services were arranged over two sites. Women up to 12 weeks pregnant attended the early pregnancy unit based at the Harbourside gynaecology centre on the main hospital site. The nurse led clinic enabled women to have prompt access to early pregnancy related concerns, ultrasound scans and blood hormone tests (HCG and progesterone).Women diagnosed with a miscarriage or ectopic pregnancy were offered a choice of conservative (natural) or medical treatment options.
- The day assessment unit based at the maternity hospital was open from 7.30am until 2am daily. The unit was staffed by midwives who managed most of the care and decided if any follow up treatment was required. Doctors who worked on the labour ward or antenatal clinic were contacted for further advice and support if required. Women over 12 weeks pregnant were able to make appointments to attend the unit or were referred by their GP or community midwife. Community midwives were able to refer women to the unit to confirm the presentation of their baby. Midwives told us this saved time for women and reduced unnecessary hospital based clinic attendances.
- Women over six weeks pregnant were able to self-refer for maternity booking as well as attending a GP for referral.
- Pregnant women had prompt access to maternity services. The national and trust target for booking women for ante natal care by 12 weeks and 6 days gestation was 90%. The hospital consistently exceeded the trust and national targets for April 2015 to September 2015 with an average of 96.2% of women booked within the timeframe.
- The trust wide bed occupancy rates for maternity and gynaecology were higher than the England average and fluctuated between 65% and 83%. For example, between April 2015 and June 2016, the trust reported a bed occupancy rate of 82.8% compared with the England average of just over 60%.
- Discharge information was sent to community midwives and GPs when women were discharged from the services. This was to ensure they were aware of the treatment women had received during their admission to hospital.
- The scan reception desk was left unmanned. Radiographers told us the administrator based at the reception desk had left and had not been replaced. They were unable to staff the desk themselves. They told us this meant women were often "wandering around" trying to find staff. During our inspection we saw two women waiting at the unmanned reception desk. This meant women were not able to notify radiography staff of their arrival. One woman told us, "I am worried they won't know I am here".
- There was no receptionist on the labour ward. This resulted in visitors to the labour ward having to wait to be allowed in and midwives had to break off from clinical duties to answer non-clinical phone calls and allow access to visitors.
- Women had prompt access to gynaecological services. For the period January 2015 to December 2015 the hospital exceeded the target of 92% of patients waiting less than 18 weeks for treatment following referral (incomplete pathway).

Meeting people's individual needs

- Women told us they felt they were cared for as individuals. One woman told us "They offered to get me a special chair for the long clinic appointments as I have hip pain."
- Women and families who had experienced a stillbirth or unexpected death of their baby had access to a dedicated area called the Spring Suite. This area was away from the main body of the ward and contained a bed and chairs and hot drinks making facilities to ensure people were as comfortable as possible.
- There were specialist midwives trained to meet a variety of complex needs. For example drug and alcohol dependency, safeguarding and teenage pregnancy. These midwives were assigned women to support throughout the duration of their pregnancy to provide continuity of care.

Maternity and gynaecology

- Women told us staff provided personalised care and treatment. We saw birth plans that had been discussed with women and women told us they had been given sufficient information to allow them to make choices about their delivery
- Midwives ran a vaginal birth after caesarean (VBAC) clinic. Women who had previously had a caesarean discussed the risks and benefits of attempting to deliver their next baby vaginally.
- Supervisors of Midwives worked to develop safe plans with women who requested a home birth against medical advice. Women would then be supported to stay at home after risks were assessed and mitigated against.
- Midwives ran the pregnancy information on nutrition and exercise (PINE) clinic which all women with a body mass index (BMI) greater than 35 were referred to. Women were seen at 14 and 34 weeks of pregnancy to discuss nutrition and exercise and were given information about how they could reduce the increased risk of complications due to obesity.
- Babies who were suspected of having a tongue-tie could be seen at St Mary's and any necessary frenotomy (snipping the extra skin to improve the baby's feeding) was performed by a midwife. This ensured women were not required to travel to another hospital.
- We read in one woman's notes a variety of healthcare professionals had been involved to ensure robust plans were in place to support any mental health needs in the post-natal period.
- Information that covered a wide variety of maternity and gynaecological concerns was displayed throughout the areas we visited. The information was in English. One member of staff told us it was "difficult" to obtain information in other languages. However, one woman's partner told us she had not been offered any information in her language, despite not understanding any English. Staff across both services told us there was access to translation facilities via a telephone service if required.
- Women had access to counselling services if required.
- Women in the Haven Birthing Suite had access to en-suite toilets and showers.
- There was one en-suite room in the delivery suite. The other women in labour had no access to private facilities. There were two toilets and showers on the delivery suite however one had been out of order since the end of October 2015.

Learning from complaints and concerns

- Information was displayed in patient areas to inform them about how to make a complaint. Women we spoke to in the maternity service said they had no complaints but they knew how to make a complaint if they needed to.
- Complaints were monitored in regular risk management meetings and presented in the maternity and gynaecology quality reports. We saw the maternity service had received 42 complaints between January 2015 and December 2015. We were not sent the yearly figures for gynaecology however we saw that between July 2015 and September 2015 there had been two complaints. We saw one complaint about nurse staffing had been investigated and resolved and the other complaint about the surgical procedure was on-going at the time of the report.
- Senior managers from St. Marys and another hospital were working together in response to complaints about poor communication. There were plans to develop a single point of access for women from both hospitals. This was to ensure women with antenatal concerns or women in labour had co-ordinated access to treatment.
- In response to complaints from women, partners were able to stay with them in the post-natal ward. However, there were on-going complaints from women and staff about behaviours exhibited by some partners. Midwives told us "at times the situation is difficult". One midwife told us "I have raised my concerns again and again and nothing is being done".

Are maternity and gynaecology services well-led?

Good

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

We rated well led as 'good.'

- There was a clear strategy and plans for the maternity and gynaecology services. The trust was also part of the ongoing Dorset wide clinical service review and the Developing One Dorset vanguard to integrate acute care.
- There was a clear statement of the trust values driven by quality and safety.
- There were good systems were in place to share information and learning.
- Staff on ward B2 described positive working relationships between all members of the team.
- We observed positive relationships between midwives, medical staff and their immediate managers.
- The maternity service was developing a telephone triage line, the aim of which was to deliver a 24 hour a day, seven day a week service for pregnant women. They worked closely with other trusts and the ambulance service to develop this.
- Governance arrangements were developed in gynaecology to manage and monitor risks.
- We observed positive relationships between nurses, medical staff and managers in the gynaecology services.

However

- Senior managers did not consistently demonstrate an understanding of current service risks.
- The risk register did not identify department risks or staff concerns. For example, the concerns regarding delays to care and the inability to consistently provide one to one care in labour had not been documented on the maternity risk register.
- Senior midwives described a dis-connect between themselves and senior managers. They felt unable to speak freely and said they felt they were not always listened to.

Vision and strategy for this service

- There was a clear strategy for maternity services. Senior managers had produced plans for a new maternity unit, but they were not approved. The strategy for 2016 to 2017 included plans to reduce the length of stay for gynaecology patients and further development of seven day services. Plans for maternity included an increase in consultant hours and a reduction in the caesarean section rate. Also included was improving patient flow and engagement from service users. Senior managers told us the strategy had not yet been presented to the board for approval. The trust was part of the Dorset wide clinical service review. Senior managers told us the results of the review may impact on the maternity service. Alongside the review three Dorset trusts (which included Poole) had been chosen to work together to integrate acute care as part of the Developing One Dorset vanguard project. Senior managers told us, "what happens in Poole will be affected by what happens in Dorset".
- All of the midwifery staff we spoke with were aware of the clinical services review and the vanguard. However, none of them were aware of the strategy for the service.
- All of the staff we spoke with in maternity were aware of the trust wide values called The Poole Approach but were not able to fully describe them to us. The Poole Approach was a philosophy of care devised to underpin the hospital's work. The aim was to provide friendly, professional, patient centred care with dignity and respect for all. Our observation of practice, review of records and conversation with midwives confirmed they provided care which met the aims of the Poole Approach. However, whilst they conformed to the trust wide philosophy staff were unaware their practice was representative of The Poole Approach.
- Staff on ward B2 were clear about the trust wide values and were able to describe them to us.

Governance, risk management and quality measurement

- Senior managers did not consistently demonstrate an understanding of current service risks in the maternity service. There were two maternity risks on the risk register. These were the size of the labour rooms in the delivery suite and the call bell system. The service dashboard had identified that women did not consistently receive one to one care in labour. This had not been identified as a risk. The delays in care, identified through the incident reporting system had also not been identified as a risk. Although the delays in care had been investigated by senior managers, there was no acknowledgment this presented a risk. The documentation of these risks, on the risk register would have enabled plans to have been developed and regularly reviewed to mitigate the risks.
- Senior managers told us the maternity dashboard was not presented to the trust board to enable board members to have oversight of the service and

performance data. However, risks to the service had been presented to the quality and safety committee which ensured senior staff had oversight of the risks to the service.

- There was a dedicated risk manager for the service .The risk manager demonstrated an awareness of all the other risks and subsequent action plans to reduce further risks. For example the manager had produced plans to monitor tends in incident reporting and the rate of third and fourth degree tears. We saw from minutes of meetings that all risks and incidents were presented at risk meetings and learning was shared across the trust**.**
- Within the maternity service the labour ward held monthly forums to discuss areas of concern or practice. Further service wide meetings were held which oversaw quality, audit, risk activity and performance. For example monthly performance reports were linked to service dashboards and reports were reviewed in monthly business unit meetings, which were discussed at board level.
- The labour ward conducted a '60 seconds' briefing at the beginning of every shift. This was to ensure information relating to incidents, risks and safety were handed over to staff.
- There was a clear governance structure within the gynaecology service. Service wide meetings were held which oversaw quality, audit risk activity and performance. The service also reported to the surgical care group risk meetings to ensure information and learning was shared.

Leadership of service

- Midwives reported board members rarely visited their clinical areas. One midwife told us "I really wouldn't know who they are". Senior managers told us board members visited the hospital every "6-8 weeks".
- The junior midwives were positive about their relationships with their immediate managers.
- We spoke with six senior midwives who described a dis-connect between themselves and some senior managers. They told us, "there is a hierarchical style".
- Staff on ward B2 described positive relationships with their senior managers.

Culture within the service

- During our visit in the maternity service we observed staff interactions with each other and their immediate managers. We saw that staff treated each other with respect and they were able to speak freely with managers. However,some senior midwives told us they were unable to speak freely with some managers. They told us, "they don't always listen".
- Throughout the gynaecology service all staff reported positive working relationships. We observed staff treated each other with respect and managers were seen responding positively to staff questions and concerns.

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Public engagement

- Women were able to feedback their experiences of care through the county wide Maternity Voices group. Women were able to access this group either by a social media page or through quarterly meetings.

Staff engagement

- Midwives told us they had little engagement with service plans; however they confirmed they had been consulted with regards to the proposed change in shift patterns.
- Staff in the Harbourside unit told us they had been consulted about the delivery of the service. They told us they were actively involved in the development of further outpatient services.

Innovation, improvement and sustainability

- The community midwives had identified that some women in areas of deprivation did not attend antenatal appointments. In response they had set up a weekly nail bar in a children's centre. Women were able to attend and have their nails painted and discuss any concerns about their pregnancy. Managers told us as a result of this initiative there had been an increase in women's attendance.
- The maternity service were working closely with other trusts and the ambulance service to develop a telephone triage line. The aim of this was to deliver a 24 hour a day, seven day a week service for pregnant women.
- Midwives felt strongly that the service was no longer sustainable since the introduction of long shifts. In response , the trust had produced a consultation paper to formally consult with staff with a view to the introduction of shorter shifts. The trust planned to formally ask staff their views shortly after our inspection.

Services for children and young people

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

Information about the service

Poole Hospital NHS Foundation Trust provides services for children and young people living in East Dorset. The trust works with the Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust to cross-provide children and young people services.

The hospital provides care for young people up to the age of 18 years with complex and chronic illnesses, many who require investigative, day care or inpatient treatment. The in-patient services provide care for children and young people up to 16 years of age with medical, surgical, ear nose and throat, ophthalmology, dermatology and orthopaedic conditions.'

The service had two general wards, an assessment unit, and an outpatient department. Children and young people are also cared for in other areas of the hospital depending upon their needs. In addition, there is a level 2 Neonatal unit for premature and sick babies.

The two general paediatric wards have a total of 26 cots/ beds arranged in a 4-bedded bay, a 3-bedded bay and 19 cubicles. One ward has 15 beds/cots and the other a total of 11 beds/cots, which includes a 4/5 bedded high dependency unit. The ward facilities are such that enable parents to stay with their child overnight. The ward also has a schoolroom with teaching staff that enables children to receive education during their hospital stays.

The assessment unit is adjacent to the general wards. It enables rapid access for GP referrals for children and young people to gain urgent advice from paediatricians without having to attend the hospital's emergency department.

The Neonatal Unit provides care and treatment for babies who were born prematurely or who need medical care. The neonatal unit has 20 cots, four intensive care cots, six high dependency cots and ten special care cots.

Children are also cared for in other areas of the hospital for example for surgery and the emergency department.

A community paediatric service provides medical support within the local area and a medical service for pre-school and school children with special needs.

We also spoke with 19 parents and six children and young people. We spoke with 20 staff members, including nurses, consultants, medical staff, managers and support staff during our inspection. We inspected all paediatric areas as well as areas in which related facilities were shared with adult services. We observed care and examined 15 care records and other documents in all inspected areas. We also reviewed other documents from stakeholders, and reviewed performance data about the trust.

Services for children and young people

Summary of findings

We rated the services for children and young people as requires improvement for safety and well led. We rated effective, caring and responsive as good.

Our key findings are:

There were not sufficient number of nurses on the paediatric ward based on the Royal College of Nursing guidance. There was not a flagging alert system to identify Looked After Children within the trust. The trust did not have policies such as an absconding protocol and a restraint policy for children and young people. Learning from incidents was not always embedded in practice.

However, there was openness and transparency about safety, and continual learning was encouraged. Staff were supported to report incidents, including near misses. There were secure access systems in place, however these were not consistently robust on the paediatric wards at night.

Staff were clear about their responsibilities if there were concerns about a child's safety. Safeguarding procedures were understood and followed, and staff had completed the appropriate level of training in safeguarding and other mandatory training. A paediatric early warning system was used for early detection of any deterioration in a child's condition.

Care and treatment was planned and delivered in line with evidence-based guidance, standards and best practice. The individual needs of children and young people were assessed and care and treatment was planned to meet those needs. Care pathways and multidisciplinary records were used to support practice. Staff assessed patients' pain effectively and obtained consent to treatment appropriately and in line with legal guidance.

Staff were trained and had the skills and knowledge required to undertake their role. Staff undertook appropriate competence assessments. Appraisals and supervision took place and this helped staff to maintain and further develop their skills and experience. Services, including access to consultant paediatricians, were provided seven days a week. However, concerns were raised regarding attendance for training for junior doctors.

Feedback from children, young people and parents about the care and kindness received from staff was positive. All the children and families we spoke with were happy with the care and support provided by staff. Staff treated children, young people and their families with compassion, kindness, dignity and respect. Staff worked in partnership with parents, children and young people in their care.

Inpatient services were tailored to meet the needs of individual children and young people. There were good facilities on wards for babies, children and young people and their families. A 24 hour paediatric assessment unit improved patient access and flow through the hospital. There were no barriers for those making a complaint. Staff listened to the feedback given to them by parents. Play therapy staff ensured children were supported during their hospital stay. Parents told us how they provided a much needed break sometime for them. Play therapists were not engaged by the outpatient department to help children cope during outpatient procedures. There was a risk children would be distressed in the outpatients clinics, as they were treated with adult patients who were treated at the fracture clinic.

There was not a service-wide strategy and vision for paediatric services. The paediatric service had lacked effective leadership until the recent appointment of an acting new matron. This had an impact on nursing staffing as the lack of nurses was not formally highlighted neither on the risk register nor on the quality reports submitted to the executive team.

Staff at all levels of the organisation were proud to work in this department and were familiar with the Poole approach of being compassionate, open, respectful, accountable and safe.

Services for children and young people

Are services for children and young people safe?

Requires improvement

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

We rated safe as "requires improvement"

- Processes and procedures were not consistently followed for staff to learn from incidents.
- There was not a flagging alert system to identify Looked After Children within the trust.
- Secure access arrangements to the paediatric unit out of hours were not as robust as during working hours.
- The trust did not have policies and protocols for children and young people for absconding or for restraint.
- The paediatric wards were not always staffed as planned and there was not a system to assess safer staffing level.

However,

- There was openness and transparency about safety. Staff were supported to report incidents, including near misses. There were two serious incidents for the period July 2014 to December 2015 and both were investigated.
- The environment and equipment were well maintained. Age-appropriate specialist and emergency equipment was available and maintained. The environment was child-friendly.
- Medicines were appropriately managed with exception at the neonatal unit where there had been some errors in medication administration. These errors reduced after the unit introduced new monitoring system.
- Staff were clear about their responsibilities if there were concerns about a child's safety. They understood and followed trust safeguarding procedures. Staff had completed the appropriate level of safeguarding training and other mandatory training.
- Staff were aware of their responsibilities if a major incident was declared.
- A paediatric early warning system was used for early detection of any deterioration in a child's condition.

Incidents

- Staff were open, transparent and honest about reporting incidents. Systems were in place to make sure that incidents were reported and investigated appropriately. All staff told us that they would report incidents without hesitation. There was evidence that incidents had been reported. They knew which incidents to report. All staff received training on incident reporting at induction and through periodic updates. Staff leading investigations received training in root cause analysis.
- The matron reviewed reported incidents and investigated them where necessary. Some staff told us they were able to get feedback on incidents they reported. However, feedback was variable with some staff reporting that it was not always forthcoming. There was no evidence that learning from incidents was discussed with nursing staff in a structured manner, for example, at team meetings, or shared by displaying updated guidance.
- Management and governance staff reviewed incident reporting activity at their regular meetings, but this was not consistently cascaded to staff.
- For the children's services there were two serious incidents reported under the Strategic Executive Information System (STEIS) or never events (serious, largely preventable patient safety incidents that should not occur if the available preventative measures had been implemented) reported for the period July 2014 to December 2015. Both these incidents had been investigated and learning from these incidents had been shared with some staff.
- There had been a medication incident in the neonatal unit (NNU) relating to a failure to administer the doses on time. As a result, cot cards had been provided to identify babies on the post-natal ward that needed to attend the NNU for their antibiotics.
- The children services held paediatric mortality and morbidity meetings and minutes showed cases were discussed and learning points and actions taken were documented.
- 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. The principles aim to improve openness and transparency in the NHS.

- Information posters on Duty of Candour were displayed in the NNU and in staff areas of the paediatric unit. Staff had also been provided with guidance. Staff told us of an incident where they had applied this duty where a safety incident had resulted in severe harm to a patient. Staff had completed this within the 10 day time period and they had maintained notes of the meeting. The parents were informed of the learning that had taken place and were offered the option of the care of the child to be provided by another health care professional. We were informed that the parents did not take up the offer and requested the care to be continually provided by the same health care professional.
- All staff we spoke with understood the principles of openness and transparency; nurses told us that the ward sister talked to parents if anything went wrong.

Cleanliness, infection control and hygiene

- There had been no cases of MRSA bacteraemia or Clostridium difficile in the child health service during 2015. There was an information leaflet for parents explaining MRSA.
- From March 2015 to December 2015, there had been two cases of MRSA in the NNU. Both were investigated and it transpired one was acquired within the hospital. Learning from this incident was shared with staff and parents.
- In the NNU, all areas were visibly clean and kept tidy. However, the ward area was cluttered and some bays/ rooms were not clean. The medicine storage room was dusty. We highlighted these to the matron. At the unannounced follow up inspection, we found the wards and medicine storage areas were visibly clean and clutter had been removed.
- Staff had received infection control and prevention training as part of their essential annual training programme.
- Staff used ward cleaning schedules and we observed cleaning of areas after patients were discharged and staff ensured the areas wee clean.
- The infection control team regularly carried out environmental cleaning audits and the paediatric wards consistently scored over 97% and the NNU 100%. The infection prevention control team was available for advice, if required
- We observed staff adhered to the infection control policies, including 'bare below the elbows', hand hygiene and appropriate use of personal protective equipment, such as disposable aprons and gloves. Extra care was taken for children and young people with suppressed immune systems, including cohorting and appropriate use of isolation facilities. There were a sufficient number of side rooms across the unit to isolate patients who were at risk of spreading infections. There were signs outside isolation rooms reminding staff of transmission risks.
- Signs reminded staff and visitors to use hand hygiene gel to sanitise hands on admission to the unit and wards.
- Hand hygiene observation audits were undertaken monthly. Overall scores for NNU for the time period April 2015 to December 2015 were 100%. The four paediatric wards scored on average 99% for the time period April 2015 to December 2015.
- The matron carried out daily random infection control checks.
- There were designated areas on the NNU for used/dirty equipment, which was then cleaned and ready for use. The paediatric wards had a storage area for clean equipment.
- Families commented positively on the cleanliness of the units and staff attention to hand hygiene.

Environment and equipment

- The paediatric unit was a locked unit, with receptionist entry 9am to 5pm Monday to Friday. Out of hours, all visitors reported to the main reception desk and the door to the unit was released to allow access. Some staff raised concern that there was a higher risk of 'tailgating' through the doors at these times. Out of hours, we observed staff came to the main door before letting visitors in. However, when visitors left the unit out of hours, we observed them holding the door open for others. There were no signs asking people not to let others into the unit. This presented a security hazard.
- The NNU was a secure unit with entry by call bell system. This was secure out of hours.

- The paediatric unit and the NNU were well equipped. An equipment officer oversaw the ordering of equipment and making sure equipment was charged, quality tested and ready for use.
- There was a schedule of maintenance for specialist equipment and hoists. For example the equipment in the resuscitation room had been recently serviced.
- Emergency trolleys were appropriately sited and stocked. Emergency equipment was regularly checked and all in date.
- There was a designated high dependency unit for children, with the correct paediatric safety equipment. This was maintained under contract and checked daily.

Medicines

- Medicines were securely stored in locked cupboards, drug fridges and controlled drug cabinets in treatment rooms secured by keypad locks. There were records of daily checks to confirm medicines in fridges were kept at optimal temperatures.
- At the time of inspection, the medicine storage area for fluids was not clearly identified. We saw dextrose solutions in the same container as the saline solution, which presented a hazard. Although, the storage containers were labelled appropriately with the right solution and the correct strength, solutions made to different strengths were not physically separated to minimise the risk of errors. The strengths of the different solutions were also not separated. We highlighted these concerns to the matron.
- Allergies and weights were recorded on prescription charts, and administration records were complete on those we reviewed.
- Take home medicines were dispensed on the ward out of hours and in hours they were dispensed by the pharmacy team.
- Parents understood the medications prescribed. Some parents were trained and assessed to administer intravenous antibiotics and there were guidelines for parents and young adults on home intravenous antibiotic therapy.
- There were monthly practice development days for staff which included, for example, learning from medication incidents.

Records

- Paediatric patient paper records were multidisciplinary and standardised. There were assessment and care record documents for specific care pathways, such as head injury, orthopaedic and trauma, children's traction, ear nose and throat (ENT) and surgical emergency.
- The care records covered relevant assessments of care needs and risk assessments. Care plans were patient centred and personalised. Staff were focused on ensuring patient and parental understanding and involvement.
- Patients were weighed and their height measured. Staff maintained observation charts, paediatric early warning systems (PEWS) and fluid charts were used. High dependency observation charts were completed for higher risk patients.
- Records showed daily reviews of patients by consultants and clear management plans.
- However a recent audit (August 2015) in the emergency department regarding information sharing highlighted that these forms were not being completed correctly by the emergency department. Steps were being taken to improve the quality of completion.
- We saw the five steps to safer surgery checklists were completed for children and young people who had undergone surgery.
- Records were securely stored and were accessible only to relevant people.

Safeguarding

- There were clear policies and procedures in place for safeguarding. Staff showed a comprehensive understanding of differing safeguarding issues for example, child abuse, female genital mutilation.
- The trust had not developed some key policies for keeping children safe. For example, there was not a protocol for children and young people who might abscond. In such an event, staff would use adult protocols for absconding. In addition, there was not a specific policy on restraint for children and young people, only one for adults. There was not a policy on the abduction of children from the paediatric unit. In the event, staff would follow the maternity department's newborn security escalation alert process.
- There was a safeguarding website that was well populated with safeguarding information. For example, there were electronic safeguarding referrals forms and contact details for safeguarding professionals at the trust and social services.

- There was a secure safeguarding mailbox with social care, for the receipt and sending of safeguarding referral forms and a clear referral pathway for raising safeguarding children concerns.
- There was a joint safeguarding newsletter for children and adults to inform staff of new updates and learning outcomes from serious case reviews and incidents. For example, a recent newsletter (December 2015) reinforced the guidance on the mandatory statutory reporting of female genital mutilation (FGM) for all professionals.
- A named nurse and named doctor for safeguarding children and young adults were available for assessment and advice and to ensure the trust fulfilled its legal obligations. There was a clear policy and procedures for safeguarding children and young people, with guidance on what to do and who to contact if there were any concerns.
- In January 2016, 98.5% of all paediatric staff were trained to level 2 and 93% were trained to level 3 in safeguarding children. All paediatric consultants had attended level 3 training, which meant they were trained to recognise and take the correct actions if a child was considered at risk of harm. In the NNU, 96% staff had completed level 3 training. Across the trust, level 3 training was multiagency based and there was 91% uptake.
- Staff were also required to attend safeguarding adults training, and 86.3% of all staff were trained to level 2 and 85.8% were trained to level 3.
- Trust safeguarding procedure for Child Sexual Exploitation (CSE) linked into Dorset Social Services Multiagency procedures and the trust was represented at high risk multiagency meetings for CSE.
- Safeguarding was considered within all assessments. Staff completed a safeguarding checklist for patients on admission to the assessment unit or the wards. They also checked if children were subject to a child safeguarding plan. Safeguarding questions were recorded in paediatric and NNU records. Staff used safeguarding children proformas to document details of safeguarding concerns. In-house training on the use of proformas was provided and the documentation was audited. A guidance document had been developed to support correct completion.
- Some staff told us they did not receive safeguarding children supervision or group supervision. It's good practice to ensure staff support, supervision was available as part of part of staff development.

Mandatory training

- The trust had a 85%% target for compliance with mandatory training. Trust data received during the inspection showed compliance rates of 90–100% for nursing staff across the range of training, including blood awareness, complaints and claims, risk management, infection control, basic life support, health and safety, fire safety, and moving and handling. Compliance with training by medical staff in child health was 82% and in paediatrics was 80%. The clinical director had directed all medical staff without current compliance to ensure they had booked onto the relevant courses by the year end.
- NNU staff attended study days set up to support staff in completing their mandatory training.

Assessing and responding to patient risk

- The NNU had implemented the early warning trigger system to identify when observations are outside the normal limit according to gestation.
- The paediatric service followed a system of retrospective checks on the ward. This was also done in NNU. These checks included reviews of risk assessments and screening of children, checking the quality and safety of security tags and observing whether discharge summaries were completed prior to discharge. Targets for compliance had been set and where compliance was not met, ward sisters were informed of areas requiring improvement.
- Staff used PEWS to identify and escalate deterioration in a child's condition. PEWS observation charts for children of different ages clearly identified when observations were outside the normal range and what actions to take for different scores. Staff told us they understood what actions to take in the case of a suddenly ill or collapsed child or infant.
- A CAMHS referral assessment procedure in place. Children deemed at risk (ie. .Self-harm or CAMHS patients) would be assessed by the CAMHS and/or medical/nursing team with attention taken to where this patient was being nursed within the unit, their room environment, assessment if 1:1 care was needed. The reception team would be alerted and the unit handover

sheet would have the patient 'flagged' to indicate the risk. This would all be documented and shared as necessary and a risk assessment undertaken as part of the patient's plan of care.

- For Looked After Children (LAC) there was not a flagging alert system to identify LAC within the trust. As such, patterns for significant events could not be established. Information was collected via CAS was robust, it would not always identify looked after children. There were gaps in the information collected. For example, information on certain issues was not collected. Questions like, "Is the child looked after or living in residential care home?" were not included. For example, if a young person attended emergency department without foster carer or if they had absconded from care and were a missing person, the system would not necessarily identify them as LAC.
- There were clear protocols and transfer arrangements for children who needed to be ventilated or required transfer for treatment on the specialist unit.
- There was a service level agreement with Bournemouth Hospital to ensure the transfer of a child whose condition may deteriorate after eye surgery at Bournemouth Hospital.

Nursing staffing

- The Royal College of Nursing guidelines for paediatric wards state there should be a minimum of 70 registered to 30 unregistered staff, i.e. a 70:30 split. The guidance states a higher proportion of registered nurses is recommended in areas such as children's intensive care or specialist wards. It has been recommended that there should be a minimum of two registered children's nurses at all times in all inpatient and day care areas and at least one nurse per shift, in each clinical area, trained in advanced or European paediatric life support.
- Nurses were all registered children's nurses; staff worked 12-hour shifts. The present model for Acrewood was, three trained and one nursing assistant for night and day. This ward has 11 beds which includes a 4/5 bedded high dependency unit.
- For Bearwood, the current model was two trained and two nursing assistants for 15 beds/cots. For the Elmwood assessment ward, the present model was two trained nurses for night and day. Staff told us the level of nursing staff was stretched. In addition there were currently on 3.5 wte band 6 nurses and 2 WTE band 7's. This meant that the senior nurse on duty particularly at night could be a band 5. Examples were shared where Elmwood was fully occupied and had one trained nurse and one untrained staff member.
- A number of staff told us it was not unusual for either wards (Bearwood and Acrewood) to be staffed by two nurses at night. The decision was taken after appropriate risk assessment. In addition staff told us is was quite usual for one nurse and one nursing assistant to provide care for up to 8 patients. The acting matron confirmed this. We looked at both issues and found evidence from the nursing rota that re-confirmed that one nurse would provide care for up to 8 patients supported by one nurse assistant.
- There was no formal tool to assess the acuity of patients and the required staffing levels for paediatrics. In the absence of any formal validated acuity / dependency tool for children, staff used professional judgement and benchmarking for the staffing review carried out in December 2015.
- The review of staffing to the board for child health stated, "There is an active recruitment campaign to reduce the vacancy factor." The report did not mention that nursing numbers for child health were going to be increased. Furthermore, there was no reference in the Nursing and Midwifery Safe Staffing Exception Report December 2015 to the board that there were concerns regarding staffing on the paediatric wards.
- The NNU recognised it was not compliant with the British Association of Perinatal Medicine (BAPM) professional guidelines for staffing. It also was not compliant with the Neonatal Toolkit recommendations. As a result, it had submitted a business case to increase staffing. It had also raised this as a quality concern as part of their quarterly report for child health. At our inspection in January 2016, our inspectors raised concerns regarding staffing. During our unannounced inspection in February 2016, we were told that a proposal was going to be put forward to increase the numbers of staff. We asked for information of these changes and whether they were formally documented. We were given a rough guide of a proposal that was to be put forward. This proposal was going to increase Band 7's from two to three and Band 6's from four to seven. This would provide 24 hour a day Band 6 cover for the wards. The proposal put forward would also increase Bearwood to three trained staff for night and

day and increasing nursing staff on Elmwood from two trained night and day and add an additional twilight shift of a trained staff. In practice, these changes would provide a 70/30 skill mix in all paediatric areas.

Medical staffing

- Medical staffing did not meet the Royal College of Paediatrics and Child Health Guidelines for medical staffing for acute paediatric patients. There were allocated consultants for covering acute services out of hours and weekends in general paediatrics. All paediatric inpatients were seen by a paediatric consultant within 24 hours of admission.

There were 17 Consultants in total within the child health directorate. Eight consultant paediatricians plus one associate specialist on the acute paediatric rota, four consultant neonatologists plus one associate specialist covering the neonatal unit. There were five consultant community paediatricians and six tier 2 posts working alongside the acute doctors in a separate team.

- Data on medical staffing skill mix showed a higher proportion of consultant and middle-career doctors and lower proportion of registrar-level doctors than the national average. There were 8% junior doctors compared with the 7% England average.
- The junior doctors told us they were well supported by consultants and registrars, including out of hours.
- Surgical junior doctors supported paediatric surgical patients, with paediatrician support as needed. The duty consultant was the named paediatrician for surgical patients.
- The NNU was staffed by five consultant neonatologists with one non-training grade doctor. The service was BAPM accredited for a level 2 unit. There was a named consultant of the week and the unit had an on-call consultant who was resident to 9pm. Thereafter, the individual was on call from home.
- The medical handover on the paediatric unit was structured around a handover sheet with information about patients updated by the duty doctor before morning and afternoon handovers. We observed positive communication and supportive relationships between consultants and junior doctors.
- We observed a morning medical handover on the paediatric unit, which was attended by a consultant, three registrars and a senior house officer. There was appropriate information sharing and decision making.

Major incident awareness and training

- The service had a major incident plan. Emergency plans and procedures clearly identified what paediatric measures would be required. Staff were aware of actions to follow.
- During the inspection, we observed a 'water leak' and found the contingency plans were followed in line with an agreed policy.

Are services for children and young people effective?

Good

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

We rated effective as "good",

- Care and treatment was planned and delivered in line with evidence-based and national guidance.
- The individual needs of children and young people were assessed and care and treatment was planned to meet those needs. Care pathways and multidisciplinary records were used to support practice.
- Pain was adequately assessed and children received timely pain relief
- Consent to treatment was obtained appropriately.
- Outcomes of care and treatment were positive and met expectations, when monitored using national and local audits.
- Staff were trained and had the skills and knowledge required to undertake their role. Appraisals and supervision took place and this helped staff to maintain and further develop their skills and experience.
- Services, including access to consultant paediatricians, were provided seven days a week.
- Multidisciplinary working was very strong within the service.
- Young people, with chronic conditions, were appropriately transferred to adult services with the right arrangements in place.

However,

- The level of nurse supervision varied because of the staffing levels on the wards.

Evidence-based care and treatment

- The service was providing evidence-based care and treatment. Trust policies and guidelines had been developed that took account of national policy. These included the National Institute for Health and Care Excellence (NICE) guidelines and the Royal College of Paediatrics and Child Health. Policies were available to all staff via the trust intranet system and staff demonstrated they knew how to access them. NICE quality standards and guidance were discussed at monthly governance meetings.
- We saw a number of guidelines being used. For example, there were pre-theatre checks had been correctly completed. These guidelines were also audited.
- Clinical pathways were in place for the most common reasons where children presented to hospital, including head injury, abdominal pain and fever. These gave clear and consistent guidance about how to treat these conditions.
- The NNU followed the NICE guidance for antibiotics and for jaundice.
- The trust review of NICE guidance in paediatrics in January 2016, reported compliance across seven quality standards and partially compliant with 14 standards. Action was being taken to address these. Compliance had yet to be determined for four standards
- Clinical guideline folders with latest updates, indexed and dated, were available in clinical areas.

Pain relief

- Acute pain management guidelines were available to staff.
- There was an acute pain team was available to support the paediatric service.
- Paediatric pain assessment charts were in use in the nursing documentation we reviewed. Staff reviewed patients' pain relief for effectiveness and made changes if necessary.
- There was guidance in care plans about pain management for children where it was appropriate, for example after surgery. We observed pain relief was discussed with patients and/or their parents. Staff used a visual pain assessment chart and gave parents an information leaflet about pain relief at home after children's surgery. We observed staff asked children directly rather than their parent or carer.
- Medication records showed clear prescribing of pain relief and the time, route and dose of the medication administered.

Nutrition and hydration

- Staff consistently checked the temperature of food before serving. Meal times were protected and parents were supported in feeding the children. Parents gave examples of how food was served in appetising ways.
- There was a three-week rolling menu with an appropriate range of choices. Religious and cultural dietary needs were accommodated. We spoke to a parent who told us how they had been offered appropriate vegetarian food for their child.
- Staff supported mothers to give breast milk to their babies and the service was working to increase the number of mothers giving breast milk after the child was discharged.
- There was dietetic support for both units. There was a breast feeding group for neonates that met monthly to support mothers.
- A guidance and competency assessment booklet was used to train and support parents with tube feeding their babies and children. Parents welcomed this initiative and found the support helpful.

Patient outcomes

- The multiple readmission rate from July 2013 to June 2014 (1–17 years) relating to asthma and diabetes was worse than the England average. It was slightly better for epilepsy. There were no results for the under 1 age range as the numbers for these were low.
- Elective emergency readmission rates were higher than expected for the 1-17 age range.
- The non-elective paediatric emergency readmission rate within two days was better for the under 1 age range but worse than expected for the 1-17 age range.
- The main finding of the national audit of paediatric asthma 2013 was improvements were needed in discharge information. The national audit of pneumonia found children not able to access physiotherapy services compared to similar hospitals. Since then criteria for referral to physiotherapy have since been established.

- According to the 2013/14 Paediatric Diabetes Audit, proportionately more children with diabetes had their diabetes under control (HbA1c<58 mmol/mol) than the England average. The mean HbA1c level was better than the England average.
- Action had been taken to address issues raised in the diabetic peer review, carried out in February 2014. For example, the service had set up a system for annual review by using one of their four multidisciplinary team clinic appointments for this purpose. During this clinic appointment, staff offered psychological screening, to help identify children and young people who would benefit from psychological interventions.
- The service used data downloaded from glucose monitors and with additional insulin pumps, the paediatric diabetes audit (2015) showed that patient outcomes had improved.
- In the 2014 National Neonatal Audit Programme (NNAP), the service was meeting or above all the standards.
- The service compared favourably with other units in Wessex and the UK in the Epilepsy 12 (RCPCH) national audit in 2014. Although the trust was partially compliant overall there were significant improvements in two standards over the year and had 95% patient/carer satisfaction. The trust was a positive outlier in one standard of water safety. The trust was a negative outlier in one standard of EEG. Work was ongoing against an action plan
- The service had participated in and had taken actions to address the findings of Cystic Fibrosis Trust peer review June 2014. Improvements included better access to dietetics. The service was rated “compliant” for models of care.

Competent staff

- All staff had specialist knowledge and skills to treat children with their presenting conditions.
- All nursing staff within the unit had been trained in paediatric life support and consultants had also been trained in advanced paediatric life support. There was a commitment to training and education within the service. Staff told us there was good team work and they were supported to access training. Staff were encouraged to keep up-to-date with their continuing professional development.
- There was a trust wide electronic staff record where all training attended was documented. Managers were informed of training completed and alerted when staff required updates.
- Most staff we spoke with were positive about the quality of supervision. However, they shared their concerns that the level of activity on wards meant that the frequency of clinical supervision was variable.
- All the staff we spoke with told us they had received an appraisal during the last year. The figures provided by the trust showed a compliance rate of 100% for the children and young people’s services. Staff learning needs were identified through the appraisal process and through supervision meetings.
- There was a clear focus on appraisal across the service. Trust records for the child health directorate for October to December 2015 showed 93% compliance overall. We were shown records that confirmed that 100% of the medical staff were on target to complete their appraisal by 31 March 2016. At the time of the inspection 85% of the medical appraisals had been completed.
- Junior doctor trainees we spoke with told us their induction was good, with an emphasis on patient safety.
- Junior doctor skills were monitored and they were compliant with expected competencies.
- Surgeons and anaesthetists had appropriate training and competence to handle emergency surgical care of children. Theatre nurses were required to maintain paediatric competency. Theatre matron maintained this information.

Multidisciplinary working

- There was an appropriate range of multidisciplinary staff providing care and treatment to patients on the paediatric unit and the NNU, including paediatric physiotherapists, pharmacists, dietician, play specialists and school teacher but not in outpatient department.
- We saw evidence that staff worked professionally and cooperatively across different disciplines and organisations to ensure care was co-ordinated to meet the needs of children and young people. Staff reported good multidisciplinary team working with meetings to discuss children and young people’s care and treatment.
- Consultants told us they worked within the range of their professional competence and they were well supported by colleagues within their networks.

Services for children and young people

- There was evidence of effective multidisciplinary working and handovers on the wards and the NNU. Full multidisciplinary meetings were held every week.
- There was good liaison and working between the neonatal service and colleagues in obstetrics and wider paediatric services.
- There was daily access to paediatric physiotherapy and speech and language therapy (SALT) on wards with occupational therapy provided on request.
- Physiotherapy was provided weekly on the neonatal unit and SALT was available for any baby with a low birth weight.
- Paediatric dieticians provided nutritional support, advice and education to children and parents about diet and enteral feeding.
- Play specialists helped children to understand their condition and medical treatment. They provided preparation and support for potentially stressful experiences such as medical or surgical procedures.
- The play team visit all ward areas and most paediatric outpatients to support children in this area. They set up play areas with toys and materials. They also provided support to siblings.
- The clinical teams on the paediatric ward and the neonatal unit were assisted by administrative staff covering tasks such as preparing and dispatching letters, preparing discharge reports, answering telephone calls and arranging appointments.
- The trust had a policy for the transition of children to adult services. This addressed the medical, psychological and educational or vocational needs of the young person and the needs of their parents or carers.
- Most young people transferring to adult services were following a 'Ready Steady Go' transition pathway where young people and their family were initially introduced to the concept of transition. We were given examples of how staff helped children develop their confidence. This included helping them understand their condition and supporting young people to have a considerable degree of autonomy over their own care. Transition procedures were well established for the sub-specialties such as diabetes, respiratory and oncology.

Seven-day services

- Paediatric consultant job plans covered weekends. This was in line with RCPCH recommendations and current evidence on patient outcomes.
- There was 24 hour medical cover with medical presence over the weekend seven days a week on the units with access to radiology support at weekends and an on-call pharmacy outside normal working hours.
- The neonatal transport service operated over a 24-hour period seven days a week.
- The weekend paediatric ophthalmology service was run from the site at Bournemouth.

Access to information

- The wards used joint multidisciplinary records that supported good communication across the team.
- Staff reported good access to laboratory test results and diagnostics through electronic systems.
- Staff told us they had access to notes when they needed it. Notes were placed with the nurses in clinics.
- There were some delays in typing and sending full discharge letters or outpatient letters to GPs because of changes to the administrative support. They were usually sent within seven working days.
- GPs had access to advice from consultant paediatricians Monday to Friday and could phone the unit for information about a child.

Consent

- The consent process was clearly described within the range of information leaflets available to parents and young people. Young people were assessed to be able to give consent depending on their maturity and the nature of the decision. Staff undertook competency assessment and, when a patient was found not competent, only a person with parental responsibility was able to give consent.
- Staff used an assessment checklist to confirm if consent had been obtained using the principles of the Mental Capacity Act 2005 (MCA). However, there were no audits for use of the MCA in child and adolescent mental health services (CAMHS) and young people aged 16-18 years
- Staff told us they obtained consent from children, young people and their parents or carers prior to commencing care or treatment.
- Staff told us how they dealt with consent issues for young people who did not want to tell their parents. In such circumstances, staff followed national guidance and ensured the young person received the help they needed. They always gave children and young people choices when they accessed their service.

- Consent forms for surgical procedures that we reviewed were fully completed and signed, and included information about risks and benefits of the procedure.
- We observed staff discussing the treatment and care options available to children, young people and their parents.

Are services for children and young people caring?

Good

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

We rated caring as "good",

- Feedback from children, young people and parents about the care and kindness received from staff were positive.
- All the children and families we spoke with were happy with the care and support provided by staff.
- Staff treated children, young people and their families with compassion, kindness, dignity and respect.
- There were very good relationships between staff and those using services. Staff worked in partnership with parents, children and young people in their care.
- Parents and families were fully informed and involved in care.
- Children, young people and their parents were positive about the emotional support provided to them.

Compassionate care

- During our inspection we observed children, young people and their parents being treated with dignity and respect at all times.
- We heard and saw written responses from patients and parents regarding the care provided. All these comments were positive.
- Feedback comments showed that parents found the staff to be efficient and friendly and would recommend the service.
- During our inspection we observed good interactions between staff, children, young people and their families. We saw that these interactions were caring and compassionate. Staff were skilled in talking and caring for children and young people. Parents were encouraged to provide as much care for their children as they wished with appropriate training and upskilling where necessary. Staff encouraged young people to be as independent as possible.
- Children, young people and their parents we met spoke highly of the service they received. They told us they felt "cared for." They told us how good the staff had been in looking after them. Comments from children and young people included "the staff asked what I wanted to eat" "the staff are nice and explain what is happening to me."
- Care from the nursing and medical staff was delivered with kindness and patience. The atmosphere was calm and professional without losing warmth and reassurance.
- The recent parent's questionnaire (October 2015) demonstrated good feedback on care of babies, parents and siblings. Ninety seven percent of the parents said they would recommend the unit to their family and friends.
- The NNU had not been included in this test. They had developed their own questionnaire and that also showed high level of satisfaction with the service (97%). There were plans to include NNU in the Friends and Family Test at a later date.

Understanding and involvement of patients and those close to them

- We observed staff explaining things to parents, children and young people in a way they could understand.
- Parents and families we spoke with were fully informed and involved in care. Parents felt in control and were taught aspects of care to support their child. Care records detailed joint decisions between parents and staff.
- Parents were encouraged to be involved in the care of their babies and children as much as they felt able to. We observed that children and young people were also involved in their own care. Children, young people and parents that we spoke to all confirmed this was the case.
- Parents were aware of the named nurse caring for their baby, child or young person.
- Parents, children and young people told us the nurse who was looking after them always introduced themselves.
- Play therapy staff ensured children were supported during their hospital stay. Parents and children told us how they supported them. Parents told us how they provided a much needed break sometime for them.

Services for children and young people

- For three questions on the children's survey, the trust rated better than other trusts for written information to parents to take home regarding their child's treatment or condition. It also performed better with regard to parents being able to take appropriate action if they were worried about their child once they got home. Finally, it performed better than others trusts regarding information given to parents about the operation or procedure their child was going to have. Overall, they rated similar to other trusts.

Emotional support

- The services received numerous letters of thanks mentioning the emotional support provided by staff. These letters highlighted the dedicated and caring staff.
- Children, young people and their parents were positive about the emotional support provided by specialist nurses and play therapist staff.
- We observed staff providing emotional support to children, young people and their parents. Children's individual concerns were identified and responded to in a positive and reassuring way.
- We observed staff on the neonatal unit (NNU) were compassionate and welcoming to parents, who were made to feel at ease at a very stressful time.

Are services for children and young people responsive?

Good

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

We rated responsive as "good", this is because;

- Services were tailored to meet the needs of individual children and young people. They were delivered in a flexible way
- A 24 hour paediatric assessment unit improved patient access and flow through the hospital.
- There were good facilities on wards for babies, children and young people and their families.
- The provision for palliative care and end of life was outstanding The unit was a purpose-built design that provided privacy and dignity for parents and their families who required palliative and end-of-life care
- Parents had access to information leaflets.
- There were no barriers for those making a complaint. Staff listened to the feedback given to them by parents.

However,

- Outpatient clinics were not always planned to meet the specific needs of children. For example, adults and children would be treated in the same area.
- Play therapists were not engaged by the outpatient department to help children cope during outpatient procedures.

Service planning and delivery to meet the needs of local people

- The services were planned with the the neighbouring NHS hospital. The paediatric wards and the neonatal unit were designed to meet the needs of babies, children and young people and their families.
- Young people were given choice of attendance on adult or paedatric wards.
- Staff told us the 24 hour paediatric assessment unit improved patient flow. They felt having a facility whereby patients could be observed for longer than four hours allowed the paediatric team to reduce their admission rate to inpatient areas.
- Transfers to other local paediatric intensive care units such as Southampton were arranged by consultants and managed by the appropriate staff during the transfer.
- Parents were encouraged to stay with their child on the paediatric wards and there were no restrictions to visiting. One parent per child was welcome to stay overnight and beds or reclining chairs were provided next to their child.
- There were clear pathways for staff to follow when children did not attend appointment. There was also a separate pathway to follow if parents of young children cancelled appointment. Staff we spoke with were aware of these pathways
- There was a frequent attender check list threshold regarding attendance to emergency department. If a child attended more than three times a year, this would be escalated to the GP and the health visitor/school nurse.
- Staff told us they were working long hours to mitigate safety concerns, but this was not sustainable. Sometimes actions taken were not effectively

communicated. For example, the temporary closure of beds in response to staffing concerns had a knock on effect in terms of paediatric waiting times for admission in the emergency department

Access and flow

- GPs could refer children to the assessment unit, and following triage children were then admitted or they could return home. There was a system for recording waiting time within the assessment unit.
- Staff in the assessment unit told us they prioritised care and treatment for people with the most urgent needs. During our inspection, we spoke to parents who were relieved they did not have to go through the accident and emergency and were admitted directly onto the wards.

Meeting people's individual needs

- The paediatric unit provided a 'child-friendly' environment. There was a playroom and a school room and access to a sensory room. There were a variety of toys and play equipment
- There was one paediatric outpatient clinic area, with seven consulting rooms and associated facilities. In addition the general outpatients, mainly used for adults provided for a range of specialties including fracture clinics and eye clinics
- In the neonatal unit, there were two parents' en-suite rooms for overnight stays.
- Outpatient clinics were not planned to meet the specific needs of children. For example, children attending ENT, maxillofacial unit and fracture clinics, attended with other adult patients. For example, a child coming to the clinic because they needed their plaster removed would likely share the treatment room with an adult. In addition, there were no consideration given to distracting children during clinical interventions.
- The outpatient department was not integrated with the paediatric department and a play therapist was not available to help children cope with outpatient procedures.
- Play therapist organised daily play services in the playroom and at bedside. They provided play to help children fear and anxiety by supporting them of frightening and unfamiliar experiences. They also helped children cope with pain. They were available on the wards but not in all clinic areas.
- The National Children's and Young People's Inpatient and Day care Survey (2014) indicated that the children services at the trust matched those provided at other sites. However, the trust did not meet the target of 70% of children and young people having their fundamental needs for play and recreation met while they are in hospital. In June 2015 51% of children and 55% of young people had their play and recreational needs met. Since that date, the trust had recruited an additional specialist with a special interest in children with special needs.
- In the NNU, parents had a specified area for eating and drinking away from the cot side. The paediatric unit had beds for parents at the patient's bedside.
- All areas were wheelchair accessible.
- For neonates, children and young people receiving palliative care, the trust had designed a special unit called the Gully's Place Suite. This was a purpose-designed space located at the far end of children's unit. The aim of this suite was to provide privacy and dignity for parents and their families who required palliative and end-of-life care This facility was also used when there had been a sudden death of a child or young person in the community, in the emergency department or on the children's unit. The unit was also used as a transition to home area for children with complex health needs.
- The children assessment unit had developed a patient information leaflet about the service it provided.
- Bereavement services were available through the trust chaplaincy. Consultants would always write to parents following the death of their child and arrange to meet with them.
- There were a wide range of information leaflets on common illnesses and conditions. There was also guidance information for parents to support their involvement in care. The NNU used information leaflets, many produced by the charity BLISS, to support parents' understanding and involvement in the care and treatment of their babies.

Learning from complaints and concerns

- There was guidance about how to raise concerns or complaints in all the patient and parent information leaflets.

Services for children and young people

- Staff were encouraged to respond to and resolve concerns raised by parents at an early stage. Parents told us when concerns were raised, staff addressed these immediately.
- There was some informal learning from complaints, but there was not a systematic approach to cascading learning among staff.
- Complaints were monitored monthly. There were no complaints longer than 12 months that had not yet been resolved. Six complaints related to delays in treatment on the assessment unit and staffing level. During our inspection in January 2016, there were eight on-going complaints mostly related to communication between parents and staff.
- Parents told us they were happy to escalate any concerns and that staff, and especially ward sisters, were very responsive.

Are services for children and young people well-led?

Requires improvement

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

We rated well-led as "requires improvement"

- There was not a service-wide strategy or vision for paediatric services.
- The risk register did not include key issues such as the lack of staffing on the paediatric wards.
- The paediatric service had lacked leadership at a senior nursing level until an acting matron was appointed in January 2016.
- When the issues of lack of staffing were identified, they were not raised formally in quality reports that were used to escalate issues to the Executive team

However,

- The recent appointment of the acting paediatric matron had already started making a difference. Changes to the staffing numbers had begun. Staff felt that the service had begun to improve.
- There was strong visible clinical leadership in the neonatal services from both the director for the service and the matron.
- The NNU was undertaking a service improvement programme to improve the quality of the service by bench-marking its service to other comparative similar sized neonatal unit.
- There was on-going day surgery development on the children's unit. For example, a new unit was being commissioned to come into operation in April 2016.
- Staff at all levels of the organisation were proud to work in this department.

Vision and strategy for this service

- There was not a service-wide strategy for paediatric services. The service was awaiting the outcome of the Dorset-wide clinical service review, which included a review of children's services. Staff were not aware of any interim documents regarding the service. The trust submitted a business plan for the service following the inspection.
- There was recognition by the leadership team of the need to work collaboratively with stakeholders, but without a clear vision and plans with timescales to support the service. For example, closer links were established with a neighbouring trust. However, there were no plans on how these links were going to operate within the vision of the service.
- All staff were familiar with The Poole Approach of being compassionate, open, respectful, accountable and safe as part of the values of the trust.

Governance, risk management and quality measurement

- There was governance structure to manage quality and risk.
- Child health was part of the children's services directorate. There was a governance structure and mechanisms for measuring quality and escalating risk within paediatric and neonatal services.
- A quality dashboard had recently been agreed (December 2015) and there was a schedule for child health governance and risk meetings. However, the issue of a lack of nurses on paediatric wards had not been raised at this meeting.
- The risk register for the department was discussed at the quarterly quality meeting with the Executive team.

However, issues relating to lack of nursing staff on the paediatric wards did not appear in the quality reports nor were they recorded on the risk register. These issues were therefore not escalated for discussion with the Executive team.
- There was a quarterly quality report from the child health service to the Executive team.
- At service level there were a range of quality initiatives such as audits and parent satisfaction questionnaires.
- An executive director undertook monthly patient safety walkabouts. Actions were identified and progress reported.

Leadership of service

- There was a designated children's matron nurse lead. . This lead was responsible for managing quality assurance. However, during our inspection we found that patient safety issues whilst recognised, had not been adequately escalated and addressed.
- The department had recently (four days before our inspection) appointed a new interim acting matron. This interim appointment had started to make improvements, for example, there were draft proposals to increasing the number of nursing staff on the paediatric wards. There was a strong visible clinical leadership in the neonatal services from both the director for the service and the matron. The lead for neonatal unit was responsible for quality assurance.

Culture within the service

- The service had made a commitment to creating an open culture of learning, reflection and improvement. This included listening to and empowering and involving children, young people their families and staff.
- Staff at all levels felt valued and were proud of the service, patient outcomes and parent feedback. They felt supported to provide high-quality care.
- There were very positive working relationships and cohesive team working between nursing and medical and allied healthcare professionals, built on mutual respect. All had clear roles and accountabilities and were focused on working towards high-quality patient care.
- We found a culture of multidisciplinary learning and development and positive team work across the service.

Public engagement

- Staff actively sought parents' views on ideas for improvements. Parents raised the issue of staffing levels on the wards with the inspectors. There were regular surveys and opportunities for feedback. Families we spoke with were keen to fund raise for the children's unit in recognition of the high standard of care they felt they had received.
- Feedback from children, young people and parents was actively sought through surveys. Action was taken in response. For example, certain menus items were removed as a result of feedback from children and parents.
- There were regular parent meetings and surveys on the NNU and staff made changes to facilities for parents as a result.
- The directorate produced a quarterly quality report for the Executive team. However, this detailed quality report was not shared with front-line staff.
- Parents and staff were involved in the current refurbishment of the unit. For example, staff designed the nurses station and storage of equipment.

Innovation, improvement and sustainability

- The NNU was undertaking a service improvement programme to reduce the length of stay, increase rapid discharge and avoid re-admissions. The programme was using information from other trusts and comparing practices with similar sized neonatal units.
- The children's assessment unit had developed a patient information leaflet about the service it provided. The leaflets had been designed by parents whose children had been treated on the wards.
- There was on-going day surgery development on the children's unit. This unit was going to take paediatric patients starting April 2016. For example, a new unit was being commissioned to come into operation in April 2016.
- The paediatric unit was involved in 11 research studies, three of these studies were in collaboration with adult research teams. The NNU was involved in one research study.
- Through innovation, and with support from the trust, the head of the NNU was part of Bournemouth University research unit.

End of life care

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

Information about the service

End of life care at Poole Hospital is provided across inpatient wards and at Forest Holme, a 12-bedded hospice that provides specialist palliative care. Forest Holme is a short walk away from the main hospital site. The hospital specialist palliative care team and the end of life care facilitator provide a service to all adult wards in the trust. The community specialist palliative care nurses provide palliative care in the community across the whole of the hospital's population. Between July 2014 and June 2015 there were 1,207 in-hospital deaths across Poole Hospital NHS Foundation Trust.

During our inspection, we spoke with three patients, three relatives and 37 staff, including nurses, doctors, health care assistants, ward sisters, occupational therapists, members of the hospital and community specialist palliative care teams, the end of life care facilitator, the bereavement officer, mortuary and portering staff and members of the chaplaincy team.

We interviewed the service leads for end of life care across Poole hospital, including the Director of Nursing. We observed interactions between patients, their relatives and staff, considered the environment, and looked at 11 'Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) orders and 11 sets of medical and nursing care records. Before our inspection, we reviewed performance information from, and about, the hospital.

Summary of findings

End of life care at this hospital was rated as 'good'. We rated the service as requiring improvement for responsive care. We rated the service good for safe, effective, caring and well-led care.

The trust had taken part in the National Care of the Dying Audit (NCDA) between 2013 - 2014 and at that time had not achieved six out of the seven key organisational targets and scored below the national average for six of the ten clinical key performance indicators. In the 2014 – 2015 NCDA the trust performed better than the national average in 10 out 12 measured indicators of performance. The data could not be directly compared as it did not measure against exactly the same performance indicators. However, it did suggest improvement when compared nationally with other end of life services.

Patients were protected from avoidable harm and abuse. There were reliable systems and processes in place to ensure that safe care was being delivered. Staffing levels were sufficient to provide safe care.

Staff at this hospital delivered person-centred care and treated people with compassion, dignity, kindness and respect. Feedback from patients and relatives was consistently positive.

There was good multidisciplinary working and staff were effectively trained. End of life care formed part of the

End of life care

mandatory training and staff induction programme at this trust. Staff received training in advanced communication which equipped them well when having sensitive discussions with patients and their relatives.

Staff across the trust reported timely access to advice and support from the specialist palliative care team and who were able to meet response times as outlined in the Operational Policy for Poole Palliative Care Service. The end of life care facilitator supported the care of dying patients across the hospital.

Patients were offered a range of pain relief interventions including medication and complementary therapies and pain was assessed, monitored and managed effectively. Staff had good working knowledge of end of life pain medicines to include anticipatory prescribing.

The leadership for end of life care was good. Service leads have produced a five year strategy which includes seven day working for the specialist palliative care team. The overalls aims and vision for end of life care were well understood by staff working in specialist palliative care and the trust had an awareness of the need to embed the strategy with staff working across the whole hospital. The Director of Nursing provided end of life care leadership at trust board level and had good oversight of end of life care issues across both the hospice and the main hospital.

The trust were undertaking regular audits to assess some patient outcomes in specific areas. However, the trust did not have an agreed set of performance indicators in order to measure the quality of the service on a continuous basis. The trust were collecting a variety of patient data at a local and national level but were not effectively using the data to improve patient outcomes.

DNA CPR orders were not always recorded by, or endorsed, by a consultant which meant decisions being made a patients resuscitation status may not have been shared by the consultant in charge of the person's care.

The trust operated a Rapid Discharge Home to Die (RDHD) pathway which served to discharge patients who were diagnosed as dying with 24-48 hours if they expressed a wish to die at home. Local audit results from March to April 2015 showed that patients were not being discharged within 24 – 48 hours and the trust could not demonstrate improvement following this audit. Patients who were dying and had expressed a wish to die at home were not routinely discharged in a timely way. The trust were not routinely monitoring discharge delays for patients on the RDHD.

End of life care

Are end of life care services safe?

Good

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

We rated safe as 'good'

- Patients were protected from avoidable harm and abuse. Staff understood and fulfilled their responsibility to report incidents and near misses and raise concerns. Where incidents had been raised, actions were taken to improve processes and practice to avoid future incidents. Clinical staff that we spoke to were aware of duty of candour and gave examples of when it had been used.
- Arrangements to minimise risks to patients were in place with measures to prevent falls and pressure ulcers.
- Staff demonstrated a good understanding of the early identification of a deteriorating patient. Monitoring of risks to patients was positive with actions considered to minimise future risks. Staff understood the need to minimise futile and unnecessary interventions when a patient is dying.
- Infection prevention and control practices were followed.
- Medicines were stored and managed safely at the hospice. Patients were prescribed anticipatory medicines so that they received timely treatment.
- Patient's records were safely managed.
- Safeguarding vulnerable adults was given sufficient priority and staff were able to identify safeguarding concerns as they arose.
- Nursing and medical staff were appropriately trained, and staffing levels allowed the delivery of safe care and treatment. There were appropriate arrangements in place for out of hours care.

Incidents

- Incidents were reported through the trust's electronic recording system which had replaced paper recording in 2015. All staff we spoke to knew how to report incidents, near misses and accidents using the trust's electronic reporting system. Staff told us that they were encouraged to report incidents. Between October 2014 and September 2015, the trust reported 117 incidents relative to palliative and end of life care and care of the deceased: Of these 87 were directly reported by and related to care at the hospice including 17 acquired (that is, developed during care whilst in hospital) grade 2 pressure ulcers, 15 reported slips, trips or falls and three safeguarding alerts.
- There was a safety incident in December 2015 which related to the transfer of a deceased person to the mortuary. Staff in the mortuary, the medical wards and the hospice were aware of this incident and could tell the inspection team measures they needed to take to ensure that similar incidents did not happen again such as improved identity checks and communication between portering and ward staff.
- The hospice ward sister completed a pressure ulcer review of acquired pressure ulcers between May 2015 and October 2015 and had put in actions which included having tissue viability champions on the hospice nursing team who would meet monthly to review all cases and ordering new variable pressure relieving mattresses for all 12 hospice beds.
- 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. The trust monitored duty of candour through their electronic incident reporting system. Clinical staff that we spoke to were aware of duty of candour and talked about the importance of being open and transparent with patients and their families. We saw where Duty of Candour had been applied in practice following a medication error.

Safety thermometer

- The hospice monitored the incidence of pressure ulcers, falls with harm, catheter associated urinary tract infections (CUTI) and venous thromboembolism (VTE) through the use of the NHS safety thermometer. The NHS safety thermometer allows teams to measure harm and the proportion of patients that are 'harm free' during the working day. This means teams can measure, assess, learn and improve the safety of the care they provide. Safety thermometer data for the period January to December 2015 showed harm free care had been delivered in three out of 12 months. In the nine months where harm had occurred this was due to

pressure ulcers and in one month due to CUTI. Where the CUTI had occurred this was one out of 11 patients in that month and the only CUTI that occurred in that 12 month period. In the month when the highest proportion of pressure ulcer harm occurred (December 2015), this was in two out of a possible seven patients.

- Safety thermometer information was not publicly displayed at the hospice. This meant patients and the public could not see how the hospice was performing in relation to patient safety. Nursing staff told us that data was not displayed because they wanted the hospice to be as non-clinical an environment as possible and the nursing sister said they had safety thermometer information available if it was requested by patients or relatives.

Cleanliness, infection control and hygiene

- Forest Holme hospice was visibly very clean and well maintained. The environment was well organised with clear procedures for the management, storage and disposal of clinical waste, environmental cleanliness and prevention of healthcare acquired infection guidance.
- There were permanent domestic staff working at Forest Holme who took pride in their work and ensured that the ward was visibly clean for patients and visitors.
- We observed equipment with clearly labelled last cleaning date stickers which ensured that equipment was clean before use.
- Throughout the hospice, we observed all staff to be adhering to best practice in relation to hand washing and infection prevention and control in line with trust policy. Staff were observed to wash their hands or use sanitising gel between each episode of direct patient care. There was access to handwashing facilities and there was a good and well organised supply of personal protective equipment, including gloves and aprons. All staff were observed to be 'bare below the elbows' in line with the trust Hand Hygiene Guidelines for Healthcare Workers.

Environment and equipment

- The hospice used a wireless nurse call system. Nurses told us that this eliminated the traditional call bell noise, minimising disruption to the patients and their visitors. The system also allowed staff to monitor the number of nurse contacts the patients were requiring which was useful when assessing patients' needs or feeding back to relatives how much assistance a patient has required during a shift.
- The trust used syringe pumps for end of life patients who required a continuous infusion to control their pain. We observed the use of syringe pumps at the hospice which met the requirements of the Medicines and Healthcare Regulatory Agency (MHRA). Patients were protected from harm when a syringe pump was used as the syringe pumps were tamperproof and had the recommended alarm features.
- The mortuary was well organised and appeared clean and well maintained. Equipment servicing was up to date and recorded. The mortuary attendant kept orderly and accurate records of environmental checks.
- The mortuary had sufficient bariatric equipment (equipment to support care of obese people) and environmental risk assessments considered the equipment needs of bariatric patients.
- Resuscitation equipment was stored appropriately and was checked and recorded weekly by nursing staff.

Medicines

- The trust had standard operating procedures for the prescribing of anticipatory medicines, medicines prescribed for the key symptoms of the dying phase (i.e. pain, agitation, excessive respiratory secretions, nausea, vomiting and breathlessness). We reviewed three medical and nursing case notes for those patients who were identified as being in the last hours or days of life. We saw where anticipatory medicines were prescribed appropriately, including medications that were prescribed on discharge.
- Medicines were stored safely at the hospice. We looked at the clinic room where medication was stored and found that the medicines fridge and the overall room temperature was being recorded daily. We reviewed the storage of controlled drugs (prescription medicines that are controlled under Misuse of Drugs legislation). Controlled drugs were stored and recorded safely.
- Staff had appropriate medicines management training which included the use of anticipatory medicines.

Records

- We saw medical and nursing notes for end of life patients were stored securely in the main office in the hospice which was locked when not in use.

End of life care

- We reviewed 11 sets of nursing and medical notes, including 'Do Not Attempt Cardio Pulmonary Resuscitation' (DNA CPR) records, for patients who were receiving palliative care including three patients who were in the last days or hours of life. The notes were legible, dated, timed and signed. Care plans for end of life care were recorded and updated clearly.
- We reviewed 11 'Do Not Attempt Cardio Pulmonary Resuscitation' (DNA CPR) forms. Our review showed that these forms had mostly been completed fully to a good standard and discussions held were further recorded in the nursing and medical notes. However, two of the 11 were not endorsed by the consultant which meant that less experienced medical staff could be making decisions which were not shared by the consultant in charge of the patient's care. The patients resuscitation status may not have been shared by the consultant in charge of the person's care.
- We saw the use of the electronic patient record where key patient information was captured to aid integrated working. Staff use a unique identification sequence of numbers and letters to gain access and computers were cited in the main office away from public view.
- We were shown the recording system for the movement of the deceased through the mortuary. There was a clear recording process in place from the point of arrival until the deceased was collected by funeral directors.

Safeguarding

- There was a trust policy which described the processes to safeguard vulnerable adults, children and young people.
- Nursing staff we spoke to had a clear understanding of how to identify report and protect patients from potential harm or abuse. Staff reported that they would need to record a safeguarding alert electronically using the trust's electronic reporting system as well as refer through to the local authority safeguarding team.
- The community specialist palliative care nurses were able to give examples of when safeguarding issues had been identified reported and responded to.

Mandatory training

- Staff working in the hospital palliative care team were up to date with their mandatory training. The nurses explained how they received email reminders when updates were due and had to be booked.
- The staff team working in the hospice were 100% compliant with mandatory training and the hospice sister kept a log of all staff and their mandatory training due for completion dates.

Assessing and responding to patient risk

- The hospice had a handover twice daily at 7.30am and at 7.30pm. Staff told us that during the handover they would discuss any deteriorating patients and would review the patient's care plan to ensure their needs were being met.
- We reviewed the nursing notes of three patients identified as being in the last hours or days of life who were being nursed on medical wards in the hospital. Risks to patients, for example falls, malnutrition and pressure damage, were assessed, monitored and managed on a shift to shift basis.
- We observed through the handover and through reviewing patient's records that nursing and medical staff understood the importance of preventing futile and unnecessary interventions when a patient is dying.
- Nationally recognised rating scales were not used for assessing tissue viability. The sister at Forest Holme was planning to work with the tissue viability nurse specialists to introduce a nationally recognised rating scale with an expected completion date of February 2016.
- Nursing staff used an early warning system, based on the National Early Warning Score (NEWS) to record routine observations. Where patients physiological observations were deteriorating staff told us that the consultant would complete a treatment escalation plan. Treatment escalation plans outlined the level of intervention required should the patient's condition worsen. Physiological observations were appropriately not recorded for patients who were in the dying phase of their illness.
- Staff were able to contact members of the palliative care team for advice about deteriorating patients. Nursing and medical staff said the team were responsive and supportive to urgent requests for advice.

Nursing staffing

- Nursing staff told us there were sufficient staff at the hospice for patients to be nursed safely at the time that we inspected. The ward sister rostered on two trained nurses on duty at all times with two healthcare assistants working with them during the day. There was

an extra trained nurse on days when there were multidisciplinary meetings. Most staff worked longer day shifts which they said helped with continuity of care. There were two trained staff working across the night shift. The matron told us there was a recruitment plan in place to have an additional 2.76 (whole time equivalent-WTE) healthcare assistants working nights to support the trained nurses.

- The hospice sister told us they were working with less nursing staff than they were funded to have with vacant posts for 2.85 (WTE) band 5 nurses. There were vacant healthcare assistant posts but these had largely been recruited to with the new recruits due to start at the hospice in February 2016. There was a recruitment plan in place for the remaining unfilled posts and staff told us that they use regular bank staff and their own staff work extra paid hours to ensure continuity of care.
- The trust employed two clinical nurse specialists to provide palliative care advice and support to patients, relatives and staff across the hospital. These nursing specialists advised on symptom control and complex discharge planning. They also had a role in providing support and education to staff and helping with transfers to the hospice inpatient unit. The hospital palliative nurse specialists told us they could provide sufficient clinical care, support and specialist advice within their job roles. They told us they routinely prioritised clinical work which led to good patient care but also meant that they could not contribute to service development and training of less experienced staff as much as they would have preferred.
- The trust employed seven (6.5 WTE) community specialist palliative care nurses who told us they had an average caseload of 25-32 patients per each nurse which is in line with the Operational Policy for the Poole Palliative Care Service, December 2014, updated January 2015. The matron had active recruitment plans in place for several upcoming vacant posts in the team so there would be no gaps in staffing the service.
- The trust employ an end of life care facilitator who works across the hospital supporting teams in delivering end of life care. At the time of the inspection funding had been secured through support of a business case and and through budget setting for this post to be made substantive as from 1 April 2016. Previously the post was fixed term until March 2016.
- We were not made aware of any acuity and/or dependency tool used in the hospice to decide on required staffing numbers.

Medical staffing

- Medical support for palliative care was led by a team of three part time consultants, who worked across all wards, the hospice and also undertook work in the community. Consultant ratios met the recommendations of the Association for Palliative Medicine of Great Britain and the national Council for Palliative Care of one whole time equivalent consultant to every 250 hospital beds. The consultants provided advice and support to the clinical nurse specialists and to hospital medical staff. They provided education sessions on palliative care for the junior doctors. Nursing staff told us that they felt well supported by the consultants.
- The trust also employed an Associate Specialist who supported the work of the consultants. At the time of the inspection the hospice had a General Practitioner (GP) speciality trainee working at the hospice.
- The consultants participated in an on-call rota. They were on-call for one week at a time and the rota was shared across Poole and a neighbouring locality. The lead consultant said this meant they were on call once in every five to seven weeks.

Major incident awareness and training

- All staff were aware of the trust's major incident policy and several staff said it had been included in their induction programme when they joined the trust. Business continuity plans were in place should there be any disruption to the day to day running of the service.
- The mortuary had mass fatality incident contingency plans in place which included using a Royal Marines facility locally in the event of an unpredicted mass fatality incident, and options for temporary mortuary storage on site if required. The plans were accessible to mortuary staff including those staff that may be required to cover the mortuary out of hours.

End of life care

Are end of life care services effective?

Requires improvement

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

We rated effective as 'good' because,

- In response to the 2013 review of the Liverpool Care Pathway the trust had developed the 'Personalised Care Plan for the Last Days of Life' record. Evidence based care and treatment was delivered in line with national guidance and National Institute for Health and Care Excellence (NICE) quality standards and local guidance was in place. These were followed for the effective management of the five key symptoms for symptoms at the end of life.
- Patients had their needs assessed and delivered in relation to best practice guidance.
- Patient's symptoms of pain and their nutrition and hydration needs were effectively managed.
- We saw evidence of effective multidisciplinary working both at the hospice and on across the wider hospital.
- There was good access to the specialist palliative care team and the trusts had recognised, and were working towards, improved access through seven day working.
- The trust had taken part in the National Care of the Dying Audit (NCDA) between 2013 - 2014 and at that time had not achieved six out of the seven key organisational targets and scored below the national average for six of the ten clinical key performance indicators. The NCDA results for 2014 – 2015 showed that the trust had improved and were preforming better than the national average in 10 out of 12 areas.
- DNA CPR forms were reviewed were appropriately completed in terms of discussion with patients and relatives.

However,

- The hospice was contributing data about palliative and end of life care to the National Minimum Data Set (MDS) but this data was not being used by the trust to improve local patient outcomes.
- The trust were collecting data on the actual numbers of patients who were on the 'Personalised Care Plan for the Last Days of Life' and those who had a 'Treatment Escalation Plan' but this data was not being used to improve patient outcomes.
- Audit data was not available to identify if DNA CPR forms were being appropriately discussed with patient and relatives.

Evidence-based care and treatment

- Following the national withdrawal of the Liverpool Care Pathway in July 2013 the trust had implemented a number of improvements plans to replace this methodology. Action was also being taken to address the five core recommendations for care of patients in the last few days of life in the Department of Health End of Life Care Strategy 2008. The recommendations from "One chance to get it right" published by the Leadership Alliance for the Care of the Dying were also being worked towards. Care was being delivered in line with National Institute for Health and Care Excellence (NICE) guidance S13 and we saw where the trust had benchmarked against these standards.
- Patients had their needs assessed and their care planned and delivered in line with evidence-based, guidance, standards and best practice.
- Patients in the last days of life are supported by a 'Personalised Care Plan for the Last Days of Life' (PCPLDL) which locally replaced the Liverpool Care Pathway. This is recorded on EPR and is available for staff to view to assist with the identification of patients believed to be in last days of life.
- All staff reported having access to the Wessex Palliative Care Handbook of Clinical Guidelines (2014) and several staff told us that this provided a good reference should they require guidance in end of life and palliative care delivery. The palliative consultants at this hospital had contributed to the publication of the handbook.
- The trust had trialled the use of the AMBER (Assessment, Management, Best-practice, Engagement, Recovery uncertain) care bundle. The AMBER care bundle is a simple approach used in hospitals when medical staff are uncertain whether a patient may recover and may only have a few months to live. Several senior staff told us AMBER had not been successful at the trust as it did not advocate advanced care planning. The trust were instead using treatment escalation plans, which included anticipatory medicines, to outline the level of

interventions required should a patient's condition worsen. We reviewed 11 sets of patients' records that were on the palliative care pathway, including three records of patients that were in the last hours or days of life and saw evidence of treatment escalation plans being used in practice.
- The trust were not undertaking any Commissioning for Quality and Innovation (CQUIN) initiative projects related to end of life care.

Pain relief

- Patients we spoke with had been asked about their pain at regular intervals and given pain relief where appropriate. All staff were pro-active in managing patient's pain. We reviewed three nursing records for patients in the last days of life and saw where pain assessments were included in the Personalised Care Plan for the Last Days of Life (PCPLDL) and responded to.
- During a doctors' handover on the hospice we saw when the Abbey Pain Scale had been used to assess the physiological pain of a person living with dementia who was unable to communicate verbally. The Abbey Pain Scale is a nationally recognised tool for assessing pain in individuals who cannot verbalise.
- Staff we spoke to from the hospice and the wider hospital were able to tell us correctly which anticipatory medicines would be used in end of life care.
- The specialist palliative care team were able to respond quickly in supporting staff with pain management to ensure there were no delays in responding to a patient's increase in pain as it occurred.
- Pain was monitored using an assessment tool. Pain scoring was completed for patients every time their observations were recorded. For patients on the end of life care framework this was a minimum of three times a day and after any interventions, including medicines, were given.
- A review of three medical and nursing records showed symptom control for end of life patients had been managed in accordance in the relevant NICE Quality Standard. This defines best practice for the safe and effective prescribing of strong opioids for pain the palliative care of adults.
- In the National Care of the Dying Audit 2014, this trust had scored well above the England average for ensuring that patients were prescribed anticipatory medicines in the dying phase of their illness. 81% of all cases assessed scored five out of five compared to the England average of 51%. This was not measured in the 2014 – 2015 NCDA.

Nutrition and hydration

- The hospice was served by the hospital's main kitchen. Patients told us that the food was of a good standard. Nursing staff at the hospice told us that the kitchen provided a variety of nutritional and culturally appropriate options to patients on the palliative care pathway such a light snacks, soft diets and flexible meal times. Nursing staff stored and prepared breakfast at the hospice. Patients and relatives were able to store and prepare their own food in a small kitchen facility at the hospice. We saw where this was labelled and stored appropriately. Nursing staff checked the fridge temperature and the food contents daily.
- Nutrition and hydration needs were included in patient's individual care pathways. We saw where specialist dietician input was given. In patient records we saw that Malnutrition Universal Screening Tool (MUST) assessments had been completed and were regularly updated. . We saw where nutritional needs were assessed using the Malnutrition Universal Screening Tool (MUST) and increasing risk was responded to by updating the patient's care plan.
- In the Personalised Care Plan for the Last Days of Life (PCPLDL) document, guidance was included around feeding and fluids. Nursing staff assessed patients' hydration and nutritional needs at least three times daily and recorded whether artificial hydration and nutrition was appropriate. Nursing staff at the hospice used food diaries to record what patients were eating and drinking and each patient had access to a fresh supply of water or their preferred drink. We saw nursing staff offering a range of drinks to patients. The PCPLDL requires nursing staff to offer mouth care and oral fluids at least hourly and offered food as appropriate. We saw where this had been followed at the hospice.

Patient outcomes

- The trust had taken part in the National Care of the Dying Audit (NCDA) between 2013 -2014 and at that time had not achieved six out of the seven key organisational targets and scored below the national average for six of the ten clinical key performance indicators. In the 2014 – 2015 NCDA the trust performed better than the national

average in 10 out of 12 performance indicators. The data is not directly comparable as the NCDA did not audit against exactly the same criteria. However, the trust had showed improvement with regard to patient outcomes when compared nationally.

- The trust had audited the introduction of the personalised Care Plan for the Last days of Life (PCPLDL) using some of the same criteria used in the NCDA between April and June 2014 which showed that in nine out of ten areas patient outcomes were worse than in May 2013 when they submitted data to the NCDA. The NCDA results showed that in 52% of care episodes audited , there was multidisciplinary recognition that the patient was dying and that in 54% of cases this had been discussed with the patient. The trust audit showed that these results were worse in 2014 with 51% of cases achieving multidisciplinary recognition that the patient was dying and that in only 36% of these cases it had been discussed with the patient. The audit lead had written an action plan from this re-audit which included introducing a baseline assessment when a patient has a PCPLDL and increased training and development of staff working across the wider hospital but the actions did not address the wide range of indicators that were not being met. The 2014 -2015 NCDA results showed that 88% of patients who were identified as being in the last 24 hours of their life had a holistic assessment of their needs which informed their care plan.
- The hospice was contributing data about palliative and end of life care to the National Minimum Data Set (MDS). The MDS for specialist palliative care services is collected by The National Council for Palliative Care on a yearly basis, with the aim of providing an accurate picture of national specialist palliative care activity. It is the only annual data to cover patient activity in specialist services within the voluntary sector and the NHS in England, Wales and Northern Ireland. The collection of the MDS is important and allows trusts to benchmark against a national agreed data set. We were not made aware of any ways in which the trust were using this data to improve local patient outcomes.
- The trust said that they were collecting data monthly on patients who were on PCPLDL and patients with Treatment Escalation Plans (TEPs). However, the trust recorded only the numbers of patients who had a PCPLDL or a TEP but did not identify trends or those patients who should have been on PCPLDL but were not, or should have had a TEP but did not. It was not clear how the trust could use this data to improve patient outcomes.

The trust was a phase one site for the national transform programme to improve end of life care, and had been selected as one of ten trusts nationally to participate in 'building on the best', a programme developed by the National Council for Palliative Care (NCPC) and Macmillan.

Competent staff

- Staff were supported to develop their knowledge and competences within this specialist field.
- Nursing staff we spoke to told us that they had an appraisal within the last 12 months. This was evidenced by the appraisal records submitted by the trust which showed that staff had received appraisals. Seven out of the required 31 members of staff working in palliative and end of life care had not been done within the annual timescale but very soon after.
- The trust delivered end of life care as part of the trust induction and mandatory training programme. The trust provided evidence that nurses revalidation dates are recorded, monitored and linked to the appraisal process.
- The end of life care educational steering group met quarterly to discuss end of life training at the trust. The palliative care training programme showed the education programme for the coming year which includes 'Do not attempt cardio-pulmonary resuscitation' (DNACPR) competency training and training updates for General Practitioners (GPs).
- All staff we spoke to said that they had good access to training and development and felt equipped with the skills required to deliver effective patient care. We were told that mortuary staff were considered as part of the end of life care team and shared the same access to training and development.
- The community specialist palliative care team had completed a wide range of further professional development activity. Four out of seven of the community specialist palliative care nurses had either completed or were studying towards the non-medical prescribing certificate. The specialist palliative care nurses received monthly clinical reflective practice from an external psychologist and there was a plan in place for hospice staff to have the same from February 2016.

- The matron encouraged all senior staff to participate on a two day advanced communication skills programme to assist staff in having challenging conversations with patients and relatives.

Multidisciplinary working

- The community specialist palliative care nurses are aligned with particular GP practices and attend regular Gold Standard Framework meetings, multi-disciplinary team meetings and run an annual education programme which includes supportive training in palliative care for GPs.
- The palliative care multidisciplinary team clinical meeting is held weekly and minutes are sent to GPs within 5 working days of the meeting.
- All staff we spoke with were positive about multidisciplinary working. We observed ward meetings between palliative care staff, ward based nurses and medical staff which were professional and effective and ensured high quality care. Two medical consultants we spoke with said the palliative care team were good at networking throughout the hospital and always responded quickly to requests for advice and input about patient care and treatment.
- The end of life care facilitator told us there was good engagement from the medical staff over the new documentation that had been introduced.
- There were multidisciplinary team meetings on every ward at the start of the day. Notes were not kept of these meetings but the ward board was updated and relevant information was entered into a patients notes. Nursing staff could discuss any concerns around end of life care before the medical staff visited a patient.
- The multi faith chaplaincy services were represented on the trust end of life strategy group and also attended the hospice multi-disciplinary meeting.
- Staff on the wards felt having the expertise of the hospice staff on site helped with the sharing of good practice.
- The hospice had an agreement with a local funeral director to collect the deceased's body. Where a deceased patient had a notifiable disease, had been referred to the coroner or a post-mortem was required, the funeral director would transport the body to the mortuary at the main Poole hospital site.
- Patient's, relatives, nursing and medical staff were aware who had overall responsibility for their care. The three patients we spoke to at the hospice could tell us the names of their named nurse and their named consultant.
- The hospice did not have dedicated occupational therapists or physiotherapists. Nursing staff told us patients could be referred to the oncology service therapists if required and we saw where physiotherapists had recorded in patients notes following interventions. The trust were in the process of recruiting a therapy assistant to be based at the hospice and to work under the support of the senior therapists delivering occupational and physiotherapy interventions.

Seven-day services

- The hospital and community specialist palliative care teams were available five days a week from 9am-5pm. The hospice nurses provided telephone support to patients outside of these hours. Between September 2015 and January 2016 only 9% of 54 patients who responded to the NHS Patient Experience Survey said they called the out of hour's advice line, though all 54 were made aware of the service.
- Mortuary services were available 8am to 4pm five days a week with on-call cover outside of these hours. Staff from the wards told us that families were able to view their deceased loved ones outside of usual working hours by arrangement with the site manager.
- Chaplaincy services were available from 9am-5pm five days a week with on-call cover out of hours. The chaplains told us that outside of usual working hours they could provide an urgent response if requested. Nursing staff at the hospice told us that the on-call chaplains could provide a faith leader usually within two hours both inside and outside of usual working hours.
- The service leads outlined their commitment to developing 'seven day access to face to face palliative care assessment' in the Palliative and End of Life Care Strategy, 2015 – 2018.
- Consultants and nurses were keen for the specialist palliative care service to be extended to seven day working but said they felt this required additional staffing to be run effectively. We were told by the leads of the service that a business case for this service had been submitted as part of the end of life strategy plan and the trust were seeking additional funding.

End of life care

Access to information

- At present Primary care and secondary care do not share a unified electronic record. Poole Hospital has an electronic patient record (EPR) which is available to authorised clinical staff within the trust. . Primary care staff are able to access this record if they have accessed the relevant IT training. Any patient known to the specialist palliative care team in East Dorset will have a 'Palliative Care Multi-Disciplinary Team (MDT)' care planning document on EPR. This records information specific to the patient's condition, changes to care and treatment, treatment management and patient choice as appropriate and enhances communication between healthcare professionals. EPR includes the ability to document treatment escalation plans, advance care planning tools and PEACE (Proactive Elderly Advance CarE.). Dorset has a unified Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) form which is also available on EPR. Patients may attend Poole Hospital with a 'gold standards framework' passport from the community to highlight they are in the last year of their life
- Information needed to deliver effective care was given in a timely and accessible way. For example, the hospice nurses accessed a communications folder each shift which included any palliative or end of life care updates.
- Staff also had access to hospital policies and guidance specific to palliative and end of life care via the trust intranet.

There was a 24 hour advice line that was manned by the hospice staff team that hospital staff and community partners could use to get timely advice to support effective care and treatment. Patients and relatives were given a leaflet which included contact details for the telephone advice line.**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

- We reviewed 11 sets of nursing and medical notes of patients on the palliative care pathway. We saw that consent to care and treatment was obtained in line with legislation and guidance and where applicable relatives were included in the discussions and these discussions were recorded. We saw where capacity was formally assessed when there were concerns about the patient's capacity to consent to decisions about their care and treatment.
- The trust had audited the use of DNA CPR forms in February 2015 and found that in 44% the decision had not been communicated to the patient and in 56% the decision had not been communicated to relatives. From these findings, the trust had set up a DNA CPR working party and were expecting to see improvements in the results of the latest audit due in February 2016. We did not have this latest data.
- We reviewed 11 'Do Not Attempt Cardio Pulmonary Resuscitation' (DNA CPR) forms. Our review showed that these forms had mostly been completed fully to a good standard and discussions were with patients and relatives and recorded in the medical and nursing notes.
- Staff told us how best interest meetings were organised and the decisions recorded. We saw the record of one meeting which was recorded in the patient's notes.

Are end of life care services caring?

Good

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

We rated caring as 'good'

- All staff we spoke with were committed to providing excellent care to patients throughout palliative illness and end of life as well as compassionate care to their loved ones including post bereavement.
- We observed a person centred culture where staff involved patients and their relatives and offered kind and compassionate care.
- Feedback from patients and their relatives was consistently positive about all aspects of palliative and end of life care. Medical and nursing staff showed sensitivity when communicating with patients and relatives.
- There was good access to the multi-faith chaplaincy service for patients and their families. Emotionally, patients and relatives were well supported by staff at the hospice, the chaplaincy department, the specialist palliative care team and the counselling service.

Compassionate care

- Throughout our inspection we saw patients and their relatives being treated with compassion, dignity and

respect. We observed a medical handover at the hospice where medical and nursing staff showed an awareness of treating patients and their families in a sensitive and compassionate manner.
- We observed the end of life care facilitator delivering exemplary compassionate care to a dying patient offering kindness, dignity and respect throughout.
- Between September 2015 and January 2016 we saw where 54 people who were known to the specialist palliative care team had responded to the NHS patient experience (Picker Institute) survey. 98% of the 54 responders said they would recommend the specialist palliative care service to their friends or family if they needed similar treatment and comments were generally very positive. Respondents' fed-back positively about the care provided with comments such as 'I cannot fault the care and consideration given to me' and 'I feel that everything that can done for me is done well and with compassion'.
- We saw a visitor's book at the hospice, full of messages of thanks to staff for the care provided to their relatives. We saw thank you cards and letters from patients and relatives in the nursing office at the hospice. We saw a bereaved relative coming to the hospice after their loved one had died at home to thank the staff at the hospice for the care given during their relative's last year of life.
- Three patients and one relative we spoke to at the hospice described the nursing care as 'excellent'.
- The hospice sister had recently obtained new reclining chairs so that relatives could stay comfortably at the patient's bedside in the bays if required.
- One patient had gone out for a meal with a friend on the day of our inspection and staff told us they were pleased to support this as it was important to the patient in the palliative stage of their illness.
- One staff nurse from a medical ward gave an example of a recent death and said they were proud to have achieved 'a good death' whereby the patient was comfortable, pain free and treated with dignity and respect.

Understanding and involvement of patients and those close to them

- We reviewed 11 sets of nursing and medical records and found detailed notes about caring discussions held with patients and those close to them.
- We observed nursing staff at the hospice having compassionate and inclusive conversations with relatives which were then recorded in the nursing notes. We found that medical and nursing notes recorded caring and considerate discussions held with patients and their relatives.
- We spoke with three relatives who all said they felt involved in decisions about their loved one's care and treatment.

Emotional support

- Nursing staff reported good access to the chaplaincy department. They knew the members of the chaplaincy team by name and said that the chaplains would frequently visit the hospice. During our inspection one of the chaplains had offered emotional support to a bereaved relative who had gone to the hospital on an anniversary after the death of their loved one. Another chaplain had attended the hospice to discuss spirituality with a patient at a hospice on the day of their request.
- Staff told us the matron delivered accessible training on holding difficult conversations which they found helped them in giving emotional support to patients and their relatives.
- Staff recognised and respected the emotional needs of bereaved relatives. The community specialist palliative care nurses would ring the deceased relatives within two days of a death to offer their condolences and emotional support, and would follow up with a hand written card and the offer of a home visit. The nurses could refer relatives to the counselling (family support) services if required.
- The trust employed one psychotherapist and two counsellors who worked across the hospice and oncology wards providing emotional support to patients, their relatives and staff. The counsellors accept any referral for patients on the palliative care pathway and their loved ones. The counselling manager told us that the counselling service had good links with the mental health liaison team and could refer in a timely way if needed. The counselling service operated flexibly and offered bereavement counselling if appropriate.
- The feedback from patients was very positive with comments such as "my counsellor was excellent. She was patient, kind, insightful and helped me to find peace. I feel so lucky to have had the opportunity to talk to her and will be forever grateful. Thank you so much".

End of life care

- Relatives of patients who had died at the hospice were invited to attend a drop-in bereavement support afternoon four times a year for up to two years after the death of a loved one.

Are end of life care services responsive?

Good

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

We rated responsive as 'requires improvement'

- The trust operated a Rapid Discharge Home to Die (RDHD) pathway which served to discharge a dying patient who expressed wanting to die at home within 24 hours. The trust did not have any data to demonstrate improvement against their local audit in March – April 2015 which showed that patients were not being discharged within 24-48 hours as outlined in the Rapid Discharge Home to Die Pathway. The trust had recognised through audit results that there was a lack of understanding of the Continuing Health Care (CHC) funding process and staff were not always identifying patients appropriate for CHC fast track discharge planning.
- Patients who were dying and had expressed a wish to die at home were not always able to do so in a timely way.

However,

- The service took account of individual differences, preferences, cultural expectations and spiritual needs.
- The hospital delivered patient centred specialist assessments in a timely way. The hospital specialist palliative care teams assessed newly referred patients within 24 hours as outlined in the Operational Policy for the Poole Palliative Care Service. The community specialist palliative care nurses assessed patients within three days of the referral.
- The medical wards in the main hospital had enough side rooms for patients in their last hours of life to be cared for in privacy. In the hospice, nursing staff told us they would use the individual rooms for patients who were in the last days or hours of life. Facilities were available for relatives to stay close by.
- The needs and wishes of individual patients were important to the planning and delivery of care at the hospice. Staff demonstrated a good awareness of the language needs of the local community and could access translation services if needed.
- There had been very few complaints in end of life care. Staff were committed to trying to resolve issues at the earliest opportunity to avoid escalations to formal complaints. Where concerns were raised, we saw where these had been considered and action had been taken.

Service planning and delivery to meet the needs of local people

- The trust collected specific data to ensure the service delivered reflected the needs of the local population requiring this service. The trust were contributing data about palliative and end of life care to the National Minimum Data Set (MDS) which meant they could review data about referral and re-referral rates, bed occupancy, diagnosis of patients being treated as well as demographic factors such as gender, age and ethnicity.
- There were designated beds for patients receiving palliative care. Forest Holme hospice had 5 single occupancy rooms and two separate male and female bays. There was no day-hospice facility at Forest Holme but patients could access a neighbouring day hospice.
- Facilities were available for relatives to stay close by. Relatives were offered the use of the relatives' room which had en-suite bathroom facilities or were able to stay in the single-occupancy rooms with their relative.
- The medical wards had side rooms available for patients in the last days or hours of life. The Rapid Access Consultant Evaluation (RACE) unit for the elderly had 16 available side rooms and the acute stroke unit had 11 side rooms and nursing staff told us that there was always side rooms available if needed for patients at the end of life. However, as the side-rooms were not used only for patients in the last hours or days or life this could not be guaranteed and there may not be side-rooms available if there was an increase in the need for patients to be nursed in isolation eg if there was an infection control outbreak.
- Complementary therapies were available for all palliative care patients through referral to the cancer care centre including relaxation, aromatherapy and massage.

End of life care

- The trust told us that they were collecting data monthly on the percentages of patients who were dying in their preferred location but this data was not made available to the inspection team.
- The counselling service collected feedback from 52 patients who had completed their counselling treatment between January and December 2015. 100% of those who responded said they would be extremely likely (98%) or likely (2%) to recommend the counselling service to friends and family if they were in similar need.

Meeting people's individual needs

- The needs and preferences of patients and their relatives were important to the planning and delivery of care at the hospice. We observed nursing staff and healthcare assistants taking time to find how the patient viewed their needs and offering flexible choices to meet those needs.
- Staff demonstrated a good awareness of the language needs of the local community. Nursing staff from the hospice and the community specialist palliative care nurses told us they could access translation services if needed.
- We saw where reasonable adjustments were made for patients living with dementia at the hospital such as using non-verbal communication tools and using picture boards as memory prompts.
- The community specialist palliative care nurses had a good overview of their individual caseloads including the social, economic and cultural diversity. One community nurse gave examples of having worked closely with the fire brigade and the police in meeting the individual needs of one patient with an extensive offending history and another patient who was assessed as a high fire risk due to smoking tobacco in the vicinity of oxygen cylinders.
- The hospice had produced a bereavement pack which included a booklet entitled 'Help and Care in Bereavement" which provided clear information and guidance for relatives for what they needed to do following the death of a loved one.
- We saw where patient's individual needs and preferences, including spiritual needs and cultural expectations, were recorded clearly on the PCPLDL.
- The Department of Health End of Life Care Strategy, 2008, outlines that healthcare providers involved in end of life care should hold advanced discussions and record an individual's preferred place of care when the person reaches the dying phase of their illness. The trust had audited 104 records of patients at the hospice between November and December 2014 and found that 73% of records clearly detailed the patient's preferred place of care. The trust were awaiting the results of the 2015 audit cycle. However, the audit of PCPLDL between April and June 2014 showed that only 19% of patients on medical wards at Poole Hospital, excluding the hospice, had a documented preferred place of care in their records. We were not made aware of any focussed trust action in response to these findings.

Access and flow

- This trust scored four out of a possible five with regards to patients being given access to information about death and dying which was the same as the England average in the National Care of the Dying Audit, 2014. This trust scored four out of a possible five with regard to patients being given access to specialist palliative care treatment and support in the same audit which was also the same as the England average. This was not measured in the 2014 -2015 NCDA.
- Patients were admitted to the hospice from home or transferred from hospital. Admissions mainly occurred between 8am and 7pm. The community specialist palliative care nurses told us there were rarely delays in admitting patients to the hospice. Where delays did occur, and the patient could not be supported at home by community nursing services, an overnight admission to an acute hospital bed might occur until transfer to the hospice could take place.
- The trust had audited patients who had been admitted to Poole hospital (excluding Forest Holme) who were already known to the palliative care team over one month between April and May 2015. 43 patients were admitted to Poole hospital acute wards during the data collection with 27 of those patients having been known to Forest Holme specialist palliative care team. The remaining 16 were known to neighbouring trusts' palliative care teams. 5 of the total 43 patients were reviewed as being admitted to Poole hospital when their needs could have been best met in a different place of care. 2% of patients admitted to the acute wards were assessed as having been admitted to an acute ward as there was no specialist palliative care bed available. The referring care teams had only sought specialist palliative care advice for 32% of the total patients before an acute admission was agreed. Following the audit results, the

service leads had produced leaflets about the out of hours advice line to encourage patients and potential referrers to seek specialist palliative care advice as well as seeking funding for a seven day specialist palliative care team. The trust were awaiting the results of the latest audit in December 2015 at the time of our inspection.

- The trust operated a Rapid Discharge Home to Die (RDHD) pathway for patients who were thought to be in their last days of life and had requested to die at home. The pathway includes a comprehensive list of actions which ensure that a patient can be discharged home in a safe and timely manner and includes liaison with primary care, voluntary sector services and relatives. The pathway aims to discharge patients home within 24 – 48 hours. Nursing staff told us that they could usually get patients on the RDHD pathway home within 24 – 48 hours and said that the paperwork used at the trust was a very useful guide as to what actions needed to happen within specific timescales. Several nursing staff told us that they work hard to ensure prompt discharge when a patient wishes to die at home. One nurse said they 'pull out all the stops'. The National Framework for NHS Continuing Health Care (CHC) and NHS Funded Nursing Care was published in 2007, and revised in 2012. This framework sets 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. The trust had completed an audit in March and April of 2015 to see whether patients were being discharged home to die within 48 hours after CHC funding has been agreed. The audit showed that no patients out of a possible 24 were discharged within 48 hours of CHC funding being agreed with an average length of delay to discharge being 14.8 days. This meant that patients were not having their wish to be cared for at home towards the end of their life met in a timely and responsive way at that time.
- Whilst the CHC funding process was not resourced by the trust, the audit showed that only 8% of applications for CHC funding were completed and sent internally to the discharge team within 24 hours, as outlined in the RDHD pathway. The trust identified through this audit that the hospital made the lowest number of CHC fast track applications compared with the other end of life providers in the Dorset network. The audit findings identified that patients who may have met the fast track criteria were not always being identified. The trust had recognised through this audit that there was a 'widespread deficit in the knowledge and understanding of the CHC process within the trust'. The trust did not have any data to demonstrate improvement against the audit results of 2015.
- The specialist palliative care teams, both hospital and community, saw newly referred patients within the agreed timescales as outlined in the Operational Policy for the Poole Palliative Care Service, April 2014, updated January 2015. For the community specialist care team the policy stated that the patient should be assessed within 3 days of the referral being made and for the hospital specialist palliative nurses the policy stated assessment should occur within 24 hours. The trust had reviewed referral to assessment times between September 2014 and February 2015 and found that the hospital specialist palliative care team had seen all patients referred on the day of referral except in one month in the six when the average wait had been within one day. The community specialist palliative care team were achieving initial telephone contact within one day and face to face contact within an average of four to five days in this period of data collection.

Learning from complaints and concerns

- We saw where Patient Advice and Liaison Service (PALS) leaflets were available in communal areas at the hospice.
- There are very few complaints about end of life care at this hospital. Between 2014 and 2015 the trust received 479 written complaints which did not highlight any recurring themes or concerns about end of life care at the hospice or wider hospital. There was one complaint from a relative in January 2016 about the palliative care received by their loved one. The matron met with the relative who was satisfied with the lessons learnt and actions going forward.
- Staff in the hospice told us they try and resolve any concerns from patients or relatives in a timely way to quickly improve the outcome for the patient and to avoid escalation to a formal complaint.

End of life care

Are end of life care services well-led?

Good

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

We rated well-led as 'good'

- There was evidence of leadership in both the palliative care team and at board level. The strategy, although newly developed, was widely shared with the senior team with plans for sharing with frontline staff in place. The trust had an up to date operational policy for palliative care across the hospital. There was a clear vision and aims for the service which was shared by frontline staff working in specialist palliative care. The trust were aware of the need to share and embed the strategy across the whole hospital.
- The specialist palliative care service had a clear education strategy outlining their vision and challenges for the next five years.
- Staff in the hospice worked in a positive and open culture and felt supported by their colleagues and line managers. Staff felt valued by the trust and felt proud of the services they delivered. We saw effective teamwork and an open culture of support, openness and mutual respect. Nursing staff at the hospice told felt positive about leadership changes in the last year having positive outcomes for patients.
- The specialist palliative care team nurses contributed to the overall leadership of palliative and end of life care but clinical priorities took precedent meaning their involvement in service development was not fully established.
- The Director of Nursing provides end of life care leadership at trust board level and had good oversight of end of life care issues across both specialist palliative care and the acute medical wards.

However,

- The trust did not have an agreed set of performance indicators in place for end of life care.

Vision and strategy for this service

- The service leads had produced a Palliative and End of Life Care Strategy in November 2015 which outlined its vision and aims for 2015 – 2018. The trust had benchmarked where it was now against where it needed to be by 2018. The service leads and senior staff were familiar and committed to delivering the aims of the strategy but frontline staff did not know there was a strategy as it was a new strategy. The service leads said they planned to work with frontline staff to embed the vision and aims for the service throughout 2016. However, when the hospice staff spoke about the priorities for palliative and end of life care they were in line with those outlined in the strategy document. Staff involved in end of life care across the hospital were not aware of the strategy and did not know the overall aims for end of life care at Poole Hospital.
- The specialist palliative care service had produced an education strategy document in November 2015 which covered their aims and challenges for the next five years. This was supported by an action plan which included developing a competency framework for all staff working in specialist palliative care, providing in-house teaching for specialist palliative care staff, developing a yearly education programme run by the hospice and developing a webpage and branding to advertise educational events. These actions were all due for completion by the end of 2016 with some already having been achieved.
- The trust had an end of life steering group chaired by the assistant director of nursing. The purpose of this group was to promote and drive the end of life care agenda as well as provide a clear link to the trust board. Meetings were held quarterly and included multidisciplinary representation from other services from across the trust such as anaesthetists, chaplaincy and elderly medicine. Minutes from the last year's quarterly meetings show good emphasis on driving forward the end of life agenda, improving partnership working with external stakeholders and improving patient experience. Where actions had been identified, we saw where they had been completed.
- The Director of Nursing was the executive board lead for end of life care but this had only been agreed in the latter part of 2015 so the link was not fully established. However, we found the director of nursing had good oversight of end of life issues both within specialist palliative care and across the acute medical wards.

End of life care

- We were not made aware of there being a non-executive board director with lead responsibilities for end of life care.

Governance, risk management and quality measurement

- The palliative consultants had clear responsibilities in terms of the governance of end of life care with a designated lead for audits, patient and carer issues and clinical leads.
- The end of life care group meet quarterly and issues are escalated to the clinical governance group as needed which in turns feeds up to the trust board meetings. The Director of Nursing was the nominated board lead for end of life care but this had only been established in November 2015. The Director of Nursing forms part of the end of life care group, the clinical governance group and the trust board and showed good oversight of issues relating to end of life care and the overall strategic direction including any risk incidents and associated actions arising.
- The clinical lead met quarterly with the Dorset Specialist Palliative Care Group. Membership included palliative care leads and consultants from surrounding trusts with representation from local commissioning groups and county councils. The purpose of this group was to standardise care across the Dorset region.
- The end of life steering group discussed risks and ensured that actions occurred to mitigate identified risks. The service leads told us of risks held within end of life such as not having a 24 hour specialist palliative care team and risks associated with transferring deceased patients to the mortuary and these were recorded on the relevant risk registers in line with the overall governance structure. For example, risks associated with the mortuary were recorded on the support services risk register.
- End of life care leads did not have agreed set of performance measures in use at this trust. Whilst the trust was engaged in a robust audit cycle, there was no system in place to measure overall performance indicators on a continuous basis. For example, the trust was undertaking periodic audits of referral to assessment times for specialist palliative care but this information was not being routinely captured. This meant that if there were delays in referral response times this would not be picked up in a timely or proactive way.

Leadership of service

- Leadership within end of life care was strong and extended beyond the palliative care specialist teams. There were clearly defined responsibilities for all staff delivering care. The clinical lead was enthusiastic and keen to develop and improve end of life care across the hospital. Senior staff we spoke to on medical wards of the hospital reported feeling well supported by the matron, the director of nursing, the board and the chief executive in delivering end of life care. Staff at the hospice said they would like a more visible presence from senior leaders but acknowledged they knew how to access senior leadership support if required and they received regular communication from the senior team. Nursing staff delivering end of life care on the medical wards reported a strong visible presence from the matron, the director of nursing and the chief executive which they valued.
- All the staff we spoke to felt their line managers were approachable and supportive. Nursing staff at the hospice told us they were happy with the leadership changes that had happened within the last year which were already having a positive impact on the service.
- The specialist palliative care nurses told us that they were not able to contribute as effectively as they would like to service development, due to time constraints as they had to prioritise direct patient care.

Culture within the service

- We saw effective team working at the hospice with a culture of support, openness and mutual respect.
- Staff we spoke to at the hospice told us they felt proud to work at Poole Hospital as it they believed it had a good local reputation. Staff at the hospice also told us how they felt the 'Poole approach' of person centred compassionate care helped hospice and hospital staff to deliver a patient centred service.
- We observed good team working and supportive conversations held between staff members. One student nurse at the hospice told us they had been well supported to by their mentor to address their own bereavement issues whilst on work placement.
- Several staff at the hospice told us they 'loved' their job and took pride in providing excellent palliative and end of life care. Every member of staff we spoke with was committed to providing excellent end of life care.

End of life care

- Staff told us the end of life care facilitator had made a positive contribution in supporting staff on the medical wards in care of patients in the dying phase of their illness. We observed the end of life care facilitator having supportive, yet directive, discussion about end of life patient care which contributed positively to the care the patient received.

Public engagement

- In order to improve the services the trust provide to patients in their last days of life and their relatives and/ or friends, the trust was planning to start collecting feedback from bereaved people to ask them a number of questions about their experiences. The bereavement officer was going to oversee the data collection with leadership support from the counselling service manager.
- The chaplaincy organise a wide range of multi-faith events with faith leaders, the general public, minority groups , staff and patients where issues around spirituality, death and dying are explored.
- The trust hosts an annual event at the hospital to promote issues related to death and dying which is attended by patients, relatives, staff and members of the public in May each year.

Staff engagement

- The trust recognised the hard work and commitment of their staff and publicly thanked staff through a hospital award scheme. We saw where individual staff, including the palliative care service lead, and the hospice as a whole service, had received nominations or awards.
- Information was provided to the staff through a regular trust newsletter and also from email updates from the chief executive.
- The service leads for end of life care produced a twice yearly newsletter for staff detailing any updates, good practice or learning in relation to palliative and end of life care. Similarly, a newsletter was produced and sent to local GPs on an annual basis.
- Staff told us they were encouraged to participate in the annual staff survey and would get feedback about the results.

Innovation, improvement and sustainability

- One of the specialist palliative care nurses facilitated "Schwartz" rounds which were well attended by staff involved in palliative and end of life care. These are a forum for staff from different backgrounds to come together to talk about the emotional and social challenges of caring for patients. These meetings usually focus on the non-clinical aspects of care in multi-disciplinary meeting forum.
- Recognition of staff through Poole hospital awards contributed to staff satisfaction. We saw where palliative care staff had been nominated for these awards. Staff felt valued by the trust and motivated to provide a valuable end of life service.
- The trust were involved in several improvement projects including the C-Change research programme (systematic reviews for the Cochrane Collaboration) and the Public Health England palliative care clinical data set.

Outpatients and diagnostic imaging

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

Information about the service

Poole Hospital NHS Foundation Trust provides outpatient and diagnostic imaging services for a range of medical and surgical clinics including ophthalmology, rheumatology, dermatology, cardiology, ENT (ear, nose and throat) and orthopaedics.

Outpatient appointments were available from 8:30am to 5pm, Monday to Friday. In 2015, the outpatient department provided 92,997 new outpatient appointments and169,086 follow up appointments.

The diagnostic imaging department was open for appointments from 8.30am to 5.30pm, Monday to Friday for outpatients and offered plain film radiography, MRI, CT, ultrasound, fluoroscopy, interventional radiology, breast imaging, nuclear medicine and medical physics. There was a diagnostic imaging service available 24 hours a day, seven days a week for emergency radiology and inpatient services.

During the inspection we visited the outpatient department and diagnostic imaging services as well as the breast unit and the outpatient therapy unit. We spoke with 10 patients and 58 members of staff including nurses, consultants and other medical staff, physiotherapists, radiographers, occupational therapists, health care assistants, administrators, receptionists and managers.

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

Outpatients and diagnostic imaging

Summary of findings

We found the outpatients and diagnostic departments at Poole Hospital were good for safe, caring, responsive and well-led services.

Staff were encouraged to report incidents and the learning was shared to improve services.

Staff compliance with mandatory training was good in outpatients and diagnostic imaging.

Two radiographers worked overnight and were responsible for plain film X-rays for the main hospital and the emergency department. One on-call radiographer carried out computerised tomography (CT) scans and worked alone if called in. Radiographers reported a heavy workload and raised issues regarding manual handling. Between 10.00pm and 8am, radiology was supported by an overnight, outsourced radiologist service. Staff confirmed that this service worked well and did not compromise patient care.

In diagnostic imaging, staff were confident in reporting ionised radiation medical exposure (IR(ME)R) incidents. Staff followed procedures to report incidents to the radiation protection team and the care quality commission.

The environments were visibly clean and staff followed infection control procedures. There were monthly environmental audits carried out by the infection prevention team. There was appropriate management and storage of medicines. Records were available for clinics using an electronic document management system. Patients were assessed and observations were performed, where appropriate. However, there was not a tool in use to help identify a deteriorating patient.

Nurse staffing levels in the department were appropriate to patient needs, and there were few vacancies (approximately 8% at November 2015). Radiographer staffing levels were five vacancies (25%) across the CT and MR staffing groups. Staff reported this affected the on-call rota and was placing a strain on their workloads. However, there was an ongoing recruitment plan for nurses and radiographers.

There was evidence that care was being provided according to National Institute for Health and Care Excellence (NICE) guidelines.

Staff had access to training and had annual appraisal but did not have formal clinical supervision.

Staff provided compassionate care, and ensured patients and relatives were well supported whilst in the department. Patients were well informed and routinely involved in the planning of their care and treatment. Staff recognised when a patient required extra support to be able to be included in understanding their treatment plans. Patients and relatives we spoke with gave us positive feedback about the department.

There was evidence of service planning to meet people's needs. For example, with there had been changes to seven day working in radiology, and a re-design of the therapies directorate. National waiting times were consistently met for outpatient appointments, cancer referrals and treatment and diagnostic imaging. There was good support provided for patients with a mental health condition and patients living with dementia.

Patients whose first language was not English had access an interpreter although some staff were not aware of how to access this service. The self-service checking in system, located in outpatients, presented multiple languages on screen. The service received very few complaints that were upheld and, where possible, concerns were resolved locally.

Governance processes to monitor risks and quality required further development in the outpatient and diagnostic department.

Staff were not clear about the overall vision and values of the trust but told us that the departmental patient experience and the provision of high quality care was their main concern. All staff spoke of the 'Poole Approach', which is a culture, embedded across the whole trust.

Nursing staff in the outpatient department felt well supported by their immediate line managers. They told us that they felt well supported and valued. However,

Outpatients and diagnostic imaging

some staff in diagnostic imaging did not identify a strong leadership presence and did not feel well supported. All staff said they enjoyed working for the trust due to the strong team support from colleagues.

Public and patient engagement occurred through feedback such as surveys and comment cards.

Are outpatient and diagnostic imaging services safe?

Good

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

We rated safe as 'good'.

- Staff were encouraged to report incidents and the learning was shared to improve services.
- In diagnostic imaging, staff were confident in reporting ionised radiation medical exposure (IR(ME)R) incidents. They followed correct procedures to report these incidents to the radiation protection team and the Care Quality Commission.
- Senior staff understood the requirements of the Duty of Candour.
- Infection control processes had been followed and monthly audits demonstrated good adherence to infection control procedures.
- The environment was visibly clean and well maintained. Hand-washing facilities and hand gels for patients and staff were available in all clinical areas.
- Equipment in use was well maintained and had been regularly serviced. The resuscitation trolleys were checked daily, and staff followed procedures to ensure that all equipment was in date.
- Medicines were stored securely and managed correctly. Patient group directions (PGD), which allow trained staff to administer medicines without prescription, were in date.
- Staff compliance with mandatory training was high. Staff had a good understanding of safeguarding procedures.
- Electronic patient records were available for all clinics. These electronic records were protected by passwords to keep patients information safe.
- Nurse staffing levels were appropriate and there were few vacancies.

However,

- There was not a specific assessment tool used to help identify a patient whose condition might deteriorate.

Outpatients and diagnostic imaging

- Vacancies for radiographers were 25% which was a concern for the department. Managers were aware of the situation and there was an on-going recruitment process to fill these vacancies.
- Not all staff had received training on how to use the electronic incident reporting system, which could lead to a delay in reporting incidents or incidents not being reported.
- Some clinicians identified that documents on the new electronic patient record were not always filed correctly, which meant patient information could be missed.

Incidents

- In outpatient clinics and diagnostic imaging services, incidents were reported on the trust reporting system. In mid-2015 a trust wide electronic reporting system had been introduced. Staff felt confident with the process for reporting incidents however not all staff had yet received training to use the new system.
- Outpatient staff confirmed that feedback from reported incidents was shared during team meetings, to share learning and reduce risk. Staff reported that team meetings in diagnostic imaging had not been held for several months due to workload pressures.
- Medical, nursing and support staff were aware of their responsibilities in reporting incidents and we saw examples that had been submitted across the department. Staff were aware of the benefits of reporting "near misses" and told us that they did this.
- There had been eight serious incidents within the outpatient and diagnostic imaging departments between 1 January 2015 and 31 December 2015. These incidents were each subject to an investigation using root cause analysis (RCA). The investigations stated these incidents were discussed at departmental staff meetings, quality and governance risk meetings and at serious incident panel meetings. The serious incident panel meetings included representation from the trust board. Minutes from these meetings, and RCA reports, showed that learning from these incidents had been appropriately shared.
- The requirements of the Duty of Candour were recorded as discharged in all incidents. 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.
- Some staff were aware of the requirements of the Duty of Candour, but this knowledge was not consistent across the department. There was no specific training offered to staff in relation to the Duty of Candour. Staff could identify the need to be open and transparent about the care patients received and said they would raise any issues.
- In diagnostic imaging, reportable incidents around IR(ME)R were reported to the trust's radiation protection team and to the Care Quality Commission under IR(ME)R guidelines. Radiographers told us that there was an open reporting culture in relation to incident reporting and that their line managers encouraged staff to report incidents where applicable. Between May 2015 and November 2015 the trust had reported incidents to the Care Quality Commission. The trust was not an outlier for diagnostic imaging, nuclear medicine or radiotherapy. The number of reports was within the expected range and was similar to other trusts when compared with the same level of activity.

Cleanliness, infection control and hygiene

- Outpatient clinics and diagnostic imaging areas were visibly clean and well maintained.
- The infection control team carried out monthly audits to ensure the cleanliness of facilities and equipment. We saw equipment that had been cleaned and was labelled as ready for use.
- Monthly infection control audits were carried out in relation to hand hygiene, with compliance across all outpatient departments being between 91% and 100% against a trust target of 95% from January to October 2015. There were no notice boards in waiting areas to inform patients of the department infection control performance.
- Audits of 'bare below the elbow' in outpatient departments showed compliance of between 97% and 100% against a trust target of 95% from January to October 2015.
- In all clinical areas there was good evidence of personal protective equipment (PPE), such as gloves and aprons being available and used appropriately by staff.
- Handwashing facilities were available in all clinical areas and hand gels were provided for staff and patients in all communal and clinical areas. We found one hand gel dispenser empty in the Ladybird Clinic, but this had been reported to reception by a patient. The receptionist had arranged for it to be replaced.

Outpatients and diagnostic imaging

- In the outpatient department there were limited signs that directed patients and visitors to use hand gels dispensers.

Environment and equipment

- There was appropriate access to resuscitation equipment in each clinical area.
- The resuscitation trolleys in outpatients and diagnostic imaging had been checked daily against a check list, and all the equipment was found to be in-date.
- The environment in outpatients and diagnostic imaging was clean and well maintained.
- In the outpatient department managers had a detailed list of the equipment in the department and when it was due for a maintenance check. This enabled staff to have an overview of the testing dates. The equipment we looked at had all been checked, and portable appliance testing were all in date.
- In diagnostic imaging there was appropriate signage to alert patients to potential radiation hazards in relevant areas.
- Records showed that the radiation protection adviser had done checks on X-ray equipment every six months.

Medicines

- Medicine cupboards were locked and secured, and drug fridges were checked and in order. Fridge temperatures were checked and recorded daily and were in line with national guidance.
- Prescription pads were stored securely in lockable drawers with serial numbers recorded and checked.
- There were patient group directions in outpatients (PGD). In diagnostic imaging, all PGD's were in date and in accordance with trust guidelines.

Records

- Electronic medical notes were available for all patients attending outpatient clinics. Clinic letters were scanned onto the Electronic Patient Record (EPR). Clinicians reported some disruption to clinics when the new EPR system had been implemented, but as staff got used to using the new system, they felt the disruption had reduced.
- Outpatient administration staff prepared a green folder for each patient prior to consultation. The folder contained the latest patient referral letter, a blank clinical history sheet and a set of patient address labels. The trust scanning team scanned the completed history sheet, and any additional documentation, onto the patient electronic record after the appointment. This ensured the continuity of patient information for future attendance at the hospital. Once scanned, the paper notes were destroyed securely
- The trust identified that 0.01% of patients had been seen without their full medical record.
- Medical staff told us that everything they needed was on the system, including diagnostic results. However, some patient information was difficult to find because of the way it had been scanned and filed. There were incident reports detailing how patient records had been mis-filed. Medical staff identified that patient information could be missed if not filled in chronological order, and this was a risk when planning care and treatment.
- The trust was responding to feedback and was developing ways in which the administrative support for the IT system could be improved. Senior managers in outpatients confirmed they are working closely with trust in-house document scanning team and outsourced scanning company to ensure better accuracy when filing.
- In diagnostic imaging the picture archiving and communication (PACS) system was in place to view images that had been taken at other local hospitals. A further electronic system was in use that allowed radiology staff to review images generated within 98% of the hospitals in England.

Safeguarding

- Staff knew how to report safeguarding concerns. They knew how to access further advice on the trust intranet if required, and had felt well supported by their line managers if they had encountered more complex safeguarding issues.
- Seventy Nine percent of staff in outpatients and diagnostic imaging had completed their level 2 safeguarding training, as at 31 December 2015. We saw reports that showed department managers regularly review mandatory training compliance.

Mandatory training

- Mandatory training included; infection control, health and safety, fire safety, equality and diversity, manual handling, adult basic life support and safeguarding.

- The training was booked on the trust electronic system. Some training was available as e-learning, and some face to face in a classroom environment.
- Staff referred to the 'red, amber, green' colours which alerted them when their mandatory training was coming close or due to be renewed on the electronic staff record. Staff were able to book into available training slots, and told us that they had no difficulty in being given time off to complete their mandatory training.
- Line managers and staff were alerted when a member of their team was due for their mandatory training. This enabled them to monitor staff compliance with their mandatory training.
- Mandatory training across outpatients and diagnostic imaging departments was 81%, against the trust target of 95%, as at 31 December 2015. Managers were aware of the non-compliance and were providing training time for individual members of staff.

Assessing and responding to patient risk

- All staff understood the procedure to follow should a patient collapse or become acutely unwell in the outpatient or diagnostic imaging departments.
- In the outpatient and diagnostic imaging departments, Staff were told us that they would look at a patient's observations and record them in the patient record. The department did not use the national early warning score, to identify a patient whose condition might deteriorate. Written guidelines were available for staff to follow when managing an unwell patient or visitor in outpatients. Staff we spoke with were aware of these guidelines and directed us to them for review.
- Within the imaging department signs alerted patients, and information was provided in waiting areas, where radiation exposure would be taking place. There were also signs and posters to remind women who may be pregnant to inform the radiographer before their X-ray.
- There was a Radiation Protection team and a Radiation Protection Supervisor to provide advice and ensure the requesting of X-rays is in line with IR(ME)R guidelines.
- In interventional radiology, a thorough risk assessment process was followed. Prior to any procedure commencing, the clinician used a modified WHO safety checklist to address key clinical risks within the environment, there were clear patient protocols in place.
- Staff referred to the Royal College of Radiologists standards for the administering of intravascular contrast.
- Radiation exposure details in the form of diagnostic reference levels, local rules and guidelines were displayed in imaging rooms.

Nursing/Radiography staffing

- In the outpatient department there is no acuity tool used within outpatient departments to plan staffing levels. There were few vacancies across the service, and recruitment was underway to fill the vacant posts.
- Bank staff were used to fill gaps in staffing. Induction was thorough. New bank staff were initially supernumerary and had to complete a competency checklist before being able to work unsupported in clinical areas. No agency staff were used in the outpatient department.
- Outpatients provided placements for student nurses.
- In diagnostic imaging, staffing was a concern. There were five radiographer vacancies across magnetic resonance imaging (MRI) and CT, four for CT and one for MRI. This accounted for 25% of the workforce. Staff reported heavy workloads and concerns with the demands on the on-call rotas.
- As a result of staffing concerns in radiology several agency staff were present to support the service, two in CT and one in MR, as well as support in the general x-ray department from agency and bank staff.

Medical staffing

- Senior nursing staff told us that there were adequate levels of consultant cover for all outpatient clinic specialities. The outpatient management team organised the consultant rota to ensure suitable cover for all clinics.
- Consultant appointment times were allied to clinic times. The outpatient department was generally opened from at 8am to 6pm with appointments from 8.30am to 5pm.
- Nursing and radiography staff felt that the radiologist cover was adequate.
- There were 16 consultant radiologists working in Poole hospital. Each radiologist had an area in which they specialised, however they were able to sub specialise which provided good cover across the department.

Outpatients and diagnostic imaging

- Consultants in outpatients confirmed that they had good working relationships with junior doctors in the trust.

Major incident awareness and training

- Major incident awareness training was available to all new staff during the corporate induction programme. Training records indicated that this was carried out during induction.
- In the outpatient department there was a folder in the nurse's office where the major incident policy and responsibilities for the department were kept.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

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

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

- People's care and treatment was planned and delivered in line with current evidence-based guidance, standards, best practice and legislation. This was monitored to ensure consistency of practice. Radiography staff followed the Royal College of Radiology standards.
- There was good evidence of local and national audit.
- There was good evidence of multidisciplinary team (MDT) working practices.
- Seven day services were available in diagnostic imaging for inpatients. Diagnostic imaging provided a 24hour service for X-ray, MRI and CT scans both during the week and at weekends.
- Staff had a good understanding around consent procedures and there were clinical protocols and comprehensive consent documentation in place. There was good understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards which ensures that decisions are made in patients' best interests.
- Most staff in outpatients had received an annual appraisal and felt able to access relevant training to update their clinical skills specific to their roles.
- In radiology appraisal rates were particularly low compared to the trust target. Senior managers had identified this and the situation was being managed. The reason was attributed to low staffing levels and heavy workloads.
- Some staff in radiology felt unable to take time to undertake additional training to develop their skills due to heavy workloads. Staff in radiology expressed concerns regarding the seven day working and the impact on the on-call rota.
- Students were offered placements in outpatient and diagnostic imaging teams.

Evidence-based care and treatment

- Outpatient services took account of the relevant National Institute for Health and Care Excellence (NICE) guidelines to treat patients.
- In diagnostic imaging there was written evidence of good clinical protocols. There were comprehensive examples of specialist consent forms in place, which were observed being used in everyday practice.
- There was good evidence of adherence to local policies in diagnostic imaging. For example, the 'pause and check' system to ensure the correct identification of patients prior to imaging was observed to be used in everyday practice.
- In outpatients, the fracture clinic was set up around a central hub. Doctors, nurses and therapy staff would review images centrally prior to the patient consultation. Patients were allocated to a consulting room and the most appropriate member of staff would attend the patient, having already discussed the patient's condition as a team. The patient therefore received a better experience as scans were reviewed and discussed prior to consultation.

Patient outcomes

- In radiology, there was evidence of participation in local and national audits, these included the CT colonography audit, national dopamine transporter scan (DaTSCAN) audit and infection control.
- The follow up to new appointment rate for outpatients was 2.0 which was lower (better) than the rate for England, which was 2.4 (July 2014 to June 2015).

Outpatients and diagnostic imaging

Competent staff

- In outpatients 97% of nursing and clerical staff had completed an annual appraisal. The trust target was 95%. Managers were able to demonstrate the reason why staff had not received an appraisal. This was mainly due to long term staff absence.
- In diagnostic imaging 85% of staff had received their annual appraisal. The low rate of compliance was attributed to the low staffing rates. Senior managers were addressing this by allocating trained staff to carry out appraisals for those who had not had one.
- Staff across outpatients and diagnostic imaging felt there were good opportunities to develop professionally. They were offered training to update their skills and knowledge relevant to their post. Staff reported that they did not always have the time to carry out training due to heavy workloads.
- The trust encouraged a 'grow your own' ethos in relation to staff development. For example, health care assistants in outpatients told us that they had been offered the opportunity to study to become registered nurses. Two health care assistants had commenced their nurse training in September 2015 and had been sponsored by the trust.
- The outpatient department provided placements for student nurses. Student nurses we spoke with felt supported in their placements. Students had mentors, access to training and development opportunities. Students we spoke with confirmed good corporate and local induction.
- Nursing staff were aware of the requirements for revalidation and what their responsibilities were. They had received some information from the trust in relation to this.

Multidisciplinary working

- All nursing staff across the outpatients department told us that they had good working relationships with the consultants from each speciality. They felt that effective communication with medical colleagues improved a patient's experience within the department.
- Staff told us that the multidisciplinary team (MDT) worked well. Nurses, radiographers, surgeons, radiologists and oncology specialists worked together to ensure that patients received the best possible care and treatment. Documentation confirmed that well supported MDT meetings took place when required.
- Teleconferencing systems were used effectively to enable MDT meetings between neighbouring trusts. This meant clinicians could attend meetings without the need for travel.
- In diagnostic imaging, staff told us they felt well supported by the radiologists. They felt part of a team where everyone was recognised for their individual contributions. The team priority was to ensure that patients were given the best possible treatment.

Seven-day services

- Outpatient appointments were offered Monday to Friday 8:00am – 5:00pm. Clinics were sometimes held at weekends to meet demands on the service.
- In diagnostic imaging, outpatient appointments were available Monday to Friday between 8:00am – 5:00pm. Since January 2016 diagnostic imaging had been providing a seven day service for outpatients.
- Two radiographers were available overnight and at weekends for inpatients that required plain film X-rays, with an on-call radiographer available for computerised tomography (CT) scanning. These services were also available for patients using the emergency department.
- A radiologist was available on site between 9:00am – 6:00pm on weekdays (5:00pm weekends) and on call off site between 6:00pm – 10:00pm on weekdays (5:00pm – 10:00pm weekends). Between 10:00pm – 8:00am, radiology support was outsourced to an external service provider.

Access to information

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

Outpatients and diagnostic imaging

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff had an understanding around consent procedures and how patients should be supported in every day practice. There was good evidence of consent being sought and comprehensive documentation being used in interventional radiology.
- Staff could not demonstrate a good understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards, to ensure decisions were taken in a person's best interest. There was no specific training provided by the trust in relation to this.

Are outpatient and diagnostic imaging services caring?

Good

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

We rated caring as 'good'.

- Patients provided examples of their experiences of a good standard of care from staff across outpatients and diagnostic imaging services. During our inspection, we observed compassionate, caring interactions from nursing, medical and radiography staff. There were examples of staff supporting patients and their relatives who were distressed.
- Nurses greeted patients warmly in outpatient clinics and introduced themselves straight away.
- Staff knocked on doors and waited for a response before entering. In diagnostic imaging and in the breast clinic, there were privacy screens to separate patients who were undressed for examinations from other patients within the waiting room.
- Patients told us that they were included in the decision making regarding their care and treatment and staff recognised when a patient required extra support to be able to be included in understanding their treatment plans.
- Staff demonstrated a real understanding of the support needed for patients that were in physical discomfort and took time to provide the additional care that they required. Staff demonstrated good communication skills and made patients feel welcome within the department.
- Staff used quiet rooms in order to provide emotional support when giving bad news to patients or relatives.
- Chaperone signs were on display in waiting areas and we observed staff asking patients respectfully if they required a chaperone during their consultations, to protect their dignity.

Compassionate care

- We saw positive interactions between nurses, radiographers, medical staff and their patients. All staff clearly enabled supportive relationships with patients and their relatives.
- Staff provided examples that demonstrated where they had gone beyond expectation to support patients. For example, when clinics were running late recognising that this causes a lot of stress for patients, we heard staff advising patients to wait in the cafe adjacent to the clinic. Staff advised them that they would then go and collect them when their appointment was due. Staff told us they would wait with patients after their shift had finished if patient transport was delayed.
- Staff approached patients proactively rather than waiting for requests for assistance. Help and advice for patients was always available. For example, volunteers were positioned in the entrance to the main outpatient department to assist patients using the self-check in system.
- Chaperone signs were not displayed across outpatient and diagnostic imaging waiting areas. However, staff were observed asking patients if they required a chaperone during their consultation.
- Staff knocked on doors and waited for a response before entering to support the patient's privacy and dignity.
- The Friends and Family test had been completed recently. The results showed that 88% of patients completing the survey agreed that they would recommend the hospital to family and friends.

Understanding and involvement of patients and those close to them

Outpatients and diagnostic imaging

- All the patients we spoke with felt well informed and involved in the decision making regarding their care and treatment.
- We observed staff explaining issues to patients and families in a way they could understand. Staff employed different techniques to ensure effective communication. Staff recognised when patients required extra support to be able to become involved in their treatment plans.

Emotional support

- Staff demonstrated understanding of supporting patients who were distressed or in physical discomfort and took time to provide the additional care that these patients required. For example we observed staff supporting a patient in x-ray who was confused and disorientated in a calm and compassionate manner. The radiographer was able to complete the scan quickly and efficiently without upsetting the patient.
- Staff treated patients with dignity and respect, and recognised individual patient's needs.
- We observed staff as they realised and took action for patients who were in distress or anxious, before they had voiced or demonstrated this concern.
- Staff used quiet rooms for patients who had been given bad news and the trust chaplaincy service was available to support patients if required.

Are outpatient and diagnostic imaging services responsive?

Good

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

We rated responsive as 'good'.

- Services were planned and delivered to meet the needs of the local population. The environment was appropriately planned for the delivery of the service and to meet patients' needs.
- Therapy services had been re-designed to meet the needs of their patients. Hospital therapy teams were rotated into community settings, with community teams coming into the hospital. This provided staff with a greater understanding of patient needs.
- 'Did not attend' rates were lower (better) than the England average and phone calls and texts were used to remind patients of appointments.
- The national standard for referral to treatment for patients to wait less than 18 weeks was consistently being met. Cancer waiting times for urgent referral appointments within 2 weeks were also being met.
- The trust short notice cancellation rate for appointments were lower (better) than the England average.
- The trust reported that 6.2% of patients waited over 30 minutes to see a clinician.
- Patients whose first language was not English had access to an interpreter. Staff would access the service through the trust intranet, although some staff were not aware of how to use this service.
- Some outpatient reception areas had self-service touch screen booking in facilities which offered a booking in facility in other languages. There were quiet rooms available for patients who had been given bad news and the trust chaplaincy service was available if required.
- There were privacy screens in waiting areas, once in gowns patients waited in mixed sex areas behind the privacy screens.
- The service received very few complaints, and concerns were resolved locally, evidence was seen that changes were made as people raised concerns.

Service planning and delivery to meet the needs of local people

- Outpatient administration staff managed the specialty clinic lists. The outpatient nursing team as a department provided the nursing staff and room capacity to meet the needs of the clinics. The diagnostic imaging department offered a GP appointment service from 8.30am to 5pm, Monday to Friday.
- Blood test appointments were offered by booked appointment system from 7.30am to 5.50pm, Monday to Friday, and 8am to 12pm on Saturday. The department would also accept some GP walk-in patients who had not booked an appointment.

Access and flow

- In outpatient services, some patients used choose and book to arrange appointments that were at a suitable time for them.

Outpatients and diagnostic imaging

- In diagnostic imaging, electronic booking same day appointment facilities were available, which decreased the waiting times for patients requiring a more urgent review.
- 'Did not attend' rates had increased from 6.5 to 7.0% (April 2015 – October 2015); the England average was 7.8%. Phone calls and texts were used to remind patients of appointments.
- For the period April 2015 to December 2015, the trust achieved the referral-to-treatment (RTT) standard for incomplete pathways of 92% in every month and was above the England average for the same period.
- For the period April 2015 to December 2015 the RTT target of 95% of patients who were waiting less than 18 weeks to start treatment that did not involve an admission (non-admitted pathway) was not met at 92.8%.
- For the period April 2015 to December 2015 the national standards for cancer wait times were being met and the trust was consistently above the standard. This included 99% of people whose first consultant appointment was within two weeks of an urgent GP referral, 98.8% of people who waited at most, one month from a decision to treat to a first treatment for cancer. Eighty four point nine percent of people who waited at most two months from urgent GP referral for a first treatment for cancer wait clinics.
- In diagnostic imaging, for the period April 2015 to December 2015, overall less than 0.98% of patients experienced diagnostic waiting times of more than six weeks. This is better than the England average of 2.5%.
- In the period April 2015 to September 2015, an average of 6.2% of patients waited over 30 minutes to see a clinician. In outpatient clinics, there were television screens displaying the current waiting times for patients. We heard reception staff using a tannoy system to advise patients of delays in clinics. Some clinics without electronic facilities advised patients of clinic delays using notice boards.

Meeting people's individual needs

- The environment in outpatients and diagnostic imaging had adequate seating arrangements for patients to wait for appointments, X-rays and scans. At busy times the waiting area for blood tests was sometimes full and we saw patients queuing out into the corridor. However, during the inspection period, these queues quickly subsided.
- All the waiting areas, consulting and imaging rooms were all accessible to patients with disabilities.
- In clinical areas there was adequate provision to maintain a patient's privacy and dignity. Doors to clinic rooms were all closed during patient consultation. Where patients needed to change into gowns, for an X-ray for example, the changing facilities we suitable to enable privacy to be maintained.
- Waiting areas in outpatients and diagnostic imaging were spacious. Signs were adequate but it was recognised by the trust that signage within the hospital needed to be reviewed and this was an on-going improvement project.
- The outpatient clinic areas were split into four coloured areas – yellow, blue, red and green, to help patients navigate around the department. Each clinic had a separate reception and generally the same specialties used the same clinical area.
- There were separate booking desks for both outpatients and radiology located within the outpatient department where patients could query or arrange, in person, their next appointment.
- There was no signage in the department in other languages, and no information leaflets were available in any other languages. However, on request patients could be provided with information leaflets in other languages via the Patient Liaison and Advice service.
- At the entrance to the outpatient department a self-service touch screen booking in facilities were available. They provided patients who did not speak English as their first language with the option to book in for appointments in their own language. In the main outpatient department a member of the outpatient nursing staff or a hospital volunteer was available to assist patients using the self-service facilities. All patients had to use this service before going to the appropriate colour coded clinic reception.
- The trust had an interpreter service. Interpreters were available over the telephone or would attend in person to support patients during their consultations. Not all staff demonstrated had knowledge of this service or how to access it.
- Staff gave good examples of where reasonable adjustments were made for patients who lived with dementia. Dementia 'champions' had been trained and supported the outpatient team as a whole by providing

advice and support when required. Nursing and radiography staff told us that if a patient was particularly distressed due to dementia, they would be prioritised in the clinic list.

Learning from complaints and concerns

- There was information in the waiting room to inform patients how to make a complaint. Staff advised us that they give patients who express a concern a PALS leaflet.
- In the period January 2015 to October 2015, the outpatient department received 68 complaints (of which 13 were upheld). These were categorised by the trust into four main themes relating to: appointment delays or cancellations, attitude of staff, communication to patients and queries regarding clinical treatment. These had been responded to in a timely way and with an appropriate explanation or apology.
- Where complaints were upheld action plans had been put into place to improve the service or change behaviour. The ranged from additional customer service training for staff to reviewing departmental processes.
- Patient feedback was sought and welcomed across the trust. This feedback was obtained from patient surveys and comment cards. The comments were largely positive.

Are outpatient and diagnostic imaging services well-led?

Good

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

We rated well-led as 'good'.

- The outpatient department had a strategy that was aligned to the values and vision of the trust. There was an on-going outpatient transformation project which was reviewing the effectiveness of the department. The outpatient department strategy included recruitment and retention of staff, both clinical and clerical. Staff were not specifically aware of how the strategy would develop in their department but expressed an awareness of the vision and values of the trust.
- Governance processes in the outpatient department were at divisional level, and were well developed to manage risk and quality. Information about incidents and patient experience was shared among staff. Risks were collated at service and divisional level. Governance processes in diagnostic imaging were overall, well developed and effective.
- Staff in outpatients spoke highly of their immediate line managers. Medical staff told us the service worked very well in radiology with good relationships between medical staff and radiographers. They continually told us they felt well supported and valued. Staff told us that they enjoyed working for the trust due to the strong team support from colleagues.
- Public and patient engagement occurred through feedback such as surveys and comment cards.
- Leadership in outpatients was strong both in the nursing and administration teams. There was effective engagement with staff through team meetings and knowledge sharing.
- Managers in outpatients had formed relationships with peer groups in neighbouring trusts to share best practice and ideas to develop the service.

However,

- Staff in diagnostic imaging were less positive about senior management. They did not always feel supported and reported that concerns were not always listened to or that concerns were appropriately dealt with. Departmental meetings were not held frequently.
- Staff reported changes to the seven-day service, within diagnostic imaging, was poorly implemented.

Vision and strategy for this service

- Not all staff were not clear about the specific aspects of the trust wide outpatients strategy with regard to the outpatient transformation project. However, some outpatient staff had been involved in patient engagement events. Most staff told us that their main vision for the departmental service was continually improving the patient experience and providing them with high quality care.
- In diagnostic imaging there was a strategy to develop seven day services. The plan included, developing the skill mix of staff, for example, the training of radiographer assistants, increasing capacity, developing

education opportunities to develop and retain staff locally. As well as integration of the diagnostic imaging service across sites, so that clinical and administrative processes were aligned.

Governance, risk management and quality measurement

- The outpatient department held monthly performance review meetings, to which all senior staff were invited. Governance issues were emailed out to all the outpatient staff, this included patient experience comments and data. However, information on clinical risks and complaints was not shared widely with staff.
- Diagnostic imaging services held monthly governance meetings. During these meetings radiation protection issues were discussed. Radiation protection meetings were held twice per year and the minutes from both meetings were disseminated to all staff by email. Staff told us that they felt they were kept up-to-date in relation to governance issues.
- In outpatients the senior nursing staff met monthly. The focus of this meeting was incident reporting and learning from incidents. Evidence was seen in relation to these meetings and copies of the minutes were kept in the nurses' offices.
- The outpatients and diagnostic imaging departments had their own risk registers which formed part of the divisional risk register. Risks were identified and mitigating actions being taken were recorded. The highest risk was identified as the difficulty in finding chronological patient medical information on the electronic patient record. This had been escalated to the trust risk register.

Leadership of service

- Staff in outpatients spoke highly of their immediate line managers. They consistently told us that they felt well supported and valued. Staff felt confident that they could go to their direct supervisors with any concerns or feedback they might have, and that it would be acted upon fairly and professionally. The staff in outpatients frequently saw the outpatient service lead and nurse manager.
- Some staff in outpatients and diagnostic imaging felt that the executive team provided a strong, visible presence within the trust. Some staff had spoken to the CEO and found her to be approachable and accessible. Staff did not feel that other board members were as visible within the trust. In diagnostic imaging staff felt less positive about support from senior management. Staff told us that the introduction of seven-day working was poorly managed. Implementation of the new service was rushed, some areas were given only 24 hours' notice to change rotas. This had a negative effect on morale within the diagnostic imaging department and had impacted on the ability of the team to cover some rotas effectively.
- In diagnostic imaging, staff shortages and increasing workloads have meant that departmental staff meetings had not been held regularly. It was reported that when meeting are held there was a poor turnout due to staff availability. Staff were concerned therefore that they did not have an opportunity to meet, share ideas and discuss concerns with management.

Culture within the service

- Staff at all levels spoke of the 'Poole Approach' which is a patient-centred culture embedded across the whole trust.
- All staff we spoke to across outpatients and diagnostic imaging told us that their teams and the supportive relationships forged with their colleagues were the main reasons they enjoyed working for the trust.
- Most staff had been in post for a significant number of years and really felt part of the outpatients or diagnostic imaging team as well as part of the trust as a whole.
- Staff demonstrated by what they told us and how they interacted with patients that the provision of high quality care for patients was at the forefront of their daily practice. We saw staff supporting each other to ensure the best possible service was provided for all patients.

Public engagement

- Quality was measured by survey, comments cards and the friends and family test results. 'You said, we did' boards were displayed in some patient waiting areas Comments cards and patient satisfaction surveys had taken place within outpatients and diagnostic imaging.
- During November 2015 staff in outpatients held a listening event with patients. Patients were asked ten questions regarding their experience of their outpatient visit. At the time of inspection the results of the event had not yet been published. It was hoped that the feedback would provide the outpatient team with suggestions for improvements.

Outpatients and diagnostic imaging

Staff engagement

- The trust produces a quarterly newsletter, called Grapevine. The newsletter detailed news, achievements and developments for and by staff, volunteers and supports of the hospital. The newsletter included mentions for members of staff who had been employed by the trust for certain significant periods of years.
- Minutes of meetings showed the outpatient nursing management team met regularly with the OPD nursing staff. They discussed and fed back on various topics including training, complaints and infection control.
- Due to staff shortages and increasing workloads, staff engagement in diagnostic imaging was a challenge. Team meetings were held infrequently and attendance was poor. Managers were looking at different ways of sharing information for example, by developing a department newsletter. However, at the time of inspection this was not yet in production.

Innovation, improvement and sustainability

- In outpatients the lead nurse is forging inter-professional relationships with colleagues in neighbouring trusts. This is a forum to share ideas and best practice. An initial meeting has been held to outline the format of future meetings.
- The nuclear medicine department demonstrated innovation introducing two new radiopharmaceuticals based on scientific evidence. The medical physics department had developed a new dental phantom, which had developed in to a commercial product.
- In non invasive cardiology in CT and MRI imaging had developed non-invasive cross sectional cardiac imaging. This development has reduced the need for invasive tests on patients with low and medium risk of coronary disease whilst ensuring high risk patients are transferred quickly to Bournemouth. There is excellent team working between cardiology and radiology to provide this service

Outstanding practice and areas for improvement

Outstanding practice

- The trust had developed a set of values called "The Poole Approach". The Poole Approach was established in the early 1990s as a philosophy of care. It pledges thatstaff at Poole Hospitalwill strive at all times to provide friendly, professional, patient-centred care with dignity and respect for all. These values were well embedded with staff working in the hospital. Staff were consistently kind and compassionate, putting the patient at the centre of care. Receptionists at the front door made a concerted effort to put any visitors or patients at ease, and this level of high support and regard continued throughout the hospital. Staff told us they were encouraged, no matter how busy, to stop to take time to help or reassure anyone in the hospital.
- The rapid assessment consultant evaluation (RACE) unit provided a high multi-disciplinary quality of care specifically for older patients, over the age of 80. The unit provided a seven day service and was reducing the number of elderly patient admissions and the length of stay for elderly patients that were admitted.
- For neonates, children and young people receiving palliative care, the trust had designed a special unit called the Gully's Place Suite. This was a purpose-designed space which provided privacy and dignity for parents and families of babies, children and young people who required palliative and end-of-life care.
- Nuclear medicine was an exceptionally well led multidisciplinary service. Despite an increasing workload, with no breaches of waiting times. Patients interviewed confirmed an outstanding level of care, information to provided patients and concerns responded to appropriately. The department has also safely introduced two new radio pharmaceuticals based on scientific evidence. Medical physics have developed a new dental phantom; a commercial product.
- Non-invasive cardiology in CT and MRI imaging have reduced the need for invasive tests on patients with low and medium risk of coronary disease whilst ensuring high risk patients are transferred quickly to the neighbouring NHS hospital. There is excellent team working between cardiology and radiology to provide this service.

Areas for improvement

Action the hospital MUST take to improve

Action the hospital MUST take to improve

To ensure

- Action is taken to improve the cleanliness of clinical areas at St. Marys hospital and this is monitored to ensure good infection control practices.
- Delivery rooms meet with Department of Health regulations
- A review of the midwifery staffing to ensure sufficient staff are available to provide one to one care in labour.
- Medicines are stored at the appropriate fridge temperature and are recorded daily.
- Medicines are stored safely and securely including intravenous fluids. This should be in line with current legislations, trust's policies and standard operating procedures.
- Appropriate dates are placed on medicines once opened.
- Patient group directions are correctly completed and in-date for staff to use.
- Flooring is accessible for cleaning purposes and that equipment is clean and protected from dust.
- There is a process for calling for emergency assistance in the theatre complex.
- There is appropriate support for patients with a learning disability including better flagging and referral for patients to specialist.
- Equipment on the wards is in date and stored in a safe manner.
- The five steps to safer surgery checklist is appropriately completed.
- Review the emergency theatre arrangements to ensure patient safety and wellbeing is not adversely affected.

Outstanding practice and areas for improvement

- The staffing levels and skills mix is assessed in all areas and staffing is delivered as planned.
- Patient records are securely stored so as not to breech patient confidentiality and to prevent unauthorised access, particularly in medicine and maternity departments.
- All staff participate in mandatory training.
- Risk register includes all factors that may adversely affect patient safety.
- Learning from incidents are embedded in practice.
- Implement a flagging alert system to identify Looked After Children within the trust
- Ensure secure access arrangements are in place to the paediatric unit out of hours.
- Implement policies and protocols for children and young people for absconding or for restraint.
- Patients and members are informed of the public of the safety thermometer results.
- Where relevant, DNA CPR forms must be endorsed by a consultant grade doctor.
- There is a clear and measurable action plan which details how they will improve patient outcomes with regard to the organisational targets and key performance indicators as measured in the National Care of the Dying Audit.
- Service leads review how they use data to improve patient outcomes.
- An end-of-life care policy is developed that addresses the withdrawal and withholding of life-sustaining treatment for critical care patients.
- End of life care patients are given sufficient opportunity to identify their preferred place of care.
- There are no mixed sex breaches in critical care.

Action the hospital SHOULD take to improve

Action the hospital SHOULD take to improve

To ensure

- Consultant presence in the delivery suite meets the Royal College of Gynaecologists and Obstetricians guidelines.
- Clear guidelines for staff regarding the maximum numbers of women accepted the induction of labour.
- Conduct a needs analysis to ensure the service is meeting the needs of the local population.
- Develop clear plans to deliver the maternity service strategy.
- Encourage improved working relationships between senior midwives and their managers.
- Patients in the department are correctly identified with name bands in a timely way.
- Review necessary improvements to achieve referral to treatment time targets.
- There is a process used for monitoring requests for agency and bank nurses and whether they are fulfilled or not
- Patients are given the opportunity to wash or clean their hands before meals.
- Staff check equipment regularly, and equipment is maintained or replaced in line with trust policy.
- Staff complete risk assessments and actions required to reduce risks to a patient, in a timely way.
- Appropriate arrangements happen with the local mental health trust to improve patient assessment and out of hours support.
- Staff are offered regular supervisions and appraisals to promote staff development.
- Training provision should ensure all staff have an accurate understanding of the trust's deprivation of liberty safeguards policy.
- Improvements in the care pathways for stroke and heart failure are embedded and sustained.
- A decrease in the number of bed moves, and patients moved overnight.
- An increase in the number of complaints responded to within 25 working days.
- Delayed discharges from CCU should be improved including out of hours discharges from the unit.
- Resuscitation trolleys in the critical care unit should be tamper-evident.
- Mandatory training updates for critical care staff should meet trust targets ensuring staff complete updates in essential and core training.
- Development of a safety checklist for patients undergoing invasive procedures such as insertion of central venous catheters.
- Access to a follow-up clinic for patients discharged from the critical care unit should be further developed and to include better access for psychological and other support.
- The hospital improves the access and flow of patients in order to reduce delays from critical care for patients being discharged to wards.
- There is dedicated dietetics support for patient in critical care.

Outstanding practice and areas for improvement

- Policies and procedures should be regularly reviewed to provide up to date guidance for staff including withdrawal of treatment policy.
- Support and develop the paediatric service so it can deliver service-wide strategy and vision.
- Outpatient clinics are planned to meet the specific needs of children.
- Play therapists are used by the outpatient department to help children cope during outpatient procedures.
- Documents within electronic records for patients are filed appropriately once scanned to enable clinicians to find relevant information effectively.
- Departmental and team meetings are held at an agreed frequency to enable good communication between managers and staff.
- Seven day service provision in diagnostic imaging is reviewed and monitored to ensure stability of staffing.
- Managers in diagnostic imaging provide forums for staff engagement.
- All staff within outpatients and diagnostic imaging are aware of the department strategy.
- There is an agreed set of performance indicators for end of life care to measure service quality in a timely manner.
- Staff working across end of life have a sound understanding of the CHC funding process and are able to identify patients that may be eligible for fast track discharge home to die.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Dignity and respect Regulation 10(2) (a) People's privacy and dignity were not maintained at all times. · People should have access to appropriate and segregated washing and toilet facilities to meet their individual needs and promote their privacy and dignity.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014: Safe care and treatment 12 (1) (2) (d) (e) (f) (h) People who use services and others were not protected against the risks associated with unsafe care or treatment. · Medicines management were not in line with current legislation · There should be a process for calling for emergency assistance in the theatre complex. • The five steps to safer surgery checklist was not always appropriately completed.

This section is primarily information for the provider

Requirement notices

- Emergency theatre arrangements required review to ensure patient safety and wellbeing is not adversely affected.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3) Regulation 15(1)(a) (c),(2) Premises and equipment must be kept clean and cleaning must be done in line with current legislation and guidance. Areas in the delivery suite and ANDA were visibly dirty. Flooring needs to be accessible for cleaning purposes and equipment should be clean and protected from dust. Premises must be suitable for the service provided and be big enough to accommodate the potential number of people using the service at any one time. The delivery rooms were not big enough to accommodate resuscitation equipment or specialist people in the event of a baby requiring resuscitation.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3) Regulation 17(2)(c)

This section is primarily information for the provider

Requirement notices

Records must be stored in accordance with current legislation and guidance. Records on wards and B2 and in the delivery suite were not securely stored to prevent unauthorised access.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3) Regulation 18 (1) (2) Staffing** • Midwifery staffing levels has not been assessed and staff were unable to provide one to one care in labour • There were not suitable numbers of staff or skill mix as planned on medical and elderly care wards. . • Paediatric nurse staffing levels had not been assessed and there was staffing levels as planned for the paediatric wards • The staffing levels for radiographers was as planned and current working patterns were not sustainable. • Compliance with mandatory training needs to improve.