

Harrogate and District NHS Foundation Trust

RCD

Urgent care services

Quality Report

Lancaster Park Road
Harrogate
North Yorkshire
HG2 7SX
Tel: 01423 885959
Website: www.hdft.nhs.uk

Date of inspection visit: 2-5 February 2016
Date of publication: 27/07/2016

Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/unit/team)	Postcode of service (ward/unit/team)
RCD02	Ripon and District Community Hospital	Minor Injuries Unit	HG4 2PR
RCBXD	Selby War Memorial Hospital	Minor Injuries Unit	YO8 9BX






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

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

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

Summary of findings

Ratings

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

Summary of findings

Contents

Summary of this inspection

	Page
Overall summary	5
Background to the service	6
Our inspection team	6
Why we carried out this inspection	6
How we carried out this inspection	6
What people who use the provider say	7
Areas for improvement	7

Detailed findings from this inspection

The five questions we ask about core services and what we found	8
Action we have told the provider to take	19

Summary of findings

Overall summary

The service prioritised patient protection from avoidable harm and abuse. Patients were seen and treated quickly; in an appropriate environment with good facilities. The departments met the national standard for seeing, treating and discharging patients within four hours.

Patients' complaints were taken seriously and responded to in a timely way. Feedback from patients was positive and patients were treated with compassion, dignity and respect.

Staff had the appropriate qualifications however; there were no competency packages for new or non-qualified staff. Structures, processes and systems of accountability including governance and management partnerships, and joint working arrangements were not clearly set out. The minor injuries units and ED worked in isolation of each other.

There were lack of clinical audits of patient outcomes at the MIU's and a lack of presence of senior leaders.

Summary of findings

Background to the service

Information about the service

Urgent and Emergency services were provided from the emergency department at Harrogate District Hospital, which is the main emergency department (ED) and minor injuries units (MIU) at two hospitals in the community, Selby and Ripon. This report will focus on the CQC inspection findings at the minor injury units at Selby and Ripon. A separate report will discuss the findings of the CQC inspection at the main emergency department at Harrogate District Hospital.

The minor injury unit at Selby is open from 7.30am to 9pm seven days a week and the minor injury unit at Ripon is open from 8am to 9pm seven days per week.

Patients attending the minor injury units normally self-refer unless they call an ambulance. If ambulance personnel decide their injury or illness can be dealt with at the minor injury unit they will transfer to the appropriate unit. Nurse practitioners, with specialised training in the assessment and treatment of minor injury and illness, run the units. The units deal with non-life threatening injuries and illness such as lower and upper limb injury, wound care, minor burns, coughs, colds, ear problems, sore throat and insect bites.

Our inspection team

Our inspection team was led by:

Chair: Elaine Jeffers, Independent Chair

Head of Inspection: Julie Walton, Care Quality Commission

Team Leader: Karen Knapton, Inspection Manager, Care Quality Commission

The team included CQC inspectors and a variety of specialists including an A&E Nurse Manager and Operations Manager.

Why we carried out this inspection

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

How we carried out this inspection

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

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

Before visiting, we reviewed a range of information we held about the service and asked other organisations to

share what they knew. We analysed both trust-wide and service specific information provided by the organisation and information that we requested to inform our decisions about whether the services were safe, effective, caring, responsive and well led. We carried out an announced visit from 2 to 5 February 2016

During the inspection, we visited the minor injuries units at Ripon and district community hospital and at Selby war memorial hospital.

Summary of findings

We observed how people were being cared for and talked with patients and family members who shared their views and experiences of the care they had received. We reviewed care and treatment records of children and young people who used the services.

We spoke with six patients and relatives and three of the four members of staff on duty. We observed care and treatment and looked at care records for 14 people.

What people who use the provider say

Feedback we received from patients and their relatives, about the minor injury units, was consistently positive. Patients praised the staff and all said they were treated kindly, with dignity and respect.

The CQC comments card feedback from people was very positive.

Areas for improvement

Action the provider **MUST** or **SHOULD** take to improve

The trust must:

- Ensure that PGDs (Patient group directives) are updated in the MIUs.
- Ensure a protocol is in place for treating children under one years old.
- Ensure staff receive resuscitation training for adults and paediatrics in line with the Resuscitation Council (UK) recommendations.

The trust should:

- Ensure staff are up to date with major incident training and understand their role in a major incident.

- Ensure peer review takes place and audits of patient outcomes to ensure best practice guidelines are adhered to.
- Review staffing and lone working within the units.
- Ensure patients are assessed and given timely pain relief.
- Have robust systems in place to record, monitor and audit when discussing or referring patients to an external trust
- Formalise joint workings arrangements with GP OOH
- Ensure nurse independent and supplementary prescribers maintain their skill base.

Harrogate and District NHS Foundation Trust

Urgent care services

Detailed findings from this inspection

Requires improvement 

Are services safe?

By safe, we mean that people are protected from abuse

Summary

We rated safe as requires improvement because:

- There were periods at the beginning and end of the day when there was a lone nurse practitioner on duty.
- We found no evidence of infection prevention or cleanliness audits carried out at Selby MIU.
- Patient group directives were out of date and in use, despite nurse practitioners being qualified as independent prescribers.
- There were some inconsistencies with systems for checking controlled drug stocks.
- There was no protocol in place for the treatment of children under one year old.
- The number of staff trained in resuscitation for adults and paediatrics was low
- Staff had not received training in major incident awareness and were unsure of their role in a major incident.

However,

- The service prioritised patient protection from avoidable harm and abuse. Incident reporting was good and staff felt they learnt from feedback.
- The departments were clean. Infection prevention and control audits were completed at Ripon MIU.

- The standard of record keeping was good and in line with trust policy.
- The departments had systems in place to manage patients at risk of deterioration.
- Medicines storage was appropriate, except for checking controlled drugs, and in line with trust policy.

Detailed findings

Incident reporting, learning and improvement

- From September 2014 to September 2015, there were 12 reported incidents at the Selby MIU and 28 reported incidents at Ripon MIU. One resulted in 'moderate harm', five resulted in 'low minimal harm' and the remaining resulted in 'no harm'. The highest number of no harm incidents were related to IT issues. The moderate harm incident was because of incorrect treatment.
- To report incidents staff used an electronic system. Staff were confident about using the system and were encouraged to report incidents.
- Serious incidents were reported through the Strategic Executive Information System (STEIS). There were no serious incidents between September 2014 to September 2015.

Are services safe?

- Between September 2014 to September 2015 the MIU's did not report any 'never events', (which are defined as serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented).
- Following investigations of incidents of harm or risk of harm, staff told us they always received feedback.
- In the Emergency Department Care Quality Group monthly meetings, incidents which resulted in harm, including those in the MIU's and any actions taken because of those incidents, as well as lessons learnt were discussed.

The duty of candour

- The duty of candour sets out key principles, including a general duty on the organisation to act in an open and transparent way in relation to care provided to patients. This means that as soon as reasonably practical after a notifiable patient safety incident occurs, staff should tell the patient (or their representative) about it in person
- The trust had policy and procedures for complying with the duty of candour. The nurse practitioners we spoke to were aware of the application of the duty of candour. An example given of this was regarding a missed diagnosis of a fracture.

Safeguarding

- The department had systems in place for the identification and management of adults and children at risk of abuse (including domestic violence).
- Staff said they knew how to recognise and report both adult and children safeguarding concerns.
- We observed staff accessing the trust safeguarding guidelines, which were readily available in a folder and on the trust intranet. This provided information of how to make referrals, and the contact details of the safeguarding team, when staff had concerns about a child or adults' safety.
- There were safeguarding lead nurses in the trust and a robust referral system in place.
- Mandatory training records indicated MIU staff received safeguarding adults Level 1, and children's' Level 1 and Level 3 training. 100% of nurses received safeguarding Level 1 training, 71% of nurses had received safeguarding children and young people training Level 1 and 64% of nurses had received safeguarding children and young people Level 3 training.

- Staff were aware of the assessment for child exploitation and female genital mutilation.

Medicines management

- Staff followed systems that demonstrated compliance with the Medicine Act 1968 and the Misuse of Drugs Act 1971.
- We looked at the storage of medicines, which were in a room with swipe card access at Selby MIU and keypad access at Ripon MIU. Which provided only authorised access for staff. All medicines were stored in an appropriate locked cupboard.
- Controlled drugs should be checked daily according to trust policy. We found 15 days between November 2015 and January 2016 when checking had been missed at Ripon MIU. Three days in December were missed at Selby MIU. The usage of controlled drugs was rare.
- The storage of medical gases was appropriate.
- Although all the nurse practitioners were independent prescribers, patient group directives (PGDs) were used and the nurse practitioners were not using their prescribing rights. PGDs are documents permitting the supply of prescription only medicines to groups of patients without individual prescriptions. We found all of the PGDs had passed the date they should have been reviewed to ensure they were up to date with best practice. The authorised signature lists were not up to date and there was no system in place to ensure that signatures corresponded to the most recent edition of the PGD. The trust policy stated it was the ward/ department managers' responsibility to ensure PGDs were suitable for use and that staff were appropriately trained. In addition, signatures were not always ratified by a senior authorising healthcare professional.
- There was a lead nurse practitioner for medicine management at each location.
- A pharmacist from Harrogate District Hospital would visit each location and check the medicine stock and controlled drug registers.
- Medication fridge temperatures were checked daily to ensure that they were in the appropriate range as per policy. The temperature recording was high on one occasion and this had been reported and fixed, with appropriate actions taken.

Safety of equipment

Are services safe?

- Daily checks were made of the resuscitation trolleys. Each one was fully equipped. The resuscitation trolley at Ripon MIU was stored on the ward but easily accessible.
- Checks of oxygen took place and cylinders were in date.
- We observed that all, electrocardiogram (ECG) and Dinamap (monitors vital signs) machines were electrically (PAT) tested and serviced.

Records and management

- We checked 14 sets of records in total across the two minor injury units. All the records were completed electronically. There were different IT systems used. Ripon MIU used three systems, one for patients who were referred for routine treatments, e.g. dressings, one for non-routine and one when they saw patients referred from the GP out of hours' service.
- We found that the general standard of records was good, accurate and complete.
- The frequency and documentation of the recording of patients' observations was appropriate.
- The recording of the patients' allergy status was on each patient's notes.
- The electronic system alerted staff to any patient specific concerns or risks. For example, if a patient had a previous infection or a safeguarding concern.

Cleanliness, infection control and hygiene

- The units were visibly clean in all areas. We observed cleaning in progress.
- There was a checklist for cleaning and these were up to date. In some areas at Ripon MIU paintwork was tired and chipped.
- We observed staff wash their hands, use hand gel between patients and observed staff comply with 'bare below the elbows' policies.
- We saw the availability of personal protective equipment (PPE) when dealing with patients on all occasions.
- Sharps bins were not overfilled and were dated and signed.
- There were sinks with non-touch taps in each treatment room.
- Disposable curtains were used at Selby MIU; however, they had not been changed since May 2015, therefore were dusty.

- Infection control audits of the Ripon showed 100% compliance for cleanliness between April 2015 to June 2015 and 99% in October 2015 to December 2015. We did not see any evidence of infection prevention audits for Selby MIU.
- We saw evidence of a hand hygiene audit carried out in Ripon MIU in October 2015 that scored 100%. There was no evidence of monthly hand hygiene audits at Selby MIU.

Mandatory training

- There was a trust mandatory training policy in place, which referenced 30 statutory training requirements, mandatory training requirements and training in essential skills, which included such topic areas as safeguarding for adults and children, infection prevention and control, medicines management, the Mental Capacity Act 2005, the deprivation of liberty safeguards (DoLS) and others.
- For each training element the staff groups were identified and the frequency of each training element. Employees had a personal training account, which reflected the mandatory/essential training needs required by them as an individual and reflected if their training was up to date and when it would expire.
- Compliance with training was managed through a RAG (red, amber green) rated system for the individual through to directorate and trust level.
- The compliance rates for the directorates/trust were set at 95%. They were rated as green if they were 75% or above – this was explained as the trust identifying that they would have been on track to meet trajectory. Figures below 75% were rated as red or amber dependent on the percentage.
- The Selby MIU overall was 91% compliant and Ripon MIU overall was 93% compliant with mandatory training
- Resuscitation training compliance was poor. Selby MIU had no staff trained in adult intermediate life support and 67% of staff (6 out of 9) trained in paediatric intermediate life support. Ripon MIU had 38% of staff (3 out of 8) trained in adult intermediate life support and 50% of staff (4 out of 8) trained in paediatric intermediate life support.
- Staff completed most mandatory training using e-learning however, there were some clinical skills that resulted in competency based classroom sessions.

Are services safe?

- Time was allocated in the off-duty for face to face mandatory training, although staff did on-line learning in their own time or at work if time was available.
- New staff received a corporate induction programme that included some face to face mandatory training.

Assessing and responding to patient risk

- There was no triage system in place; however, reception staff would escalate if they had any concerns about a patient. At Ripon MIU, a clinical support worker registers patients at the reception; at Selby MIU a receptionist would do this.
- A 'See and Treat' system was used. This involved seeing patients when they arrived, assessing their needs, and providing treatment.
- Patients were seen in order of arrival unless there were any concerns.
- National Early Warning Scores (NEWS) scores were not routinely used. NEWS scores would be used to quickly determine the degree of illness of a patient. However, staff were aware of NEWS scores and had access to a copy of these if they had an unwell patient and needed to communicate to the acute hospital or ambulance service.
- There were no specific protocols or operating procedures in place for children under 1 years old. A paediatric warning score was used for ill children and referral would be made to an Emergency Department if the nurses deemed necessary.
- An ambulance referral criterion was in place if patients required transfer to an acute hospital.
- There was no formal escalation procedure in place if the department became full. However, the staff would contact a senior manager on call. This rarely happened.
- If staff had concerns regarding a patient and needed advice, Ripon MIU would contact Harrogate ED and Selby MIU would contact York ED, which are the nearest ED's for transfer.

Staffing levels and caseload

- The minor injury units were nurse led. There were nurse practitioners and clinical support workers at each unit.

- Most staff worked part time hours. Between both MIU's there were 15 trained nurses and five unqualified nurses. Staff turnover was low.
- We found that existing staff backfilled vacancies, sickness and staff holidays. Agency staff were only used occasionally at Ripon MIU.
- We were told no acuity tool was used when setting the staffing establishments.
- Planned staffing was two nurse practitioners (NP) on duty between 8am and 8pm at Selby and two nurse practitioners (NP) between 10am to 6pm at Ripon MIU. However, the units open from 8am to 9pm, leaving one NP to work alone at the beginning and end of the day. The clinical support workers hours varied around clinics and supporting the GP out of hours' service.
- We found staffing levels and shift times to be inconsistent, and a lone worker at times was a risk. We were informed Ripon MIU had closed early at times due to staffing problems.
- The average sickness levels from August 2015 to January 2016 were 4.18% for Ripon MIU and 5.56% for Selby MIU.

Managing anticipated risks

- There were instructions with the reception staff for various conditions in which the nurse would see the patient immediately, such as chest pain, an unwell baby, overdose or poisoning.
- Lack of security arrangements and one lone worker at the beginning and end of the shift could be a potential risk. However, there were no reported incidents in the last 6 months of incidents we reviewed.

Major incident awareness and training

- Staff were aware of how to treat a patient with suspected Ebola and a Ebola awareness document was available.
- Staff were unaware of a plan specifically for the units, although they were aware there was a trust wide major incident policy.
- We reviewed the trust wide major incident plan and there were actions for the MIU's.
- Staff had not received any training in major incidents.

Are services effective?

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

Summary

We rated effective as requires improvement because:

- Staff were qualified to carry out their roles effectively and in line with best practice. However, clinical audits and other monitoring activities such as peer reviews were not shared internally and externally to improve care and treatment of people's outcomes.
- There were no audits regarding patient outcomes.
- There were no formal training arrangements or competency packages for new staff; training was done on an ad-hoc basis.
- If required, the Selby MIU would refer patients to another trust, as this was the nearest ED. However, if only advice was required there was no formalised system to record or audit clinical advice given by another organisation.
- There was no formalised joint working arrangements with the GP out of hours service.
- There were no clinical pathways in place

Detailed findings

Evidence based care and treatment

- Staff said they were able to access all policies and procedures on the intranet. There were also printed copies available for the more commonly used policy and procedures.
- The teams worked within the trust's policies, procedures and guidelines that originate from nationally recognised best practice guidance such as the National Institute for Health and Care Excellence (NICE).
- There were no clinical pathways in place.
- We were told that peer review was carried out within the MIU among their own nurse practitioners, where they would randomly look at each other's notes. However, we did not see evidence of this and this did not extend to a medical review from the consultants or review from the other MIU or ED staff. This would ensure consistency in practice and ensure best practice guidance was followed.

Pain relief

- In the records we reviewed pain scores were rarely recorded and there was no record that analgesia had been given when deemed it was needed.
- The units did not audit pain scores.
- The patients we spoke with and the feedback we received patients had no complaints in the way their pain was managed.

Nutrition and hydration

- Staff advised that kitchen staff would provide patients with tea, biscuits or diabetic lunch boxes if they had an extensive wait to be seen or transferred.
- There was an on-site café and vending machines available within the hospital buildings.

Outcomes of care and treatment

- We saw no evidence of any audits carried out.
- There were no figures for unplanned re-attendance rates to the MIU's
- From the patient records we viewed, all patients were seen within one to seventeen minutes of arrival, which is better than England standard of patients being seen and treated within four hours for emergency departments.

Competent staff

- The team leader was responsible for undertaking their team's appraisals; 73% of nurses and 75% of additional clinical staff had received their annual appraisal in January 2016. This was in line with the trust target of 85% by April 2016.
- New nursing staff were allocated a mentor supported their learning, and they had a supernumerary period of time that varied depending on their previous experience and learning needs.
- There was no formal in house training; we were told this was done on an ad-hoc basis.
- Qualified nurses had completed the minor illness and minor injury courses at a local university. The trust had supported this.

Are services effective?

- We were told there was no specific competency training for clinical support workers; however, they had a Level 2 qualification and had undertaken training, for example, taking blood samples.
- Staff told us peer support was good and that team members worked well together. Staff felt able to approach colleagues for advice within their unit. However, there was no supervision in place or peer review from outside the individual units.

Multidisciplinary working and coordination of care pathways

- Minor injury unit nursing staff worked together with GPs, consultants, x-ray technicians, and other hospitals both internal and external to the trust.
- Staff felt the mental health teams were not as responsive as they expected; however, they would refer patients to the local acute trust ED if they were concerned about their mental health.
- We did not see any evidence of standardised, documented pathways or agreed care plans.
- Both MIU's worked alongside the GP service, where joint care was given to some patients, for example GP's could book patients to have minor procedures done in MIU, or MIU nurse practitioners (NP)s could refer to GP's for wound assessment.
- There was no formalised joint working arrangements with the GP out of hours service.

Referral, transfer, discharge and transition

- An ambulance referral criteria was in place if patients required transfer to an acute hospital.
- Staff stated that the majority of delays were due to waiting for ambulance transfers as these were prioritised by the ambulance service.
- We did not see any discharge protocols for both adults and children. Staff explained they made discharge decisions regarding adults and children, however, if they had any concerns they would discuss with the doctors at the ED.
- Staff at Selby MIU would refer patients to York ED as this was the nearest ED, whilst Ripon MIU would refer patients to Harrogate ED.

- There was no formalised system between the ED's of recording when advice was given, other than the nurse documenting in the patients notes. No documentation was made by the ED giving the advice.

Availability of information

- We observed that patient records were stored securely on the IT system and no patient identifiable information was visible to people attending the departments.
- Records were available for nursing staff and there were no reports of concerns obtaining relevant information about patients.
- We found that sharing of confidential information between teams and the local authority was in line with the trust policy and procedures.
- Staff had access to information, policies and procedures via the trust intranet.

Consent

- Nurses obtained verbal consent from patients before providing care and treatment. We heard staff explaining treatments and diagnoses to patients, checking their understanding, and asking permission to undertake examination and perform tests.
- Training in the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards was included within the mandatory safeguarding training. Staff understood the legal requirements of the Mental Capacity Act 2005 and had access to social workers and staff trained in working with vulnerable patients, such as their safeguarding lead.
- Staff were clear about their responsibilities in gaining consent from people including those who lacked capacity to provide informed consent to care and treatment. Staff used Gillick competency principles when assessing capacity, decision making and obtaining consent from children. They must be able to demonstrate sufficient maturity and intelligence to understand the nature and implications of the proposed treatment, including the risks and alternative courses of actions.

Are services caring?

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

Summary

The minor injuries service rating for caring was good.

- The minor injury units provided a caring and compassionate service. We observed staff treating patients with dignity and respect.
- Feedback from patients, relatives and carers was consistently positive about the way staff treated people.
- People were treated with dignity, respect and kindness during all interactions with staff and relationships with staff were positive. People felt supported and said staff cared about them.
- Staff responded compassionately when people needed help and support.
- People's privacy and confidentiality were respected.

Detailed findings

Dignity, respect and compassionate care

- During the inspection we spoke to four patients and two relatives. The patients all gave positive feedback and were satisfied with the care they had received.
- We received feedback from 32 patients via CQC comments cards. Themes from the feedback were patients were treated promptly, with dignity and respect, and staff were friendly and professional.

- Feedback highlighted that all staff treated patients with understanding and kindness, felt their confidential details were secure and were happy with the care they received.

Patient understanding and involvement

- Patients told us that the nursing staff made a great deal of effort to explain tasks and processes. Patients highlighted that staff checked they understood and were always available to ask questions.
- We saw staff educating patients about their condition to prevent further problems.

Emotional support

- Staff were clear on the importance of emotional support needed when delivering care.
- We observed positive interactions between staff and patients.
- Patients had access to the full range of support provided at the trust. For example there was support available for the bereaved from the multi-faith chaplaincy service.
- The spiritual needs of patients were provided by a 24-hour chaplaincy support that provided sacramental care in the trust chapels.

Are services responsive to people's needs?

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

Summary

The minor injuries service rating for responsive was good because:

- The service responded to people's needs. People from all communities could access treatment if they met the service criteria for the minor injury units.
- The facilities and premises were appropriate for the services delivered.
- People could access care quickly; waiting times were minimal and managed appropriately.
- It was easy for people to complain or raise a concern and there was openness and transparency in how complaints were dealt with. Complaints and concerns were taken seriously and responded to in a timely way.

Detailed findings

Planning and delivering services which meet people's needs

- The MIU's were situated in community hospitals at Selby and Ripon. There was no emergency department within the hospitals.
- Patients presenting with major injuries or illnesses were taken by ambulance to the nearest emergency department.
- The staff informed us they had appropriate facilities and equipment to care for patients attending the minor injury unit.
- Data showed that between 1 April 2015 and 1 October 2015 Ripon MIU had 3998 attendances. This was an average of 154 patients a week.
- Selby was the busier of the two units. Between 1 April and 1 October 2015 they had 7682 attendances. This was an average of 295 patients a week.
- X-ray facilities were provided by the MIU's however, these were not available during the MIU full opening hours. If a patient needed an urgent x-ray they were referred to the nearest ED, or they would return the following day if the x-ray was not urgent.
- We were told the MIU had access to 'hot reporting', which meant a consultant radiologist reviewed the x-ray

immediately. Selby MIU x-ray facilities linked with a local ED in another trust and Ripon x-ray facilities linked with Harrogate ED. Consultants at those ED's could review x-rays on request.

Equality and diversity

- Minor injury units across the two locations delivered personalised patient centred care in line with patient preferences, individual and cultural needs.
- The trust's multi-faith chaplaincy team provided comfort and support to people in hospitals across the trust.

Meeting the needs of people in vulnerable circumstances

- Staff received dementia training as part of their mandatory training. However, there was not anything specific in place to care for patients with dementia who attended MIU. Staff told us if patients were distressed they would see them as quickly as possible, and encourage their carers to stay with them.
- Staff told us they did not have any specific guidance to assist them on how to support patients with a learning disability. They told us they would encourage their carer to stay with the patient to help alleviate any anxieties the patient may have. A 'VIP' card had been introduced which contained medical and personal information and used for patients with a learning disability.
- During the time of inspection we did not see a patient with a learning disability or dementia
- The nurses were aware of how to contact the mental health teams; however, due to any potential delays in assessment the nurses would refer these patients to the ED if they felt they needed a quicker assessment or if they had concerns about their mental health.
- A range of information leaflets were available for patients to help them manage their condition after discharge. Leaflets were available in English only.
- Interpreting and translation services were available. These could be either face to face or by telephone. Staff were aware how to access these. Staff told us it was rare these were needed.

Are services responsive to people's needs?

- Disabled toilets and baby changing facilities were available in the waiting room. Wheelchairs were accessible
- The reception area had a designated hearing loop.

Access and flow

- Minor injury unit locations were situated in rural areas to help improve access.. We found that each hospital was easy to access for local people.
- The MIU's had no triage arrangement in place, patients were seen on a first come first served basis. However, if the receptionist or nurse observed a patient needing immediate help, they would see them immediately.
- Performance on MIU waiting times and compliance to national targets such as seeing, treating and discharging patients within four hours of referral was met by the MIU's consistently.
- Access to advice and support from other departments was available by telephone when required.

- The nurse practitioners could refer directly to other specialities such as ENT.

Complaints handling and learning from feedback

- We found that four complaints had been made across the two minor injury units between September 2014 and August 2015. Three complaints were related to aspects of clinical treatment. One was regarding nursing care. We were told each complaint was investigated, an action plan was agreed and staff feedback was given.
- Response letters to complainants included an apology when things had not gone as planned. This is in accordance with the expectation that services operate under a duty of candour.
- We found that the staff could describe complaint escalation procedures, the role of the Patient Advice and Liaison Service (PALS) and the mechanisms for making a formal complaint.

Are services well-led?

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

Summary

We rated well led as requires improvement because:

- Structures, processes and systems of accountability including governance, management partnerships and joint working arrangements were not clearly set out.
- The minor injuries units and ED worked in isolation of each other with little consistency between them.
- There was lack of presence of senior leaders at the MIU's.

Detailed findings

Service vision and strategy

- The minor injury units were part of the acute and cancer care directorate.
- Patients and staff told us the service was valued by the local community.
- The directorate had a business plan that included a redesign of emergency and urgent care services. This would aim to prevent admission wherever appropriate to promote self-care. There were three actions, all of which should have been completed by September 2015: to improve appropriate referrals to other services; to introduce patient prophylactic VTE packs and; to develop practitioner guidance to ensure practitioners were working in line with national guidance and standardising practice across the service.
- Senior staff at the trust told us the vision would be better integration with primary care services.
- The staff we spoke with at the minor injuries units were aware of this vision

Governance, risk management and quality measurement

- The team leader would attend the care quality group meetings held by the ED where discussions took place regarding incidents, complaints and lessons learnt. However, the minutes we viewed of these meetings did not have a representative from the MIU's present and none of the discussions related to MIU.

- A directorate monthly senior leadership team meeting took place that discussed finance, performance data, changes to clinical practice and audit activity. Both these meetings fed into trust wide governance meetings.
- There appeared little consistency between the three departments and all appeared to work in isolation of each other. There was no joint staff meetings or liaison between sites.
- Governance systems did not appear to flow across all three departments. Consistency of meetings and uniformity across the departments were detached.
- There were no audits on patient outcomes and both MIU's lacked governance monitoring.
- There was no apparent agreement with and management of clinical advice received from a local ED for staff at the Selby unit.
- There was no formal arrangements with regard to joint working with the GP out of hours service

Leadership of this service

- The relationship between both the MIU's and the emergency department appeared segregated.
- Senior clinical management and leaders from the acute trust at Harrogate were not visible in the MIU's.
- The MIU's were described by their staff as a close knit team, they were managed by a team leader at Selby and a manager at Ripon. Staff felt well supported by their immediate managers and felt they were approachable.

Culture within this service

- Staff told us the units and the trust had an open culture and they felt confident about reporting any concerns.
- Staff spoke positively about the service they provided for patients.
- Morale appeared good across the two minor injury units. Staff were positive in their attitude and all said they enjoyed working in the units.

Public and staff engagement

Are services well-led?

- The MIUs did not take part in the friends and family national survey. However, the comments on the CQC comment cards were all positive and staff said they get good feedback from patients.
- Internal communication was in the form of staff have access to weekly e-bulletins, emails, intranet and extranet.
- The directorate had a business plan and had action plans in place to improve and sustain the urgent and emergency care service. These included promoting self-care and admission avoidance.
- As part of the unplanned care clinical transformation team, an urgent care and admissions avoidance-working group was set up, which were working on a number of projects to improve the service.

Innovation, improvement and sustainability

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	<p>Regulation 17 HSCA (RA) Regulations 2014 Good governance</p> <p>How the regulation was not being met: The patient group directives (PGDs) used to administer medication to patients were not up to date and there was no protocol in place for treating children under one years old.</p> <p>The trust must:</p> <ul style="list-style-type: none">· Ensure that PGDs are updated in the MIUs. Reg17(2)(a)· Ensure a protocol in place for treating children under one years old. Reg17(2)(a)