

Yeovil District Hospital NHS Foundation Trust

Yeovil District Hospital

Quality Report

Higher Kingston

Yeovil

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

Ratings

Overall rating for this hospital

Requires improvement



Urgent and emergency services

Requires improvement



Medical care (including older people's care)

Requires improvement



Surgery

Good



Critical care

Good



Maternity and gynaecology

Requires improvement



Services for children and young people

Requires improvement



End of life care

Requires improvement



Outpatients and diagnostic imaging

Good



Summary of findings

Letter from the Chief Inspector of Hospitals

The Care Quality Commission (CQC) carried out a comprehensive inspection between the 15 and 17 March 2016. We also carried out an unannounced inspection on 24 March 2016. We carried out this comprehensive inspection at Yeovil District Hospital Foundation Trust as part of our comprehensive inspection programme. The trust has one main location.

The hospital opened in 1973 and was established as an NHS Foundation Trust in June 2006. The trust delivers services to a population of approximately 200,000 primarily from the rural areas of South Somerset, North and West Dorset and parts of Mendip. The trust provides outpatient and inpatient consultant services for a range of specialties primarily from its main site Yeovil District Hospital. It also provides outpatient and diagnostic services in a number of hospitals in the surrounding area, including the Yeatman Hospital in Sherborne and Wincanton, Crewkerne, Chard and South Petherton community hospitals. We did not review the care at the community hospitals at this inspection. At previous inspections the trust had been found to be compliant with the regulations we reviewed.

At this inspection we found that the trust was working hard with other stakeholders to improve the services offered to the local community. We found a highly committed workforce who put the patient at the centre of care. We saw some examples of very good practice which included the stroke buddying group and the ways in which maternity staff were involving vulnerable young women in maternity care. However we also found an emergency department which when under pressure was not responsive to the needs of patients. We struggled to understand the rationale for placing adult patients on the children's ward and had to formally request information and reassurances from the trust around the safety of doing this. We found that the trust were responsive to the concerns we raised on and after the inspection and put in place actions to address these.

Our key findings were as follows:

- Staff were caring in delivering care to patients. We observed many examples of compassionate care which staff delivered to patients with respectful and considerate approaches.
- Feedback from patients, relatives and carers was positive throughout our inspection.
- Staff were proud to work at Yeovil District Hospital. We found staff were part of a hospital based community in which staff worked together to try to meet the needs of patients.
- In many areas staff felt well supported by their line managers and were aware of the trust's vision and strategy. Many staff were aware of the trust's iCARE strategy which incorporates the values of communicate, attitude, respect and environment.
- We saw most staff complied with infection prevention and control best practice in relation to hand washing and remaining bare below the elbow. However, this was not consistent throughout the hospital.
- Most areas of the hospital were visibly clean however we found equipment was not always stored appropriately and in a way which controlled and reduced the risk of infection.
- Protected meal times were in place and staff offered patients food and drinks. Most areas assessed patients for their risk of malnutrition however we found nutritional screening assessments on surgical wards were not always completed in line with trust policies.
- We found that whilst most patients received appropriate and completed risk assessments, on admission, the trust did not use individualised care plans to document on-going care, treatment and actions taken to mitigate risks to patients.
- There were a greater proportion of middle grade and junior doctors employed at the hospital compared to the England average. We found emergency consultant cover in the Emergency Department did not meet the Royal College of Emergency Medicine standard for senior clinical cover in a listed trauma unit.

We saw several areas of outstanding practice including:

Summary of findings

- Snack box training had been set up to deliver specific and focussed small pieces of training to staff that can be accessed during their lunch break.
- Development of a hospital garden for the use of patients, including patients living with dementia.
- Development of an integrated care model supporting patients with three or more long-term conditions.
- A 'buddy system' was used in critical care where nurses were paired to work together, this was to ensure adequate supervision of patients during staff meal breaks and for checking medicines.
- Patient diaries in critical care were extremely well managed. The unit kept a copy of the diaries to ensure staff knew what the diaries contained; this enabled on-going support to be given to patients families after the diaries had been collected.
- At the foot of every bed space in the critical care unit there was an analogue clock, with the date also displayed and a very clear sign which said, 'You are in intensive care, you are in Yeovil Hospital.' This had been provided in response to patient feedback and helped to orientate patients to where they were being cared for and to the time and date.
- The critical care outreach team had produced and implemented a patient assessment document to aid the early recognition and prompt treatment of sepsis. As part of the education package unit staff had produced a video. A staff badge had been introduced to acknowledge hospital staff who had used the tool to identify and manage a patient with sepsis.
- In maternity and gynaecology services, the Acorn team provided specialist care for women who were vulnerable, were known to be at risk of domestic abuse, who smoked or were prone to substance abuse. Women under the age of 19 and women who had a learning disability could also be referred to the Acorn team.
- The children and young people's services' community nursing team provided a range of different services to meet the needs of patients. The team included specialists or nurses with an interest in specific conditions such as cystic fibrosis, oncology and end of life care.
- Services for children and young people had a school based within the children's outpatients department. The school had a qualified teacher, working Monday to Friday, to provide education to patients who had been in hospital for long periods.

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

Importantly, the trust must:

- Ensure systems and processes to prevent and control the spread of infection are operated effectively and in line with trust policies, current legislation and best practice guidance. The trust must work to improve standards of hand hygiene across children's services.
- Ensure equipment is stored appropriately and in a way that reduces infection risk. Ensure equipment used by cleaning staff is not stored in the sluice area and toilet rolls are not stored on commodes. Ensure commodes are completely clean before returning them to clean utility rooms. Ensure clean equipment is stored off the floor to prevent contamination. Ensure the covers on metal linen shelving units are kept closed when not in use to prevent cross infection. Ensure contaminated disposable items are not stored with clean disposable items. Ensure systems and processes to prevent and control the spread of infection are operated effectively and in line with trust policies, current legislation and best practice guidance within the maternity operating theatre.
- The trust must ensure resuscitation equipment is routinely checked. The emergency department must ensure all resuscitation equipment is checked. Children's resuscitation equipment must be available in the children's assessment area in the emergency department. The trust must ensure all emergency lifesaving equipment, is sufficient and safe for use in maternity and gynaecology services and that there is evidence it has been checked in line with the trust policy.

Summary of findings

- The trust must ensure medical and nursing staffing is sufficient to meet the needs of patients. The emergency department must undertake a review of staffing levels using a recognised assessment tool. The trust must recruit sufficient medical and nursing staff to enable the operational and staffing standards for intensive care units to be met. Ensure sufficient medical staff are on duty in the medical business unit at night. The trust must ensure staffing levels reflect the acuity of patients in accordance with British Association of Perinatal Medicine (BAPM) standards.
- Ensure that all patients receive appropriate and completed risk assessments, including those for dementia, on admission and an individualised care plan commenced to demonstrate the on-going actions taken to mitigate risk. The trust must also ensure nutritional screening assessments on surgical wards are completed in line with trust policies. Ensure the completion of documentation and of patient risk assessments on the gynaecology ward.
- Ensure that controlled drugs are managed in accordance with trust policies, legislation and best practice in the discharge lounge. Ensure oxygen, when required for patients, is prescribed appropriately. Ensure medicines are always safely managed in line with trust policies, current legislation and best practice guidance in maternity and gynaecology services. The radiology department must ensure that guidance is in existence surrounding patient group directive medications.
- Ensure that at least 90% of all staff receive an annual appraisal. Ensure nursing staff in specialist areas are trained on recruitment or placement to become efficient and competent members of their staff team. The trust must train all staff who have direct input into assessing, delivering, and intervening in the care of children and young people, in level three child safeguarding in line with intercollegiate guidance. The trust must improve the numbers of staff trained in European Paediatric Life Support (EPLS) to ensure they meet Royal College of Nursing guidance of at least one EPLS trained member of staff working every shift. Ensure all overseas staff are supported to achieve a good standard of the English language to reduce risks to patients.
- The emergency department must put systems and processes in place to ensure patients receive initial assessment (triage) by an appropriately qualified clinical member of staff within 15 minutes of arrival to the emergency department.
- The emergency department must take action to ensure the safety of children in the waiting area of the emergency department.
- The emergency department must provide daily clinical and managerial leadership with oversight of capacity and demand. The emergency department must develop robust escalation processes.
- Ensure that all patient records are kept securely and located away from the public to maintain confidentiality.
- Ensure all wards have single sex accommodation including sleeping accommodation, bathroom and toilet facilities and do not need to pass members of the opposite sex to use the facilities.
- Ensure the sepsis protocol is embedded with all staff groups to achieve and maintain high levels of compliance with sepsis identification and antibiotic administration.
- The trust must ensure young adults (patients between the ages 18 to 24) meet the criteria for admission onto the Young Persons Unit.
- The trust must review the physical environment of Ward 10 and explore options to separate the Young Persons Unit from Ward 10 to ensure patients over the age of 18 do not have access to children.
- Ensure 'do not attempt cardio-pulmonary resuscitation' (DNACPR) forms are completed appropriately and in accordance with national guidance and best practice. The trust must also ensure DNACPR decisions are documented fully in accordance with the legal framework of the Mental Capacity Act 2005.
- Radiology must continue to target the quality assurance backlog of equipment.
- The radiology department must develop audits and action plans to address incomplete five steps to safer surgery checklists. The radiology leads must ensure guidance surrounding trauma computerised tomography (CAT) scanning is clear and not open to individual interpretation.
- The outpatients department must continue to support improvements to meet the national referral to treatment times.
- The trust must ensure that fewer appointments are cancelled by the hospital at short notice.

Summary of findings

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service

Urgent and emergency services

Requires improvement

Rating



Why have we given this rating?

Safety in the emergency department was found to require improvement for the following reasons. There were not robust systems in place to ensure patients were protected from infection. Nurse-staffing levels were not adequate with a reliance on bank and agency nurses. Patients experienced waiting times of up to 75 minutes for initial clinical assessment (triage), meaning there was a risk of unobserved patient deterioration. For children the designated children's waiting area did not ensure their safety and the children's examination room was not fit for purpose due to limited space and access to emergency equipment. Specialist consultant on-site cover did not meet the college of emergency medicine recommendation of 16 hours on-site presence in each 24 hours. During an unannounced inspection, ten days after the initial inspection, the trust had taken action to address areas of concern. This included an increased nursing establishment, reducing triage time and to support patients waiting in the corridor. The trust also increased specialist registrar cover during the evening and improved security for the children's waiting area. We saw these improvements on our unannounced inspection. There was a positive reporting culture and staff were knowledgeable about major incident procedures.

The emergency department was rated as requires improvement for effective for the following reasons. There were gaps in support arrangements for junior medical staff and no local induction programme. There was a range of treatment pathways available for use in the emergency department however; these were not always applied effectively, putting patients at risk. Nursing and non-clinical staff appraisal rates were below the trust target of 90%. However, we found the department had received a positive outcome following peer review for trauma unit status. Nurses had access to external advanced practitioner training and there was an effective multidisciplinary steering group.

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Caring was rated as good with staff showing compassion and respect for privacy and dignity when patients and visitors attended the emergency department. Parents told us they were kept fully informed of their children's condition and treatment whilst in the department. Volunteers provided excellent support to patients and visitors. However we found patient's privacy and dignity was compromised when they were being cared for in the major's area corridor and patients were not kept informed of waiting times or provided with updates on their treatment plan whilst in the department. Responsive in the emergency department was rated as requires improvement because the emergency department did not meet the needs of the local population. During the inspection, the department was experiencing a period of high demand for which there was a lack of effective escalation and management. The department did not meet the department of health (DOH) targets for initial clinical triage and time to treatment or discharge. The department did not meet the Health Building Note (HBN 15-01) for the provision of emergency care. However there was good facilities provided by the trust for patients and visitors in the waiting area and there was ready access to translation services. For well led we considered the emergency department to require improvement. We found there was a lack of active leadership or continual monitoring of capacity and demand. This resulted in crisis rather than proactive management of escalation situations. Staff in the emergency department were not aware of the emergency department vision for the future. However, we did see a copy of the department's vision document, which was part of the trust's vision and business strategy 2016/17. The trust had supported the development of a nurse led acute ambulatory care unit in the emergency department.

Medical care (including older people's care)

Requires improvement



Overall, we found the medical services at Yeovil District Hospital required improvement; however we did find that effective and caring were good. We found that safe, responsive and well led required improvement. There was a significant breach of patient information and confidentiality within one ward,

Summary of findings

which, despite the inspection team bringing this to the attention of the trust, did not act immediately to rectify this. We also found isolated cases throughout the medical wards where medical record trolleys were left open or notes were left open and accessible to the public at nurses' stations.

Patient risk assessments were generally completed on admission with the exception of a few isolated incidents where we found incomplete assessments. However, the medical business unit did not use individualised care plans for patients, making it difficult to identify if staff were taking action to mitigate any risks found in the initial assessments. Medicine management within the medical business unit was generally good. However the recording of controlled drugs (CDs) in the discharge lounge caused concern. It was not possible from the records available to identify if patients had received their CD medicines to take home with them.

Staff were following relevant National Institute for Health and Clinical Excellence (NICE) guidance. Staff regularly assessed patients for pain and provided pain relief in a timely manner for those who required it. All new staff attended a corporate induction programme which was supplemented with a local induction to their ward or department. Patients we spoke with during our inspection told us they received care, which was dignified and respectful, and were complimentary about the staff providing the care. We saw examples where staff provided care that was compassionate and kind and reflected feedback from the patients themselves.

The trust had been experiencing high demand with high levels of bed occupancy, which reached 100% for the medical business unit during our inspection. The escalation ward, which was often opened to care for patients of both sexes at times of high demand, was not equipped to accommodate patients for long periods and could not meet the personal hygiene needs of patients. During our inspection, patients had been admitted onto the ward for periods from 48 hours to several days. The

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area was not meeting the single sex requirements with patients of the opposite sex often having to walk past other patients to get to the toileting facilities.

With high demand and high bed occupancy, we saw large numbers of medical outliers throughout the hospital. The consultants from the medical business unit had made improvements to how some patients in non-medical specialty wards were cared for; however this was not consistent throughout the hospital. Younger adults, between the ages of 18 and 23 were being cared for on the children's ward and we found staff on both the children's ward and the gynaecology ward were experiencing difficulties when trying to access doctors from the medical business unit to care and review outlying medical patients.

Overall, the trust had mechanisms in place where they would try to meet the individual needs of patients, which included the use of activities to occupy patients living with dementia. However this was not consistent across the wards in the medical business unit and was reflected in the Patient-Led Assessment of the Care Environment (PLACE) score for the provision of care for patients living with dementia.

There was a mixed response as to whether the executive managers were visible on a regular basis; some staff had not seen any of them in their areas before. Although there was a business unit risk register, we were not assured that governance processes were in place to appropriately reduce and manage risks. However, staff spoke positively of their immediate managers and matrons. They also added there was an open and honest culture in the business unit and managers had an 'open door' approach.

Surgery

Good



Overall, we rated surgical services as Good. Staff were not aware of current infection prevention and control guidelines, particularly in relation to documentation of water testing for legionella. Cleaning schedules and logs were not available. However equipment was available, which appeared

Summary of findings

visibly clean, safe and well maintained. Controlled medicines were managed and stored correctly, however we found some documentation relating to intravenous medication to be out of date.

Staff attended mandatory training. We found staffing levels were within establishment boundaries, the ward teams were not able to provide the trust recommended 1:8 nurse to patient ratio. Patients were on the whole risk assessed appropriately although were not provided with individualised care plans. Patients were assessed individually for pain relief and for their nutritional requirements. However the Malnutrition Universal Screening Tool (MUST) was not used consistently across all areas.

Safe systems were in place for reporting incidents, duty of candour and safeguarding issues. However, there had been one never event in the reporting period. We found that the five steps to safer surgery checklists were completed consistently.

Staff provided care and monitored compliance in line with national best practice guidelines. Surgical wards received a relatively high number of medical patients, for whom the medical wards did not have sufficient capacity. This impacted on the quality of care for all patients.

Patients, carers and families were positive about the care and treatment provided. They felt supported, involved and staff actively engaged with patients whilst providing kind, compassionate care. We observed positive interactions when staff obtained consent. Staff supported patients and relatives with their emotional and spiritual needs. The surgical care group participated in a number of local and national clinical audits and acted upon any recommendations. Data from the audits was positive and the trust had action plans in place. Staff were competent and supported by managers. Multidisciplinary team working was established and effective within the surgical wards and theatres. Service planning and delivery took into account the needs of local people. Discharges were planned with the multidisciplinary team, however due to community pressures these were not always timely. NHS England data showed that the national 18 week referral to treatment time targets were not being met. The number of cancelled elective

Summary of findings

operations as a percentage of elective admissions was consistently above the England average. However, of the 101 cancelled operations between October 2015 and January 2016 all but six have been rebooked within 28 days which was consistently lower than the England average. There were clear governance structures in place and lines of accountability. Leaders were visible and staff were positive about local leadership. Trust values were understood by staff and embedded in appraisal documentation. Information on how the public could provide feedback was displayed in some departmental areas.

Critical care

Good



The overall rating for the critical care services was good.

We rated the safety of critical care as good. Patient safety was given sufficient priority. An effective system was in place for the reporting and investigation of incidents, and this had led to improvements in the delivery of patient care and outcomes. There was sufficient equipment for the delivery of patient care and the environment was clean.

The unit had nursing and medical staff vacancies and recruitment was a challenge. Additional intensive care consultants were needed to enable the care of all patients on the critical care unit to be led and managed by an intensive care consultant at all times.

Senior nurses supported the critical care outreach service on a rotational basis which provided a good development opportunity but also impacted on the number experienced staff on the unit. Senior staff continually monitored staffing levels to ensure patient safety was maintained. The outreach service assisted in the early recognition of patients who were at risk of deterioration throughout the hospital and the follow up of patients who had been discharged from critical care.

We rated the effectiveness of critical care as good. Patients received evidenced based care that was based on comprehensive patient assessments and regular evaluation. Patient outcomes were monitored and were good.

Despite not having a dedicated clinical educator staff overall were supported in their personal

Summary of findings

development and training. Access to the critical care post registration qualification however was limited to two staff per year and less than 50% of the nurses currently held this critical care qualification as required by the Core Standards for Intensive Care. Although the multidisciplinary team (MDT) was an integral part of the patient care, a daily MDT ward round involving all members of the team did not take place.

We rated caring on the unit as good. Patient and relative feedback was very positive and care was patient centred. Staff understood the impact critical illness had on both patients and their relatives and this was reflected in the care that was delivered and how it was delivered. Patient diaries were well managed and assisted patients to recover and relatives to feel supported following a period of critical illness.

We rated the responsiveness of critical care as good. Critical care was delivered in a way that met the individual needs of critically ill patients. Patients were not always discharged from the unit within four hours of the decision being made to discharge them or before 10pm. Whilst this was not in line with the Core Standard for Intensive Care requirements, the timeliness of discharging patients was influenced by the availability of beds within the hospital. This was not in the direct control of the critical care unit. There was no evidence to suggest that bed availability was leading to non-clinical transfers of critically ill patients to other hospitals however elective operations had been cancelled due to critical care beds being available. Patients were offered the appropriate support with their rehabilitation following a critical illness, and a clear rehabilitation pathway was in place which included a follow up clinic visit.

Senior nursing staff were visible and accessible to patients, visitors and staff. The senior sister provided clear and professional leadership. There was an open and honest culture and staff were passionate about patient care. The senior leadership team were clear in their objective of wanting to meet the Core Standards for Intensive Care and have a closed unit model of care; with care being led by a consultant in intensive care

Summary of findings

medicine. At present any consultant can admit a patient to the unit without review by an intensivist. They were actively recruiting medical staff to enable this objective to be met.

Maternity and gynaecology

Requires improvement



Overall, maternity and gynaecology services at Yeovil District Hospital were rated as requires improvement.

The safety of maternity and gynaecology was rated as requires improvement. Infection prevention and control was not always given sufficient priority within the maternity operating theatre. Where daily schedules were required for cleaning, these were not available for staff to sign indicate cleaning had been done and where the environment did not comply with national standards we did not see a long term plan to address this. We saw that the maternity theatre was in a state of disrepair and that medicines were not stored securely. The theatre refurbishment was on the trusts risk register but funding was not currently available. We were so concerned that we immediately informed the trust senior management team. The trust closed the theatre to make repairs and undertake a deep clean. We saw on our unannounced inspection that these had been undertaken.

Where daily checks were required for the checking of emergency and resuscitation equipment, staff had not always signed to indicate this had been done in either gynaecology or in maternity. There was a heavy reliance on agency and bank staff on the gynaecology ward and there were times when the skill mix did not meet the care requirements of women undergoing gynaecological procedures. Staffing was planned to provide a ratio of one qualified nurse for every eight patients; however, one nurse we spoke with had been responsible for overseeing the care of fifteen patients at the time of our inspection. However, staffing levels and skill mix on the maternity and labour ward were planned, implemented and reviewed to keep patient's safe at all times. Staffing shortages were acted upon appropriately. There was adequate consultant obstetric cover in the delivery suite at 40 hours a week which was in line with Royal College of Obstetricians and Gynaecologists RCOG guidelines (2007).

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We rated the effectiveness of maternity and gynaecology services as good. The maternity service had achieved full UNICEF Baby Friendly accreditation and breastfeeding rates for initiation were good. Women said that they were able to access pain relief in labour and after they had had their babies, and this was provided to them in a timely manner. Midwives were qualified and had the skills they needed to carry out their roles effectively and in line with best practice. They were supported to deliver effective care and treatment through clinical supervision, the appraisal process and peer to peer support.

There was an enhanced recovery programme for women undergoing gynaecology surgery. However we also found that patients on the gynaecology ward did not always have a comprehensive assessment of their needs, which included nutrition and hydration and physical and emotional aspects of their care.

The care given to women using maternity and gynaecology services was good. Feedback about midwifery services was positive, staff were well motivated, dedicated to their roles and women told us they felt safe and well cared for. Women were treated with dignity, respect and kindness during all interactions.

The responsiveness of maternity and gynaecology services required improvement. The gynaecology ward was being used as an escalation ward and the gynaecology day-case unit was being used for patients to stay overnight because of bed capacity issues throughout the trust, which meant elective gynaecology surgery was being cancelled. The operating table in the gynaecology theatre was not suitable for women who had a high body mass index (BMI). Women with a weight above 140kg had to have their surgery performed in the main operating theatre in the main hospital. This led to difficulties in arranging surgery for these women at a time that was convenient for the gynaecologists. Because of bed capacity issues, women who were undergoing a termination of pregnancy, either because of an unwanted pregnancy or because of fetal abnormalities at times were nursed in bays with elderly women, some of whom were living with dementia.

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Colposcopies took place in a room off the gynaecology ward. There was one consulting room with a couch where the women were consulted and colposcopies were performed. There was no recovery area and women who had undergone the procedure were required to recover in the day room with women who were waiting to be seen. The colposcopy room was small and there was no separate changing area for women to get changed, so women had to get changed in the colposcopy room. There were plans to upgrade this service. Plans were in place and had been approved. However, we also found that women were given a choice of birth in line with national guidance and services were mostly arranged to meet the needs of women and there were a range of specialist midwives and clinics to support them.

The leadership of maternity and gynaecology services required improvement. There was no established strategy or vision for maternity and gynaecology services, although there was evidence of staff being involved in the future development of a vision and strategy. There was a maternity and gynaecology risk register and senior staff at governance meetings had discussed the risks but there was little evidence that the risk register had been recently updated or that there were any action plans for the risks identified. The risks relating to the maternity operating theatre had been on the risk register since 2014 and no action had been taken to mitigate the risks.

At ward level we observed examples of good leadership principles; however, business unit managers had not addressed the issues which were known to them such as the poor maintenance, long standing repair issues and infection control issues in the maternity theatre and did not have plans in place to ensure that women were cared for safely and in a responsive manner. However, we also found there was a positive culture throughout the service. Staff reported positive working relationships and there was good public and staff engagement.

Summary of findings

Services for children and young people

Requires improvement



Overall, we rated services for children and young people as requires improvement. We found: The environment on Ward 10 presented a potential risk to young patients and children. The ward included a young person's unit, which cared for adult patients up to the age of 24 years of age. There was no barrier between the different areas and no way of preventing adults from potentially having access to young children. This also presented safeguarding risks to patients. We raised this immediately with senior managers at the trust. Senior managers said they were assured that patients were safe. However, we also wrote a letter outlining our serious concerns to the trust shortly after the inspection. Following our letter, the trust ensured through its senior team that the admission criteria for the young person's unit was followed i.e. that only patients in transition or those who have specific vulnerabilities were admitted. The trust have also commissioned a review of the area by the Royal College of Paediatrics and Child Health and have committed to implement their findings. Post inspection, the trust reported all admissions to this unit so stakeholders could monitor actions taken. Whilst staff had been trained in safeguarding procedures there was not enough staff appropriately trained in child safeguarding as per intercollegiate guidance. A lack of appropriate training presented a risk to patients and a risk of staff not recognising signs of abuse. We saw there was a lack of specialist beds for young people with mental health conditions. This meant that staff on Ward 10 cared for patients who required specialist mental health support rather than medical care. Staff and patients were at risk of harm from some patients who needed specialist mental health support. Staff had not had appropriate training to manage patients with aggressive behaviour. There were not enough members of staff trained in European Paediatric Life Support (EPLS) training to meet Royal College of Nursing guidance of one EPLS trained member of staff on each shift. Medical staff were trained in EPLS and were available 24hours per day.

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Data from the trust showed staff observing policies on hand hygiene had consistently been below trust standards

We saw managers did not always change staffing levels to reflect the acuity of patients on Ward 10. We saw from rotas provided by the trust the service did not always have access to a senior children's nurse at all times during a 24-hour period in accordance with British Association of Perinatal Medicine (BAPM) standards.

The service had not reviewed guidelines for staff since 2013. Four out of seven guidelines we reviewed did not have review dates meaning there was no assurance trust guidelines met the latest national guidance.

There were a limited number of transitional services available for young people.

The trust did not have a play service or play specialist. Hospital play specialists work with children, and their parents and carers, to help them cope while being treated in hospital or at clinics.

The environment presented a challenge to services. For example, parts of the building needed additional work and repair and patients could not use an outside play area due to it requiring further development. In addition, some facilities on Ward 10 were not suitable for disabled patients.

Outpatient clinics used a 'full booking' system for follow up appointments. The system provided patients with an appointment date upon leaving the clinic. This meant clinics could be booked up months in advance reducing the flexibility to manage appointments and contributing to higher cancellation rates.

The service could not assure the inspection team they had addressed risks presented to children and young people on Ward 10. There was a lack of oversight of ward admissions and a lack of progress against recommendations identified in a review of the service in 2012.

The governance and management of children's outpatients meant there was a lack of supervision, performance management and delays to allocating appointments. This led to some staff in outpatients feeling unsupported and a lack of leadership visibility on occasion.

However we also found:

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Staff knew how to report incidents and when they had done so. We saw incidents investigated in accordance with trust policy and staff gave us examples of learning from incidents. We saw staff observed the Duty of candour in incident investigations. Staff had received training on the Duty of candour and could demonstrate how they had used it when things went wrong.

Equipment, including resuscitation equipment was suitable for patients of all ages. We saw staff checked and tested equipment regularly.

Medicines were stored in locked rooms, cupboards, and fridges. Staff monitored fridge temperatures using an automated monitoring system. Staff recorded and clearly documented key patient information on drug charts.

Staff worked together to assess and plan ongoing care and treatment in a timely way when patients were due to move between teams or services, including referral, discharge and transition.

Staff demonstrated through discussion their understanding of Gillick competence and understood the consent process. We saw staff ask parents about consent to treat patients and where parents were not present staff telephoned parents to gain consent.

There were appropriate assessments of patient nutrition and hydration. Where required, children, young people and baby's care plans included comprehensive nutrition and hydration requirements.

We saw strong and positive relationships between staff and patients, in particular regular users of children's services. Staff spent time getting to know patients and understanding their needs.

Staff involved patients, carers, and parents in care and treatment and ensured they understood their treatment and conditions. Staff in the Special Care Baby Unit encouraged parent involvement in their baby's care and treatment wherever possible.

Staff were compassionate and caring towards patients. Patients and their relatives/carers were positive about their care and treatment. The service had positive patient feedback results on the care and treatment they delivered.

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The community nursing team provided a range of different services to meet the needs of patients. The team included specialists or nurses with an interest in specific conditions such as cystic fibrosis, oncology and end of life care.

Services for children and young people had a school based within the children's outpatients department. The school had a qualified teacher working Monday to Friday to provide education to patients who had been in hospital for long periods. The trust had specialist staff to support and care for patients with learning disabilities and diabetes. Services could access translators, translation materials and interpreters.

Staff had access to specialist support for patients with mental health conditions. Staff could also access out of hours psychiatric advice and support for patients.

End of life care

Requires improvement



Overall, we rated end of life care services as requires improvement. We rated safe, caring and responsive for end of life care services as good, with effective and well-led requiring improvement.

Risk assessments for patients were completed appropriately and were re-evaluated within the required time frame to ensure risks were minimised. The wards we inspected had appropriate systems for the safe storage of medicines. Medical notes were also safely stored in locked medical notes trolleys. We found care records were mostly maintained in line with trust policy. Staff understood their responsibilities in following safeguarding procedures.

Staff understood their responsibilities in following safeguarding procedures.

We also found that The National Council for Palliative Care recommends one WTE consultant for every 250 beds; the hospital had 345 beds and therefore the trust did not meet this, as the consultant staffing provision was not in line with recommended guidelines.

We looked at 26 'Do Not Attempt Cardio Pulmonary Resuscitation' orders (DNACPR) across the trust and found there were inconsistencies in how these were

Summary of findings

completed. We found that out of 26 DNACPR orders, nine were completed correctly (35%). We found staff had not always followed trust policy when they completed DNACPR orders.

The trust had participated in the National Care of the Dying Audit 2013/14 but had not developed an action plan to address four of the seven organisational indicators and the one clinical key performance indicator that had been missed. The trust participated in the National Care of the Dying Audit 2015. This was not published until after our inspection in March 2016. The trust had not had the opportunity to review or respond to the 2015 audit report at the time of the inspection.

However, we saw that care and treatment was delivered in line with recognised guidance and evidence based practice. The last days of life care plan had recently been rolled out throughout the trust. The trust had effective multidisciplinary working in place.

We observed patients being cared for with dignity and respect. Staff were seen to be compassionate and we observed them treating patients and their families with dignity and respect. Patients we spoke with told us that staff were caring and looked after them well.

A bereavement service was offered on site, with staff available to support family members with practical and support issues following bereavement. The chaplaincy service provided a 24 hour, seven days a week on call service for patients in the hospital, as well as their relatives, and aimed to see people within the hour. Patients who were referred to the specialist palliative care team were seen according to their needs.

During 2014/15 the specialist palliative care team (SPCT) received 564 referrals, 60% of these were patients with a diagnosis of cancer and 40% of patients with a non-cancer diagnosis. This indicated that specialist care was being provided for patients with other life shortening conditions. Ward staff said the SPCT normally responded within 12 hours of referrals.

Summary of findings

The trust did not have a Rapid Discharge Home to Die Pathway. Discharge in these circumstances was arranged by the palliative care clinical nurse specialist and could be facilitated within a few hours for patients wishing to return home. There was no written strategy for end of life care throughout the trust. The trust was an integral member of the Somerset Palliative Care and End of Life Programme Group and had been involved in developing the Somerset End of life Strategy which was due for final review in June 2016. This will subsequently inform the local strategy once ratified. There was no internal audit results for end of life care services available at the time of our inspection. However a plan was in place to conduct audits in the coming year. . However, staff spoke positively about the service they provided for patients. High quality, compassionate patient care was seen as a priority. Staff within the specialist palliative care team spoke positively and passionately about the service and care, they provided for patients. The trust's iCARE strategy incorporates the values of communicate, attitude, respect and environment. The mortuary won iCARE team of the year in 2015.

Outpatients and diagnostic imaging

Good



We rated outpatients and diagnostic services (OPD) at Yeovil District Hospital as good overall. Systems were in place for keeping people safe. Staff were aware of how to report incidents, safeguarding issues and the Duty of Candour process. Risks to patients using the service were assessed and appropriately managed. Consent to care and treatment was obtained in line with legislation and guidance. Staff were suitably qualified and skilled to carry out their roles effectively. Staff described a good learning environment, with good role progression. We saw good examples of the service being redesigned and improvements made to meet the needs of the patients. Patients spoke positively of staff that they encountered, and the care they received. Staff were observed to be caring and compassionate in the way they cared for patients, their families and carers.

Summary of findings

Changes made to appointment booking and reminder system were structured to target the clinics with highest did not attend rate. These changes were monitored before implementation throughout the department.

Staff felt included in the changes made in the unit. They described a supportive environment in which to work.

Yeovil District Hospital

Detailed findings

Services we looked at

Urgent & 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 & Diagnostic Imaging.

Detailed findings

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Background to Yeovil District Hospital

The hospital was established as an NHS Foundation Trust in June 2006. The trust delivers services to a population of approximately 200,000 primarily from the rural areas of South Somerset, North and West Dorset and parts of Mendip. The trust provides outpatient and inpatient consultant services for a range of specialties primarily from its main site Yeovil District Hospital. It also provides outpatient and diagnostic services in a number of hospitals in the surrounding area, including the Yeatman Hospital in Sherborne and Wincanton, Crewkerne, Chard and South Petherton community hospitals.

The Hospital has 345 beds and cares for around 190,000 patients a year. The health of people in South Somerset is varied compared with the England average. Deprivation is lower than average, however about 13% children live in poverty. Life expectancy for both men and women is higher than the England average. Hospital stays for self-harm and recorded diabetes is worse than the England average.

We inspected the hospital as part of our comprehensive inspection programme.

Our inspection team

Our inspection team was led by:

Chair: Martin Lee, Medical Director, NHS England Area Team

Head of Hospital Inspections: Fiona Allinson, Care Quality Commission

The team included 17 CQC inspectors and a variety of specialists including: Consultants; obstetrician, Neonatologist, radiographer an anaesthetist and general surgeon, a junior doctor, a chief nurse and seven nurses in a variety of specialities and levels of nursing.

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?

Detailed findings

Before our inspection, we reviewed a wide range of information about Yeovil District Hospital NHS Foundation Trust and asked other organisations to share the information they held. We sought the views of the clinical commissioning group (CCG), NHS England, Monitor, Health Education England, the General Medical Council, the Nursing and Midwifery Council, the Royal Colleges and the local Healthwatch team.

The announced inspection took place between the 15 and 17 March 2016. We held focus groups with a range of staff in the hospital, including nurses, junior and middle

grade doctors, consultants, midwives, student nurses, administrative and clerical staff, physiotherapists and occupational therapists prior to the inspection. We also spoke with staff individually.

We held a listening event in Yeovil, Somerset on 4 March 2016 where members of the public were able to share their views and experience of the trust with us. The feedback we received on most aspects was often conflicting depending on individual experience however; people reported that care was excellent.

Facts and data about Yeovil District Hospital

The trust delivers services to a population of approximately 200,000 primarily from the rural areas of South Somerset, North and West Dorset and parts of Mendip. The trust provides outpatient and inpatient consultant services for a range of specialties primarily from its main site Yeovil District Hospital. It also provides outpatient and diagnostic services in a number of hospitals in the surrounding area, including the Yeatman Hospital in Sherborne and Wincanton, Crewkerne, Chard and South Petherton community hospitals.

• **Beds:** 350

- 314 General and acute
- 26 Maternity and Gynaecology
- 10 Critical care

• **Staff:** 1,848

- 221 Medical

- 535 Nursing

- 1092 Other

• **Revenue: £120,343,00**

• **Full Cost: £130,900,000**

• **Surplus (deficit): (£10,557,000)**

- (The deficit includes an impairment of £3.1m against the full cost and there was a further impairment of £2.2m against the revaluation reserve which is a technical adjustment below the I&E deficit line.)

Activity summary (Acute)

Activity type Jan15 – June 15

Inpatient admissions 11,500 (excluding day cases)

Outpatient (total attendances) 79,251

Accident & Emergency 22,444 (attendances)

Our ratings for this hospital

Our ratings for this hospital are:







Detailed findings

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

Notes

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

Urgent and emergency services

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

Information about the service

The Emergency Department at Yeovil District Hospital NHS Foundation Trust is designated as Type 1. This means it was consultant led and provides a twenty-four hour service, with full resuscitation facilities. In 2012, the department was listed as a Trauma Unit, as part of the Severn Major Trauma Network.

The department had 46,481 patient attendances during the year April 2014 to March 2015. Data provided by the trust showed adults to be 73% of attendances and children 27%. The department saw approximately 260 major trauma cases per year.

Patients presented to the department either by independent means or by ambulance. There are facilities for assessment and treatment of minor and major injuries, a resuscitation area and an integrated ambulatory care /clinical decisions unit. In addition, there was a children's area consisting of a waiting area and dedicated examination room. The department was small with six major's cubicles and three resuscitation bays, one of which was equipped for treating children. Minors cubicles are for 'see and treat' conditions, majors cubicles are for assessment and treatment of more serious conditions and resuscitation is for patients with actual or potential life-threatening conditions requiring more intensive treatment and support.

During our inspection, we observed care in the clinical environment and spoke with 24 members of staff including doctors, nurses, support staff and managers. We also spoke with six ambulance crew and two hospital volunteers. We

spoke with six patients and six relatives, including two parents attending with children. We examined 14 sets of emergency department patient notes and 16 patient admission notes.

Urgent and emergency services

Summary of findings

Safety in the emergency department was found to require improvement for the following reasons. There were not robust systems in place to ensure patients were protected from infection. Nurse-staffing levels were not adequate with a reliance on bank and agency nurses. Patients experienced waiting times of up to 75 minutes for initial clinical assessment (triage), meaning there was a risk of unobserved patient deterioration. For children the designated children's waiting area did not ensure their safety and the children's examination room was not fit for purpose due to limited space and access to emergency equipment. Specialist consultant on-site cover did not meet the college of emergency medicine recommendation of 16 hours on-site presence in each 24 hours.

During an unannounced inspection, ten days after the initial inspection, the trust had taken action to address areas of concern. This included an increased nursing establishment, reducing triage time and to support patients waiting in the corridor. The trust also increased specialist registrar cover during the evening and improved security for the children's waiting area. We saw these improvements on our unannounced inspection.

There was a positive reporting culture and staff were knowledgeable about major incident procedures.

The emergency department was rated as requires improvement for effective for the following reasons. There was a range of treatment pathways available for use in the emergency department however; these were not always applied effectively, putting patients at risk. Nursing and non-clinical staff appraisal rates were below the trust target of 90%. However, we found the department had received a positive outcome following peer review for trauma unit status. Nurses had access to external advanced practitioner training and there was an effective multidisciplinary steering group.

Caring was rated as good with staff showing compassion and respect for privacy and dignity when patients and visitors attended the emergency department. Parents told us they were kept fully informed of their children's condition and treatment whilst in the department.

Volunteers provided excellent support to patients and visitors. However we found patient's privacy and dignity was compromised when they were being cared for in the major's area corridor and patients were not kept informed of waiting times or provided with updates on their treatment plan whilst in the department.

Responsive in the emergency department was rated as requires improvement because the emergency department did not meet the needs of the local population. During the inspection, the department was experiencing a period of high demand for which there was a lack of effective escalation and management. The department did not meet the department of health (DOH) targets for initial clinical triage and time to treatment or discharge. The department did not meet the Health Building Note (HBN 15-01) for the provision of emergency care. However there was good facilities provided by the trust for patients and visitors in the waiting area and there was ready access to translation services.

For well led we considered the emergency department to require improvement. We found there was a lack of active leadership or continual monitoring of capacity and demand. This resulted in crisis rather than proactive management of escalation situations. Staff in the emergency department were not aware of the emergency department vision for the future. However, we did see a copy of the department's vision document, which was part of the trust's vision and business strategy 2016/17. The trust had supported the development of a nurse led acute ambulatory care unit in the emergency department.

Urgent and emergency services

Are urgent and emergency services safe?

Requires improvement



The urgent and emergency services were rated as requires improvement for safe.

We found;

- During our announced inspection we found the department was experiencing a large increase in attendance. This led to a department that did not protect patients from potential risk of harm. We found that patients waited longer than 15 minutes to be triaged and assessed due to a shortage of staff in the department. There was a lack of senior cover and the security for the children's area was not maintained. We found that there were areas within the emergency department, which were visibly unclean. We saw inadequate cleaning of cubicles between patients. We raised these issues with the trust on inspection and via a serious concerns letter. The trust took action to address these issues. During our unannounced inspection on 24 March 2016, we found the department to be visibly clean, the children's area was secured and additional staff was in place to protect patients from potential risk of harm.
- The children's assessment room was not fit for purpose due to size and lack of access to emergency equipment.
- Adult and children's resuscitation equipment was not fully checked on a daily basis.
- Patients at risk of sepsis were not consistently identified at initial assessment, resulting in delays to commencement of treatment. However, the trust reported 89% of patients were screened for sepsis where applicable.
- Safeguarding training was below trust target for level three (for staff with direct contact with children).

However;

- Staff knew how to report incidents and there was evidence of sharing and learning.
- Staff were knowledgeable about the major incident policy and their individual responsibilities.
- Safeguarding training at level one and two met the trust target.

Incidents

- The trust had an incident reporting policy. The urgent and emergency care incident report showed 296 incidents reported between September 2015 and December 2015. The top three themes were clinical care, slips, trips and falls and medication issues. The majority (281) were categorised as low or no harm with ten as moderate.
- Five serious incidents were reported during the same period. Serious incidents are events in health care where the potential for learning was so great, or the consequences to patients, families and carers, staff or organisations are so significant, they warrant a comprehensive investigation (NHS England, March 2015). We requested an example of an incident report. Information received showed outcomes and actions for the incident, signed off by the clinical director.
- Outcomes, actions and shared learning were discussed at the emergency department governance meetings. We saw evidence of this in samples of governance meeting minutes provided for June 2015 and September 2015. Additionally we saw the staff newsletter published which included incident information.
- Trust staff had access to the online reporting system. One senior staff member told us staff actively reported incidents and there was a positive reporting culture. Staff spoken with understood their responsibility to report incidents and knew how to access the reporting system. A member of staff gave an example of an incident they had reported and told us a confirmation email was received and one to one feedback provided.
- Recently introduced monthly governance 'dashboard' was available on the hospital intranet. This included data about incidents and complaints.
- Duty of Candour is a regulatory duty which required providers of health and social care services to disclose details to patients (or other relevant persons) of 'notifiable safety incidents' as defined in the regulation. This includes giving details of the enquiries made, as well as offering an apology. Nursing and medical staff told us they received a briefing about Duty of Candour at trust induction. Not all staff were aware of the term 'Duty of Candour' but understood the need to be open and honest.
- Mortality and morbidity discussions were part of the weekly case review meetings.

Cleanliness, infection control and hygiene

Urgent and emergency services

- Not all of the emergency department was visibly clean at our announced inspection. The clean utility room, used to store sterile equipment and fluids, was visibly dirty. A medical swab and disposable glove were on the floor and storage areas appeared stained and unclean. The wall mounted medicines cabinet had visible dust on the top. There were two pieces of equipment, which had noticeable dirt on them including dried gel on an ultrasound machine. We brought this to the attention of a senior member of staff in the department. On our unannounced inspection on 24 March 2016 we the department looked visibly clean.
- There was a sink for hand washing situated in each of the minor, triage, eye room, major's cubicles and corridor. Hand washing sinks were also located in the resuscitation area, one in the children's assessment room and one in the acute assessment area.
- Staff were 'bare below the elbow' as per good infection control practice. Hand-cleansing gel was available throughout the department and we saw staff using this and encouraging visitors to do so.
- Hand hygiene audits for June 2015 showed 69% with improvement to 100% in December 2015. Trust target 100%.
- Personal protective equipment (PPE), including gloves and aprons, were available. We observed staff using these appropriately.
- On 15 March 2016, we saw two patients, in separate curtained cubicles with signs indicating they were in isolation. The sign requested washing hands with soap and water, wearing gloves and aprons. We observed staff using PPE when entering the cubicles. The department had six major's cubicles, five with curtains and one with a door; this presented the department with limited facilities for infection control.
- Cubicles were not routinely cleaned between patients. One nurse told us they wiped the surfaces and equipment in the cubicles whenever they could. During a period of high activity, we saw one patient moved out of a cubicle and another moved in, without any wipe down of the surfaces or equipment. This meant we were not reassured of systems being in place for cleaning and decontamination of cubicles between patients at our announced inspection. During our inspection on 24 March 2016 we saw that cubicles were being cleaned between patients.
- We were informed a 'deep clean' service was provided by the trust, 18 hours per day. During the inspection, we did not observe the department accessing this service. Staff spoken with explained they were expected to clean cubicles between patients and at night when fewer patients were in the department.
- We observed one patient who had recently returned from travelling abroad, present with signs of infection. A member of staff allocated the patient to a minor's cubicle, with a curtain. There was a delay of five hours prior to contacting infection control, who advised the department to barrier nurse the patient. This meant other patients in the emergency department (ED) were at risk of cross infection. Barrier nursing is a technique used to protect people against infection from another patient.
- The sluice door was propped open by a clinical waste bin. The sluice is an area used for the disposal of clinical waste products and was therefore an unclean environment. The door should remain closed.
- Processes and procedures were in place for the management, storage and disposal of general and clinical waste. This complied with HBN 15-01: Accident & Emergency Departments. We saw staff adhering to these processes and procedures.

Environment and equipment

- We examined 12 pieces of medical equipment in the department, which included blood pressure machines, electro-cardiology (ECG) machines and defibrillators. Servicing and portable appliance testing was found to be in date for all of these items. However, a weighing platform (for patient trolleys) was labelled as last recalibrated in 2012. We informed the nurse in charge of this. We were not made aware of any action taken in response to the concern raised and the platform was not labelled as out of order during the remainder of the inspection.
- The children's waiting room was in the main body of the emergency department, adjacent to the main entrance. Access to the department was by a silver push pad at our announced inspection. The entrance was secured between 10pm and 6am. This meant paediatric patients were not protected from possible harm when the entrance was unsecured. The trust was made aware of this risk in our serious concerns letter. At our unannounced inspection on 24 March 2016, the push button entry system was disabled and the trust had installed a swipe card access. Staff had been supplied with swipe cards.

Urgent and emergency services

- The children's examination room, accessed directly from the children's waiting room, was not fit for purpose. The room did not facilitate patient examination from both sides of the couch and was not equipped to manage clinical emergencies. Staff informed us of the procedure to take a child through the department to the children's resuscitation bay. We saw patients on trolleys in the corridor leading through the department to the resuscitation bay. This meant there was a risk of obstructed access. In addition, there was no guarantee the children's bay was available due to its frequent use for adult patients.
- There was minimum provision of facilities for children. The recommended standard for children and young people in the emergency setting states one dedicated clinical cubicle or trolley space is a requirement for every 5,000 annual child attendances. The department had approximately 10,000 child attendances per year. Provision included one identified (not dedicated) children's resuscitation bay and one children's examination room.
- A children's transport trolley with advanced airway and resuscitation equipment was stored on the intensive care unit and transferred to the ED when a child required transfer to another specialist centre.
- The children's resuscitation bay daily checklist was partly completed for the day of our inspection. When this was brought to the attention of the nurse in charge, she explained that the paediatric nurse had not had time to complete the daily checks. This did not assure us that the department was always prepared to receive paediatric resuscitation patients.
- We further examined the records of resuscitation equipment in the resuscitation area, for adults and children. We found daily checks had not been completed or signed for ten of the 16 days in March 2016. A member of nursing staff told us there was not time to check all of the equipment. This was brought to the attention of a senior nurse on duty.
- Adult resuscitation trolleys were available in the main resuscitation area and the acute ambulatory unit (AAU). However, there was no resuscitation trolley in the minor's area and limited equipment in the children's examination room.
- The resuscitation area had three bays; staff told us this was not sufficient to meet demand. The nurse in charge told us patients in major's cubicles one and two, nearest to resuscitation, could be relocated to another area of

the department if additional resuscitation space was required. These cubicles had limited space and monitoring equipment making them unsuitable for this purpose.

- The AAU consisted of five curtained cubicles and a seating area.
- There was a room used for assessing patients with mental health needs. Ligature points were noted and reported to the senior nurse. These were removed prior to the completion of the inspection.

Medicines

- A cupboard situated in the major's area, behind the nurse's station, contained medicines to take home and a stock of adult and children's medications. The pharmacy inspector stated that although this could cause confusion due to different dose requirements of adults and children, the risk was limited as nursing staff were familiar with the different dose requirements for adults and children. The senior clinical nurse told us of plans to install a new children's medicines cupboard to mitigate this risk. Post inspection, the chief pharmacist for the trust has confirmed, new cupboards have been installed.
- Controlled drugs were stored securely in line with recommendations. However, daily stock checks were not always completed in line with trust policy. We saw three empty signature boxes on the check sheet.
- We found an opened bottle of liquid medicine that has a shortened expiry date once opened. This liquid had no 'date of opening' written on it, which meant there was no way of knowing when this medicine was 'out of date.' It is considered good practice to record an opening date.
- Staff we spoke with had limited understanding or knowledge of the trust's Illicit Controlled Drugs Policy. Staff were unsure of actions required if an illicit substance was brought into the department. A senior clinical nurse told us illicit substances should be placed in the controlled drugs cupboard, recorded in the controlled drug register and pharmacy contacted for disposal. The trust stated that a separate page would be used to record any illicit substances.
- Emergency medicines were available for adults, children and neonates. They were in date and sealed.
- Staff recorded patient's allergy status at triage. We reviewed 14 patient records; two did not have their allergy status completed.

Urgent and emergency services

- Medical gases were stored in the area between the ambulance entrance and the resuscitation room. We observed large oxygen cylinders secured to the wall, however, there were ten small compressed oxygen cylinders, which were unsecured. This meant there was a risk of theft. This does not meet the recommendations of NHS guidance for the security and storage of medical gas cylinders (August 2014). This was highlighted to a senior nurse on duty.
 - Two mobile Entonox cylinders were situated directly in front of the doors to the resuscitation room. These doors gave direct access to patients arriving by ambulance and could cause an obstruction. This was brought to the attention of the nurse in charge on the first day of inspection who moved them. However, on the final day of the inspection we found the cylinders had returned to their original position.
 - Medicine prescription pads (FP10SS) were stored securely and usage recorded in a prescription log book, according to national guidance,
 - A key coded locking system secured all of the medicine fridges. There was central monitoring and temperature control of all fridges.
 - In the resuscitation area, the power source for the fridge was a plug into an electrical socket. This does not meet the safety recommendations of Public Health England who recommend power sources for fridges to be sealed units to prevent inadvertent disconnection resulting in deterioration of temperature sensitive medicines. There are plans for renovation in this area which includes hard wiring of fridges to facilitate remote monitoring. Where if turned off inadvertently an alarm cascade would be triggered, on the basis of a trend increase in temperature well before the fridge actually became out of range.
 - Registered nurses in the department were working under patient group direction (PGD) for the prescription of antibiotics, pain relief and salbutamol (a medicine used to treat airway problems). PGDs provide a legal framework allowing some registered health professionals to supply and/or administer specified medicines to a predefined group of patients. Lists of all PGDs were available on the trust intranet and linked to staff competency, there was a process in place for monitoring renewal dates for PGDs.
 - The main cupboards for accessing medicines for patients in the major's area was in the resuscitation room next to the allocated children's bay. Staff told us this caused difficulty in accessing timely medicines at times when the resuscitation room was busy.
 - The emergency department had supplies of medicines labelled and ready for patients to take home. A list of these medications was on a computer system with pre-worded doses. A senior clinical nurse told us prescribers were encouraged to prescribe from this as the prescription contained all relevant medicine details.
 - The department had introduced a separate controlled drugs cupboard in response to demand for increasing security and managing the risk of potential diversion for Diazepam and Codeine. Medication supplied through emergency services is for simple medications. In line with the Carter Report driving the reduction in the percentage of pharmacy infrastructure (dispensing) services. The trust consider it acceptable for these medications to be supplied either directly from ED or from Community Pharmacy via the FP10 route (Prescription).
- ## Records
- The department undertook record keeping audits. We saw reported evidence and action plans of these audits in the governance meeting minutes.
 - Emergency Department assessment records were not stored securely. They were placed in holders on the wall or in patient cubicles. This meant they were easily accessible to people passing through the department.
 - Medical notes were stored in a trolley accessed only by using a combination lock.
 - On the acute ambulatory unit, nurses completed the trust admission paperwork and all assessments were completed. This included pressure ulcer, nutrition and hydration, falls, mental capacity and hygiene needs, all of which were documented.
 - We looked at 16 patient records of care and found all entries were signed, dated and legible.
 - On five occasions we saw unlocked computers, left unattended, which meant there was a risk of unauthorised access to patient information.
- ## Safeguarding

Urgent and emergency services

- The trust had a dedicated adult and child safeguarding team. A named nurse for safeguarding children is present on a daily basis within the emergency department. Two ED registered nurses have additional responsibilities for safeguarding.
- There was a child protection and a trust Adult Safeguarding policy, both of which were in date, for review January 2019. Staff told us they would escalate safeguarding concerns to the nurse in charge.
- All new staff attended child protection training as part of the trust induction programme.
- Data for ED showed 77% of nursing staff and 84% of medical staff had completed adult safeguarding training.
- Children's safeguarding training had been completed by 91% of registered and 81% of unregistered nurses at level two. In addition, 29% of registered nurses, including all senior nurses, and 69% of medical staff had completed children's safeguarding at level three. Safeguarding training has three levels; level one for non-clinical staff, level two for clinical staff and level three for staff working directly with children and young people. The department did not meet the trust target of 90% for groups requiring training to level three. All administration and clerical staff in ED had received training to level one, as per trust target.
- There was a domestic abuse policy in place for those patients who may be at risk of domestic abuse.
- Members of staff in the emergency department completed a domestic abuse alert form if there was a suspicion of domestic abuse. The trust employs a health independent domestic abuse advocate (IDVA) and is one of three trusts in the region to provide this service.
- Arrangements to safeguard women and children with, or at risk of, female genital mutilation were included in the trusts FGM policy. However at a local level the senior nurse was not familiar with the policy and told us they had not had training in this subject.
- A senior clinical nurse told us shared learning related to safeguarding was accessed through attendance at sisters' meetings, one to one meetings with staff and at governance meetings. There was evidence in governance minutes of shared learning from a serious case review, which recommended staff to make a routine enquiry to patients regarding domestic abuse.
- Mandatory training for all groups of staff included fire safety, infection control, manual handling, mental capacity act, equality and diversity, information governance and basic life support.
- Data provided by the trust indicated staff met or exceeded the trust target of 90% for fire safety, manual handling and infection control. However, attendance was below target for resuscitation training at 84% and an average of 30% for mental capacity act training.
- Staff in the emergency department received training in intermediate life support (ILS) and paediatric intermediate life support (PILS). All ED middle grade doctors and consultants leading shifts were APLS, ATLS and ALS trained.
- In addition to mandatory training, the trust provides 'Snack Box' training, which was a 15-minute sessions, held during lunch or refreshment breaks, covering topics such as dementia care, mental capacity, pressure ulcers and diabetic emergencies. A complimentary snack and drink was provided to those who attend. Several staff we spoke with had attended one or more of these sessions finding them useful and informative.

Assessing and responding to patient risk

- On arrival to the emergency department (ED), the receptionist took the patient's details. The reception staff told us they had an emergency bell to alert someone in case of emergency and would alert the triage nurse if they had any concerns about a patient. There were no visible guidelines indicating when the receptionist should raise a concern and no training to aid the receptionist to recognise a deteriorating patient.
- A triage nurse saw patients in order of their arrival time. The nurse prioritised who to see based on presenting complaint, checking the waiting room when calling patients through or when the receptionist raises a concern. Triage (initial assessment) to determine a patient's priority for treatment, was carried out in a cubicle within the minor's area. The triage nurse could not see patients waiting to be triaged from the minor's area. This meant nursing staff did not have oversight of patients awaiting triage. If a patient deteriorated in the waiting area, the receptionist would be required to summon help.
- There was not an effective system in place to ensure patients received an initial clinical assessment (triage) within 15 minutes of presentation to the department, in

Mandatory training

Urgent and emergency services

line with Royal College of Emergency Medicine (RCEM) guidance. On 16 March 2016, 37 patients were in the department with triage taking between 20 minutes to one hour 16 minutes.

- On the 15 March 2016 we identified five patients had waited 20 to 30 minutes for initial triage. Prompt initial assessment of patients meant they could be directed to the appropriate part of the department according to their clinical need. Life-threatening conditions can then be identified and immediate action taken to commence appropriate care.
- The national target for arrival to treatment is below 60 minutes. Information provided by the emergency department indicated arrival to treatment from July 2013 to October 2015 was similar to the national average of 50 to 55 minutes. However, during inspection on 16 March 2016 time to treatment in ED was greater than one hour. By 8pm waiting time had increased to three hours and thirty minutes. During an unannounced inspection on 24 March 2016 and following our letter of serious concern to the trust, we were saw that the trust had increased the departments nursing team to add an extra nurse per shift to deal with any increase in the need for triage.
- A nurse met patients arriving by ambulance. We observed a discreet handover from ambulance to hospital staff; however, the initial assessment (triage) was incomplete, as it did not include a full set of patient observations. The 'Royal College of Emergency Medicine' standard states; 'Patients should have respiratory rate, oxygen saturation, pulse, blood pressure, level of consciousness and temperature measured and recorded within 15 minutes of arrival.'
- Patients in the major or resuscitation areas had their observations documented using the national early warning score (NEWS). Early warning scores apply a numerical monitoring system based on a patient's respiratory rate, oxygen saturation, pulse, blood pressure, level of consciousness and temperature to assist in the recognition of the deteriorating patient. There were inconsistencies with the recording of early warning scores during triage. This meant the severity of a patient's condition was not established at the earliest opportunity. We reviewed 14 sets of observation charts; 11 did not have NEWS scoring completed.
- There was assessment information and a pathway for initiating the treatment of suspected sepsis. We observed two occasions when observations identifying

a patient to be at risk of sepsis was missed. Sepsis is a potentially life-threatening complication of an infection. Indicators of sepsis include raised temperature, raised respiratory rate, increased heart rate, acute confusion / reduced consciousness or a blood glucose of greater than 9mmol (not diabetic). The presence of two or more of these indicators should initiate further investigation and urgent treatment for suspected sepsis. We observed inconsistent recording of sepsis screening. One patient was handed over to a nurse in majors at 8.55am with observations indicating sepsis however, this was not recognised. One of the inspection team highlighted this to the matron at 10.49am. This meant there was a delay in the patient receiving timely treatment.

- On our announced inspection we witnessed an elderly patient who arrived by ambulance whose triggers for sepsis were not picked up at triage. We were concerned, as this patient appeared visibly unwell; the ambulance crew had commenced an intravenous infusion. We spoke to the ambulance crew about the patient's observations prior to arrival at ED. The observations indicated a severe inflammatory response. The nurse in charge was notified of our concerns. The nurse allocated to care for the patient was unaware of the seriousness of the patient's presentation. The nurse in charge asked her to record the patient's observations as a matter of urgency. The patient was found to be in septic shock and a doctor was called.
- Staff told us the minor's area was often used as a major's overflow. We witnessed a man placed in the minor's area by the nurse in charge despite a pre-alert of probable sepsis. The major's area had a cubicle available. We overheard an ED doctor question the decision to place him in minors. Following assessment by a registered nurse in minors, he was moved to majors with confirmed sepsis.
- During the hours, 9am to 9:30pm children were directed through to the children's waiting area for triage by a paediatric-trained nurse. Outside of these hours, children were triaged by emergency department nurses who were trained in triage but were not registered nurse child branch. The trust mitigated this risk by having an emergency nurse practitioner with training in adult and child resuscitation on duty 10am to 10pm and overnight 10pm to 6am. The paediatric ward and senior paediatric nurses also provided further assistance if required.

Nursing staffing

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- The turnover rate for staff in the department was 14% and the sickness rate was 2.6%.
- There is no definitive nurse staffing assessment tool for use in the emergency department (ED). Staffing assessment tools are used to calculate safe nursing establishments, based on a range of measures including patient attendances and dependency along with staff training and annual leave requirements. However, managers in ED informed us of plans to use the baseline emergency staff tool (BEST) to review staffing levels in the next few months.
- The nursing establishment in ED did not enable the department to meet demand and achieve the required standards and targets set by the Department of Health. The Royal College of Emergency Medicine (RCEM) state that nursing levels should be sufficient to meet demand and provide the skill mix to meet patient need. National Institute for Health and Care Excellence (NICE) 2015 recommends one registered nurse to four cubicles in either “majors” or “minors”, one registered nurse to one cubicle in triage and one nurse to two cubicles in the resuscitation area.
- There were 44.8 whole time equivalent (WTE) registered nurses and 8.8 WTE unregistered nurses. This included 0.8 WTE band eight b consultant nurse, 1.0 WTE band eight a matron, 6.7 WTE band seven nurses, 6.6 WTE band six nurses and 29.3 WTE band five nurses.
- The department rota was arranged with one shift co-ordinator, one registered nurse allocated to minors, majors, resuscitation and triage. An Emergency Nurse Practitioner was allocated to the Ambulatory Emergency Care unit and one trained and one untrained member of staff were allocated to the unit.
- When a second nurse was required for the resuscitation area, which was the case during the inspection, support was requested from intensive care or the critical care outreach team. We were told outreach was willing to support however, deployment of staff to ED could compromise the provision of the critical care outreach throughout the rest of the hospital.
- There was frequent use of agency and bank staff. On 16 March 2016, due to staff sickness, there were six bank / agency staff on duty working alongside three regular staff members. A trust protocol for induction of temporary staff was in place, which included a competency checklist. However, when asked, the temporary staff told us there had been a quick ‘show around the department’. Therefore bank and agency nurses were not fully inducted into the department as per trust protocol.
- The ED requested, daily, for an additional qualified bank nurse to provide care to patients waiting in the corridor for a cubicle to become available. Following our inspection additional funding was identified to employ an additional qualified, band five nurse, to cover this area as required.
- During the inspection, we observed the staffing level in the resuscitation area. One registered nurse was allocated to care for up to three patients. This meant patients were left unobserved if the nurse left the area for any reason. Following our inspection, we were informed action had been taken to provide an additional registered nurse 24 hours per day to work flexibly across ED; this included the resuscitation and corridor areas. A clinical services manager was also planned to be on a twilight shift to ensure that the department was sufficiently staffed.
- The children’s area had a registered sick children’s nurse (RSCN) on duty 9am to 9.30pm, seven days per week. Outside of these hours, adult trained nurses assessed and treated children. This was not sufficient to meet demand and ensure the safety of children in the department. During the evening of 16 March 2016, we observed a sick child had arrived in ED. There was not a nurse in the resuscitation room at this time. The RSCN on duty moved from the children’s assessment area to the resuscitation area to care for the child. This meant other children in the department were unobserved and treated by non-paediatric trained staff. However, on this evening there was an unprecedented number of children attending the department. Senior nurse assistance was requested and provided by the children’s ward. Following our inspection the trust planned to increase the opening hours of the paediatric assessment unit until midnight to relieve the pressure of paediatric attendances on the emergency department.

Medical staffing

- The department had a clinical lead consultant and a clinical director linked to the department.
- The medical staffing skill mix indicated the percentage of consultants was less than the England average at 21%

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(England average 23%). Middle grade and registrar provision was greater than the England average at 58% (England average 52%) and junior doctors were 21% (England average 24%).

- There were three full time consultants, one part-time consultant and an associate specialist consultant. The ED also had nine middle grade / registrar doctors and five junior doctors.
- There were two consultant vacancies being advertised.
- In addition, two general practitioners on a vocational training scheme were working as part of the emergency department team to support the management of patients.
- In the reporting period, April 2014 to March 2015 locum usage was 10% (1WTE). A local induction package for locum doctors was in place.
- Middle grade doctors expressed a concern about recent increases in rota commitment for weekends and a lack of consultant cover after 5pm. There was on-call provision after 5pm. However, during increased department pressure, caused by high levels of activity, there was a reluctance to attend to 'queue bust.' We observed two calls being made before the consultant agreed to attend the department. Following our inspection we sent a letter to the trust outlining our concerns. At our unannounced inspection on 24 March 2016 the trust had scheduled an additional middle grade doctor to be available within the emergency department at times of peak activity.
- There was a consultant presence in the emergency department eight hours per day from 9am to 5pm. This did not meet the recommended requirement for onsite consultant presence in a trauma unit. The minimum requirement to meet the Royal College of Emergency Medicine recommendation is 16 hours emergency medicine consultant cover every day. Out of hours, there was an on-call system, which met the recommendation of call to arrival time of 20 minutes.
- Paediatric consultant cover was from within the trust 9am to 5pm and an out of hours on-call cover with a maximum call to arrival time of 20 minutes. Additional paediatric cover could be accessed from the children's ward.

Major incident awareness and training

- Major incident, emergency preparedness and business continuity plans were accessible on the trust intranet.

- A major incident equipment room was accessible to all staff with a dedicated area for decontamination purposes. Staff had an awareness of their roles and responsibilities in the event of a major incident. A chemical, biological, radiological and nuclear (CBRN) box was accessible behind the reception desk, which included action cards, which staff would need to refer to in the event of an incident.
- The department had carried out simulation scenarios to prepare staff for major incident management.
- Staff we spoke to had an awareness of their roles, which related to hazardous material decontamination procedures.

Are urgent and emergency services effective?

(for example, treatment is effective)

Requires improvement



The urgent and emergency services was rated as requires improvement for effective.

We found;

- There was a range of treatment pathways available for use in the emergency department. However, the department did not always apply these effectively, putting patients at risk.
- The department had not achieved acceptable standards for two out of three national audits completed.
- The department did not orientate junior medical staff to the department.
- Appraisal rates were below the trust target for all staff groups.

However we found;

- The department had received a positive outcome following a peer review for trauma unit status.
- Nutritional screening was completed for all patients identified for admission.
- Nurses had access to external advanced practitioner training.
- There was an active multidisciplinary steering group.

Evidence-based care and treatment

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- There were a range of treatment pathways used in the emergency department (ED). For example, fractured neck of femur (NOF) pathway, version 9.5, reviewed January 2016. The NOF pathway was commenced following confirmation x-ray, an alert was then sent to the orthopaedic nursing team and the patient moved directly to an orthopaedic ward for assessment. This met recognised standards for NOF care. However, compliance with this pathway was dependent on capacity; we saw one patient with a confirmed NOF experienced a delay in transfer of six hours despite early diagnosis of the injury.
- There was an established major trauma pathway, with guidance for stabilising patients prior to transfer to a regional major trauma centre. We saw information relating to trauma patient management clearly displayed in the resuscitation area.
- There were printed pathways for use in the resuscitation area. These were based on current evidence based practice including clear flow charts with rationale for action and contact numbers for appropriate advice. Examples of pathways included; Propofol sedation pathway with consent forms and discharge information. Other pathways included a patient passport 'this is me' to support elderly patients living with dementia and a diabetes pathway aimed at empowering patients to manage their own long-term condition.
- However, we also saw an out of date proforma for thrombolysis (anti-blood clotting) use in patients with an acute myocardial infarction (heart attack). We brought this to the attention of the lead consultant who immediately removed the documentation.

Pain relief

- Patients had an initial pain assessment on arrival to the emergency department (ED). A zero to ten scale (zero being no pain; ten being severe pain) was used to monitor pain levels. We observed the use of the pain assessment tool. Senior nurses in ED had patient group directives (PGD) which meant they could supply and administer named medications, including Paracetamol for pain relief.
- One patient attending the minors area was experiencing pain and described his management as 'so-so.' He had waited two and half-hours for a prescription and was

told to walk to pharmacy to collect the medication. A volunteer offered to take him in a wheelchair. The patient was handed a leaflet on back pain but said he was not given pain relief whilst in the department.

Nutrition and hydration

- Meals were not routinely provided in the emergency department (ED). However, during escalation, the acute ambulatory unit (AAU) ordered meals for patients awaiting transfer to a ward.
- There were voluntary workers, based in ED, who provided patients and visitors with drinks, if appropriate.
- There was a water fountain in the main waiting area of ED and a café where light refreshments could be purchased.
- Patients in the AAU who were being admitted had a malnutrition universal screening tool (MUST) nutritional assessment completed as part of their admission procedure. 'MUST is a five-step screening tool to identify adults, who were malnourished or at risk of malnutrition.
- Patients who received intravenous fluid had a fluid balance chart in their documentation, recording the fluid type, volume and rate of administration.

Patient outcomes

- The emergency department (ED) completed local and national audits. We saw documentary evidence, dated 2015, of participation.
- The department had taken part in three national audits: Management of the fitting child with outcomes indicating ED met four of the five standards. However, for the other two audits including mental health assessment and cognitive impairment in the older patient ED, met one out of seven standards and one of the five standards respectively. The audit papers included methodology, outcomes and action plans for the department to meet national standards prior to the next audit.
- The local audit programme was overseen by the department consultant lead. The audit programme detailed the previous, current and planned audit activity, which covered a range of clinical areas.
- Audits undertaken included local performance against a range of the trauma, audit and research network (TARN) guidelines. For example, time to computerised

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tomography (CT) head scans from time of arrival in ED and outcomes of pre or post hospital intubation (artificial airway). The department had positive results with outcomes similar to other trauma units.

- The department had received a positive outcome following a peer review for trauma unit status.
- All audit outcomes and action plans were presented at governance meetings and to the multi-disciplinary team trauma steering group. We saw meeting minutes as evidence of audit presentation and discussion.

Competent staff

- The trust target for appraisals was 90%. Doctors in emergency department (ED) had regular annual appraisals; data indicated 92% had completed appraisals from April 2014 to December 2015.
- Doctors said they had regular teaching, supervision and support from their line manager. Teaching sessions were weekly and attended by all middle grade doctors and consultants. These were occasionally cancelled due to departmental pressures. In addition there were monthly ED teaching sessions attended by junior and middle grade doctors, these were led by a variety of specialities.
- Newly employed medical doctors attended trust induction. However, middle grade doctors required sign-off, by the ED consultant, prior to being left in charge of the department overnight.
- All consultants and middle grade doctors were advanced trauma life support (ATLS) trained.
- Registered nurses' appraisal rates for April 2014 to December 2015 were 63%, unregistered nurses 89% and admin and clerical 75% this; did not meet the trust target for appraisal of 95%.
- The consultant nurse told us an individual training plan was agreed for each nurse, based on personal development needs. A training matrix was accessible through the electronic rostering (e-rostering) system, linked to a skill base. This enabled allocation of training according to individual needs.
- All nursing staff received basic skills training, as required in ED. This included managing intravenous infusions, vena-puncture, cannulation, simple limb plastering and electrocardiograph (ECG) recording. Advanced training had been completed by 80% in initial patient assessment (triage) and advanced life support (paediatric and adult), this included all advanced nurse practitioners and those training for this advanced role.

- The department supported Advanced Trauma Nurse training, which was accessed from external providers. There were nine qualified emergency nurse practitioners (ENP) and four in training. The emergency nurse practitioners provided specialist support in the ambulatory care unit and minor injuries.
- Band seven nurses worked in supervisory roles, Monday to Friday, with responsibility to support junior staff. However, there was no formal documented supervision or established competency framework in place; this was being developed by the consultant nurse and matron for use in ED.
- Support was available for qualified nurses who were applying for revalidation to maintain their professional registration.
- The trust held sessions called 'snack-box training'; these were 15-minute information sessions on a variety of subjects. Staff received a snack bar and a drink whilst attending. One nurse in ED told us these were useful and said they had recently attended a session on mental capacity awareness.

Multidisciplinary working

- The emergency department (ED) had an established multi-disciplinary team approach to red trauma calls. Following a call from the ambulance service an adult or children's team would attend to meet the patient. This included consultant trauma specialists, speciality doctors, emergency nurse practitioners, radiographer and other speciality health professional as appropriate to the call.
- There were no physiotherapist or occupational therapists attached to ED. Allied professionals were requested to attend according to patient need.
- There was a general shift handover and work area allocation, at the major's corridor nurses desk. A more detailed handover was provided one to one in the areas of allocation, for example resuscitation.
- The multidisciplinary trauma steering group met quarterly. We reviewed minutes for this group, which covered a wide range of topics from the National Institute for Health and Care Excellence (NICE) guidelines, to implementation of treatment guidelines. The MDT was working on a local policy for safe patient transport.

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- There were delays in initial referral to some specialities. For example, we saw two patients in ED who were not referred to the appropriate speciality following assessment on arrival to the department.
- There was a lack of access to psychiatric services, which was acknowledged by the trust. Work was in process alongside a neighbouring NHS Trust to improve, in particular, the provision of children and young people's mental health services (CAMHS).

Seven-day services

- At the unannounced inspection the trust had increased their middle grade specialist registrar provision from 5pm to midnight, seven days a week.
- The trust had projects in place to increase seven day working across the hospital. Projects, which directly affected ED included increasing consultant cover in ED, extending specialist nursing cover for stroke services at weekends, seven-day frail older persons assessment service (FOPAS), dedicated Saturday trauma lists, and enhanced night night progress chasing in the ED.

Access to information

- The department recorded the patient pathway through emergency department (ED) using an electronic system. Patient information was uploaded on arrival and all times of contact recorded. All staff had access to this and a visual display indicated the ED activity status.
- The electronic system was used to locate and order patient medical notes. Some notes were stored off-site; we were told access to these was generally less than two hours.
- Blood test results and x-rays were available electronically.
- The trust intranet provided access to a wide range of information including policies, procedures and guidelines.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- There was a trust consent policy and staff were observed gaining verbal consent prior to any physical contact with patients. We did not witness any requirement for written consent.

- Information about the Mental Capacity Act 2005 (MCA) was included in the trust induction. There was no additional training provided in the emergency department (ED). One nurse told us she could not remember receiving MCA training.
- We did not see any patients with deprivation of liberty safeguards (DoLS) identified during the inspection.
- Mental capacity assessment (MCA) was included in the ED documentation. We saw signed evidence of MCA assessments being completed.
- The trust's consent for examination and treatment policy supported making the patient's best interests central to the process of obtaining consent. If a young person was under 16 and wished to consent to their own treatment. Staff followed Gillick Competency to assess whether the young person would have the maturity and intelligence to understand the risks and nature of treatments. The young person would be given time to consider all the options.

Are urgent and emergency services caring?

Good



The urgent and emergency services were rated good for caring.

We found;

- Staff responded compassionately when people needed help and support to meet their personal needs.
- Wherever possible patient's privacy and dignity was respected.
- Parents were kept fully informed of their children's condition and treatment.
- Volunteers in the department provided support to patients and visitors.
- Family and friends test results indicate 94% of respondents would recommend the emergency department to others.

However we found;

- Patient's privacy and dignity was compromised when they were being cared for in the corridor.
- Adult patients and their carers were not informed of waiting times and provided with updates on their treatment plan.

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Compassionate care

- We observed examples of compassionate care provided to patients and their visitors. We saw patients arriving by independent means and by ambulance who were greeted in a positive manner and their concerns listened to attentively. However, during peak activity we saw staff undertaking initial assessments of patients in the corridor. This did not provide the patient with privacy or ensure confidentiality.
- Where possible, privacy and dignity was protected. However, at times of peak activity this could be compromised. We saw patients moved between trolleys in the corridor with sheets used to maintain privacy, although this was not ideal.
- Visitors accompanying patients, arriving by ambulance, were welcomed and supported by a volunteer who made them a drink and, if required, sat with them until medical or nursing staff were able to update them on the patient's condition. One visitor told us they were very grateful for this, as they were very thirsty and anxious about their daughter.
- We observed prompt responses given to patients who required assistance with clothing or to access toilet facilities. A health care assistant responded immediately to a patient calling for help.
- The trust took part in the 2014 Care Quality Commission accident and emergency survey. Results indicated a performance of 'the same as' other trusts. There were 312 responses with an average score of 7.7 (out of ten). Scores ranged from 3.7 for communication about waiting times to 9.5 for ambulance handovers. We found communication about waiting times remained a concern for people attending the emergency department.
- Family and friends test indicated a consistently higher than England average would recommend the emergency department to others. For the period June 2015 to November 2015 an average of 94% respondents recorded they would recommend the department to others.
- We spoke with two patients and their visitors whose experiences had been variable. One patient told us, 'the staff are nice but no one was telling me what was happening or how long I will be here.' This was reflected

by a patient's daughter, waiting for her mother to be found a bed. The daughter told us, 'the nurses are really nice but we have been here for hours and I daren't leave as no one is telling me what was happening.'

- However, we did observe patients, waiting for admission, had water available, were offered frequent hot drinks and meals were provided.
- We spoke with three ambulance crews who told us Yeovil District Hospital was their preferred emergency department to bring patients, in the area. They told us they rarely waited to handover patients and staff were friendly and welcoming. One paramedic said Yeovil would be the ED of choice to bring their family to.

Understanding and involvement of patients and those close to them

- Patients were not always aware of their plan of care and were not updated on waiting times.
- We observed a junior doctor taking the time to explain to an elderly visitor the need to wear personal protection (apron and gloves) when visiting a friend. The doctor helped the visitor to put the items on and went with them to explain the need for protection to the patient, as the visitor was concerned about the patient's response.
- The children's nurse spoke to her patients in appropriate language and explained to their parents what the treatment choices were. One parent said staff were helpful, friendly and always informed her of what was happening.

Emotional support

- Staff told us they could request chaplaincy support through switchboard and that in an emergency someone would be available quickly.
- Volunteers in the department were proactive in being available to support patients or visitors whenever needed.

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

Requires improvement



Responsive in the emergency department was rated as requires improvement.

We found;

- The department did not meet the Health Building Note (HBN 15-01) for the provision of emergency care.
- The emergency department did not meet the needs of the local population during times of peak activity. Escalation processes were not activated in a timely manner.
- The department did not meet recommended targets for initial triage, arrival to treatment times or discharge.
- There was a lack of children's and young people's mental health services (CAMHS) in Somerset.

However;

- The trust provided facilities for patients and visitors in the emergency department (ED) waiting area.
- Translation services were available and written information provided in the most prevalent ethnic minority language.
- The trust responded positively to issues raised by the inspection team.

Service planning and delivery to meet the needs of local people

- The emergency department (ED) was a designated trauma unit, which received major trauma patients. Staff and ambulance crew told us that following a 'red call', alerting the department of an emergency, an appropriate medical team would be ready to receive the patient.
- The ED reception had a glass fronted reception desk and a waiting area. The patient waiting area had 30 bench style metal seats. Seating provision was limited and during peak activity, we saw standing room only. The waiting area had notice boards providing

information about local support groups and the hospital patient advice and liaison service (PALS), through which service users could raise concerns, complaints or compliments.

- There was limited capacity to meet the demands of peak activity in minors, majors and resuscitation areas. This included the capacity to manage the high volumes of children attending the department at the time of our inspection.
- Data provided by the trust for January 2016 there was 3,837 attendances to ED. This equates to an average of 123 patients per day. Patients under 17 years of age averaged 26 attendances per day (21%). The designated, refurbished, paediatric waiting area was not large enough to cater for children and their families and the examination room did not have enough room to facilitate examination from both sides of the couch.
- The paediatric resuscitation bay was some distance from the paediatric assessment area, without direct access for rapid transfer.
- The limited provision of major's cubicles meant the department was overcrowded, at times, with patients waiting on trolleys for a cubicle to become available. The trust was aware of this and was considering the possibility of expansion into an adjacent department.
- There was an x-ray room in the department.
- Facilities for people waiting included a hospital-managed café providing light refreshments between 11am and 11pm and a free telephone with direct access to local taxi services. The ED had a water fountain and unisex toilet with disabled access.
- Patients who arrived at reception were informed of waiting times. However, regular updates were not provided. This meant patients were not informed if waiting times increased. Two patients told us, 'you usually get seen fairly quickly but you can feel forgotten.' A senior nurse told us patients were informed of delays and advised to access other services if their condition was not an emergency.
- The ambulance arrival bay was designed with direct access to the resuscitation bays and major's cubicles. The area included seating (four chairs) for those accompanying patients. There was a kitchen, where volunteers prepared drinks for patients and visitors.
- An acute ambulatory unit (AAU), integrated with a clinical decisions unit (CDU) was based in ED. The area was designed to reduce hospital admissions wherever possible. This area consisted of a seating area and seven

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bays where patients attended following general practitioner referral. The service aim for this area was to place patients on an appropriate treatment pathway, avoiding the need for hospital admission. The AAU standard operating procedure (SOP) stated 'During periods when the Trust was in escalation, and capacity compromised, AAU bays could be used to accommodate inpatients waiting for admission.' This was the situation during our inspection. However, the area was not suitable for extended periods of stay as there were limited patient facilities or provision for gender separation.

- The ED did not meet current health building regulations for the provision of emergency care (HBN 15-01). The department had limited space and was unable to accommodate increased activity, which resulted in crowding. The trust acknowledged this and explained there was limited opportunity for expansion. However, discussions were taking place to consider the feasibility of utilising the adjacent outpatient area. We were told the adjacent outpatient and fracture clinic area were occasionally used to provide additional waiting room at times of high demand. Lack of space for expansion had not been included on the department risk register.
- Storage space for large equipment consisted of a short blind corridor, situated directly off the ambulance arrival bay. Spare trolleys and equipment for repair were placed here. The area appeared cluttered with redundant, unused lockers taking up space.
- The service provision for children was unable to meet demand. Data provided indicated 25% of attendances to ED were in the 0-17 age group. On 16 March 2016, the area was exceptionally busy with 29 children in the department at 8pm, this meant over 40% of patients in the department were under 17 years old. The children's services matron arrived to assist. Following our inspection, the trust planned to extend the evening ED provision for children to midnight, on identified peak activity days.
- Additionally the trust was undertaking a review of middle grade doctor rotas. The plan was to increase medical presence at periods of peak demand. This supported the planned introduction of a dedicated clinical lead to provide rapid assessment and treatment (RAT) in ED from 1 April 2016. The aim was to reduce time to assessment (triage) and to see a doctor.

- Data provided by the trust showed 46,481 emergency department (ED) attendances from April 2014 to March 2015, which averaged 127 attendances daily. This was at the lower end of total ED attendances when compared across England. However, the number of hospital admissions following ED attendance was 32%, which was higher than the England average of 22%. The majority of patients admitted were over 65 years of age (79%). This was proportional to the age distribution of the geographical population.
- During the inspection, ED was experiencing a high level of demand. We observed delays in patient initial assessment (triage) of up to 75 minutes; the indicator time was 15 minutes. Following triage there was further delays of 90 minutes to see a doctor; the indicator time was 60 minutes.
- A patient flow and escalation policy was in place, which provided guidance if there was a greater than 90 minute total wait time to see an ED doctor. The Royal College of Emergency Medicine (RCEM) document: 'Tackling emergency department crowding' (2015) suggested escalation using markers for overcrowding. One marker was waiting to see an ED doctor longer than one hour.
- Senior staff appeared not to have a working knowledge of the escalation policy. On the evening of 16 March 2016, senior staff in ED had not recognised the need to activate the escalation plan in accordance with trust policy. At 7.30pm, the inspection team considered patient safety was compromised with waiting times of over three hours. At 8pm, we discussed the deteriorating situation with the senior nurse on duty who contacted the lead consultant and requested them to attend. The consultant did not initially attend. However, following further contact at 8.30pm the consultant agreed to come into the department. At this time, there were 41 patients, 29 of these patients were children. The hospital had declared itself to be in black status, which meant the hospital did not have capacity to meet the unprecedented demand.
- On review of the longer term data the emergency department the trust met the 15 minute triage indicator approximately 40% of the time. In December 2015 the trust's average time to triage was 19 minutes. We saw an improving picture in February 2016 of 16 minutes. The data for time to see a doctor within 60 minutes showed a similar picture in that in December 2015 the average time was one hour 12 minutes and in February this had

Access and flow

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improved to one hour one minute. This demonstrates that on average the trust could respond to the demands placed on the department but could not respond to the unusual demand we saw during our inspection.

- On arrival, the lead consultant held a board round, prioritising activity and referring patients to appropriate specialities. The chief nurse also attended to review the situation and offered support to the staff.
- A nurse informed us of two children taken home by their parents due to the lengthy waiting times on 16 March 2016. A member of staff attempted to make contact with the parents the following day. One parent responded and a referral was made for specialist treatment.
- On 17 March 2016 at 11.30am the wait to see an ED doctor was one hour 30 minutes. Escalation had not been activated; we again raised our concerns to a senior clinical nurse. At this point, the patient flow matron, who had previously been the ED matron, called all available staff to the nurse's station and initiated escalation and a recovery plan.
- The Department of Health (DOH) target for patient arrival in ED to transfer (to a ward) or discharge was four hours for 95% of patients. The ED met this target for eight months between November 2013 and November 2014. However, the target was not achieved since December 2015 and dropped to 92%. This was attributed to increased demand. In March 2016, the department saw on average 140 patients per day compared to a general average of 117 patients per day.
- Trust data for November 2014 to November 2015 indicated two patients had waited longer than four to twelve hours from decision to admit to transfer to a ward. However, on further investigation we found the clock started once the specialist team had seen and accepted the patient. Therefore, the time waiting for specialist review was not included in the total time. We observed an example of this when one patient with a fractured neck of femur waited three and a half hours prior to referral to an orthopaedic surgeon and a further four hours before transfer to a ward. The patient spent a total of seven and a half hours in the ED.
- The percentage of patients who left the ED before being seen averaged 1.8% of all attendances per month; this was lower than the England average of 2.6%.
- Bed management meetings took place twice daily to address and escalate risks affecting patient safety, such as low staffing and bed capacity issues.

- The DOH target for ambulance crews to hand over patients to ED staff was 15 minutes, with no patients waiting longer than 30 minutes. ED met this target for 77% of ambulance handovers between October 2015 and February 2016. We spoke with three paramedic ambulance crews who told us handover delays were unusual at the trust.
- The department of health (DOH) standard for unplanned re-attendance rate to ED in seven days was 5%. For Yeovil District Hospital (YDH), ED was consistently above this standard at 6% but below the England average of 7.5%.

Meeting people's individual needs

- The trust had an acute learning disability (LD) service incorporated in the integrated safeguarding team. Two registered LD nurses had responsibility for this service. Telephone or email referrals could be made to the LD team when patients living with learning disabilities attended ED. We did not observe the use of this service although the children's trained nurses could describe the referral process. The planned electronic patient record system had automatic alerts generated on attendance or admission to hospital. The alerts went straight to the LD team.
- Yeovil District Hospital (YDH) worked closely with a neighbouring NHS Trust in the provision of children and young people's mental health services (CAMHS). It was acknowledged that access to CAMHS was limited due to vacancies in the neighbouring NHS Trust. However, there was a local plan to provide one full time CAMHS liaison nurse from June 2016. In the interim, the neighbouring NHS Trust's children's mental health unit provided contact with an on-call psychiatrist. Although, availability was variable as the on-call psychiatrist covered the whole of Somerset County.
- The ambulance entrance included a weighing platform; this meant individual patients could be weighed on arrival to ED, providing information for medication calculations. We did not observe this facility being used.
- We observed the nurse in charge meeting all ambulance patients. An initial visual assessment was made and depending on their clinical condition allocated to a cubicle in resuscitation, majors or minors for medical review. When all bays were full, patients were placed in the main department corridor, where they could be

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observed until an appropriate bay became available.

During our visit the maximum number of patients, waiting on trolleys, in the corridor was four. There was a 'corridor nurse' allocated to care for these patients.

- There were no specific facilities for patients living with dementia in ED. Confused patients were generally placed in a cubicle opposite the nurse's station. The nurse in charge told us this was so they could be easily observed if they tried to wander. Although, we noted an elderly confused patient in the isolation room, who was not being observed.
- Patients identified with memory loss in ED were recorded on the electronic patient record system and there was a plan to include patients living with dementia who attend ED. An automatic daily report would then be sent to the specialist multi-professional dementia care team. Until the EPR was established, a paper referral was sent to the dementia care team. We did not observe this in practice. A review of patient notes in AAU showed evidence of a dementia-screening tool being used for patients over 65 years of age with a signed sticker confirming completion.
- Volunteers worked regularly in ED supporting patients and visitors. Two volunteers told us they were retired local people who wanted to help support visitors to ED.
- Translation and interpretation services were commissioned from a commercial specialist translation company. The service was able to provide face-to-face interpretation (including British Sign Language for deaf patients), telephone and online translation. There was information on how to access translation services, at the ED nurses station. We did not observe the use of this service.
- Written information was available in English and Polish. The 2011 census identified Polish as the largest ethnic minority group for the geographical area at 2.7%.
- A children and young people's survey rated Yeovil District Hospital as better than other trusts for confidence, trust and friendliness of staff. One parent told us, the care provided in ED was good and the staff informed their child at all stages of the treatment provided.
- The trust provided an on-call 24-hour chaplaincy service. The trust had a multi-faith chaplaincy, available 24 hours a day.

Learning from complaints and concerns

- The emergency department reported 66 formal complaints during the period January 2015? to December 2015. The top three topics were clinical decision-making, attitude of staff and communication. Information provided in advance of the inspection recorded complaint details, apologies had been provided and actions agreed. Nine complaints for this period had not been closed, at the time of the inspection.
- Complaints were reported monthly to the patient experience working group. In addition, complaints were reviewed at service-level monthly peer review meetings. A quarterly quality report was generated for the board level governance assurance committee.
- Complaints were included in the ED staff newsletter and featured in departmental governance meeting minutes. These were available in the staff rest room and on the trust intranet.
- Staff in ED told us they would try to help a person complaining or refer to the nurse in charge. Staff were unable to recall changes made in response to complaints.

Are urgent and emergency services well-led?

Requires improvement



Well-led in the emergency department was rated as requires improvement.

We found;

- During our announced inspection there was a lack of active leadership in the emergency department or continual monitoring of capacity and demand. This resulted in crisis rather than proactive management of escalation situations. Following our raising of concerns the trust allocated a senior clinical manager to be present until midnight to ensure that oversight and effective escalation within the department was maintained.
- Whilst a number of the issues we identified were on the risk register it did not highlight some of the issues we identified. These included the security of the paediatric waiting area, the number of staff with appropriate safeguarding training and skills in treating children. The actions to mitigate overcrowding within the department

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were not enacted in a timely manner. Following our letter of serious concerns the trust implemented a number of actions to reduce the risk of potential harm to patients.

- Staff in the emergency department were not aware of the emergency department vision or strategy.
- Staff did not have the opportunity to attend governance meetings.
- There was little evidence of team working.

However;

- There was a vision for the emergency department, included in the trust's business strategy 2016/17.
- The trust had supported the development of a nurse led acute ambulatory care unit in the emergency department.
- The department held regular governance meetings and shared information through departmental newsletters and the availability of governance meeting minutes.

Vision and strategy for this service

- There was an emergency medicine business unit strategy dated 2016/17. This outlined the department's vision for developing emergency care for the local population, staff development, becoming pioneers in health care provision and utilisation of technology in health care management. The document included an action plan for each element of the strategy.
- Staff spoken with during our inspection of the emergency department (ED) were not aware of the department strategy but were aware of the trust's iCare programme and values. The trust iCare strategy, developed through collaboration with staff, described the trust's plans for service development. The emergency medicine business unit strategy reflected the trust wide strategy.

Governance, risk management and quality measurement

- The emergency department (ED) had governance structures, processes and systems in place with departmental governance meetings, chaired by the clinical director and attended by senior staff from the emergency department. Senior managers explained that meetings took place on different days and times to enable staff of all professions and grades to attend. However, the meeting minutes did not reflect this. Meetings were at the same time (10:00) and there was

no evidence of staff attendance. Copies of the clinical governance meetings were available for staff through the trust intranet and printed copies were in the staff rest room. An example of information provided in the governance meeting minutes was details of a children's documentation audit. Positive outcomes were reported regarding recording of patient demographics (including address, next of kin, date of birth, general practitioner) and an issue raised about recording the exact timing of interventions.

- The ED risk register identified seven items, four related to medical and nursing staff levels and three related to service continuity. All risks had actions and a named person with responsibility.
- Two areas of significant risk were overcrowding in ED and staffing levels. Whilst the escalation due to overcrowding was highlighted as part of the mitigation of the risk of overcrowding we saw that this was not enacted appropriately during our inspection. Risks that we identified such as the security of the paediatric waiting area, the number of staff with appropriate safeguarding training and skills in treating children were not identified on the risk register. Therefore we could not be assured that the department's senior team had a grasp on all the risks within the department.
- We raised our concerns at the time of our announced inspection to the senior management team. We also sent them a letter outlining these concerns. Following receipt of the letter the trust implemented a number of actions such as installing a swipe access to the paediatric waiting area, increasing the number of nurses and medical staff within the department. The trust also began to implement longer term actions such as asking the Emergency Care Intensive Support Team to review the ED pathways with a particular focus on triage and time to doctor, reviewing and engaging increased staffing numbers as appropriate, opening the paediatric assessment unit for longer and ensuring oversight by a clinical manager. We saw the immediate actions that the trust had taken were in place at our unannounced inspection on 24 March 2016.
- The ED audit programme indicated two active audits, one commenced June 2015, which related to the treatment of fractured neck of femur and one on-going audit commenced in 2010, which monitored documentation of children's attendances to ED.

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- The ED had undertaken a range of audits, including local audits, which contributed to The Royal College of Emergency Medicine (RCEM) audit programme.
- A department monthly newsletter included information about incidents, complaints and patient safety alerts in addition to general departmental staff news.

Leadership of service

- The overall lead for the emergency department was a director, supported by associate medical and nursing directors, clinical business unit manager, clinical director and matron. In addition, an emergency department (ED) nurse consultant had key responsibilities for staff and service development.
- Following a recent reorganisation, an experienced ED matron had transferred to the role of patient flow manager. A new matron was appointed to enhance and develop leadership in the unit. At the time of our inspection, the matron had been in post for three weeks and was undergoing a period of orientation into the role. This meant the department was heavily dependent on the continued support of the patient flow manager. We observed this at a time of high demand when the patient flow manager took control, calling all nurses to the central nurses station (described as a huddle) to allocate workload and maximise patient flow.
- During inspection, there was no evidence of a visible emergency consultant in charge with oversight of the emergency department. Total occupancy did not appear to be routinely monitored. Co-ordination of flow appeared to be carried out by administrative support based in the major's area of the department. Although an escalation policy was in place it was not utilised effectively resulting in an inability of the department to respond and manage increased demand effectively.
- During inspection there appeared to be a lack of communication between the senior nursing staff and medical leads about the continuous review of real-time escalation status to identify impending pressures on the department.
- We saw regular board rounds took place twice daily between nursing and medical staff.
- We found the departmental clinical leads were not always visible in ED.
- There was a lack of timely awareness of capacity and demand status in the ED. Senior staff were not aware of escalating waiting times in the department resulting in crisis rather than pro-active leadership of escalating

situations. We were informed some senior staff rarely had direct contact with patients. We observed the consultant undertaking office work and not being made aware of deteriorating patient waiting times within the department.

- There was a failure of senior leadership communication about trust escalation levels. ED was not aware of the trust's escalation status. This was evident during our inspection when the department told us the trust was at red escalation level when in reality the escalation status was black.
- Escalation was based on triggers, which reflect the capacity and demand status of the trust. Green was normal working; Amber was persistent excess pressure requiring significant additional management to address demand and congestion. Red was severe and or prolonged excess pressure requiring support from external agencies to address demand and congestion and Black meant the trust was in a critical position with ED or other departments being clinically unsafe.

Culture within the service

- The inspection team acknowledged ED was busy during the two and half days they were in the department. However, the inspection team were concerned about a culture which did not promote internal teamwork to address increasing workloads.
- The staff expressed dissatisfaction with the support provided in the acute areas of ED during periods of high capacity and demand. This led to staff being unhappy with the pressure of work and their inability to complete the non-nursing tasks required of them. For example, daily safety checks of equipment.
- The department had recognised a need to improve the working culture. An occupational psychologist had been commissioned to look at how the culture could be improved.

Public and staff engagement

- F&FT questionnaires were readily available in the ED waiting area and collection boxes were located at the nurse's station. When asked about handing out the questionnaires in the acute ambulatory unit we were told 'we do it if we remember.' We did not observe any questionnaires being handed to patients during our visit.







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- The trust's iCare comment cards were available to patients and visitors in ED. Boxes were provided for the cards to be posted on completion.
- Staff spoken to told us they had taken part in the development of the iCare strategy through attendance at iCare events.

Innovation, improvement and sustainability

- The emergency department had an established nurse led acute ambulatory care unit (AAU) where general practitioners could refer patients for assessment and possible admission. There was a standard operating procedure (SOP) for the AAU with the stated aim; 'For patients who present as an urgent 'ambulatory' GP referral to be placed on the most appropriate pathway based on their clinical need. To work on a model of 'assess to admit' rather than 'admit to assess.'
- We saw information, which related to the identification of sepsis in ED and were told about a trust staff 'star award' for individuals who identified and initiated timely treatment of potential sepsis. There was a poster celebrating staff who had been awarded the 'sepsis star.'

Medical care (including older people's care)

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

Information about the service

Yeovil District Hospital medical care services are managed by three business units within the trust; internal medicine, long-term conditions and cancer, oncology and haematology rheumatology, endocrinology and care of the elderly. One director is responsible for all three units.

Specialties included respiratory, gastroenterology, cardiology, stroke medicine, diabetes and oncology.

There were 19,756 admissions for medical care services at Yeovil District Hospital in 2015 of which 50% were emergency admissions, 2% were elective and 48% were day cases. Almost half the admissions (45%) were for general medicine. The medical care services at Yeovil District Hospital comprise of six wards, the endoscopy department and the Macmillan oncology unit.

During our inspection, we visited six wards as well as the oncology day unit during daytime and evening hours. We carried out an unannounced inspection visit on 24 March 2016 visiting three medical wards. We also visited five wards where medical outliers were being cared for. Due to the lack of beds in medical wards, many patients are placed in other departments' wards, for example surgery or orthopaedics; these are called outliers.

We used a variety of methods to gather evidence. We spoke with consultants, junior doctors, registered nurses, healthcare assistants, allied healthcare professionals and other support staff. We spoke with 23 patients and six patient's relatives. We interviewed senior doctors and the

director for medical services. We observed care and the environment and looked at a range of documents including patient care records, including specific pathways of care, audit results, action plans and policies.

Medical care (including older people's care)

Summary of findings

Overall, we found the medical services at Yeovil District Hospital required improvement; however we did find that effective and caring were good. We found that safe, responsive and well led required improvement.

There was a significant breach of patient information and confidentiality within one ward, which, despite the inspection team bringing this to the attention of the trust, did not act immediately to rectify this. We also found isolated cases throughout the medical wards where medical record trolleys were left open or notes were left open and accessible to the public at nurses' stations.

Patient risk assessments were generally completed on admission with the exception of a few isolated incidents where we found incomplete assessments. However, the medical business unit did not use individualised care plans for patients, making it difficult to identify if staff were taking action to mitigate any risks found in the initial assessments.

Medicine management within the medical business unit was generally good. However the recording of controlled drugs (CDs) in the discharge lounge caused concern. It was not possible from the records available to identify if patients had received their CD medicines to take home with them.

Staff were following relevant National Institute for Health and Clinical Excellence (NICE) guidance. Staff regularly assessed patients for pain and provided pain relief in a timely manner for those who required it. All new staff attended a corporate induction programme which was supplemented with a local induction to their ward or department.

Patients we spoke with during our inspection told us they received care, which was dignified and respectful, and were complimentary about the staff providing the care. We saw examples where staff provided care that was compassionate and kind and reflected feedback from the patients themselves.

The trust had been experiencing high demand with high levels of bed occupancy, which reached 100% for the medical business unit during our inspection. The

escalation ward, which was often opened to care for patients of both sexes at times of high demand, was not equipped to accommodate patients for long periods and could not meet the personal hygiene needs of patients. During our inspection, patients had been admitted onto the ward for periods from 48 hours to several days. The area was not meeting the single sex requirements with patients of the opposite sex often having to walk past other patients to get to the toileting facilities.

With high demand and high bed occupancy, we saw large numbers of medical outliers throughout the hospital. The consultants from the medical business unit had made improvements to how some patients in non-medical specialty wards were cared for; however this was not consistent throughout the hospital. Younger adults, between the ages of 18 and 23 were being cared for on the children's ward and we found staff on both the children's ward and the gynaecology ward were experiencing difficulties when trying to access doctors from the medical business unit to care and review outlying medical patients.

Overall, the trust had mechanisms in place where they would try to meet the individual needs of patients, which included the use of activities to occupy patients living with dementia. However this was not consistent across the wards in the medical business unit and was reflected in the Patient-Led Assessment of the Care Environment (PLACE) score for the provision of care for patients living with dementia.

There was a mixed response as to whether the executive managers were visible on a regular basis; some staff had not seen any of them in their areas before. Although there was a business unit risk register, we were not assured that governance processes were in place to appropriately reduce and manage risks. However, staff spoke positively of their immediate managers and matrons. They also added there was an open and honest culture in the business unit and managers had an 'open door' approach.

Medical care (including older people's care)

Are medical care services safe?

Requires improvement



We rated safe as requires improvement. We found:

- Boxes of medical notes had been left in an area on one ward which was accessible to the public. After informing the trust, actions had still not been taken to rectify this.
- The checks for the resuscitation trolley that we saw for the month of inspection had some gaps within them.
- The Clinical Decisions Unit Plus (CDUP) was used for periods of escalation although it had no facilities to meet patients' hygiene requirements.
- Controlled drugs (CDs) were not being recorded correctly in the discharge lounge making it difficult to track whether patients had been given their CDs to take home.
- Patients were risk assessed on admission, however there were no general or individualised nursing care plans completed for patients once a risk assessment had been completed.
- Staff were not always conforming to infection control processes. We found that clean and dirty mattresses were stored together on one ward, covers for clean linen were not used appropriately and staff were not always using personal protective equipment.
- The sepsis protocol was not embedded within the trust. We found varying levels of compliance with antibiotic administration within 60 minutes. Whilst the trust was monitoring adherence to this protocol it was not being implemented and consistent levels of administration achieved.
- One hundred and eighty blood specimen bottles on one ward were seen to be out of date. The trust took immediate action to remove these during our inspection.

However we also found:

- A good awareness of the duty of candour in all levels of staff.
- All staff had a good understanding of the trust's incident reporting system and reported having feedback from any incidents they submitted.

- There had been no cases of Methicillin resistant *Staphylococcus aureus* (MRSA) bacteraemia this year and four cases of *Clostridium difficile* (C. difficile) due to lapses in care.

Incidents

- Incidents were reported through the trust's electronic reporting system. All the staff we spoke with were aware of the need to report incidents, near misses and accidents and knew how to use the trust's electronic reporting system.
- The trust had an incident reporting policy, which outlined staff responsibilities and timelines for reporting incidents.
- Two of the wards visited had a regular update on their staff notice boards. This gave, amongst other subjects, information relating to learning from the incidents they had raised. For example following a patient falling, it was found an incorrect falls alarm had been used. On one ward we saw changes to the incident reporting system in relation to medication had been highlighted. The changes had been identified for staff to follow.
- The trust had introduced large TV screens on each ward to display information for patients, visitors and staff. This will include incidents of pressure ulcers, falls, infection control data and changes made as a result of incidents.
- On another ward, following an investigation, the trust had introduced a nasogastric insertion and position record for patients receiving nutrition through a naso-gastric tube. A naso-gastric tube is a fine plastic tube passed into a patient's nose and down into their stomach. It is sometimes used for patients who are unable to swallow food.
- Of the 1,687 incidents reported between 1 January 2015 and 31 December 2015, 1,137 had been categorised as no harm, 370 as moderate harm, six as severe harm, one death and 122 near misses.
- Twenty three serious incidents requiring investigation had been reported in the medical wards between October 2014 and September 2015. Of those 23, 16 had been due to pressure ulcers and seven to slips, trips and falls.
- There had been no never events recorded at the hospital between October 2014 and September 2015. Never events are serious incidents that are wholly

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preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should be implemented by all healthcare providers.

- Patients who were at high risk of falls were equipped with falls alarms to alert staff to when they were moving in their beds or getting up from a chair. In addition, where it was possible to do so, patients who were at risk of falling were placed in bays near the nurses' station so their movements could be seen more easily.
- A root cause analysis had been undertaken for all serious incidents with actions taken to prevent any reoccurrence. We reviewed one root cause analysis which was thorough in its content and outlined actions that had been taken to prevent similar occurrences.
- The medicine business unit had local arrangements for undertaking morbidity and mortality reviews that were reported via monthly rolling governance meetings. An online tool had been developed within the trust with the intention of standardising the approach across the hospital.
- We reviewed the minutes from four medicine mortality and morbidity meetings from September 2015 to December 2015. Each showed the case discussed, any issues that were highlighted in the management of the patients, questions raised as a result of them and actions taken to reduce risks. For example, a patient who had suffered a stroke had not been cared for on the stroke ward or prescribed Aspirin straight away. Incorrect results from a diagnostic test had also been highlighted as an issue. Actions were taken as a result of the mortality and morbidity meetings to reduce risks in the future.
- We spoke to staff about their understanding of the duty of candour. The duty of candour is a regulatory duty that requires providers of health and social care services to disclose details to patients (or other relevant persons) of 'notifiable safety incidents' as defined in the regulation. This includes giving them details of the enquiries made as well as offering an apology.
- Duty of candour processes had been written into in the trust's incident reporting policy.
- All the staff we asked about duty of candour knew what it was and how to deal with such issues. One member of staff told us about such an incident; the trust was speaking with the family which was being arranged at the time of our inspection.

Safety thermometer

- The medical care services at Yeovil District Hospital took part in the national safety thermometer scheme. Data was collected on an identified day each month to indicate performance in key safety areas. This included pressure ulcers, falls, urine and urinary catheter infections and incidence of blood clots.
- Data from the safety thermometer was not displayed in all wards, which meant patients and the public could not see how some wards were performing in relation to patient safety. Boards, which contained safety thermometer data, had however been displayed in corridors which did not have a great footfall of staff, patients or relatives and therefore were not viewed routinely. On the Emergency Admissions Unit (EAU) safety thermometer data was clearly visible. On one ward we were informed the board had only just been put up. On another ward the data was displayed in an office. Staff on this ward told us the sister discussed their data during ward meetings. On a fourth ward, staff we spoke with were pleased their data had improved. The trust was in the process of installing digital displays to ensure consistency of displaying this data.
- Between December 2014 and December 2015 data showed the rate of pressure ulcers on the medical wards had been consistent; the number of pressure ulcers at grades two, three and four had been between two and six per month. The most pressure ulcers had occurred in July 2015.
- Fourteen falls causing harm had occurred between December 2014 and December 2015. Most falls had occurred in April 2015.
- Nineteen catheter acquired urinary tract infections had occurred between December 2014 and December 2015. Six of those had occurred in June 2015.
- The data showed that most pressure ulcers, falls and catheter acquired urinary tract infections occurred between April 2015 and July 2015. This meant most incidents occurred in the four month period of April 2015 to July 2015. An upward trend for pressure ulcers and falls resulting in harm was noted up to November 2015. However further evidence requested from the trust showed the numbers had started to follow a downward trend with the exception of the number of new pressure ulcers recorded on one ward.

Cleanliness, infection control and hygiene

Medical care (including older people's care)

- Overall, we found the medical care wards at the hospital were visibly clean although some equipment was not stored appropriately. For example in the endoscopy suite, whilst the endoscopes were stored correctly other equipment was stored in the corridor including commodes, an electrocardiograph (ECG) machine, storage cabinets and lockers. Equipment used by cleaning staff was stored in the sluice area and toilet rolls were left on commodes. This means that equipment was not being stored in a way that reduced the risk of infection.
- There had been no cases of Methicillin resistant *Staphylococcus aureus* (MRSA) bacteraemia at the hospital in the current financial year. (MRSA is an infection which is sometimes very difficult to treat).
- From April 2015 to March 2016, there had been 15 cases of *Clostridium difficile* (C.Diff) within the trust with nine of those occurring on medical wards. Four wards where patients had been identified as having C. diff had failed the trust's C. diff audits. The audits highlighted whether the correct pathways had been completed, the Bristol stool chart had been used and whether patients had the correct isolation signage in place to reduce the risk of infection to others. The Bristol stool chart is a tool designed to classify the consistency of faeces.
- The trust's 2015/2016 threshold for C diff. cases due to lapses of care was eight. Of the 15 cases the trust had identified, four of those had been identified as lapses of care. From the root cause analyses (RCA) of the C. difficile cases, the common lapse in care was due to inappropriate antimicrobial (antibiotic) prescribing.
- Patients with infections were prioritised to be nursed in side rooms and the necessary precautions displayed on the doors for staff and visitors to see. Where patients with infections required doors to the side rooms to be left open for safety reasons, a risk assessment was completed and documented in the patient's notes.
- The trust used an electronic system to monitor all patients with an infection risk.
- In one medical ward, we identified that some clinical hand washing sinks had plugs attached to them and were therefore not compliant with HBN 00-09 infection control in the build environment.
- There were adequate hand washing facilities in all clinical areas and we observed staff washing their hands or using hand cleansing gel between patients and when leaving or entering different areas. The gel bottles we used during our inspection were all functioning and dispensing gel.
- Hand hygiene and personal protective equipment (PPE) audits had been undertaken throughout the medical wards and results were variable. For example on ward 9b hand hygiene audits undertaken on a monthly basis between June 2015 and August 2015, showed of the 27 observed hand hygiene moments across all groups of staff, 20 were compliant with good practice and seven were non-compliant. The worst performing group were doctors. The five moments of hand hygiene define the key moments which add value to any hand hygiene improvement strategy. For example before and after touching a patient and their surroundings.
- All clinical staff observed were compliant with the trust's bare below the elbows policy. However, we saw members of administrative staff working in the endoscopy suite, Clinical Decision Unit Plus (CDUP) and ward 9b who were not bare below the elbows even though they were working in a clinical environment. We asked a sister on ward 9b whether all staff including non-clinical staff should be BBE, she informed us that their policy was that all members of staff on the ward should be bare below the elbow. However the trust told us that this was not in the current policy which stated that only clinical staff were required to be bare below the elbow.
- Staff in the endoscopy suite followed appropriate decontamination procedures for cleaning endoscopes after use.
- During our observations in all medical areas, there were plentiful supplies of PPE available. However, staff were not always observed wearing PPE correctly. We saw one member of domestic staff removing waste from a ward wearing gloves but no disposable apron. We also observed clinical staff performing tasks which involved blood and bodily fluid exposure wearing gloves but no apron. This meant uniforms were not always protected and the risk of spreading organisms was increased.
- We requested more recent data from the trust which showed that in general, staff knowledge on the correct use of PPE was increasing. However, there were still some staff who were unsure as to when FFP3 (filtering face piece) masks should be used. FFP 3 masks should be worn when caring for patients with infectious respiratory infections such as influenza and

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Tuberculosis (TB) where transmission (spread) may occur when providing care and treatment. All staff should undergo specific training to make sure they apply the masks correctly, therefore reducing the risk of catching the infection themselves. The trust assured us that this training was given in relevant areas.

- We reviewed cleaning audits for medical wards from December 2015. All the wards apart from 8b scored above 95%. Ward 8b scored 93%. This shows the cleaning of medical wards was, in the main, above the trust's target of 95%.
- As per trust policy only commodes were labelled with 'I am clean tape' other equipment was not labelled in this manner. We could not be assured that other equipment was cleaned in line with trust policy. The standard cleaning of bed space and mattresses were undertaken by nursing staff but there was no evidence to indicate that these had been cleaned. There was also evidence of items being stored in clean utility rooms which had not been adequately cleaned. An example of this was on ward 9b where two out of four commodes checked were found to still be dirty. In addition, all the commodes had toilet rolls attached to them. This meant infection could be spread from one patient to another.
- On the same ward we saw a piece of equipment which warms patients up and prevents unintentional hypothermia (cooling). We were informed it had been cleaned and there was a visible decontamination certificate placed on the item. However this had been left on the floor and could easily become contaminated before being used again.
- Deep cleaning of rooms or cubicles was undertaken by housekeeping staff during the day and up until 2am. Outside of that time deep cleaning was undertaken by ward staff. We were informed deep cleaning included using a sodium hypochlorite/bleach type liquid on all hard surfaces and replacing all the curtains.
- Clinical and domestic waste was appropriately separated and arrangements were in place for the separation of high risk linen, for example linen used for patients with infections or linen that was soiled.
- Clean linen was stored on metal shelving units that had zipped covers to prevent cross contamination. However, we found the covers on all wards were not always being zipped up to protect the clean linen. This increased the risk of cross contamination.

- Used sharps were placed in appropriate containers which were sealed before being removed from clinical areas. This meant the medical wards complied with the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013.
- On ward 8a we found 180 out of date clinical items (mainly blood bottles). This increased the risk of inaccurate blood results. The trust took immediate action to remove these during our inspection.
- On the same ward we found two cannulas that had blood on the packaging placed back into a draw with clean items. This could have led to the contamination of other pieces of equipment.

Environment and equipment

- A new 24 bedded modular ward, called the Emergency Assessment Unit, had opened within the hospital. This had been designed, planned and delivered within a ten month period and had helped to provide care and treatment for the increasing number of medical patients requiring admission. We found the unit was spacious and well equipped and could ensure care for both male and female patients. Shower and toilet facilities were available in each bay to ensure patients had no need to access other areas of the ward in order to use the facilities.
- We looked at resuscitation trolleys in all wards we visited. We found that on general wards one resuscitation trolley was available between two wards on the same floor. If a second trolley was required this would be obtained by the portering staff and brought to the area of need.
- We were only able to observe the daily checking of resuscitation trolleys for the month of our inspection. Previous months' checks had been removed and stored elsewhere. Daily checks were in the main undertaken with only a few examples of a day being missed during the first 17 days of March, the month of our inspection.
- Ward 10 cared for children as well as younger adults up to and including the age of 23. We found the resuscitation trolley on the ward was equipped to care for adults as well as children.
- We saw many items of equipment stored on wards, including walking frames, commodes and Bilevel Positive Airway Pressure (BIPAP) machines. (BIPAP machines are used to assist patients to breathe for conditions such as congestive heart failure, lung disorders or certain neuromuscular disorders). Some

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equipment was stored appropriately but where space was limited we saw equipment stored on floors and in corridors. For example, during our evening visit we saw two mattresses standing on their sides in corridors. One had no label on it; the other was labelled stating that a check had been undertaken and there was no visible contamination. We were informed the mattresses were awaiting removal.

- An equipment library was accessible for other items, for example syringe drivers, intravenous pumps, and falls alarms.

Medicines

- Medicines were stored securely in locked trolleys and cupboards. Intravenous fluids were stored appropriately and off the floor. Keys to medicine cupboards were held by an appropriate member of staff in each clinical area. On one ward a medicine cupboard we asked to see could not be unlocked. The trust's estate management team dealt with this appropriately.
- Medicines requiring refrigeration were stored in dedicated medicines fridges. Temperatures for the fridges were checked centrally and electronically by an external provider. Any temperature variances outside acceptable parameters were dealt with appropriately between the external provider and the trust to ensure the medicines remained effective.
- The management of controlled drugs (CDs) on wards met legal requirements. CDs are prescription medicines which are controlled under the Misuse of Drugs legislation. Patients in the discharge lounge who required controlled drugs (CDs) to take home had their medicine recorded in the discharge lounge's CD requisition book. However, they were then given directly to the patient without any recording of such action in the requisition book. This meant it was not possible to tell from the CD records whether CDs had been given to patients.
- Oxygen is a prescription only medicine, unless given in an emergency. However this was not always prescribed for patients receiving it.
- Prescription charts were legible and complete and patient's allergies were noted. Doctor's signing prescriptions had been identified by their internal 'bleep' number. This meant they could be contacted if there was a query about a patient's medicines.
- Medicines were administered by appropriately trained staff who had been assessed as competent to do so.

From our observations we saw qualified nurses following the Nursing and Midwifery Council's 'Standards for Medicines Management.' Nurses undertaking medicine administration wore red tabards indicating they were not to be disturbed during medicine rounds.

- We observed staff checking patient's details before administering medicines to them. This ensured the patient was receiving the correct medicines.
- Prescription charts had evidence of a clinical pharmacy review including medicines reconciliation. (The aim of medicines reconciliation for patients admitted to hospital is to ensure that medicines prescribed on admission correspond to those the patient was taking prior to their admission).
- A ward based pharmacy service was in place and visits were undertaken by pharmacy technicians who were supported by a pharmacist. Patient's prescriptions were checked by a pharmacist to ensure their medicines treatment was safe, effective and met current guidance. Clinical staff could access a pharmacist for advice when required.
- Pharmacy was open from 9am to 5.30pm Monday to Friday; 9am to 12.30pm on Saturdays and 10am to 12pm on Sundays. Out of hours, authorised staff had a swipe card which they used to access commonly used medicine from a locked cupboard. In addition, the on-call pharmacist could dispense medicines remotely if this was required.
- Antimicrobial stewardship within the medical wards demonstrated variable levels of compliance with best practice. Audits conducted by the trust in December 2015 showed medical staff were prescribing patients with the right antimicrobial according to the trust's policy. However, they were not including a stop/review date or an indication for the antimicrobial. We reviewed five prescription charts which supported the findings of these audits. This meant patients were not always receiving antibiotics according in line with best practice. Patients sometimes experienced delays in obtaining their medicines to take home on discharge. This resulted in those patients having to stay in the hospital's discharge lounge for prolonged periods.
- There had been six medicine errors on the medical wards between January 2015 and December 2015; there were no common themes or trends that could be identified.

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- Data from the National Diabetes Inpatient Audit (NaDIA) demonstrated the trust had performed worse than the England average for insulin errors since 2013. (Insulin is a medicine given to diabetics). Data requested from the trust showed there had been nine reported insulin errors on medical wards from 1 November 2015 to 30 April 2016. Four of those occurred on the Emergency Admissions Unit and one had been classed as a 'near miss'. A near miss is an incident in which no personal injury was sustained, but where, given a slight shift in time, damage or injury could easily have occurred.

Records

- Patient care records were in paper format. In the majority of clinical areas we saw patient records were stored securely in records trolleys and were locked when not in use. However, in the clinical decision unit on the morning of 17 March 2016 we found the medical records trolley was open and unlocked. On ward 9a during our evening visit on 16 March 2016, we found a small cupboard with no door, containing cardboard boxes full of patients' medical records. We informed the trust the next morning about this information governance breach so they could take immediate action. However, later that day when we returned to the ward we found no action had been taken to secure the medical records. On the same ward, we found patients' medical records left unsecured on the reception desk. This meant people who were not authorised to access them could access the records. This constituted a breach of information governance and patient confidentiality.
- Staff filed medical and nursing records separately and records were available to those who needed to use them. We looked at six sets of medical and nursing records. Nursing records such as fluid balance charts and care rounding checklists were kept at the patients' bedside. (Care rounding is a system of checking patients are safe and comfortable on a regular basis). At Yeovil District Hospital, how frequently care rounding took place depended on the outcome of risk assessments such as those undertaken to determine a patient's risk associated with falling, pressure damage, incontinence, nutritional status and hearing, visual or speech impairment.
- Care documentation/care bundles included risk assessments such as those used to assess risk associated with falls, pressure ulcers, nasogastric tube

insertion, heel protection, diarrhoea and vomiting. All the documentation we viewed had been labelled with the patient's name appropriately although none of the six sets of records had been completed in full. An example of this was a patient who had been identified as a high risk of developing a pressure ulcer; however, this section of the form, which then requires the user to complete specific actions taken, had not been completed.

- Minutes of a sister's meeting held on 3 February 2016 showed multidisciplinary assessment forms were not being used properly and the first four hours of a patient's assessment should be discussed during handover from one shift to the next.
- There were no nursing care plans in place for patients on the medical wards. A nursing care plan is used to describe the services and support being provided and should be put together and agreed with the patient through the process of care planning. The trust were moving to electronic records which would include a care plan. At present staff were to complete risk assessments and individualise care in the box provided on the risk assessment form. However we found that this was seldom completed. This meant that care staff may be unaware of individual needs or preferences.
- We observed a nursing handover between a shift change during our evening visit and saw the handover sheet identified each patient on the ward and which bay they were in. Whilst each patient's diagnosis and resuscitation status was mentioned there were no details of the plan of individualised care for them. Staff used the handover sheet to document what they needed to do for each patient. They then kept the sheet in their pocket and referred to it during their shift. This acted as a 'task list' for nursing staff but did not relate to each patient's overall plan of care.
- Specific documentation was in place for patients who had been transferred to the 'medically fit for discharge ward.' It included a tick list for the referral process to ensure only patients who met the criteria for admission to the ward could be considered for transfer.

Safeguarding

- The trust had a safeguarding lead in place and staff we spoke with knew who this was.
- There was a child protection and a trust adult safeguarding policy, both of which were in date, for review January 2019.

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- A safeguarding adults working group was in place and at their meeting in October 2015 it was agreed the adults and children's working groups should be combined.
- At a meeting in November 2015, a joint meeting with representatives from a local mental health trust agreed that a single training strategy should be developed and implemented across all health and social care providers in Somerset. This aimed to ensure there was consistency on levels of training, target audiences and use of resources.
- As part of the training strategy, level three 'PREVENT' training should have been undertaken by all clinical staff working with adults. PREVENT is part of the government's strategy to prevent radicalisation. Information received from the trust showed that this training was a module which was combined with the level one adult safeguarding training. The trust were planning to appoint a lead for the PREVENT training and intended to conduct specific training throughout the next year using their 'snack box' method. (The snack box method was short fifteen minute timeslots for delivering a variety of training).
- Level two safeguarding training was delivered as part of the staff mandatory training programme for all staff on medical wards. This was undertaken as a face-to-face session for one and a half hours with a work book to complete for all participants. Any new staff received the training as part of their induction process.
- Qualified nurses and medical staff had not achieved the trust target training level of 90% for adult safeguarding. The attained levels were 83% and 87% respectively. However the service had achieved the trust target for child protection training with levels of 94% and 97%.
- Staff we spoke with were able to identify different types of abuse including female genital mutilation (FGM) and spoke confidently about the actions they would take if they suspected that a patient was experiencing abuse.
- Between 1 May 2015 and 30 April 2016, 209 referrals were made to the trust's safeguarding team from the medical wards. Twenty five of those were referred on to the local adult social services safeguarding team. Nineteen of the 209 referrals were for patients with a learning disability, although none of the 19 required onward referral to the social services safeguarding team. The figures indicated that staff had a good awareness of safeguarding adults and referred appropriately.
- There were arrangements in place to provide mandatory training for all staff on an annual basis. Staff we spoke with were aware of the mandatory training they were required to undertake. Mandatory training included fire, infection prevention and control, manual handling, mental capacity, information governance and safeguarding training.
- Data provided by the trust showed there were variable completion rates for staff across the medical wards. For example, stroke and elderly care staff had achieved 93% for 2015. The Emergency Admission Unit completion rates were 95%; wards 9A and 9B were 94% and 96% respectively. Ward 8A showed 81% and Acute Coronary Care Unit was 79%. The trust's target rate for completion of mandatory training was 90%. The trust informed us that there was a 10% sickness and vacancy rate on ward 8A which impacted on compliance with the trusts target.

Assessing and responding to patient risk

- Patients were monitored in line with National Institute for Health and Care Excellence (NICE) guidance (Acutely Ill Patients in Hospital).
- Sepsis is a life-threatening condition that arises when the body's response to infection injures its own tissues and organs. The sepsis antibiotic administration and screening audit was part of the trust's Commissioning for Quality and Innovation (CQUINs) payments framework. CQUINs encourage care providers to share and continually improve how care is delivered and to achieve transparency and overall improvement in healthcare.
- The trust's sepsis screening audit had improved from 30% in June 2015 to 81% in December 2015. From January 2016 to March 2016 the results from the sepsis audit demonstrated variable levels of compliance with the trust screening protocol. Compliance dropped in January 2016 to 69% but had increased again to 91% in March 2016. The trust was working to embed the screening protocol with all staff so that a consistently high compliance could be achieved.
- Antibiotic administration within an hour of admission for patients with sepsis had increased from 44% in April 2015 to 100% in December 2015. The results from the most recent audit showed that compliance with administering antibiotics within an hour of admission had dropped to 57% in January 2016 and 59% in

Mandatory training

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February 2016. This shows that the sepsis protocol was not embedded within the trust due to inconsistent compliance with antibiotic administration for a patient identified as being septic.

- The trust was introducing a system of e-observations records across the hospital including the medical wards. However, paper observation records were being used on all the wards we visited.
- Nursing staff used a National Early Warning System (NEWS) to record routine physiological observations such as blood pressure, temperature and heart rate throughout the medical wards. The NEWS system was designed to enable staff to recognise and respond to acute illness, acute clinical deterioration and to trigger different levels of clinical response proportionate to the severity of deterioration. We saw that NEWS charts were completed appropriately and patients who were at risk of deteriorating escalated. During night-time hours when the number of medical staff was reduced, a senior site nurse was available for advice and support when a patient deteriorated.
- A critical care outreach team could attend wards when required to support ward staff and doctors until the patient's condition had stabilised.
- Patients who were medical outliers did not always receive the same standard of care as they would if they were on their specialty ward. Staff on three wards told us about the frustrations they had in trying to get a doctor to review their medical patients.
- The trust provided us with Commissioning for Quality and Innovation (CQUIN) data for sepsis management in 2015. The most recent results (February 2016) demonstrated that of the 47 patients who should have received sepsis screening, 43 were screened, representing 91%. Fifty nine percent of patients with sepsis received antibiotics within one hour. (CQUINs are a payment framework which enables commissioners of the trusts' services to reward excellence, by linking a proportion of healthcare providers' income to the achievement of local quality improvement goals.) The trust was working to embed the screening protocol with all staff so that a consistently high compliance could be achieved.
- We saw no evidence of any care plans, generic or individualised which provided other healthcare professionals with information about the care required for that patient in response to the comprehensive assessments completed. Staff on the wards relied on

their handover sheets to be able to identify what individualised care a patient required. Some staff informed us that if they lost their handover notes, they would not know what care to provide for their patients.

- We reviewed minutes of an anaesthetic clinical governance meeting dated 16 February 2016. An item had been raised about the management of patients on the High Dependency Unit (HDU) and Intensive Therapy Unit (ITU) who were under the care of the medical team, but whose care management had given rise for concern. Very junior doctors had been sent to HDU to deal with patients/relatives without proper experience. Staff were concerned at the seniority of doctor reviewing patients and responding to requests from relatives. They requested input from senior medical staff.

Nursing staffing

- Between January 2014 and December 2015, the average sickness absence rates for nursing staff across the trust were below the English national average for NHS acute trusts. Sickness rates were between 3% and 4%; in comparison to the national average which was between 4% and 5%.
- Data provided by the trust showed the sickness rate for registered nurses for a 12 month period ending February 2016 was 2% which remained below the England average. The sickness rate for unregistered nurses for the same period was 6%.
- In the same period vacancy rates for nursing staff across medical care services at Yeovil District Hospital was 15% for registered nurses and 12% for unregistered nurses. The staff who we spoke with told us that staff turnover appeared relatively low with many staff telling us how they had worked at the hospital since qualifying as a nurse which was several years ago. An exception to this was on ward 8a which had recently seen a high turnover of staff on the ward, with senior staff nurses leaving their positions. The manager of the ward had not identified any themes associated with the reasons for staff leaving but made it clear this was a rare occurrence for the trust.
- The trust had acknowledged that recruiting nursing staff had been a priority in common with other NHS trusts during 2015. The trust had made significant efforts to integrate new recruits and fill nurse vacancies. The trust had implemented an overseas recruitment strategy and had filled 120 posts with nurses from Europe. Thirteen overseas nurses had been recruited across two wards. This had sometimes caused concerns for other nursing

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staff on the wards with regard to supervising and mentoring them at the beginning of their employment. The difference in languages caused concern to staff as their colleagues and patients had not always understood them. Overseas nurses had been asked not to speak in their own language but to use English. An additional matron had been appointed to support the induction and training of overseas nurses working on medical wards to ensure effective mentoring and supervision was provided. The trust had provided the overseas nurses with additional English lessons.

- We observed handovers between the night and day nursing staff on the medical wards. The process was factual with patients discussed briefly and their resuscitation status explained.
- We received information from the trust showing the planned and actual number of hours for trained and health care support workers in the months from November 2015 to February 2016 for the medical wards at the hospital. The average percentage for the medical wards over the period indicated the medical wards had between 98% and 114% of actual allocated staff hours of registered nurses. Care staff average percentage showed between 98% and 107% of allocated hours.
- The hospital's bank nursing staff had been utilised in the period April 2015 to February 2016. Bank staff are staff who are employed by the trust and who undertake additional hours to support the trust when they are required.
- In the same period nurse agency usage for medical wards ranged from 37% on ward 6b in April 2015 to 1% on CCU in November 2015. All medicine specialty wards had used nurse agency staff to support the trust's own staff during the entire period. This had also happened in other acute trusts across England. Agency nurses received an induction from the permanent ward nursing staff.
- Dependency levels of patients were calculated each morning prior to the multi-disciplinary team meeting at 9am.
- Nursing staff we spoke with said that in general they felt they had sufficient staff to give good care to patients although at times they struggled because of the high dependency of patients they cared for.
- Staffing levels were assessed using the Association of UK University Hospital (AUKUH) acuity dependency tool, which has recently been modified by Shelford. This tool measured the individual dependency of patients and

calculated how many nurses were needed to care for them. In general the suggested ratio of nurses to patients was 1:8 however the actual number of nurses depended on the acuity of patients on the ward. In general the trust staffed to meet the assessment of nursing numbers required to care for the acuity of patients on the ward.

- During our evening visit, we spoke to nursing staff who were concerned about the staff mix on the wards, especially on night duty. For example, there were three trained staff on a medical ward of 30 patients where the dependency of patients was high. This included three patients at risk of falls, four patients with a diagnosis of a dementia and nine patients requiring frequent interventions by nurses. The majority of patients were older people. Two health care support workers were on duty supporting the trained staff. The nurse in charge of the shift was worried about the responsibility they had because of their lack of experience and was at risk of losing one of their trained colleagues to support another ward. They confirmed that losing a trained member of staff was commonplace. If this had occurred, the registered nurse/patient ratio would have been reduced to 1:15. Decisions to move staff between clinical areas to meet acuity and dependency needs is supported by the use of a risk assessment, using the acuity dependency tool, to ensure safe staffing levels across the trust.
- Staff informed us the duty site manager was always approachable at night time if they were needed. In addition the outreach team were available and they would attend the ward if required. This was particularly important if medical staff were delayed in attending the ward.
- Generally nurses undertook 12 hour shifts, starting at either 7.30am or 7.30pm. When night staff commenced duties, patients had not necessarily settled for the night and visitors were still on the wards. This meant the wards were still busy although staffing numbers were reduced.

Medical staffing

- The trust's medical staffing showed that 37% of the skill mix was made up of consultants. This was better than the national average which was 34%. The trust had a higher level of middle grade doctors (10%) than the English national average (6%) for acute trusts. In addition the trust had a lower than average number of

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registrars with 36% compared to the England average of 39% and higher than average number of junior doctors (27% for this trust; 22% England average). This meant the service was more dependent on junior and middle grade doctors.

- The trust had recognised they faced a recruitment challenge in relation to recruiting medical staff to care of the elderly. Locum usage in the medicines business unit from April 2015 to March 2016 ranged from 20% in care of the elderly from April 2015 to July 2015 to 4% in emergency medicine in March 2016. Locum staff are doctors who temporarily undertake the duties of another doctor when a hospital is short staffed. Consultant cover for the Emergency Assessment Unit (EAU) was from 8am to 8pm daily. After this, the on-call consultant provided assistance if required.
- Consultants worked an on call rota to ensure there was senior cover for both week days and weekends.
- Our discussions with senior medical staff revealed the trust had recruited nine additional doctors. Two doctors had been recruited when the new emergency admissions unit had opened. These doctors are those who are undertaking a two year generic training programme which forms the bridge between medical school and specialist or general practice training. The trainees have the opportunity to gain experience in a series of placements in a variety of specialties and healthcare settings and are supervised by senior colleagues.
- The increase in middle grade doctors had uplifted the total number of doctors to 17. This allowed 15 doctors to be working on a rota, ensuring there were two doctors covering each medical ward with an additional two doctors going where they were needed or providing holiday cover.
- The on-call day team consisted of one consultant, one registrar and two middle grade doctors. This team provided cover from 9.30am to 10pm. In addition to the three members of staff, there was a further doctor who would complete a twilight shift to boost resources at the expected busiest times. They worked from 11am to 10pm.
- The on-call night team consisted of one registrar and one middle grade who provided cover for the whole of the medical business unit between 10pm to 9am. This was in addition to the consultant that was on-call who may be off site. Some of the staff we spoke with felt this was not enough staff to cover the medical business unit

at night, especially if there was a high influx of patients arriving at the Emergency Admissions Unit. They had previously suggested changing the hours for the twilight doctor so that it covered some of the on-call hours for the night-time shift; however this had not happened due to perceived issues with the staffing in the day time.

- Medical staffing handover arrangements were both verbal and electronic. Staff identified patients requiring further examination, patients who were deteriorating, and the status of patients requiring treatment and care. There were clear actions and medical staff were aware of their responsibilities at the start of their shift.

Major incident awareness and training

- There was a trust wide major incident plan in place to guide staff of all levels and in all locations as to what actions they needed to take in the event of a major incident being declared.
- There was a patient flow and escalation plan available for staff to follow in the event that the hospital was experiencing high demand, seasonal pressures and major incidents. Within the plan, the trust had identified where additional capacity could be sought to enable them to meet the demand. Additional standard operating procedures (SOPs) were also provided within the escalation plan for areas where additional capacity was provided so all staff involved in providing care in those areas knew their roles and responsibilities.
- Staff told us they knew about the major incident policies and that they were kept on the trust's electronic intranet. Some staff also told us they had been involved with some practice fire drills that took place on an annual basis. Following the drill, staff received feedback on how they performed as a ward or department.

Are medical care services effective?

Good



We rated effective as good. We found:

- Staff were following relevant National Institute for Health and Clinical Excellence (NICE) guidance.
- We saw evidence of staff conducting comprehensive assessments of patients on admission. Staff regularly assessed patients for pain and provided pain relief in a timely manner for those who required it.

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- There was an audit programme for medicine, which covered all departments. All audits were mapped against relevant national best practice guidance. When completed there was evidence of recommended improvements to practice and local policies.
- The trust performed in line with the national average in relation to thrombolysis and national audits for diabetes and heart failure.
- Whilst the mechanisms for highlighting patients who required support to eat and drink were inconsistent we found that staff assisted patients who required support.
- All new staff attended a corporate induction programme which was supplemented with a local induction to their ward or department.

However, we found that:

- The endoscopy department had been deferred for the Joint Advisory Group (JAG) re accreditation due to an increase in waiting times for procedures. However a recovery plan was in place to meet the deadline for reducing the waiting list. The unit remained JAG accredited at the time of our inspection.
- Appraisal rates were below the trust target for all staff groups.
- The trust performed worse than the England average for two out of three measures on the Myocardial Ischaemia National Audit Project (MINAP).

Evidence-based care and treatment

- Staff were aware of National Institute for Health and Clinical Excellence (NICE) guidance relevant to their work. We observed staff providing care which was compliant with relevant guidance. We specifically looked at the guidance relating to patients who had a cardiac condition and patients who had experienced a stroke.
- We viewed the trust's data for patients requiring thrombolysis following a stroke. Thrombolysis, which is commonly known as 'clot busting', must take place within four and a half hours from the onset of a stroke if it is to be effective. Data received from the trust for the previous 12 months showed that 49 patients had required thrombolysis. Of these 49 patients, five patients (10%) had received the treatment within 30 minutes of arrival at hospital and a total of 29 patients (59%) had received treatment within 60 minutes of arrival at hospital. This was better than expected.

- Across the acute medical services, we saw evidence of staff following NICE guidance CG92 in the assessment and treatment of venous thromboembolism (VTE).
- Clinical policies and guidelines were available for all staff on the trust intranet and we saw staff using the system to locate policies when required.
- We saw evidence of staff conducting comprehensive assessments of patients on admission which covered most health needs including physical, mental, emotional and spiritual health as well as any clinical needs.
- The acute medical services participated in all national clinical audits they were eligible for. This included the heart failure audit, the Myocardial Ischaemia National Audit Project (MINAP), the Sentinel Stroke National Audit Programme (SSNAP) and the National Diabetes Inpatient Audit (NaDIA).
- There was an audit programme for medicine, which covered all departments. All audits were mapped against relevant national best practice guidance. When completed there was evidence of recommended improvements to practice and local policies. We reviewed an example of a completed audit that had been completed on chest drain insertion. This audit was reviewing compliance against the British Thoracic Society (BTS) guidelines. The audit found that although practice was compliant, documentation did not meet the required standard and actions were put in place to address this.
- Ward staff conducted monthly fundamentals of care audits within their areas and this information was fed back to staff during ward meetings.
- Care pathways were in place for patients who were admitted with circulatory and cardiac conditions, respiratory conditions and a range of other medical conditions including cellulitis, abscesses and acute oncology patients. (Cellulitis is a spreading bacterial infection just below the skin surface).
- Each patient had a magnetic white board at the head of their bed. Signs were used to indicate, for example, whether a patient was at risk of falling, or whether they were living with a dementia. The whiteboards, however, were not being consistently used or updated throughout the medical wards. We saw 11 patients on different wards who had no signage above their beds even though staff told us they required it. Staff informed

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us they did not always have time to place the signage on the boards; they could only do that when they were not busy. This meant that patients were at risk of receiving inappropriate care and treatment.

Pain relief

- We observed staff assessing patients' pain. They recorded the information and took appropriate action to alleviate it. Staff assessed patients' pain whilst undertaking their clinical observations and completing care rounds. Care rounds were performed on a one to two hourly frequency which focussed on improving patient safety and the patients' experience within the hospital. Staff recorded the patient's pain score on their observation chart.
- Medical staff prescribed analgesia (pain relief) on each patient's prescription chart. We saw evidence of patients being prescribed regular and as required analgesia. Patients we spoke with told us they were always given pain relief without delay when they asked the staff for it.
- We observed staff discussing patients' pain levels during handover and the actions taken to try to reduce it. For patients who had persistent pain a specialist pain team was available to advise on appropriate treatment.
- The trust had not completed any pain relief audits during 2015. Through analysis of national survey data, 93% of patients were happy with the way in which staff managed their pain. In 2016, the trust was planning to complete a pain relief audit on patients living with dementia. Wards caring for patients living with a dementia used a recognised pain scale appropriate for those patients.

Nutrition and hydration

- All the medical wards and departments in the hospital used the Malnutrition Universal Screening Tool (MUST). The MUST tool is a five-step screening tool which is used to identify patients who are malnourished, at risk of malnutrition or are classed as obese. The tool also indicates management guidelines for at risk patients, which can form the basis for individualised care plans. Staff told us that any patients who had been identified as being nutritionally at risk would be referred to the dietetics department for review by a dietician.

- Food charts were used for some patients to record their daily intake and to provide assurance that the patient was receiving adequate nutrition. Staff told us food charts would be used if the MUST assessment indicated the patient was at risk of malnutrition.
- There was a system in place on the medical wards which used symbols above a patient's bed to indicate patients who required assistance with eating and drinking. This also included a sign for patients who had swallowing difficulties and required their drinks to be thickened. However, not all wards were using these effectively, with some patients not having signs above their beds who required them.
- We observed a red top jug and red plate system on one ward, which was used to identify patients living with a dementia who required assistance with eating and drinking. Staff told us the use of the system was inconsistent and not all patients who required this system had it put in place.
- During our inspection, we observed staff helping patients who required assistance to eat and drink. We observed staff sitting with patients whilst they were helping them, which is good practice. When staff had finished helping patients, we saw them replace the patient's table at the side of them, making sure they could reach their drinks.
- The hospital was able to provide finger food for patients who preferred not to sit at a table and eat but who liked to walk around; these were high in calories. Snack boxes were also available which meant patients could have something to eat at any time.
- The Patient-led Assessments of the Care Environment (PLACE) from 2015 scored 67% for the food that was served to patients. This was below the national average of 88.5%.
- Staff on one ward informed us they had stores of adaptable cutlery for patients who required it to promote independence; we saw this in use.
- Protected meal times were used to enable patients to eat sufficiently and uninterrupted. Staff told us if the patients had relatives or visitors who wished to support them to eat, this was welcomed and encouraged. During our inspection, we did not see any interruptions to the protected meal times.
- The hospital's speech and language therapy (SALT) team provided assistance to the stroke ward during working hours. Between Monday and Friday they made sure all patients who had experienced a stroke had a

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swallowing assessment performed and their condition reviewed if required. The SALT team provided general swallowing assessments in other medical wards on Mondays, Wednesdays and Fridays.

Patient outcomes

- The Standardised Relative Risk (SRR) of re-admission for elective medical admissions at this trust was 74, which was below the England average benchmark of 100. The SRR of re-admission for non-elective admissions was 70, which was also below the England average benchmark of 100. This meant the trust was performing better than the England average, as there were fewer observed re-admissions than expected.
- Monitoring by the Care Quality Commission (CQC) had not identified any areas where medical services at the hospital would be considered as a statistical outlier in mortality when compared with other hospitals. The last time the hospital was identified as having mortality outliers was in 2012. (Outliers are statistical observations that are markedly different in value from the others of the sample).
- The endoscopy department was originally awarded Joint Advisory Group (JAG) accreditation in 2014. (JAG accreditation is a process which assesses an endoscopy department to ensure that best practice guidelines are met.) Departments are required to submit annual report cards to demonstrate they continue to meet these guidelines. An endoscopy is a procedure used to examine the interior of a hollow organ or cavity of the body. Unlike most other medical imaging techniques, endoscopes are inserted directly into the organ.
- The trust was deferred on their renewal of accreditation due to not meeting best practice guidance concerning waiting times. In order to address this, the department produced a recovery plan, which was to be completed by the end of April 2016. The lead nurse for the endoscopy department had worked to complete the required recovery plan and informed us at the time of our inspection the trust was on target for completing it. The unit retained their JAG accreditation until reassessed.
- Patient outcomes for those undergoing an endoscopy procedure were captured locally using specific electronic systems. This is an essential element of

retaining JAG accreditation. The outcomes reported at the hospital reflected the findings nationally for patients who had a late diagnosis of cancer becoming palliative patients.

- The Sentinel Stroke National Audit Programme (SSNAP) for July-September 2015 showed the hospital achieved an overall rating of band C for patient centred and team centred performance indicators. The rating for the hospital has remained stable since January 2015.
- In the most recent National Heart Failure audit report 2013 to 2014, the trust scored above the England average for all of the in-hospital care measures, for example in five of the seven discharge measures, the hospital scored above the England average. In the remaining two measures, the hospital scored below the England average.
- In the 2014 Lung Cancer Audit the trust performed better than the national average in all measures.
- The hospital participated in the 2013 to 2014 Myocardial Ischaemia National Audit Project (MINAP). (The MINAP is a national clinical audit of the management of heart attacks). The results showed the trust performed better than the England average for patients being seen by a cardiologist or a member of the cardiology team. However, the trust performed worse than the England average for patients being admitted to a cardiac unit or ward and for the number of patients who were referred or received angiography, which includes those patients who received this after discharge. (Angiography is a procedure performed to view blood vessels after injecting them with a radiopaque dye that outlines them on x-ray). This is potentially because the trust does not submit data of patients who have an angiography post discharge.
- The national Diabetes Inpatient Audit (NaDIA) results for 2015 showed the trust was performing better or the same as the England average for seven of the 21 indicators and worse in the remaining 14 indicators. This had seen a decrease in performance since the audit was last completed in 2013, when the trust performed better than the England average in 14 indicators and worse in the remaining seven.
- The Macmillan oncology service had demonstrated that it was able to provide high standards of care for the patients who used the department.

Competent staff

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- Agency staff who had not worked on a ward before were given a 10 minute induction at the start of their shift on the ward by the nurse in charge.
- Staff told us they received regular appraisals and that they felt that they were meaningful. Data provided by the trust from November 2015 showed appraisal rates for staff working within medical wards and departments ranged from 44% to 93%. The trust's target rate was 90%. In November 2015, 68% of staff on the Emergency Assessment Unit (EAU) were recorded as having had an appraisal. During our inspection, the manager for the unit told us they had worked hard to improve their appraisal and training rates and now all staff apart from one who was on long-term sickness had received their appraisal, which we reviewed.
- Medical staff appraisal rates in medicine were at 97% and for the acute physicians 100% who were eligible were appraised at the time of the CQC Inspection.
- All new staff attended a corporate induction programme which was supplemented with a local induction to their ward or department. Staff told us they felt adequately inducted into their role.
- Staff on the respiratory ward regularly cared for patients receiving Bilevel Positive Airway Pressure (BIPAP). Staff we spoke with on this ward told us they did not have to complete any competencies to provide this level of care. However, if they did not feel competent or confident on providing BIPAP care, they would not be expected to do it.
- On the unannounced inspection we visited the Coronary Care Unit; an eight bedded unit not only caring for cardiology patients but also those who had a stroke or patients who had a high dependency level and had been transferred from the intensive therapy unit (ITU). (Thrombolysis or 'clot busting' is a treatment to dissolve dangerous clots in blood vessels, improve blood flow, and prevent damage to tissues and organs).
- We spoke with a member of nursing staff who, although having worked on the unit for six months, did not always feel confident nursing patients. A training programme for them had been due to commence in November 2015 lasting five weeks but it had not occurred because the course had not been advertised well. The ward manager acknowledged there were skills gaps in some of the staff on the unit especially as there had been a lot of new staff recruited to the unit.
- The endoscopy department had devised an orientation and induction book, which all new staff to the department were required to complete. Competencies were also in use, and staff had to demonstrate and have signed off as they achieved them. The competencies were in line with the requirements for Joint Advisory Group (JAG) accreditation.
- The annual revalidation report conducted on behalf of NHS England had demonstrated a positive upward trend on the appraisal and revalidation rates for all doctors employed at the trust. (Revalidation is a process by which doctors, and now nurses, demonstrate that they practice safely. Revalidation for nurses is a new process, which all registered nurses are required to complete). Staff told us the trust had been supportive in the revalidation process and provided training around this.
- There was a return to the acute care environment (RACE) programme in place which aimed to support new overseas nurses, as well as nurses who may have had a period of time away from the acute care environment. Staff who were on the RACE programme or who had previously been on it told us that during the programme they were well supported by both the academy and their team members in their departments. The academy provided them with a period of preceptorship, which enabled them to complete all their required competencies. During that time, they were provided with a mentor from their wards or departments who they worked closely with during their preceptorship.
- The hospital had provided apprenticeships for healthcare assistants (HCAs). Two HCA apprentices told us they were provided with fundamental training prior to starting their apprenticeship which included what they could expect from their apprenticeship. Candidates remained on the same ward whilst undergoing their apprenticeship which had helped them to build up their confidence and competence.
- The trust had devised agency induction app, which was to be completed for each agency member of staff when they attended for a shift. We saw evidence of agency staff being orientated to their local department including important areas within the ward, for example the sluice and treatment areas, and fire exits.
- The nurse consultant for dementia had provided specialist training for 1,066 staff members in the past six months. This had mainly been achieved through the new 'snack box' training. The trust developed snack box training to provide short training programmes for staff at

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a convenient location and time to encourage continued learning. Dementia was contained in the pilot phase of this training and was deemed very successful. Staff told us the training they had received had improved their knowledge of how to care for patients living with a dementia.

- A report by Health Education England (HEE) concluded that overall Yeovil was compliant with the learning and development agreement for doctors. However, postgraduate trainees within medicine had raised concerns about their workload, clinical supervision and the amount of hours they were practising. They felt there was an unsupportive environment. HHE requested that the trust completed an action plan to address these concerns. HEE were closely monitoring the progress made against the action plan.
- In order to increase the level of clinical supervision for their staff, the trust was planning to introduce Schwartz rounds. (Schwartz rounds are discussion groups for all staff to come together in a safe environment to discuss the emotional and social challenges of caring for patients).

Multidisciplinary working

- Ward teams informed us that they had access to a range of allied health professionals (AHPs) which included physiotherapists, occupational therapists, speech and language therapists (SALT) and dieticians. The relationship within the teams was very positive. We observed interactions between members of the multidisciplinary team (MDT) which supported what the staff were telling us. The interactions were very positive and respectful of each other.
- During our inspection, we saw evidence of medical and nursing staff working well together within their medical speciality.
- We saw documented evidence of MDT working within patient records where patients had been referred to and seen by members of the MDT, including AHPs and specialist nurses.
- Daily huddles had been introduced within many of the medical wards and departments. This was an opportunity for all members of the MDT to gather and discuss important issues for each patient on the ward.
- The MDT also worked closely with the local authority to discuss the delayed transfers of care and discharges.

- Staff told us that they had a good relationship with a wide variety of nurse specialists including dementia, oncology and learning disability nurse specialists who were always able to provide additional support when required.
- Staff on one ward told us they had positive experiences of input from mental health teams. They had recently noticed an increase in the number of patients requiring mental health input and we were informed that good relations with the mental health nurse had been developed. All staff on the ward had received additional support from the mental health specialists to increase their ability to care for these patients.

Seven-day services

- Stroke nurse specialists and occupational therapists were available for patients who had experienced a stroke. They were available to provide care Monday to Friday from 8am to 6pm and Saturdays and Sundays between 9am and 2pm. The weekend provision had been available for patients since October 2015.
- Physiotherapy was available seven days a week; this was introduced in 2013. Patients were seen according to their need for physiotherapy at weekends. We spoke with a physiotherapist who informed us a list of patients requiring their services was compiled on a Friday afternoon and worked into the weekend physiotherapist's timetable to ensure patients received their treatment.
- Cardiac nurse specialists were available Monday to Friday between 8am and 4pm and Saturdays and Sundays between 9am and 2pm. Weekend provision had been available since October 2015.
- There was an acute oncology nurse available between 9am – 5pm Monday to Friday and between 9am - 1pm on Saturdays and Sundays. In addition there is a consultant on-call 24 hours every day.
- There was an outreach service that provided support for deteriorating patients. They routinely worked a seven-day service, operating between the hours of 8am and 8pm. Out of hours, staff could contact the clinical site manager if they required support with a deteriorating patient.
- Routine out of hours medicine cover consisted of one Trust Grade, GP trainee or Core Medical Trainee doctor and one registrar with consultant cover, covering the medical care service between the hours of 9.30pm and 10am. A twilight Trust Grade, GP trainee or Core Medical

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Trainee provided cover from 11am to 10pm. Consultant cover was provided 24 hours a day from Monday to Thursday. Friday consultant cover was provided from 1pm to 5pm onsite, then 8pm to 8am on call. Weekend consultant cover was provided between 8am and 8pm on site over the weekend.

- A member of the medical team reviewed all patients on the medical wards on a daily basis. Medical staff documented patient specific management plans on a handover sheet for the teams covering at weekends. We saw evidence of a weekend management plan for a patient on one of the medical wards.
- The endoscopy department were currently operating Monday to Friday. Additional funding had been sought to provide an ERCP service on Saturdays.
- Access to diagnostic and imaging services was available seven days a week, for example, X-rays, magnetic resonance imaging (MRI), computerised tomography (CT) scans and routine laboratory services.

Access to information

- Hospital staff were able to access patient related information and records, including medical records and test results. There were systems in place for wards to complete a detailed handover of patients to a receiving ward/department. During our inspection, we saw evidence of a written handover filed in a patient's medical records. We also observed staff receiving verbal handover for a patient being transferred to their ward. We judged the handovers as being comprehensive in content.
- Medical and nursing staff completed discharge summaries which were sent to each patient's GP to ensure continuity of care. This included detailed information about the patient's admission, treatment and medication given to the patient on discharge.
- Staff in the endoscopy suite told us that all patients received a copy of their report, which was also explained to them before they were discharged home. A copy of the report along with a covering letter was faxed to the patient's GP or referring doctor the following day.
- Results from any specimens taken during the procedure were received by the department within five working days. The information was forwarded to the patient's GP or referring doctor and the patient as soon as the department received it.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The trust had an up-to-date Mental Capacity Act 2005 (MCA) policy, which included Deprivation of Liberty Safeguards (DoLS) within it. The Mental Capacity Act 2005 aims to empower and protect people who may not be able to make decisions for themselves. It also enables people to make advanced decisions about important aspects of care in the eventuality that they are unable to make them for themselves in the future. DoLS aim to make sure people who are located in a healthcare environment, such as a hospital, are looked after in a way that does not inappropriately restrict their freedom.
- The trust provided evidence of applications made by hospital staff for DoLS, which had been sent to the trust safeguarding team. In each case the safeguarding team had carried out assessments to ensure the deprivation was applied in the patient's best interest. In the past 12 months, there had been 89 DoLS applications made for patients on the medical wards.
- During our inspection, staff told us the process that they undertook to make a DoLS application. Staff spoke confidently about how they would do this and gave examples of when this would be required.
- Staff undertook MCA and DoLS training as part of their mandatory safeguarding training. The current level of compliance with training was below the target rate of 90%, with 83% of nursing staff and 87% of medical staff having undertaken this training. The snack box training which the trust had developed had also included the topic of MCA and DoLS as a way of updating and refreshing staff knowledge.
- One person was being deprived of their liberty on the medically fit for discharge ward. We saw the person had a deprivation of liberty safeguards (DoLS) assessment in their medical notes, but we could not find a mental capacity assessment. This meant the DoLS was not appropriate as only people who lack the mental capacity to make a decision can be deprived of their liberty. As there was no mental capacity assessment to show the person was not capacitated, this meant the patient was restrained inappropriately, thereby violating article five and article eight of their Human Rights. We

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escalated this to the ward manager who addressed this immediately. When we returned to the ward later, we found the mental capacity assessment had been completed.

- We observed staff appropriately obtaining consent from patients during our inspection. All patients we spoke with were happy with the amount of information they received to make an informed decision about their care.
- In the endoscopy department, staff told us that all patients were consented prior to their procedure. Patients were usually given full details of the procedure during their consultation before they consented and were referred to the department for their procedure. The practitioner conducting the endoscopy always made sure the patient was fully aware of the procedure to ensure the consent had been fully informed. Consent forms were completed appropriately.
- Endoscopy department staff were required to complete a record of withdrawn consent and had a procedure surrounding this. The staff could only provide details of one occasion when a patient withdrew their consent for the procedure; this was because the person had not received all the details for the procedure.
- Staff in the endoscopy department were knowledgeable about the MCA and had a policy in place for patients attending the department in case there were any concerns relating to capacity. In addition, they told us if a patient attended who was non-English speaking, they would pre-arrange for an interpreter to be present at the patient's appointment so that informed consent could be sought.

Are medical care services caring?

Good



We rated caring as good. We found:

- Staff treated patients in a respectful, kind and professional manner, maintaining their privacy and dignity at all times.
- Patients and their relatives that we spoke with were pleased with the standard of care they received. The Friends and Family Test (FFT) results for February 2016 reported that overall, 82.3% of the NHS patients treated

within the medical core service would recommend the service to their family and friends. Discussion with patients and relatives during our inspection corroborated this.

- Staff provided patients and relatives with relevant information and support whilst admitted within the medical wards and the additional services attached to the medical core service.
- There were specialist support services provided to deliver additional emotional support for those patients identified as requiring specialist input.

Compassionate care

- During our inspection, we spoke with 23 patients and six relatives about their experience with the service. All patients reported positive experiences about their care and told us how happy they were with the way staff treated them despite acknowledging how busy the staff were. Patients told us, and we saw that staff introduced themselves to patients.
- On ward 8a, a patient told us despite there being a challenging patient close by to where they were located, the staff always checked on them making sure they were well looked after. This made the patient feel safe and well cared for.
- During our inspection, we saw staff were quick to answer patient call bells and shouts for help from patients. When approaching the patients who were shouting out, we observed staff approach them in a calm and caring manner, reassuring them they were safe.
- When providing personal care for patients, staff always maintained the patient's privacy and dignity by closing the curtains around the bed space.
- On wards such as 8a, we observed staff interacting with patients in a positive, respectful and caring manner reflecting their individual needs.
- The trust used the NHS Friends and Family test (FFT) to obtain feedback from patients. (This is a single question survey which asks patients whether they would recommend the NHS service to their friends and family). The trust's response rate was about the same as the England average at 36%.
- For medicine, the results of the FFT from February 2016 demonstrated that 82% of patients who responded would recommend the service to their friends and family. This ranged from 82% to 95% across the medical services in February 2016.

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- Not all wards displayed the results of their FFT. During our inspection, only ward 8a had their results for the month visible for all staff, patients and visitors to see.
- Each year, the endoscopy department completed their own patient satisfaction survey. The results of the survey in 2015 were very positive and all patients said they would be happy to return to the department for further care in the future. Patients reported they were treated with dignity during their time in the department and were cared for by professional and caring staff who made them feel safe.
- One response on the endoscopy satisfaction survey was received from a patient about staff not maintaining confidentiality due to speaking quite loudly and within an open area while discussing personal details. All other respondents found that staff discussed private details in a confidential manner.
- The most recent results of the Care Quality Commission (CQC) in-patient survey from 2014 showed the trust scored about the same as other trusts in questions relating to care including doctors, nurses, care and treatment and leaving hospital. We did not have the results of 2015 for the trust as this had not been published at the time of the inspection.
- The cancer patient experience survey (CPES) for 2013/14 demonstrated the trust was within the top 20% of trusts in England for 20 of the 34 elements; was within the middle 60% of all trusts for 13 out of 34 elements and was within the bottom 20% of trusts for one element out of 34. This element related to the trust not doing everything to help control patients' pain all of the time. The trust was placed ninth nationally overall with 97% of respondents rating their care as excellent or very good.
- The trust completed their own gastrointestinal service user satisfaction survey in 2014/15 which found patients using the service felt well cared for throughout their experience and appreciated their kindness. Specific comments in the report included patients finding staff very supportive; it was reported the staff were friendly and made patients feel cared for.
- The iCARE vision for the trust included good communication, positive attitudes towards work and patients, respect for patients and creating an environment which was conducive to good care and recovery. It reflected the '6 C's' which is fundamental in the NHS caring culture. We observed staff providing care which was in line with this vision. The 6Cs – care,

compassion, courage, communication, commitment and competence – are central to 'Compassion in Practice', which was drawn up by NHS England and launched in December 2012.

- During our inspection, we observed one member of staff asking a patient if they could disclose some confidential information they had told them earlier in their shift. We observed a discussion which took place in the middle of the bay and the patient appeared uncomfortable because other patients, relatives and staff were within hearing distance.

Understanding and involvement of patients and those close to them.

- During our inspection, we saw staff actively involving patients and those who were important to them in their treatment and care. We observed staff discussing with patients and those important to them details of their care and treatment, and giving them the opportunity to ask questions if there was anything they did not understand.
- Patients told us they understood the information given to them about their condition and the care and treatment required. Staff used terminology that enabled patients to understand. Patients also told us they would feel comfortable asking questions if there was something they did not understand.
- A relative we spoke to informed us their family member had only been admitted for 24 hours, however they had been kept up to date about the care and treatment that they were receiving. The discussions were recorded in the patient's medical notes. This was corroborated with medical notes which contained detailed in-depth discussions with patients and their relatives about the care and treatment of patients.

Emotional support

- Patients could access a range of specialist nurses for specific support if they or their relatives required this. During our inspection, we observed patients receiving support from nurses such as the specialist palliative care nurses where specific emotional support was being delivered to patients receiving palliative care.
- In the gastrointestinal service patients' satisfaction survey, patients had provided positive feedback about receiving follow up emotional support from staff in the hospital and from the palliative care team via telephone if it was required, following their diagnosis.

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- The hospital had a chaplaincy service which staff could access to request support for patients on the wards if this was required.
- In the endoscopy satisfaction survey, a patient had provided positive feedback about a member of staff providing emotional support during their procedure which they found particularly distressing and unpleasant at the time.
- We observed staff providing emotional support and reassurance to patients who were distressed or confused.

Are medical care services responsive?

Requires improvement



We rated responsive as requires improvement. We found:

- The trust was at risk of breaching same-sex accommodation on one ward.
- The business unit was running at capacity, regularly opening the escalation facility with little room for flexibility. Bed occupancy during our inspection reached 100% for the business unit.
- Large numbers of medical outliers were recorded daily with three wards stating they found it difficult to get those patients reviewed by the correct medical team.
- Staff were not always completing dementia assessments for patients who had been identified as requiring one.
- We did not see the wards consistently using the 'forget me not' symbol to identify patients living with dementia. This meant staff may not be aware of their individual needs.
- The recent Patient-Led Assessment of the Care Environment (PLACE) in 2015 scored the trust 42.3% for the provision of care provided for patients living with dementia. However, the trust had appointed a nurse consultant in dementia who was working on improving the care provided to patients.

However:

- The trust on the whole had mechanisms in place to help meet the individual needs of patients.
- Complaints were handled effectively and timely in line with the trust policy.

- A frail older person assessment service (FOPAS) had been established to improve the service provided to older patients experiencing a medical crisis.
- Medicine services were instrumental in developing an integrated care model called the Symphony Care Hub. It had been developed by patients, carers, health and social care staff and voluntary organisations as a better way of supporting people living with three or more specific long-term conditions.

Service planning and delivery to meet the needs of local people

- A new emergency assessment unit (EAU) had opened in February 2016 providing an additional 24 beds in total for the hospital. This was a 24 hours a day, seven days a week service. Previously, the service had been located on ward 7b where there had been 36 beds available. Staff told us the reduction in beds had impacted on the service which it provided and added to the occupancy problems.
- The ward which was previously used as the EAU had been converted into a medically fit for discharge (MFFD) ward. The ward has been established to help to reduce the number of patients located within the medical wards who were medically fit for discharge but were awaiting safe discharge arrangements which included a package of care to be provided for them. This allowed acutely unwell patients to be allocated to the correct place for their care.
- A frail older person assessment service (FOPAS) had been established to improve the care of frail older people attending the hospital who were experiencing a medical crisis but did not require immediate hospital admission. Patients who met specific criteria were assessed in a rapid access clinic within the FOPAS department by a team of geriatricians who were able to provide a comprehensive assessment and make senior decisions about the ongoing care the patient required. This prevented admission at that point and possibly prevented future hospital admissions.
- As part of the trust's five-year strategic plan, medicine services were instrumental in developing an integrated care model called the Symphony Care Hub. It had been developed by patients, carers, health and social care staff and voluntary organisations as a better way of supporting people living with three or more specific long-term conditions. This care model had reduced admissions by 30% in the first year.

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Access and flow

- Patients accessed medical care services at the hospital via their own GP or by direct admission through the emergency department.
- A patient flow and escalation pack was in place which directed senior management as to when further bed capacity was required. The pack contained information about where additional capacity should be sought and actions for all staff members to try and improve the situation. The actions depended upon what level of escalation the hospital was at. During our inspection, the hospital was on a black escalation trigger (the highest level), with the clinical decisions unit plus (CDUP) being constantly open.
- Meetings on bed availability within the hospital were held regularly throughout the day to determine priorities, capacity and demand for all specialities. The meetings were well organised with clear actions for all attendees to take away and deliver on.
- The England average bed occupancy from April 2015 to December 2015 was within the range of 87% and 89%. From April 2015 to September 2015 the trust performed better than the England average with general and acute bed occupancy rates of 84%. The trust reported a higher than England average bed occupancy rate from October 2015 to December 2015 of 90%. During our inspection, the hospital was experiencing a higher than normal patient flow. Data provided by the trust showed that between 15 March 2016 and 17 March 2016 bed occupancy rates for medical wards and departments was between 99% and 100%. This meant that generally, unless patients were discharged, no beds were available for new admissions.
- During October 2014 and December 2014 there had been a closure of 70 community beds in the local community. This continued to have a significant impact on the number of delayed discharges, heightened bed occupancy rates and opening of resilience wards within the trust.
- The hospital had discharge co-ordinators who supported the staff on the wards with upcoming discharges. Discharge co-ordinators had the responsibility for patient flow and discharges from the wards. During our inspection, we saw discharge co-ordinators visiting the medical wards seeking information about upcoming discharges.
- If patients waiting for discharge were not in a bed or on a trolley and were not acutely unwell, they were transferred to a discharge lounge to await transport. The discharge lounge was open between 8.30am and 7.30pm Monday to Friday and contained 11 chairs. At periods of high demand, discharge lounge staff were able to place patients in the nearby day unit.
- Data received from the trust showed that between April 2013 and August 2015, 20% of all delayed discharges were attributed to waiting for further NHS funded non-acute care facilities to become available.
- In December 2015, the trust had secured a six month partnership with a local nursing home to provide an additional 18 beds to help alleviate the pressures on bed occupancy. These beds were available for patients who were either medically fit for discharge but awaiting a package of care or a placement at a residential or nursing home. In addition, patients who required a short-term intensive rehabilitation programme before returning to their usual place of residence were also placed there.
- Between January and December 2014 the average length of stay for elective patients at the hospital was 4.6 days which was above the England average of 3.8 days. The average length of stay for non-elective patients between January and December 2014 was 6.9 days which was about the same as the England average of 6.8 days.
- From the data provided, geriatric medicine and cardiology had a better and lower average length of stay than the England average for emergency admissions.
- The 18 week referral to treatment performance between December 2014 and December 2015 was better than the England average and national indicator of 90%. The trust scored 100% for most of the specialities within the medicine core service, with gastroenterology being the only specialty to drop below this at 96%.
- The bed management system aimed to ensure that patients who were considered a medical outlier had their needs met. Medical outliers are patients who were under the care of medical consultants but placed on other wards due to bed shortages on medical wards. During our inspection, the trust identified a total of 114 medical outliers between 15 March and 17 March 2016. This amounted to 17% of all medical admissions between the three days.
- Despite the bed management meeting trying to ensure the needs of all medical outlier patients were being met,

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we found some patients were not happy with the care they were receiving on the wards. Younger adult medical outliers and staff on the young person's unit (YPU) raised a concern over doctors not attending to them as they presumed they did not come under their care. In addition, the younger adults on the ward informed us they had not been given a choice where they were admitted to. Younger adults on the children's ward were aged between 18 and 23 years old.

- As medical outliers had become a common occurrence in the hospital, the medical consultants had organised a 'buddy system' on two of the non-medical wards. The system aimed to ensure that 12 patients on each ward (shared between two consultants) were reviewed every day in line with patients receiving care on a medical ward. Staff on the wards were aware of who they needed to contact if any issues arose with those patients. The doctors however acknowledged that if there were more than 12 outlier patients located on the wards, the remainder of the medical outliers would remain under the care of their admitting consultant, which could result in difficulties obtaining patient reviews.
- Data received by the trust showed that between December 2014 and November 2015 18,180 admissions were recorded for the medical core service. 63% of the patients did not move wards or departments during their stay which meant the majority of patients received continuity of care; this showed a 2% decrease from the previous year's data. The remaining 37% of patients had been moved between one and four times within the hospital.
- The trust provided six months data on night moves within the hospital. Between July and December 2015, 536 patients were moved after 10pm from a medical ward or department. The department which made the most bed moves after 10pm was the emergency assessment unit (EAU).

Meeting people's individual needs

- The Macmillan chemotherapy unit provided a quiet space for patients receiving chemotherapy. Patients told us they were very happy with the layout of the unit and did not mind attending for their treatment. This meant the environment met the needs of the patients using it.
- Patients were risk assessed on admission by nursing staff and examined by medical staff. In addition, input

from other members of the multidisciplinary team (MDT) was sought when this was required, for example speech and language therapists (SALT) for stroke patients.

- The Clinical Decisions Unit Plus (CDUP) in the hospital was being used as additional bed space for 12 patients. A medical consultant we spoke with informed us patients on the unit were awaiting treatment decisions and were not for those who were going to remain in hospital.
- During our inspection, we were concerned the CDUP was at risk of breaching the single sex policy. In 2009 the Department of Health introduced standards relating to same-sex accommodation. Same-sex accommodation means patients share sleeping accommodation, bathroom and toilet facilities only with people of the same gender. However, the facility did not provide appropriate accommodation for patients of either sex.
- On CDUP both male and female patients were admitted into this area with no designated single gender area. Although each cubicle had privacy curtains there was no single gender designated toilet facilities and patients shared the facilities available. Patients had to walk past other patients to get to the facilities and consequently needed to pass members of the opposite gender. A similar breach had been reported by the trust in November 2014. In addition, CDUP did not have any bathing or shower facilities. One male patient on the ward informed us they had been a patient on the ward for three days and had been unable to have a shower, which they found unacceptable. Because there was no bed table, patients had eaten their meals off their lap and the bag of intravenous fluid they were having administered to them had been hung on a hook behind their bed as a drip stand was not available.
- We saw evidence of the trust acknowledging National Institute for Health and Clinical Excellence (NICE) guidance CG42 on dementia care. However, we did not always find evidence of staff following through with certain aspects of the dementia pathway. In particular the assessment of patients who met the criteria for assessment. The trust had developed a label to apply to patient's notes to alert clinicians when patients met the criteria for dementia assessment. We found that a lot of the labels had not been completed to demonstrate that an assessment had been undertaken.
- The hospital had designed the new emergency assessment unit (EAU) so that it was dementia friendly.

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This included the colour coding of each bay to enable patients to identify which bay they were located in. The toilet and washroom facilities had also been fitted to support patients who were living with dementia. Staff told us another ward within the hospital had been refurbished to meet the requirements of becoming a dementia friendly environment; however, this had been used for orthopaedic patients who had a low number of patients living with dementia admitted there.

- The trust had employed a dementia specialist nurse consultant who was taking the trust's dementia strategy forward. Since their appointment, dementia training had increased and some wards had dedicated dementia champions. The trust's dementia strategy aimed to ensure all staff registered as dementia friends. The recent Patient-Led Assessment of the Care Environment (PLACE) survey in 2015 showed the trust scored 42% for their provision of care for patients living with dementia which was below the England average of 75%.
- We saw there had been improvements made for those living with dementia. There were activities targeted for patients living with dementia including jigsaws, books and music playing in some wards. There were also 'dementia boxes' which contained items to provide diversion therapy. We saw evidence of knitted hand muffs or bands that had additional textures, buttons, and material attached being used by patients living with dementia. Staff used them to help patients living with dementia to keep their hands busy rather than pulling at catheters or cannulas. All these activities had a positive impact on patient well-being, although not all of the activities were replicated in all the wards. Staff on one ward told us they had been required to dispose of their dementia boxes despite the positive impact they had on patients. This had been due to infection control reasons. However, the infection control team were unaware of this issue. One ward in the hospital had been designated as an area for patients who had been declared medically fit for discharge but were waiting for packages of care or care home placement. Many of the patients were living with a dementia. The ward actively supported those patients with a number of the initiatives described, which were designed to promote well-being.
- All the medical wards had been issued with 'forget me not' flower signs for placement on patients' magnetic white boards behind patient's beds to identify them as an individual living with dementia. This was a system

designed to help provide all staff involved in the patient's care with the knowledge that additional assistance may be required. During our inspection, we found the system was not being effectively implemented throughout all of the wards and so patients were not always correctly identified as patients living with dementia who required additional and individual support.

- The dementia nurse consultant was trying to raise compliance within the trust of using the 'This is me' booklet. ('This is me' is a booklet which was designed for people living with dementia. It contains information which lets health and care professionals know about each individual's personal history, needs, interests, preferences, likes and dislikes.) Using them when caring for a patient living with dementia assists staff to individualise a patient's care, making their experience in hospital less stressful for them. During our inspection, we found the use of the booklets was variable throughout the wards. Staff on one ward were aware of the documents but admitted they did not use them. Staff on a different ward found them to be really important in helping to provide a positive experience for the patient on their ward. However, it has been acknowledged that the completion of this document relied heavily on the active input of patients' families or people who knew the patient really well.
- Staff told us that when patients living with dementia or learning difficulties were admitted to the medical wards, they would accommodate open visiting for their relatives and carers, and where appropriate would encourage them to be involved in their care. However we found that on the gynaecology ward there were a number of medical patients living with dementia who were not receiving this support. This impacted on their levels of confusion as well as on ladies recovering from gynaecological procedures.
- The hospital had been awarded funds to set up a garden which could be accessed by patients. The garden was in use at the time of our visit.
- All wards and departments within the medical services were aware of how to access interpreter services for patients who may not have English as their first language. Staff told us in the endoscopy department they would usually be aware before a patient arrived in the department for their procedure if they had any special requirements. This included the requirement for an interpreter so this could be arranged in advance.

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Where possible, the trust would use staff who spoke other languages to provide interpretation, however if this was not possible, the trust had access to a local service. Staff were aware that a patient's relatives should not be used for interpreting.

- Staff had access to British Sign Language (BSL) interpreters when they were required for patients with a hearing impairment. Where possible, advance notice of a patient requiring a BSL interpreter was sought, but staff stated there was very little delay in an interpreter being available.
- All patient information leaflets were written in English. Leaflets could be ordered in other languages if required. In endoscopy, staff had developed a wide range of leaflets in Spanish and Portuguese as they identified these were common languages that patients could speak and read.
- During our inspection, one ward had a patient with learning difficulties admitted. The staff spoke positively about caring for this patient as they used the patient's passport, which the carer had provided for them. Staff told us that they always asked carers if there were any specific documents available to help provide individualised care for patients with learning difficulties. The aim of the hospital passport is to assist people with learning disabilities to provide hospital staff with important information about them and their health when they are admitted to hospital. It can be completed and kept at home in case of an emergency admission, deterioration in the individual's health or can be completed prior to a planned admission when it may also be used to aid assessment and planning.
- Staff also told us when a patient with learning difficulties was admitted, a member of the learning disabilities team would visit the ward to help provide support and advice for the staff.
- Patients had access to a wide variety of menus to support their nutritional and religious requirements.
- On one ward we visited, an onsite hairdresser was providing a hairdressing service for patients. Patients who used the service were expected to visit the hairdresser in their room. Staff stated the service was well utilised and appreciated by long stay patients. All patients could use the service, including those with known infectious conditions. If a patient who had a known infection wished to visit the hairdresser, they would schedule the appointment at the end of the day to allow appropriate cleaning of the room afterwards.

- During our inspection, we observed that staff were flexible with visiting times for patients but ensured this did not impact negatively on other patients.
- Patients informed us if they required further information about their treatment and care, staff were able to provide it in the form of literature and details of support groups relevant to their needs which they would discuss with them.
- Relatives and carers of patients with a dementia were able to access an 'I'm a carer' token as well as receiving a meal voucher for the hospital's restaurant. This meant patients were able to see more of the people they knew and were less stressed as a result.
- Staff could become a dementia champion. Dementia champions promote the wellbeing of patients living with a dementia on wards as well as their carer, family and friends. Dementia champions were not in place on all the wards. One ward sister aspired to all staff becoming dementia champions.

Learning from complaints and concerns

- Staff were aware of how to manage complaints from patients. This included what actions they would take locally to try and resolve the concerns and who they would refer it on to if a local resolution was not possible.
- The complaints procedure underwent a transformation at the beginning of 2014 which had resulted in a lower number of formal complaints. When patients and/or their relatives visited the patient advice and liaison service (PALS) they were asked if they would like to try to resolve the issue immediately. During 2014/2015, the trust had received a total of 115 formal complaints compared to 206 the previous year. Of these 115 complaints, 18 were identified as being attributed to the medical services. We were unable to identify from the data received if there were any specific trends in the complaints although the main issues raised involved clinical treatment and nursing care.
- Staff informed us that ward managers would investigate any formal complaints involving their departments and give them feedback on specific issues during ward meetings. If there were general lessons which could be learnt from other complaints not directly involving their ward or department, these were also shared at ward meetings. This meant lessons were learned from investigations into complaints.
- Patients told us they knew how to complain if they had any serious concerns about their care and treatment.

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- We saw posters and leaflets on wards and departments advising patients on how to make a complaint.

Are medical care services well-led?

Requires improvement



We rated well-led as requires improvement. We found:

- Staff were unable to tell us about a specific vision or strategy for the medical business unit.
- There was a mixed response to the visibility of the trust executive team and the medical service senior team from staff in the medical business unit.
- Although there was a business unit risk register, we were not assured that governance processes were in place to appropriately reduce and manage risks.

However, we also found:

- Staff felt supported by their managers and there was good communication.
- There was an open and honest culture within the business unit with managers having an open door policy.
- Staff from the frail and older persons assessment service (FOPAS) had received recognition for their contribution to improving the care and general experience for this category of patients.

Vision and strategy for this service

- Staff were unable to tell us about a specific vision or strategy for the medical business unit, however there was a trust level strategy which the medical business unit was part of and which staff were aware of.
- The trust values were around the iCARE principles. All members of staff were expected to be committed to living the iCARE values; communication, attitude, respect and environment. During our inspection, all staff spoke confidently about the trust values and we observed them demonstrating these values in their practice. The trust's values were displayed throughout the hospital so they were visible to staff, patients and visitors.

Governance, risk management and quality measurement

- The medical business unit risk register was reviewed at the monthly strategic business unit meetings and the

bi-monthly medicine governance meetings. Although the business unit risk register contained risks from all of the medical specialties, a separate risk register was in place for the oncology service which fed into the larger medicine business unit risk register.

- On reviewing the registers, we found identified risks had existing controls in place and evidence of on-going reviews with additional actions taken to mitigate risks. If the business unit risk register contained a risk that scored nine (significant) or over, the risks were escalated to the trust risk register through the clinical governance committee.
- A high risk in the Clinical Decisions Unit Plus (CDUP) unit had been entered on 12 October 2015 on the corporate risk register. It related to the inability to maintain safe staffing levels and safe services in times of escalation. An action dated 8 January 2016 had stated an 'environmental audit' to be carried out as soon as possible with actions accordingly' and the risk had dropped to 'significant.' However we found single sex breaches in CDPU during our inspection which meant insufficient actions to the environment had taken place to prevent breaches.
- Lack of comprehensive care planning and secure storage of patient notes had not been included on either the medical or corporate risk registers; these had been identified during our inspection. We were therefore not assured robust governance processes were in place to reduce risks.
- The business unit risk register was located on the trust's internal electronic system or intranet, which was accessible to all staff. Any member of staff could input additional risks on to the risk register. During our inspection, staff informed us they had recently placed a new risk on to the register concerning the increasing numbers of medical outlier patients.
- We reviewed minutes from the medicine governance meetings which detailed discussions around clinical audits, risk and incident analysis. Recommendations were made through this group, which focused on quality improvement and patient safety. From the minutes provided, we saw there was a focus on shared learning at these meetings with regular feedback from root cause analyses (RCA) being presented and discussed.
- We saw evidence of separate monthly mortality and morbidity (M&M) meetings taking place within the business unit. Discussions around improvement in

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practice and agreed actions to take forward were evident within the minutes. The outcomes of these meetings were then discussed at the medicine governance meetings.

- Each ward and department told us of the monthly team meetings to discuss any governance issues. Any recent incidents were discussed and shared learning experienced. In between these meetings, each ward produced a newsletter which informed staff of any relevant governance details. We reviewed minutes of team meetings and the newsletters; they confirmed what staff had told us.
- All wards and departments had a quality dashboard that was available via the trust's intranet. They contained details of how wards or departments were performing against set quality and performance targets. Large television monitors were in the process of being installed which would display the data so staff, patients and visitors would be aware of the performance figures.
- At the time of our inspection, information on quality and performance was printed and displayed on notice boards within each area. However, there was no consistent approach to where the boards were placed or how the information was displayed. In some wards, the boards were located in an area where patients and visitors would not readily be able to view it.

Leadership of service

- There was a mixed response from staff at all levels about the trust's executive team and the senior leaders within the medical service. Staff in some areas felt they were well supported by the senior staff and knew who they were. Staff in other areas reported never seeing any of the senior team and would not know who they were. Staff mentioned other business units had more input with the executive team and felt the medical business unit was sometimes 'forgotten about.'
- Staff in each area said leadership at ward level was good with clear communication and good support from their immediate managers. On one ward where there had been many changes with staffing at all levels, staff reported good support from their ward manager.
- Nursing staff felt they were well supported by their managers and could always ask for help if it was needed.
- Ward managers we spoke with all reported they felt supported by their managers and by the trust. Two of

the ward managers had started at the trust as newly qualified nurses and had been supported to go through the promotion stages to reach their current managerial positions.

- Staff at ward level told us matrons were visible and approachable and often visited their ward areas. They also told us at times of high patient flow, matrons were willing to help staff on the wards with clinical tasks. During our inspection, the matrons involved with the medical business unit were very visible in all wards and departments.
- Most of the doctors we spoke with felt well supported by their senior colleagues. However evidence from Health Education England (HEE) had highlighted junior doctors had voiced concerns around supervision and workload in an unsupportive environment.
- One doctor felt when they raised concerns and offered suggestions, they were listened to although acknowledged their suggestions could not always be acted upon. Another doctor felt their peers and colleagues did not take their concerns seriously and did not feel supported by their superiors.

Culture within the service

- The majority of staff described the trust as a 'great place to work' and added that there was an atmosphere similar to that found with a 'high community spirit.'
- Morale and job satisfaction was high and if staff were not happy they would find an alternative place to work.
- All staff spoke positively about the standard of care they delivered to the patients in their wards and departments, especially when the flow of patients was as high as it had been recently. However, two senior members of staff were concerned that due to the high demand within their areas they often worried they could not deliver the standard of care they really wanted to provide. Members of staff that attended a focus group also told us of this.
- The culture at the hospital encouraged candour, openness and honesty. Staff informed us they could be honest and open with colleagues and their managers.
- All managers had an open door policy which meant all staff could approach them with any concerns.

Public engagement

- The deputy director of the medical services identified public engagement with projects could sometimes be difficult as some people may have ongoing grievances

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against elements of the trust. However, the public were encouraged to become involved with ongoing trust issues through an invitation to the public voice committee. Members of the public were recruited via the patient advice and liaison service (PALS) to join the committee where they were able to voice their opinions on services and projects at the trust.

- The trust welcomed patient feedback and promoted different mechanisms of receiving this feedback. The trust participated in the Friends and Family Test (FFT) as well as promoting their in-house satisfaction surveys and a 'share your experience' section on the trust internet website.
- The trust website also encouraged the public to use the NHS choices website to share their feedback about their experiences at the hospital.
- A patient experience report was completed annually, which provided details on patient feedback and complaints or concerns from patients as well as any engagement opportunities held throughout the year where the public participated.

Staff engagement







- The trust had introduced iCARE awards which were designed to recognise the exceptional input from the staff and volunteers who work there. The medically fit for discharge ward and the frail and old persons assessment service (FOPAS) had been recognised for their contributions in the latest awards. These had helped to boost morale amongst staff and made them feel valued by senior managers.
- Staff were aware of the whistleblowing policy, although none of the members of staff we spoke with had felt they needed to use it. Staff told us if they had concerns, they would approach their immediate managers.

- Systems were in place to engage with staff. The staff attitude survey results for 2015 showed staff were largely happy with working at the trust and in some areas had seen an increase in the number of very satisfied or satisfied responses. An example of this was in response to the statement about managers recognising their good work and the number of staff who would recommend the hospital as a place to work.
- In one of the ward newsletters, there had been positive praise for newly qualified nurses and positive feedback for staff on the ward from recently discharged patients and their relatives.

Innovation, improvement and sustainability

- The frail and old persons assessment service (FOPAS) had seen an improvement in the way frail older people were assessed and cared for, and had reduced the amount of unnecessary hospital admissions.
- One of the diabetes consultants had received high accolade by being selected to become a diabetes champion by the charity Diabetes UK. As part of their role as diabetes champion, they would be responsible for driving improvements in diabetes care within the hospital.
- In December 2015, the trust launched a six month partnership with a local nursing home to provide 18 beds for patients who were requiring a short term rehabilitation therapy programme before returning to their usual place of residence, as well as being able to provide interim accommodation. It also included patients who were considered medically fit for discharge but were awaiting a package of care or a placement in a nursing or residential home. The additional 18 beds were designed to help relieve the pressures on patient flow within the hospital as a result of an increase in bed occupancy.

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

Information about the service

Yeovil District Hospital Foundation Trust provides a range of surgery and associated services for residents in the Somerset area. Surgical services are contained in two business units, theatre services including theatre services, critical care, anaesthetics and sterile services department (SSD). The surgery and orthopaedics business unit which includes general surgery, orthopaedics and the Kingston wing (private ward).

The surgical division provided 91 inpatient beds across three surgical ward areas and 14 day case beds. This included the Kingston wing which was a 14 bedded unit providing accommodation for private surgical inpatients. Inpatient services included general surgical specialties including upper gastrointestinal, colorectal, urology, breast and trauma/orthopaedics. Services for surgical patients were provided in outpatient consultation sessions, the pre-operative assessment unit, day surgery and inpatient wards.

There were designated anaesthetic and operating theatres for the surgical business unit and an attached surgical recovery unit. The surgical division had four theatres, two of which were laminar flow (this is a type of air conditioning that reduces air borne infections) and two theatres for day case surgery. One theatre of these was available for emergencies on nine afternoons every fortnight. Between July 2014 and June 2015 the trust treated 13,000 surgical patients. Fifty-one percent were day surgery cases, 17%

were elective admissions and 31% were emergency admissions. The further one percent were attributed to cases performed at the Yeatman Hospital, which was not inspected at this time.

We inspected the pre-operative assessment clinic, theatre admissions lounge, discharge lounge, day surgery unit, operating theatres and recovery, three surgical wards, Kingston wing, SSD and the equipment library.

During our inspection we spoke with 15 patients and six visiting relatives. We spoke with 38 staff from a range of various surgical related roles including doctors, nurses, physiotherapists, occupational therapists, health care assistants, trainee doctors and senior managers. Additionally, we spoke with members of the public at a listening event prior to the inspection. We received comments from people who contacted us to tell us about their experiences. Before the inspection, we reviewed performance information about the trust.

Over the three days of our inspection, we reviewed treatment and care records for 21 patients and made observations of staff interactions with patients during the course of their activities. We also reviewed the arrangements in place to support the delivery of elective and emergency surgery, including the environment and provision of resources.

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Summary of findings

Overall, we rated surgical services as Good.

Staff were not aware of current infection prevention and control guidelines, particularly in relation to documentation of water testing for legionella. Cleaning schedules and logs were not available. However equipment was available, which appeared visibly clean, safe and well maintained. Controlled medicines were managed and stored correctly, however we found some documentation relating to intravenous medication to be out of date.

Staff attended mandatory training. We found staffing levels were within establishment boundaries, the ward teams were not able to provide the trust recommended 1:8 nurse to patient ratio. Patients were on the whole risk assessed appropriately although were not provided with individualised care plans. Patients were assessed individually for pain relief and for their nutritional requirements. However the Malnutrition Universal Screening Tool (MUST) was not used consistently across all areas.

Safe systems were in place for reporting incidents, duty of candour and safeguarding issues. However, there had been one never event in the reporting period. We found that the five steps to safer surgery checklists were completed consistently.

Staff provided care and monitored compliance in line with national best practice guidelines. Surgical wards received a relatively high number of medical patients, for whom the medical wards did not have sufficient capacity. This impacted on the quality of care for all patients.

Patients, carers and families were positive about the care and treatment provided. They felt supported, involved and staff actively engaged with patients whilst providing kind, compassionate care. We observed positive interactions when staff obtained consent. Staff supported patients and relatives with their emotional and spiritual needs.

The surgical care group participated in a number of local and national clinical audits and acted upon any recommendations. Data from the audits was positive and the trust had action plans in place.

Staff were competent and supported by managers. Multidisciplinary team working was established and effective within the surgical wards and theatres.

Service planning and delivery took into account the needs of local people. Discharges were planned with the multidisciplinary team, however due to community pressures these were not always timely.

NHS England data showed that the national 18 week referral to treatment time targets were not being met. The number of cancelled elective operations as a percentage of elective admissions was consistently above the England average. However, of the 101 cancelled operations between October 2015 and January 2016 all but six have been rebooked within 28 days which was consistently lower than the England average.

There were clear governance structures in place and lines of accountability. Leaders were visible and staff were positive about local leadership. Trust values were understood by staff and embedded in appraisal documentation. Information on how the public could provide feedback was displayed in some departmental areas.

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Are surgery services safe?

Requires improvement



Overall we judged the safety of surgery services required improvement.

We found;

- Staff were not aware of current infection prevention and control guidelines, particularly in relation to documentation of water testing for legionella. However, legionella flushing was undertaken by housekeeping staff and log books and cleaning schedules were kept by the trust.
- We found staffing levels were within establishment boundaries. However the ward nurses were often caring for up to ten patients. This did not always meet the acuity of these patients.
- Patients were on the whole risk assessed appropriately although they were not provided with individualised care plans.

However we also found;

- Staff were familiar with and used the electronic system for reporting errors, incidents and near misses. Lessons learnt were shared with staff and improvements were put in place.
- Staff attended mandatory training.
- Most equipment was well maintained and stored.

Incidents

- The trust reported one never event in the surgical business unit between October 2014 to September 2015. (Never events are defined as having the potential to cause serious potential harm or death.) The never event involved wrong site surgery during foot surgery. A thorough root cause analysis was carried out with the surgeons and the documentation available the investigation concluded that the incident was as a result of human factors. However learning was shared and patient marking systems changed to ensure each area to be operated on is marked specifically.
- For the period October 2014 to September 2015 there were seven serious incidents which required investigation within the surgical division. Four of these were incidents which met the serious incident reporting criteria related to pressure ulcers.

- The trust's serious medication errors report for January 2015 to December 2015 identified no incidents within the surgical business unit.
- An electronic incident reporting system, which all staff could access, was in use on all surgical wards for reporting incidents, near misses or errors. Ward staff we spoke with, including agency nurses, had a full understanding of this system. Staff were able to provide examples of how the process worked from start to finish, including where lessons learned had been shared.
- Staff told us about learning from incidents. An example of this was when a patient's own controlled medication had been administered instead of stock medication resulting in inconsistencies in the number of tablets available. This was reported via the hospital's electronic reporting system, the incident was investigated and changes were made to the medicines checking process.
- We found that lessons from incidents were generally shared well on the wards and in theatres. Safety briefings each morning created the forum for these conversations, which were supported by weekly emails and newsletters for those who could not attend. We observed three safety briefings in theatres. Information was handed over appropriately and staff were informed of safety issues and ongoing concerns.
- 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. Being open and honest with patients was an embedded part of the surgical division's culture. When something went wrong (however serious) patients were told, given an apology and informed of actions taken as a result.
- Nurses and doctors gave us multiple examples of where they had apologised to patients, which were then well documented in their medical records. An example of this was identified after a patient fall; the ward senior sister met with the patient and family to apologise and discuss what had happened.
- Within the surgical division, morbidity and mortality (M&M) meetings were held monthly. These meetings reviewed patient deaths and complications, in order to develop improvements to patient safety and aid professional learning. Minutes of these meetings demonstrated that all unexpected deaths were reviewed and trends were identified.

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Safety thermometer

- We reviewed the safety thermometer dashboards on the wards we inspected. The NHS Safety Thermometer is an improvement tool used for measuring, monitoring and analysing patient harms and 'harm-free' care. The service monitored the incidence of pressure ulcers, falls, catheters and urinary tract infections, and venous thromboembolisms (VTEs). VTE is a collective term for deep vein thrombosis (DVT) – a blood clot that forms in the veins of the leg; and pulmonary embolism (PE) – a blood clot in the lungs.
- Each surgical ward area collected information on a range of safety measures based on individual patient risk assessments. This was clearly displayed on a live electronic system at the entrance to every surgical ward. The results were part of the ward's performance monitoring and included information such as number of inpatient falls, number of hospital acquired pressure ulcers in each of the grading categories and number of medication administration errors. This meant patients and visitors could see how the ward was performing in relation to patient safety.
- On all surgical wards this information was displayed appropriately to give transparency on each ward's safety performance. The ward sisters attended a monthly safety thermometer meeting and peer review to discuss performance and plan actions for their areas. If they identified that standards were slipping using the information they were given, this was raised in the daily safety briefing to all staff and through emailed newsletters and ward meetings.
- The National Institute for Health and Care Excellence (NICE) Quality Standard (QS) 3, statement 1 stated that all patients, on admission, should receive an assessment of VTE and bleeding risk using a risk assessment criteria described in a nationally recognised tool. The trust's performance report for February 2016 showed completed assessments were done on admission. The trust's target was 95%. The surgical business unit's average percentage of completed VTE assessments was 95.4%.
- However documentation we reviewed during inspection did not provide evidence that VTE prescriptions were reviewed after 24 hours of admission, despite the medication chart prompting a review. This might put patients at a higher risk of complications from anticoagulant (blood thinning) therapy.

- The NICE QS3 statement 4 stated that patients should be reassessed within 24 hours of admission for the risk of VTE and bleeding. We found that these reassessments were not done in all 21 patient records we looked at. This increased the risk of harm to patients.

Cleanliness, Infection Control and Hygiene

- We saw most staff complied with infection prevention and control best practice in relation to hand washing and remaining bare below the elbow. However we saw three clinical staff wearing long sleeves or watches which meant these staff had not followed best practice guidance or trust policy.
- There was access to hand washing and drying facilities on wards and a good supply of personal protective equipment, which included gloves and aprons. These items were used by staff and disposed of correctly afterwards. We observed staff wash or cleanse their hands between patient care duties and when going about their activities on wards. We saw staff followed best practice guidance when giving intravenous fluids and taking blood samples.
- Throughout the hospital and on each surgical ward, there were alcohol hand gel dispensers or hand wash facilities.
- In the surgical ward areas, pre-assessment rooms, operating theatres and recovery, we found the standard of cleanliness was visibly good however there were no nursing or housekeeping cleaning schedules available to confirm cleaning was carried out regularly. Nursing staff told us that cleaning was, 'done at night or when there was time.' Schedules of cleaning were requested post inspection but were not supplied by the trust. The trust supplied audits of cleaning activity which showed that in general compliance was over 90%. However nursing staff compliance ranged from 20% to 100% over the five month period from October 2015 to February 2016.
- Throughout the hospital privacy curtains were non disposable. There was a schedule for changing them and they were changed if visibly soiled or in isolation rooms. The trust provided the cleaning policy which stated that curtains should be laundered every three months or when visibly soiled. Curtains and blinds were checked on the monthly audit.

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- We observed a red plastic linen bag (used for soiled or infected linen), which was half full, in a clean linen storage area. Some of the clean linen was also on the floor. This posed a risk of cross contamination of clean linen.
- Senior nursing staff we spoke to were not aware of the trust policy regarding tap flushing for legionella and no record of flushing was available in the ward areas. The policy stated that the head of department or ward manager has responsibility for identifying all infrequently used outlets in their area and subjecting them to a thrice weekly flushing programme. However, legionella flushing was undertaken by housekeeping staff and log books and cleaning schedules were kept by the trust. After the inspection, we requested surgical ward legionella flushing records for three months prior to our inspection. A selection were provided from before, during and after the inspection.
- The service reported no cases of Methicillin Resistant Staphylococcus Aureus (MRSA) or Clostridium difficile (c.diff) from November 2014 up to and including the time of our inspection in March 2016.
- Patients were screened pre-operatively for MRSA and as soon as possible when admitted as an emergency. This was in line with local policy and national guidance.
- We saw that patients who were in isolation were nursed in side rooms and appropriate signage was in place to alert staff and visitors of the action to take.
- Commodes appeared visibly clean and on one ward 'I am clean' stickers were in place, staff told us that they followed the rule 'if you use it you clean it.' This was not consistent on all wards and no cleaning schedules were available.
- We saw that in Sterile Services Department (SSD) a trolley wash was used for decontaminating ward commodes. We were told this was on a rotation with each ward having commodes cleaned at least weekly. The trust provided us with a record that demonstrated this.
- Within theatres we observed there was alcohol gel on entry to anaesthetic rooms. Theatre staff were observed to adhere to best practice principles for scrubbing up prior to surgery and for the management of surgical equipment in the operating environment.
- We observed staff in all surgical areas following guidance for the safe disposal of different types of clinical and domestic waste and used sharp items such as needles.
- Surgical staff were observed to be following the National Institute for Health and Clinical Excellence (NICE) guidelines for the prevention and treatment of surgical site infections.
- The trust reported one surgical site infection for the year 2015. A full investigation was carried out for the one infection however a cause could not be identified. Surgical site infection surveillance (SSIS) is mandatory for all trusts however, not all categories of surgery are required to be reported on. The trust reported on surgical site infections where hip and knee replacement surgery had been undertaken. We saw that a range of equipment used by patients appeared to be visibly clean and appropriate for use. However there were no equipment cleaning schedules.
- In the SSD each specialist piece of surgical equipment had its own serial number which facilitated tracking of the equipment when in use and while it was being sterilised. We saw separate clean and dirty areas in SSD and suitable systems for equipment to flow through without being contaminated.
- There were separate clean preparation areas and facilities for removing used instruments from the operating theatres to the hospital decontamination unit. Special sterilising equipment was tested before use and staff kept records of this.
- Patient washbowls were plastic and non-disposable, they were stacked wet on the floor and at hand washing sinks on two of the wards we visited. They appeared old and stained. This was a risk to patient safety and possible pseudomonas contamination and also in contravention of the trust policy.
- We saw the water used to wash patients disposed of in hand wash sinks. This would significantly increase the risk of hand and environmental contamination (Health Building Note 00-09: Infection control in the built environment 3.63).

Environment and equipment

- There were single rooms for use on each ward by patients who were particularly unwell or needed to be isolated because of infection.
- Resuscitation equipment, including emergency drugs, was readily available in all surgical areas, including theatres. A difficult airway trolley was also available in theatre two anaesthetic room. Records showed the

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equipment was checked daily by staff as per trust policy. However records were only available for the previous month so we were not assured this was a consistent practice.

- Technical equipment used for monitoring patients had been safety tested and stickers indicated the next date for checks to be made.
- Theatre staff reported having sufficient equipment to undertake their roles.
- Resuscitation trolleys were shared between surgical wards adjacent to each other. This occasionally led to inconsistencies in checking equipment when they shared the checking responsibility. This meant it equipment on resuscitation trolleys might have been used without accurate and consistent checking. In the Kingston Wing the resuscitation equipment checklists available were consistently completed.

Medicines

- There were suitable arrangements in place for the storage and management of medicines in surgical areas, including theatres and recovery. Disposal arrangements were also in place for expired medicines, or medicines which were no longer required.
- Medicines errors, including errors resulting in harm, were reported as part of the incident reporting process. Staff were able to discuss incidents where errors had occurred and the resulting actions that had taken place to help prevent a similar. For example, prescription charts were checked at all handovers of staff to ensure any missed doses or signatures could be rectified immediately.
- Controlled drugs on the wards and in theatres were stored appropriately and controlled drug records were accurately completed. Emergency medicines were available for use and these were in date and replaced by pharmacy when used.
- Nursing staff confirmed that they had access to regular pharmacy advice. The pharmacists visited the wards Monday to Friday, twice a day and checked prescription records and raised any queries with doctors. They also undertook checks on antibiotic prescribing and compliance within agreed protocols. These measures helped to ensure safe practice.
- On all of the wards we inspected, the temperature checks for the medicine fridges were undertaken centrally by pharmacy. We were told that this was because a new system was now in place. The fridge

electronically recorded the temperatures and would alarm and pharmacy would be alerted, should the temperatures fall or increase outside safe limits.

Pharmacy would then telephone the ward to tell them what they needed to do, however none of the wards recorded this information so there were no logs of when issues had occurred and what had been done about them. A log of issues and actions taken was stored electronically in pharmacy, not at ward level. None of the staff we spoke to said they had received any training concerning this, although the trust confirmed that staff listed on the call cascade for temperature alarms had received training. Wards and departments using the remote temperature monitoring system had a process flow chart to provide information on the steps required to investigate and record an action for an alarm. This mitigated the risk that an 'out of temperature' alarm would not be correctly responded to.'

- We also found on one ward the build-up supplements were stored in the corridor, in a fridge as a cool temperature makes them more palatable. We found that this fridge was unlocked and when asked, staff members could not identify who was accountable for its temperature checks. Following the inspection we were told that the fridge temperature was monitored by housekeeping staff. We observed one relative of a patient taking a drink from this fridge without informing a member of staff. Intravenous fluids were stored in locked cupboards in treatment rooms on wards. This reduced the risk that intravenous fluids could be tampered with or taken.

Records

- In general, medical and nursing records were completed appropriately. Patients were on the whole risk assessed appropriately although they were not provided with individualised care plans. The trust was in the process of moving to an electronic patient record which would incorporate a care plan. However, at present care staff were required to complete the box on the risk assessment to indicate individualised action to be taken or personal preferences of patients.
- The pre-operative checklists were completed, as were records of consent. The surgical wards completed appropriate risk assessments. These included risk assessments for falls, pressure ulcers and bed rails.
- All the staff we spoke with were aware of their responsibilities for the safe keeping of records and

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confidentiality of patient information. Throughout the wards and theatres, we saw patient identifiable information was mostly stored securely. The interactive whiteboards on each ward were in the office behind the nurses' station. This meant that patient confidentiality was maintained.

- Current patient records were stored securely in a notes trolley on each of the surgical wards visited. However, older volumes of notes were stored underneath the notes trolleys. We also witnessed six sets of notes left unattended on a desk and three nursing handover sheets (which contained confidential patient information) in various places on one ward, which could have led to a breach of patient confidentiality.

Safeguarding

- Most staff were aware of the safeguarding policies and procedures and had received appropriate training. Staff told us they knew how to report concerns. We found on the Kingston wing that two members of nursing staff we spoke with were unclear about their responsibilities around safeguarding. However, inspectors were assured they would escalate to managers where appropriate.
- Trust requirements were that 90% of staff were trained to level one and two safeguarding depending on their duties. General surgery, theatres and orthopaedic clinical staff achieved between 75% and 89%, which was below trust targets. Kingston ward exceeded the trust target for clinical staff with 93% to 100% completed training in levels one and two
- All theatre staff were trained in safeguarding at level one and over 96% at level two.

Mandatory training

- Staff completed mandatory training in a range of subjects, for example; health and safety, moving and handling, infection prevention and control, equality and diversity and basic life support. A formal system was used to monitor uptake and senior staff were seen to be proactive in prompting staff who needed to attend. Ward sisters and individual staff received an email approximately four months before training was required in order to allow time for booking it onto staff rotas. Information provided showed more than 89% of staff in the surgical division attended mandatory training in 2014, which was above the trust target of 85%.

- Staff we spoke with confirmed they were up to date with mandatory clinical training which included attending annual cardiac and pulmonary resuscitation training.
- Senior staff we spoke with discussed with inspectors the processes involved if staff repeatedly failed to attend training. We were told that once they had failed to attend booked training for three times they would be supported to attend or face disciplinary action.

Assessing and responding to patient risk

- Clinical staff were seen following the nationally recognised five steps to safer surgery checklist. Staff used a document based on the World Health Organisation (WHO) safety procedures to ensure each stage of the patient journey from ward through anaesthetic procedures, operating room and recovery was managed safely. The use of this document was audited every six months and training undertaken if compliance fell below 90%. We observed this procedure being followed during our inspection.
- Audits over the previous 12 months show a steady increase in compliance with the participation of Surgeon, Anaesthetist and Scrub staff with over 90% compliance. Whilst the audit shows increasing compliance in respect of debriefing staff (55%) this is below the trusts target of 100%. The trust had begun to use electronic data collection systems to assist in improving compliance
- National Early Warning System (NEWS) was used for patients across the hospital to assist staff in the early recognition of a deteriorating patient. NEWS is a system that staff can use to assess whether patients are developing potentially life threatening conditions. We saw NEWS documentation was completed appropriately which meant that patients were being appropriately monitored for signs of deterioration and could be treated as necessary. We saw two staff with a 'gold star badge,' this was awarded to them for them accurately following and implementing procedures related to early recognition and treatment of a deteriorating patient. This enabled them to monitor and encourage other staff on the ward.
- Staff took the time to identify and respond to the changing risks of patients. Safety briefings were held each day on the wards to discuss in detail individual patient needs and risks. This highlighted to staff which patients needed most attention and allowed them to gain an oversight of the ward as a whole. We found on

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Kingston ward, 6A, and 6B, that these were done in separate teams (for each area in the ward) which then amalgamated to a joint safety brief either before or afterwards.

- Access to an emergency theatre was available five afternoons a week, for emergency cases in the morning an elective list would be stopped if required. However we were told this was very rare. At the weekend one theatre was staffed from 8.30am to 9pm. A dedicated trauma team was on call 24 hours a day seven days a week and could be in theatre within 30 minutes of being called.
- We saw an electronic theatre data system in use; this was an operating theatre management system to assist with the tasks needed to provide safe and efficient care to patients.

Nursing staffing

- Staffing levels were assessed using the Association of UK University Hospital (AUKUH) acuity dependency tool, which has recently been modified by Shelford. This tool measured the individual dependency of patients and calculated how many nurses were needed to care for them.
- The information was displayed on an electronic ward board which was reviewed daily by the staffing matron to review the skill mix on each ward. Generally we found the day time staffing levels did not meet the planned numbers. The trust reported a ratio of one nurse to eight patients during the day however we found the staffing ratio was one nurse to ten patients. This meant the actual nursing staffing levels were not in accordance with the identified assessment.
- A report on the nursing staffing levels to the trust board in February 2016 showed that all three surgical wards and the Kingston unit were staffed to establishment sufficient for patient dependency. This had been calculated according to recommended figures from the National Safe Staffing Alliance. Staff numbers were increased on wards and theatres as required to meet patients' needs using agency and bank staff. This was assessed according to individual ward dependency and discussed at twice daily bed management meetings.
- Staff on wards reported feeling the skill mix of senior and junior staff in some instances was not safe. Staff felt that the new overseas nursing staff were not as experienced as existing staff and that this impacted on the skill mix within the ward area. However the trust had

ensured that all overseas nurses were qualified and that they had appropriate competencies. Ward sisters told us skill mix on surgical areas had been considered as part of the planning rotas. There were always senior staff on duty to support junior staff, including sisters and matrons. The rotas we reviewed indicated there was one nurse on each shift qualified to 'take charge.' Staff told us this was a problem if that nurse was off sick because it left the ward skill mix short of a 'take charge' nurse.

- In theatres there was a nominated band six nurse on each shift for the day to day management. An electronic roster was used, which staff told us was new and was causing problems with covering shifts. There is one full theatre team present within the hospital overnight and at weekends primarily to support obstetric emergencies but also any other surgery as required. A second team is placed on-call should an additional emergency arise that cannot await completion of current case. Some nurses felt that the theatre shifts were forced upon them rather than discussed with them. This had led to shift patterns being irregular, which had adversely impacted on staff member's ability to plan their personal lives.
- Agency and bank staff were used on the majority of surgical wards and in theatre and this was confirmed by our review of staff rotas and discussions with staff. Agency staff received an induction to the ward by permanent staff members.

Surgical Staffing

- Surgical doctors, registrars and consultants from all specialities were on call to provide advice and care 24 hours a day. Doctors and registrars were available on site during the day, including at weekends. Consultants were on site during the week days and were available to attend the hospital out of hours when necessary.
- Surgical consultants worked an emergency on call rota, seven days per week. A consultant was on call Monday to Thursday then another one Friday to Sunday. This maintained continuity for patients within the division.
- Within surgery, similar rates of consultant medical staffing to the England average levels were noted. Consultant staffing at Yeovil District Hospital was 40% compared to an England average of 41%. However registrar grade medical staffing at the hospital was worse at 15%, versus the England average of 37%. There

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was a higher number of middle grade staff at 31% to the England average of 11%. Junior medical staffing at the hospital was 14% versus the England average of 12%.

This provided a stable team of medical staff in surgery.

- In December 2015, the surgical division risk register showed that lack of orthopaedic specialists in training was a high risk. Discussions were taking place with the deanery regarding covering the positions.
- There were low levels of locum doctors employed in surgery and orthopaedics at 4%, with a rate of 0% in anaesthetics since November 2015.
- Handover took place twice daily, seven days a week for all general surgical and orthopaedic patients. A separate trauma handover took place between the outgoing doctors with the incoming team prior to the consultant ward round. The on call doctors (F2 or trust doctor level) had a 30 minute overlap in their shifts which allowed for a handover of all admissions and any concerns regarding particularly unstable patients.
- A theatre meeting also took place each morning attended by the anaesthetic team, theatre team, consultant and surgeon on call for the day to decide any changes to the lists. Medical handover for anaesthetics took place twice a day for theatres.

Major incident awareness and training

- The staff we spoke to were aware of the trust's major incident and continuity plan.
- Staff were able to show inspectors where to find the major incident plan and could describe their responsibilities as part of it.
- The staff we spoke to were unaware of any major incident exercises which had taken place in theatres or wards.

Are surgery services effective?

Good



Overall we rated the effectiveness of the service as good.

We found;

- Staff consistently monitored patients' levels of hydration where this was required. Staff also assisted patients to eat and drink.

- All staff we spoke to received an annual performance appraisal and uptake of appraisal was in line with the trust's own target.
- Care and treatment were evidence based and followed recognised national guidance. Patients were asked appropriately for their consent before procedures were carried out.
- Pain management was effective and patients received appropriate pain relief in a timely manner.
- Surgical outcomes for patients were monitored and were mostly within the national average. Where outcomes were worse than the national average these had been identified and measures were in place to make improvements.
- There was good multidisciplinary working in all the wards and departments we inspected.

However we also found;

- The National Emergency Laparotomy Audit (NELA) showed that the Yeovil District Hospital was rated amber (50-69%) for most measures. However, the trust performed poorly for consultant assessment.
- Whilst malnutrition assessments were undertaken these were not always completed appropriately.

Evidence-based care and treatment

- Pre-operative investigations and assessments and surgical procedures were carried out in accordance with National Institute for Health and Clinical Excellence (NICE) clinical guidelines and professional standards. There was a well-defined elective pathway that was followed; patients were seen up to eight weeks before surgery. If their operation was cancelled or delayed and the next appointment date was longer than eight weeks, the pre-assessment would be repeated.
- Any potential complications identified at the pre-assessment stage were escalated to the anaesthetist. A consultant anaesthetist was available at night for urgent queries.

Pain relief

- Patients were appropriately prescribed pain relief which was administered in the recovery room after undergoing surgery. Pre-planned pain relief was also administered for orthopaedic patients.
- Staff told us there was a pain nurse specialist available Monday to Friday. All patients who required major

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elective surgery were referred to the pain nurse pre-operatively to ensure they visited patients post operatively. Out of hours the on call anaesthetist was contacted should pain be an issue for a patient.

- There were no clinical audits of pain during 2015. However, we asked 15 patients if they had their pain levels assessed by staff and if they received pain relief medicine as and when they required. All patients told us staff asked about their pain regularly. The majority of patients said their pain was managed well. Patients said they did not have to wait for tablets or pain relief medicines. We checked prescription charts and found patients had been prescribed and given pain relief medicines.

Nutrition and hydration

- We reviewed 13 sets of fluid intake and output charts and found that 12 were complete. This meant that patients' fluid requirements were on the whole being monitored accurately.
- Malnutrition Universal Screening Tools (MUST) assessments were not completed in a timely manner in the 21 sets of notes we looked at. This could compromised patient safety with regard to management of nutritional status which could compromise post-operative healing.
- During this inspection, we saw that all patients who required assistance with eating and drinking were identified on the wards and assisted accordingly. There were protected meal times in place on surgical wards, which enabled staff to help patients. However four members of nursing staff reported that, 'protected mealtimes was not enforced like it was when it was first introduced' [sic], which had led to some interruptions.
- At lunch time we observed these patients were provided with a good level of support. We saw staff were kind and respectful when supporting patients to eat and drink and took sufficient time to enable patients to take their meals and drinks.
- Patients told us they were satisfied with the food provided at the hospital.
- Staff said that referrals to dieticians and speech and language therapists were easy to arrange.

Patient outcomes

- There were no current mortality outliers relevant to surgery. This meant there had been no more deaths than expected for patients undergoing surgery.

- The trust contributed to all national surgical audits for which it was eligible. In the 2015 Hip Fracture Audit, Yeovil District Hospital performed worse than the England average in six out of eight relevant measures. These included patients being admitted to orthopaedic care within four hours (38.8% compared to a national average of 46%), and pre-operative assessment by a geriatrician (65.9% compared to a national average of 85%). The trust stated that this was due to a vacancy in this area. However surgery on the day of admission or the day after was better than the England average (73.5% compared to a national average of 72%).
- In the 2014 Bowel Cancer Audit, Yeovil District Hospital achieved a 'Good' rating in one measure (case ascertainment rate) and performed better than the England average in three measures. These were for patients being discussed in a multidisciplinary team (MDT) meeting, patients seen by a specialist nurse and patients having a reported computed tomography (CT) scan. Other scores were comparable to the England averages.
- The National Emergency Laparotomy Audit (NELA) is a national tool used to establish the quality of care provided for patients undergoing an emergency laparotomy (a surgical procedure involving a large incision through the abdominal wall to gain access into the abdominal cavity). In the 2015 NELA, Yeovil District Hospital was rated amber (50-69%) for most measures. However, the trust performed poorly for a consultant review being conducted within 12 hours of emergency admission, and the assessment by a Medicine for Care of Older People (MCOP) specialist in patients over 70 years old.
- PROM (Patient Reported Outcome Measure) scores for the trust for April 2014 to March 2015 were better than the England averages in terms of patients' health status after an operation. These audits measure the patient outcome for hip and knee replacements and groin hernias. The trust results showed better than average outcomes in all eight indicators.
- The standardised relative risk of readmission was below the England average overall. However it was noted that the readmission rates for upper gastrointestinal surgery were 728 compared to the England average of 100. We were provided with evidence that these were predominantly readmissions without a surgical procedure which had affected the figures.

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Competent staff

- Appraisals in the surgical division completed up to November 2015 were reported to be 80% overall.
- All the staff we spoke with described their appraisal as a positive experience and a process that enabled them to identify their learning needs for the following year.
- Therapy staff received monthly supervision. Staff told us they had one hour 'protected' time, which contributed to their continuing professional development.
- Staff told us they attended a corporate induction and local induction when they commenced work at the trust. The trust target for attendance at the corporate induction was 90%. Ninety-two per cent of relevant staff, within the surgical division, had attended the trust corporate induction in the last year, which was better than the trust target.
- Some staff told us that although training opportunities were available, it was sometimes difficult to attend because of staffing pressures on the wards. The trust addressed this with 'snack box' training, which were 10 minute sessions delivered on a monthly basis in themes such as end of life. Staff attended short training sessions on the ward areas, a snack was provided and training was delivered at ward level to facilitate less time away from the patients. Examples of snack box training included Deprivation of Liberty Safeguards (DOLS) and Mental Capacity Assessment (MCA). Staff commented that these sessions were positive and enhanced their learning without being too time consuming.
- Most junior doctors in surgery told us they attended teaching sessions and participated in clinical audits. The junior doctors' quality improvement sessions were held on Tuesday evenings and encouraged sharing of innovative new ideas for practice. For example management of the 'twin-bin' which ensured that on each level of the hospital there were stores of the correct equipment for regularly performed procedures. This reduced time spent searching for equipment so increasing time with the patient.
- Junior doctors told us they had good ward-based teaching and were well supported by the ward team and could approach their seniors if they had concerns.
- The majority of patients who spoke with us reported a high level of confidence in medical and nursing staff with regard to their knowledge and their skills.

- All nurses we asked were involved in the revalidation processes. All nursing staff had been issued a revalidation folder and allocated a buddy to discuss issues or concerns. There were also drop in sessions for all nurses to discuss revalidation.

Multidisciplinary working

- We found there was good multidisciplinary (MDT) working across surgical areas.
- We observed therapy staff assisting with patient therapy sessions through encouragement of mobilisation and self-care activities. Therapy staff contributed to daily 'board' rounds which included the nurse in charge, the matron, a doctor and the bed manager. The MDT discussed each patient's condition and progress.
- Therapy staff told us there was effective communication and partnership working between the surgical MDT. They met regularly to identify patients who required visits or to discuss any changes to the care of patients.
- When a patient was discharged, communication was generated electronically and sent to their GP. This detailed the reason for admission, any investigation results and treatment undertaken. However staff we spoke with told us that they regularly printed this information and posted it to the GP as they were not sure that this information was sent electronically.

Seven-day services

- Daily ward rounds were arranged for all patients seven days a week.
- Consultants were available on-call out of hours and would attend when required to see patients at weekends.
- Access to diagnostic services was available seven days a week, for example, x-rays, magnetic resonance imaging (MRI) and computerised tomography (CT) scans.
- There was an on-call pharmacist available out of hours. Pharmacy staff were available on site during the week.
- Physiotherapists and occupational therapists told us that in addition to Monday to Friday provision, physiotherapy was available at weekends for patients.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Consent was sought in accordance with legal requirements and we saw staff recorded discussions with patients about risks, benefits and options about their care and treatment.

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- Patients we spoke with confirmed they had been given sufficient information to help them to decide to proceed with investigations and surgical procedures. They reported they had signed a consent form prior to surgery and also verbally consented to blood tests and scans. We observed staff asking for consent both verbally and in writing. On checking patient records we saw copies of signed consent forms, all of which had been completed appropriately.
- Staff told us they were aware of, and had access to the trust policy and procedures for consent.
- Mental Capacity Assessment (MCA) and Deprivation of Liberty Safeguards (DoLS) updates were included as part of 'snack box' training. However, most of the staff we spoke with had limited knowledge concerning MCAs. None of the nursing staff we spoke with had confidence when undertaking MCAs. Due to an increase in DoLS referrals from wards to the safeguarding team, we were told nurses completed applications with minimal training. However, there was a policy and a flow chart to assist them.
- Within the surgical division MCA and DoLS training was included in safeguarding training. Staff we spoke with said in the case of any concerns that they would refer consideration of deprivation of a patient's liberty to the hospital safeguarding team.

Are surgery services caring?

Good



Overall we judged the caring delivered to patients was good.

We found;

- Staff were kind, compassionate and caring towards patients.
- They communicated well with patients and were attentive to patients' needs, providing support and care with courtesy and respect.
- Patients were involved in decisions about their care options and were given enough information about their condition.
- Staff provided patients and relatives with emotional and spiritual support.

However we also found;

- Some staff did not involve the patients in the bedside handover process.

Compassionate care

- Patients we spoke to were mostly positive about their experience within the surgical division. Patients told us they were treated with dignity and staff were caring.
- We observed positive interactions between staff and patients. We observed staff speaking with patients and providing care and support in a kind, calm, friendly and unhurried manner. Where staff were assisting patients to move they ensured patients were covered and their clothing was in place which maintained their dignity. We saw how when one patient wished to use the toilet staff sensitively supported them and did not rush the patient. We saw one person was supported to eat. Staff were patient and communicated well with this person who appeared to have been put at ease. On every ward we inspected, patients were treated with compassion, dignity and empathy.
- We spoke with the relatives of a patient who had recently undergone surgery; the relatives described the excellent support delivered by the nursing and medical staff.
- This was confirmed in the Cancer Patient Experience Survey 2013. The trust scored highly for giving patients enough privacy and treating patients with respect and dignity.
- Friends and family test results were displayed on each ward we visited, with average scores reported from people who had commented on the service. We looked at data on individual wards, which showed that the majority of patients were 'extremely likely' or 'likely' to recommend the service to their family and friends. In February 2016 96% of patients would recommend the wards to family and friends.
- Each patient had a named nurse to ensure continuity of care, although two relatives said they found it difficult to identify who they needed to speak to in order to understand their parents' treatment plan.
- Wards were organised and included single-sex accommodation, which promoted privacy and dignity. There were no reported times when men and women were treated in the same ward bay.

Understanding and involvement of patients and those close to them

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- Most patients we spoke with felt they understood their care options and were given enough information about their condition.
- Detailed information was available for patients about their procedure and what to expect. They were given contact numbers of specialist nurses to ensure they had adequate support on discharge.
- Staff at the preoperative assessment clinic informed patients of details concerning their surgery, answered any questions and collected information about their health. All aspects of the hospital stay, operation and discharge were explained at the pre-assessment stage.
- In the Cancer Patient Experience Survey 2013 the trust scored highly for giving patients a choice of different types of treatment. However, the trust did not perform so well in the area of patients' views being taken into account by doctors and nurses when discussing treatment.

Emotional support

- Patients said that they felt able to talk to ward staff about any concerns they had, either about their care or in general.
- Clinical nurse specialist care and support for patients was available in areas including pain management, colorectal, stoma and breast care.
- Staff told us they were not aware of a designated counselling service but confirmed there was access to clinical psychologists if needed. Patients and relatives also had access to the hospital chaplaincy for spiritual, religious or pastoral care.
- A designated bereavement service was available at the trust to provide a sensitive, empathetic approach to the individual needs of relatives, at their time of loss.

Are surgery services responsive?

Good



We rated responsive as Good.

We found;

- Evidence of how the trust was working with outside organisations (such as clinical commissioning groups, other acute hospitals and general practices) to reduce the waiting lists.

- Evidence collected showed that there were no mix sex breaches in the surgical division, that the average length of stay was better than the national average and that the number of cancelled operations remained low.
- Patient had access to a wide range of resources and materials, both online and in paper formats, which were individualised and tailored to their needs. One good example of this was with rapid recovery programmes.
- The surgical division had clear processes in place for the management of patients living with dementia and learning difficulties. Staff could describe their responsibilities to these patients and we were told of examples where these patients had their specific needs met.

However we also found;

- Four of the six surgical specialties did not meet the 90% standard of the proportion of patients waiting less than 18 weeks from referral to treatment time. However patients awaiting general surgery waiting less than 9.5 weeks to be treated.
- The referral to treatment time (RTT) of patients admitted and treated within 18 weeks of referral was on average 62% (for general surgery, trauma and orthopaedics and urology) which was worse than the national indicator of 90%.
- From July 2015 bed occupancy increased to 95% which was worse than the England average of 85%. The pressure for beds within the hospital meant that elective patients were not receiving surgery in a timely way. There were waiting lists in most specialties. The trust's risk register included the risk that increased numbers of emergency medical patients meant at times patients were placed on a surgical ward because medical wards had no capacity.
- We did not consistently see leaflets for patients relating to any specialist services on the wards.
- Ward staff told us that some complaints raised by patients were dealt with by the ward, but were not always documented. This meant themes and trends could not be properly evaluated.

Service planning and delivery to meet the needs of local people

- Surgical services were available 24 hours, seven days a week with emergency access to operating theatres outside of normal working hours.

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- The trust had an escalation policy and procedure to deal with bed availability at busy times. This gave clear guidance to staff regarding how to proceed when bed availability was an issue.
 - Bed capacity meetings were held twice daily to monitor bed availability in the hospital; they included reviews of planned discharges to assess future bed availability.
 - During times of high patient demand, elective patients were reviewed in order of priority to prevent urgent and cancer patients being cancelled.
 - When attending the preoperative clinics all patients were given an information pack to take home with them which included pre-surgery drinks, information on quitting smoking (if requested) and advice specific to the type of anaesthesia and surgery they would be receiving.
 - Four patients we spoke with said they had received information on their operation in good time before attending the hospital. However felt advice within the hospital was conflicting with regard to fasting times.
 - Three elective patients told us they had been starved for surgery between 12 and 14 hours. The fasting policy supplied by the trust was due for review in June 2015 and had been updated at the time of our inspection in March 2016. However the department were unaware of this.
 - Three patients in TAL said they liked the idea of the 'My Surgery' app but wished they had known about it prior to the day of admission.
- improve flow. However senior managers could not assure us they were aware of the exact number of patients waiting and if their health had deteriorated, making them now unfit for a procedure.
 - Patients were admitted for elective surgery by referral from their GP to relevant consultants. Patients could also be admitted via the emergency department as an emergency or as a direct admission via the GP. Elective surgery patients attended the pre-assessment clinics, where all patients expected to have a general anaesthetic procedure were seen by the pre-assessment nurse.
 - Most patients were assessed by the multidisciplinary team, including an anaesthetist, before admission. Patients were only admitted to the day surgery unit if they met specific criteria, including not having any high risk factors. These included for example high blood pressure, a history of heart attack in the previous year, insulin controlled diabetes and respiratory problems. This allowed staff to identify patients' care needs before their operation and have plans in place for their recovery.
 - The number of cancelled operations for those treated within 28 days and those who were not has fluctuated throughout the reporting period with October 2014 to March 2015 seeing the highest numbers. However the number of cancelled operations as a percentage of elective admissions has been within 0.5% of the national average for the previous two years. On average 15 patients may have their operation cancelled each month.
 - Planned surgical operations in the morning were cancelled to prioritise emergency procedures. However we were told this was rare and that there had been one case in six months.
 - All potential elective cancellations were discussed with senior managers to review clinical urgency and length of wait for treatment. A weekly theatre activity planning meeting prioritised all the following week's lists.
 - The average length of stay for surgical elective patients between July 2014 and June 2015 was three days, which was better than the England average of 3.3 days. The average length of stay for surgical non-elective patients was 5.1 days, which was slightly better than the England average of 5.2 days. The non-elective trauma and orthopaedic length of stay was better than the England average at 6.9 days compared to the England average of 8.7 days.

Access and flow

- National indicators show that 90% of admitted patients should start consultant-led treatment within 18 weeks of referral, after taking into account clock pauses (medical pauses in treatment), patients electively choosing to wait for treatment, and patients declining treatment altogether. The referral to treatment time (RTT) of patients admitted and treated within 18 weeks of referral was on average 62% (for general surgery, trauma and orthopaedics and urology) which was worse than the national indicator of 90%.
- The trust told us that they were working with local area teams and commissioners to develop a recovery plan to improve consultant-led RTTs. These included the availability of rehabilitation beds in a local nursing home to enable more timely discharges in order to

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- From October 2014 to June 2015 the trust bed occupancy rate was consistently below the England average of 85%; research has shown bed occupancy rates above 85% can result in decreased quality of care. However, from July 2015 bed occupancy increased to 95% which was worse than the England average of 85%. We were told this was as a result of closures in community beds which had caused a delay in discharges.
- On the trust's risk register we saw that increased numbers of emergency medical patients meant that at times patients were placed on a surgical ward because medical wards had no capacity. This posed a risk to elective surgery as there was reduced capacity on the surgical wards for elective surgical patients. Rates of elective surgery were monitored daily and at the time of our inspection, 29 medical patients remained on surgical wards.
- Ward nursing staff told us they frequently had medical patients, especially during the high pressure winter months. This led to disruption for patients and decreased continuity of care. Staff told us even patients in vulnerable circumstances, such as those living with dementia, were moved to surgical wards.
- Managers also told us that other limiting factors to the flow of patients in the surgical division were access to beds and access to critical care beds, and recruitment issues for theatre staff.
- The numbers of cancelled operations where the patient had not been treated within 28 days had generally been low over the reporting period up to September 2014. Although this had been above the England average, from January to September 2014, this was only six patients
- The trust participated in the National Hip Fracture Audit. Findings from the 2015 report showed the hospital was worse than the national average in many areas. However Surgery on the day of or day after admission was 73.5% better than the England average of 72.1%, also mean total length of stay at 18 days was better than the England average of 20.3 days.
- The proportion of patients experiencing unnecessary delays in being able to leave hospital was low, at less than 2%. Delays to discharges were reported to be related to external factors, such as community care and

lack of rehabilitation beds. We were advised by nursing staff that a number of patients on the orthopaedic and trauma ward were waiting for community rehabilitation beds.

- Staff told us that delays in patient discharge also happened when there was a shortage of social care in the community. This meant that 'medically fit for discharge' patients were kept in hospital thereby occupying a bed which was then unavailable for surgical patients.
- We observed good communication and team working around planning people's discharge from hospital. Nursing staff said discharge planning started at the time of patient admission and was multidisciplinary. However completion of discharge planning documents was inconsistent across all surgical wards.

Meeting people's individual needs

- Patients told us their individual needs were met by staff and, decisions and choices had been respected. Comments included, "Sometimes they go above and beyond the call of duty."
- Patients who were going home confirmed they had been involved in planning their discharge. A discharge lounge was available for patients to use. This allowed beds to be freed up promptly for new admissions. However patients could be waiting for transport for an extended time in the discharge lounge with no entertainment. Staff were trying to raise money for a television for discharge patients to watch while they waited for transport.
- There was no specialist dementia care pathway for patients living with dementia. The trust had a dementia strategy dated September 2015. Most surgical staff had attended mandatory training which included a dementia awareness session.
- The surgical division had clear processes in place for the management of patients living with dementia and learning difficulties. Staff could describe their responsibilities to these patients and we were told of examples where these patients had their specific needs met.
- For example, we saw three patients living with dementia; they all had 'about me' documents which ensured that staff were aware of the patients' specific needs during their hospital stay. One patient also had a laminated chart explaining to them why they were in hospital so that they could keep reading it.

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- Patients living with dementia were identified using a blue flower sticker on their medication card and name board.
- There was a lead nurse for patients with a learning disability, who could help support patients and provide resources for nursing staff.
- Staff were able to access interpreting services for people whose first language was not English.
- Menus we saw showed that choices of gluten-free, vegetarian and soft diets were available.
- We were also told alternative menus could be offered however three staff we spoke to were unsure how these were ordered.
- Patient had access to a wide range of resources and materials, both online and in paper formats, which were individualised and tailored to their needs. One good example of this was with rapid recovery programmes.
- We did not consistently see leaflets for patients relating to any specialist services on the wards.

Learning from complaints and concerns

- We spoke with ward sisters about the management of complaints on the wards. We were told that de-escalation of complaints and managing them at the time they happened was encouraged.
- We were given examples where staff had managed complaints locally and telephoned patients and their carers to discuss their complaint and the learning taken from them.
- We saw leaflets throughout the surgical business unit for the Patient Advice and Liaison Service (PALS). They were easily accessible by all patients and visitors. Pre-operative information packs also contained information about how to make a complaint.
- Complaints were handled in line with trust policy on most wards. Information was given to patients about how to make a comment, compliment or complaint. There were processes in place for dealing with complaints at ward level and through the PALS team.
- A total of 101 complaints were received by the trust between April 2014 and March 2015. Of these complaints 24% were related to surgery. Themes included the attitudes of staff, and poor medical and nursing care and treatment.

- Ward staff told us that some complaints raised by patients were dealt with by the ward, but were not always documented. This meant themes and trends could not be properly evaluated.
- Most staff told us they received feedback from complaints and concerns at staff meetings or through the monthly ward newsletter.

Are surgery services well-led?

Good



We rated well-led as good.

We found;

- An effective governance structure in place which was supported by both time and resources in this area. There was clear evidence of discussions and review of risks, incidents, audits, complaints, and quality performance data at divisional level with clear processes to escalate concerns and disseminate learning.
- Governance arrangements identified risks and regular monitoring of these, with progress on action plans reported at business unit meetings.
- The culture of the service was open and transparent with the patient's best interests at the centre of care. Feedback from service users was regularly collected through the use of a questionnaire and we saw examples where this had changed practice and the patients' experience.
- Staff were aware of and understood the values of the trust and demonstrated enthusiasm and commitment to the provision of a quality service to patients.
- Innovative practice was encouraged and we saw examples of projects that had led to improvement for patients.

However we also found;

- Not all staff were aware of the leadership team structure from board to ward.

Vision and strategy for this service

- The trust's vision was communicate, attitude, respect and environment (iCARE). This was visible throughout

Surgery

the surgical division and on the trust's website. There were clear aims and objectives. The trust's values and objectives had been cascaded across the surgical wards and were visible on ward areas.

- Staff demonstrated an awareness of the vision and the values of the trust and had a clear understanding of what these involved.
- The trust had a clinical strategy 2015/2016 based on work by the Symphony Project, to deliver a Primary and Acute integrated Care System (PACS). This was aligned to the NHS Five Year Forward View. The trust had been working with Somerset Clinical Commissioning Group (CCG), South Somerset GPs, and the County Council following its achievement of Vanguard status.
- In addition to this the surgical and orthopaedic business units had clinical strategies outlining their plans for 2016/2017. This set out the priority objectives, it included aligning service delivery to meet national referral to treatment times (RTT) and cancer targets and a system to provide trauma and orthopaedic patients with a 24 hour virtual review.

Governance, risk management and quality measurement

- All staff across the surgical division demonstrated a good awareness of governance arrangements.
- Within theatres an electronic risk register was maintained and shared with critical care; risks identified were discussed at a monthly theatre risk group meeting.
- Our discussions with senior managers showed they were aware of the main risks and challenges for the surgical division. For example, we saw where the referral to treatment times had been highlighted as a significant risk for the trust and had a recovery programme was in place.
- Sharing of learning from Never Events and serious incidents took place at local governance meetings and information discussed contributed to the trust quality review committee.
- Within anaesthetics, staff were able to identify incidents within their services and gave examples of reporting, feedback and current audit and research. We reviewed the minutes of the monthly anaesthetics governance meeting.
- Most nursing staff told us they attended monthly ward or department meetings. Ward managers told us they attended peer review and safety thermometer meetings

and had regular one to one meetings with their line manager. These meetings allowed staff to be updated on organisational changes and developments, discuss specific matters and concerns, receive feedback on incidents and participate in shared learning.

- Senior nursing staff were aware of specific issues, which had been identified on the risk register, including for example staffing levels and recruitment.
- Monthly staff meetings or newsletters were available on all of the wards we inspected.

Leadership of service

- The surgical services were led by a director, deputy director and associate medical and nursing directors. General surgery and orthopaedics had separate clinical business managers, matrons and clinical directors reporting into the senior team. This structure was replicated throughout the trust.
- Staff were aware of their roles and responsibilities. We found there was good ward leadership and staff said they felt supported.
- Most staff from a range of surgical roles described senior managers within the surgical division as managers who were approachable, visible and committed to ensuring care delivery within surgery was patient-focussed.
- A few staff reported a 'disconnect' between middle management and themselves; an example of this was the issue of movement of surgical patients to make way for medical patients which had been escalated almost daily for the past few months before our inspection, but there had been no feedback on this for staff.
- Each ward had a 'nominated director' who visited regularly. Some staff knew the named director for their ward, however did not know when they had last visited.

Culture within the service

- Generally, morale amongst the staff in the surgical division was good.
- Medical and nursing staff spoke positively of each other and reported that working relationships were effective and supportive.
- Across the surgical division staff consistently told us of their commitment to provide safe and caring services and reported an open and transparent culture within the surgical division. They reported good engagement at ward level and felt they were able to raise concerns and these would be acted on.

Surgery

- We met with staff in the operating theatre department, they were clearly proud of their work and the high level of care they provided to patients. They had a clear understanding of the values of the unit and the management's vision in taking the service forward. However three members of staff reported since the introduction of the new rostering system they felt less valued.
- The majority of trainee doctors and student nurses considered the surgical areas provided a good experience and opportunities for learning and developing their skills.
- Within the surgical division the staff sickness rate was 3.8% which was just below the trust's target of 4%. Staff turnover levels were slightly higher than expectations. Reasons given for leaving included relocation and work life balance.

Public and Staff Engagement

- Throughout the surgical wards we saw the friends and family test results were clearly displayed on the wards with patient's feedback comments. If there were negative comments, information was provided on what had been done about these. The friends and family test for the trust in-patients had a response rate for in-patients of an average of 40%.

- The staff survey for 2015 showed 81% of staff felt satisfied with the quality of their work and patient care they were able to deliver. A further 90% of staff felt their role made a difference to patients.

Innovation, improvement and sustainability

- There were systems in place to enable learning and improve performance, which included the collection of national data, audits and learning from incidents, complaints and accidents.
- Innovative practice was encouraged and we saw examples of projects that had led to improvement for patients. An example of this was the partnership with Somerset Care to provide 18 re-ablement and 'Time to Think' beds in a local nursing home.
- Staff recruitment from Europe including Spain, Portugal and Italy which have significantly improved recruitment, which resulted in full nurse establishment from November 2015.
- The establishment of the Junior Doctors Quality Improvement Programme, which was a nine month programme of training, resulted in the delivery of tangible improvements in care.

Critical care

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

Information about the service

Critical care at Yeovil District Hospital is managed within the theatres, critical care and anaesthetics business unit. This is part of the Elective Care Strategic Business Unit.

The critical care unit is located on the fifth floor of the hospital adjacent to the operating theatre department. The unit was opened in 2007 and combined what were previously separate facilities for intensive care and high dependency patients into one unit. The critical care unit is currently staffed for four intensive therapy beds (ITU) and six high dependency beds (HDU). Access to the unit is not controlled by the intensivists at the trust, therefore any consultant can admit a patient to the unit if there is availability. This is known as an open unit.

The critical care unit provides critical care at levels two and three as defined by the Intensive Care Society. Level two patients are those requiring observation that is more detailed or intervention including support for a single failing organ system, or post-operative care and those 'stepping down' from higher levels of care. Level two patients require one nurse to two patients. Level three patients are those requiring advanced respiratory support alone, or monitoring and support for two or more organ systems. This level includes all patients requiring support for multi-organ failure. Level three patients require one nurse to one patient.

For the reporting period April 2015 to December 2015, there were 579 admissions to critical care.

During our inspection, we spoke with three patients, three relatives and 30 staff, including managers, junior and senior nurses, junior and senior doctors, allied health professionals, pharmacist staff, administrative and clerical staff and volunteers.

As part of our inspection, we observed interactions between patients, their relatives and staff. We considered the environment and looked at eight medical and nursing care records and five medication prescription charts. Before our inspection, we reviewed performance information from and about the hospital.

Critical care

Summary of findings

The overall rating for the critical care services was good.

We rated the safety of critical care as good. Patient safety was given sufficient priority. An effective system was in place for the reporting and investigation of incidents, and this had led to improvements in the delivery of patient care and outcomes. There was sufficient equipment for the delivery of patient care and the environment was clean.

The unit had nursing and medical staff vacancies and recruitment was a challenge. Additional intensive care consultants were needed to enable the care of all patients on the critical care unit to be led and managed by an intensive care consultant at all times.

Senior nurses supported the critical care outreach service on a rotational basis which provided a good development opportunity but also impacted on the number experienced staff on the unit. Senior staff continually monitored staffing levels to ensure patient safety was maintained. The outreach service assisted in the early recognition of patients who were at risk of deterioration throughout the hospital and the follow up of patients who had been discharged from critical care.

We rated the effectiveness of critical care as good. Patients received evidenced based care that was based on comprehensive patient assessments and regular evaluation. Patient outcomes were monitored and were good.

Despite not having a dedicated clinical educator staff overall were supported in their personal development and training. Access to the critical care post registration qualification however was limited to two staff per year and less than 50% of the nurses currently held this critical care qualification as required by the Core Standards for Intensive Care. Although the multidisciplinary team (MDT) was an integral part of the patient care, a daily MDT ward round involving all members of the team did not take place.

We rated caring on the unit as good. Patient and relative feedback was very positive and care was patient centred. Staff understood the impact critical illness had on both patients and their relatives and this was

reflected in the care that was delivered and how it was delivered. Patient diaries were well managed and assisted patients to recover and relatives to feel supported following a period of critical illness.

We rated the responsiveness of critical care as good. Critical care was delivered in a way that met the individual needs of critically ill patients. Patients were not always discharged from the unit within four hours of the decision being made to discharge them or before 10pm. Whilst this was not in line with the Core Standard for Intensive Care requirements, the timeliness of discharging patients was influenced by the availability of beds within the hospital. This was not in the direct control of the critical care unit. There was no evidence to suggest that bed availability was leading to non-clinical transfers of critically ill patients to other hospitals however elective operations had been cancelled due to critical care beds being available. Patients were offered the appropriate support with their rehabilitation following a critical illness, and a clear rehabilitation pathway was in place which included a follow up clinic visit.

Senior nursing staff were visible and accessible to patients, visitors and staff. The senior sister provided clear and professional leadership. There was an open and honest culture and staff were passionate about patient care. The senior leadership team were clear in their objective of wanting to meet the Core Standards for Intensive Care and have a closed unit model of care; with care being led by a consultant in intensive care medicine. At present any consultant can admit a patient to the unit without review by an intensivist. They were actively recruiting medical staff to enable this objective to be met.

Critical care

Are critical care services safe?

Good



The safety of the critical care services at Yeovil Hospital was Good.

We found;

- The reporting of incidents was encouraged, incidents were investigated by senior staff which led to improvements.
- Twice daily safety briefings were comprehensive and used to inform staff of relevant safety information regarding patients, staff and the environment.
- Sufficient equipment was available to deliver safe patient care.
- All staff were seen to take infection control and prevention measures.
- Staffing levels were monitored and adjusted to meet patient dependency.
- Mandatory training had been completed by the majority of staff. Records for February 2016 showed a completion rate of 94% for all staff on the critical care unit. This was above the trust target of 90%.

However we also found;

- There were no critical care specific mortality and morbidity meetings taking place as required by Guidelines for the Provision of Intensive Care Services. (GPICS)
- The unit was not a “closed unit.” This means that at present any consultant can admit a patient to the unit and they remain the responsibility of that unit. In a closed unit the consultant in intensive care medicine leads care in the unit all the time. This had been added to the critical care unit risk register as a potential significant risk.

Incidents

- In the reporting period January 2015 to December 2015 there were 163 critical care incidents recorded through the trust on line incident reporting system.
- The majority, 84% of the reported incidents, resulted in either no or minor harm and near miss incidents accounted for 10% with 6% of incidents resulting in moderate harm. The highest category of reported incidents related to patient pressure areas, where staff

had noted deterioration in a patient’s skin condition either on or following admission to the unit. This category accounted for 36 of the total 163 incidents, which was 57% of all incidents reported by critical care services.

- Staff had reported one serious incident between January 2015 and December 2015, this was a near miss incident, where patient harm had been prevented. A comprehensive root cause analysis had been completed following the incident. The outstanding risk was documented and managed through the unit risk register.
- The trust had provided information on and staff understood the incident reporting process, which demonstrated a positive culture of incident reporting by nursing, medical and support staff.
- Trust records and staff knowledge confirmed incidents were investigated and learning had been shared with staff. Senior staff were able to discuss previous incidents, their investigation process and the action that had been taken.
- An incident that had taken place immediately prior to the inspection had been reported promptly and comprehensively with initial learning documented.
- Following seven incidents, where the device securing the breathing tube had caused pressure on patients’ mouths, a new product had been used which led to improved patient outcomes.
- Staff received feedback from incidents through information boards and a twice daily safety briefing. Staff also received detailed feedback through email. Safety briefing records from the previous month showed this was an on-going method of sharing learning. We observed a patient safety briefing at morning handover, which provided a comprehensive update to all the staff on the shift of any actual and potential safety concerns.
- February 2016 incident reporting data was displayed on a unit notice board. Minutes of recent staff meeting provided a record of incident trends being highlighted to staff.
- The incident reporting form had been amended to improve the accuracy of the reporting process.
- The critical care team did not hold formal mortality and morbidity meetings specifically for critical care services. Core Standards for Intensive Care Units 2013 state that

Critical care

units must hold multi professional clinical governance meetings, including analysis of mortality and morbidity. The purpose of mortality and morbidity meetings is to review deaths as part of professional learning.

- The senior staff told us critical care medical staff of various grades and senior nursing staff did attend the monthly anaesthetic department governance meeting. Recent meeting minutes provided evidence of this. However there was no record to show a review of any deaths related to critical care services had taken place. We noted minutes from a recent anaesthetic department governance meeting, which suggested critical care mortality and morbidity meetings would be useful, however these meetings were not in place at the time of our inspection.
- The duty of candour is a regulatory duty relating 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 asked 15 staff, including nurses, medical staff and allied health professionals, about their understanding of the duty of candour. All the staff were aware of what the duty of candour meant. We were given an example of where the duty of candour process had been followed. Whilst a patient was in critical care an investigation had started into the care the patient had received prior to admission to critical care. Senior critical care staff had spoken to the family of this patient as a first step in the duty of candour process.

Safety thermometer

- The NHS Safety Thermometer is a local improvement tool for measuring, monitoring and analysing patient harms and harm free care. It focuses on four avoidable harms; pressure ulcers, falls, urinary tract infections in patients with a catheter and blood clots or venous thromboembolism (VTE). Results from the safety thermometer were available on the unit, for relatives and for staff to view and were displayed on a large information screen in the centre of the unit.
- The critical care safety thermometer results for December 2014 to December 2015 showed there were three pressure area ulcers of grade two to four. There had been two falls and, there were no catheter acquired urine infections reported.

- The safety thermometer results had been used by the unit to help identify a problem with ventilator tube securing methods causing pressure damage to patient mouths.

Cleanliness, infection control and hygiene

- The critical care environment was visibly clean; surfaces were uncluttered, easily wipe able and visibly free from dust.
- Housekeeping staff worked on the unit routinely and were seen throughout the inspection, they were able to explain their role in keeping the environment clean.
- There was a documented procedure in place for the deep cleaning of the unit, housekeeping staff demonstrated an understanding of this procedure.
- Housekeeping staff told us the patient's bathroom was cleaned daily. There was no documented record to confirm when this had been done however the bathroom was checked on two separate occasions during the inspection and was found to be clean and tidy.
- Cleaning equipment, for example buckets, were colour coded to prevent cross contamination between different areas of the unit.
- There was a schedule in place for cleaning drug fridges every week, and records showed this had been carried out. We checked one drug fridge during the inspection; we found it was visibly clean and medicines were stored appropriately to prevent spillage.
- We checked two commodes, which were visibly clean and ready for use. In line with the trust policy for cleaning commodes, (February 2016) labels had been applied to confirm this was the case.
- A hand washing station located inside the unit entrance announced a recorded alert message; 'Stop, gel your hands, please think of our patients and staff.' We saw staff using this hand washing station throughout the inspection.
- All staff, without exception, were bare below the elbows. We observed medical, allied health professionals and nursing staff using personal protective equipment, for example aprons and gloves. Hand gel was available throughout the unit and was positioned near written reminders on how to and when to use the gel.
- Additional signage was in use to alert staff and visitors to known infection risks and this was also cascaded to staff as part of the handover safety briefing.

Critical care

- There was one side room equipped with the facility of negative pressure airflow control, which had a separate lobby with a clinical sink. This room could be used to isolate patients with a suspected or confirmed airborne infectious disease. The room had a fixed patient hoist, which meant mobile hoists on the unit did not need to come into contact with an area of increased risk of infection which minimised cross infection.
 - There were a further four side rooms on the unit which could be used to maintain a degree of separation between patients if required.
 - Processes and procedures were in place for the management, storage and disposal of general and clinical waste, disposal of sharps such as needles and environmental cleanliness.
 - The unit was part of the trust wide infection control audit programme. An audit of hand hygiene had been completed between June 2015 and August 2015. Compliance was between 86% and 100%, In October 2015 an audit of two members of staff and their use of personal protective equipment was completed where 100% compliance was achieved.
 - An internal hand hygiene audit completed in December 2015 showed an overall compliance rate of 80%, the lowest area of compliance (60%) was for hand hygiene being carried out after contact with the environment. The unit achieved 100% compliance for hand hygiene being performed before an aseptic procedure and after patient contact. An internal cleaning audit had been completed in December 2015, the unit achieved a score of 99%.
 - Intensive Care National Audit and Research Centre (ICNARC) data for the reporting period April 2015 to December 2015 showed the unit had no cases of unit acquired infections in the blood and this performance was better than other similar units. During the reporting period July 2015 to September 2015 there were no cases of unit acquired *Clostridium difficile* infections (*C. difficile* is a bacteria affecting the digestive system, it often affects people who have been given antibiotics). There had been one case of unit acquired Methicillin-resistant *Staphylococcus aureus*. (MRSA is a type of bacterial infection and is resistant to many antibiotics).
- dependency patients. This provided flexibility within the unit to meet an increasing or decreasing level of patient dependency without the patient being physically moved. Five of the beds were in separate cubicles and five were in bay areas with curtains. Electrical and medical gas supplies were located in pendants at each bed space.
- Entry to the unit was secure and the doors were kept locked. Access was obtained through a call bell and a staff controlled door release system. The reception area was spacious and tidy; volunteers worked on the reception desk and provided a first point of contact for everyone who came to the unit.
 - The general environment appeared in a good state of repair. The environment was spacious, with a good source of natural light to all areas and dimmable lighting in patient areas.
 - Intercom facilities were available throughout the unit including the staff rest area. We observed nursing staff using the intercom to ask for equipment, this meant staff were able to observe patients without disruption. We observed nurses remained in very close proximity to the patients throughout their shift
 - The unit had two store rooms, which contained most of the equipment and these were kept secure by use of a coded door entry system. Sterile supplies were kept clean and dry; everything was easily accessible and stored neatly. Ventilators and high flow oxygen equipment, which were not in use, were located on the unit in an observable position. They were clean and covered over to protect them from dust.
 - The sluice was in a central location and was of sufficient size for items to be kept tidy and stored safely.
 - Office space on the unit was limited and accommodated support staff, senior nursing staff, including the critical care outreach team and medical staff.
 - We found two window blinds where the break point in the cord appeared to have been broken and the cord ends tied together, this left no break point in the cord. These could have posed a potential ligature risk and we raised this at the time of inspection. Critical care staff escalated the concerns immediately to the hospital estates department. We were informed the unit had last been subject to an audit of the window blinds in response to a previous patient safety alert regarding the ligature risk of blind cords. No action was required at that time. We were informed that a further review of the environment took place following the inspection and

Environment and equipment

- The unit had 10 beds all of which had sufficient space and facilities to be used for intensive care or high

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that the broken blind cords were repaired to ensure all the blinds had break points. Actions were also taken to ensure all staff were made aware that all repairs to blinds must be carried out by the estates department.

- We looked at 12 pieces of equipment that were used directly in the delivery of patient care, we found labelling on five of these to state that they were past their scheduled maintenance check date. We raised this at the time of inspection. Senior staff immediately contacted the hospitals equipment maintenance department who had responsibility for the maintenance of the equipment. We were informed that records had been checked and that 4 of the pieces of equipment had been labelled incorrectly and that the equipment was not yet due for servicing. The equipment was re labelled during the inspection. One piece of equipment was outside its service date and this was removed from the patient area.
- Equipment returned to the unit following servicing was labelled to alert staff that alarms, control settings and patient circuits required checking prior to use.
- The unit had a documented procedure for checking their emergency resuscitation and transfer equipment including the defibrillator, which was checked daily. An internal emergency equipment trolley audit completed in February 2016 had shown the unit equipment to be compliant with the trust resuscitation policy. During the inspection, we noted patient transfer bags which were scheduled to be checked on the first of every month but had not been checked on the 1 of March 2016. We brought this to the attention of the senior nursing staff on the unit.
- In addition to the standard emergency resuscitation equipment, the unit also had appropriate airway management equipment to respond immediately to a difficult intubation. Intubation is the insertion of a plastic tube into the windpipe to enable assistance to be given with breathing.
- A majority of the equipment on critical care was permanently based on the unit, however if additional equipment was required, for example a specialist mattress or bed, then these would be sourced from either the equipment store within the hospital or loaned from specialist companies. Staff told us there was usually no problem obtaining equipment.

- The unit had its own transfer trolley specifically designed for the transfer of critically ill patients. This contained all the equipment required to transport a ventilated patient to a location outside of the unit.

Medicines

- There were 34 medicine related incidents reported by critical care between January 2015 and December 2015. Of these, 32 resulted in no patient harm. The other two incidents were reported as low and moderate harm incidents. Senior nurse meeting minutes from November 2015 showed medicine incidents were being monitored and investigated.
- We observed two nurses who checked the preparation and administration of an intravenous medicine; this was in line with the trust management of medicine policy.
- There was a designated pharmacist for the critical care unit, who was supported by a pharmacy technician. The technician was responsible for date code checking and stock levels. A weekend and out of hours service was available through an on call pharmacist.
- We reviewed the storage and associated documentation of the controlled drugs on the unit. (A controlled drug or medicine is covered by misuse of drugs legislation. The law determines the storage, production, supply and prescribing of these medicines). The controlled drug order book was stored securely and the register was completed following the administration of medicines.
- We looked at the controlled drugs register checks for the previous 75 days, we found that on six days (8%) the daily balance check for the controlled drugs had not been signed. This was not in line with the trust management of medicine policy.
- A comprehensive file containing information about the prescribing and administration of intravenous medicines was located in the area where medicines were stored and prepared prior to their administration. However, we found some of these information sheets were not dated and others were dated 2014, no date was documented as to when this information required reviewing. Additional information on the prescribing and administration of medicines was available for staff on the trust intranet.
- All medicines and intravenous fluids were stored in locked cupboards; the cupboard keys were kept in a coded key safe.

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- Drug fridges were locked and the keys kept secure in a coded key safe. Drug fridge temperatures were visible and monitored centrally by the trust. We checked a drug fridge and this confirmed it was solely being used for the storage of medicines.
- Lockable bedside medicine storage cabinets were available and the key was kept in an adjacent key safe, we observed these cabinets were kept locked.
- We reviewed five prescription sheets. All medicines were prescribed, dated, signed, and any known medicine patient allergies were documented. Where antibiotics had been prescribed, they had been reviewed or had a planned review date documented in four out of the five prescription charts we looked at. The National Institute for Health Care Excellence (NICE) Guidelines 2015 on Antimicrobial Stewardship, recommends prescribers of intravenous antimicrobials to review all prescriptions at 48 - 72 hours. Anti-microbial stewardship is a coordinated program that promotes the appropriate use of antimicrobials (including antibiotics), improves patient outcomes, reduces microbial resistance, and decreases the spread of infections caused by multidrug-resistant organisms. On two out of the five prescription charts where a medicine had been omitted we did not see a reason documented for these omissions.
- Out of hours, non-stock medicines or additional stock were available from the emergency drug cupboard situated in the hospital. The site manager for the hospital had access to some medicines stored in the pharmacy department and there was also an on call pharmacist service.

Records

- Patient medical records were stored securely in a locked trolley, access to which was obtained through a coded lock. Staff were seen using the locked trolley.
- We witnessed a volunteer taking particular care to ensure that confidential patient information on paper records was kept secure.
- A piece of work was on going by the trust to introduce a fully integrated electronic health record. Senior critical care staff had been very closely involved in the development of this project.
- We reviewed eight patient records. Nursing and medical records were paper based. We saw consistent evidence that the multidisciplinary team had been involved in the review of patient care and treatment, and families were

kept up to date with the patient's condition. In seven out of the eight sets of notes, we saw evidence that a consultant had reviewed the patients on admission to critical care and in six sets treatment plans were documented.

- Care records showed staff had used recognised risk assessment tools to assess patients' care and treatment needs. There was documented evidence that nurses had assessed patient's pressure areas, nutritional status and sedation requirements.
- A large computer screen was located adjacent to the nurse's central station. This was clearly visible and contained a large amount of patient information, including name, age, hospital record number and whether they were medically fit for discharge. We noted information about one patient included details of their condition. Any person standing adjacent to the nurse's station, including relatives could read this information. No screen saver was in use; therefore the information was permanently visible. The inspection team raised this as a concern at the time of the inspection as a potential breach of patient confidentiality. The screen was still in use at the end of the inspection.
- We also noted staff did not always lock the computer screens on the nurses' station after use and therefore confidential data may have been accessible to people who were not authorised to view it.

Safeguarding

- We spoke with 12 staff about their safeguarding knowledge and training. The majority of the staff had received level two safeguarding training, with two of the more senior staff being trained to level three.
- We were given appropriate examples of what would be considered a safeguarding concern including detail on the different types of abuse. Staff were also clear their responsibility extended beyond the patients on the unit and included visitors to the unit as well. Staff knew who the safeguarding lead was and would contact them for any advice.
- Senior staff gave an example where a safeguarding referral had previously been made when staff had concerns for a family member who was a visitor to the unit.
- Safeguarding training was included as part of the trust mandatory training agenda.
- There 14 safeguarding alerts raised by critical care during the reporting period April 2015 to March 2016.

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Mandatory training

- The trust academy coordinated mandatory training, which was provided through mandatory and essential skills training days. Staff had received reminders of when their updates were due for completion.
- Mandatory training and essential skills course dates were displayed in the staff room. Courses were available for most months throughout 2016. Mandatory training day topics included equality and diversity, conflict resolution and infection prevention and control. Essential skills training included a blood transfusion update, mentorship and medicines management.
- We asked 22 staff about their mandatory training. All of them had completed their training within the last 12 months. Records for February 2016 showed a completion rate of 94% for all staff on the critical care unit. This was above the trust target of 90%.

Assessing and responding to patient risk

- The nurse led critical care outreach team (CCOT) currently consisted of a band seven nurse who led the service and a band six critical care nurse covering a period of leave within the team. Band six nurses covered outreach as part of a pre-planned rota. The service was currently available from 8am to 8pm seven days a week. There was funding now in place to extend this service to include Friday, Saturday and Sunday night.
- Between 8pm and 8am, the on call medical staff managed patients with referrals made to the on call critical care medical team when required. Staff explained that on occasions the outreach team worked after 8pm to assist in the management of a deteriorating patient as there was no one to hand over their individual role to.
- The outreach service responded to patients who were deteriorating on the wards and reviewed patients who had been discharged from critical care.
- Patients across the hospital were assessed using an early warning scoring system, which provided a clear escalation protocol in the event of a patient deteriorating.

An early warning system is a scoring system that staff can use to assess whether patients are developing a potentially life-threatening condition and enable early recognition of deteriorating patients.

- We observed a telephone referral being received by the outreach service from one of the wards in the hospital. Immediate advice was available to the ward staff, the patient's current observations and laboratory results were available through the on line database and a plan was made for the outreach team to review the patient.
- The outreach team provided informal and formal training to staff throughout the hospital. As part of this education role, the lead nurse for the CCOT had led on producing a 'sepsis proforma' which has now been implemented across the trust. The proforma is an assessment tool to aid the early recognition and early treatment of sepsis.
- Patients in the critical care unit were under constant observation and staff regularly assessed their condition. We saw observations were taken, recorded at appropriate intervals and treatment escalated where it was indicated. Trained staff were available to respond immediately to a change in a patient's condition and emergency equipment was available.
- Patients were assessed using nationally recognised assessment tools, enabling a consistent approach to the assessment process. From the eight patient records we reviewed, we saw evidence of risk based tools being used including the assessment of patient's pressure areas. Staff had altered patient's treatment according to the assessment results.
- Staff used the British Association for Enteral and Parenteral Nutrition, Malnutrition Universal Scoring Tool (MUST), to establish the patient's nutritional needs and risk of malnutrition.

Nursing staffing

- The unit was currently funded to have eight registered nurses per shift. In principle this was to provide nursing care to four level three patients, having one to one nursing care, and six level two patients having one nurse to two patients.
- A supernumerary clinical coordinator was rostered on each shift this was in line with the Core Standards for Intensive Care Units 2013.
- Senior staff produced planned rosters using a computer based software package. They told us this system has produced some poor shift patterns, which have needed amending before the rosters could be used.
- The Association of UK University Hospitals acuity/dependency tool (AUKUH), was used for determining the

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actual number of nursing staff required to deliver safe care and treatment taking into account the actual current numbers and dependency of patients on the unit.

- Where there was a shortfall in the rostered number of nurses or due to increasing numbers or patient acuity, which was not covered by existing staffing levels, additional staff were sought. Initially unit staff would be offered a cash incentive to work an extra shift. Then a request for bank staff was made and if neither of these were successful, an agency nurse would be sourced.
- For the period December 2015 to February 2016 there were 49 registered nurse shifts covered by bank nurses and 175 covered by the use of agency nurses out of a total number of registered nurse shifts for this period of 1,424. The fill rates for all staff for this period ranged from 87% to 100%. Fill rates reflected the use of professional judgement by senior staff to determine whether the actual patient numbers and dependency could leave shifts safely un-filled. Over this period there were 387 registered nurse shifts left unfilled by using professional judgement and one left unfilled due to the unavailability of a registered nurse.
- Contacting staff employed by the trust was done through a text facility which enabled a large number of staff to be contacted quickly.
- The turnover for all staff on critical care was reported by the trust to be 16% in December 2015. (Turnover is the percentage of staff who leave and are replaced by new staff and affects whether newly recruited staff increase actual staffing numbers or just replace staff that have left)
- With the current staffing vacancies, the planned staffing levels were seven registered nurses per shift. The staff told us this had also led to the shift coordinator looking after patients rather than being supernumerary. A record of when this had happened had been maintained on the unit. From these records we established between February 2016 to the day of the inspection the shift coordinator had looked after a patient during 36% of the shifts. In the 10 weeks prior to the inspection there had been 22 occasions recorded where critical care staff had been moved to work on other wards. After our inspection, the provider told us a re- assessment of patient dependency took place before staff were re-deployed to ensure safe staffing levels were maintained at a level to ensure patient safety.
- Following recent nurse appointments, the unit still had the equivalent of five whole time equivalent (WTE) band five registered nurse vacancies. Staff explained nurse recruitment was managed centrally by the trust. This had led to senior critical care staff having very little input in the recruitment process. Staff felt this may have led to some staff retention difficulties where new staff had not been fully aware of what their role would entail until they started.
- There was a support worker position currently funded for 29 hours per week Monday to Friday with plans for these hours to be extended to provide support cover seven days a week from 7.30am to 11.30pm.
- Band six nurses were providing cover for the critical care outreach service. On occasions where there were no band six nurses on shift, a senior band five nurse took charge of the unit with additional support provided by the senior sister.
- Planned and actual staffing numbers on each shift were displayed near to the entrance of the unit. These were current and kept up to date.
- We observed shift handover between the night shift coordinator and the nursing staff coming on duty. The critical care outreach nurse and the senior nurse also attended the handover. A shift handover took place twice a day; there was a structured format which incorporated a safety briefing. The shift handover was followed by a one to one nurse handover at the patient's bedside. The shift handover provided key information including patient dependency, possible admissions, planned discharges, resuscitation status, and detailed safety information.
- A 'buddy system' was used where nurses were paired to work together, this was to ensure adequate supervision of patients during staff meal breaks and for checking medicines. We saw this system in use during the inspection where nurses worked together to deliver patient care.

Medical staffing

- There was a designated clinical director responsible for the critical care unit.
- There was a Faculty of Intensive Care Medicine (FICM) consultant presence, Monday to Friday between the hours of 8am and 6pm. During this time, the consultant did not have any other clinical commitments. Outside of these hours the consultant cover was provided by an on

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call rota, during this time the consultant did have additional on call commitments. This was not in line with the Core Standards for Intensive Care Units 2013 which state that during the period of on call the consultant must not be responsible for delivering other services.

- Monday to Friday during the hours of 8am and 6pm, the intensivist managed the care of both the intensive care and high dependency patients. Outside of these hours the responsibility for high dependency, level two, patients was transferred to the admitting consultant and their team. The unit admission policy set out the seniority and regularity of the reviews which should take place by the patient's own team during the overnight and weekend periods.
- The decision to admit high dependency patients did not always involve the consultant on call for the critical care unit and they were not always reviewed by an intensivist within 12 hours of admission to the critical care unit.
- The critical care on call consultant rota was covered by 12 anaesthetic consultants, six of the consultants were intensivists. (An intensivist is a medical doctor with special training and experience in treating critically ill patients).
- The consultant to patient ratio did not exceed the target range of between 1:8 and 1:15.
- Staff told us that consultants who were on call could attend the hospital within 20 minutes of being called. Nursing staff told us the on call anaesthetists were always available. Staff explained the on call critical care medical staff were always available and they would always help if there was a concern about a high dependency patient's condition. Medical staff explained consultants were available within 20 to 30 minutes when they were on call.
- Part of the consultant on call rota included being present on the unit on Saturday and Sunday morning but these sessions were extended based on patient dependency.
- There was 24 hour cover, seven days a week provided by two middle grade doctors, both having advanced airway skills. (middle grade doctors are staff grades, specialty doctors and specialist registrars). One of these doctors was primarily responsible for critical care but also covered emergencies elsewhere in the hospital and

would be first on call for emergency theatres. The second doctor, usually the more senior doctor, was available to assist and to provide anaesthetic cover primarily for maternity patients.

- Medical trainees, including doctors training in intensive care medicine and anaesthetics, worked on the unit and assisted with patient reviews.
- Handover between critical care medical staff took place at 8am. A bed side ward round was carried out by the consultant, the doctor covering critical care, nursing staff and medical trainees. Staff told us that the consultants had their own approach to ward rounds and that they didn't all follow a standardised format
- For the period April 2015 to February 2016 there were low levels of locum medical cover for anaesthetics. Locum staff had been required during four of the months during this period. Anaesthetic locum cover included critical care and theatres.
- Out of hours when the care and management of high dependency patients was the responsibility of their admitting consultant staff told us getting the patients reviewed was a problem and it felt the high dependency patients were 'dis owned' by the medical and surgical teams. A nurse told us, "getting high dependency patients reviewed at a weekend was a problem, and medical and surgical teams have to be asked to review their patients."
- In October 2015, the following was added to the critical care unit risk register 'Inadequate number of junior medical staff to run a closed unit (ICU / HDU) in accordance with the Faculty of Intensive Care Medicines' as a potential significant risk. A closed unit model is where, when a patient is admitted to critical care the responsibility for the patient and their treatment is transferred to the intensivist. This has been shown to improve mortality and morbidity outcomes. Recruitment to both middle and junior medical grades was identified as being required.
- Recruitment was in progress for two additional anaesthetic consultants to enable a consultant on call rota dedicated to critical care to be established. Senior leaders told us a national shortage of intensive care consultants had contributed to the unit struggling to recruit and retain suitably qualified staff.

Major incident awareness and training

- Staff were able to explain the current major incident plan was available on the hospital intranet and major

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incident awareness training was included in the mandatory training day hosted by the academy. Information about forthcoming training dates confirmed major incident awareness was on the agenda.

- Not all the staff we spoke to had received major incident awareness training. One nurse had only received training on the use of special masks designed to protect staff from serious airborne infections.
- A member of nursing staff explained they had received additional critical care specific information on a previous training day. This had discussed the more practical steps of a major incident and the evacuation of a critical care unit.
- In preparation for a major incident there was information readily available on which patients were suitable for discharge should a sudden need to create empty bed capacity be required. Contact details for all staff were readily available. In addition, a text message facility was in place which would enable all staff to be contacted quickly if additional staffing resources were required.
- Senior nursing staff explained how they would manage an evacuation of the unit. The operating theatres could be used as an alternative location for the care of critically ill patients in the event of a major incident within the hospital requiring evacuation.
- Staff were able to identify escape routes and evacuation equipment, for example mats and additional oxygen cylinders.
- An evacuation plan was documented in the safety briefing folder and this was seen to be completed on a daily basis and kept up to date.
- The unit had quite recently dealt with an unplanned interruption to their medical air supply to the unit. An investigation into this incident reported staff dealt with this emergency situation appropriately and staff actions kept patients safe.

Are critical care services effective?

Good



The effectiveness of Yeovil District Hospital critical care unit was good.

We found;

- Evidenced based care was provided in line with current practice and patient outcomes were good.
- Unit and department audits had led to changes in practice to improve patient outcomes.
- Mortality rates were better than those for similar units.
- New staff felt well supported by existing staff and had received a period of induction, the length of which was specific to their individual needs.
- There was a multidisciplinary team (MDT) approach to care. .

However we also found;

- The multidisciplinary approach was not formalised as MDT ward rounds took place just twice a week.
- Thirty seven percent of the registered nurses on the unit had the post registration qualification in critical care. This did not meet the of the core standards for intensive care units 2013 requirement of 50% of intensive care nurses holding the post registration qualification.
- There was no clinical nurse educator for the unit as required by the core standards for intensive care units 2013.

Evidence-based care and treatment

- The unit used policies based on national guidelines. This included the National Institute for Health and Care Excellence (NICE) guidelines for the rehabilitation after critical illness in adults (CG83). A documented process for a short clinical assessment was in place to identify commencement of the rehabilitation pathway. We reviewed four care records, which showed this assessment process was being used. Patients were also assessed for the risk of Venous Thromboembolism (VTE), in line with NICE guidance CG92 Venous Thromboembolism – Reducing the risk for patients in hospital, to ensure preventative treatment was commenced where appropriate. The eight patient records we looked at confirmed this preventative protocol was being followed.
- Evidenced based care bundles were in use for several aspects of patient care delivery. Care bundles are a documented set of evidence based practices that have been proven to improve patient outcomes. Care bundles used included the insertion of a central venous catheter and ventilator care bundles. An internal audit programme to check the unit's compliance to care bundles was in place. Audit data showed varying levels

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of audit activity and compliance. Compliance to the ventilator care bundle during the reporting period November 2015 to March 2016 was largely complete and showed 100% compliance. During the same reporting period, compliance to the peripheral line insertion bundle was between 28.5% to 100% and on-going peripheral line care between 75% to 100%. In December 2015 the frequency of audit and the compliance levels had been raised with shift coordinators with steps being taken to improve compliance. In February 2016 all compliance levels that had been less than 100% showed some improvement. From our review of eight sets of patient notes, we found they all included details of intravenous lines being reviewed in line with the relevant care bundles.

- A consultant led internal audit had taken place between April 2015 and July 2015, which looked at renal replacement therapy in intensive care. Recommendations from this audit had been implemented which brought the unit's practice in line with the Kidney Disease Improving Global Outcomes recommendations. The unit had introduced citrate based haemodiafiltration (haemodiafiltration is a process to remove the waste products from the body when the kidneys are not working and involves filtering the blood). The new citrate based treatment has meant the critical care unit was suitable to treat a wider range of patients.
- An internal audit was completed using the NICE guidance (CG103) Delirium, prevention diagnosis and management to assess the unit's current level of compliance to the guidance. The collection of data finished in March 2015. From looking at five patient records we determined delirium scoring was now being carried out on intensive care patients.
- Local policies were available in a folder at each bedside, they were known as 'bedside buddies.' A member of staff told us that these documents were used. We noted some of the protocols had not been recently reviewed and some had no review dates documented on them. For example, 'Initiating feeding in the critically ill, Yeovil District Hospital July 2011 - Clinical Guidelines for Adult Enteral Feed.' The documents we looked at still reflected current practice. We informed the critical care senior management team of our findings during the inspection.
- There was an anaesthetics/intensive care audit calendar in use with a programme of future and current audits

and action plans documented for those which had been completed in the previous 24 months. We followed up the actions of two of these audits and found new treatments had been commenced and new assessment tools were in use.

Pain relief

- There was a consultant led acute pain service at the hospital as set out in the Faculty of Pain Medicine Core Standards for Pain Management Services in the UK. The service included a pain and substance abuse specialist nurse, who was available during the week.
- Staff explained how planned surgical admissions to critical care were referred to the pain team prior to patients having their operation. Staff followed up patients post operatively about their pain management.
- Thirty-seven patients who had been cared for on the unit between April 2015 and December 2015 had been asked if staff had done everything to control their pain, 32 replied yes all of the time and five replied yes some of the time. We asked two patients during our inspection whether they had been offered pain relief, both of them confirmed pain relief had been available and given to them when they needed it.
- We reviewed four sets of patient's records and found staff had completed an assessment of the patient's pain using a numerical pain scoring assessment process.

Nutrition and hydration

- Patient's nutrition and hydration needs were assessed, in the eight sets of patient records we looked at there was a record in all of them of assessments being completed of the patient's fluid requirements. Detailed fluid balance charts were incorporated in the critical care observation chart and we saw records were kept up to date.
- Nutritional assessments were carried out using The British Association for Enteral and Parenteral Nutrition, Malnutrition Universal Scoring Tool (MUST), to establish the patient's nutritional needs and risk of malnutrition. Staff told us a high MUST score would trigger a referral to the dietician if they were not already involved in their care.
- The dietician saw all the intensive care patients and would see the high dependency patients on request. The dietician was reviewing patients on the unit during our inspection.

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- We saw evidence in four patient records where enteral feeding had been established on admission or the reason why this had not been started had been documented.
- Patient specific Total Parenteral Nutrition (TPN) was prescribed based on individual patient needs. TPN is used where a patient is unable to have any food in their stomach and fluid, which contains the nutrients the patient needs, is given into a vein.

Patient outcomes

- The Intensive Care National Audit and Research Centre (ICNARC) provides data of patient outcomes in critical care. The unit participated in the Case Mix Programme (CMP) which was an audit of patient outcomes from adult, general critical care units covering England, Wales and Northern Ireland. The unit's data was compared with the outcomes from other similar patients, other similar units and all the units on the CMP.
- The incidence of patients being re admitted to critical care within 48 hours of their discharge is a measure applied nationally to assess whether patients are discharged from critical care appropriately. Yeovil District Hospital critical care data from the reporting period April 2015 to December 2015 showed of the 409 patients discharged to wards within the hospital, six were readmitted to the unit within the following 48 hours. This readmission rate of 1.5% was slightly higher than the 1.2% than other similar units.
- The number of critical care patients that die before leaving hospital is a measure that is applied nationally to monitor patient outcomes. Yeovil District Hospital critical care data from the reporting period April 2015 to December 2015 showed better than expected outcomes. Of the 382 admissions, predicted as having a less than 20% expectation of dying, 19 patients had died compared to an expected number of 23 patients.
- The unit was currently part of the national Breathe Study. This was a ventilator weaning study evaluating patient outcomes following different weaning methods. Weaning is the gradual reduction of ventilator support. We were told the number of patients who able to be part of the study had been limited by the specific patient criteria the study required. The critical care outreach team were currently participating in 'The Medical Emergency Team: Hospital Outcomes after a Day (METHOD) study' which was evaluating patient outcomes 24 hours after critical care outreach

intervention. This data was being collated in addition to the data the critical care outreach team collated. Activity data collated by the outreach team for the period December 2015 to February 2016 reported that 73 % of the 129 patients discharged from the critical care unit during this period were seen by the outreach team after discharge.

- The unit submitted data to the National Potential Donor Audit, this enabled outcomes to be considered against national data.

Competent staff

- The academy, the hospital's in-house education and training facility, provided educational support to the unit. One member of staff told us they had found it easy to book academy courses, for example on chest drains and epidural care, which had increased their level of understanding and improved their skills.
- Critical care nurses explained they had struggled to get to some recent training hosted by the academy on the wards. These were 'snack box' 15 minute training sessions held on a range of clinical topics. This had also been noted by the trust in their feedback of the snack box training sessions.
- Information was displayed on the unit for study days hosted by the academy including a developmental study day on orthopaedic and trauma management, acute kidney injuries and acute pain management and sepsis. Staff names had been assigned to another planned study day on nutrition.
- Specific training had been available on transfer of the critically ill patient, and medical staff confirmed this had taken place and would be completed prior to transferring a critically ill patient.
- The academy took a lead role in the nurse's new revalidation process and a band six nurse on the unit was a link nurse for the nursing staff.
- There was no dedicated clinical nurse educator for the critical care unit as required by the Core Standards for Intensive Care Units 2013. Recruitment of a critical care unit clinical educator had been identified as a key investment priority for 2016 /17.
- The increased number of junior staff currently having limited competency had been identified as having the potential to put patients at risk. This was being managed through the unit risk register. There was also a programme of internal training and a four week supernumerary period in place.

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- The more senior and experienced nursing staff provided support and information for the less experienced staff. Staff told us teaching on the unit had been limited by staff being moved to other wards in the hospital to cover shortfalls in staffing.
- There were 18 out of the 49 critical care nursing staff with a post registration award in critical care nursing, which was 37%. This did not meet the Core Standards for Intensive Care Units 2013 requirement of a minimum of 50% of the registered nursing staff to have this qualification. Two nurses were scheduled to complete the qualification later this year. Over the last six months there had been recruitment to band five nurse positions on the unit. This increase in numbers of staff had lowered the actual staff holding the post registration qualification as a percentage. Staff told us there were limited places available on the course each year. They told us they would like to have done the course but staff had to compete for the spaces. Another member of staff explained there would be two places available on the next course but five staff had applied.
- We spoke with three nurses who had recently started working on the unit and they all gave a positive account of their experience. One nurse explained the length of time staff were supernumerary had been increased which meant newer nursing staff had more time to develop their skills and competencies.
- Another new member of staff spoke of feeling very well supported, having allocated mentors and of the unit staff being very helpful. They had a one month period of supernumerary working and were currently completing the trust intravenous drug training programme before being able to administer intravenous medications. All the staff who were part of the critical care outreach service had more than three years critical care experience and the lead outreach nurse had a post registration qualification in critical care.
- Staff told us bank and agency nursing staff completed an induction skills checklist before starting work on the unit, to enable their level of experience to be assessed. This was carried out prior to patient allocation. We saw completed agency and bank induction forms between January 2016 and March 2016. Agency staff working on the unit confirmed there was an induction process for agency staff. Senior staff also explained there was a process in place to provide feedback after agency staff had worked on the unit.
- Unit staff told us they felt agency staff were mostly well inducted, and additional relevant training had been identified for some staff.
- No annual competency based assessment of core and additional competencies had taken place as set out in the National Outreach Forum, Operational Standards and Competencies for Critical Care Outreach Services 2012. There was a period of induction and supervision in place for the band six unit nurses currently working in the outreach team. The clinical skills of the outreach team were in line with those recommended in the operational standards and included obtaining blood gas samples and establishing non-invasive ventilation. Since the inspection a core set of clinical skills and competencies based on the National Outreach Forum Competencies has been established as part of the Critical Care Outreach Teams Standard Operational Policy April 2016.
- We asked 22 staff whether they had had an appraisal in the last 12 months and if it had been a useful process for them. Twenty-one staff confirmed this had been the case, one member of staff had their appraisal booked. Staff explained how their appraisal was useful and that they could be an opportunity for nursing staff to discuss their interest in the post registration qualification.
- Medical staff told us they were well supported, received supervision and one to one teaching. Senior staff told us medical induction appraisals and clinical supervision were all completed in a timely manner.

Multidisciplinary working

- From reviewing patient records there was evidence the multi-disciplinary team were involved in the care and treatment of patients.
- There was a daily multi-disciplinary therapy ward round with allied health professionals, nursing and medical staff in attendance. Consultant microbiologist rounds take place twice a week, with access to microbiology advice and support being available 24 hours a day based at Musgrove Park hospital in Taunton.
- The unit had a senior physiotherapist who led the physiotherapy team, which provided physiotherapy on the critical care unit Monday to Friday. The physiotherapy team provided respiratory care and rehabilitation care.
- Occupational therapy services were available although there was no designated occupational therapist assigned for the critical care unit.

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- The National Institute for Health and Care Excellence (NICE CG83) provides best practice guideline on rehabilitation after critical illness in adults. The guidance sets out a rehabilitation pathway including assessment, intervention and follow ups, with the aim of optimising patient recovery from critical illness. The senior physiotherapist facilitated the rehabilitation programme for critical care patients and in conjunction with a consultant provided follow up clinics for patients following discharge.
- The follow up clinic appointment was an opportunity for patients and or their families to re-visit the critical care unit, which in some circumstances can help patients to understand their critical illness and their treatment.
- There was a designated pharmacist for the critical care unit, who was supported by a pharmacy technician. The pharmacist attended the twice weekly multi-disciplinary ward rounds, we observed the pharmacist working on the unit and providing advice to the medical staff regarding patient medicines.
- There was a designated lead dietician for the critical care unit. The dietician reviewed all the intensive care patients on the unit and the high dependency patients would be reviewed following a referral. Staff spoke of the dietician always being available in the week and medical staff spoke of their being regular dietetic input to patient care. A review of patient records confirmed the dietician was involved in patient care and treatment.
- Microbiology services were provided by a service level agreement from a neighbouring provider. A service level agreement is part of a contract which sets out exactly what services will be provided. A microbiologist participated in the multidisciplinary ward rounds twice a week and was available to be contacted at all other times.
- There was access to speech and language therapists through an on line referral system. Staff explained the therapists would review all patients who had a tracheostomy and they were involved in their weaning plans. Speech and language therapy services were provided through a service level agreement with a neighbouring provider.
- The regional specialist nurse for organ donation was in daily contact with the critical care unit to ensure support was available to both staff and relatives if required.
- In one out of the eight sets of the patient records we looked at, we could not find any details of a medical review taking place over a weekend period when the patient was in high dependency care and under the care of their admitting consultant. The patient had been reviewed after the weekend and before our inspection. There was also a record in the minutes of a recent anaesthetic department clinical governance meeting which noted another high dependency patient had not been reviewed for five days by their substantive team, this also included a weekend period.
- Physiotherapists visited the unit every day, at weekends all intensive care patients were reviewed and treated. High dependency patients were assessed for their need for planned weekend physiotherapy using a priority matrix. There was also an on call physiotherapy service available.
- Diagnostic imaging services were available by the out of hours on call service.

Access to information

- We observed the critical care outreach service had direct access to patient information, observations and laboratory results for patients being cared on the hospital wards. Information was accessed immediately during a telephone referral about a patient. This enabled a very meaningful conversation to take place regarding the patient's current condition and treatment at the time of referral.
- The safety briefing sheet used at shift handover was retained so information could be accessed throughout the shift and was available to be updated as required.
- Staff had access to up to date trust policies on the hospital intranet.

Consent and Mental Capacity Act

- We asked 11 staff if they had received training on the Mental Capacity Act and Deprivation of Liberty Safeguards. Ten of the staff said they had received training.
- In four sets of patient records we reviewed, we saw evidence of consent being documented or a record of the decisions had been made where a patient was not able to provide consent.
- We observed verbal consent being obtained on several occasions during our inspection, including prior to nursing care being carried out and before a medical examination was commenced.

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- One member of staff we asked explained how and where to access the information and guidelines on deprivation of liberty safeguards, another explained about how decisions were made in the best interest of the patients.
- We saw evidence of a deprivation of liberty safeguard application which had been made and the documentation was all completed correctly.

Are critical care services caring?

Good



The care provided to patients in critical care was good.

We found;

- Patients were cared for in a compassionate manner.
- Feedback from patients and families was mostly positive.
- Staff were aware of the potential emotional effects of critical illness on patients and their families.
- Patient diaries were well managed and compiled to a high standard.

Compassionate care

- We spoke to three patients and two relatives and we observed staff caring for patients. Nurses were always near to the patients and were attentive to their needs. We saw patients being made comfortable
- Patients told us staff had treated them with kindness and respected their privacy when they were providing care. One patient explained everything that could be done had been done; another explained they were happy with their care.
- We observed patients privacy and dignity being respected. Staff ensured curtains were drawn and doors were closed before providing care. Staff asked or knocked before entering rooms. We observed a nurse repositioning bed clothes to maintain a patient's dignity. We witnessed staff responding immediately when a patient explained they had pain and ensured they were comfortable after they had helped them to change their position.
- We heard patients being spoken to in a kind manner, nurses said please and thank you and introduced themselves and other staff to the patients. A patient also confirmed staff did introduce themselves. ...

- Patients appeared comfortable and the environment was calm. A patient told us they had slept well and they had not been disturbed by noise or lights. As part of a monthly 'your care patient survey taken of patients discharged from the unit between April 2015 and December 2015, 44 patients were asked if noise had bothered them at night. Twenty eight patients said no which was 64%, 12 said to some extent and four said yes definitely. Patients recalled the noise being from a variety of sources which included staff chattering, machine alarms, a loud television and hard soled shoes.
- We were informed nurses considered noise levels when checking equipment, the defibrillator was checked during the day not at night to prevent the noise from it disturbing patients. We observed morning handover from the night staff, the nurse in charge on nights informed the nurses coming on duty that the defibrillator would need checking in the morning and that all other checks had been completed.
- The trust used the NHS Friends and Family Test (FFT) to obtain feedback from patients. This national survey asks patients whether they would recommend the NHS service they had received to their friends and family. Between November 2015 and March 2016, 50 replies had received about the critical care unit and 49 of these (98%) stated they would be very likely or likely to recommend the unit to their friends or family.

Understanding and involvement of patients and those close to them

- In all of the eight patient records we looked at we saw records of conversations which had taken place with families providing information about their relatives care.
- We saw patients were involved in choosing their meals from the food menu.
- The two patients we spoke to both said their families had been kept up to date when they visited and information was explained in detail.
- The relatives we spoke to said they had been kept up to date and involved in decisions had been made about their relatives' care.
- From feedback from 41 patients discharged from the unit between April 2015 and December 2015, 32 patients had been sufficiently involved in the decisions about their care and treatment all of the time, this was 78% of patients. Nine patients had been involved in their care

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to some extent. When asked if their family and carers had been kept informed of their condition; 37 patients replied yes, three patients said to some extent and one patient replied no.

- We witnessed staff welcoming visitors and visitors appeared comfortable sat at the patient's bedside. Visiting times were flexible taking into account the individual circumstances of both patients and the relatives.

Emotional support

- Patients and relatives could access the support of the hospital chaplaincy services at any time. Information about this service had been made available in the relative waiting area.
- Staff understood the impact that critical illness could have on both patients and families. Patient diaries were being used, these were a diary which was compiled by staff and visitors about the patient's journey through their critical illness. The diaries can be used to fill in the 'missing gaps' for the patient and are known to help patient recovery.
- The diaries we saw on the unit were of a high standard. They had been compiled in a way that recognised some patients would not want to see photos but would want to read information and messages. Photos had been taken but had been kept separate from the main diary to give people a choice.
- The staff were sensitive to the individual preferences of patients and families. After discharge, patients or bereaved families were contacted and asked if they would like to arrange to have the diary. A meeting was arranged or at the follow up clinic appointment, the diary would be given to the family. This was done in a supportive environment with the opportunity for explanations to be given about the patient's critical illness and their treatment. A copy of the diary was kept on the unit so staff knew what information had been provided should the patient or family re-contact them in the future.
- We looked at feedback from eight families or patients who had received diaries over the last few months. The feedback was very positive with patients explaining how it had helped them understand their time in critical care.

Are critical care services responsive?

Good



We found the responsiveness of the critical care unit to be good.

We found;

- The unit was able to meet individual patient needs, and the patient was at the centre of the care that was delivered.
- The service was part of the regional critical care network enabling services to be planned to meet local, regional and national requirements.
- Staff were interested in the feedback which had been received from patients and their families and this was used to make improvements.

However we also found ;

- A quarter of patient discharges to the ward were delayed for more than one day.
- There were more out of hour's discharges than on other similar units between April and December 2015.

Service planning and delivery to meet the needs of local people

- The unit provided a 24 hour emergency critical care service for patients who were admitted from other areas within the hospital, including the emergency department, wards, operating theatres or from other hospitals.
- The unit also took planned admissions following surgery.
- The 10 bedded unit was currently funded for four intensive care beds and 6 high dependency beds however there was a degree of flexibility to this ratio. All the bed spaces could be used for either dependency of patient. Taking current staffing levels into account, the critical care unit could potentially care for seven intensive care patients.
- The unit was part of the South West Critical Care Network. Being part of the network enabled the unit to work alongside other units in the region in the development and delivery of critical care services in line with both national and local requirements.

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- The unit provided and had access to the south west regional bed bureau data, which enabled the unit to quickly establish the current regional status of critical care beds.

Meeting people's individual needs

- We saw above the foot of every bed space there was an analogue clock, with the date also displayed and a very clear sign which said, 'You are in intensive care you are in Yeovil Hospital.' We spoke to staff and they explained that they had been put in place following feedback from patients. Patients had told them they did not know what time it was, what day it was or where they were.
- Equipment specifically designed to support bariatric patients was available from the hospital equipment library and included a hover matt, chairs and beds. The unit also loaned equipment direct from manufacturers if the hospital did not have suitable equipment available. The unit's transfer trolley was able to be adapted to transport bariatric patients.
- We saw patient call bells were placed in their reach and one patient confirmed when they used their nurse call bell it was answered. In the 'Your care survey' of 42 discharged patients who were asked about call bells being answered, three patients said they were not responded to quickly enough and five said they were sometimes. The remaining 34 patients, 81%, were happy with the response they received.
- Patients who had been ventilated for 48 hours were placed on the high risk rehabilitation pathway. Patients received on going in patient therapy both on critical care and on the ward following their unit discharge. Three months following discharge from the hospital patients attended a follow up clinic. An assessment of their physical and psychological rehabilitation progress was completed and areas of new or on-going support were identified. Further follow up appointments were offered where required. Staff told us the high risk rehabilitation pathway had begun to also include patients who had required non – invasive ventilation for longer than four days.
- Staff told us communication aids were available to help patients where communication was difficult. Aids included laminated letter boards and loop hearing aid devices available from the audiology department.
- To help communication with patients and their families whose first language was not English, the unit had access details for language line. They also sought the assistance of staff within the hospital and more specifically the unit who were able to communicate in more than one language.
- We spoke to one member of staff who knew the language line facility existed but they had made use of on line text translation facilities.
- Volunteers were available at the reception desk to the unit, we observed them greeting visitors to the unit. They were a friendly and professional first point of contact for families. They spoke of having the time to spend with visitors and being available to offer support or to provide information.
- There was an area for relatives on the unit; it included a waiting area with refreshment and toilet facilities and use of a computer. Two private interview rooms provided privacy for families and overnight accommodation was available to rent on site.
- We witnessed an individual meal order being placed with the hospital kitchen which included the patient's personal preferences.
- We saw a patient was sat out of bed eating their lunch and this had been well presented on a clean bed table and was in easy reach of the patient. The patient explained they were enjoying the food and the nurse had been helpful in providing them with the food liked.
- There was a choice of snack foods available on the unit for patients who wanted something to eat in between their main meals. Main meals were provided by the hospital kitchen with final preparation being carried out on the unit.
- A patient bathroom was available which was a very generous size and had a patient shower and bath. The bathroom had piped oxygen and suction, which enabled patients who still needed respiratory support to use the facilities.
- We saw patients being given a period of rest in an afternoon, when lights were dimmed and voices lowered and disturbances were kept to a minimum. A screen was placed across the unit doors informing visitors to the unit it was a period of rest and quiet time for the patients.
- As part of the rehabilitation pathway, patients would be offered a follow up clinic appointment. Part of the patient assessment included identifying any signs of post-traumatic stress so they could be offered

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appropriate support. A clinical psychologist had been involved when the follow up clinics were established and had offered staff training so staff were able to carry out these patient assessments.

- There was relevant information available for visitors, including details of the chaplain services, parking information, leaflets providing details of relatives' support groups and information about specific care and treatments and on what families may see or expect.
- Staff were able to give us examples where patient care had been tailored to patients' individual needs. This included a patient who was being weaned off the ventilator going outside to see their dog, whilst receiving support with their breathing from a portable ventilator.
- Staff explained in the last few months a patient had been taken outside into the sensory garden.
- A member of staff was able to recall contacting the learning disabilities specialist nurse for the trust for advice and also contacting the patient's care home this was to obtain specific information to be obtained to ensure the care met the individual needs of the patient were met.
- The unit discreetly noted which patients were living with dementia on their patient information screen by using the words 'forget me not.'

Access and flow

- The Intensive Care National Audit and Research Centre (ICNARC) data for the reporting period April 2015 to December 2015 showed there were 579 admissions to the critical care unit. Of these admissions, 231 of the patients were admitted via the emergency department, 162 were admissions were following surgery, 181 were from another ward area and five were from other critical care units where patients were being transferred nearer to their own home area.
- There was one (0.2% of the 579 admissions) non-clinical transfer out of the unit; this was the same percentage as other similar units.
- In the reporting period April 2015 to December 2015 there were a higher number of out of hours discharges compared to other similar units. Out of hours discharges are recorded as those that take place to hospital wards between 10pm and 7am and where the discharge had not been delayed. Discharges overnight have been associated with increased mortality. For the reporting

period April 2015 to December 2015 the unit discharged 17 patients between the hours of 10pm and 7pm. This was 4.2% of the 409 discharges made to the wards.

Other similar units had 2.9% of out of hours discharges.

- The Core Standards for Intensive Care 2013 state discharges to a ward should take place within four hours of the decision to discharge being made. During our inspection a patient who had been declared well enough to be discharged two days previously was still waiting for a ward bed. Once patients were medically fit for discharge from high dependency care they came under the sole medical care of their admitting medical team. Nursing care was still provided by critical care. This patient was transferred to the ward very late the next evening to make a bed available for a patient to be admitted following an operation.
- In the reporting period April 2015 to December 2015, 11.6% of all the bed days of care available on the unit for that period were used to provide care to patients whose discharge had been delayed for more than eight hours. (Bed days of care are the total number of days in the period multiplied by the number of beds on the unit to give total bed days of care). This was worse than other similar units which provided 9.8% of their bed days of care to delayed discharges.
- Mixed sex breaches, where patients of different sexes are using the same facilities, could be avoided within the unit due to the high number of side rooms available.
- Staff spoke of discharges being delayed when the ward medical teams did not make a decision about a patient being fit for discharge.
- Between June 2015 and January 2016 there were five elective operations cancelled due to no intensive care or high dependency beds being available.
- The Core Standards for Intensive Care Units 2013, Operational Standards set out the decision to admit to critical care must be documented in the patient record and the admission should occur within four hours of the decision being made. Out of the six cases where this was applicable the time was recorded in four cases and this evidenced the admission had taken place within four hours of the decision.

Learning from complaints and concerns

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- There was information displayed in prominent places on the unit informing relatives whom they could speak to if they had a concern. Posters included photos of senior staff, their contact details and times they were available.
- Feedback was used to make improvements, for example analogue clocks and information signs were put at each bed space in response to patient feedback.
- Information leaflets were on the reception desk at the entrance to the unit that explained about the hospital's Patient Advice and Liaison Service (PALS), how they could be contacted and what their role was regarding concerns or complaints.
- Unit complaint and PALS data from the previous 12 months was displayed on a unit notice board. No complaints had been received during this period. The most common enquiries related to lost or damaged property and communication with relatives or carers. Improving communication was one of the areas where work was being completed by the unit as part of the South West Quality Improvement Consortium. Information for relatives was displayed explaining that they may see things being done differently as part of this improvement process.
- The unit actively sought feedback from patients and their families. Patients were asked to complete an 'I want great care questionnaire' when they were discharged and there was a suggestions and comments box in the relatives' waiting area. Previous relative comments were also displayed. Feedback was also obtained from patients and families who had been given patient diaries.
- Staff were interested in the feedback from patients given during their follow up clinic visit after discharge.
- Staff were informed of the feedback they received. We saw an update had been given to staff in a previous shift handover about the unit being highly recommended following the feedback they had received in the 'I want great care questionnaire.' The completion rate for patient feedback was also discussed at senior staff meetings.

- There was a clear focus to deliver high quality patient care and obtain the best possible outcomes for patients
- There was a clear management structure in place and staff felt supported in their roles.
- There was a visible presence of senior unit staff.
- The unit proactively sought feedback to help improve services.
- The unit aspired to meet the Core Standards for Intensive Care Units. This was outlined in the units business plan.

However we found;

- There were no critical care specific clinical governance meetings or mortality and morbidity meetings being held.
- Staff meetings were not being held for all staff on the unit.

Vision and strategy for this service

- Critical care staff at all levels of seniority were aware of the trust's values. We spoke to 20 staff, all staff knew about 'iCare values' and over half had a very clear understanding. Some recalled training they had received when 'iCare values' were first introduced. We observed care being delivered in line with the values and staff demonstrated the values in their work. 'iCare' stands for communicate, attitude, respect and environment.
- In line with the trust values the local strategy placed 'a contented and satisfied patient and family' at the centre of the service.
- The key investment priorities outlined in the local strategy for critical care both focused on increasing the workforce. These were to establish a clinical educator position for the unit and, after recognising the benefits a support role had on patient care, there was the intention to increase the number of hours this was available.
- Within the local strategy, a closed intensive care unit patient pathway had been identified as an influence on business planning for 2016 to 2017.
- The future direction of the unit was part of a policy document from October 2015 on the admission and review of high dependency patients on the unit. This policy identified the successful recruitment of intensive care consultants and junior medical staff as key to the unit achieving full compliance with the core standards for intensive care units, including being a closed unit

Are critical care services well-led?

Good



The leadership of critical care services was good,

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run by intensivists. The senior management team confirmed the recruitment of both medical and nursing staff was a key and current priority which remained very challenging.

- Senior unit leaders confirmed they had faced challenges with the operating model of the unit. A pilot study had been on going where care between the admitting team and the anaesthetists was shared, however the unit leaders were working towards a closed model unit, where the patient care would be led by an intensivist. Recruitment to medical positions was on-going but more intensivists and junior doctors were required before a closed unit model could be adopted.

Governance, risk management and quality measurement

- There was a critical care unit risk register, which was managed by the business manager, unit clinical director and unit matron. The risks reflected what senior managers had told us were their main concerns and included the management of a risk identified from a previous serious incident. The senior nursing staff on the unit were not aware of the risk register.
- A critical care work plan was in place, which was managed at unit level and this facilitated the on-going management of actions covering a range of work.
- Current work included making changes to the patient handover process for patients admitted from the emergency department. Completed work from 2015 included staff education to improve hand hygiene audit results, with reported improvement in results and a record of the actions taken. The work plan duplicated some of the risks on the unit risk register for example staffing levels. The two documents were managed separately and the work plan appeared to be managing identified risks that were not included on the risk register.
- The unit submitted data to the Intensive Care National Audit and Research Centre (ICNARC) and the quarterly reports were scheduled as quarterly agenda items for discussion by the critical care delivery group. In the months prior to our inspection there was no record of this having taken place, including in October 2015 when it was a scheduled agenda item. There was a designated data coordinator working on the unit who managed the collection and submission of data.
- There were no specific clinical governance meetings for critical care. The senior team told us that the focus of

the anaesthetic clinical governance meetings were mainly theatres and anaesthetics. Meeting minutes from the previous three meetings showed a varied agenda with very little discussion of intensive care related matters.

- There were no formal critical care mortality and morbidity meetings being held. Core Standards for Intensive Care Units 2013 (4.1) states that units must hold multi professional clinical governance meetings, including analysis of mortality and morbidity. There was no record of this being discussed in the anaesthetic clinical governance meetings.
- Critical care delivery group meetings were held monthly. The senior team told us that these meetings functioned poorly. The intention was to achieve wider representation at the group than was currently achieved.

Leadership of service

- The senior leadership team for critical care consisted of a clinical business unit manager, a clinical director and a matron. All the senior staff on the critical care unit were qualified and very experienced in critical care nursing. The clinical business unit manager also managed theatres, anaesthetics and the sterile services. The unit matron usually had responsibility for outpatients and phlebotomy. At the time of the inspection the matron was part of the team responsible for the hospital's transition to a fully integrated electronic health record system so did not have responsibility for these other two areas.
- The unit had a senior sister who managed the unit on a day to day basis, with one day a week specifically allocated to office management duties for example duty rotas. During the inspection, due to staff illness, the senior sister carried out the role of shift co-ordinator offering immediate leadership support to the team enabling safe levels of staffing to be maintained.
- Staff we spoke to on the unit and the wider multidisciplinary team knew who the lead members of staff were for the unit.
- The shift coordinator was easy to identify because they wore a different uniform to the rest of the team.
- The matron and senior nurse did not take planned leave at the same time. The senior sister had recognised the more senior staff on the unit could be offered

Critical care

opportunities to develop wider leadership skills. This had been discussed at a recent staff meeting and shift coordinators had started to be involved in following up reported incidents.

Culture within the service

- The senior staff were described as being really caring. Staff spoke of how proud they felt of working at the trust.
- We spoke to the senior team, they were proud of the standard of care being delivered to patients. They spoke of the positive feedback they received from patients and relatives and of how the staff were enthusiastic about their work. Senior staff felt the executive team were approachable.
- Staff told us both medical and nursing staff recognised and had mutual respect for each other's expertise, including the critical care outreach team who had established credibility within the trust.
- From speaking to staff and from our observations on the unit we saw senior staff encouraged an open and honest culture within the service. Changes had been made in response to incidents and safety and managing risk were built into the shift coordinator's role.
- Staff across all professional disciplines reported feeling part of one team, one member of staff described morale as excellent and we witnessed good teamwork on the unit with staff making themselves available to help each other.
- Staff helped one another and everyone worked together as a team. We observed that the unit seemed a friendly place.
- Senior staff were aware nursing staff were unhappy about being moved to work outside the critical care unit to assist with staffing capacity and demands from other hospital areas. Senior staff explained it was sometimes difficult to get the staff back from the wards if they were needed on the unit if the dependency or numbers of patients changed during the shift.
- Several staff who had been asked to work elsewhere in the hospital told us they felt they were asked to move towards they were unfamiliar with, this appeared to be affecting staff morale.

Public engagement

- There was welcome to ICU (Intensive Care Unit) information at the entrance to the unit and at bed spaces. This included pictures and names of the

matron, senior sister, outreach sister and information explaining to visitors how they could speak to the nurse looking after their relative, or ask to speak to a more senior member of staff.

- Information to obtain feedback from friends and family was clearly displayed in the relatives' area, this included PALS information and information about how to make a complaint.
- A comments and suggestion box was provided on the unit for visitors to give feedback to the staff. Some of the feedback had been received was displayed in the relatives' waiting area.

Staff engagement

- Senior staff had tried different approaches to hold unit staff meetings however we were told there had been low attendance at staff meetings due to staff availability. Senior nurse meetings had been held away from the unit and minutes from three previous meetings showed these were well attended. There were currently no meetings organised for the other nursing staff on the unit.
- Staff mentioned the information on notice boards and handovers were two of the ways the leaders on the unit kept them up to date. Notice boards were located in both the staff and general areas of the unit, all contained current and relevant feedback for staff.
- One nurse explained when there had been good feedback from a relative, the matron would speak to the member of staff in person.

Innovation, improvement and sustainability

- The unit was part of the South West Quality Improvement Project and were currently working on ways to improve communication, to reduce infections, multidisciplinary working and rehabilitation after critical illness.
- As part of the rehabilitation pathway, specialist equipment had been purchased including a stretcher chair which enabled a patient's position to be changed from lying to sitting with minimal exertion. League of friends funding had seen secured for a motorised bike, which could be used by patients in bed as part of their rehabilitation programme.
- Citrate – based haemodiafiltration had recently been introduced. (Haemodiafiltration is a process to remove the waste products from the body when the kidneys are







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not working and involves filtering the blood.) The new citrate based treatment has meant the critical care unit was suitable to provide care for a wider range of patients.

- The critical care outreach team have led on producing a 'sepsis proforma' which has now been implemented across the trust. The proforma is an assessment tool to

aid the early recognition and early treatment of sepsis. Following on from this as part of the education tool, the concept of 'sepsis stars' has been introduced, where staff who have successfully recognised sepsis and all the key first line treatment had been given in the correct timescale, received a sepsis star badge. The unit staff also produced a sepsis video as a staff education tool.

Maternity and gynaecology

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

Information about the service

Yeovil District Hospital NHS Foundation Trust provides an integrated maternity and gynaecology services to the population of South Somerset, North and West Dorset and parts of Mendip. The trust reports 1565 babies were born under the care of maternity services between April 2014 and March 2015.

The trust's maternity and gynaecology services are located across four floors in the women's hospital in the grounds of the main hospital site.

Antenatal clinics, gynaecology clinics and a scan department are located on the ground floor which was refurbished in 2014 with funding from the Flying Colours Appeal. There are two lifts from this floor from which the rest of maternity and gynaecology services can be accessed.

On the first floor there is a gynaecology ward (Jasmine ward) and a gynaecology operating theatre which provides care for women undergoing elective gynaecology surgery, breast surgery and women experiencing acute gynaecological problems. There is an early pregnancy assessment clinic (EPAC) which provides early scans and consultations for women experiencing problems in pregnancy from six to 18 weeks based on this ward. The gynaecology outpatients also runs a dedicated unplanned pregnancy service. There is also a room in which outpatient colposcopies and hysteroscopies are performed. In addition, there is also four day-case beds located on the gynaecology ward.

On the second floor is the maternity ward (Freya ward) which provides inpatient antenatal and postnatal care for women and their babies. There is also a level one, eight bedded special care baby unit (SCBU) on this floor which provides care for babies from 32 weeks old who need extra support.

On the third floor there is a labour ward and maternity theatre. The Labour Ward has eight individual rooms, six of which have an en-suite bathroom and one which has a birthing pool and a birthing couch.

Women have been assessed as low risk are given a choice of a home birth or a midwifery led birth within the hospital. There are six community midwifery teams two of which are attached to GP surgeries and four attached to the hospital. There is a team specialising in the care of vulnerable women with substance misuse domestic violence and teenage pregnancy.

We used a variety of methods to help us gather evidence in order to assess and judge the provision of maternity and gynaecology services at Yeovil District Hospital NHS Foundation Trust. During our inspection we visited all of the wards and departments relevant to both services. We spoke with 14 patients or those who were close to them and 55 members of staff, including registered midwives and nurses, midwife support workers, health care assistants, junior and senior doctors, housekeepers, bank and agency staff, pharmacy staff and administrative and clerical staff. We observed interactions between women, their relatives and staff, considered the environment and looked at nine sets of medical and nursing records. Before our inspection we reviewed performance information from and about the hospital and the service.

Maternity and gynaecology

The inspection team consisted of two inspectors, one with a midwifery background, a supervisor of midwives and a consultant obstetrician.

Summary of findings

Overall, maternity and gynaecology services at Yeovil District Hospital were rated as requires improvement.

The safety of maternity and gynaecology was rated as requires improvement. Infection prevention and control was not always given sufficient priority within the maternity operating theatre. Where daily schedules were required for cleaning, these were not available for staff to sign indicate cleaning had been done and where the environment did not comply with national standards we did not see a long term plan to address this. We saw that the maternity theatre was in a state of disrepair and that medicines were not stored securely. The theatre refurbishment was on the trusts risk register but funding was not currently available. We were so concerned that we immediately informed the trust senior management team. The trust closed the theatre to make repairs and undertake a deep clean. We saw on our unannounced inspection that these had been undertaken.

Where daily checks were required for the checking of emergency and resuscitation equipment, staff had not always signed to indicate this had been done in either gynaecology or in maternity.

There was a heavy reliance on agency and bank staff on the gynaecology ward and there were times when the skill mix did not meet the care requirements of women undergoing gynaecological procedures. Staffing was planned to provide a ratio of one qualified nurse for every eight patients; however, one nurse we spoke with had been responsible for overseeing the care of fifteen patients at the time of our inspection. However, staffing levels and skill mix on the maternity and labour ward were planned, implemented and reviewed to keep patient's safe at all times. Staffing shortages were acted upon appropriately. There was adequate consultant obstetric cover in the delivery suite at 40 hours a week which was in line with Royal College of Obstetricians and Gynaecologists RCOG guidelines (2007).

We rated the effectiveness of maternity and gynaecology services as good. The maternity service had achieved full UNICEF Baby Friendly accreditation and breastfeeding rates for initiation were good. Women

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said that they were able to access pain relief in labour and after they had had their babies, and this was provided to them in a timely manner. Midwives were qualified and had the skills they needed to carry out their roles effectively and in line with best practice. They were supported to deliver effective care and treatment through clinical supervision, the appraisal process and peer to peer support.

There was an enhanced recovery programme for women undergoing gynaecology surgery. However we also found that patients on the gynaecology ward did not always have a comprehensive assessment of their needs, which included nutrition and hydration and physical and emotional aspects of their care.

The care given to women using maternity and gynaecology services was good. Feedback about midwifery services was positive, staff were well motivated, dedicated to their roles and women told us they felt safe and well cared for. Women were treated with dignity, respect and kindness during all interactions.

The responsiveness of maternity and gynaecology services required improvement. The gynaecology ward was being used as an escalation ward and the gynaecology day-case unit was being used for patients to stay overnight because of bed capacity issues throughout the trust, which meant elective gynaecology surgery was being cancelled. The operating table in the gynaecology theatre was not suitable for women who had a high body mass index (BMI). Women with a weight above 140kg had to have their surgery performed in the main operating theatre in the main hospital. This led to difficulties in arranging surgery for these women at a time that was convenient for the gynaecologists. Because of bed capacity issues, women who were undergoing a termination of pregnancy, either because of an unwanted pregnancy or because of fetal abnormalities at times were nursed in bays with elderly women, some of whom were living with dementia.

Colposcopies took place in a room off the gynaecology ward. There was one consulting room with a couch where the women were consulted and colposcopies were performed. There was no recovery area and women who had undergone the procedure were required to recover in the day room with women who

were waiting to be seen. The colposcopy room was small and there was no separate changing area for women to get changed, so women had to get changed in the colposcopy room. There were plans to upgrade this service. Plans were in place and had been approved. However, we also found that women were given a choice of birth in line with national guidance and services were mostly arranged to meet the needs of women and there were a range of specialist midwives and clinics to support them.

The leadership of maternity and gynaecology services required improvement. There was no established strategy or vision for maternity and gynaecology services, although there was evidence of staff being involved in the future development of a vision and strategy. There was a maternity and gynaecology risk register and senior staff at governance meetings had discussed the risks but there was little evidence that the risk register had been recently updated or that there were any action plans for the risks identified. The risks relating to the maternity operating theatre had been on the risk register since 2014 and no action had been taken to mitigate the risks.

At ward level we observed examples of good leadership principles; however, business unit managers had not addressed the issues which were known to them such as the poor maintenance, long standing repair issues and infection control issues in the maternity theatre and did not have plans in place to ensure that women were cared for safely and in a responsive manner. However, we also found there was a positive culture throughout the service. Staff reported positive working relationships and there was good public and staff engagement.

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Are maternity and gynaecology services safe?

Requires improvement



The safety of maternity and gynaecology services at Yeovil District Hospital required improvement.

We found:

- Infection prevention and control and maintenance of the maternity operating theatre was inadequate. We found significant infection risks to the safety of women who were operated on in this theatre. We also found that the theatre area was poorly maintained and there were long standing repair issues which had not been addressed due to lack of funding. Medication within the maternity operating theatre was left unattended and used ampoules were not disposed of correctly. We were so concerned that we raised this issue with senior midwives and the senior team immediately. The trust closed the theatre to undertake repairs and a deep clean. During our unannounced inspection we found that the theatre was in a good state of cleanliness and repair.
- Where daily schedules were required for cleaning, these were not available for staff to sign indicate cleaning had been done.
- Where daily checks were required for the checking of emergency and resuscitation equipment, staff had not always signed to indicate this had been done in either the gynaecology ward or in maternity.
- Midwifery staff caring for the high dependency women had not received additional training in the care of the critically ill women in line with guidance from the Royal College of Anaesthetists 2011.
- There was a heavy reliance on agency and bank staff on the gynaecology ward and there were times when the skill mix did not meet the care requirements of women undergoing gynaecological procedures.

However we also found:

- Openness and transparency about safety was encouraged.

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses and we saw good opportunities for learning from adverse events.
- Performance showed a good track record and steady improvements in safety with low levels of patient harm identified.
- Staffing levels and skill mix on the maternity and labour ward were planned, implemented and reviewed to keep patient's safe at all times. Staffing shortages were acted upon appropriately.
- There was adequate consultant obstetric cover in the delivery suite at 40 hours a week which was in line with Royal College of Obstetricians and Gynaecologists RCOG guidelines (2007).

Incidents

- The trust had an incident reporting and management policy which set out the responsibilities of staff at all levels throughout the incident management process.
- Incidents were reported through the trust's electronic reporting system. All the staff we spoke with were familiar with the process for reporting incidents, near misses and accidents using the trust's electronic reporting system.
- All staff employed by the trust confirmed they could access the incident reporting system. Agency staff on Jasmine ward told us they would report any concerns to the nurse in charge, who would then make the decision to report the incident.
- All of the staff we spoke with told us they were encouraged to report incidents and that they received feedback about incidents they had reported.
- There had been 591 Incidents reported for maternity and gynaecology for the reporting period January to December 2015. Low or no harm incidents accounted for 79% of all reported incidents. There were 92 moderate harm incidents and 26 incidents had been reported as a near-miss incident. [A near miss incident is an unplanned event that did not result in injury, illness, or damage, but had the potential to do so]. Three incidents were classified as 'severe harm'.
- Following these serious incidents we saw where root cause analysis investigations had taken place. [Root cause analysis is an approach for identifying the underlying causes of why an incident occurred]. We

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requested the serious investigation reports for these incidents and saw there had been full investigations. Learning from the incidents had been recorded along with agreed actions.

- The most frequently reported incident categories related to inadequate staffing levels for workload, readmission of a baby and failure of staff to follow trust policy. Labour ward was the highest reporter of incidents with 64%, whilst 18% related to Freya ward and 4% related to Jasmine ward.
- The matron for risk and public health was responsible for following up incidents that had been reported throughout maternity and gynaecology services. At the time of our inspection there were 15 open incidents, two of which required investigation.
- The service held monthly multidisciplinary perinatal mortality and morbidity meetings where babies that had experienced difficult births, became ill after birth, or had a poor outcome were discussed. We looked at the record and action logs for three meetings. Cases were noted and although there was a column for actions, no agreed actions had been allocated at any of the meetings. In addition, there was no evidence to outline any learning or required changes to practice.
- All of the senior staff and most of the junior staff we spoke with had a good understanding about the duty of candour regulation and their responsibilities relating to duty of candour. [The duty of candour is a regulatory duty that requires providers of health and social care services to disclose details to patients (or other relevant persons) of 'notifiable safety incidents' as defined in the regulation. This includes giving them details of the enquiries made, as well as offering an apology].
- Duty of candour was clearly explained in the trust's incident reporting and management policy and we saw the actions the trust had taken to address duty of candour when reviewing the root cause analysis investigations.

Safety thermometer

- Maternity and gynaecology services at Yeovil District Hospital took part in the national safety thermometer scheme. Data for this was collected from Jasmine ward for gynaecology and maternity safety thermometer data was collected for Freya ward, which provided antenatal and postnatal care. Data for this was collected on an

identified day each month to indicate performance in key safety issues. This included four key areas, pressure ulcers, falls, urinary catheter related infections and blood clots.

- From March 2015 to Feb 2016 Freya ward reported no pressure ulcers, urinary catheter related infections, falls or blood clots. For the same reporting period, Jasmine ward reported nine pressure ulcers and two catheter related infections. We were however unable to establish whether these related to gynaecological women or other outlying medical or surgical patients.
- Safety thermometer information was not displayed in any of the areas we inspected.
- The labour ward did not take part in the national maternity safety thermometer scheme. The maternity safety thermometer was launched by the Royal College of Obstetricians and Gynaecologists (RCOG) in October 2014. The maternity safety thermometer measures harm from Perineal (area between the vagina and anus) and/or abdominal trauma, post-partum haemorrhage, infection, separation from baby and psychological Safety. In addition, the maternity safety thermometer collects data about those babies with an Apgar score of less than seven at five minutes (the Apgar score is an assessment of overall new born well-being) and/or those who have been admitted to a neonatal unit.

Cleanliness, infection control and hygiene

- The Department of Health's Code of Practice on the Prevention and Control of Infections was not always adhered to within maternity and gynaecology services.
- We found the cleanliness, infection control and maintenance issues within the maternity operating theatre to be inadequate. We found high and low level dust along the walls and windows and dust on the top of a resuscitaire in the maternity operating theatre. [A resuscitaire is a specialist piece of equipment that is used for babies who may need some help with their breathing at birth]. There was visible dust and debris around the corners of the floor in the maternity operating theatre and the flooring had grout missing from the floor tiles around the operating table making it more difficult to keep the floor clean. We observed bare wood around the door frame to the maternity operating theatre. This was due to the wood being knocked by trolleys and equipment causing the paint to chip away

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from the door frame. This meant the door frames could not easily be wiped and created an environment in which microorganisms such as bacteria could collect and multiply.

- We were also concerned about the level of cleanliness in a store room which was used to store sterile equipment. We found boxes of sterile equipment were being stored on the floor of the store room with some equipment being stored below a sign which stated “Do not store equipment here as the window leaks when it rains”. The room had not been cleaned for some time as there were dusty cobwebs which spanned the high level windows from one side of the room to the other. There was also an extractor fan in the store room that was extremely dusty.
- We observed the management of sharp instruments such as needles and glass ampoules mostly complied with Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. However, we found sharp instruments had not always been correctly disposed of in the maternity operating theatre. We found the tops from two glass ampoules on the floor of the theatre and we found a tray containing two open and used glass ampoules in the anaesthetic preparation room of the theatre. This meant staff were at increased risk of sustaining an avoidable sharps injury because the sharps had not been appropriately disposed of.
- We immediately raised our concerns with the head of midwifery who told us the responsibility for cleaning and the prevention and control of infection within the maternity operating theatre lay with the main operating theatre staff. There was no effective monitoring of these standards.
- We spoke with a senior member of staff in the gynaecology theatres however; they were unable to tell us who was responsible for cleaning and infection control in the maternity theatre. We raised our serious concerns with the trusts senior management staff. The trust took the decision to close the maternity theatre and undertake maternity surgery in the gynaecology theatre.
- At our unannounced inspection, we found the trust had taken immediate steps to rectify the problems we had identified within the maternity theatre. The maternity theatre had been deep cleaned and in line with the main operating theatres, there was a plan to undertake a deep clean following each theatre list. The maternity theatre was also being cleaned in between cases. Staff from the main theatres had taken responsibility for the cleaning of the maternity theatre. We saw there was a daily checklist, which was being used to monitor the standard of cleanliness in the maternity theatre.
- Where it was suspected a patient had an infection, they were cared for in side rooms with signage to alert staff and visitors of the risk of infection. However, on Jasmine ward, where there was a high number of medical and surgical outliers as well as patients requiring gynaecological procedures, staff were not consistent in isolating patients at risk of spreading infections. [Outliers are patients under the care of medical or surgical consultants but placed on other wards due to a shortage of bed space on the appropriate medical or surgical ward). We saw three doors open when it was identified the patient might present an infection control risk to others. We asked a member of staff whether the doors should be open and they told us they should be closed and closed them immediately.
- The trust reported no cases of Methicillin Resistant Staphylococcus Aureus (MRSA) or Clostridium Difficile (C. Diff) infections for maternity and gynaecology services for the reporting period up to and including the time of our inspection.
- Staff told us that they had completed infection control training, and were able to tell us about precautions taken to prevent and control the spread of infection in the hospital. Infection control training was mandatory throughout the trust and compliance with training was above the trust target of 90% for all staff groups throughout maternity and gynaecology services.
- Staff were compliant with some of the trust’s infection control policies and protocols such as hand hygiene and bare below elbows policies.
- Staff mostly demonstrated a good understanding of infection prevention and control. There were supplies of personal protective equipment such as gloves and aprons available in clinical areas and we observed staff using them appropriately. Staff wore visibly clean uniforms.
- All ward and clinical areas had antibacterial hand gel dispensers at their entrances and by each patient bed space. Appropriate signage regarding hand washing for staff and visitors was on display.
- Compliance with hand hygiene was audited. We looked at the audit for gynaecology theatres. The audit looked at the five moments for hand hygiene. [The five moments for hand hygiene focuses on five moments

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when hand hygiene should take place, these are, before patient contact, before undertaking a clean or aseptic procedure, following an exposure risk, after patient contact and after contact with a patient's surroundings.] An audit took place in September 2015, followed by a further audit in December 2015. The audits showed that in September 2015 staff were not always compliant with hand hygiene requirements. For moment two, only 33% of staff were compliant prior to undertaking a clean or an aseptic procedure. For moment five, following contact with a patient's surroundings, 100% of the staff audited were non-compliant. We looked at the results of the December 2015 audit and we saw that staff were 100% compliant for moments one to four, however moment five had not been audited. We were therefore not fully assured that staff members in gynaecology theatres were fully compliant with the five moments hand hygiene audit undertaken in December 2015. We looked at the same audit for Freya ward for September 2015 and December 2015 and we found 100% of the staff audited were compliant with the five moments for hand hygiene audit.

- The trust submitted no data relating to hand hygiene audits for the maternity ward or maternity operating theatre.
- Housekeeping staff told us there were no control of substances hazardous to health (COSHH) sheets for housekeeping staff to follow on labour ward. However the trust informed us that these were available on the trusts intranet. This meant that staff did not access to information about the chemicals they were using and may not take the necessary precautions to avoid causing harm to themselves or to other people.

Environment and equipment

- In order to maintain the security of women and babies, doors to ward areas were locked and visitors were required to use a buzzer system to gain entry. Staff had swipe cards which enabled them to enter areas they were authorised to enter. The trust also used closed circuit television (CCTV) to further enhance security throughout maternity and gynaecology services.
- We reviewed a sample of equipment on Freya ward, the labour ward, Jasmine ward gynaecology theatres and maternity theatres and found that equipment had been serviced and safety tested.
- We checked adult resuscitation trolleys in all of the areas we inspected. We examined the adult

resuscitation trolley on Jasmine ward to ensure daily checks were taking place and the equipment was safe to use and fit for purpose. We found the resuscitation trolley had not been checked on three out of 16 days in March 2016. We checked the adult resuscitation trolley on labour ward and found that out of 16 days it had not been checked on five occasions. We then checked the resuscitation trolley in the recovery area of the gynaecology operating theatre. We saw there was a checklist but this had only been signed on one day out of 16 days in March 2016. We spoke with a sister about this who told us checks did take place and that they had seen an anaesthetic assistant undertaking the checks that morning. Although we acknowledged staff may forget to sign the sheet, we could not be assured that checks were taking place on a daily basis as was necessary. We checked a resuscitaire which was located outside room 6 on labour ward again we found this had not been consistently checked as it should have been. There were five days out of 16 when this resuscitaire had not been checked. In addition, we also found where equipment such as oxygen masks had been taken out of their sterile packaging and placed on resuscitaires on the maternity ward. This meant that staff had no way of checking the expiry date on that piece of equipment and increased the risk of equipment being used after their expiry date. We checked the adult resuscitation trolley on Freya ward and found that out of 16 days it had not been checked on four occasions. This meant the equipment on the resuscitation trolleys were not always checked appropriately and therefore staff could not be assured it was fit for purpose. We asked to review the previous month's check sheet, but were told the previous sheets were not available at ward level.

- The shortfalls in monitoring the resuscitation equipment meant that staff were in breach of the trust resuscitation policy which identified that 'checks on resuscitation equipment are to be carried out and recorded daily by ward/department staff with records maintained on the resuscitation trolley'. We escalated our concerns to the head of midwifery. Following our inspection we asked the trust to submit the previous six months check sheets for resuscitation equipment throughout maternity and gynaecology services. The trust provided this information for three months for maternity services and six months for the gynaecology ward. The documents submitted highlighted numerous occasions when staff had not signed to say they had

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checked the resuscitation equipment. In addition, we saw where equipment had been highlighted as needing to be replaced but this had not always been replaced in a timely manner. For example, in January 2016 a neonatal resuscitation trolley had not been checked on 14 occasions out of 31 days. In addition, the documentation for checking resuscitation equipment was not standardised throughout the service

- We checked the grab and go boxes on labour ward and mostly found them to contain the equipment required. However we found out of date medicine and a small amount of out of date equipment in a postpartum haemorrhage grab and go box. We escalated this immediately to the labour ward coordinator.
- We checked a blood glucose monitoring kit and found the last quality control check had been undertaken in October 2013. We were therefore not assured that this piece of equipment gave accurate results. We escalated this to the labour ward coordinator who removed the piece of equipment immediately and told us it had been taken out of use.
- On labour ward we found some blood bottles which had passed their expiry date. We also escalated this to the labour ward coordinator.
- We looked at Cardiotocography equipment (CTG) on the labour ward. CTG equipment can be used to monitor a baby's heart rate and a mother's contractions while the baby is in the uterus. The CTG equipment we looked at had been checked and labelled when the date of the next maintenance check was due. However we found one CTG machine outside the birthing pool room on labour ward where the leads to the machine were very dirty. We escalated this to the labour ward coordinator.
- We saw that pinard stethoscopes were readily available to midwives and midwives told us they used them. [A pinard stethoscope is a cone shaped tool that midwives use to manually listen to the heartbeat of a baby during pregnancy]. There was a pinard stethoscope on each of the CTG machines we looked at.
- Midwives working in the community were issued with lone working devices. All of the midwives we spoke with told us they did not use them. Midwives told us they were not issued with work telephones and they would have to use their own mobile telephone in an emergency. Midwives told us if they were visiting a

woman for the first time they would always attend the visit in pairs, they would never go alone. Matrons told us that each community midwife team had been issued with one mobile telephone.

Medicines

- Medicines were not always stored appropriately. We looked in all of the clinical rooms where medicines were stored. For example within the maternity operating theatre area we found medicines were not kept securely. We found two medicine cupboards and the medicine refrigerator was unlocked and medicines for intravenous use were left out on the side.
- Within maternity theatres we found medicines that had been pre-prepared and placed in the medicines fridge. Staff told us this also happened in the gynaecology theatres. Staff told us this was common practice and they were emergency medicines which were drawn up each morning and placed in the fridge in case they were required quickly in an emergency. This meant that staff in maternity and gynaecology theatres were not following the trust's medicines management policy which stated "Medicines for injection must not be routinely prepared at ward level in advance of their immediate use. Individuals must not administer medicines prepared by another practitioner when not in their presence unless the product is an already established infusion which has been instigated by another practitioner in accordance with their professional code of practice or products that have been prepared and supplied by the pharmacy department". At our unannounced inspection we noted that cupboards were locked but the medicine fridge remained unlocked. Staff told us this was for ease of accessing medicine during times when women were undergoing caesarean sections.
- On the gynaecology ward and the labour ward we found inappropriate storage of oxygen and Entonox cylinders. The cylinders were not secured to a wall and there was no external signage to indicate the storage of the cylinders. We raised this with a senior member of staff who agreed that immediate action needed to be taken.
- Controlled drugs (CDs) were stored appropriately in all of the clinical areas we inspected. [CDs are medicines which have extra security controls over them. They are stored in a separate cupboard and their use recorded in a CD register].

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- CDs had been checked according to trust policy in all areas of maternity and gynaecology. The practice in the maternity operating theatre was that there was a twice daily check of CDs. Although these medicines had been checked once daily they had not been checked for a second time for five out of 17 days in March. However this was in line with trust policy of a single check each day.
- Records showed the administration of CDs were subject to a second, independent check. After administration, the stock balance of an individual preparation was confirmed to be correct and the balance recorded.
- Medicines that required storage at a low temperature were stored in pharmaceutical fridges. Temperatures for medicine refrigerators were recorded electronically and reported to an external company. There was a central response to out of range temperatures [the recommended temperature range for pharmaceutical fridges is 2 to 8°C] and a call cascade system was used to ensure action was taken to rectify any out of range issues. There were however no audits or reports from the external company to demonstrate assurance and governance.
- The hospital used paper prescription and medicine administration record charts for patients. A pharmacist checked medicine prescription charts, and the checks recorded in green ink on the prescription charts to help guide staff in the safe administration of medicines.
- We saw appropriate arrangements were in place for recording the administration of medicines. The records were clear and fully completed. The records showed patients were getting medicines when they needed them, and any reasons for not giving women their medicines were recorded. These meant women were receiving their medicines as prescribed.
- If women were allergic to any medicines this was recorded on their prescription chart.
- Child health records known as 'red books' were given to mothers for each new born baby following the completion of new-born and infant physical examinations.
- Appropriate recording and documentation of termination of pregnancy was evidenced in two sets of patient records and demonstrated compliance with the Abortion Act 1967 and associated guidelines through the recording of the care pathway. These notes were signed, dated, legible and clear records of discussions with the woman were recorded. Specialist nursing staff were available should staff have concerns about young women being exploited.
- Nursing care plans were not used to plan care throughout gynaecology services, this meant that agency staff working on the ward may not always have the most up-to-date information relating to the nursing care requirements of patients using the service. We spoke with a senior member of staff on the gynaecology ward about our concerns. They told us this being addressed as the trust was introducing an electronic patient record system within the next 12 months.
- The trust's team of Supervisors of Midwives (SoMs) undertook an audit of documentation in maternity services on an annual basis. Between January 2015 and October 2015 the SoMs audited the records of 56 mothers and 12 babies. Whilst the audit demonstrated many areas of good practice in relation to documentation, there were also areas of poor practice. For example, staff did not always record the woman or the baby's name on every page of their documentation, with a compliance rate of 54% against the services' target of 90%. Documentation was not always clear and legible with a compliance rate of 77% against the trust's target of 90% and guidelines were not always followed when alterations were made to documentation with a compliance rate of 75% against the services' target of 90%. Following the audit an action plan was developed which highlighted that SoMs would undertake weekly audits of records, involve women in the process of auditing records where possible and to provide training sessions focusing on record.

Records

- Patient care records were in paper format. On the gynaecology ward, nursing records were held at the patient's bedside whilst medical records were kept in filing trolleys that were protected by a security code.
- Women using the maternity service were provided with their own set of hand held care records to bring into the hospital with them. The hospital also held records relating to each woman.

Safeguarding

- The head of midwifery was the safeguarding lead for midwifery services; the safeguarding role however was undertaken by one of the midwifery matrons.

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- There were effective processes for safeguarding mothers and babies. The service had a dedicated, full-time midwife responsible for safeguarding vulnerable women who liaised with multi-agency safeguarding teams across the catchment areas.
- The trust had a safeguarding committee which met bi-monthly. The head of midwifery and the midwifery matron for public health and risk along with a number of midwives were members of this committee and attended the meetings.
- Safeguarding policies were up-to-date and included relevant guidance and legislation. The trust had a standalone female genital mutilation (FGM) policy which was developed with input from the trust's obstetrics and gynaecology team, nurses and midwives, paediatric team and safeguarding team. All of the staff we spoke with understood their responsibilities to adhere to safeguarding policies and procedures and could articulate the circumstances under which they would need to make a safeguarding referral. All staff we spoke with were aware of their responsibilities to adhere to the FGM policy and the actions to take if they had concerns about a woman in relation to FGM.
- Staff received safeguarding training, however, levels of training for the safeguarding of children and adults for midwives and nurses working in obstetrics and gynaecology was below the trust's target of 90%. Seventy three per cent of obstetrics and gynaecology nurses and midwifery staff were trained in safeguarding children level 3 against a trust target of 90%. Eighty two per cent of obstetrics and gynaecology nursing and midwifery staff were trained in safeguarding adults' level 2 against the trust target of 90%.
- Women who had complex social, medical or obstetric needs could be referred by their community team to the Acorn team for additional support. The Acorn team provided specialist care for women in vulnerable circumstances, were known to be at risk of domestic abuse, who smoked or were prone to substance abuse. Women under the age of 19 and women who had a learning disability could also be referred to the Acorn team. There were two midwives who worked in the Acorn team who had a specialist interest in supporting women who had additional needs.
- In February 2016, mandatory training across the maternity service was 98% against the trust target of 90%, whilst maternity specific training was 93%. This was being monitored on a monthly basis.
- Information provided by the trust indicated that none of the senior managers within obstetrics and gynaecology surgery services had undertaken mandatory training such as fire training, infection control, resuscitation, manual handling or child protection.
- Seventy nine per cent of medical staff had undertaken mandatory resuscitation training against the trust target of 90%. Nursing and midwifery staff had mostly exceeded the trust target of 90% for mandatory training except in basic life support where 81% of nursing and midwifery staff had completed this training against the trust target of 90%. Information provided by the trust however did not give any dates for which these statistics were relevant.

Assessing and responding to patient risk

- Midwifery and nursing handovers occurred at every shift change, during which staff communicated any changes to ensure actions were taken to minimise any potential risk to patients. We attended a morning midwifery handover between night staff and day staff. We noted the handover was not multidisciplinary but took place between midwives and midwifery support workers. There was no formal paperwork for handover, which followed a 'situation, background, assessment, recommendation (SBAR) format.
- We also observed a morning medical handover on the labour ward. The coordinating midwife, junior & middle grade doctors & consultant obstetrician were present. Patient risk was discussed with full participation from all staff present in this detailed handover.
- We reviewed eight sets of medical and nursing records, which included four on the gynaecology ward, one on the labour ward and three on the antenatal and postnatal ward. The records we reviewed on the gynaecology ward were not always fully completed. The ward did not use care plans but instead used a multidisciplinary assessment record booklet. This consisted of a section to be completed within four hours of admission, a section to be completed within eight hours of admission, a section to be completed within 48 hours of admission, a section to be completed any time during admission and a section to be completed 48 hours prior to the woman's expected discharge date. In

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addition, in gynaecology services, we found that patient's Venous Thromboembolism (VTE) risk assessments were not always completed. We looked at four patients' gynaecology records and found one without a completed VTE risk assessment. We spoke with the sister in charge about this who confirmed the woman had been prescribed the appropriate medication but a risk assessment had not been completed.

- In maternity services, although the majority of risk assessments we looked at were completed, we found that patient's VTE risk assessments were not always completed. We looked at four patients' maternity records and found one without a completed VTE risk assessment.
- We found of the four sets of multidisciplinary assessment records we reviewed on the gynaecology ward none of these records were fully completed. For example, in all four sets of records we reviewed, risk assessments for falls, moving and handling, malnutrition and skin integrity had not been fully completed.
- A medical and vulnerability risk identification form was used to screen women for increased risks associated with their pregnancy. We saw these were completed as women were booked into the hospital. Complex care plans were then completed for women who were deemed high risk throughout their pregnancy.
- An electronic system was used on the gynaecology ward to monitor patients' physiological observations, for example; patients' temperature, pulse rate, blood pressure, respiratory rate and pain score. Each member of staff had a hand held device to record the observations. Each observation was scored and this was used to calculate an early warning score which gave an indication of whether a patient was deteriorating.
- Midwifery staff used a paper based early warning assessment tool known as the Modified Early Warning System (MEWS) to assess the health and wellbeing of women who were identified as being at risk. This assessment tool enabled staff to identify and respond with additional medical support if required. The records we reviewed contained completed MEWS tools for women who had been identified as at risk.
- A New born Early Warning Score (NEWS) was used to identify signs of instability and clinical concern in new-born babies.
- Audits of NEWS and MEWS had not been undertaken throughout maternity and gynaecology services in the 12 months preceding our inspection, we could therefore not evidence that women were appropriately escalated if their condition deteriorated.
- A critical care outreach team was available seven days a week between the hours of 8am and 8pm to support staff with women who were at risk of deteriorating. There was a supervisor of midwives on call 24 hours a day, seven days a week and could access specialist support from staff on the critical care unit.
- There were arrangements to ensure that checks were made prior to, during and after surgical procedures in accordance with best practice principles. This included completion in obstetric theatres of the Patient Safety First's Five Steps to Safer Surgery – an adaptation of the World Health Organization (WHO) surgical safety checklist.
- We observed the theatre team completing the Five Steps to Safer Surgery throughout the sign in before induction of anaesthesia to the sign-out as the patient left theatre.
- An obstetric audit of the WHO checklist for the period January 2015 to September 2015 (sample size 37 sets of records) showed the WHO checklist was present in 31 out of the 37 (84%) sets of notes. 90% of these records had 'sign-in' documented whilst only 39% documented 'time-out' against a target of 100%. There was a plan for the surgeon to remain in theatre until the 'sign out' had been completed and a re-audit was going to take place to ascertain whether the service was achieving the gold standard of 100%.
- Staff caring for high dependency women had not received additional training in the care of the critically ill woman. This did not follow the best practice guidance, 'Providing Equity of Critical and Maternity Care for the Critically Ill Pregnant or Recently Pregnant Woman.' (The Royal College of Anaesthetists 2011). However, senior staff told us that the critical care outreach team were available to support staff looking after women who needed high dependency care.
- There was a maternity postoperative transfer pathway for women transferred from maternity theatre back to the ward and a maternity situation, background, assessment and recommendations (SBAR) transfer checklist was completed.

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- There was an assessment form and a pathway for the treatment of sepsis. [Sepsis is a life-threatening condition that happens when the body's response to an infection injures its own tissues and organs. If not recognised and treated early it can lead to death]. Staff in maternity and gynaecology demonstrated an understanding of the signs and symptoms of sepsis. Staff recognised sepsis as a clinical emergency and could tell us the actions they would take if they suspected a patient was deteriorating and showed signs of sepsis.
- Women always had a named midwife who was responsible for their care. However staff told us that continuity of care was difficult, especially after a woman had given birth. This had also been highlighted as a recurring theme within the maternity services 2014 to 2015 annual report.

Midwifery staffing

- The maternity staffing template had been reviewed in 2015 to determine a historical shortfall of midwifery staffing in relation to workload acuity. [Acuity is the measurement of the intensity of nursing care required by a patient]. The Head of Midwifery had presented a subsequent business case to the Board and an uplift of 5.5 full time equivalent midwives was agreed. These midwives came into post in November 2015. There were 63.74 full time equivalent midwives in post, which met the birth-rate plus recommendation. [Birth-rate plus is a tool used to calculate midwifery staffing levels, based on the ward activity and needs of the women]. At the time of our inspection, the service met the national benchmark for midwifery staffing set out in the Royal College of Obstetricians and Gynaecologists guidance (Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour) with a current ratio of 1:28.
- In terms of day-to-day acuity monitoring, the National Patient Safety Agency (NPSA) Intrapartum scorecard was completed at four hourly intervals and as of December 2015 this also included monitoring of maternity red flag indicators. Shortfalls in staffing were also reported via the trust's Safeguard reporting system and monitored via risk management processes. Midwife to birth ratios were calculated monthly and reported on the service's

clinical dashboard. We saw that between January 2015 and November 2015 this varied and for nine of the months the midwife to birth ratio was above 1:28 and in August 2015 it peaked at 1:39.

- From December 2015 the trust indicated they had introduced red flag indicators for staffing in line with NICE NG4 – 'Safe Midwifery Staffing'. However when we spoke with one of the labour ward coordinators they did not know anything about this. The trust shared with us their monitoring of red flag incidents which indicated there had been 16 red flag incidents between December 2015 and March 2016.
- The head of midwifery had taken into account the aging population of midwives and recognised that many of them were coming up to retirement age. Recruitment had taken place and the head of midwifery had purposefully over-recruited to take account of the upcoming shortfall.
- Gaps in the rota were filled with bank staff. Agency staff were not used throughout maternity services.
- Midwives provided one to one care when women were in labour.
- There were six integrated teams of community midwives, with ten midwives in each team. Four teams were hospital based and two teams were community based. There were six community midwives on duty on day shift, five of which covered the community, whilst one covered the hospital.

Nursing staffing

- Senior staff told us the biggest risk to the service was nurse staffing on the gynaecology ward.
- The gynaecology ward and early pregnancy assessment centre (EPAC) were staffed together. Expected levels and actual levels of staffing were displayed on a notice board in the sister's office so was not readily available for the public to see. However information about staffing levels were published on the trust's website for the public to see. Each month a report was submitted to the board in relation to staffing levels.
- Nurse staffing levels were assessed using The Association of UK University Hospital (AUKUH) Acuity/dependency tool, which had been recently modified by Shelford. [This tool measures the individual dependency of patients and calculates how many nurses are needed to care for them]. Staff on Jasmine ward told us that staffing was planned to provide a ratio

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of one qualified nurse for every eight patients; however, one nurse we spoke with had been responsible for overseeing the care of fifteen patients at the time of our inspection.

- The gynaecology ward had six full time equivalent vacancies for registered nurses and six whole time equivalent vacancies for health care assistants. The trust was working to recruit and fill these vacancies but was finding this difficult. The ward relied heavily on agency and bank nurses and health care assistants. There were presently no healthcare assistants employed on the ward.

Medical staffing

- Obstetric consultant cover met best practice guidelines for 40 hours per week.
- Maternity services at Yeovil District Hospital had a higher numbers of consultants, middle grade and junior doctors than the England.
- There were five full time equivalent Obstetrics and Gynaecology Consultants, one associate specialist, six middle grade doctors and seven junior doctors.
- Maternity services were always covered by three doctors, one of which was a consultant, one a middle grade doctor and one a junior doctor.
- Senior medical staff told us the number of doctors were sufficient as long as nobody went off sick.
- Anaesthetic cover was provided twenty four hours a day with an on call anaesthetist who was immediately available to cover for women who needed to go to theatre in an emergency.
- Medical staff described good working relationships within the department.
- There were 10 dedicated consultant labour ward sessions per week. These were from 9am until 5pm Monday to Friday. Consultants were present on site for maternity and gynaecology emergencies during their 'hot week' this meant they had no other fixed commitments. Out of these dedicated sessions consultants were required to be present within 30 minutes of being called. Doctors of other grades undertook 12 hour shifts.

Major incident awareness and training

- There were arrangements to respond to emergencies and major incidents. A trust-wide major incident plan was in place to guide staff in responding quickly and effectively to any major incident.

Are maternity and gynaecology services effective?

Good



The effectiveness of maternity and gynaecology services at Yeovil district Hospital was rated as good.

We found:

- The maternity service had achieved full UNICEF Baby Friendly accreditation and breastfeeding rates for initiation were good.
- Women said that they were able to access pain relief in labour and after they had had their babies, and this was provided to them in a timely manner.
- Staff worked well together with women and their families to plan the women's care throughout the pregnancy and after birth.
- Patients care and treatment, and their outcomes, was routinely collected and monitored. Outcomes for patients were mostly positive.
- Midwives were qualified and had the skills they needed to carry out their roles effectively and in line with best practice. They were supported to deliver effective care and treatment through clinical supervision, the appraisal process and peer to peer support.
- There was an enhanced recovery programme for women undergoing gynaecology surgery.

However we also found:

- Care and treatment was mostly planned and delivered in line with current evidence-based guidance, standards, best practice and legislation, however, the service was non-compliant with some guidance.
- Some indicators on the maternity dashboard were not benchmarked which meant staff may not be able to check if performance was within acceptable limits.
- Patients on the gynaecology ward did not always have a comprehensive assessment of their needs, which included pain management, nutrition and hydration and, physical and emotional aspects of their care.
- Only four nurses on the gynaecology ward were gynaecology trained and there were times when there were no gynaecology-trained nurses on the gynaecology ward. In addition, staff were providing care for patients,

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many of whom were elderly and were living with dementia. Staff told us they had not received dementia awareness training and they felt out of their depth caring for these patients.

Evidence-based care and treatment

- Local policies and guidelines were based on guidance issued by professional bodies such as the National Institute for Health and Care Excellence (NICE) and the Royal College of Obstetricians and Gynaecologists (RCOG) safer childbirth guidelines. Within gynaecology, the care of women requesting induced abortion (RCOG) and the Department of Health, termination of pregnancy for fetal abnormality guidance were also followed.
- While signed consent was not required for the disposal of fetal remains, guidance states women should be offered a choice of how to manage the remains, and as such the conversation should be recorded. Notes reviewed showed clear written consent was obtained indicating the woman's choice of disposal. In addition, staff we spoke with were articulate in their knowledge of this requirement. We were therefore assured that the service obtained consent from all women for disposal of pregnancy remains which followed Human Tissue Authority guidance (2015).
- We reviewed nine guidelines, these were easily accessible on the trust's intranet, however we found three of the nine sets of guidelines had passed their review date. These included guidelines for the management of pregnant women with mental illness, including the care pathway for antenatal and postnatal mental health; obesity in pregnancy and thromboprophylaxis during pregnancy, labour and puerperium. Staff we spoke with were aware that the thromboprophylaxis guideline needed to be reviewed and were waiting for input from the consultants.
- NICE Quality Standard 22 (antenatal care) had been reviewed by the matron for public health and risk in November 2015 and the service was compliant for all but two of the quality statements where it was partially compliant with quality statement number two and four.
- NICE Quality Standard 32 (caesarean section) had been reviewed by the matron for public health and risk in November 2015 and was found to be fully compliant with all nine quality statements.
- The trust shared with us that they were not able to fully implement the RCOG 2013 guideline in relation to 'investigation and management of small for gestational age'. This was because there were insufficient sonographers to undertake ultrasound sessions within the trust. This was currently being addressed by the superintendent in the ultrasound department.
- Other obstetric guidelines had been updated in accordance with NICE guidelines, for example the intrapartum care and CTG guidance, however the RCOG guidance on 'reducing the risk of VTE' was in the process of being reviewed but had not yet been completed.
- There was a programme of local audits being undertaken by doctors and midwives throughout maternity and gynaecology services.
- There was an enhanced recovery programme for women undergoing elective gynaecological surgery. [Enhanced recovery is an evidence-based approach used to enable people to recover more quickly following surgery]. Pre-operative assessment was an integral component of the enhanced recovery programme where women were given information to enable them to play an active role in their care. For example women were given information about nutrition, exercise and lifestyle choices such as smoking and drinking alcohol. Where appropriate minimally invasive surgical techniques were used and careful consideration for pain relief was adopted. Post-operatively women were encouraged to eat and drink as soon as possible and with good pain control, they were encouraged to mobilise at the earliest opportunity. There were also plans to introduce an enhanced recovery programme for women undergoing an elective caesarean section.
- There was a Somerset-wide tongue tie pathway in place. The Trust had adopted this guideline and care pathway and employed an infant feeding specialist who was trained to undertake frenulotomy on site. Midwives could also refer to another service practitioner.

Pain relief

- Pain was assessed and recorded on women's maternity modified early warning score (MEWS) chart.
- There was a birthing pool that women could use as pain relief in labour. Women also used a bath to assist with their pain control.
- Entonox (a pain relieving gas) was piped in all labour rooms. Pethidine and diamorphine was available for women who required stronger pain relief.

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- Epidurals were available for women on labour ward 24 hours a day, seven days a week. The rate of epidural usage between January 2015 and November 2015 the percentage of epidurals administered for vaginal deliveries was between 3% and 9%.
- Women were able to access pain relief during birth and post operatively in a timely manner. Analgesia was offered regularly and women told us their pain was well managed.
- In the gynaecology ward women told us their pain was well managed and they were offered pain relief.

Nutrition and hydration

- The trust had a food, nutrition and hydration policy which outlined the steps required to ensure all patients received optimal nutritional care. The policy took into account access to facilities for breast feeding.
- The maternity service had achieved full UNICEF Baby Friendly accreditation in 2013 and was due to undergo reaccreditation later in 2016. [The Baby Friendly initiative is a worldwide programme of the World Health Organisation and UNICEF to promote breast feeding].
- Between January 2015 and November 2015, 77% of babies had received breast milk within 48 hours of being born and 73% of women were still breastfeeding on discharge from hospital. The trust had not set a breastfeeding target.
- The trust had a breast feeding policy, which gave parents guidance on how staff would support them with breast feeding.
- The service was able to offer a procedure to divide tongue-tie in babies. This enabled a prompt response to solve any identified feeding problems. [Tongue-tie is a problem affecting some babies with a tight piece of skin between the underside of their tongue and the floor of their mouth]. These clinics took place in the department on a weekly basis by an infant feeding specialist. However, staff told us that the midwife responsible for the referral of babies to the tongue-tie clinic had been on sick leave for several months and there had been no one to replace them. The trust told us that any midwife could refer babies to the tongue tie clinic, however some midwives were unaware of the processes for referral. The tongue-tie service was also available in the community.

- The Malnutrition Universal Screening Tool (MUST) was used to screen patients for their risk of malnutrition throughout gynaecology services, however, this was not always completed.
- Patients all had access to drinking water beside their bed unless they were nil by mouth.
- A choice of meals was available and patients completed menu choices for the day.
- There was multi-disciplinary team (MDT) support to ensure nutrition and hydration were assessed and managed effectively from a dietitian and pharmacist.
- On Freya ward women had a hot meal every day. Frozen meals could be obtained from the kitchen and could be heated up in a microwave any time of day. This enabled women to have flexibility around when they chose to eat.
- Menu choices catered for all types of diet and women could also help themselves to snacks such as fruit, cereal, toast, sandwiches and yoghurt, any time, day or night.
- Hot food was supplied from Freya ward to the labour ward and extra food was ordered in case it was required.
- There were trays in the labour ward rooms with tea and coffee and women could help themselves.

Patient outcomes

- The service maintained a maternity dashboard which reported on the clinical outcome indicators including those recommended by the Royal College of Obstetrics and Gynaecology (RCOG) 2008. However, we did not see this document on display for staff and members of the public.
- As of December 2015 the maternity service was not indicated as a maternity outlier. (Maternity outliers are where the trust performs worse than the national average) for maternal readmissions, neonatal readmissions or maternal infections diagnosed within six weeks of birth.
- The trust's home birth rate was around 3%. This was lower (worse than) the trust target of 5% but higher than the national average of 2%
- Women who were eligible were offered screening for Down's syndrome. Data provided by the trust indicated that 100% of women who were eligible were offered this test. This was better than the trust's target of 95%.
- Between January 2015 and November 2015 91% of women undertook a carbon monoxide (CO) test. [A CO test is used to identify women who may be at risk of CO

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exposure, through either smoking or passive smoking. Exposure to CO when pregnant can affect the baby's access to oxygen, which is needed for healthy growth and development].

- Between January 2015 and November 2015 there had been 1402 births at the trust. The normal birth rate within this reporting period was 60%. This was in line with the England average of 60%. The trust did not have a target range for normal deliveries.
- The caesarean section rate between January 2015 and November 2015 was 24%, this was slightly worse than the trust's target of 23%. Of these caesarean sections, 12% were planned and 13% were unscheduled. Whilst the planned caesarean section rate was slightly higher than the England average of 11% the rate for unscheduled caesarean sections was lower than the England average of 15%.
- Between January 2015 and November 2015 10% of babies were delivered by medically assisted instrumental delivery (forceps and ventouse extraction). This was in line with the trusts target of 10%.
- Between January 2015 and November 2015 106 women had experienced an obstetric haemorrhage (bleeding following birth) of between 1000mls and 1999mls. Although the total figure was within the trust's target of 10 a month, in January 2015 16 women experienced an obstetric haemorrhage of between 1000mls and 1999mls. This was worse than the trust's target of 10 for this month.
- Between January 2015 and November 2015 the number of women who experienced a major obstetric haemorrhage of 2000mls or more was 15. This was worse than the trust's target of none.
- Between January 2015 and November 2015, 25 women who had a normal delivery experienced serious perineal trauma. Apart from January 2015, the trust achieved its target of below five per month. For the same reporting period seven women who had an instrumental delivery experienced serious perineal trauma. The target for the trust was one per month, which was achieved apart from July 2015 when the figure increased to two.
- The rate of epidural usage was low for a consultant led unit. Between January 2015 and November 2015 the percentage of epidurals administered for vaginal deliveries was between 3% and 9%.
- Between January 2015 and November 2015, the number of babies readmitted within 28 days because of difficulties feeding was six. The trust did not have a target for this outcome.
- Between April 2014 and March 2015 maternity services had experienced seven stillbirths and one early neonatal death. This was an increase from five stillbirths from the previous year.
- Between January 2015 and November 2015, 118 full term babies were admitted to the special care baby unit.
- The NHS screening programme sets key performance indicators (KPI) for antenatal and new-born screening programmes. The trust was only meeting acceptable levels within two of the KPIs for July 2015 to September 2015.
- In February 2015 the service became an early implementer for the NHS England Stillbirth Reduction care Bundle 'saving babies lives' Information provided by the trust indicated the service was fully compliant with two of the four elements of care. These were carbon monoxide testing for pregnant women and effective fetal monitoring in labour. The service however were not yet fully compliant with identification and surveillance of pregnancies with fetal growth reduction (FGR) and raising awareness of fetal movement.
- An audit of fetal heart rate monitoring had last taken place in 2012. The audit looked at various aspects of CTG monitoring from documenting the name of the woman to the outcome being documented on the CTG trace. There were elements of the audit that showed compliance, however, there were areas where there were non-compliance, for example 21% of cases had APGAR scores documented on the trace. There was however no evidence of a further audit taking place or that any recommendations or action plans had been submitted to ensure the service achieved compliance with the trust's own CTG documentation policy. Midwives used a 'fresh eyes' approach for CTG hourly observations. ['Fresh eyes' is an approach which requires a colleague to review fetal monitoring readings as an additional safety check to prevent complications being missed].

Competent staff

- There were seven Supervisors of Midwives (SoM) within the maternity service at Yeovil District Hospital. SoMs help midwives provide safe care and were accountable

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to the local supervising authority midwifery officer (LSAMO). The national recommendation for caseloads for SoMs was 1:15. The ratio of SoMs to midwives at the trust was 1:14. This meant the service was compliant with national expectations.

- A preceptorship programme was provided for all newly qualified midwives, which had to be completed before progressing to a higher grade, staff within this group told us that they had been allocated a named mentor and felt well supported.
- Midwives told us their appraisals were meaningful and gave them an opportunity to discuss specialist training and career development.
- Midwives told us there were three mandatory study days a year in which they received updates about the latest research and innovations from specialist midwives.
- The SoMs were supporting staff to prepare for revalidation.
- Only four nurses on the gynaecology ward were gynaecology trained and there were times when there were no gynaecology-trained nurses on the gynaecology ward. In addition, staff were providing care for medical patients, many of whom were elderly and were living with dementia. Staff told us they had not received dementia awareness training and they felt out of their depth caring for these patients. This meant patients were at increased risk of receiving inappropriate care that did not meet their needs.
- Medical staff told us they felt well supported and received regular teaching by the consultants. All of the medical staff we spoke with told us they received appraisals. Information provided by the trust indicated 100% of medical staff had received an appraisal between April 2015 and December 2015. For the same reporting time period 82% of nursing and midwifery registered staff and 74% of unregistered staff had received an appraisal against the trust's target of 90%.

Multidisciplinary working

- The maternity service promoted multidisciplinary team working, the multidisciplinary team included antenatal services, outpatient services, community midwives, anaesthetists, obstetric consultants, and the neonatal unit, physiotherapists, dietitians, general practitioners, health visitors and social services.
- Both hospital and community staff reported good working relationships between the teams.

- The physiotherapists, occupational therapists and where necessary dietitians supported women post-surgery.
- Women were referred to neighbouring hospitals where there were facilities to support women who were at higher risk in pregnancy.
- A level one special care baby unit (SCBU) was located opposite Freya ward (the antenatal and postnatal ward). SCBU did not form part of the maternity service and was being managed by the urgent and long term conditions strategic business unit. The service did not have a transitional care pathway for babies from SCBU to postnatal care. This meant that babies requiring extra care would be separated from their mothers. Midwives however told us that women could come and go as they wished to spend time with their babies in the SCBU.

Seven-day services

- The Early Pregnancy Assessment Clinic (EPAC) which provided early scans and consultations for women experiencing problems in pregnancy between 6 and 18 weeks gestation was based on Jasmine ward and was open between 11.30am and 1.30pm Monday to Friday.
- A Supervisor of Midwives (SoM) was available 24 hours a day, seven days a week through an on-call rota. This on-call system provided midwives with access and support at all times. Midwives told us they could contact the SoM directly and didn't have to go through switchboard.
- Community midwives were available 24 hours a day, seven days a week to facilitate home births.
- A consultant anaesthetist told us there were two consultant anaesthetists with a special interest in obstetrics but all consultant anaesthetists covered labour ward. A middle grade anaesthetist was on call 24 hours a day seven days a week.

Access to information

- Patient care records were in paper format. On the gynaecology ward, nursing records were held at the patient's bedside whilst medical records were kept in filing trolleys that were protected by a security code. This meant that authorised staff had access to the records.
- Women using the maternity service were provided with their own set of hand held care records to bring into the hospital with them.

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- Records were readily available to staff to refer to during the time of a woman's admission.
- GPs were able to make direct referrals to the gynaecology service.
- Staff were able to access test results via the trust's IT system.
- Hospital staff could access policies and procedures via the trust's intranet system. However these could not be accessed by agency staff. Agency staff on Jasmine ward told us they would refer to a permanent member of staff if they required guidance.
- Community midwives did not have access to information technology when working in the community. This meant they could not remotely access current clinical guidelines which could increase the risk of potential variations in care.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The trust had a Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) policy, however, this had no date of approval or date of review on it. The trust also had a consent for examination and treatment policy.
- Training on the MCA and DoLS was included in the safeguarding training.
- Consent to care was obtained in line with national legislation and guidance, including the MCA 2005.
- Within the termination of pregnancy clinic, as part of the patient's pathway patients were given sufficient time to ask questions and to spend time with a counsellor prior to giving consent to the procedure. During this time all options were sensitively discussed with the woman and where appropriate their partner. Women were offered a second consultation if they were not entirely certain about their decision to terminate their pregnancy.
- We randomly selected two sets of records and both contained signed consent forms from women. Possible complications and side-effects were recorded and had been explained to each woman. We saw that before a termination of pregnancy took place two doctors had authorised the procedure, at least one of whom had spoken with the woman.
- The trust's consent for examination and treatment policy supported making the patient's best interests central to the process of obtaining consent. If a young person was under 16 and wished to consent to their own treatment, for example if they wished to undergo a

- termination of pregnancy, staff followed Gillick Competency and Fraser guidelines to assess whether the young person would have the maturity and intelligence to understand the risks and nature of treatments. The young person would be given time to consider all the options. [Gillick competency and Fraser guidelines are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions].
- Staff members within the termination of pregnancy clinic were aware of the complications that could arise from using family members to interpret for women who did not speak English and were considering a termination of pregnancy. The staff had access to translation facilities to overcome this.
 - Patients gave informal consent for their care and treatment, and this was clearly documented in women's records. We observed staff asking for consent prior to undertaking care and treatment such as blood tests and physiological observations.
 - On checking patient records we saw signed consent forms, all of which had been completed in line with the trust's consent for examination or treatment policy. Patients we spoke with told us they had been given enough information to enable them to make decisions about their care and treatment.

Are maternity and gynaecology services caring?

Good



The care provided to patients in maternity and gynaecology services at Yeovil District Hospital was good.

We found:

- Feedback about midwifery services was positive, staff were well motivated, dedicated to their roles and women told us they felt safe and well cared for.
- The percentage of women who would recommend the maternity ward (Freya ward) was above the England average between December 2014 and November 2015.
- Women were treated with dignity, respect and kindness during all interactions.
- Women felt involved and were encouraged to be partners in their care and in making decisions with the support they needed.

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- Women were encouraged to manage their own health and care and to remain independent where they could.
- Staff helped women and those close to them to cope emotionally with their care and treatment.

Compassionate care

- Without exception, women, their partners and relatives were positive about the care they had received. All of the women we spoke with told us staff were kind and caring and that they had been treated with dignity and respect.
- We observed staff respecting the privacy and dignity of women by knocking on doors and waiting to be invited in to the room.
- Staff we spoke with demonstrated an understanding of the importance of respect for women's personal, cultural, social and religious needs.
- The service used the NHS Friends and Family Test (FFT) to obtain feedback from patients. This was a single question survey which asked patients whether they would recommend the NHS service they had received to friends and family who needed similar care or treatment. The percentage of women who would recommend the maternity ward (Freya ward) was above the England average between December 2014 and November 2015 whilst the number of women who would recommend the hospital to give birth was in line with the national average for the same reporting period.
- The trust scored similarly to other trusts in 13 and better than other trusts in four of the questions in the Care Quality Commission Survey of Women's Experiences of Maternity Services 2015.
- Maternity and gynaecology services undertook a number of inpatient surveys to ascertain the views of women who had used the service.
- Freya ward undertook a 'your care' survey and had developed a dashboard around 12 outcomes of the survey. Results for each month from April 2015 to October 2015 were displayed on the dashboard. The results were given a rating of red, amber or green, with the exception of April, most of the ratings were green, which meant the responses were within the trust's target.
- The trust undertook a termination of pregnancy clinic patient survey. Women undergoing a termination of pregnancy were given the opportunity to feedback on their experience. Participation was strictly voluntary and questionnaires were only left with patients who

expressed they were happy to provide feedback. The questionnaires were given out by staff on the day of the procedure following a sensitive explanation of the purpose of the questionnaire. Women were provided with a pre-paid envelope for the purpose of returning the questionnaire. We looked at the results of the survey which showed that 100% of women who returned the survey felt they had been treated with dignity and respect and 100% of women felt they had been treated with kindness and respect.

Understanding and involvement of patients and those close to them

- Women were supported to make informed choices. Women told us they were well informed about their choices.
- The 'Your care' report undertaken on the postnatal ward indicated that between April 2015 and October 2015 between 84% and 100% of women felt involved in decision making about their care and for the same time period, 100% of women felt their choices had been respected.
- Partners we spoke with told us that staff made them feel involved. A patient in the antenatal clinic also told us they felt their partner was included in discussions.

Emotional support

- Women were screened for conditions such as anxiety and depression as part of the booking in process.
- Women considering termination of pregnancy should have access to pre-termination counselling. All of the women undergoing termination of pregnancy at Yeovil District Hospital were provided with pre-termination counselling by an appropriately trained counsellor. Women who were anxious or unsure about their decision were provided with extra support.
- Following a termination of pregnancy procedure women could access counselling services external to Yeovil hospital however in exceptional circumstances some women received further counselling support from the counsellor based at the hospital. For those women who had undergone a termination of pregnancy for fetal abnormality, referrals were made to specialist organisations.

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- Staff supported women who had experienced a miscarriage, termination for fetal abnormality, still birth or a neonatal death. In addition, there was a specialist antenatal new-born screening midwife who had a specialist interest in bereavement support.
- The hospital chaplain was also available to provide emotional support to women and those important to them.
- The hospital ran a self-support group called the snowdrop group for parents and families who had suffered the loss of a baby. The group was run by midwives, nurses and the hospital chaplain together with parents who had suffered the death of a baby in the past. This was a befriending group which aimed to support parents who had lost their baby more recently.

Are maternity and gynaecology services responsive?

Requires improvement



We found the responsiveness of maternity and gynaecology services at Yeovil District Hospital to be requiring improvement.

We found:

- The gynaecology ward was being used as an escalation ward and the gynaecology day-case unit was being used for patients to stay overnight because of bed capacity issues throughout the trust, which meant elective gynaecology surgery was being cancelled.
- Because of bed capacity issues, women who were undergoing a termination of pregnancy, either because of an unwanted pregnancy or because of fetal abnormalities were at times nursed in bays with elderly women, some of whom were living with dementia.
- Colposcopies took place in a room off the gynaecology ward. There was one consulting room with a couch where the women were consulted and colposcopies were performed. There was no recovery area and women who had undergone the procedure were required to recover in the waiting area with women who were waiting to be seen. The colposcopy room was small and there was no separate changing area for

women to get changed, so women had to get changed in the colposcopy room. There were plans to upgrade this service but plans were in the early stages and had not yet been approved.

However, we also found:

- Women were given a choice of birth in line with national guidance.
- Services were mostly arranged to meet the needs of women and there were a range of specialist midwives and clinics to support them.
- The service offered specialist antenatal clinics including diabetes and Next baby clinics.
- There were a low number of complaints about the service. Complaints and concerns were managed appropriately at local and divisional level with evidence of shared learning as a result.

Service planning and delivery to meet the needs of local people

- Women were given a choice of where they wished to give birth in line with national guidance, which recommended both a choice in place of birth and a lead carer. This included the choice of a home birth or birth in a hospital supported by midwives, consultant obstetricians and anaesthetists. The service did not provide a designated midwifery led unit, although women who were deemed to be at low risk did receive midwifery led one-to-one care in labour.
- Women who went in to labour earlier than 32 weeks were transferred out to one of the larger maternity units. The South West Newborn Emergency Stabilisation and Transport Team (NEST) transferred babies who were born unexpectedly in a poor condition.
- Early pregnancy assessments and a fertility clinic were available on early pregnancy assessment unit (EPAC) and outpatients' clinic.
- Women who were admitted for a termination of pregnancy were admitted directly to the gynaecology ward but were not always allocated a single room. Because of bed capacity issues, women who were undergoing a termination of pregnancy, either because of an unwanted pregnancy or because of fetal abnormalities were at times nursed in bays with elderly women, some of whom were living with dementia.
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were performed. There was no recovery area and women who had undergone the procedure were required to recover in the waiting area with women who were waiting to be seen. The colposcopy room was small and there was no separate changing area for women to get changed, so women had to get changed in the colposcopy room. There were plans to upgrade this service but plans were in the early stages and had not yet been approved. Antenatal care was provided in general practitioner (GP) surgeries, children's centres and at the maternity unit. The service offered specialist antenatal clinics including a multidisciplinary diabetic clinic.

- There was an antenatal and new born screening coordinator. The service provided antenatal screening, but referred women who required invasive screening to a hospital in Bristol.
- Specialist midwifery care was available for women in vulnerable circumstances. This was provided by the Acorn team who provided care to women who had safeguarding concerns, those who were experienced substance misuse and teenagers.
- Three sessions were run from a children's centre bi-monthly for pregnant teenagers. These focussed on topics such as resuscitation and care of the infant, safe handling of baby, recognising domestic abuse and labour and birth. Belly painting was also undertaken at these sessions. Local facilities such as a mother and baby care shop donated goody bags and a gym donated day swim passes that were given to women who attended the sessions. These sessions were designed to encouraged young, hard to reach mums to attend.
- Parent education classes comprised an all-day session that took place on Saturdays. This meant that women using the service did not have to attend on multiple dates.
- In addition to parent education classes, the community midwives ran weekly aqua natal support sessions provided at a local swimming pool. Women could attend the sessions throughout their pregnancy. Three midwives had undertaken specialist training to provide the service. The main purpose of the service was to prepare women for childbirth.
- Prior to 2014/2015 women requiring antenatal support and intervention were cared for on the labour ward. A review of the service found this was impacting on labour ward resources and the quality of care for both antenatal and labouring women. A three month review

of the service was undertaken and found that up to 35% of admissions could have been seen in an outpatient setting. Following consultation, in April 2015 there was a trial which saw this workload moved from the labour ward and a midwife was allocated to care for these women on an appointment basis within an antenatal day assessment setting. At the time of our inspection, refurbishment work was being undertaken on Freya ward and SCBU and the antenatal day assessment unit was located on the labour ward, however there were plans for it to be moved to the refurbished area once the work had been completed.

- At the time of our inspection there was no funded specialist support for women who were experiencing a mental health condition.

Access and flow

- There were four temporary closures of maternity services between January 2014 and June 2015. This meant that the hospital was closed to new admissions as part of the escalation procedure, and women had to be diverted to other hospitals. Three of these episodes were due to staffing issues, and one related to high workload and capacity and the closures ranged between four hours, 35 minutes and 17 hours, 55 minutes.
- Bed occupancy in maternity services ranged between 46% and 57% between October 2013 and June 2015 which was below (better than) the England average of between 55% and 60%.
- In 2013 the gynaecology inpatient ward was closed and six beds were ring fenced on a surgical ward for gynaecology patients. The gynaecology ward had just re-opened one month prior to our inspection. At the time of our inspection the ward was also being used for medical patients, many of whom were elderly who were deemed fit for discharge and were waiting for packages of care or placement.
- There was a day ward on the gynaecology ward, however, these were being used as escalation beds, this meant there may be times when gynaecology beds were not available for women requiring gynaecology procedures. Throughout our inspection, the matron for gynaecology assured us there were no gynaecology outliers on other wards throughout the hospital.
- At the time of our inspection the hospital was on an internal critical alert due to capacity and flow issues. We saw how this impacted on patients who had been listed

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for surgery and were told of two patients listed for sensitive gynaecological surgical procedures who had to have their operations cancelled. A doctor told us that gynaecology operations were often cancelled because there were no beds due to outliers on the gynaecology ward. We saw evidence of this throughout our inspection where two women who had been scheduled to have a termination of pregnancy had been cancelled due to there being no beds available.

- Between January 2015 and December 2015, maternity services received 1,641 bookings for antenatal care. 89% of these women attended an antenatal appointment within 12 weeks of their pregnancy. This was better than the trust's target of 80%.
- There was no separate waiting area for women attending maternity outpatient appointments and gynaecology outpatient appointments although women who were waiting to be seen in relation to termination of pregnancy waited in a separate area of the clinic.
- The trust did not collect data relating to the percentage of women seen by a midwife within 30 minutes and a consultant within 60 minutes during labour. However, staff told us that all women were seen immediately on transfer to the delivery suite.
- The trust did not audit the time taken for a consultant review for women who were admitted as an emergency to the gynaecology or maternity ward.

Meeting people's individual needs

- All information on notice boards and leaflets were presented in English. However, staff told us they could get leaflets and information printed in different languages if this was required.
- Staff were able to access interpreting services for women who did not speak English as their first language. The 'Bigword' was available to facilitate this.
- There was a lead nurse for individuals living with a learning disability, who could help support women and provide resources for nursing and midwifery staff. However staff told us that women who had a learning disability were usually accompanied by family or support workers. Staff also told us they would initiate a 'this is me booklet' for women living with dementia or with a learning disability. Staff had not received any training in supporting women who had learning disabilities but told us they thought this would be very useful.
- Staff told us they could get specialist equipment for women who had a high body mass index (BMI). However the operating trolley in the gynaecology theatres was not suitable for any woman who weighed more than 140kg. Women who were above 140kg had to have their procedures undertaken in the main theatres at the hospital and staff told us it was often difficult to arrange this theatre time.
- Mothers who had a baby in SCBU would be discharged from Freya ward once they were medically fit to be discharged. They could not stay on the ward as a patient to be nearer to their baby, however staff told us these mothers could use the kitchen and day room facilities on Freya ward if they wished to.
- Women who had complex social, medical or obstetric needs could be referred by their community team to the 'Acorn' team for additional support. The Acorn team provided specialist care for women in vulnerable circumstances, were known to be at risk of domestic abuse, who smoked or were prone to substance abuse. Women under the age of 19 and women who had a learning disability could also be referred to the Acorn team.
- The mix of specialities on the gynaecology ward was not conducive to providing sensitive care for women who were undergoing sensitive gynaecological procedures such as termination of pregnancy. Although staff tried hard to ensure women who were undergoing sensitive procedures were allocated a side room, this did not always happen. Throughout our inspection we observed at least two occasions where women were undergoing sensitive gynaecological procedures and were placed in a bay with elderly women, some of whom had dementia. Staff told us they realised this was far from acceptable, but there was no other option because of the mix of patients on the ward.
- None of the single rooms had en-suite facilities on Freya ward. This meant women who were being induced would have either to use a commode or use the ward's communal facilities if she needed the toilet.
- There was a dedicated (snowdrop) bereavement suite situated on the labour ward. This was a large room with a fold out double bed where parents and families could spend as much time as they wished with their deceased baby. There were also memory boxes that maternity staff gave to women who had lost a baby, these were sensitively thought out and also contained information about bereavement support.

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- There was a book of remembrance in the hospital's chapel for families who had lost a baby.
- Partners were not encouraged to stay overnight on Freya ward. The ward did not have facilities to enable partners to stay overnight.
- A free parking pass was available for five days for the family of labouring women.

Learning from complaints and concerns

- Patient Advice and Liaison Service (PALS) information leaflets were displayed in clinical areas and information about contacting PALS was available on the trust's website.
- Between January 2015 and November 2015 there had been six complaints relating to maternity and gynaecology services.
- Complaints in maternity and gynaecology were addressed at the risk management meetings.
- The service was able to demonstrate learning from complaints, for example the service had made changes to the times of the fertility clinic and the antenatal clinic so that appointments for these clinics were scheduled at different times.

Are maternity and gynaecology services well-led?

Requires improvement



The leadership of maternity and gynaecology services at Yeovil District Hospital required improvement.

We found:

- There was no established strategy or vision for maternity and gynaecology services. Although there was evidence of staff being involved in the future development of a vision and strategy.
- There was a maternity and gynaecology risk register and risks had been discussed at governance meetings but there was little evidence that the risk register had been recently been updated or that there were any action plans for the risks identified. The risks relating to the maternity operating theatre had been on the risk register since 2014 and no action had been taken to mitigate the risks until our inspection.
- There was a lack of oversight of the issues we highlighted such as appropriate experienced staff, care for women and the impact of medical outliers on the gynaecology ward.
- At ward level we observed examples of good leadership principles; however, business unit managers had not addressed the issues which were known to them and did not have plans in place to ensure that women were cared for safely and in a responsive manner.

However, we also found:

- There was a positive culture throughout the service. Staff reported positive working relationships and we observed that staff were respectful towards each other, not only within their area of work but across all disciplines.
- There was good public and staff engagement. Staff had been encouraged to contribute to the services vision for the future.
- The head of midwifery was visible throughout the service.

Vision and strategy for this service

- The trust did not have an established strategy or vision for maternity and gynaecology services.
- The leads for maternity and gynaecology services told us the strategy and vision for the service was in its early stages of development. They shared with us a power point presentation which consisted of five slides. This was entitled the 'Business unit strategy and vision for obstetrics, maternity and gynaecology services'. This outlined the trust's vision to be the UK leader in delivering new models of care. It contained an outline of the vision for maternity and gynaecology which included the development of an integrated approach to women's services, the development of a leadership structure on Jasmine ward, to develop maternity care pathways and seven day emergency gynaecology services and to explore the use of technology to improve the safety of lone workers. The strategy included an action plan for implementation of the services strategic objectives. It did not however include dates or timelines for completion, and actions had not been assigned to any particular person. We were therefore unable to ascertain when the development of the strategy began, by whom or when it would be completed.
- The trust's vision was visible throughout maternity and gynaecology services. Staff knew about and

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demonstrated the trust's values but the vision and values for maternity and gynaecology services were still in their infancy, although staff were being encouraged to contribute to them. This was evident within the minutes of a team meeting which took place in January where it was highlighted that the lack of vision was something that inspectors would pick up on.

Governance, risk management and quality measurement

- Maternity and gynaecology services held bi-monthly risk management and clinical governance meetings where specific incidents and trends were reviewed. A review of these minutes demonstrated a multidisciplinary team approach and covered topics such as incident reporting, guidelines for circulation, presentations, and discussions around action plans, dashboards and risks within the service.
- Trust wide governance assurance committee meetings took place on a monthly basis. The clinical and leads for obstetrics and gynaecology services had attended the trust wide governance assurance committee to present. The Head of Midwifery had attended the meeting in November 2015 to present the maternity services annual report. At the November meeting, the governance assurance committee had agreed the recruitment of a specialist lead for perinatal health in women should be added to the trust's risk register. We looked at the trust's risk register and could not see that this had been added. The clinical lead for obstetrics and gynaecology had attended the October meeting to give an update relating to the Royal College of Obstetricians and gynaecologists assurance visit.
- We asked for minutes of any meetings between the head of midwifery and the director of nursing but the trust told us there were no recorded minutes between the head of midwifery and the director of nursing. We could therefore not evidence whether issues were raised or actions were taken.
- In 2014 a Royal College of Obstetricians and gynaecologists (RCOG) review of the trust's department of obstetrics and gynaecology was commissioned by the trust's medical director where a number of concerns were found throughout the service. Following the review an action plan was completed to address the recommendations and take action to make improvements within the service. We saw the action plan was being monitored through the governance assurance committee and several recommended changes had already been made. This was particularly evident in relation to senior management changes in obstetrics and gynaecology.
- Senior staff within maternity and gynaecology services told us their biggest worry was Jasmine ward because there was no regular cohort of staff and it had been difficult to recruit. They were concerned because of the mix of medical and gynaecology women and there had been some inappropriate admissions. They also told us they were unsure what plans the executive team had made but there were plans in place. They told us they would continue to escalate risks as they had been doing.
- There was a risk register for the service which contained 19 risks. Business unit managers aware of the local risks but we were not assured that all steps had been taken to mitigate risks. For example we found concerns relating to the prevention and control of infection in the maternity theatre and when we spoke with senior staff about this there had been a lack of oversight for who was responsible for mitigating this risk within the theatre. Although the risk register contained action points for each risk, and risks had been assigned to the appropriate person there was no date to indicate when risks had been reviewed or indeed if they had been reviewed. In addition, there was no target date for completion.
- The risks around maternity theatre was first entered onto the risk register in June 2014 and according to the risk register the risk had reduced from a significant risk to a moderate risk. However we were unable to ascertain what actions had taken place to reduce the risk.
- We reviewed the minutes of a team meeting which took place in January 2016. We saw that the risks within maternity theatre had been discussed and it was disclosed that maternity theatre did not receive deep cleans. The responsibility for scrubbing was being taken over by main theatres and we saw an entry within the minutes stating "when main theatres take over it is up to them how they run it".
- There was a multidisciplinary labour ward council meeting which took place once a month where perinatal and obstetric interventions were discussed.
- The service used a quality dashboard that was reviewed on a monthly basis which used the red, amber, green

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(RAG) flagging system to highlight areas of concern.

These were not however displayed throughout the service for staff and members of the public to see and targets had not always been set.

- The government had commissioned an independent investigation into maternity and neonatal services nationally (the Kirkup report, 2015), to examine concerns raised by the occurrence of serious incidents. The service had completed a full gap analysis [a gap analysis is where current practice is compared with what is required] responding to the Kirkup report. Senior managers had benchmarked themselves as fully compliant for 10 of the recommendations and partially compliant for seven. Although recommended actions were included in the gap analysis an action plan with target completion dates and delegation of responsibilities had not been included.

Leadership of service

- The 2014 Royal College of Obstetricians and gynaecologists review looked at the functionality of the service and found there to be a lack of leadership in midwifery. Following this review the trust had taken steps to establish effective leadership throughout the service.
- Obstetrics, gynaecology and maternity services sat within the trust's elective care strategic business unit. There was an obstetric lead consultant for maternity and an obstetric lead consultant for labour ward, in addition, the head of midwifery was the clinical lead for maternity and gynaecology.
- In addition to the leads for maternity and gynaecology services, there were three matrons, one was responsible for maternity and gynaecology services; one for antenatal, postnatal and community services and one for public health and risk.
- Each ward area had a ward manager who provided day-to-day leadership for staff on the ward. Ward staff told us they felt supported by their ward managers, ward sisters and matrons and told us they felt they could raise concerns with them.
- The matrons we spoke with had good knowledge of the areas for which they were responsible. Staff we spoke with had confidence in their local leaders and told us that matrons were approachable and visible and had regular presence on the wards.

- Junior doctors told us they felt well supported by consultants throughout the maternity and gynaecology service.
- Staff in maternity services spoke highly of the trust executive team and told us about a day when the Chief Executive Officer (CEO) spent a day working with them. The same experience however had not occurred within gynaecology services.

Culture within the service

- The trust had an iCARE philosophy of treating both staff and patients as individuals.
- The trust had a strapline 'the standard of care you walk past is the standard you expect'. This could be seen on walls throughout the hospital.
- Midwives, nurses and medical staff spoke positively about the care they provided for women. Staff reported positive working relationships and we observed that staff were respectful towards each other, not only within their area of work but across all disciplines.
- All staff were professional, friendly and welcoming. The midwives we spoke with were enthusiastic and were striving to deliver good quality care. Without exception, staff of all grades told us they were proud to work at the hospital and told us it was a good place to work. Many staff we spoke with would recommend maternity services and many of the nurses and midwives had received care and treatment there throughout their pregnancy and had delivered their babies there.
- The nurses we spoke with on Jasmine ward told us they were being supported by their matron and ward sisters but they were a new team who had been brought together to provide care and treatment for women requiring gynaecological procedures. Senior staff told us it had been difficult to recruit to the ward. There was a high vacancy rate and on the ward and a high usage of agency staff. There was a skills gap and a high number of medical and surgical outliers on the ward. Morale on the ward was low.
- Women and families we spoke with acknowledged a caring and positive culture and were mostly happy with their experience of care.
- Most midwives told us they felt supported to develop professionally.

Public engagement

- Feedback from women who had used the service was obtained in a number of ways, for example through

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informal discussions with women and their families, communications with the patient advice and liaison service (PALS), complaints and the NHS Friends and Family Test (FFT)

- Women undergoing a termination of pregnancy were given the opportunity to feedback on their experience. Participation was strictly voluntary and questionnaires were only left with patients who expressed they were happy to provide feedback. The questionnaires were given out by staff on the day of the procedure following a sensitive explanation of the purpose of the questionnaire. Women were provided with a pre-paid envelope for the purpose of returning the questionnaire.
- The trust had a social media page through which it advertised aqua natal classes.

Staff engagement







- The head of midwifery, midwifery matrons and community midwives attended meetings of the Somerset Service Liaison Committee (MSLC) on a quarterly basis. The MSLC is a forum for maternity service users, providers and commissioners of maternity services to come together to design services, that meet the needs of local women, parents and their families. For example, minutes of the meeting in September 2015 stated there were discussions around funding for breastfeeding clinics and mental health services.
- As part of their familiarisation with the service, the head of midwifery commissioned a staff survey in February 2015. The results of the survey were to be used to inform the future development of the service. The main aim of the survey was to enable the head of midwifery to establish what mattered to the staff. The results of the survey were mostly positive and the service was mostly seen as a friendly place to work which provided a good standard of care to women and their families. The head of midwifery anticipated the survey would be used to encourage staff to come forward to influence the future development of the service.
- Staff had been encouraged to contribute to the services vision for the future. This was particularly evident on Jasmine ward where there was a strong ethos around this being a new ward, a new team and building a new culture.

- At the time of our inspection midwives were working 13 hour days and 11 hour nights, there was due to be a consultation to change the working hours to 12 hour days and 12 hour nights. Union representatives were involved and some staff had expressed they were not happy about this.

Innovation, improvement and sustainability

- There was an enhanced recovery programme for women undergoing elective gynaecological surgery. [Enhanced recovery is an evidence-based approach used to enable people to recover more quickly following surgery]. Pre-operative assessment was an integral component of the enhanced recovery programme where women were given information to enable them to play an active role in their care. For example women were given information about nutrition, exercise and lifestyle choices such as smoking and drinking alcohol. Where appropriate minimally invasive surgical techniques were used and careful consideration for pain relief was adopted. Post-operatively women were encouraged to eat and drink as soon as possible and with good pain control they were encouraged to mobilise at the earliest opportunity.
- In order to prevent women being admitted to hospital to have procedures undertaken in an operating theatre, the service had developed an outpatient procedure clinic for minor procedures.
- A one stop outpatient clinic had been set up in January 2016 to offer women with abnormal menstrual bleeding a diagnostic hysteroscopy and treatment.
- In 2014 a Royal College of Obstetricians and gynaecologists (RCOG) review of the trust's department of obstetrics and gynaecology was commissioned by the trust's medical director. The purpose of the review was to assess the functionality and long term sustainability of the service, given the size of the service and leadership issues within the department. The findings revealed the service was sustainable given the distance from Yeovil to other surrounding units, but also highlighted areas of concern and recommendations for improvement.

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

Information about the service

Yeovil District Hospital provides a 24/7 service for children from birth through to adolescence. Services included a Special Baby Care Unit (SCBU) with eight cots, a 24-bed children's inpatient ward, and children outpatient services. Inpatient facilities have approximately 2,700 admissions each year. The inpatient ward had a dedicated oncology bed and beds for young adults up to 24 years. Outpatient services see approximately 9000 patients annually and SCBU has around 200 admissions per year.

Services for children included: cardiology, immunology, rheumatology, endocrinology, neurology, urology, paediatric surgery, clinical genetics, allergy, nephrology, cystic fibrosis, haematology/oncology and orthopaedics. Surgical services include day theatre with dedicated paediatric operating slots. Children also attend general outpatient clinics for ophthalmology, ENT (Ear Nose and Throat) and dermatology services.

We used a variety of methods to help us gather evidence in order to assess and rate services for children and young people based at Yeovil District Hospital. During our inspection, we visited the children's inpatient ward, the special care baby unit, children's outpatients, and surgical and critical care provision for children. We spoke with 13 patients or their relatives and 36 staff, including junior and senior nurses, nursery nurses, junior and senior doctors, allied health professionals, administrative and clerical staff.

We observed interactions between patients, their relatives, and staff, considered the environment and looked at 13 medical and nursing care records. Before our inspection, we reviewed performance information from and about the hospital.

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Summary of findings

Overall, we rated services for children and young people as requires improvement. We found:

The environment on Ward 10 presented a potential risk to young patients and children. The ward included a young person's unit, which cared for adult patients up to the age of 24 years of age. There was no barrier between the different areas and no way of preventing adults from potentially having access to young children. This also presented safeguarding risks to patients. We raised this immediately with senior managers at the trust. Senior managers said they were assured that patients were safe. However, we also wrote a letter outlining our serious concerns to the trust shortly after the inspection. Following our letter, the trust ensured through its senior team that the admission criteria for the young person's unit was followed i.e. that only patients in transition or those who have specific vulnerabilities were admitted. The trust have also commissioned a review of the area by the Royal College of Paediatrics and Child Health and have committed to implement their findings. Post inspection, the trust reported all admissions to this unit so stakeholders could monitor actions taken.

Whilst staff had been trained in safeguarding procedures there was not enough staff appropriately trained in child safeguarding as per intercollegiate guidance. A lack of appropriate training presented a risk to patients and a risk of staff not recognising signs of abuse.

We saw there was a lack of specialist beds for young people with mental health conditions. This meant that staff on Ward 10 cared for patients who required specialist mental health support rather than medical care. Staff and patients were at risk of harm from some patients who needed specialist mental health support. Staff had not had appropriate training to manage patients with aggressive behaviour.

There were not enough members of staff trained in European Paediatric Life Support (EPLS) training to meet Royal College of Nursing guidance of one EPLS trained member of staff on each shift. Medical staff were trained in EPLS and were available 24hours per day.

Data from the trust showed staff observing policies on hand hygiene had consistently been below trust standards

We saw managers did not always change staffing levels to reflect the acuity of patients on Ward 10. We saw from rotas provided by the trust the service did not always have access to a senior children's nurse at all times during a 24-hour period in accordance with British Association of Perinatal Medicine (BAPM) standards.

The service had not reviewed guidelines for staff since 2013. Four out of seven guidelines we reviewed did not have review dates meaning there was no assurance trust guidelines met the latest national guidance.

There were a limited number of transitional services available for young people.

The trust did not have a play service or play specialist. Hospital play specialists work with children, and their parents and carers, to help them cope while being treated in hospital or at clinics.

The environment presented a challenge to services. For example, parts of the building needed additional work and repair and patients could not use an outside play area due to it requiring further development. In addition, some facilities on Ward 10 were not suitable for disabled patients.

Outpatient clinics used a 'full booking' system for follow up appointments. The system provided patients with an appointment date upon leaving the clinic. This meant clinics could be booked up months in advance reducing the flexibility to manage appointments and contributing to higher cancellation rates.

The service could not assure the inspection team they had addressed risks presented to children and young people on Ward 10. There was a lack of oversight of ward admissions and a lack of progress against recommendations identified in a review of the service in 2012.

The governance and management of children's outpatients meant there was a lack of supervision, performance management and delays to allocating appointments. This led to some staff in outpatients feeling unsupported and a lack of leadership visibility on occasion.

Services for children and young people

However we also found:

Staff knew how to report incidents and when they had done so. We saw incidents investigated in accordance with trust policy and staff gave us examples of learning from incidents. We saw staff observed the Duty of candour in incident investigations. Staff had received training on the Duty of candour and could demonstrate how they had used it when things went wrong.

Equipment, including resuscitation equipment was suitable for patients of all ages. We saw staff checked and tested equipment regularly.

Medicines were stored in locked rooms, cupboards, and fridges. Staff monitored fridge temperatures using an automated monitoring system. Staff recorded and clearly documented key patient information on drug charts.

Staff worked together to assess and plan ongoing care and treatment in a timely way when patients were due to move between teams or services, including referral, discharge and transition.

Staff demonstrated through discussion their understanding of Gillick competence and understood the consent process. We saw staff ask parents about consent to treat patients and where parents were not present staff telephoned parents to gain consent.

There were appropriate assessments of patient nutrition and hydration. Where required, children, young people and baby's care plans included comprehensive nutrition and hydration requirements.

We saw strong and positive relationships between staff and patients, in particular regular users of children's services. Staff spent time getting to know patients and understanding their needs.

Staff involved patients, carers, and parents in care and treatment and ensured they understood their treatment and conditions. Staff in the Special Care Baby Unit encouraged parent involvement in their baby's care and treatment wherever possible.

Staff were compassionate and caring towards patients. Patients and their relatives/carers were positive about their care and treatment. The service had positive patient feedback results on the care and treatment they delivered.

The community nursing team provided a range of different services to meet the needs of patients. The team included specialists or nurses with an interest in specific conditions such as cystic fibrosis, oncology and end of life care.

Services for children and young people had a school based within the children's outpatients department. The school had a qualified teacher working Monday to Friday to provide education to patients who had been in hospital for long periods.

The trust had specialist staff to support and care for patients with learning disabilities and diabetes. Services could access translators, translation materials and interpreters.

Staff had access to specialist support for patients with mental health conditions. Staff could also access out of hours psychiatric advice and support for patients.

Services for children and young people

Are services for children and young people safe?

Requires improvement



Overall, we rated the safety of children and young people services at Yeovil District Hospital as Requires Improvement.

We found:

- Staff could not adequately protect children and young adults from potential abuse due to the mix of patients on the ward. The ward environment did not ensure that patients were safe from abuse and harm. We raised this immediately with senior managers at the trust. Senior managers said they were assured that patients were safe. However, we also wrote a letter outlining our serious concerns to the trust shortly after the inspection. Following our letter, the trust reviewed the admission criteria for the young person's unit. This included actions to ensure that all admissions would be in line with the trust's admission criteria. Following the inspection, the trust reported all admissions to this unit so stakeholders could monitor actions taken.
- The environment on Ward 10 presented a risk to young patients and children due to facilities not being suitable for disabled patients and poor maintenance and risk assessment.
- There was not enough staff appropriately trained in child safeguarding as per intercollegiate guidance. A lack of appropriate training presented a risk to patients and a risk of staff not recognising signs of abuse.
- There was a lack of countywide specialist beds for young people with mental health conditions. Staff and patients were at risk of harm from some patients who needed specialist mental health support. Staff had not had appropriate training to manage patients with aggressive behaviour.
- There were not enough members of staff trained in European Paediatric Life Support (EPLS) training to meet Royal College of Nursing guidance of one EPLS trained member of staff on each shift.
- Data from the trust showed staff observing policies on hand hygiene had consistently been below trust standards.

- Staffing levels met the average number of children and young people admitted to the ward area. However we saw from the data provided that when children and young people required individualised nursing additional nursing staff was difficult to obtain.
- We saw from rotas provided by the trust the service did not always have access to a senior children's nurse at all times during a 24-hour period in accordance with British Association of Perinatal Medicine (BAPM) standards.

However, we also found:

- Staff knew how to report incidents and when they had done so. The service investigated incidents in accordance with trust policy and staff gave us examples of learning from incidents.
- Staff had received training on the Duty of candour and could demonstrate how they had used it when things went wrong.
- Equipment, including resuscitation equipment was suitable for patients of all ages. We saw staff checked and tested equipment regularly.
- Medicines were stored in locked rooms, cupboards, and fridges. Staff monitored fridge temperatures using an automated monitoring system. Staff recorded and clearly documented key patient information on drug charts.
- Records were securely stored in locked trolleys. Records were comprehensive, clear and documented in accordance with General Medical Council standards.

Incidents

- Between January and December 2015, the service reported 113 incidents. Ward 10 reported the majority of incidents (75). Sixteen incidents related to clinical care (10 of which concerned staffing levels), 17 medication issues, 16 'failures to adhere to policy and procedure', and 26 security concerns including physical abuse, verbal abuse and self-harm. Of the 113 incidents, 84 were low/no harm, 13 moderate harm, and one severe harm.
- Serious incidents are events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, they warrant using additional resources to mount a comprehensive response. Between January and December 2015, the service reported one serious incident. The incident involved a 21 year old female self-harming, using a ligature to inflict harm. Managers

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investigated the incident in accordance with trust policy. The investigation identified actions and learning and we saw the ward had undertaken a review of ligature points on the ward.

- Staff knew how to report incidents, including near misses, through the trusts web-based reporting system. This followed the trusts incident reporting policy. The service had a clear procedure concerning investigating incidents. Senior nurses carried out initial action and management of incidents. They reviewed the impact and severity of the reported incident. A nominated investigating officer investigated the incident at the appropriate level. Senior managers were responsible for ensuring investigations were robust, identified trends and monitored progress against actions. This meant staff had clear roles and responsibilities in terms of incident investigation.
- The Patient Safety Steering Group identified and shared key themes and lessons learnt from serious incidents. The majority of staff we spoke with said they received feedback and learning from incidents. Managers shared feedback with staff by email, through team meetings and through one to ones with senior nurses. Staff gave us examples of learning from incidents and where practice had changed. For example, staff undertaking more frequent checks on patients known to have a history of self-harm and improving patient placement so they were more visible to staff.
- Staff reported incidents affecting the safeguarding of children and young people. We saw from reviewing incidents reported between January and December 2015. Incidents related to self-harm, abuse, and eating disorders. This was as per the trust incident reporting policy. We saw from details of the incident investigations staff contacted and worked with other stakeholders such as the police, Child and Adolescent Mental Health Services (CAMHS) and the local authority when required.
- Children's services had monthly perinatal mortality and morbidity meetings. Mortality and morbidity meetings were multi-disciplinary meetings to review deaths as part of professional learning. The meetings were attended by consultants, junior doctors and senior nurses from maternity and children's services. Staff recorded the meetings, we saw from minutes cases discussed, and learning identified. However, we did not see actions taken as a after the discussion recorded in the minutes of the meeting.
- The service conducted Child Death Reviews (CDR) in accordance with national guidance and in response to requests from the CDR Manager. Managers considered morbidity on a case-by-case basis with case note review and formal RCA undertaken. However, this was dependent on the level of complication. Staff discussed cases at rolling monthly governance meetings.
- The duty of candour is a regulatory duty relating 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 Patient Experience Manager contacted and involved patients and their families during the incident investigation. However, senior nurses and staff also informed patients and their families at the time of the incident to ensure they were aware of what had happened. The serious incident review group were responsible for ensuring staff had applied the duty of candour.
- All staff received a briefing on duty of candour at trust induction training as part of a session on 'Delivering High Quality Care'. The majority of staff we spoke with understood the principles of the duty of candour and gave examples of when they had applied them. One example we were given was a minor drugs error where no harm had come to the patient. However, staff informed the parents immediately and provided them with all the information they needed to know. Staff gave another example of when blood samples went missing from children's outpatients. We saw staff applied the duty of candour and recorded in incident investigations.

Cleanliness, infection control and hygiene

- Clostridium Difficile (C-Difficile) is a bacterium affecting the digestive system. It often affects people who have been given antibiotics. There were no reported cases of C-Difficile for children's services for the period January to December 2015.
- For the reporting period January to December 2015, the service reported zero cases of Methicillin-Susceptible Staphylococcus Aureus (MSSA). MSSA can cause infections called Septicaemia (blood poisoning) if it gets into the bloodstream. The service reported zero incidents of Methicillin Resistant Staphylococcus Aureus (MRSA) for the same period. MRSA is an infection that can cause problems if it gets into wounds or into the bloodstream.

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- The trust had a ward-based process in place requiring ward clerks to routinely monitor length of patient stays. They would alert the nurses when patients met the 28-day criteria for MRSA screening. The infection prevention and control team (IPCT) validated this with a trust-wide audit every six months. The IPCT provided feedback to senior nurses and staff at the time of the audit. The IPCT monitor MRSA cases using an electronic case management system. This meant should cases of MRSA occur systems were in place to monitor and manage the condition.
- As part of the trust mandatory training programme staff were required to undertake training on infection, prevention, and control. Data from the trust showed 92% of staff across the child health division had completed this training. This was better than the trust target of 90%.
- The service conducted hand hygiene audits. Staff achieved compliance by cleaning hands at points of patient contact for example, before and after providing care and treatment to a patient. Data from the trust showed overall compliance with hand hygiene on Ward 10 varied and was not consistent. Trust policy stated all staff should clean their hands before and after contact with patients. However, data for the period October 2015 to February 2016 audit showed compliance varied between 50% and 100%. This meant staff did not always clean their hands as often as they should have.
- The trust conducted a yearly patient-led assessment of the care environment (PLACE) survey. Patients and members of the trust conducted the PLACE to assess cleanliness, food, privacy, dignity and the environment. Data from the PLACE survey showed the trust performed better than the England average from 2013 to 2015. In 2015, the trust scored 100%, better than the national average of 98% for cleanliness.
- Ward cleaning schedules were visible and we observed staff adhering to these. In addition, staff (including nursing and domestic) said additional cleaning, including deep cleans, could be added to the schedule where required. We saw the ward was visibly clean with dated, green stickers attached to equipment to identify when staff had last cleaned it. However the cleaning schedule was dated 2011 and had not been updated since this time.
- We saw personal protective equipment (PPE) was available outside cubicles and bays. We observed staff using gloves and aprons when required and then disposing of them once they had finished their care of treatment of patients. This was as per trust policy.
- Wards had hand gel dispensers placed around the ward and we observed staff using them. All dispensers we checked were working and had gel in them. Ward 10 had hand gel dispensers lower down the walls for children to use encouraging children and young people to adhere to infection control practices.
- Staff employed safety systems and practices to ensure the risk of infection for patients was low. We saw SCBU staff changed baby-feeding tubes on a regular basis to ensure they fed babies through clean tubes and preventing blockages. Staff also changed cots and incubators on a regular basis to help ensure they treated babies in a clean environment.

Safety Thermometer

- The NHS safety thermometer is a national initiative, which uses a local improvement tool for measuring, monitoring, and analysing patient harm, and harm free care. It provides a monthly snapshot audit of avoidable harm including falls, new pressure ulcers; catheter related and urinary tract infections (CUTI). Staff reported any of these occurrences as incidents. Data from the trust prior to the inspection showed one incident of a grade 2 pressure ulcer reported in January 2015. There were no reported incidents of falls or CUTIs for the same period.
- The service used Paediatric Early Warning Scores (PEWS) to capture safety thermometer information. We looked at seven sets of patient records. Staff had completed all PEWS and risk assessments. We saw staff took appropriate action against findings and this was evidenced in care plans and patient notes. For example, we saw staff following catheter care bundles.

Environment and equipment

- The young person's unit (YPU) was situated at the entrance to the children's ward. The trust created the YPU for "those patients who were in transition from paediatrics to adult services for the management of complex and often chronic disorders. They anticipated there would also be individuals with special needs, including physical and intellectual disabilities that would prefer admission to an YPU. It consisted of two

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side rooms, a bay containing up to six beds and two bathrooms. There was no barrier between this area and the main children's ward. Staff informed inspectors of an invisible line between the two areas which adult patients should not cross. However, we saw children and young people in this area interacting on a regular basis. Staff stated that during busy periods, there was no way of being able to monitor the movement of adult patients. Therefore staff could not assure they protected younger patients from harm. The children's services staff survey identified staff concerns and suggestions there should be an age limit on the ward or a separate unit built. We wrote to the trust about our concerns and the trust have contacted the Royal College of Paediatricians and Child Health to conduct a review of the area. The trust have agreed to a review and redesign of this area following this review.

- On the 17 March 2016, we saw the children's toilet was out of service due to planned upgrading work. Therefore, children had to walk up to the young adult's area to use their facilities. This meant both adults and children were using the same toilet facilities. This presented a safety risk to younger patients.
- Children's and young people services used an environmental risk assessment tool and action plan to address possible ligature points around Ward 10. The risk register and subsequent actions helped staff to consider the placement of the most at risk patients on the ward. We saw the risk assessment and subsequent actions updated and reviewed. This helped patients to receive care and treatment in a safe and suitable environment.
- The environment and equipment were visibly clean. We checked 14 pieces of equipment and saw they had all been checked, tested and in date.
- Resuscitation equipment was available across the site where staff anaesthetised children. The equipment was appropriate for children and young people including the defibrillator. This was as per the Standards for Children's Surgery by The Royal College of Surgeons, 2013.
- We checked resuscitation equipment on Ward 10. The trolley and equipment was clean and staff checked them daily. All equipment was in date and ready to use. The trolley was equipped with equipment required for resuscitating children and young people of all ages, including adults.
- Staff in the SCBU stored baby milk in a milk kitchen. Staff stored milk (including mother's breast milk) in

locked fridges and freezers. Staff used a checklist to monitor the fridge and freezer temperatures to ensure milk was stored at the correct temperature. We reviewed the checklists and saw staff regularly checked the fridges and freezers.

Medicines

- Controlled drugs (CD) are medicines requiring additional security. Staff kept medicines in locked rooms and were only accessed by staff. Medicines were all in date, sealed and stored securely in locked fridges and cupboards. Staff monitored fridge temperatures using an automated fridge temperature recording and monitoring system. Staff could describe the escalation procedure if the temperature was not within the defined limits. Staff also recorded this as an incident through the incident reporting system.
- We looked at five patient drug charts. Staff recorded and clearly patient allergies, height and weight on admission. Staff weighed the majority of children and young people with minimal clothing to allow for accurate calculations of drugs. This was in line with Royal College of Nursing 2013, Standards for the weighing of infants, children and young people in the acute health care setting and the Children's British National Formulary, which states, staff should take into account a patient's height when prescribing medication. During the inspection, we saw a pharmacist checking drug charts to ensure they were accurate.
- Nursing staff were aware of policies on administration of controlled drugs as per the Nursing and Midwifery Council, Standards for Medicine Management.
- A senior paediatric pharmacist provided support in oncology, with prescribing support provided by another provider. This was because it was a small hospital and they did not have high enough patient numbers to keep competencies up. This arrangement reduced risks to patients.

Records

- We looked at 13 sets of patient records. Records were comprehensive, clear, legible, signed and dated as per General Medical Council standards. Doctors used structured forms to record examinations and we saw they filled them in, dated and signed them after every examination. Care plans were personalised and reflected risk assessments and diagnosis.

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- Medical records were all stored in lockable trolleys. We saw the trolleys were locked the majority of time ensuring patient confidentiality. We observed one occasion where staff left a trolley open and unattended.

Safeguarding

- The trust has a child protection policy and procedures, developed in line with the South West Child Protection Procedures. This is available to all staff via the trust intranet. The trust works with the South Somerset and Mendip MARAC. (Multi Agency Risk Assessment Conference). The trust hold bi monthly safeguarding meetings and works with the local safeguarding children's board.
- The service had designed the YPU to support the trusts transitional arrangements for young people who may have been known to the children's ward. In addition, the service designed the YPU for young adults with long-term conditions and complex needs. The Yeovil District Hospital Safeguarding Children, Biannual report 2013-2015, states, "It is important to emphasise that the patients admitted to the YPU be viewed as being potentially in need of safeguarding themselves". However, during our inspection we saw the YPU had seven adults between 18 and 24 years old admitted to the ward who did not meet the criteria. Three members of staff and one parent of a patient told us they were concerned about adults placed on a children's ward. This presented a risk of adults not known to the service having unsupervised access to children on the ward.
- Staff said adults and children were located at separate ends of the ward and staff monitored patient activity and movement around the ward. However, during our inspection, we saw on two occasions where adult and children patients were mixing on the ward. There was also an adult patient placed in a bed in the children's area of the ward. When the inspection team spoke to ward staff, they said there was no physical barrier by way of preventing adult patients from wandering down the ward unsupervised, especially during busy periods for staff.
- During our inspection, we spoke with a female patient accompanied by her children and partner onto the ward. This patient's family remained on the ward while the patient left the ward to receive treatment and care. We observed the children playing in the children's play area with the sick children on the ward. This presented a safety and infection control risk to all children.
- There were three incidents reported between January and December 2015 involving possible safety risks to children and young people. One involved patient on the Young Persons Unit. This was reported to the trust by the Adult Mental Health Crisis Team stating that this person had history of violence and sexual aggression. This patient was immediately removed from the unit. A further two incidents were reported which involved inappropriate behaviour by young people. While the service dealt with all these incidents appropriately this highlighted the inspection teams concern regarding the type of adults admitted to Ward 10 and lack of processes in place to prevent patients from accessing all areas of the ward. The safeguarding arrangements for children and young people were inadequate. We raised our concerns with senior managers at the trust whilst on site. Senior managers said they were assured that patients were safe. We wrote to the trust about our concerns and the trust have contacted the Royal College of Paediatricians and Child Health to conduct a review of the area. The trust have agreed to a review and redesign of this area following this review to ensure appropriate separation of children and young people. The trust have also strengthened their admission criteria to ensure that only patients in transition or those with specific vulnerabilities are admitted to the unit. Following the inspection, the trust report all admissions to this unit to stakeholders so they could monitor actions.
- Intercollegiate guidance 'Safeguarding Children and Young People: Roles and competencies for Health Care Staff' published in March 2014 sets out non-clinical and clinical staff who have some degree of contact with children and young people and/or parents/carers should be trained to level two in child safeguarding. It also states all clinical and non-clinical staff who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person should be trained to level three in safeguarding.
- Data from the trust showed 92% of non-nursing (Nursery Nurses and Healthcare Assistants) staff had completed level two child protection training. However, none of these staff were trained in level three. Data from the trust showed 54% of nursing staff had completed level three training at the time of our inspection. The overall trust completion rate for staff trained to level three was 61%. This meant staff did not have the appropriate level of training as per intercollegiate guidance and a lack of

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training could put children and young at risk. A senior nurse acknowledged not all staff were trained to level three however more sessions were being planned and it was expected those only trained to level two would attend.

- The trust had a dedicated safeguarding team and structure. The team reported to the trust safeguarding children and adults lead and included a full-time band six safeguarding children practitioner. A safeguarding practitioner, based on Ward 10, provided advice help and support to staff on the ward and children's outpatients. The safeguarding practitioner was also involved in following up did not attend (DNA) outpatient appointments with school nurses and health visitors. The team included safeguarding specialists, specialist nurses in learning disability care and dementia care. There was a regular clinic for 'looked after' children providing health reviews.
- All staff we spoke with knew what to do if they had concerns regarding the safety of a child or young person. All staff knew how to access the trust safeguarding and child protection policies and knew who their safeguarding lead was.
- The trust had processes in place to safeguard women and children at risk of female genital mutilation (FGM). We saw staff had access to FGM guidelines and protocol on the trust intranet and managers displayed a flow chart for referrals in the doctor's office. This included contacting the police immediately if staff treat a female under 18 who has had FGM as per Department of Health guidance. Staff said that although they had never used the guidance it was important to ensure processes were in place just in case.
- The trust safeguarding team had a database of children who were subject to child protection plan. A child protection plan details the ways in which the child is to be kept safe. When staff treated a patient subject to a child protection plan on the ward the safeguarding team contacted social care services to make them aware. Staff said the details of the plan would influence the care and treatment of the child.
- All children, children's social care, police and health teams had access to a paediatrician with child protection experience and skills (of at least level 3 safeguarding competencies). They could speak to the consultant of the week or a designated paediatric

doctor who could provide immediate advice and subsequent assessment, if necessary, for children under 18 years of age where there are child protection concerns.

- Staff received safeguarding supervisions. Staff supervision was case specific and held in both regular scheduled sessions and ad-hoc meetings as the caseload required. Reflective practice was encouraged and guidance offered to practitioners. Staff kept records where appropriate, in case notes / patient action plans. Whilst there were records of supervisions taking place, staff did not formally minute sessions to encourage free, open and honest discussions in a safe environment. If staff raised any issues of concern during a supervision session concerning an individual's practice, they would draw up an action plan, and the matter escalated to the appropriate senior staff.

Mandatory training

- The trust had a mandatory training programme which staff were required to attend on a yearly basis. Subjects included in the programme were fire safety, infection control and manual handling. The trust standard for mandatory training completion rate was 90%. Nursing staff had a completion rate of 91.5%, medical staff 90.5%, non-nursing staff 84.3%. All staff we spoke with said they were up to date with their mandatory training.

Assessing and responding to patient risk

- Staff used Paediatric Early Warning Scores (PEWS), to record routine physiological observations such as blood pressure, temperature and heart rate. Early warning scores enable early recognition of a patient's worsening condition by recording observations and assessing these using a scoring system. This prompted nursing staff to get a medical review at specific trigger points. The service had an escalation policy and procedures if patients hit trigger points. Staff used PEWS for surgical and non-surgical admissions as well as for post-operative observations. This was in line with Royal College of Anaesthetist and other national guidance on the use of PEWS.
- We reviewed eight sets of patient records and all contained completed risk assessments. We saw in six out of seven notes staff recorded actions and escalation to senior nurses or consultants appropriately. Staff in

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SCBU completed daily infant checks including jaundice, eyes, mouth and skin. This meant staff appropriately filled in risk assessments and recorded actions the majority of the time.

- In one set patient records we saw no action recorded after a patient's condition had met a trigger point. Therefore, there was a risk of the patient not receiving appropriate or timely care and treatment
- Surgical services allocated Consultant Anaesthetists to all theatre lists where a child was listed for surgery. This was in line with The Royal College of Anaesthetists, Guidelines for the Provision of Anaesthetic Services (GPAS) 2015.
- Allied health professionals had a prioritisation matrix for weekday service. This meant therapists could prioritise patients who had the most urgent need. The matrix contained criteria therapists used to identify the most urgent patients. Allied health professionals saw patients with the most need within 24 hours of admission.
- Trauma theatre sessions for children and young people ran daily in main theatre. The trauma co-ordinator supported and managed the transfer of children requiring surgery for trauma injuries. Theatre staff and the trauma co-ordinator worked in partnership with Ward 10 to support patient admission.
- There was a lack of countywide specialist beds for young people with mental health conditions. Ward 10 staff told us patients whom used CAMHS sometimes presented a risk to themselves, patients, and staff. This was because sometimes patients displayed aggressive, self-harming or intimidating behaviour. Some members of staff told us they had been scared or intimidated in the past. We saw from details of incidents patients 26.6% of incidents referred to issues around CAMHS patients on Ward 10 (March 2015 – February 2016). Some of these patients were over 18. Incidents included restraint, self-harm (including the use of blades and ligatures), absconding as well as physical and verbal abuse.
- Training in managing patients who used the CAMHS service was provided by staff from the CAMHS service. This was on going at the time of our inspection and not all staff had received the basic briefing session for half a day. There had been 31 patients using CAMHS admitted to Ward 10 between January and December 2015. Staff had identified in their staff survey they required further training to improve staff awareness and skills in working with patients with mental health conditions. Managers at the trust said they were going to introduce conflict resolution training for Ward 10 staff to support staff to be able to deal with difficult situations. Managers had also changed the admission criteria to ensure patients would not be admitted onto Ward 10 whose predominant need was mental health.
- There were four members of nursing staff trained in advanced or European Paediatric Life Support (EPLS) across children's services. Therefore, this meant there was not a nurse with advanced life support trained on every shift. RCN guidance states there should be at least one member of staff trained in advanced or EPLS on each shift. This presented a risk to rapidly deteriorating patients who may require specialist support and intervention. A senior nurse said more staff were booked to attend the next training over the next few months.
- There were three members of non-nursing staff working in outpatients. Outpatients had an administrator, a nursery nurse and a healthcare assistant. None of the staff had received paediatric life support training and therefore if faced with a deteriorating patient had to rely on a doctor being present or support from Ward 10. This presented a risk to patients who fell ill suddenly. Staff told us they were on the list to undertake the training and a previous session cancelled due to lack of numbers.
- Data from the trust showed 84% of nursing staff were trained in Paediatric Immediate Life Support (PILS). The resuscitation council developed PILS in response to a demand from healthcare professionals who may have to act as first responders and treat seriously ill children or children in cardiac arrest until the arrival of a cardiac arrest team.
- The service had process to manage deteriorating and seriously ill patients. In the event of a child or young person becoming seriously ill, staff transferred the patient to the hospital ITU to be stabilised before transferring them to another hospital. There were the required skills, experience, and equipment in ITU to care and treat young patients. Children's services had access to a local retrieval team who transported patients to other hospitals who specialised in treating seriously ill children. Staff said the service was well used and valuable to them when looking after for transferring seriously ill patients
- The SCBU had procedures in place with the Neonatal Emergency Stabilisation Team (NEST). The NEST Team respond to emergency calls regarding sick newborn

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babies and once they have been stabilised, transports them promptly and safely between neonatal units and hospitals across the South West. The unit spoke to the NEST team on a daily basis to provide updates on bed status, pending admissions and status of activity on the Labour Ward.

Nursing staffing

- The Royal College of Nursing (RCN) guidelines of one nurse to every three children under two years and one nurse for every four children over two years. On average there were three qualified nurses on duty supported by a healthcare assistant on day shifts and three qualified nurses on night duty. This number was not sufficient to meet the guidelines if the ward was full. However having reviewed the data submitted by the trust on average over the last four months the trust had only six patients on the ward a day. Of these a third (two patients) are likely to be under two years of age. Therefore the numbers planned are sufficient for the number of patients on the ward.
- Senior nursing staff said staffing levels changed according to bed occupancy and patient acuity. This included dependency and acuity of CAMHS patients, the need for one to one care, elective activity, and age range of patients. Matron or the clinical site manager (in the absence of Matron) made decisions on additional staffing requirements. The service mostly filled staff absences or provided additional filled with RSCNs and nurses who work regularly within the team.
- Royal College of Nursing guidance, Defining staffing levels for children and young people's services, states where services are provided to children there should be access to a senior children's nurse for advice at all times throughout the 24-hour period. Information provided by the trust showed planned rotas did not have a senior nurse available throughout the 24-hour period.
- The service did not subscribe to a formal acuity tool. However, staff knew the core standards set by the Royal College of Nursing (RCN) Guidelines for Safe Staffing for Children and Young People Services. The guidance states nursing ratios of over 70:30 registered to unregistered nurses, including two, usually three Registered Nurse Child Branch on duty at all times. Nursery Nurses acted as the non-registered portion of the skill mix and we saw registered staffing levels met this standard.
- Senior nursing staff conducted acuity audits to ensure the right levels of staffing were in place to care for the different needs of patients. We reviewed patient acuity audits between May 2015 and December 2015 and saw staffing levels did not always meet patient need. For example, we saw when the ward had either high dependency patients, patients using CAMHS, or patients who required one to one support there no adjustments in staffing ratios in six out of the eight months we reviewed. Half the staff we spoke with said it was sometimes difficult to get extra care for patients who needed lots of support.
- The acuity audits were not fully completed twice daily in five out of the eight months (August to December) as per British Association of Perinatal Medicine (BAPM) standards.
- There was a low number of vacancies in Children and Young People's services. There was 0.4 whole time equivalent (WTE) vacancy in nursing staffing. The sickness rate for the service was 3.3% slightly above the trust average of 1.7%. The turnover rate was 7% (three members of staff), below the trust average of 8.5% for nursing staff. This suggested it was a stable service with patients receiving consistent and continuity of care.
- Ward 10 had an average of 11% bank and agency use between April 2015 and February 2016, the Special Care Baby Unit (SCBU) 10.7% for the same period and outpatients zero percent. Senior nurses managed vacancies and absences by using agency, bank staff or qualified children's nurses from other areas of the hospital. Bank staff were mainly staff currently employed by the trust meaning patients received care and treatment from staff correctly trained and familiar to them.
- The service had twice-daily nursing handovers. Staff conducted handovers in a private office to ensure patient privacy and confidentiality. We observed a nursing handover and saw it was comprehensive with staff discussing staffing for the ward and each patient in turn. Staff discussed patient diagnosis, care, treatment and any outstanding issues.

Allied Health Professional and Non-Nursing Staffing

- Allied health professional staff included occupational therapists, dieticians and physiotherapists. Between August and November 2015, the sickness rate for allied health professionals was an average of 0.6%.

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- Data from the trust for the period September to November 2015 showed actual allied health professional staffing met or was above planned levels. Dieticians were almost in line with the planned 8.6 WTE with 8.4 WTE staff working during this period. In-patient therapists rose between 37 and 39.8 WTE against planned levels of 33.4 WTE.
- A Healthcare Assistant (HCA), a nursery nurse, and a receptionist staffed the children's outpatients department. The HCA and nursery nurse supported consultants and took patient measurements. However, we saw the receptionist had limited capacity due to the range of tasks and roles involved in running the outpatients department. The number of administrative tasks affected the booking and processing of appointments. In the event of the receptionist being absent from work managers filled the absence with temporary staff who were unfamiliar with the processes and systems in outpatients. A receptionist said working on children's outpatients was "the most stressful job I've ever had". Managers we spoke with said they were looking at how to improve support to the reception role and streamline processes.

Medical staffing

- Services for children and young people had a total medical staffing establishment of 16 whole time equivalents (WTE). Most of the staffing establishment consisted of consultant posts (38%), with 19% middle career grades, 25% registrars, and 19% foundation year doctors. There were no vacancies for medical staff and despite trust data identifying zero percent locum use (April 2015 to February 2016), two locum consultants worked in children's services at the time of the inspection.
- At any one time there were up to seven consultants working during the day. The service was planning to make a locum consultant post substantive to add to the numbers of permanent medical staff. This was in response to a shortage of senior doctors.
- The Royal College of Paediatrics and Child Health (RCPCH) recommendations for medical staffing are a minimum of ten senior doctors working an on-call rota. The on call team consisted of one consultant, one middle grade and one Senior House Officer (SHO) doctor. Therefore, the service was not meeting this guidance. However, the service was small compared to other trusts and the inspection team saw rotas were safe for a service of this size. In addition, the trust provided 24 hour, seven days a week paediatric consultant cover with full middle-grade "safety net" and junior support.
- On call day shifts for middle grades and SHO doctors ran from 8:30am to 9:00pm. The night team began shifts at 8:45pm to 9:00am to allow for handover. On call consultants were resident during the day from 8:30am to 5:00pm and the non-resident consultants on call from 5:00pm to 8:30am.
- Medical staffing for the special care baby unit met British Association of Perinatal Medicine (BAPM) standards. One SHO and one middle grade doctor worked on the ward from 8:30am to 4:30pm. There was consultant cover for a 14-hour period during the day, more than the 12-hour period recommended by the BAPM.
- Children's services operated a "Consultant of the Week" system with each consultant responsible for the care of all inpatients for a week starting on a Friday morning. During this week, other consultants covered three nights on call. At night and weekends, there was a resident middle-grade and junior doctor, and non-resident consultant on-call. A consultant on a daily basis reviewed all inpatients.
- The service had two medical handovers during the course of a 24-hour period. Handovers occurred at 8:30am and 8:30pm between day and night shifts. We observed a medical handover during our inspection. Each doctor had a computer-generated list, which included patient details and was patient focussed. The handover discussed patient's current problems and their care plans. However, we saw handovers were unstructured and other medical staff constantly interrupted junior doctors. The handover did not discuss expected patients, risks or staffing arrangements meaning there was a lack of planning and awareness of what medical staff expected for the upcoming shift. The trust had a formal handover agenda which included these items.
- Patients saw and had access to a consultant within 14 hours of admission to the paediatric ward. We reviewed patient notes and saw consultants saw patients in a timely manner by consultants and junior doctors. A paediatrician saw or discussed with patients their case before discharge and we saw minutes of discharge meetings reflecting this.

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- Consultant surgeons managed the ongoing care of postoperative patients, with support from consultant paediatricians where necessary. This was in line with The Royal College of Surgeons 2013 Standards for Children's Surgery. Patients and their relatives we spoke with said they had seen their surgical consultant pre and post operation.

Major incident awareness and training

- Children's services were included as part of the trust major incident policy. The service had procedures in place, in light of a major incident occurring, to use outpatients to look after staff children should they require childcare. In addition, staff on Ward 10 would also support the emergency department triaging patients as well as any 'walking wounded' patients cared for on Ward 10.

Are services for children and young people effective?

Good



Overall, we found effective in services for children and young people as Good.

We found:

- There were appropriate assessments of patient nutrition and hydration. Where required, children, young people and baby's care plans included comprehensive nutrition and hydration requirements.
- Nurses recruited from overseas received a comprehensive induction to the trust including competency assessment. Nursing staff at different levels supported overseas nurses to integrate into the service.
- Staff said training and professional development was good. Staff gave us examples of extra training they planned to take or had taken to enhance their skills.
- Staff worked together to assess and plan ongoing care and treatment in a timely way when patients were due to move between teams or services, including referral, discharge and transition.
- Staff demonstrated through discussion their understanding of Gillick competence and understood the consent process. We saw staff ask parents about consent to treat patients and where parents were not present staff telephoned parents to gain consent.

However, we also found:

- Staff did not always work to the latest National Institute for Health and Care Excellence (NICE) guidance.
- The service had not reviewed guidelines for staff since 2013. Four out of seven guidelines we reviewed did not have review dates meaning there was no assurance trust guidelines met the latest national guidance.
- There were a limited number of transitional services available for young people.
- The trust did not have a play service or play specialist. Hospital play specialists work with children, and their parents and carers, to help them cope while being treated in hospital or at clinics.
- There was not always quick access to information when booking children's outpatient appointments.

Evidence-based care and treatment

- Staff worked to guidelines based on Royal College or National Institute for Health and Care Excellence (NICE) guidance including diabetes, neonatal jaundice and forensic paediatric examination. Staff used charts and forms to inform the examination of patients. Staff used charts and forms based on the latest guidance.
- We reviewed guidelines produced by the trust for elements of patient care including general paediatric medicine, oncology, neonatal medicine, cystic fibrosis and epilepsy. We saw the service had not reviewed the majority of guidelines since 2013. For example, 69 out of 71 oncology guidelines, not been reviewed since 2013. We looked at seven guidelines in detail and four out of seven did not have review dates meaning processes to review policies were inconsistent.
- We asked staff about how they delivered evidence-based care and treatment. Most staff we spoke with, including a band six nurse could not tell us what national guidance they used to deliver care and treatment to patients. We saw two trust guidelines did not refer to NICE or other national guidance meaning staff would have not been aware of what national guidelines they were following. For example, Bronchiolitis guidelines reviewed in 2015 did not mention the NICE 2015 (NG9) Bronchiolitis in Children: diagnosis and management guidance.

Pain relief

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- In a survey conducted by the trust an average of 91.4% of patients said they thought doctors and nurses did everything they could to make the pain go away.
- The Acute Pain Team covered the paediatric ward and service. If called to see a child/teenager for pain control, formal liaison with a senior pharmacist and ward staff occurred, as doses were usually weight based. The pain team and staff liaised with Great Ormond Street Hospital for advice on the pain needs and management of babies.
- The Acute Pain Nurse was not trained specifically in paediatrics but worked closely with the paediatric team so all aspects of pain management could be considered.

Nutrition and hydration

- There were appropriate assessments of patient nutrition and hydration. Where required, children, young people and baby's care plans included comprehensive nutrition and hydration requirements. On SCBU, charts were fully completed detailing baby feeds, the amount the baby received and how the baby consumed the food (through a tube or bottle). This meant staff appropriately assessed planned and monitored nutrition and hydration.
- Patients told us they had able to get a range of drinks regularly when required. The food was varied and of a good standard. Parents and carers said staff checked drinks orders to ensure they were correct according to any dietary or patient requirements.
- Nurses stored milk securely for babies and each baby had their own milk box which contained milk and feeding equipment specific to the baby. This included equipment used for milk preparation. This helped staff to check babies received the right milk. Incident data from the trust between January and December 2016 showed there had been no reported incidents of babies receiving the wrong milk.

Patient outcomes

- The service reviewed the effectiveness of treatment at care through national audits including the Paediatric Diabetes Audit and National Neonatal Audit.
- The Paediatric Diabetes Audit is an audit to highlight how many patients have controlled diabetes. Results from the 2013/14 audit showed Yeovil District Hospital performed better than the England average for numbers of patients with controlled diabetes. This demonstrates the effectiveness of care for children and young people

with diabetes. We saw evidence of learning from this audit. The trust had identified seven recommendations to improve services for patients. We reviewed the work plan and saw the service was on target to achieving the recommendations by April 2016.

- The National Neonatal Audit Programme (NNAP) 2014 showed the trust performing worse than the NNAP standards in three out of five audit areas. This included the percentage of babies less than 29 weeks having their temperature taken within first hour after birth (0% against a target of 98-100%). However, this was because the trust had very small numbers of babies under 29 weeks old (one in 2014 and two, in 2013).
- The trust performed worse than NNAP standards for mothers receiving any dose of antenatal steroids (77% against a target of 85%), and documented consultation with parents by a senior member of the neonatal team (90% against a target of 100%). Service managers said the mothers who did not receive steroids delivered at the hospital very shortly after arriving at the unit and there was not enough time to either transfer the mother to a regional unit or give her steroids before delivery. In 2014, the trust scored well for other standards including 100% for breast feeding rates for infants throughout their stay.
- The service conducted local audits to measure patient outcomes. This included an audit of Palivizumab Use for RSV Prophylaxis. Palivizumab is an antibody produced by DNA technology. It is used in the prevention of respiratory syncytial virus (RSV) infections. Findings showed there was improvement in the use of Palivizumab against trust guidelines with 100% of selected cases (previously 67%) meeting the guidelines. As part of the action plan and recommendations, the trust had changed its guidance to reflect 'gold standard' guidance.
- The trust also conducted a local audit on Essential Medical Surveillance for children with Down's Syndrome. Children with Down Syndrome are a higher risk of developing potentially treatable conditions. The Down Syndrome medical interest group (DSMIG) had set out a minimum standard of basic medical surveillance. The aim of this study was to audit current practice for surveillance of Down Syndrome across the trust and compare to guidelines from DSMIG. The service introduced a sticker to use in order to make sure staff

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documented investigations clearly based on audit recommendations and findings. The service planned a re-audit in two years to assess the effectiveness of the sticker.

- The emergency re-admission rate within 2 days is better than the England average for non-elective admissions for children between 1 – 17 years. The rate of multiple readmissions within 12 months for asthma is better than the England average for children 1 – 17 years. There were no emergency readmissions for children between birth and 17 years.
- Some staff including band six nurses did not know how they collected, monitored and shared outcomes. This meant staff could not identify learning from audits, how they changed or influenced practice.
- Consultants filled in patient outcome forms after clinic appointments. The form included change of address, the date and details of the next appointment, external referrals, referral to treatment time, and information on did not attend (DNA). Medical staff had not filled in seven out of 14 outcome forms we reviewed, or they had information missing. The receptionist would obtain information from consultants in the event of missing information. The service audited outcome forms and administrative staff added the information to the Patient Administration System (PAS).

Competent staff

- The appraisal rate for all staff across paediatrics was 85.6% for the reporting period April to December 2016. The trust measured appraisal rates from April to March each year. All medical staff (100%), 68% of nursing staff and 86% non-nursing staff had received an appraisal. Eighty Nine percent of administrative had received appraisals by December 2015. All staff we spoke with said they had received an appraisal.
- The service had recruited a number of nurses from overseas. The trust provided the nurses with a thorough three-month induction programme including theory sessions and a 13-week placement. If the nurse met the required standards at the end of this period, they would obtain their pin numbers. We spoke to one overseas nurse who said peers and senior nurses had supported her at every step of her transition into the hospital.
- All departmental Nursing and Midwifery Council (NMC) registered nurses hold a paediatric qualification. Nursery nurses provided additional support to nursing staff on Ward 10. Nursery nurses were trained in level

three childcare and received health care assistant training so they could perform basic medical care duties. This meant staff were appropriately trained to care for children and young people.

- The trust trained nursery nurses working in children's outpatients to take blood samples and electrocardiograms (ECG). An ECG is a test, which measures the electrical activity of your heart to show whether it is working normally. There were plans to introduce this training to the four Nursery nurses working on Ward 10 so they could develop their competencies.
- All staff we spoke to said in house training and development was good. We saw junior medical staff acting up in senior roles. Junior doctors said they received plenty of time for training and they received support from consultants. One junior doctor said consultants will "even come in to support with tricky families" and difficult situations. Non-nursing and nursing staff said there were many opportunities for development and study days allocated for training and learning.
- Nursing and non-nursing staff had link roles within children's services. Link roles have the responsibility of keeping up to date with and informing staff of specific subjects to aid continuous learning. Nursing and non-nursing staff usually undertake these roles on hospital wards..
- Nursing and non-nursing staff said they received support and regular one-to-one supervisions from senior nursing staff.
- Children's services had policies in place to manage the transfer of a child with a time sensitive condition and to manage critically ill children when there was a delay in retrieval from a Paediatric Intensive Care Unit (PICU) retrieval team. Staff knew the policies to call the South West Retrieval Team when required.
- We saw from patient children referred with an acute medical problem were seen by, or had their case discussed with, a clinician with the necessary skills and competencies before they were discharged. Minutes of multi-disciplinary meetings demonstrated the involvement of therapists, doctors, community and acute nurses who were specialists relevant to the patient's ongoing care.
- One member of staff working in children's outpatients had not received any learning or development objectives since arriving in October 2015. The member

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of staff was unclear on line manager and supporting arrangements. Managers said this was due to ongoing discussions on line management arrangements. This was because of the member of staff's specific role within the service. This issue was due to be resolved shortly after our inspection in March 2016.

Multidisciplinary working

- The trust had a limited number of transition service available for young people and at the time of the inspection were developing a transition policy. The service had a young person's unit situated on Ward 10 to support young people's transition into adult medical services. Adult doctors would treat young people between 18 and 24 years but in a familiar environment to the patient. There were some specific transitional clinics for children and young people including diabetes and rheumatology where adult clinicians would sit in paediatric clinics with young people and get to know them prior to transferring their care.
- The trust cystic fibrosis service stopped at the age of 18 for patients. However, there were arrangements to refer patients on to other services. The service referred patients to adult services at another trust, which specialised in care for adult patients with cystic fibrosis.
- The trust had set up a steering group to monitor and deliver an action plan of improvements and developments to transitional services. Areas of development included; diabetic services, young people with complex needs, cardiac and epilepsy. Children's and young people's services were also in the process of adopting the Ready, Steady, Go programme used by a nearby trust. The Ready, Steady, Go programme supports children and young people over 11 years of age to have the confidence to move into adult services.
- In addition, there was a dedicated action plan for the management of paediatric patients with diabetes, which included the use of Ready, Steady Go materials, self-management apps, skype consultations and text messaging to increase engagement. All diabetic patients in transition had a named co-coordinator and the trust achieves Best Practice Tariff for these patients.
- The trust did not have a play service or play specialist. Hospital play specialists work with children, and their parents and carers, to help them cope while being treated in hospital or at clinics. Senior nurses knew the

value of the service and the importance of the role. The Matron had submitted a request to the board for further funding to reintroduce the service and at the time of the inspection was waiting to hear the outcome.

- Staff worked together to assess and plan ongoing care and treatment in a timely way when patients were due to move between teams or services, including referral, discharge and transition. The service had multidisciplinary meetings internally and with a range of providers, including social care and we saw evidence of these in patient records and minutes of multidisciplinary meetings. For example we reviewed minutes of a discharge planning meeting which involved hospital nursing and medical staff, social care, GPs, therapists the patient and their family. This also demonstrated the service had mechanisms for sharing appropriate information with GPs, other relevant professionals and ensured the child and family fully understood what was happening.
- Children's services had access to an integrated physiotherapy and occupational service. The service had dual trained rehabilitation assistants. Physiotherapy and occupational therapy were available to patients seven days a week. We saw evidence of physiotherapy input in patient records and therapists attended children's MDT meetings.

Seven-day services

- The physiotherapy and occupational therapy department at Yeovil District Hospital NHS Foundation Trust provides a seven day flexible service to ensure the maximum number of patients can be seen and the priorities within the service are covered safely
- Outpatient services were available Monday to Friday 8:30am to 4:30pm.

Access to information

- When patients moved between teams and services, including at referral, discharge, transfer and transition, staff shared the information needed for their ongoing care appropriately and in a timely way. Staff shared information through meetings and staff had access to the appropriate information so they could discuss ongoing patient care. The SCBU staff shared information on a daily basis with the Neonatal Emergency Stabilisation Team (NEST) to ensure they had the very latest information to respond and transfer seriously unwell babies quickly.

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- When patients transferred between hospital teams, for example after operations, we saw surgical teams handing over to medical teams verbally and through patient records and charts. This meant staff had access to the right information in a timely manner to ensure the continuation of care for patients.
- Medical staff sent care summaries to GP practices as part of ongoing work to plan the patients care in the community. Care and patient records were available and discussed with GPs at meetings, over the phone, or by letter. Paediatricians were available on the phone to discuss with GPs any elements of patient care.
- The Paediatric Outpatient Receptionist was responsible for booking all follow-up appointments, in line with the rest of the trust. When a “new” patient referral was received via the e-Referral system (formerly known as Choose and Book) by the Outpatient Receptionist, they would reserve an appointment slot for this patient but the actual booking activity was completed for all e-Referrals by the contact centre. Initial booking information arrived at the central contact centre that in turn sent the information on to reception. Reception staff sent the information to the consultant who would sign off the referral and pass it back to reception who could then book the appointment. This process meant staff did not always deal with referrals quickly as a result.
- Data from the trust showed 99.9% of patients had their full medical records available for outpatient clinics. Therefore, consultants had access to patient records and could recommend care and treatment based on the full information available to them. The clinic preparation team monitored and recorded records that were not available for clinics.

Consent

- Gillick competence is a term used in medical law to decide whether a child (16 years or younger) is able to consent to his or her own medical treatment, without the need for parental permission. Staff demonstrated through discussion their understanding of Gillick competence and understood the consent process.
- Staff gave examples of how they obtained parental or appropriate consent including before taking blood samples. We saw staff ask parents about consent to treat patients and where parents were not present staff telephoned parents to gain consent.

- We saw staff had consent forms had spaces for both parents and older children/young people to sign. Staff encouraged both parent and child to sign the form and we saw in patient's notes occasions where this had happened.
- We reviewed children's and babies notes for evidence of consent processes and saw completed consent forms for specific investigations, for example, prior to surgery. Staff sought consent for surgical procedures on the day of procedures. We saw evidence parents and children were involved in the consent process.

Are services for children and young people caring?

Good



Overall, we rated caring for children and young people services as Good.

We found:

- Staff were compassionate and caring towards patients. Patients and their relatives/carers were positive about their care and treatment. The service had positive patient feedback results on the care and treatment they delivered.
- Staff respected patient and parent's privacy and dignity.
- We saw strong and positive relationships between staff and patients, in particular regular users of children's services. Staff spent time getting to know patients and understanding their needs.
- Staff involved patients, carers, and parents in care and treatment and ensured they understood their treatment and conditions. Staff in the special care baby unit encouraged parent involvement in their baby's care and treatment wherever possible.
- Patients, their carers or parents could access emotional support if they needed it or in the event of a loss.

Compassionate care

- Throughout our inspection, we observed members of medical and nursing staff provided compassionate and sensitive care that met the needs of babies, children, young people and their parents and carers. Patients said staff were caring, kind and supportive. Patients,

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relatives, and carers described staff as “lovely”, “helpful” and “really friendly”. Staff had a positive and friendly approach and explained what they were doing, for example when completing their clinical observations.

- Staff respected patient and parent’s privacy and dignity. For example, breast-feeding mothers could express their milk in privacy using screens if needed. We also saw staff using privacy curtains to conduct patient care and treatment.
- Staff built strong relationships with patients and made the effort to get to know the patients. We observed in outpatients staff and patients recognising each other and referring to each other by their first name. Staff asked how the patient was and asked about school and social aspects of their life. On Ward 10, staff had specific link roles or relationships with particular patients to ensure continuous care and strong relationships while providing care and treatment. One patient said, “The nurses are kind and they know us”.
- Staff took the time to interact and communicate with patients and their relatives/carers. They encouraged, advocated and supported the family in the care of patients.
- The trust used the NHS Friends and Family Test (FFT) to obtain feedback from patients. This was a single question survey asking patients whether they would recommend the NHS service they had received to friends and family, who needed similar care or treatment. Between April 2015 and November 2015 Ward 10 an average of 94.8% of patients aged 16 years or under said they were likely or extremely likely to recommend the service to others.
- Data from the CQC Children’s survey in 2014 showed that the trust was about the same as other trusts in all but one question. The trust scored better than other trusts for parents having confidence in the members of staff treating their child.
- In addition to the FFT, the trust conducted its own patient (Your Care) survey about the care and treatment patients received. Questions included whether patients felt welcome, privacy and the ability to talk to doctors and nurses when required. Overall, between April 2015 and March 2016 an average 97.7% of patients felt staff looked after them in hospital, 87.5% of said they could talk to a doctor or a nurse about any worries they had and 87.8% of patients said they felt welcomed on to the

ward. In addition, an average of 82.5% of patients said staff provided somewhere private to talk to doctors and nurses and 65.1% said staff gave them enough privacy when being examined and treated.

Understanding and involvement of patients and those close to them

- Staff involved patients in their care and treatment. We observed staff discussing care plans with patients, parents or carers and ensuring they understood their treatment and condition. Patients and those important to them we spoke with told us staff gave them enough information about their care and treatment. One parent said, “Staff explain why they are doing things to both the parent and patient” and another said, “They talk you through what’s going to happen”.
- Staff in SCBU involved parents in their baby’s care and treatment. Wherever possible, staff encouraged parents to take an active role whether it was bathing or feeding. We observed interactions with parents and saw staff regularly documented in patient records. Staff provided parents with a face-to-face introduction to the unit.
- Staff said parents, relatives, and carers helped to get to know patients. We observed staff talking to parents and carers and asking them for further information about the patient. This supported the provision of person-centred care. It included providing information such as social background, networks and the things they liked and enjoyed doing.
- Staff recognised when patients required additional support to enable them to be involved in their care. Staff documented additional support requirements in patient records and where saw support in place where it was required. We saw an example of where staff had identified communication needs for a patient and therefore used cue cards to enable the patient to communicate whether they understood what staff told them.
- Staff asked patients if they understood what staff had said to them. Patients were encouraged to ask questions and all staff spent time with the patient answering them. The majority of patients, relatives and carers said they felt informed and they could ask questions if needed.
- Staff did not have specific tools to communicate with patients who had learning disabilities. However, staff could provide examples and talk through how they

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would explain care and treatment prior to it starting. One example were given was outpatients staff explaining how blood samples would be taken by demonstrating and showing the veins to the patient.

- Children's services had a polish consultant working at the hospital. The consultant provided some translation services to patients and parents, particularly those attending outpatient appointments. This meant patients and relatives could understand what doctors were telling them and be involved in the treatment and care of the patient. It also allowed polish patients to build up trust and relationships with staff at the hospital.
- The trust Your Care survey of patient care showed an average of 87.2% patients (between April 2015 and March 2016) said doctors and nurses talked to them in way patient understood. Sixty Eight percent of patients said they had a say in deciding how they were treated in hospital and 96.3% of patients said staff listened to them.

Emotional support

- Staff attended multidisciplinary meetings of the palliative care and mortuary teams, and worked closely with the bereavement and mortuary services to provide timely and effective support to those who suffered a loss, especially the most vulnerable.
- Staff offered emotional support and reassurance to children, young people, and their relatives or carers. Staff used private rooms or spaces to talk to parents when giving them bad news preserve their confidentiality and dignity. We observed examples of staff taking parents and patients into private rooms to have sensitive conversations.
- The trust had recently employed a child psychologist. They had not started their role at the time of the inspection however; a child psychologist would support patients using CAMHS or those with complex needs.
- There was support available for patients and their families who received bad news. Staff offered emotional support and re-assurance. Outpatient staff were aware of any patients attending clinic who would receive bad news so they could make necessary arrangements including private space ensuring specialist or community nurses were available to speak to patients and their family.

Are services for children and young people responsive?

Good



Overall, we rated responsive for children and young people's services as Good.

We found:

- The service had facilities available for parents including beds, en-suite facilities, a dedicated parents/carer room on Ward 10 and private flats, which family members or carers could rent out.
- Discharge planning was comprehensive. There were clear plans in place identifying goals and actions for the patient and the multidisciplinary team. We saw in patient records staff began discharge planning the moment the patient arrived in hospital.
- The trust had specialist staff to support and care for patients with learning disabilities and diabetes.
- Services could access translators, translation materials and interpreters.
- Staff had access to specialist support for patients with mental health conditions. Staff could also access out of hours psychiatric advice and support for patients.
- The community nursing team provided a range of different services to meet the needs of patients. The team included specialists or nurses with an interest in specific conditions such as cystic fibrosis, oncology and end of life care.
- Services for children and young people had a school based within the children's outpatients department. The school had a qualified teacher working Monday to Friday to provide education to patients who had been in hospital for long periods.

However, we also found:

- The environment presented a challenge to services. For example, parts of the building needed additional work and repair and patients could not use an outside play area due to it requiring further development. In addition, some facilities on Ward 10 were not suitable for disabled patients.
- Outpatient clinics used a 'full booking' system for follow up appointments. The system provided patients with an

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appointment date upon leaving the clinic. This meant clinics could be booked up months in advance reducing the flexibility to manage appointments and contributing to higher cancellation rates.

- There were no formal systems or arrangements to manage urgent bookings or late cancellations for outpatient appointments.

Service planning and delivery to meet the needs of local people

- The service delivered the majority of paediatric clinical services on Level 10 within the hospital. All services such as in-patients and day-case care, oncology in-patient care, and the majority of outpatient paediatric activities were co-located on level 10. Paediatric care provided outside of level 10 included Emergency Department (ED) and Paediatric Assessment Unit with in ED, fracture clinic, and other paediatric outpatient clinics for example, urology, orthopaedics, and ophthalmology.
- The trust based paediatric in-patient and outpatient clinical services within the footprint of one ward. Adjacent to services on level 10 was the footprint of a second ward, which was void 'outside' space. The outside space (flat roof of the hospital) is not currently suitable for access due to health and safety reasons and discussions are underway to redevelop this area to create a safe and therapeutic area for patients and visitors.
- The services provided by the trust reflected the needs of the local population. The service worked with a range of specialist teams and provision including the local Youth Offending Team and Child and Adolescent Mental Health Service, an outreach/home treatment team provided intensive support and treatment for children and young people with very complex mental health needs. The service had an additional needs resource team for children and young people with learning disability/autistic spectrum conditions and a team of community nurses to support patient discharges and ongoing care.
- The trust worked with other childcare providers such as school nurses, health visitors, and GPs to provide support for children and young people who experienced mental health difficulties. This was in addition to but not at the level of severity or concern which means young people needed to be referred to specialist CAMHS.
- The service had facilities available for parents and carers on Ward 10. Some of the side rooms had built in beds and a number had en-suite facilities. In the main ward area some of the spaces also had built in beds, located next to the patients' bed. There were portable beds, which moved to any area in the ward where the built in facility was not available. There was a small parent's room so they could make drinks and have an area if they needed some space away from the ward area. There were also parent toilet facilities which can be used both for resident and non-resident parents. One parent said they liked the fact there were separate facilities for parents.
- Parents could have the use of flats within the hospital complex for a nominal fee, if a more private or extended stay for families was required. Included with this provision is a paid breakfast and subsidised parking. The trust provided parking passes for other parents depending on need.
- The environment for children was appropriate with play areas and age appropriate toys and games for younger children and families. The children's play area on Ward 10 was opposite the nurse's station so staff could observe children. Older children and adolescents had access to age appropriate entertainment including DVD players, televisions, books and games consoles. These were available for use upon requests from patients.
- The outpatient's environment was suitable for patients and their relatives or carers. There was plenty of seating so adults could observe children playing. Toys and activities were plentiful but more appropriate for younger children rather than older. The environment was bright and decorated in a child friendly way. However, the weighing area in outpatients was a small alcove just off the main corridor separated by a privacy curtain. This meant staff weighed patients (sometimes with little clothing on) and conducted observations while patients and other members of staff could hear or walk past.
- In some areas the environment was ageing and in need of refurbishment. Managers said they needed to improve the environment for babies, children and young adult inpatients. The service had plans in place to change the environment and managers were to present a feasibility study to the board. Work to create clear plans to improve the environment was ongoing at the time of our inspection. A new SCBU was due to open in

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April 2016. We went to see the new environment and saw it was comfortable and spacious for parents and their babies, including a family/counselling room, and modernised medical equipment.

- Surgical services included day theatre with dedicated paediatric operating slots and specialist surgery. Children also attended general outpatient clinics for ophthalmology, ENT and dermatology services. The service had a consultant radiologist with special expertise in paediatric radiology, with magnetic resonance imaging (MRI), computed tomography (CT) and ultrasound facilities available.
- Some facilities on Ward 10 were not suitable for patients with disabilities. For example, the ward did not have a bath and therefore disabled patients had to go to a different ward to wash. We spoke with a patient who had a disability and they confirmed they had to go to a ward downstairs for a bath.

Access and flow

- Between July 2014 and July 2015 1,905 children and young people used services at Yeovil District Hospital. Eighty eight percent of attendances were through emergency admissions, 11% elective and 2% day case. The number was lower than the England average for children and young people's services. Most child admissions (14%) were for patients with acute bronchitis.
- For children between one and 17 years of age admissions by abdominal pain, superficial injuries, poisoning by medication or drugs, and fracture of upper limb were more than the England average. Most admissions of this age group were due to abdominal pain (9.2%) and viral infections (7.5%).
- The average length of stay for non-elective patients between birth and 17 years of age was in line with England average of one day. For children under one year the average length of stay was three days for elective patients. This was worse than the England average of zero days.
- The trust had challenges due to the lack of tier 4 CAMHS capacity in Somerset. They had developed an action plan to enhance knowledge and skills with the workforce to manage CAMHS patients. Ward 10 admitted 31 patients using CAMHS between January and December 2015. The average length of stay for these patients was 4.7 days, which was longer than the trust average of 1 day. It was common for patients to be

admitted to Ward 10 as a place of safety who had a mental health need rather than a medical need due to shortage of specialist beds. The service had a CAMHS improvement plan, which identified working with other providers to improve access to appropriate support for children and young people.

- The service had an eligibility criteria and referral form for Somerset Specialist CAMHS. The local CAMHS team accepted telephone referrals between 8.30 am and 5.00 pm, Monday to Friday. Staff said they usually got a response on the same day. This meant the service could refer and support patients to access specialist mental health support.
- Paediatric bed occupancy levels between February 2015 and February 2016 averaged at 47.8%. Between November 2015 and February 2016, the service saw its highest bed occupancy rates rising to just above 60%. This meant the service had capacity to deal and manage with increased patient numbers and flow. In addition, fewer patients to manage meant staff could concentrate on individualised care.
- The trust used an electronic booking system to refer patients to children's outpatient services. GP's and inpatients services were the most common referrers. GP's also on occasion wrote letters (paper referrals) to refer children to services especially when there were no slots via the electronic booking system.
- Outpatient clinics used a 'full booking' system for follow up appointments. The system provided patients with an appointment date upon leaving the clinic. While this gave the patient an appointment date, it meant that clinics could be booked up months in advance reducing the flexibility to manage appointments and contributing to higher cancellation rates. Data from the trust showed the cancellation rate was 11%, which was worse than the England average of 7%. This meant that a greater number of patients would potentially have appointments cancelled and rearranged. A member of staff said, "When the consultant is on leave we have to move everyone's appointments."
- The booking system did not allow flexible booking so patients requiring more than one clinic appointment had numerous visits to the hospital.
- Booking processes for children's first outpatient appointments led to delays allocating appointments and contacting patients. For example, we reviewed eight outpatient referrals and saw the time from referral to consultant sign off and booking was between four and

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38 days. The average time was seven calendar days.

Outpatient staff told us when the outpatient receptionist was unavailable there was a lack of adequate cover and in turn delays occurred. Managers acknowledged the system was slow and said they were working to simplify outpatient-booking arrangements.

- There were no formal systems or arrangements to manage urgent bookings or late cancellations. A receptionist had to create additional slots for urgent appointments due to booking slots filled in advance. The receptionist put patients on an urgent cancellation list for those who requested it. However, this was a paper list managed by the receptionist and not electronic. Outpatient staff said many patients wanted to go on the urgent appointment list but one receptionist could not physically manage the number of people waiting.
- The national standard for NHS trusts is 95% of non-admitted patients should start consultant-led treatment within 18 weeks of referral. The trust had consistently had achieved better than these standards for four out of five months between October 2015 and February 2016. In January 2016, the trust fell short of the target scoring 94.4%. This meant the majority of patients were starting consultant led treatment within 18 weeks of referral.
- The children's outpatient service did not formally monitor appointment waiting times once patients arrived for clinics. Staff told us they wrote down the arrival time of the patient and if clinics ran late then they would apologise and explain to patients. By not monitoring waiting times, managers would be unable to identify if there were any issues concerning the running of outpatient clinics. The trust was moving to an electronic system which would address this issue.
- The surgical day unit worked in partnership with Ward 10, to support patient admission and flow across the department. On days where children attended day surgery, a nurse with paediatric qualification was present to provide support and care alongside the regular nursing team.
- The trust had the children's community nursing team on site. This meant staff could liaise with community team on planning the discharge of patients. We saw the community nursing team visiting daily and taking

referrals for patients who required further care in the community. This helped to facilitate a quicker discharge for patients. Staff said they valued the community nursing team.

- Discharge planning was comprehensive. There were clear plans in place identifying goals and actions for the patient and the multidisciplinary team. We saw in patient records staff began discharge planning the moment the patient arrived in hospital. Staff notified GP's in writing or GPs were involved in discharge planning meetings so they were aware of the patient's ongoing treatment and care.

Meeting people's individual needs

- The service could identify patients with a learning disability following admission but were working with the Clinical Commissioning Group (CCG) and the Local Authority to obtain a comprehensive list of known patients to identify patients with learning disabilities earlier. Staff identified patients or parents with learning disabilities before admission who were familiar to the service. The Electronic Patient Record (EPR), due for initial implementation in May 2016, will allow alerts to be utilised by all trust services.
- The trust had an acute learning disability service incorporated within the Integrated Safeguarding Team. There were two registered learning disability nurses employed as part of the team who had responsibility for overseeing delivery of this service under the direction of the head of safeguarding. Staff said safeguarding practitioners responded to referrals and gave advice to inpatient and outpatient departments. Staff could telephone or email referrals to the team on, or prior to, admission to allow early intervention. The trust was due to introduce an EPR, which would generate automatic alerts on attendance or admission directly to staff in the future.
- On referral, staff assessed patients for evidence of a Health Passport and particular risks associated with their disability. This included, impaired swallowing, level of supervision required, level of care support available from formal carers, and an understanding of any gaps this created. We saw in care records reasonable adjustments agreed with clinical teams, families and carers to ensure recognition and agreement of a consistent approach.
- Staff assessed patients on an individual, case-by-case basis dependent on their condition, symptoms and

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identification of additional needs including hearing and visual impairment. Staff recorded the information and needs in the multi-disciplinary assessment record. Ward 10 had sensory toys for children with complex needs to help keep them stimulated and entertained while in hospital

- The trust had a dedicated inpatient diabetes service. This consisted of 2.16 whole time equivalent (WTE) diabetic nurse specialists with input from a specialist podiatrist, dietetics and two consultant diabetologists. Staff worked with a diabetes nurse consultant from another trust to provide antenatal care and accepted referrals via telephone.
- Staff could access translation and interpretation services provided by a third party provider. This included face-to-face interpretation, telephone translation and online translation. For outpatient services consultant secretaries booked translators. The trust produced printed patient information in other languages on an as required basis, with the exception of patient information leaflets translated into Polish. This was because there was a large Polish community in Yeovil.
- A 24-hour chaplaincy service assessed and supported patient and parent spiritual needs. This included contact with patients, their relatives and ward and outpatient visits. The chaplaincy provided a multi-faith chapel and quiet room accessible to everyone. The chapel is open 24 hours a day.
- Every resident parent was offered breakfast and within the parents sitting room there was a fridge and microwave for their use. Parents could use facilities in the parents room. At all other times parents and carers were required to go to the hospital canteen if they required food during the day or evening.
- Data from the trust Patient Led Assessment of the Care Environment (PLACE) survey showed the trust performed better than the England average for facilities. Ninety four percent of patients and members of the public were positive about the facilities in 2015, the England average being 90%.
- Staff had access to CAMHS support via direct telephone contact with the young person's team based in Yeovil, to request an assessment and collaborative care planning, including signposting, to the appropriate level of support and intervention for patients. The CAMHS service was available for patients Monday to Friday during working hours.
- There were arrangements for providing out of hours psychiatric advice and support. Staff could contact the on call psychiatrist via a local children and young people's inpatient unit.
- Visiting hours were flexible for parent and carers. Staff could facilitate visits from parents depending on the needs of the family. One patient said they were pleased their parent was able to visit later in the evening because they worked shifts. This demonstrated ward staff were sensitive to the needs of patients and their families.
- Patients and their relatives or carers had access to information in outpatients, Ward 10 and SCBU. Information included leaflets on meningitis, asthma and diabetes. The information was visible and accessible to patients and their relatives or carers. Ward 10 also had information on assessing capacity and deprivation of liberty safeguards (DoLS) for young people and adults on the ward.
- For patients, relatives and visitors large roller banners in public areas advised how to access support whatever their faith or belief. The chaplaincy provided bookmarks with contact details and the trust website contained information about pastoral and spiritual support.
- Staff in outpatients used toys and teddy bears to distract young children while they attended clinics. This helped children to feel relaxed and not feel anxious when being examined.
- The community nursing team provided a range of different services to meet the needs of patients. The team included specialists or nurses with an interest in specific conditions such as cystic fibrosis, oncology and end of life care. A specialist nurse coordinated end of life care alongside a doctor, but the whole of the team were involved in supporting patients with their end of life care.
- Services for children and young people had a school based within the children's outpatients department. The school had a qualified teacher working Monday to Friday to provide education to patients who had been in hospital for long periods. Children could access education and engage in other activities other than ward-based ones. One teenage patient we spoke with said, "The best bit is being able to get off the ward and go to school".

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- Children's outpatients had a dedicated breastfeeding area for parents wishing to have a separate space to breastfeed their babies. The space was private, had partitions and was clearly signposted "welcome to our breastfeeding areas".
- Staff on SCBU gave parents an admission pack, a car park permit and explained what the equipment was and what it did.
- We saw in patient records and on patient information boards, staff identified and recorded communication difficulties. Staff communicated with patients who were severely deaf by writing on pieces of paper and staff recorded their responses in medical notes. This demonstrated staff understanding and involving patients in their own care and treatment.

Learning from complaints and concerns

- Patients could access information on how to raise concerns or make formal complaints on the trust website, ward displays and dedicated information leaflets. The patient experience team were located in main reception and patients could access the service 7 days of the week. Staff knew about the trust complaints procedures and knew how to escalate complaints or concerns they were unable to deal with. All staff knew to refer complaints to the Patient Advice and Liaison Service (PALS) or escalate issues to senior nursing staff. There was information available on the ward about complaints and staff could refer patients to the information.
- Patients and their relatives or carers said they knew how to complain if required. Most young people we spoke with said they could complain online or approach ward staff. All patients, relatives and carers said they could approach staff if they had complaints and concerns. Staff we spoke with said when patients had concerns they commonly approached nursing staff and staff would try to deal with concerns and issues there and then on the ward.
- Between September 2015 and February 2016, services for children and young people received 39 complaints about the service. The types and categories of complaints varied and there was no trend in types of complaints. The patient experience and complaints managers coordinated the investigation process. They worked with the associate director of patient safety and quality to assign lead investigators where concerns met the threshold for formal root cause analysis. Patient

experience staff logged complaints electronically and paper copies held. Patient experience staff assured complaint responses before sending to the chief executive for approval and sign off.

- Staff we spoke with said they received learning and feedback from complaints. Managers added any learning identified from a complaint investigation to ward improvement (work) plans and discussed with department managers. Complaints were summarised in ward level newsletters. Staff said learning occurred through discussion with managers and other staff involved at department level. We saw from minutes of ward meetings that senior nurses discussed learning with staff at meetings.
- Complaint trends and actions formed part of the agenda at regular ward peer reviews and monthly rolling governance meetings.

Are services for children and young people well-led?

Requires improvement

Overall, we rated well-led for children and young people's service as Requires Improvement.

We found:

- At the time of the inspection, the service could not assure the inspection team they could address the risks presented to children and young people on Ward 10. There was a lack of oversight of ward admissions and a lack of progress against recommendations identified in a review of the service in 2012. Therefore we were not assured that governance systems were robust. However following the raising of our serious concerns the trust implemented its own admission criteria and now submit data on all admissions to this area to local stakeholders. The trust has also invited the Royal College of Paediatricians and Child Health to undertake a review of this service.
- The service was not protecting the well-being of children and young adults as only just over half the qualified staff on Ward 10 had level three safeguarding training. The trust had a report from 2012 which raised the issue of safeguarding concerns around the young

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person's unit but had failed to take action to address these concerns. Therefore we were not assured that all risks to children and young people's well-being were being addressed.

- The governance and management of children's outpatients meant there was a lack of supervision, performance management and delays to allocating appointments. This led to some staff in outpatients feeling unsupported and a lack of leadership visibility on occasion.
- The service did not fully complete hand hygiene audits meaning it was difficult to assess and measure compliance against trust policies on hand hygiene.
- Five members of staff across outpatients and ward 10 raised concerns about a senior nurse and their dismissive attitude towards staff. These members of staff did not feel respected or valued.

However we also found:

- There was a clear vision and strategy for the service supported by an action plan. We saw activity against the action plan had taken place. Staff had a clear understanding of the vision and strategy for the service.
- There was a clear governance structure with clear roles and responsibilities.
- The majority of staff felt supported by leaders and felt they could raise concerns freely. The majority of staff felt supported by leaders and their peers. Staff were positive about the Chief Executive
- The service had positive staff survey results.

Vision and strategy for this service

- In 2015- 2016 the trust launched a new strategy to guide the way the organisation develops and provide clarity for staff on our organisational priorities. The new trust vision declares their intention to be 'the UK leader in delivering new models of care'. This included strategic priorities for population-based care, a valued and supported workforce, collaborative, innovative care models, and partnerships, and advancements in health technology. Most of the staff we spoke with knew about the trust strategy through the chief executives emails or meetings.
- The trust had based their core values on the principles of iCARE since 2006. The values incorporated care,

attitude, respect and environment, which encompass patients, visitors and staff. All staff we spoke with knew about iCARE and the trust vision and values. Staff respected them

- There was a clear vision and strategy for children and young people services at the hospital. We saw from plans and discussions with staff and managers they reflected the trust strategy and iCARE values. Managers wanted to create a service that met the needs of children, young people and young adults going through the transition to adult services. There was a large focus on the patient environment. Work on a new Special Care Baby Unit was almost complete and the service was due to move there shortly after the inspection.
- Part of the strategy and vision was to have a fully integrated outpatient, inpatient, paediatric assessment unit, and young adults unit on the same floor by expanding the current floor layout. A feasibility study produced by the service in late 2015 identified the need to alter the environment on floor 10. At the time of the inspection, the board were considering the options presented by the feasibility study.
- The service had an action plan to support the development of the strategy for children's and young people's services. Managers updated the action plan regularly and in addition, service leads updated the board regularly on progress against the strategy.
- The senior nursing team for the service was relatively new and senior staff had been in post approximately three months. Despite this, they had a clear understanding of the vision and strategy for the service and had clear ideas of where the service needed to improve. They had been involved in developing and shaping the strategy for children and young people's services.

Governance, risk management and quality measurement

- The child health division oversaw services for children and young people. The director for urgent care and long-term conditions oversaw the division as well as urgent and emergency care, cancer, medicine, and diagnostics. Senior managers within the service spoke of good communication between departments due to them being under the same director.
- There was a clear governance structure, with explicit roles and responsibilities. A matron managed band seven senior nurses who in turn managed Ward 10,

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Outpatients and Special Care Baby Unit. The senior nurse was responsible for the management of Ward 10 and outpatients. Staff were aware of their roles and accountabilities at all levels and could tell us what these were.

- One senior nurse had management responsibility for Ward 10 and outpatients. This meant they had to split their time between departments, which at times proved difficult. Staff in outpatients said they lost the senior nurse to Ward 10 because of the demands of the ward. As a result, staff felt more disengaged from the service, less supported and unsure of the vision and strategy for the service. The department lacked performance management, which affected the workload of staff. The trust had recruited a band 6 nurse for the outpatients area who was due to commence a week after we inspected.
- Children and young people's services had systems in place within the governance structure to manage and measure quality and risk. The child health business unit had monthly business meetings and clinical governance meetings, which discussed incidents, risks, and subsequent actions and learning. Nurses and junior doctors attended clinical governance meetings as well as senior nurses and doctors. The business meetings provided quarterly reviews to the hospital management team who in turn, provided updates to the board of directors. This meant there was a two way flow of information passed up and down the governance structure alongside clear accountabilities.
- Senior managers were unaware of the risks we highlighted. No risk assessment or action plan was present at the time of inspection to ensure staff and managers mitigated risks. Managers had not addressed or implemented recommendations from a review of the service, undertaken in 2012, despite this also highlighting that the trust may be in breach of CQC regulations. Managers responsible for admitting patients to the ward did not follow the admission criteria. The lead clinician for the service did not know the admission criteria was not being used. There was no evidence of these issues identified on the children and young people risk register. At the time of our inspection all managers were satisfied that children and young people were adequately safeguarded. However following our written letter expressing our serious concerns the trust and service have reinforced the application of the admission criteria for the young person's unit and are seeking a review from the Royal College of Paediatricians and Child Health. The trust are also reviewing the design of the unit to ensure that safeguarding concerns are mitigated.
- The trust had a Transition Steering Group to address the limited availability of transition services. The director of nursing and clinical governance lead led on the work taking place on transition. In 2015 - 2016, the trust agreed a Commissioning for Quality and Innovation (CQUIN) target with the CCG to improve transition arrangements, which managers monitored, on a quarterly basis. The trust submitted a transition work plan to the regional network and the trust safeguarding committee. This plan included the development of a transition policy. The regional coordinator attended trust steering groups to review progress with plans and members of staff attended regional network events.
- The child health business unit had its own risk register. There were four risks identified on the risk register including CAMHS support, staffing levels in safeguarding team, reduced SCBU cot beds, and Increase in referrals for skin conditions in SCBU. The risk register did not contain the risks associated with the young person's unit, nor the limited access to additional staffing to meet the acuity of patients using the ward. . The majority of staff could identify staffing and support with patients using CAMHS services as key risks but were not aware of what was in the risk register itself.
- The management and governance of the outpatients department required some development. Processes required refinement and review and caused delays in allocating appointment slots. There was a lack of leadership. Managers were aware of the issues however there was no evidence of potential risks identified on the risk register and no action plan for putting improvements in place.
- The service had identified the increased demand for children with mental health needs (insufficient inpatient capacity and CAMHS support) and nursing staffing highest on corporate risk register. The service had a CAMHS improvement plan and changed the admission criteria for patients with mental health conditions to help mitigate risk to staff and patients.
- The role and numbers of reception staff did not meet demand and as a result staff felt pressured and in the absence of a receptionist, replacement staff did not

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complete some tasks such as processing appointment referrals. While managers were aware of this issue and the risk it presented this was not included on the service risk register.

- Services for children and young people used an environmental risk register to identify risks on ward 10 that could harm patients at risk. Risks identified included potential ligature points, falls from heights through ward windows, and risks from needle stick injuries. The service had an action plan to address the risks and we saw during our inspection the majority of these actions had been completed.
- The service conducted local audits to measure quality of services, these included: hand hygiene, falls, pressure ulcers, and urinary tract infections. We saw hand hygiene audits were not fully completed therefore it was difficult for staff to understand and measure compliance against trust policies properly. Hand hygiene audit results were varied between 100% and 50% compliance and a senior nurse we spoke with acknowledged this was an area for improvement. However, poor hand hygiene was not captured on risk registers and no assurance about maintaining continuing high standards.
- The business manager worked closely with senior nurses and doctors on complaints, finance, human resources, and service improvement. As a group, they met informally to sort out quick win issues, which made decision making flexible and quick when required. Because the meetings were informal staff did not minute them so we could not review them however, work was in progress for business managers to have a standardised meeting programme.

Leadership of service

- Leaders understood some of the challenges facing the department and could identify how to rectify them. However, leaders were mostly unaware of the risks and challenges presented by admitting adults onto the ward who did not fit the criteria for admission. Staff raised concerns about this issue but these were not addressed. Leaders took assurance that this service was safe despite having a review which highlighted the risks.
- Leaders were visible and the majority of staff said they were approachable. However, there was one senior nurse managing both outpatients and Ward 10 meaning there was not a senior nurse present all the time. Outpatient staff said senior nurses come over to the

department to support the department however; they felt distanced from the rest of the service and at times had to manage the department themselves without much support.

- Ward 10 and SCBU staff felt supported and leaders encouraged supportive relationships. Staff spoke of a supportive environment where they could raise issues and concerns with leaders.
- The majority of staff were positive about the chief executive. Staff received weekly briefings and updates and said they valued them.
- All consultants had job plans, which the service addressed yearly.

Culture within the service

- The majority of staff felt respected, supported and valued by senior nurses. Staff described them as friendly supportive and open. Staff described a “tight knit” and supportive culture. The majority of staff we spoke with said there were good, open working relationships between nursing, non-nursing, and medical staff. One member of medical staffing said it was a “happy” place to work.
- However, a small number of staff said they did not feel respected and valued by senior nurses. One member of staff said they were patronised and made to feel like a child by a senior nurse. Another member of staff said they got very little praise for working hard. Five members of staff across outpatients and ward 10 raised concerns about a senior nurse and their dismissive attitude towards staff. These members of staff did not feel respected or valued.
- There was a patient focussed culture in children’s services. Staff were passionate about the care they gave and all staff we spoke with had a focus on improving health outcomes for children. Staff said they were proud to work for the service and to care for children. One member of staff they had been proud to be working at the trust for 15 years.

Public engagement

- The service conducted a targeted survey of children and young people in transition to understand their experiences. As a result, the service was working on patient-centred, outcomes based transition pathways.
- A partnership with Save the Children and a trust paediatric radiologist in December gave paediatric inpatients a unique insight into paediatric care and life

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for children in India. Supported by the trust's communications department and the ward's teacher, the consultant radiologist set up a social blog for Yeovil's young inpatients. This involved sharing a diary of his visit to hospitals and schools in India, with photography, and daily interactive quizzes. The link enhanced learning for children as part of the existing curriculum taught by the ward's teachers to maintain academic achievement.

- Ward 10 had had a patient feedback box clearly visible in the children's play area opposite the nurse's station. The trust had feedback tailored for children of different ages enabling all age groups and relatives or carers to feedback. We also saw staff had a tablet device they used to obtain patient feedback before they discharged a patient from hospital. Staff could not provide many examples of where patient or their family's feedback had made changes. However, one example was the introduction of a parent's room on the ward after parent feedback showed they needed a quiet space where they could relax and have a drink.

Staff engagement

- The trust produced regular weekly newsletters from the chief executive called 'connect'. In addition, the chief executive held 'connect' meetings staff attended. Through both of these formats, managers informed staff about what was happening within the trust, the vision and its strategy. All staff we spoke with said they felt engaged by the chief executive and valued the emails and opportunities to attend meetings with him.
- Ward 10 had monthly staff meetings led by senior nurses. We saw minutes of the meetings discussed incidents, learning opportunities, and changes of practices when required. Staff were positive about the meetings and said it was a good forum to share information and discuss issues with senior nurses. Special Care Baby Unit staff attended monthly perinatal meetings organised by the obstetrics depart. Staff said they had the opportunity to discuss their work and aspects of patient care.
- Ward 10 had a series of noticeboards called 'the learning zone.' Senior nurses and managers placed messages and notices on a noticeboard for staff to read. This was a way of senior nurses and managers to ensure all staff received the same messages. The noticeboard displayed results of hand hygiene audits and learning from incidents.

- Leaders and staff we spoke with understood the value of raising concerns and were open to staff comments. The majority of staff on Ward 10 and SCBU said they could approach senior nurses and felt senior nurses listened to them and they could contribute to the development of the service.
- However, five members of staff said a senior nurse was dismissive and did not take into account their concerns or listen to them. One member of staff said they had never been thanked for their hard work and the times when they had gone over and above their normal role. Another member of staff said at times, "We are just told to get on with it". As a result, these members of staff did not feel respected or valued.
- The trust conducted a yearly staff survey. Staff were asked a range of questions including whether they felt supported, what could improve services and whether they would recommend the services they provided to others. Ninety one percent of staff said they felt supported or supported to some extent by managers and 98% said they felt their services were good or better. Staff were positive about working relationships and the support they received. Staff also identified areas for improvement including more training on mental health, improved resources and improving the environment for patients.
- The service produced an action plan in response to the staff survey. The action plan was mostly high level and did not reflect all of the themes and trends identified by staff. However, through our conversations with senior managers and reviewing other documentation we saw there were plans to address other issues identified in the staff survey such as play specialists and the environment. Work was ongoing to address themes and trends identified in the staff survey.







Innovation, improvement and sustainability

- Work was almost complete for the Trust's new Special Care Baby Unit (SCBU) within the trust Maternity Hospital. The development was funded in part by the trust's Flying Colours campaign raising more than one million pounds. The new SCBU will result in a new purpose-built environment opening in April 2016. The new SCBU looked a comfortable and spacious environment for parents and their babies. It included a family/counselling room, and modernised medical equipment.

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- Ward 10, the Trust's Children and Young People's Ward, is currently undergoing design scoping work to modernise the space for patient, families and staff. The Trust is working with designers with specific expertise in paediatric healthcare to optimise the use of the existing space through use of modular components, colour and light. This work is also exploring the potential to make use of the extensive secure roof area adjacent to the ward to provide an open-air facility conducive to recovery and relaxation for young people and their families.
- There were a number of service improvement projects either under way or projected to start later in the year. This included a project to reduce the number of short stay admissions improving the data capture of clinical outcomes and developing a dashboard.

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

Information about the service

End of life care and palliative care services at Yeovil District Hospital are provided across all wards and departments, as the hospital does not have a dedicated palliative care ward.

The specialist palliative care team (SPCT) worked closely with other health professionals in the hospital and community to ensure that all patients in their care achieved the best possible quality of life.

The specialist palliative care team who support ward staff to deliver care to patients at the end of their life were available five days a week Monday to Friday between the hours of 8am and 6pm and between 9am to 1pm on Saturday and Sunday. Out of hours advice was provided by a dedicated telephone advice service based at the nearby hospice.

The specialist palliative care team was comprised of two whole time equivalent (WTE) clinical nurse specialists and one WTE end of life discharge facilitator who provided symptom management advice and support to all patients and professionals involved in the care of the patient. Support for relatives and significant others were included along with hospital staff and one specialist palliative care consultant from the local hospice who provided two face-to-face clinical sessions per week. This was equivalent to 0.2 WTE consultant staff.

The specialist palliative care team saw 564 patients between April 2014 and March 2015. There were 660 deaths

at the hospital between July 2014 and June 2015. Of these patients 60% of patients had cancer related illnesses. End of life and palliative care services were supported by the chaplaincy team, bereavement services and the mortuary.

We visited a variety of wards at the hospital including the intensive care unit, cardiac wards, the mortuary, the hospital chapel, the clinical decision unit plus (CDUP), the stroke unit, accident and emergency, the medically fit for discharge ward, the private ward (Kingston ward) and the orthopaedic ward. We spoke to 35 members of staff including nurses, doctors, health care assistants, mortuary, bereavement and chaplaincy staff. We spoke to 11 patients who were at the end of their life and four patients' relatives.

We reviewed ten medical and nursing care records of patients at the end of life and 26 'Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR) orders. We observed the care provided by medical and nursing staff on the wards. We received comments from the public listening event which was held before our inspection and from people who contacted us separately to tell us about their experiences.

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

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Summary of findings

Overall, we rated end of life care services as requires improvement. We rated safe, caring and responsive for end of life care services as good, with effective and well-led requiring improvement.

Risk assessments for patients were completed appropriately and were re-evaluated within the required time frame to ensure risks were minimised. The wards we inspected had appropriate systems for the safe storage of medicines. Medical notes were also safely stored in locked medical notes trolleys. We found care records were mostly maintained in line with trust policy. Staff understood their responsibilities in following safeguarding procedures.

Staff understood their responsibilities in following safeguarding procedures.

We also found that The National Council for Palliative Care recommends one WTE consultant for every 250 beds; the hospital had 345 beds and therefore the trust did not meet this, as the consultant staffing provision was not in line with recommended guidelines.

We looked at 26 'Do Not Attempt Cardio Pulmonary Resuscitation' orders (DNACPR) across the trust and found there were inconsistencies in how these were completed. We found that out of 26 DNACPR orders, nine were completed correctly (35%). We found staff had not always followed trust policy when they completed DNACPR orders.

The trust had participated in the National Care of the Dying Audit 2013/14 but had not developed an action plan to address four of the seven organisational indicators and the one clinical key performance indicator that had been missed. The trust participated in the National Care of the Dying Audit 2015. This was not published until after our inspection in March 2016. The trust had not had the opportunity to review or respond to the 2015 audit report at the time of the inspection.

However, we saw that care and treatment was delivered in line with recognised guidance and evidence based practice. The last days of life care plan had recently been rolled out throughout the trust. The trust had effective multidisciplinary working in place.

We observed patients being cared for with dignity and respect. Staff were seen to be compassionate and we observed them treating patients and their families with dignity and respect. Patients we spoke with told us that staff were caring and looked after them well.

A bereavement service was offered on site, with staff available to support family members with practical and support issues following bereavement. The chaplaincy service provided a 24 hour, seven days a week on call service for patients in the hospital, as well as their relatives, and aimed to see people within the hour. Patients who were referred to the specialist palliative care team were seen according to their needs.

During 2014/15 the specialist palliative care team (SPCT) received 564 referrals, 60% of these were patients with a diagnosis of cancer and 40% of patients with a non-cancer diagnosis. This indicated that specialist care was being provided for patients with other life shortening conditions. Ward staff said the SPCT normally responded within 12 hours of referrals.

The trust did not have a Rapid Discharge Home to Die Pathway. Discharge in these circumstances was arranged by the palliative care clinical nurse specialist and could be facilitated within a few hours for patients wishing to return home.

There was no written strategy for end of life care throughout the trust. The trust was an integral member of the Somerset Palliative Care and End of Life Programme Group and had been involved in developing the Somerset End of life Strategy which was due for final review in June 2016. This will subsequently inform the local strategy once ratified.

There was no internal audit results for end of life care services available at the time of our inspection. However a plan was in place to conduct audits in the coming year. However, staff spoke positively about the service they provided for patients. High quality, compassionate patient care was seen as a priority. Staff within the specialist palliative care team spoke positively and passionately about the service and care, they provided for patients.

The trust's iCARE strategy incorporates the values of communicate, attitude, respect and environment. The mortuary won iCARE team of the year in 2015.

End of life care

Are end of life care services safe?

Good



The safety of end of life care services at Yeovil District Hospital was Good.

We found that;

- Care records were mostly maintained in line with trust policy.
- Staff understood their responsibilities in following safeguarding procedures. The staff within the service mostly understood their responsibilities for making sure patients were protected from the risk of harm and to protect people from abuse.
- The service had systems in place to recognise and minimise patient risk.
- Patient records were kept securely when not in use.

However we also found;

- The National Council for Palliative Care recommends one WTE consultant for every 250 beds; the hospital had 1,300 beds and therefore the trust did not meet this as the consultant staffing provision was not in line with recommended guidelines.

Incidents

- The specialist palliative care team (SPCT) were familiar with the process for reporting incidents, near misses and accidents using the trust electronic incident reporting system.
- Any serious incidents would be investigated through the use of root cause analysis and where necessary further training would be arranged.
- The SPCT told us there were very few reported incidents relating to end of life care and they could not remember when the last one was
- There were no incidents recorded for the SPCT for 2015, however, there had been four incidents with regard to the mortuary. These incidents had been investigated and an action plans implemented.

Duty of Candour

- The Duty of Candour is a regulatory duty that requires providers of health and social care services to disclose

details to patients (or other relevant persons) of 'notifiable safety incidents' as defined in the regulation. This includes giving them details of the enquiries made, as well as offering an apology.

- We requested statistical information from the trust about the level of training on Duty of Candour for staff. The trust did not provide us with that information, but instead sent us a statement saying that 'Duty of Candour is discussed both at induction within the Delivering High Quality Care session from the Clinical Governance Team. Members of the Specialist teams attend these sessions.'

Cleanliness, infection control and hygiene

- The mortuary waiting room was visibly clean, modern and provided facilities for relatives such as comfortable seating and information booklets about bereavement, the trust's bereavement service and organ donation.
- Staff who worked in the mortuary were aware of procedures for the prevention and control of infection, such as the management of clinical waste and environmental cleanliness. Mortuary staff had sufficient access to personal protective equipment (PPE) and there was adequate access to hand washing facilities.
- The mortuary had facilities to store the bodies of deceased patients who were deemed to be at a high risk in relation to infection control and therefore required isolation.
- We saw the trust's guidance for clinical site managers and porters working in the mortuary. It included guidance on all aspects of Health and Safety legislation, including the Health and Safety at Work Act 1974, and its codes of practice. The guidance also included the Health and Safety Executive publication 'Safe Working and Prevention of Infection in the Mortuary and Post Mortem Room.'
- Staff told us they were aware of the guidance and were following it appropriately.

Medicines

- The trust had a protocol called 'The five priorities for end of life care.' The protocol was for the last 48 hours of life and provided guidelines for staff on actions to take such as anticipatory prescribing, who to contact and how to make referrals to the SPCT.
- There were appropriate systems for the safe custody and checking of controlled drugs and syringe drivers. We

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saw on the wards we inspected that all medicines were stored safely and the record keeping was in line with the trust's policy. We found controlled drugs were managed in accordance with the Controlled Drugs Regulations 2013.

- We observed staff and saw documentation that showed all the records demonstrated that care followed the National Institute for Health and Care Excellence (NICE) Quality Standard QS61. This quality standard defines clinical best practice about how people are prescribed antibiotics in accordance with local antibiotic formularies. Additionally documentation and care followed the nursing and midwifery council standards for medicine management.
- On the wards we visited, there were appropriate systems in place to protect patients against the risks associated with the unsafe use and management of medicines. Staff followed clear guidelines for prescribing medicines for patients receiving end of life care.

Records

- The service had a centralised, computerised patient co-ordination system known as Electronic Palliative Care Coordination Systems (EPaCCS). This was a patient register, which can be accessed by primary care services in the community such as GPs, district nurses and hospice at home teams, as well the community SPCT team. EPaCCS recorded details of patients in both the palliative and dying phase, which may be up to a year in advance of a patient's end of life.
- There were plans to further develop EPaCCS in April 2016 to incorporate referrals to the SPCT.
- We saw evidence, when attending a handover meeting that the SPCT were reviewing records of patients who were at the end of life.
- The SPCT reviewed the records of their patients on a daily basis to gain information on the patient's condition. During our inspection, we saw the trust was using individualised care plans for end of life care patients.

Safeguarding

- Nursing staff we spoke with had an understanding of how to protect patients from abuse. We spoke with staff who could describe what safeguarding was and the process to refer concerns. None of the staff we spoke with could recall a recent safeguarding incident regarding an end of life care patient.

- Staff who provided end of life care were aware of the trusts whistleblowing procedures and what action to take if they had concerns.
- Staff who provided end of life care said they had received mandatory training in safeguarding children and vulnerable adults. We saw data that showed 100% of the SPCT were trained to level two in adult and children's safeguarding. The SPCT were knowledgeable about their role and responsibilities regarding the safeguarding of vulnerable adults and children and of the referral process to the safeguarding team.
- The trust told us that level 3 safeguarding training for staff was commencing in April 2016.

Mandatory training

- End of life care training was classed as mandatory training within the trust. Staff told us and we saw documentation that showed the SPCT had delivered training to ward staff throughout the trust.
- Staff told us they felt supported to undertake mandatory training.
- The trust had taken part in the National Care of the Dying Audit 2015. The organisational key performance indicator (KPI) 8A asked 'Between 1 April 2014 and 31 March 2015, did formal in-house training include/cover specifically communication skills training for care in the last hours or days of life for medical staff?' The trust response was no to this KPI against the England average of 63% for other trusts.
- The organisational KPI 8B asked 'Between 1 April 2014 and 31 March 2015, did formal in-house training include/cover specifically communication skills training for care in the last hours or days of life for nursing (registered) staff?' The trust response was no to this KPI against the England average of 71% for other trusts.
- The organisational KPI 8C asked 'Between 1 April 2014 and 31 March 2015, did formal in-house training include/cover specifically communication skills training for care in the last hours or days of life for nursing (non-registered) staff?' The trust response was no to this KPI against an England average of 62% for other trusts.
- For organisational KPI 8D, which asked 'Between 1 April 2014 and 31 March 2015, did formal in-house training include/cover specifically communication skills training for care in the last hours or days of life for allied health professional staff?' The trust response was no to this KPI against an England average of 49%.

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- At the time of our inspection, the trust did not have an action plan to address the KPI's in the National Care of the Dying Audit 2013/2014 that it had not achieved.

Assessing and responding to patient risk

- The trust used a National Early Warning Score tool (NEWS) to record routine physiological observations such as blood pressure, temperature and heart rate. We saw that early warning scores were used to monitor patients and ensure timely assessment and treatment by medical staff.
- The SPCT had a daily meeting to discuss patients who were at the end of their life. The team would follow up the care of these patients on the wards.
- We saw five risk assessments for areas such as malnutrition, falls and pressure area damage for patients were completed appropriately and were re-evaluated within the required time frame to ensure risks were minimised.

Nursing staffing

- There were no dedicated end of life care beds at the trust. Patients receiving end of life care were cared for by nursing staff throughout the trust.
- The SPCT consisted of two whole time equivalent (WTE) clinical nurse specialists who provided symptom management advice and support to all patients and professionals involved in the care of the patient.
- One of the nurses was on call at the weekends between 9am and 1pm. There was a dedicated advice line for professionals and members of the public to call between 1pm and 5pm. The cover was shared with the oncology and haematology clinical nurse specialists. This meant that not all staff providing cover were part of the SPCT.
- The team also had one WTE end of life care discharge sister who managed end of life discharges for patients into the community, as well as fast track discharges from Monday to Friday. Fast track discharges are normally used when a patient, who has a rapidly deteriorating condition which may be entering a terminal phase, wishes to return home, to a hospice or 24 hour care facility.

Medical staffing

- One specialist palliative care consultant from the local hospice provided two face-to-face clinical sessions per week. This was equivalent to 0.2 WTE staff.

- This consultant worked the remaining sessions at the local hospice, which was managed by a different provider. This meant there was some continuity of care between the patients moving from the hospital to the hospice.
- The National Council for Palliative Care recommends one WTE consultant for every 250 beds; the hospital had 345 beds and therefore the trust did not meet this, as the staffing provision was not in line with recommended guidelines.
- Out of hour's advice and guidance about symptom control was provided by doctors at the local hospice using a dedicated, 24 hour telephone advice line.

Major incident awareness and training

- The mortuary was part of the trust major incident plan. The mortuary had facilities for isolation of high risk, infectious or contaminated patients. The staff were knowledgeable on how they would manage such an event.

Are end of life care services effective?

Requires improvement

We rated the effectiveness of end of life care services at Yeovil District Hospital as Requires Improvement.

We found that;

- The trust had participated in the National Care of the Dying Audit 2013/14 but no actions were seen to address four of the seven organisational key performance indicators (KPIs) and the one clinical key performance indicator that had been missed. The trust had participated in the National Care of the Dying Audit 2015 and had performed worse than the England average in six of the eight organisational indicators.
- We saw documentation that showed the trust had not undertaken any audits on pain relief during 2015 for end of life care patients.
- At the time of our inspection, there were no link nurses on hospital wards to promote good practice for end of life care. The link nurse program was in the process of being reviewed to be replaced by ward champions.
- There was not a seven day face to face service in place. Clinical Nurse specialists provided cover for patients

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with acute oncology and palliative care needs between 9am – 5pm Monday to Friday and between 9am - 1pm on Saturdays and Sundays. In addition there was a consultant on-call 24 hours every day.

- We looked at 26 ‘Do Not Attempt Cardio Pulmonary Resuscitation’ orders (DNACPRs) across the trust and found there were inconsistencies in how these were completed. We found that out of 26, DNACPR orders, nine were completed correctly (35%). We found staff had not always followed trust policy when they completed DNACPR orders.

However we also found;

- Patients received food and drink when it was appropriate for them to do so and those who required support received assistance. We saw the malnutrition universal screening tool (MUST) being used. This is a universal five-step screening tool to identify adults who are malnourished, at risk of malnutrition or who are obese.
- Care and treatment was delivered in line with recognised guidance and evidence based practice. The last days of life care plan had recently been rolled out throughout the trust.
- The trust had effective multidisciplinary working in place.

Evidence-based care and treatment

- The trust had implemented individualised care plans for patients on the end of life care pathway called ‘The last days of life.’
- The individualised care plans recognised the five priorities for end of life care according to the Leadership Alliance for the Care of Dying People (2014).
- We saw patient’s records where staff were using individualised care plans for the dying patient. This gave clear guidance for staff on how to meet the patient’s needs in respect of repositioning, food and fluid intake and pain relief.
- The trust’s end of life-individualised care plans were being used consistently where patients were identified as end of life to ensure they received evidence based end of life care.
- Staff were able to tell us about the current guidance relating to end of life care.
- During our inspection, staff told us the trust was not contributing data concerning palliative care to the

National Minimum Data Set (MDS). The National Council collects the MDS for specialist palliative care services for palliative care on a yearly basis, with the aim of providing an accurate picture of specialist palliative care service activity. It is the only annual data collection to cover patient activity in specialist services in the voluntary sector and the NHS in England, Wales and Northern Ireland.

- All of the records we looked at demonstrated that care followed the National Institute for Health and Care Excellence (NICE) Quality Standard QS13. This quality standard defines clinical best practice in end of life care for adults.
- The trust had participated in the National Care of the Dying Audit 2013/14 but no actions were seen to address four of the seven organisational key performance indicators (KPIs) and the one clinical key performance indicator that had been missed.
- The trust had participated in the National Care of the Dying Audit 2015 and had performed worse than the England average in six of the eight organisational indicators.
- The specialist palliative care team (SPCT) did not have an action plan for the key performance indicators (KPIs) it had not reached during the National Care of the Dying Audit 2013/14.
- The trust had participated in the National Care of the Dying Audit 2015 and had performed better than the England average in three of the five clinical performance indicators and two of the eight organisational indicators.

Pain relief

- Patient’s symptoms were managed and anticipatory medicines were prescribed, (medicines that patients may need to take to make them more comfortable). We checked four medicine administration records and found that all the records demonstrated anticipatory prescribing was undertaken to reduce the risk of escalating symptoms.
- One of the specialist palliative care nurses were able to prescribe medicines
- Staff told us they would contact the specialist palliative care team (SPCT) for advice about appropriate pain relief if required.
- Patients within end of life care services had their pain control reviewed daily. Regular pain relief was prescribed in addition to ‘when required medicine’

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(PRN), which was prescribed to manage any breakthrough pain. This is pain that occurs in between regular, planned pain relief. We saw that care followed the National Institute for Health and Care Excellence (NICE) Quality Standard CG140. This quality standard defines clinical best practice in the safe and effective prescribing of strong opioids for pain in palliative care of adults.

- We saw documentation that showed the trust had not undertaken any audits on pain relief during 2015 for end of life care patients. However, the trust stated that it would be auditing pain relief for end of life care patients commencing May 2016.

Nutrition and hydration

- Protected meals times were in place on all the wards we visited. We observed all end of life care patients had access to drinks, which were within their reach. Of the ten care records we reviewed, all of them showed staff supported and advised patients who were identified as being at nutritional risk.
- We saw the malnutrition universal screening tool (MUST) being used. This is a universal five-step tool to identify adults who are malnourished, at risk of malnutrition or obese. It also included management guidelines, which can be used to develop a care plan. It is for use in hospitals, community and other care settings and can be used by all care workers.
- The patients we spoke with said the food was good or satisfactory and that there were plenty of drinks available.
- Where patients were unable to eat due to their ill health, we saw that care plans were in place for staff to monitor their food and nutrition.
- On the wards we visited we saw that a nutrition and hydration white board was clearly visible for patients and displayed information on healthy nutrition and hydration.
- We looked at the menu on each ward we visited. The menu had a main section, which included special diets, and a vegetarian section.

Patient outcomes

- The care and treatment provided achieved positive outcomes for people who used the service. The patients and relatives we spoke with indicated they were happy with the services provided.

- The SPCT had a rapid discharge pathway in place. The SPCT has an end of life discharge sister who facilitates, where possible, the rapidly deteriorating patient to their preferred place of care. In addition, a rapid discharge nurse was part of the team to facilitate this outcome for the patient.
- We saw documentation that showed an audit of patients' last place of care had commenced in January 2016, two months before our inspection. There were no previous audits prior to this one.
- The trust had taken part in the National Care of the Dying Audit 2015 and had performed better than the England average in three out of five clinical key performance indicators. For clinical KPI 5 which stated, 'Is there documented evidence in the last 24 hours of life of a holistic assessment of the patient's needs regarding an individual plan of care?' the trust scored 81% which is higher than the England average of 66%.
- The trust however did not perform as well in relation to ensuring there was documented evidence within the dying patient's last episode of care acknowledging they would probably die in the coming hours or days, or that a discussion had taken place with a nominated individual or a person who was important to the patient. For this clinical KPI the trust scored 79% against an England average result of 83%.
- The trust performed worse than the England average in six out of eight organisational KPIs in the National Care of the Dying Audit 2015. Poor performance included lack of a lay member on the trust board with a responsibility for end of life care, a lack of communication skills training for medical staff, registered nurses, allied health professionals and non-registered staff and a lack of access to face-to-face specialist palliative care between the hours of 9am to 5pm seven days a week.
- The results of the National Care of the Dying Audit 2015 had only recently been published in March 2016, after our inspection. The trust had therefore not had the opportunity to review the results of the 2015 audit and consider how the findings would be addressed.

Competent staff

- New staff attended an induction programme where they undertook mandatory training, which included end of life care. Porters received training around end of life care and transporting deceased patients to the mortuary.
- The SPCT told us they were responsible for providing end of life care teaching for ward staff. This was done by

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way of 'snack box training', which was a 15 minute session to individuals with key aspects delivered on the wards. The reason it was called snack box training was because it took place during staff breaks and there were snacks available.

- We saw documentation that showed 81 members of staff had received 'snack box training' from the SPCT during the month of February 2016. The plan was to roll out this training further throughout the hospital.
- At the time of our inspection, there were no link nurses on hospital wards to promote good practice for end of life care. The link nurse program was in the process of being reviewed to be replaced by ward champions.
- All members of the SPCT received appraisals as well as clinical supervision and these were up to date.
- The trust had taken part in the National Care of the Dying Audit 2015. For organisational KPI 10, which stated, 'Does your trust have one or more end of life care facilitators as of 1 May 2015?' The trust replied yes, this was in line with 59% of other trusts in England.
- Staff told us they felt supported to undertake mandatory training.

Multidisciplinary working

- We attended a multi-disciplinary meeting, spoke with seven staff and reviewed ten records, which confirmed effective multidisciplinary team (MDT) working practices were in place. Patients receiving end of life care received support from an end of life care MDT. This included the SPCT, consultants, nursing staff, occupational therapists, physiotherapists, oncologists and other relevant professionals. The chaplain and the bereavement team were also part of the MDT for end of life care patients.
- In accordance with the Gold Standards Framework, MDT meetings took place weekly to ensure any changes to patients needs could be addressed promptly.
- We observed a MDT meeting where there were members of the SPCT, the local hospice, a specialist occupational therapist (OT), the oncologist and the chaplaincy team present. We saw that all patients and their families were discussed.
- Discussions included all aspects of pain and symptom control, as well as all aspects of care relevant to the end of life care pathway such as discharge planning and psychological needs.

- The SPCT told us they had an effective relationship with the hospice and ensured that patients nearing the end of life were referred to the hospice in a timely fashion as required. However, there were no audits of the referrals undertaken to the hospice.
- Staff told us that patients referred to the SPCT were seen within 24 hours of referral and reviewed on a daily basis.
- All the ward staff we spoke with told us the SPCT were very responsive, visible on the wards and available to provide advice and support at all times.
- Staff in accident and emergency and in the intensive therapy unit told us of the good relationship between themselves and the SPCT in caring for end of life care patients.

Seven-day services

- The National Care of the Dying audit for hospitals in England 2015 for organisational KPI 9 asked, 'Was there face-to-face access to specialist palliative care for at least 9am to 5pm, Monday to Sunday?' The trust scored 'No' as an answer to this question, for which 37% of the trusts in England provided this service.
- Clinical Nurse specialists provide cover for patients with acute oncology and palliative care needs between 9am – 5pm Monday to Friday and between 9am - 1pm on Saturdays and Sundays. In addition there is a consultant on-call 24 hours every day.
- The end of life discharge sister told us there were rarely out of hour's discharges during weekends. This was due to there not being an equipment service at weekends. However, if there was equipment in place at home for the patient, then weekend fast track discharges could be facilitated.
- The chaplaincy service provided pastoral and spiritual support, and was contactable out of hours.
- The mortuary provided a 24 hour, seven days a week service to both the trust and the community.

Access to information

- The trust had an electronic computerised information system regarding patients who were known to be dying that could be accessed by all staff. This system was called the Electronic Palliative Care Coordination System (EPaCCs).
- Once a patient had been identified as being in the last days of life, staff would use the guidance for 'Last days of life communication pack'. The pack included information on end of life care, offering staff information

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on where they could obtain additional support or advice and details of symptom management. It also incorporated prompts for staff to assess patient symptoms, identify advance decisions, discuss values and spiritual needs and agree options regarding hydration and feeding.

- Medical and nursing notes were stored securely on all the wards we inspected.
- We saw that risk assessments and care plans were in place for patients at the end of life. Patients were cared for using relevant plans of care to meet their individual needs.
- All the records we viewed included detailed information about the management of symptoms, discussions and interventions. We also saw that when patients were seen by the specialist palliative care team information and advice was clearly recorded so that staff could easily access the guidance given.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients and relatives we spoke with told us staff did not provide any care without first asking their permission.
- All the patient records we looked at, we saw copies of signed consent forms and that consent to treatment was obtained appropriately.
- Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS) training were mandatory across the trust. This was undertaken by way of 'snack box training' plus a work booklet and e-learning. The consent process was also available on the trust website.
- Staff received mandatory training in safeguarding children and vulnerable adults that included aspects of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. We saw documentation that showed the SPCT had achieved a 100% training level against the trust target of 90%
- The SPCT told us they had received training on how to undertake a mental capacity assessment two years ago but had not received any training on deprivation of liberty safeguards assessment. However they were aware of how to refer to the safeguarding team should the need arise.
- The trust did not currently audit the mental capacity assessments. This meant that any training needs might not be identified on a formal basis and any changes in legislation or guidance on best practice might not be identified.

- We looked at 26 'Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR) orders across the trust and found there were inconsistencies in how these were completed.
- The DNACPR orders were at the front of the notes, allowing easy access in an emergency and were recorded on a standard form with a red border. All of the DNACPR orders were easy to read.
- We found that out of 26 DNACPR decisions that we looked at nine were completed correctly (35%). DNACPR orders were not completed accurately for a number of reasons. These included lack of mental capacity assessments for those deemed to lack capacity, lack of information regarding the discussions held with patients and/or their families, community DNACPR orders dated 2014 and lack of discussion with the patient. This meant the trust's DNACPR policy was not being adhered to, and the legal process of the Mental Capacity Act 2005 was not always followed.
- We asked the trust for information concerning any DNACPR audits. The information was not received during or after our inspection. However, we did review minutes of the quality committee meeting dated April 2015, which stated that an audit should take place to identify the percentage of patients who have a DNACPR form on discharge.

Are end of life care services caring?

Good



We rated caring in end of life care services as Good.

We found;

- Staff cared for patients with dignity and respect. Staff were seen to be compassionate.
- Patients we spoke with told us that staff were caring and looked after them well.
- A bereavement service was offered on site, with staff available to support family members with practical and support issues following bereavement. The patient experience team met with every bereaved relative to explain their death and the process that relatives needed to follow.

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- The chaplaincy service provided a 24 hour, seven days a week on call service for patients in the hospital as well as their relatives and aimed to see people within the hour.

Compassionate care

- We observed throughout our inspection that staff spoke about the patients they cared for with compassion, dignity and respect.
- Throughout our inspection we observed patients being treated with compassion, dignity and respect. All the patients we spoke to told us they were treated respectfully by staff and their privacy was respected.
- We spoke with the relatives of four patients who were receiving end of life care. The relatives described the care and support as excellent and said they felt well informed by the staff.
- All of the staff we spoke with showed an awareness of the importance of treating patients and their representatives in a sensitive manner.
- The trust had a bereavement service and staff who provided support for relatives, following the death of a patient.

Understanding and involvement of patients and those close to them

- Patients and family members we spoke with told us they felt involved in the care delivered. We saw that staff discussed care issues with patients and relatives where possible and these were generally clearly documented in patient's notes.
- The National Care of the Dying Audit 2015 clinical key performance indicator (KPI) 3 asked, 'Is there documented evidence that the patient was given an opportunity to have concerns listened to?' The trust scored 92%, which is higher than the England average of 84%.
- The National Care of the Dying Audit 2015 clinical KPI asked, 'Is there documented evidence that the needs of the person(s) important to the patient were asked about?' The trust scored 60%, which is higher than the England average of 56%.
- For the organisational KPI 7 which asked, 'Did your trust seek bereaved relatives' or friends' views during the last two financial years (i.e. from 1 April 2013 to 31 March 2015)?' The trust scored 'Yes'. This was in line with 80% of other trusts.

Emotional support

- The trust had a multi-faith chapel.
- The chaplaincy service provided a 24 hour seven days a week on call service for patients in the hospital, as well as their relatives, and aimed to see people within the hour. The chaplaincy service held communion at the patient's bedside if they were too ill to attend the chapel. The service told us they conducted last rites and blessed the deceased in the mortuary as required.
- The chaplain supported patients, their families and staff. There were a number of thank you cards in the multi-faith chapel.
- The chaplain was involved with the 'snowdrop group,' which was a baby bereavement group that was part of the Yeovil stillbirth and neonatal death charity.
- The chaplaincy service was not licensed to conduct weddings for end of life care patients. They told us they were able to facilitate this with one of the community registrars who would conduct weddings. The service employed volunteers who would sit with end of life care patients as required.
- We were told relatives were supported by the mortuary staff and the patient experience staff. Staff advised relatives what to expect when they viewed their deceased relative and stayed with the relatives until it was appropriate to leave. Staff also provided support for relatives and families with the planning of funeral arrangements following the death of a patient. The patient experience manager had a nursing background and could answer most questions from relatives about their loved ones death. However they would also arrange for the consultant to be available to explain further if needed. The team provided excellent emotional support and a point of contact with relatives of the deceased.
- We saw examples of care that was compassionate, caring and focused on supporting patients as much as possible during difficult times. We saw staff using the skills of empathy when speaking to patients and using good eye contact.

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Are end of life care services responsive?

Good



We rated the responsiveness of end of life care services as Good.

We found that;

- Patients who were referred to the specialist palliative care team (SPCT) were seen according to their needs. The SPCT were committed to ensuring that patients receiving end of life care services had a positive experience. Patients requiring end of life care could have access to the specialist end of life team.
- During 2014/15 the SPCT received 564 referrals. There were 660 deaths at the hospital between July 2014 and June 2015, 60% of these were patients with a diagnosis of cancer and 40% of patients with a non-cancer diagnosis. This indicated that specialist care was being provided for patients with other life shortening conditions.
- More non-cancer patients were seen compared to the previous year 2013/14, when 29% of patients had a non-cancer diagnosis. This meant in 2014/15, there was an increase of 11% in the SPCT seeing patients with a non-cancer diagnosis.
- The mortuary, chaplaincy and ward staff told us they had access to information about different cultural, religious, spiritual needs and beliefs and that they were able to respond to the individual needs of patients and their relatives.

However, we also found;

- The trust did not have a Rapid Discharge Home to Die Pathway but the Palliative Care Clinical Nurse Specialist facilitated discharge in these circumstances. The discharge from hospital could be facilitated within a few hours for patients wishing to return home.
- Ward staff said the SPCT responded normally within 12 hours to referrals. However, the staff in the SPCT said they did not audit the number of patients seen within 24 hours of the referral so were unable to provide the exact figure.

Service planning and delivery to meet the needs of local people

- During 2014/15 the SPCT received 564 referrals. There were 660 deaths at the hospital between July 2014 and June 2015, 60% of these were patients with a diagnosis of cancer and 40% of patients with a non-cancer diagnosis. This indicated that specialist care was being provided for patients with other life shortening conditions.
- More non-cancer patients were seen than the previous year for 2013/14, as 29% of patients had a non-cancer diagnosis for this period. This meant in 2014/15, there was an increase of 11% in the SPCT seeing patients with a non-cancer diagnosis. This meant that staff recognised patients who had a diagnosis other than cancer could be referred to the SPCT and that staff understood the importance of referring patients with a diagnosis other than cancer to the SPCT. However, we were not able to confirm the referral rates as the SPCT told us they do not audit referrals.
- The trust provided data about the number of patients who achieved their preferred place of death. This was recorded at the mortality and morbidity meetings. The trust do not currently collate the reasons why a patient would not achieve their preferred place of death and stated 'Whilst a formal audit has not been undertaken the team have made changes to the process and have recently introduced an electronic referral form which will enable continuous audit of the process.' The SPCT worked closely with patients who were at the end of their life, and their representatives, to ensure care was carried out in the patient's preferred place. In January 2016 16 out of 21 patients who were asked where they would like to die achieved their preferred place of death. In February 2016 seven out of 11 patients achieved this. Where patients were identified as being in the last few weeks of their life, they engaged the support of the end of life discharge facilitator to facilitate a rapid discharge home where possible for patients who identified a wish to be cared for in their own home. However we were not provided with figures on the time it took to discharge patients to their preferred place of death as the trust had yet to initiate the recording of this.
- Referrals to the SPCT could be made at any time from the patient diagnosis. This meant there could be early involvement by the SPCT and End of life Discharge Nurse and therefore they could facilitate the most appropriate care available whilst working in a multidisciplinary way with their colleagues.

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- The trust did not have a Rapid Discharge Home to Die Pathway but the Palliative Care Clinical Nurse Specialist facilitated discharge in these circumstances.
- Ward staff said the SPCT normally responded within 12 hours to referrals. However, the staff in the SPCT said they did not audit the number of patients seen within 24 hours of the referral so were unable to provide the exact figure.
- There was no introduction of the leadership alliance documentation, which is part of the 'One chance to get it right approach.' This documentation is concerned with a new approach to caring for people in the last few days and hours of life. It focuses on the needs and wishes of the dying person and those closest to them, on both the planning and delivery of care.
- Staff we spoke with said they were aware of the leadership structures and received good leadership and support from their immediate line managers
- The mortuary, chaplaincy and ward staff told us they had access to information about different cultural, religious, spiritual needs and beliefs and that they were able to respond to the individual needs of patients and their relatives.
- The chaplain told us about two weddings and a blessing that had been conducted for patients in the last few days of their life.
- Guidance literature was available for patients and their relatives. This included a booklet about the end of life and what they might expect to happen. There were also patient and relative information leaflets around the last days of life care plan and the processes involved in caring for patients at the end of life. These were also available in different languages other than English.
- As part of the individualised care plan there was a booklet called 'Information for relatives and friends'. The booklet explained in plain English what to expect when someone close to you is very ill, such as medication, changes that occur before death and the last days of the care plan.

Meeting people's individual needs

- The mortuary had a viewing suite where families could visit their relatives and loved ones. We visited the area and saw the viewing suite was divided into a waiting room and a viewing room.
- The mortuary waiting room was clean, and provided facilities for relatives such as comfortable seating, tissues and information booklets about bereavement and the trust's bereavement service. The suite was neutral with no religious symbols which allowed it to accommodate people of all religions.
- The mortuary accommodated all faiths and worked closely with Muslim and Jewish undertakers to ensure deceased patients were cared for following their cultural and religious requirements.
- There were no facilities available for the bereaved to wash the deceased. The mortuary manager told us that by agreement, all ablutions of the deceased were carried out on the ward.
- In the mortuary, the viewing of babies and children was undertaken in a discreet and personal way. Babies, if small, were placed in a Moses basket or bassinet, and brought into the dedicated viewing room, to enable the mothers and fathers to view their baby or child. This was responsive to their needs and the situation.
- We saw that Moses baskets of different sizes were used by the mortuary for the viewing of children.
- There were leaflets on the wards for relatives of a patient on the end of life care pathway. As part of the 'Last days of life communication pack', there was a leaflet called 'Last days of life information for relatives and friends.' The leaflet included information about the changes, which can occur during the final stages of life.
- We saw advice leaflets for relatives with regards to the withdrawal of treatment in intensive care. There were leaflets in both the bereavement office and the mortuary concerned with help for the bereaved and what actions to take when someone dies.
- There were leaflets on the trust website about the bereavement service. They advised how to arrange a funeral, what to do when your baby has died, information on the chaplaincy service and what to do after the funeral. Information on the hospital accommodation for relatives was also available.
- Following a patient's death, bereaved families were able to make an appointment to meet with the bereavement team the following day. The team would ensure all necessary documentation and property belonging to the patient was ready to collect, arrange and support viewing if required, and provided practical information to the family. The bereavement team discussed any

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queries regarding the patient's care or death with families, or if they were unable to answer questions, would arrange for a member of the medical team to do so.

- The bereavement office provided a partial seven day service with staff working from 1pm to 5pm Saturday and Sunday. The times at the weekends were designed to coincide with the visiting times of the trust.
- There was a bereavement suite which provided people with an environment of support and was tastefully decorated.
- We saw bereavement booklets were given out by the bereavement service and on the wards. The booklet was called 'Information for those who are bereaved.' The booklet contained a number of different sections with information to assist people with the bereavement process.
- We saw there were free parking facilities near the main entrance of the hospital for relatives when viewing at the chapel of rest. We saw some information leaflets for families in the intensive care unit, which were written in a very sensitive manner.
- Patients at the end of life would be cared for where possible in individual side rooms to give them more privacy. Staff were also able to provide temporary beds or recliner chairs in patient's side rooms.
- There were facilities for relatives to stay in overnight accommodation close to the hospital. Visiting hours were relaxed for visitors of patients who were identified as being at the end of their life on all the wards we visited and throughout the hospital. This ensured family and friends could spend unlimited time with the patient.
- There was no specialist pathway for patients living with learning disability or dementia. We were told that patients who were on the end of life care pathway and were living with a learning disability or dementia would be placed on to the clinical speciality ward that was appropriate for their needs. We did not see any of these patients during our inspection.

Access and flow

- The trust did not have a specialist palliative care ward or any specialist palliative care beds. We saw end of life care patients being cared for in side rooms wherever possible.

- The SPCT had a dedicated discharge sister who was able to fast track discharges for patients who wanted to return home or to other places of care in the community.

Learning from complaints and concerns

- The trust data did not indicate any complaints specifically related to end of life care services. During our inspection, we did not see evidence of formal complaints specifically related to end of life care services.
- The SPCT told us they did not audit complaints and that the Patient Experience team undertook this.
- There were posters in ward areas which told patients and their representatives how to make a complaint.
- Staff we spoke with told us that if a patient or relative had concerns about care being delivered they would try and address the issue at the time in order to resolve the concerns as quickly as possible.
- We were told complaints would be handled in line with trust policy. Staff told us they would advise patients to go to PALS (Patient Advice and Liaison Service) if they were unable to deal with concerns directly. Patients would be advised to make a formal complaint if their concerns remained. Staff we spoke with knew how to raise concerns or make a complaint on behalf of a patient or their relatives.

Are end of life care services well-led?

Requires improvement

We rated the leadership of end of life services as Requires Improvement.

We found that;

- There was no written strategy for end of life care throughout the trust. The trust was an integral member of the Somerset Palliative Care and End of Life Programme Group and had been involved in developing the Somerset End of life Strategy which was due for final review in June 2016. This will subsequently inform the local strategy once ratified.
- There was no action plan to monitor the actions required to meet the key performance indicators of the National Care of the Dying Audit 2013/2014.

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- There was no internal audit programme for end of life care, including a care after death audit, 'Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR) audits, last days of life audit and audits of the use of specific medicines used for patients at the end of life.

However we also found;

- There was good collaboration with local and national palliative care networks including other providers to improve quality of care and people's experiences.

Vision and strategy for this service

- There was no written strategy for end of life care throughout the trust. The trust was an integral member of the Somerset Palliative Care and End of Life Programme Group and had been involved in developing the Somerset End of life Strategy which was due for final review in June 2016. This will subsequently inform the local strategy once ratified. We saw the business planning document 2016/17, which incorporated cancer, oncology, haematology and palliative care. For the palliative and end of life care services there were four identified actions. These were; care for the population, develop our people, pioneer the future and put technology at the heart. There were also a number of strategic objectives within the plan; however, outcomes were not measurable as this had not been added to the report.
- There were no detailed action plans for each of the actions, no completion date or anything to say the action had been completed.
- The trust values of communicate, attitude, respect and environment (iCARE) were displayed behind the reception desk on all the wards we inspected. All staff we spoke with had an awareness of the values that were being promoted.

Governance, risk management and quality measurement

- The end of life care (EOLC) was part of the Haematology, Oncology and Palliative Care business unit.
- We found the specialist palliative care team (SPCT) had regular team meetings in which issues and general communications were discussed.
- The trust had an intravenous (IV) fluids lead who had overall responsibility for training, clinical governance, adult and review of IV fluid prescribing and patient outcomes.

- Actions were reported through the recognition and rescue group reporting into the Patient Safety Steering Group and to the Governance Assurance Committee.
- There was no action plan to meet or monitor the four organisational key performance indicators (KPI) which had not been met on the National Care of the Dying Audit 2013/2014.
- According to the National Care of the Dying Audit 2015, the trust did not have a lay member on the trust board with a responsibility or role for end of life care. The trust was below the England average of 49%.
- There was no internal audit programme for end of life care, including a care after death audit, 'Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR) audits, last days of life audit and audits of the use of specific medicines used for patients at the end of life. However, we did see documentation that showed an audit of patients last place of care had commenced in January 2016, two months before our inspection. A plan was in place to conduct audits in the coming year.
- The trust did not audit pain relief for end of life care or the use of anticipatory medication, however we saw documentation which showed the trust intended to commence audits of these in 2016.
- There was no auditing of the individualised care plans for the last days of life and no evaluation, although we were told the SPCT had commenced a pilot study, but this was cancelled, as there were not enough numbers for the study.
- The SPCT were not aware if a bereavement survey was conducted by the trust. We requested information from the trust who advised that, 'the trust does not currently undertake any targeted surveys in respect of the bereavement service.'
- There was no specified pathway for end of life care for patients living with dementia or learning disability.

Leadership of service

- The SPCT confirmed there were regular formal information relaying processes including messages from the chief executive and board of directors, such as monthly e-mails
- Ward staff felt management were approachable and supportive. Most of the staff we spoke with on the wards were aware of the SPCT. They could name the SPCT nurses and could give us examples of cases where they had felt involved with improving care for patients who were at the end of life.

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Culture within the service

- The SPCT reported an open and transparent culture within the trust. They reported good engagement at ward level and felt they were able to raise concerns and these would be acted on.
- The SPCT spoke positively about the service they provided for patients.
- The SPCT staff saw high quality, compassionate patient care as a priority.
- Staff within the SPCT spoke positively and passionately about the service and care they provided for patients.
- None of the staff we spoke to had undertaken Duty of Candour training and were not able to describe their responsibilities, but were able to describe the principles of Duty of Candour.

Public engagement

- The bereavement team provided an information pack to bereaved families, within this pack there was a questionnaire to give families the opportunity to feedback on the care.
- The Trust does not currently undertake any targeted surveys in respect of the bereavement service.
- Sometimes relatives of the deceased patient would contact the team to find out more information about

how their relative died. The bereavement team would arrange for the medical notes to be delivered and if required, a consultant and matron to meet with the family.







Staff engagement

- Staff excellence awards were held annually to celebrate staff achievements.
- The mortuary and bereavement staff culture was positive and enthusiastic about the provision of care at the end of a patient's life.

Innovation, improvement and sustainability

- There was good collaboration with local and national palliative care networks including other providers to improve quality of care and people's experiences.
- However, the SPCT did not use data from the national end of life care intelligence network which is demographic data to develop services.
- The trust told us they did not participate in the Transforming End of Life Care in the Acute Hospitals programme (Transform programme). The Transform programme aimed to improve the quality of end of life care within acute hospitals across England. It focuses on both the quality of care provided by acute hospitals, as well as the role acute hospitals have that provide care for people who are approaching end of life.

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

Main outpatient diagnostics and imaging services are provided at Yeovil District Hospital (YDH), with satellite community clinics at South Petherton hospital, The Yeatman Hospital, Wincanton Community Hospital and Crewkerne Hospital.

The YDH outpatient service had 159,482 attendances between September 2014 and August 2015. The service provides approximately 198 clinics per week. The main specialities are trauma and orthopaedics, ophthalmology and cardiology. Additional clinics are provided for ear nose and throat, orthodontic services, orthotics, general medicine haematology, rheumatology and care of the elderly.

The radiology department is a multi-disciplinary department providing plain film imaging, computed tomography (CT) scans, magnetic resonance imaging (MRI), ultrasound scans, breast imaging, interventional and fluoroscopic procedures and nuclear medicine.

We observed a range of clinics at Yeovil District Hospital, and services provided by the trust. We observed care and interactions between patients and staff. We spoke with 27 patients and six visitors before and after their appointments. We also spoke with 29 members of staff including doctors, managers, nurses, healthcare assistants, allied health professionals, radiologists, students, technicians, clerical staff, porters, and four volunteers. We reviewed performance information from and about the trust.

Summary of findings

We rated outpatients and diagnostic services (OPD) at Yeovil District Hospital as good overall.

Systems were in place for keeping people safe. Staff were aware of how to report incidents, safeguarding issues and the Duty of Candour process. Risks to patients using the service were assessed and appropriately managed.

Consent to care and treatment was obtained in line with legislation and guidance. Staff were suitably qualified and skilled to carry out their roles effectively. Staff described a good learning environment, with good role progression.

We saw good examples of the service being redesigned and improvements made to meet the needs of the patients.

Patients spoke positively of staff that they encountered, and the care they received. Staff were observed to be caring and compassionate in the way they cared for patients, their families and carers.

Changes made to appointment booking and reminder system were structured to target the clinics with highest did not attend rate. These changes were monitored before implementation throughout the department.

Staff felt included in the changes made in the unit. They described a supportive environment in which to work.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services safe?

Good



We rated safety of this service as Good.

We found:

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses.
- Appropriate standards of cleanliness and hygiene were maintained.
- Staff monitored risks to patients and visitors using the service.
- Staffing levels and skill mix were appropriate to the clinical needs.
- Staff implemented a pause and check prompt in line with best practice guidance.

However,

- The trust did not routinely monitor and audit the number of patients attending without notes.
- Radiology were behind on their quality assurance schedule for testing equipment. Managers in the department were in the process of addressing this.
- Checklists for safer surgery were not always completed appropriately for interventional procedures.

Incidents

- Staff reported incidents through the trust's electronic incident reporting system.
- Between January 2015 and December 2015, there were 293 reported patient safety incidents in outpatients. Most (97%) were categorised as low or no risk of harm to the patient involved. There were no incidents reported as 'major'. We saw evidence of investigation around the one reported severe incident and recommendations for more call bells within the current outpatient refurbishment. Staff described and we saw further actions surrounding communication with patient transport following a patient incident.
- Staff were aware of how to report an incident and described receiving feedback following reporting.
- We saw minutes of staff department meetings and newsletters giving feedback from incidents and learning surrounding them. The department trained a greater

number of staff to perform blood glucose monitoring after an incident. The patient had been treated appropriately, but the incident identified insufficient numbers of staff could perform blood sugar monitoring.

- The hospital had a process in place to ensure staff reported radiation incidents as required under the Ionising Radiation (Medical Exposure) Regulations 2000 (IR(ME)R).
- The Duty of Candour is a regulatory duty that requires providers of health and social care services to disclose details to patients (or other relevant persons) of 'notifiable safety incidents' as defined in the regulation. This includes giving them details of the enquiries made, as well as offering an apology. Within outpatients, senior medical and nursing staff described an understanding of the regulation and gave examples of where a duty of candour had been applied, for example the need for repeat tests due to hospital error. Junior staff did not demonstrate an awareness of the regulation, and struggled to give examples in practice.
- The incident reporting system included guidance and prompts around a duty of candour.
- The lead clinical scientist acted as the radiation protection advisor (RPA), the radiation waste advisor (RWA), medical physics expert (MPE), lead for the radiation protection service for diagnostic imaging and nuclear medicine and was the support for lasers and magnets used for diagnostics throughout the trust. They also acted as RPA and MPE for the peripheral (satellite) hospitals of the trust providing radiation advice where x-rays were carried out.
- A quality assurance (QA) programme was in place. Due to historic gaps in the medical physics and radiology workforce, routine testing of equipment was behind schedule. There were concerns that QA at the peripheral hospitals was still not being routinely performed. The unit had tasked two radiographers with reviewing and revising the QA programme and schedule of reject analysis. Reject analysis is part of the quality assurance programme, whereby rejected (non-diagnostic) images are assessed for the reason behind the rejection. We saw new action plans and it was clear via minutes of meetings, the concerns regarding quality assurance were being addressed and managed well. QA processes and testing in CT and mammography were up to date and well managed. Records of the process were clear and up to date.

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Cleanliness, infection control and hygiene

- The departments we visited appeared visibly clean and tidy with uncluttered clinics, treatment rooms and corridors. Cleaning schedules were in use and up to date.
- Staff complied with the trust policies regarding infection prevention and control. This included clinical staff being bare below the elbow and hand washing policies.
- We saw staff washing their hands and there were hand gel dispensers in the clinical areas.
- Clinical staff had access to personal protective equipment as needed, such as disposable gloves and aprons, we observed staff wearing these as appropriate.
- There were regular infection prevention and control (IPC) audits in relation to dress code and hand hygiene. Results of these audits were not displayed in waiting areas although data demonstrated 70%-100% compliance in all departments from September 2015 to December 2015. IPC staff shared action plans with ward staff on the trust intranet site (Y-cloud).
- Monthly cleaning audits were performed, in January 2016, a compliance rate of 95% to 98.5% was achieved throughout outpatients and radiology.
- Although there were no designated waiting areas for patients with communicable diseases, the sister in charge informed us, where possible, these patients would be seen in a separate treatment room, which would be deep cleaned after use.
- Within radiology, systems were in place to reduce the risk of healthcare associated infections. Patients with possible communicable diseases or infections were booked last onto radiology or interventional lists and staff deep cleaned rooms after the procedures.

Environment and equipment

- Emergency resuscitation equipment was available for use in all outpatient and diagnostic imaging departments. These were sealed and we saw records that they were checked daily to ensure the equipment was well maintained and safe for use. Staff changed safety tags sealing the equipment monthly and checked the contents of the bag to ensure equipment was in date and fit for use.
- All patient equipment we looked at had been routinely service tested, with visible stickers demonstrating when the equipment was next due for service. Members of the inspection team highlighted a piece of equipment

without a sticker. This was immediately withdrawn from use and the medical engineers department contacted to action this. Medical engineering performed a service, and the equipment placed back in use.

- All x-ray equipment was regularly serviced with routine servicing carried out by the equipment manufacturer engineers.
- Patient led assessments of the care environment (PLACE) audits demonstrated that all areas met the hospital standards.
- A medical physics team contracted from an adjacent trust supported the imaging department. The team was small, made up of two clinical scientists and two technologists. There were concerns the workforce was not substantial enough and visits not frequent enough in order for all radiation protection tasks to be undertaken. This had led to a delay in the routine testing of the equipment.
- All new radiology equipment was purchased through a procurement programme, with advice from medical physics and clinical engineering. The radiology department had projected their capital needs requirements to 2020.

Medicines

- Staff were aware of trust policies and procedures in relation to the administration, management, storage and disposal of medicines.
- Medicines were stored securely in locked cupboards with access restricted to clinical staff. Electronic monitoring systems were in place to monitor the medicines fridge temperature. The system recorded the temperatures electronically and reported to an external company. We saw staff responding to the call alerts from the company when the fridge door was left open for an extended period.
- Staff explained to patients about medicines used in the clinic or prescribed to take home. This included the purpose of the medicine and the potential side effects for patients to increase their understanding. Written information was given to patients to take home concerning medicines.
- Outpatient staff used Patient Group Directions (PGDs; legal frameworks concerning specific drugs supplied and administered by nursing staff to a group of patients) to administer eye drops for all eye examinations. A doctor reviewed all elective patient notes the day before appointment and indicated whether the patient met the

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appropriate criteria for drop administration under PGD by a competency-checked nurse. The clinical lead nurse developed competency assessments for which were checked by the trust academy.

- We examined PGDs for staff who inject contrast media and medications required during procedures. These were all dated and reviewed regularly.
- In the outpatients, copies of current PGD guidance could not be found, staff believed them to be with pharmacy for review.
- Some nursing staff were trained to prescribe medicines for patients attending clinics such as rheumatology and post-operative ophthalmology.
- Plans were in place and work had commenced for a retail pharmacy to be included in the out patients department.
- FP10 prescription books (prescriptions issued by an NHS doctor, for use at a non-hospital pharmacy) were checked daily and accounted for via serial numbers and a logbook.
- A dedicated pharmacist was available on Frail Old Person's Assessment Service (FOPAS) unit for assisting with medicine and prescription issues. This meant access to pharmacy support was easier and more beneficial for patients.

Records

- Medical records library clerks ordered and stored patient's records securely. After use, these were taken securely, to a central off-site store by a courier service seven days a week. Staff reported this prevented a backlog of notes awaiting transport.
- The trust did not routinely audit the number of patients attending clinics without records. This meant that they were unable to assess the impact on patient care and treatment. The clinic preparation staff kept a log of the notes that could not be found, and of the temporary folders, they created due to this. A snap shot audit of two months demonstrated that less than 1% of notes could not be found at the time of the clinic. A system was in place for monitoring the creation of temporary notes to prevent patients having duplicate sets of notes. Staff did not however routinely audit these figures.
- We looked at a ten sets of patient records in different clinics. Generally, notes were up to date and completed appropriately and clearly.

- The Trust utilised a radiology information system (RIS) and picture archiving and communication system (PACS) for secure storage of patient's radiological images and records.

Safeguarding

- Clinical and administration staff received safeguarding of vulnerable adults training (induction and level one) as part of their mandatory training. Level two training was mandatory for all clinical staff every two years. Safeguarding training figures for outpatients (elective care group) clerical and clinical staff, demonstrated 90% compliance, this was the same as the trust target of 90%. A breakdown of level one and level two training was not supplied.
- Nursing and clinical support staff we spoke with demonstrated good understanding of safeguarding procedures. They were able to identify their local safeguarding link staff and give examples of concerns they had reported. All five ophthalmology medical staff had received safeguarding training. Two paediatric radiographers are undertaking level 3 training.
- Following an incident, paediatric radiographers offered training to staff around non-accidental injury (NAI) imaging. NAI is a term referring to physical injury or abuse. Leaflets and information had been produced for parents explaining the process for skeletal surveys for NAI.
- Safeguarding information was displayed in clinical areas, including the process to follow and contact details for relevant agencies.

Mandatory training

- A number of mandatory topics were accessed as part of the trust essential learning programme through an online learning resource. Topics included fire safety, manual handling, infection prevention and control, basic life support and safeguarding.
- Trust wide training data reported all staff in outpatient services had met the trust target of 90%, with 90% of clerical staff and 92% of nursing staff completing their mandatory training.
- Within diagnostic imaging, mandatory training was up to date. The department was able to access mandatory training tailored specifically to the needs of the department.

Assessing and responding to patient risk

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- Staff carried out observations of patients, such as blood pressure, pulse and respirations as required. Clinical staff had been trained to perform blood glucose monitoring if indicated. Staff described the process of escalating concerns around a patient's condition. Staff described a situation where a patient's condition deteriorated requiring transfer to the ward. We saw evidence of the incident via the incident reporting system.
- The trust used electronic recording systems for patient observations. In outpatients, staff used an early warning system, based on the National Early Warning Score (NEWS), to record routine physiological observations such as blood pressure, temperature, respiration rate and heart rate. Early warning scores have been developed to enable early recognition of a patient's worsening condition by grading the severity of their condition and prompting nursing staff to obtain a medical review at specific trigger points.
- Resuscitation equipment was available in all outpatient areas and staff were all trained in basic life support. Staff in main outpatients highlighted that more emergency call bells were required. A recent redesign of the unit was underway and the new call bells were to be installed. In the interim, the staff operated a runner system to call for help in emergencies.
- Risk assessments were carried out for all new equipment and procedures. Staff reviewed and revised them regularly.
- Staff performed risk assessments on patients attending the FOPAS. These included assessing a patient's risk of sepsis (a blood poisoning caused by infection), basic observations using a NEWS score, patients Rockwood score (a tool to assist staff in measuring a person's level of frailty). Staff performed an occupational therapy assessment to determine the assistance that a person required and a falls risk assessment.
- The new RIS system had initial implementation problems that the trust solved after shared risk management process with a neighbouring trust.
- Clinical staff had a good knowledge of IR(ME)R relevant to their area. Staff had good dose awareness and knew the expected values for a range of examinations.
- A modified World Health Organisation (WHO) surgical checklist, five steps to safer surgery checklist was in use in the radiology department for minor interventional procedures. We looked at twenty WHO checklists, five had information missing. This meant the process had

not been completed correctly, which could lead to safety errors. The department were in the process of establishing a regular audit of the WHO interventional checklist.

- The department had adopted the recently endorsed Society and College of Radiographers pause and check safety procedure. This was used nationally in an attempt to reduce the number of radiation incidents.
- Within magnetic resonance imaging (MRI) safety checklists were in place prior to examinations.
- There was a policy in place for the irradiation of female patients of childbearing age. All staff were aware of the policy, and how to document patient responses. There were robust procedures in place for checking the pregnancy status for anaesthetised patients.

Nursing and allied health staffing

- In all clinics we visited, there was a registered nurse in charge of each clinic, with a mixture of registered nurses and healthcare assistants available to provide care to patients. Senior staff told us they had a 1.75 whole time equivalent (WTE) vacancies throughout outpatient departments. The number of nursing staff required was determined by the size of the clinic. The outpatient's sister allocated staff in outpatients, ophthalmology and the Macmillan clinic. Audiology, cardiology, the maxillofacial unit and the orthopaedic clinics were staffed independently with allocated staff.
- The diagnostics department employed 29 WTE radiographers with one vacancy. A recent workforce plan and review was undertaken and recruitment of staff was in progress
- The trust employed nine sonographers equating to seven WTE and seven radiography department assistants.
- Staff told us they felt that the numbers of nursing staff and the skill mix usually met the needs of the patient. Where nursing bank staff were required, the sister described a detailed induction process. Between April 2014 and March 2015 an average of 2.5% of shifts were filled by bank staff.
- Inpatient and outpatient therapy staffing sickness rates for 2015 were 1.3% and there were no current vacancies. A physiotherapist and occupational therapist worked solely on the FOPAS unit during opening hours.
- Clinical nurse specialists ran independent clinics throughout the department.

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- A risk assessment had been performed concerning staff working in the department alone. As a result of the risk assessment, strategies had been implemented to help reduce the risk, such as swipe card door entry systems, and notifying security when a lone worker was in outpatients.

Medical staffing

- Outpatient clinics were arranged by consultants to meet the needs of their specialities.
- Consultants were supported by trainee colleagues where appropriate. Junior staff both medical and nursing thought outpatient clinics were a good learning environment.
- We saw evidence of doctors covering for colleagues clinics at short notice. This was due to sickness and service needs.
- There were five substantive radiologists with funding for nine; one new appointment was awaiting final HR sign off. Locums and retired staff filled the remaining gaps in the workforce. All locum radiologists had their initial reports checked by a substantive radiologist to assure the department of the quality of work and to highlight concerns with reference to discrepancies in reporting.
- FOPAS had dedicated medical staff to assess patients attending the unit.

Major incident awareness and training

- The trust had a major incident response plan. Clinic managers and staff were aware of their roles and guidance surrounding a major incident.
- Orthopaedic outpatient's staff described the process necessary to incorporate the department into the emergency department in the event of a major incident.
- A major incident policy was in place for radiology.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

The effectiveness of outpatients and diagnostic imaging was not rated.

- In both outpatients and diagnostic imaging patient's care and treatment was planned and delivered in line with national current evidence based guidance.

- Many services were routinely offered six days a week. Evening and weekend clinics were provided as required.
- Consent to care and treatment was obtained in line with legislation and guidance.
- Staff were suitably qualified and had the skills they need to carry out their roles effectively and in line with best practice. Role development was evident in all areas.

However,

- Trauma computerised tomography scan authorisation guidelines were unclear causing questions around the appropriateness of some examinations.
- The trust performed records audit, but failed to set a target or make action plans in reference to the results.

Evidence-based care and treatment

- Staff had access to policies and procedures and other evidence-based guidance via the trust's intranet. Staff we spoke with were aware of National Institute for Health and Care Excellence (NICE) and other guidance that affected their practice. New guidance was disseminated to staff via team meetings and briefings.
- Staff followed the guidance set out in NICE guidelines, for example infection control guidelines or for assessing if, ophthalmology patients met the criteria for further treatment.
- Outpatient areas provided evidence based treatments to preserve vision in age related macular degeneration, including laser therapy and injections.
- The Trust had a radiation safety policy and all new documentation and revised procedures were ratified at senior trust management level and signed off by the clinical lead radiologist.
- National diagnostic reference levels (DRL's) were adopted and used as an aid to optimise medical exposure levels. At the time of the inspection no DRL's had been adopted for fluoroscopic procedures.
- Radiology referrals were made in accordance with national recommended guidance.
- Sonographers performed audits around transvaginal versus transabdominal scanning and the grading of thyroid lesions against national standards and practices.
- In line with NICE guidelines, one morning a week was dedicated to low risk, chest pain coronary computed tomography (CT) scanning. A cardiac nurse, senior radiographer and consultant radiologist staffed this list. The consultant radiologist was responsible for confirming examinations were justified.

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- CT trauma authorisation guidelines were broad and staff felt that at times unnecessary examinations were being performed. At the time of inspection, there was some confusion as to who authorised polytrauma scans and documentation was not clear. After discussion with the superintendent radiographer, it was apparent the documented guidelines and procedures left a question as to who ultimately confirmed the test was required. This meant unnecessary exposure to radiation could potentially occur. This was addressed at the time of the inspection with the Radiology Service Manager (RSM) who made an immediate change to reflect the practice correctly and disseminated the newly updated procedures to staff.

Nutrition and hydration

- A coffee and snack shop was available in the waiting area to enable patients to have refreshments without missing an appointment.
- Patients and relatives had access to drinking water machines in waiting areas and corridors.
- In the Queensway department, we saw staff offering patients drinks and snacks when they had been in the department a significant time.

Pain relief

- Pain relief medicine was not generally administered in the outpatients department, but the doctors in clinic could prescribe medication for any patient needing pain relief.
- Staff in the ambulatory care clinic and Frail Old Person's Assessment Service (FOPAS) described a process of assessment that included assessing patient's pain. This was combined with the advice of the dedicated pharmacist.
- Patients attending the hip and knee pre-operative assessment clinic were given guidance on expected pain, and managing pain post-surgery.
- Radiology staff used Entonox gas (a pain relieving gas) for some intervention procedures.

Patient outcomes

- The trust gathered patient feedback via an online and paper based system. Feedback for January and February 2016 showed more than 95% of patients would recommend the outpatients department to their friends and family.

- Audit programmes were in place to monitor radiation dose levels throughout the radiology department.
- We saw evidence of investigations into patient complaints, including reopening a complaint when the outcome was not to the patient's satisfaction. Staff had been nominated to speak with patients and address concerns.
- Clinic staff monitored patient outcomes via yellow outcome forms. This process was due to change in May with the use of a new electronic check in and outcome system. Managers told us this would improve their ability to audit clinic waiting times and patient outcomes.
- Ophthalmology staff described a system of monitoring patient's condition for effectiveness of treatment, and the need to change to alternative treatments.
- Radiologists held monthly discrepancy meetings. The purpose of the meeting was to facilitate collective learning from radiology discrepancies and errors in reporting. This meant that staff could learn from radiology incidents.

Competent staff

- All staff we spoke with had undergone appraisals, although data received stated 100% of switchboard staff, 79% of therapy staff and 81% of contact centre staff had completed their appraisal from April 2015 to January 2016. This was less than the trust target of 90% completion. For April 2015 to December 2015, the elective care business unit appraisal completion rate was 100% for nursing and midwifery staff.
- Most staff we spoke with confirmed that they had received support from the trust to undergo further training and professional development. For example, clinical nurse specialists were supported in completing nurse-prescribing qualifications and ophthalmology nurses received training at specialist eye hospitals.
- Within the bone densitometry department, assistant practitioners undergoing training to become operators were supported by a radiologists or a radiographer. Bone densitometry is an investigation that quickly measures the density of bone, often used for diagnosing osteopenia or osteoporosis.
- The lead sonographer ran a comprehensive and autonomous service. They undertook some musculoskeletal work, a proportion of biopsies and drainages. Senior sonographers within the department also undertook fine needle aspirations of the thyroid.

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- Junior staff did not undertake complex CT scanning, however all staff were trained to a level required for out of hours trauma and emergency examinations.
- Within diagnostics and imaging, continuous professional development was encouraged. Teams provided education and in-house lectures for radiographers on a monthly basis. All available in-house learning was advertised on staff notice boards.
- Support staff described receiving extensive training via the academy to achieve assistant practitioner status.
- We saw information with regard to the trust supporting staff with nursing revalidation.
- Staff in all areas described training sessions from senior colleagues. We saw evidence of training for staff in the new digital booking/check in service.
- Outpatient managers monitored competency assessments for clinic staff. This enabled them to allocate staff to specific clinics.
- We saw equipment training records for staff. These were comprehensive and regularly reviewed.
- New staff in the diagnostic and imaging departments received support through a buddy and mentoring system. CT training and induction was particularly comprehensive with pictorial indicators within the framework and information for training staff.
- Ultrasound trained their own sonographers and the training and competency assessments were comprehensive with final competencies assessed by consultant radiologists.
- There was an Administration of Radioactive Substances Advisory Committee' (ARSAC) licence holder in place for nuclear medicine.
- Consultants described using telemedicine (a process of remote sharing of data and images) to discuss ophthalmology cases with optometrists. This meant that treatment could be accessed in a more timely way.
- Radiologists worked with consultants from other departments in order to implement NICE guidelines within radiology.
- The interventional team was cohesive and multi-disciplinary with good communication and leadership skills. The patient pathway was effective and streamlined.
- Staff held a monthly paediatric meeting, which paediatric radiologists attended alongside junior doctors and consultant paediatricians to discuss interesting cases. These were used as a learning experience for all staff.
- Physiotherapists worked in many outpatient areas of the hospital, working alongside medical and other therapy staff.
- The team of staff in the FOPAS unit described cohesive MDT working to review patients and provide a complete care package.
- Voluntary staff worked as part of the team in all areas of the hospital, in both patient interaction and clerical roles.

Multidisciplinary working

- There was evidence of multidisciplinary team (MDT) working throughout outpatients, imaging and therapy departments. Queensway treatment and rehabilitation unit provided multi-professional 'one-stop' clinics for high risk TIA (transient ischemic attacks) patients. These were for patients experiencing stroke like symptoms. The clinic provided tests and treatments in one outpatient appointment (patient's condition permitting). A recently developed gynaecology one stop and minor procedure clinic were felt by staff to enhance patient experience. Rheumatology, Parkinson's disease specialist and ambulatory care clinics were also run in this facility.

Seven-day services

- Most clinics at Yeovil hospital were provided Monday to Friday during working hours. Due to demand, staff had started to provide a clinic one evening a week and occasional weekends. This was altered according to waiting times and appointment demands.
- The FOPAS unit offered a six day service 9am to 6pm.
- The Queensway ambulatory day care centre was open seven days a week 9am to 4 pm, including bank holidays. Patients chose the appointment time according to personal preference.
- The radiology service provided 24-hour emergency cover across all specialities seven days a week. This included access to CT, magnetic resonance imaging (MRI), ultrasound, minor interventional radiology as well as plain film imaging.

Access to information

- Clinic preparation staff requested and tracked the medical notes for each clinic. They took responsibility for searching for notes that had not been filed at the offsite storage facility. Temporary notes were created if

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notes were not available at the time of the patients visit. Clinic preparation staff and secretaries maintained the temporary folders and merged them with the original notes at an earliest opportunity.

- In November and December 2015, less than 1% of patients were seen without their medical notes. The trust told us the temporary folder created included a copy of the patient's last letter and/or the patient's referral letter. Clerical staff faxed important information to the clinic if the notes were in another hospital.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff demonstrated confidence and competence in seeking consent from patients. Patients told us staff asked consent and kept them fully informed about any procedures and treatments. Staff in therapy services performed a fundamentals of care audit. This demonstrated 80% compliance in documentation of patient consent in records. The trust did not set a target figure for the percentage of records that should contain written consent, or provide action plans.
- We did not receive data in relation to specific mental capacity training. Staff told us this was incorporated into the safeguarding training. Staff we spoke with described receiving extensive training around caring for patients living with dementia.
- Staff had a basic understanding of MCA and DoLS, and knew how to seek advice when they had concerns.

Are outpatient and diagnostic imaging services caring?

Good



The care provided to patients in outpatients and diagnostic imaging was judged as Good.

- Patients were treated with kindness dignity and respect when receiving care and treatment. Patients spoke positively about how they were treated by all members of staff.
- Patients were involved and encouraged to be partners in their care and making decisions with any support they needed.
- Appointment times were tailored to patient's emotional wellbeing.

Compassionate care

- We observed that staff were courteous and compassionate when caring for patients and were seen responding to patient's individual needs in a timely manner.
- Patients spoke positively about the staff and the care in all areas of outpatients.
- Modesty curtains were available in clinic rooms, and doors had 'in use' signs.
- We saw reception staff talking with patients in a welcoming and supportive manner. Signs were at the reception desks asking patients to respect each other's privacy.
- Signs were in all areas advising patients to ask for a chaperone if they wanted one.
- Health care assistants (HCAs) helped patients move from one waiting area to another within the clinic. They ensured patients knew which area they needed to wait in and were visible and approachable for patients.
- We saw staff trying to maintain privacy when calling patients for appointments. Staff avoided calling patient names and clinic details. Where possible the staff called the consultant name. We saw staff approaching patients to take their name rather than calling across the waiting area. Plans were in place to use a colour coded clipboard system that would be highlighted on the electronic information board.
- Volunteers were available in waiting areas. We saw a volunteer observing people closely and approaching them if they felt they appeared agitated or confused.
- Several volunteers provided emotional support to patients and relatives during the cardio and stroke rehabilitation gym sessions.
- At the time of our visit, friends and family outcomes were not displayed in the clinic areas, although a new electronic screen had been installed. Staff planned to display this information on the boards. From October 2015 to January 2016, 93% to 95% of patients would recommend Yeovil outpatient services to friends and family. This was better than the national average of 92%. The department had doubled the response rate in the last two months, although it remained low at around 2%.
- In the National Cancer Patient Experience Survey, 97% of patients rated care as excellent or very good. This was better than the England average of 89%.

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- We saw evidence of staff tailoring the care and appointments of patients with learning disabilities to the patient's individual needs.
- Within radiology, changing facilities were available and clean gowns were readily available. Patients had privacy whilst changing for examinations. Patients in gowns waited in a separate area.
- Staff performed computerised tomography (CT) colon scans at 8.15am before the main departmental working day commenced. This avoided long nil by mouth periods for patients and ensured privacy after this examination to use the toilet facilities.

Understanding and involvement of patients and those close to them

- Plans were in place to display the clinic waiting times on the new electronic boards. During our visit, this was trialled in very small script. When we highlighted this to the contact centre manager, she immediately had it rectified.
- Staff gave good explanations around plans of care in a way the patients could understand and they were seen to check patients' understanding.
- Patients told us they received good information before and after their appointment, this included information around the current parking challenges at the hospital.
- Staff had noted patients at the one stop eye clinic were not always aware appointments would take a long time they sent information with bookings, but also informed patients on arrival.

Emotional support

- We observed staff comforting patients in an appropriate way, involving relatives and carers.
- Clinical nurse specialists were available for patients with long- term conditions.
- Volunteers from the Stroke Association were available for support during stroke rehabilitation sessions.
- Staff described how they would use private areas for breaking bad news.

Are outpatient and diagnostic imaging services responsive?

Good



We rated the responsiveness of the outpatients and diagnostic imaging service as Good;

- Outpatient and diagnostic imaging services offered a range of clinics that were planned and delivered to meet the needs of the local population.
- Changes to the appointment booking and reminder system were structured to target the clinics with highest did not attend rate.
- Changes to the contact call centre monitored the call response rate.
- Staff had a good understanding and reasonable adjustments were made when caring for patients with a learning disability or living with dementia.
- Computerised tomography (CT) trauma scan times and stroke scan times were better than the national average.

However,

- The service was not meeting the national referral to treatment times, but the aim was that changes to the appointment booking system would address this.
- The times patients were waiting within the clinic were not collated. This was due to change in May 2016.

Service planning and delivery to meet the needs of local people

- Yeovil hospital provided a range of outpatient clinics to meet the needs of local people. These were either in the main hospital or in four of the community run satellite clinics.
- Patients received hospital specific information including a reminder of the current limited parking, this was also highlighted on the hospital website.
- Signage throughout the trust and in the outpatient department was very clear and easy to follow. This particularly helped patients with poor vision.
- Some overflow and patient demand clinics were held on Saturdays or in the evenings.
- Implementing the new booking and reminder system, staff targeted clinics that had the highest did not attend

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rates. Text reminders were sent five days and one day before the appointment. This was found to reduce did not attend rates from 8.8% in July 2015 to 6.8% in December 2015.

- Clinic waiting areas were spacious despite current refurbishment. There was space for patients in wheel chairs to wait with family or caregivers. Reception staff expressed concern at patients from the wards having to pass through the waiting area on beds or trolleys to access the cardio clinic or therapy department. The planned redesign of the department would reduce the need for this.
- There was a paediatric consultant radiologist who undertook computed tomography (CT) scans, magnetic resonance imaging (MRI) reporting for paediatrics. Paediatric patients were offered sedation for scans but all patients requiring general anaesthetic were transferred to a tertiary centre, as waiting times at the neighbouring trust were too long.
- We saw provision made for a patient with learning disabilities to attend a clinic during a quieter time. Staff created space in a room to enable the patient and carer to wait in the room next to the consulting room. The hospital transport waited to take the patient straight home and prevent further delay and distress.
- Radiology consultants, CT and MRI staff operated an extended working day and were available from 8am until 9pm and weekends between the hours of 9am and 5pm. Plans were in place to extend the service to a full seven day service with dedicated ward slots to support the TIA unit.
- There was a 9am to 4pm walk in GP service for plain film imaging and additional capacity at three peripheral hospitals Monday to Thursday.

Access and flow

- Patients were referred to outpatients department via their GPs, hospital consultants, other hospital departments, practitioners, or by self-referral.
- The national standard for NHS trusts is that 95% of non-admitted patients waiting to start their treatment should start consultant led treatment within 18 weeks of referral. Between August 2015 and November 2015, 92% of patients received treatment within 18 weeks. This was worse than the national recommendation. Weekly referral to treatment time meetings took place to address waiting times.

- Data supplied by the trust explained that the majority of cancelled clinics were due to the consultant being on annual leave. Consultants had to inform staff of leave six weeks in advance. Trust wide, between August 2015 and November 2015, 2.5% of clinics were cancelled within six weeks of the appointment date.
- Stroke response times in radiology were better than the national average. In 55% of cases a CT scan was performed within one hour (target 50%). Patients transferred straight to the scanner from the emergency department and head scans were performed against pre-authorised protocols to ensure a rapid availability of images.
- CT trauma scans, including head scanning also had a rapid response times from radiology and were prioritised over current workload on the scanners.
- Most patients we spoke with were satisfied with the length of time from referral to being seen in outpatients.
- Recent changes within the contact centre had streamlined outpatient bookings. Staff ensured that an appropriately trained member of staff answered 82% of calls within 20 seconds. We saw evidence of managers, governance staff and the information technology team monitoring the process in real time. The manager fed this information back to the staff on a daily basis.
- Changes to the online appointment booking system were initially implemented to three specialities to assess the success. The full implementation would be applied to all services with the electronic check-in system in May 2016.
- In May 2016, patients would be able to check-in to appointments either electronically or via a receptionist. The contact centre manager aimed for 80% of patients to use the self-check in service.
- The new care tracking system would improve the trust's data collection for in clinic waiting times. The length of time patients were waiting for their appointment once in the clinic was not currently monitored by the trust.
- A call back and text reminder system implemented in December 2015 had reduced the did not attend rate from 8.9% in August 2015 to 6.8% in December 2015.
- A dedicated team booked the urgent two-week appointments. We heard staff calling patients giving them a choice of time and location, this included considering their mode of transport and the local parking facilities.
- Patients we spoke with liked the text reminder system and found it a useful service.

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- Daily emergency ophthalmology and transient ischemic attack (TIA) appointments were available. Staff contacted patients directly to arrange appointments either the same day or the next day. The staff in these departments' booked cardiology and therapy appointments.
- Phlebotomy clinics were accessed by appointment as well as by patients who attended from outpatients and GPs who were only notified on the day.
- The ratio of new patients to follow up patients attending appointments had a bearing on how many new patients could be seen. The overall rate for the trust of new to follow up patients seen was equal to the England average.
- Weekend and evening clinics were in place according to patient demands.
- Patients were informed of waiting times for appointments via healthcare assistants, white boards or new electronic screens.
- Staff within the Frail Older Person Assessment Unit (FOPAS) worked closely with The Red Cross to provide transport to patients to and from hospital.
- The Queensway ambulatory care clinic provided a nurse led service for outpatients requiring services such as; care of venous central lines, intravenous drug administration, injections, complex wound dressings (including vacuum assisted wound dressings) and urinary catheter care. Appointments were available seven days a week 9am to 4 pm, including bank holidays. We heard examples of this providing a continuity of care for patients and reducing their travel costs.
- Cardiac and stroke rehabilitation services provided 12 week programmes within the outpatient facilities. The sessions provided education as well as fitness and emotional support.
- There was a waiting area with toys designed for young children. These were included on the weekly cleaning rota. Satellite paediatric orthotics clinics were run in the community hospitals. In diagnostics and imaging, some waiting areas were busy and overcrowded at times.
- A newly refurbished section of the main radiology waiting room was bright, well-lit with unusual x-ray related artwork.
- The lead breast radiographer was an integral part of the breast multidisciplinary team. The existence of the breast team was an asset to the department and provided an expanding service. The care focused on the patient pathway, providing a 'one stop' service for patients undergoing symptomatic breast imaging.
- Private waiting areas were available in radiology for inpatients and those on trolley beds and in chairs. This was away from the main areas where outpatients and GP patients were seated.
- A quiet room was available for patients who had received bad news, or who needed extra privacy to understand the information they were receiving.

Meeting people's individual needs

- Staff told us that if people did not have English as their first language they were offered an interpreter when they booked an appointment. Some staff said that at short notice they would use family members, which is not a recommended practice.
- Patients were given a choice of their preferred method of contact, telephone, letter or email.
- Patients with a learning disability or those living with dementia were prioritised and seen promptly so that waiting did not cause undue distress. We saw this practice during our visit. Each area had link nurses for the care of patients living with dementia.
- Staff described to us an example of the fracture clinic making time to familiarise a patient with the department prior to having a plaster change to reduce patient distress.
- Up to date information leaflets were in all areas for patients to see, although there were very few in formats other than written English.
- Information for patients in the eye clinics was displayed in large black print on a yellow background. This format was easier for people with a visual impairment to read.
- We saw displays in the ambulatory care unit on keeping warm in winter with information and tips for the more frail patients and visitors.

Learning from complaints and concerns

- Staff actively prompted patients to give feedback around outpatient services.
- Information for patients around making complaints or raising concerns was displayed in all of the clinics and public areas.
- There had been 18 complaints in the last 12 months relating to trust wide outpatient services, this was compared to 49 in 2013 to 2014. These were all for a

Outpatients and diagnostic imaging

variety of reasons and information supplied demonstrated a timely investigation and response. Actions were taken to improve the service around complaints such as better communication between GP's and radiology.

- We saw evidence of compliments and positive feedback from patients prior to and during our inspection.
- Staff had become more proactive in capturing patient feedback. They offered both paper and electronic systems to complete. These changes to patient feedback had improved the response rate by 100% in the last two months.
- Staff we spoke with tried to address patient concerns at the time, and new how to direct patients if they wished to complain further.

Are outpatient and diagnostic imaging services well-led?

Good



We rated the leadership of outpatients and diagnostic imaging as Good;

- The vision and values to improve quality were apparent throughout the unit.
- Staff in most areas felt included in the changes that were occurring.
- The radiology services manager (RSM) and clinical director (CD) demonstrated strength and ambition for the service in leading the department.
- The relationship between RSM and CD was cohesive and strong, and relationships between radiology and executive team was strong.
- There were suitable arrangements to identify and manage risks, and to monitor the quality of the service provided.
- We saw staff development in all areas of outpatients.
- Staff were proud of the service they provided and felt valued by the trust.

However,

- The cross business unit working meant staff reported to different managers.

Vision and strategy for this service

- A trust wide strategy had been developed based on four targeted areas that would help them to be a United Kingdom leader in delivering new models of care. The four areas included caring for their population, developing their staff, pioneering the future and putting technology at the heart of care. Outpatient's staff had applied these principles in their area as a strategy to target service improvement. This entailed improving patient contact via the contact centre and electronic contacts; improve the environment with a modernisation programme; staff training to increase team resilience and to embrace technology in the appointment process.
- Outpatient services sat within a number of different clinical business units. Staff in outpatient clinics identified strongly with their own area of work, but did not articulate a wider department identity or strategic vision. Due to the cross business unit nature of outpatients, some areas such as orthopaedics and gynaecology departments were not as inclusive in the changes.
- Staff were knowledgeable around the changes to the service and the necessary improvements.
- The trust values were based around an iCARE principle (communication, attitude, respect and environment). Staff spoke often of these values in their description of the care within the department.

Governance, risk management and quality measurement

- All staff we spoke with were aware of the governance structures in place and who to report any risks to. We saw from minutes of meetings that risks, complaints and incidents were discussed and actions shared.
- Each clinical area within outpatients reported to the relevant clinical business unit. We saw evidence of therapy department clinical governance meetings including actions relating to outpatients. Radiology department audits were presented at the monthly governance meeting and the minutes of these were evidenced. Senior radiographers were invited to attend as well as senior nursing staff. Plans were in place to strengthen the audit process further.
- Within diagnostics and imaging, there was an established radiation protection committee (RPC) which

Outpatients and diagnostic imaging

met annually. The committee discussed radiation protection issues for staff and patients. Staff reported incidents raised and the recommended actions to the Trust governance forums.

- Risks were identified and placed on the risk register; some had remained a risk since March 2014 due to the need for structural changes. The audiology department was not considered 'fit for purpose'. In order to improve services for patients, audiology appointments were made at satellite clinics whilst building work was in progress.
- There were quality assurance measures in place, such as local audits of cleanliness and checks of the environment. Measures to encourage more patient feedback were being developed in the outpatient service.
- The radiology services manager (RSM) utilised the NHS toolkit for benchmarking of services, and was proactive in service improvement. They were proactive in future planning of service needs, and used this data for business case proposals, such as the procurement of the suitable computerised tomography scanner.

Leadership of service

- Areas of outpatient services were managed by different senior staff according to speciality. Due to the cross-business unit nature of the outpatient service, the associate director of nursing was supporting and overseeing many of the changes. Currently there was not one manager responsible for all outpatient services, these came under the larger umbrella of elective care. The staff we spoke to expressed that having experienced many different ways of managing the department, the current system was effective. Within the orthopaedics department, it was considered more beneficial to be managed within that business unit than outpatients as a whole. Minutes of meetings demonstrated representatives from each business unit met and discussed outpatient issues, such as the department redesign.
- All staff we spoke with told us they felt well supported by their line managers. We were told managers were very approachable and hard working.
- The newly appointed outpatient sister described a detailed support process. This included a mentor

process from another sister and regular meetings with the area manager. Leadership training courses were also offered to senior staff within outpatients and diagnostic imaging.

- A radiology services manager (RSM) and the clinical director for radiology (CD) lead radiology with good support from deputies and other senior staff. The RSM was a strong leader and was highly respected throughout the department and the rest of the hospital. Radiology had a greater voice and profile since their appointment in 2013 and the executive team valued and held them in high esteem. This was partly due to their business planning to 2020, and the way staff development was encouraged and supported.
- The executive team held monthly connect meetings with the RSM and CD for radiology and all staff were encouraged to attend.
- Managers were visible in each area, and shared office space with other staff. This presented an open door policy. The clinical presence of the RSM ensured the individual was sensitive to and well informed of the needs of the staff and patients.

Culture within the service

- All staff we spoke with were proud of their service and the trust, they described it as a 'great place to work'. All the staff were very positive about their role and the support in place for staff.
- The department encouraged a team approach to work to improve communication and patient experience. Staff described feeling valued within those teams. Administration and clerical staff in all areas felt inclusive and well supported by managers.
- We saw many examples of role progression within the outpatient departments. Training and development of local staff was evident in all areas including clerical, health care and radiology staff. The trust appeared to foster a 'grow your own' philosophy to staff. They invested time and money to enable staff to progress and gain new skills. This was described by many of the staff as one of the best aspects around working at the trust.
- The ultrasound department undertook regular peer reviews of newly qualified staff and audited outcomes for sonographer led examinations.
- The CD held weekly radiologist meetings to consider general issues and attendance was high. Feedback regarding their performance was encouraged and audited.

Outpatients and diagnostic imaging

- Radiologists were proud of the service they provided. It was stated the culture of the department was supportive with productive departmental meetings and senior management listened to staff.
- There was a culture of openness and honesty in the departments and staff were not afraid to speak up or challenge if there were concerns
- In radiology we were told of how well staff had pulled together to keep the service running over the past two years due to staff retiring staff changes and the major issue with the implementation of a new radiology information system (RIS) system. Sickness levels due to stress were high at this time and the RSM ensured they were supported by occupational health as required. The RSM worked with the directors around the ongoing issues and concerns about the department and staff. A business case enabled the expansion of the team.

Public and staff engagement.

- The trust gathered patient feedback via both electronic and paper format. The patient experience team held monthly meetings.
- Patients we spoke with had not felt the need to raise concerns with the trust, but did feel staff would listen to any concerns. Patients saw the new carpark development as a positive improvement for patients.
- Minutes of outpatient department meetings demonstrated staff involvement in the current changes

and the use of available space. Unit managers asked staff to contribute ideas on the use of unused space. These rooms were available after specialist clinics moved to alternative premises.

- Staff in the contact centre and outpatient departments were proud of receiving iCARE nominations and awards. These awards and ceremony highlighted exceptional work, from both staff and volunteers, within the hospital.
- The hospital had a very active involvement with different charities providing large items, such as gymnasium equipment for the therapy services and a second computerised tomography (CT) scanner.

Innovation, improvement and sustainability

- Staff saw changes to the current contact centre into a multi-channel contact centre as a positive improvement for both staff and patients.
- The electronic appointment booking and alert system was in the process of being implemented. This aimed to improve the patient experience and reduce the did not attend (DNA) rates. Staff anticipated the changes would reduce the number of cancelled appointments.
- The outpatient redesign would include self-service check-in kiosks for patients. Staff told us these would reduce the queues at the reception desks and record the patient check in times. Appointment clerks would still be available for patients who were unable to use the automated system.

Outstanding practice and areas for improvement

Outstanding practice

- Snack box training had been set up to deliver specific and focussed small pieces of training to staff that can be accessed during their lunch break.
- Development of a hospital garden for the use of patients, including patients living with dementia.
- Development of an integrated care model supporting patients with three or more long-term conditions.
- A 'buddy system' was used in critical care where nurses were paired to work together, this was to ensure adequate supervision of patients during staff meal breaks and for checking medicines.
- Patient diaries in critical care were extremely well managed. The unit kept a copy of the diaries to ensure staff knew what the diaries contained; this enabled on-going support to be given to patients families after the diaries had been collected.
- At the foot of every bed space in the critical care unit there was an analogue clock, with the date also displayed and a very clear sign which said, 'You are in intensive care, you are in Yeovil Hospital.' This had been provided in response to patient feedback and helped to orientate patients to where they were being cared for and to the time and date.
- The critical care outreach team had produced and implemented a patient assessment document to aid the early recognition and prompt treatment of sepsis. As part of the education package unit staff had produced a video. A staff badge had been introduced to acknowledge hospital staff who had used the tool to identify and manage a patient with sepsis.
- In maternity and gynaecology services, the Acorn team provided specialist care for women who were vulnerable, were known to be at risk of domestic abuse, who smoked or were prone to substance abuse. Women under the age of 19 and women who had a learning disability could also be referred to the Acorn team.
- The children and young people's services' community nursing team provided a range of different services to meet the needs of patients. The team included specialists or nurses with an interest in specific conditions such as cystic fibrosis, oncology and end of life care.
- Services for children and young people had a school based within the children's outpatients department. The school had a qualified teacher, working Monday to Friday, to provide education to patients who had been in hospital for long periods.

Areas for improvement

Action the hospital MUST take to improve

- Ensure systems and processes to prevent and control the spread of infection are operated effectively and in line with trust policies, current legislation and best practice guidance. The trust must work to improve standards of hand hygiene across children's services.
- Ensure equipment is stored appropriately and in a way that reduces infection risk. Ensure equipment used by cleaning staff is not stored in the sluice area and toilet rolls are not stored on commodes. Ensure commodes are completely clean before returning them to clean utility rooms. Ensure clean equipment is stored off the floor to prevent contamination. Ensure the covers on metal linen shelving units are kept closed when not in use to prevent cross infection. Ensure contaminated disposable items are not stored with clean disposable items. Ensure systems and processes to prevent and control the spread of infection are operated effectively and in line with trust policies, current legislation and best practice guidance within the maternity operating theatre.
- The trust must ensure resuscitation equipment is routinely checked. The emergency department must ensure all resuscitation equipment is checked. Children's resuscitation equipment must be available in the children's assessment area in the emergency department. The trust must ensure all emergency

Outstanding practice and areas for improvement

lifesaving equipment, is sufficient and safe for use in maternity and gynaecology services and that there is evidence it has been checked in line with the trust policy.

- The trust must ensure medical and nursing staffing is sufficient to meet the needs of patients. The emergency department must undertake a review of staffing levels using a recognised assessment tool. The trust must recruit sufficient medical and nursing staff to enable the operational and staffing standards for intensive care units to be met. Ensure sufficient medical staff are on duty in the medical business unit at night. The trust must ensure staffing levels reflect the acuity of patients in accordance with British Association of Perinatal Medicine (BAPM) standards.
- Ensure that all patients receive appropriate and completed risk assessments, including those for dementia, on admission and an individualised care plan commenced to demonstrate the on-going actions taken to mitigate risk. The trust must also ensure nutritional screening assessments on surgical wards are completed in line with trust policies. Ensure the completion of documentation and of patient risk assessments on the gynaecology ward.
- Ensure that controlled drugs are managed in accordance with trust policies, legislation and best practice in the discharge lounge. Ensure oxygen, when required for patients, is prescribed appropriately. Ensure medicines are always safely managed in line with trust policies, current legislation and best practice guidance in maternity and gynaecology services. The radiology department must ensure that guidance is in existence surrounding patient group directive medicines.
- Ensure that at least 90% of all staff receive an annual appraisal. Ensure nursing staff in specialist areas are trained on recruitment or placement to become efficient and competent members of their staff team. The trust must train all staff who have direct input into assessing, delivering, and intervening in the care of children and young people, in level three child safeguarding in line with intercollegiate guidance. The trust must improve the numbers of staff trained in European Paediatric Life Support (EPLS) to ensure they meet Royal College of Nursing guidance of at least one

EPLS trained member of staff working every shift.

Ensure all overseas staff are supported to achieve a good standard of the English language to reduce risks to patients.

- The emergency department must put systems and processes in place to ensure patients receive initial assessment (triage) by an appropriately qualified clinical member of staff within 15 minutes of arrival to the emergency department.
- The emergency department must take action to ensure the safety of children in the waiting area of the emergency department.
- The emergency department must provide daily clinical and managerial leadership with oversight of capacity and demand. The emergency department must develop robust escalation processes.
- Ensure that all patient records are kept securely and located away from the public to maintain confidentiality.
- Ensure all wards have single sex accommodation including sleeping accommodation, bathroom and toilet facilities and do not need to pass members of the opposite sex to use the facilities.
- Ensure the sepsis protocol is embedded with all staff groups to achieve and maintain high levels of compliance with sepsis identification and antibiotic administration.
- The trust must ensure young adults (patients between the ages 18 to 24) meet the criteria for admission onto the Young Persons Unit.
- The trust must review the physical environment of Ward 10 and explore options to separate the Young Persons Unit from Ward 10 to ensure patients over the age of 18 do not have access to children.
- Ensure 'do not attempt cardio-pulmonary resuscitation' (DNACPR) forms are completed appropriately and in accordance with national guidance and best practice. The trust must also ensure DNACPR decisions are documented fully in accordance with the legal framework of the Mental Capacity Act 2005.
- Radiology must continue to target the quality assurance backlog of equipment.
- The radiology department must develop audits and action plans to address incomplete five steps to safer

Outstanding practice and areas for improvement

surgery checklists. The radiology leads must ensure guidance surrounding trauma computerised tomography (CAT) scanning is clear and not open to individual interpretation.

- The outpatients department must continue to support improvements to meet the national referral to treatment times.
- The trust must ensure that fewer appointments are cancelled by the hospital at short notice.

Action the hospital SHOULD take to improve

- The emergency department should review emergency consultant, on-site, presence in order to meet the Royal College of Emergency Medicine standard for senior clinical cover within a listed trauma unit.
- The emergency department should provide reception staff with clear instructions for when it is necessary to alert a clinical member of staff, about the condition of a patient arriving to the emergency department reception area. The emergency department should ensure all new and temporary nursing and medical staff receive local induction.
- The emergency department should work with infection control to develop cleaning schedules for the department. The trust should ensure there is a system implemented to identify clean items of reusable equipment within the ward/department environment.
- The emergency department should review options for expansion of the department in order to meet the needs of the local population.
- The trust should ensure there are systems in place to review all consumable items within a ward or department to reduce the risk of out of date items being used for patients.
- The trust should ensure all medical outliers receive the same standard of care and regular medical reviews, regardless of where in the hospital they are placed. The trust should ensure, that when requested to do so, medical staff attend to medical outliers in a timely way.
- The trust should ensure an adequate supply of falls alarms are available for patients in order to reduce their risks of falls.
- The trust should ensure each ward's safety thermometer data is displayed in a prominent position for staff, visitors and patients to review easily.
- The trust should ensure all staff, including medical staff, adhere to the five moments of hand hygiene to reduce the risk of cross infection. The trust should ensure administrative staff adhere to their policy of bare below the elbows whilst in a clinical environment.
- The trust should ensure that items of equipment awaiting removal from ward areas are not stored in corridors.
- The trust should ensure doctors who prescribe antimicrobial medicines do so following best practice including a stop and/or review date and the indicator for the prescription.
- The trust should ensure all risk assessments for patients are completed in full.
- The trust should consider developing their own safeguarding policy for staff to adhere to. The trust should ensure that all grades of staff attain at least their target training level of 90% for adult safeguarding.
- The trust should ensure senior medical staff support patients, staff and relatives when requested to do so, on the Intensive Therapy and High Dependency Units.
- The trust should ensure patient's whiteboards contain updated information at all times to identify those who require specialist care or treatment.
- The trust should ensure the system for identifying patients living with dementia, and who require assistance to eat and drink, is applied consistently and fully embedded across the medical wards.
- The trust should ensure all staff undertake Mental Capacity Act training to reach at least 90% compliance.
- The trust should ensure members of the executive team become more visible to staff in the medical business unit on a regular basis.
- Ensure complaints raised by patients on surgical wards, which were dealt with by the ward, are documented in order for themes and trends to be properly evaluated.
- Reduce the delayed discharges over four hours from the critical care unit to the main wards and the number of discharges out of hours between 10pm and 7am. Review the provision of the critical care outreach team service which was not being provided, as recommended in best practice, for 24 hours a day.
- The trust should hold standardised critical care mortality and morbidity meetings to provide

Outstanding practice and areas for improvement

assurance that there are no unsafe clinical practices and to provide professional learning. Consider establishing regular multi professional clinical governance meetings specifically for critical care.

- Ensure the risk management process is standardised for critical care to ensure all risks are managed using the critical care risk register and that all senior staff are involved in this process. The critical care unit should also ensure all local clinical guidelines are reviewed and that document control processes are effective so the currency and relevance of information can be assured.
- Ensure that the outcome of incident investigations are consistently shared in sufficient detail with critical care unit staff to enable learning to take place. Re-establish regular staff meetings for all critical care nursing staff and consider involving the wider multidisciplinary team in some of these meetings.
- Senior critical care unit managers should consider taking steps to become actively involved in the recruitment process of nurses to this specialised area to help reduce the high turnover of staff.
- Support more staff to obtain the post registration qualification in critical care to meet the Core Standards for Intensive Care Units 2013. The trust should consider establishing a dedicated clinical nurse educator for the critical care unit, to assist with the co-ordination of education and support for all staff, particularly the newly recruited staff.
- The trust should ensure maternity and gynaecology staff who are recovering post-operative patients, regardless of the method of anaesthesia, should have appropriate training to comply with the recommendations of the British Anaesthetic and Recovery Nurses Association (2012).
- The service should look to provide a more cohesive and responsive service for all gynaecology patients receiving care at Yeovil District Hospital. The trust should continue to recruit more substantive gynaecology trained nurses for the gynaecology ward.
- The trust should provide further training to staff on Ward 10 in order to help them care for young people with mental health conditions.
- The trust should review the governance arrangements for the children's outpatient department including streamlining booking processes. The trust should review guidelines on a regular basis to ensure they relate to the latest national guidance and best practice for children and young people's services.
- The trust should consider improving the estates environment, including the outside area of children's outpatients.
- The trust should consider the introduction of the play service to support patients, their parents and carers.
- Review the leadership arrangements and focus on end of life care to ensure that it is given sufficient priority at business unit and board level. Develop an internal audit programme for end of life care on clinical practices and put in place an improvement programme to address issues found in the audits.
- Monitor and audit the number of patients attending outpatients and diagnostic imaging services without notes available. Outpatients and diagnostic imaging services should ensure that where audits are performed, target figures and action plans are developed. The outpatient department should monitor the patient waiting times within the department.

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	<p>Regulation 9 HSCA (RA) Regulations 2014 Person-centred care</p> <p>How the regulation was not being met:</p> <p>Regulation 9 (2) Providers must make sure that they provide appropriate care and treatment that meets people's needs, but this does not mean that care and treatment should be given if it would act against the consent of the person using the service.</p> <p>The provider did not ensure 'do not attempt cardio-pulmonary resuscitation' (DNACPR) decisions were always documented legibly and completed fully in accordance with the trust's own policy, national guidance and best practice and the legal framework of the Mental Capacity Act 2005.</p>

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	<p>Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect</p> <p>How the regulation was not being met:</p> <p>Regulation 10 (2)(a) Ensuring the privacy of the patient.</p> <p>The trust did not ensure single sex accommodation, including segregated sleeping accommodation and segregated bathroom and toilet facilities, were in place on one ward. In addition, access to toilet facilities meant patients were required to pass through opposite sex areas.</p>

Regulated activity	Regulation
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Requirement notices

Diagnostic and screening procedures

Surgical procedures

Treatment of disease, disorder or injury

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

How the regulation was not being met:

Regulation 12 (1)(2)(a)(c) Assessing the risk to the health and safety of service users.

Patient initial assessment (triage) in the emergency department was not completed in a timely way by an appropriately qualified clinical member of staff within 15 minutes of arrival to the emergency department.

Patients experienced delays in their treatment pathways, delaying transfer to an appropriate ward. Robust escalation processes had not been developed in the emergency department.

The trust sepsis protocol was not embedded with all staff groups to achieve and maintain high levels of compliance with sepsis identification and antibiotic administration.

Not all staff involved in assessing, delivering, and intervening in the care of children and young people were trained in level three safeguarding.

Regulation 12 (1)(2)(g) Care and treatment must be provided in a safe way for service users by the proper and safe management of medicines.

Controlled drugs were not always managed in accordance with trust policies, legislation and best practice in the discharge lounge. Oxygen, when required for patients, was not prescribed appropriately in medical wards.

The radiology department did not have guidance available for patient group directive medications.

Requirement notices

Medications in the maternity operating theatre were not always suitably stored so were at risk of theft, being tampered with, and accidental or unintentional ingestion by unauthorised persons.

Regulation 12 (1)(2)(h) Assessing the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated.

Staff did not meet the trust's required standards for hand hygiene presenting an infection risk to patients in children and young people's services.

Regulated activity

Diagnostic and screening procedures
Treatment of disease, disorder or injury

Regulation

Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

How the regulation was not being met:

Regulation 13(1) Service users must be protected from abuse and improper treatment.

Regulation 13(2) Systems and processes must be established and operated effectively to prevent abuse of service users.

There were no effective systems and processes in place to protect children and young people on Ward 10 from abuse and harm. The Ward had an integrated young adults unit and there were no systems in place to prevent adults over 18 from harming children and young people. Managers did not follow admission criteria, meaning adults with general conditions were allowed to be placed onto the ward.

Requirement notices

Regulated activity

Diagnostic and screening procedures
Surgical procedures
Treatment of disease, disorder or injury

Regulation

Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

How the regulation was not being met:

Regulation 15(1)(a) Premises and equipment must be kept clean and cleaning must be done in line with current legislation.

Systems and processes to prevent and control the spread of infection were not operated effectively and in line with trust policies, current legislation and best practice guidance. Patient areas in the emergency department were not always cleaned between patients. Storage areas within the department were visibly dirty.

Equipment was not stored appropriately and in a way that controlled and prevented infection risk in medical wards. Systems to manage the prevention and control of infection were not in place on surgical wards.

The provider failed to ensure that the environment in the maternity operating theatre was cleaned and properly maintained.

Resuscitation equipment was not checked daily and was not maintained in areas of the emergency department, medical wards and maternity.

Regulation 15(1)(b) Security arrangements must make sure that people are safe whilst receiving treatment.

Access to the children's emergency department was by push button entry. This allowed free access and did not ensure the safety of children.

This section is primarily information for the provider

Requirement notices

Regulation 15(1)(c) Suitable for the purpose for which they are being used.

There was not adequate separation between the young adults unit and the paediatric Ward 10. This presented a risk to children and young people. A lack of physical separation meant the paediatric unit was not secure from young adults and their visitors on the ward.

Radiology had not fully managed the quality assurance backlog of equipment.

Regulated activity

Diagnostic and screening procedures
Surgical procedures
Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

How the regulation was not being met:

Regulation 17 (1)

Systems or processes must be established and operated effectively to ensure compliance with the requirements in this part.

Regulation 17 (2) (c)

Maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and decisions taken in relation to the care and treatment provided.

The trust did not store all patient records in a lockable, secure area which maintained patient confidentiality and upheld data protection. Large numbers of patient

This section is primarily information for the provider

Requirement notices

records were left in an open area which was accessible to the public. Patients' notes were not always stored securely on the wards and were accessible to patients and visitors.

The trust did not have individualised and accurate patient care plans or risk assessments in place to ensure care and treatment was and had been delivered, with the input of patients, and to mitigate identified risks.

The emergency department did not always have access to or the presence of clinical and managerial leadership, with oversight of capacity and demand.

The radiology department did not have audits and action plans to address incomplete five steps to safer surgery checklists.

Guidance surrounding trauma computerised tomography (CAT) scanning was not sufficiently clear to prevent it from being open to individual interpretation.

The outpatients department had not fully achieved improvements required to meet the national referral to treatment times. The provider had failed to minimise numbers of appointments cancelled by the hospital at short notice.

Regulated activity

Diagnostic and screening procedures

Surgical procedures

Treatment of disease, disorder or injury

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

How the regulation was not being met:

Regulation 18(1) Sufficient numbers of suitably qualified, competent, skilled and experienced staff.

Requirement notices

There was insufficient nursing staff and a reliance on bank and agency to fill shifts in the emergency department.

The resuscitation area was understaffed with one nurse to three patients. The area included provision for children.

Adequate medical cover for times of peak activity was not always available in the emergency department. A review of staffing levels using a recognised assessment tool had not been undertaken.

Specialist consultant on-site cover in the emergency department did not meet the Royal College of Emergency Medicine standard of 16 hours per day.

Fewer than 90% of all staff in the medical business unit had received an annual appraisal.

Nursing staff had not received appropriate training in specialist areas on recruitment or placement in medical wards.

Sufficient medical and nursing staff had not been recruited to the critical care unit to enable the operational and staffing standards for intensive care units to be met.

There were insufficient numbers of staff to meet Royal College of Nursing guidance of at least one European Paediatric Life Support (EPLS) working per shift. This presented a risk to seriously unwell patients. Staffing levels did not reflect the acuity of patients in accordance with British Association of Perinatal Medicine (BAPM) standards.

This section is primarily information for the provider

Enforcement actions (s.29A Warning notice)

Action we have told the provider to take

The table below shows why there is a need for significant improvements in the quality of healthcare. The provider must send CQC a report that says what action they are going to take to make the significant improvements.

Why there is a need for significant improvements

Start here...

Where these improvements need to happen

Start here...