University Hospitals Dorset NHS Foundation Trust

Poole Hospital

Inspection report

Longfleet Road
Poole
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Tel:

Date of inspection visit: 28 September and 29 September 2022
Date of publication: 10/03/2023

Ratings

Overall rating for this service	Requires Improvement
Are services safe?	**Requires Improvement**
Are services effective?	**Inspected but not rated**
Are services caring?	**Inspected but not rated**
Are services responsive to people's needs?	**Inspected but not rated**
Are services well-led?	**Requires Improvement**

Our findings

Overall summary of services at Poole Hospital

Requires Improvement 

University Hospitals Dorset NHS Foundation Trust provides acute and emergency services to people living in Poole, Bournemouth and East Dorset. University Hospitals Dorset NHS Foundation Trust provides a wide range of hospital and community-based care to a population of 771,000 based in the Dorset, New Forest and south Wiltshire areas.

Core services include urgent and emergency care, medical care, surgery, critical care, outpatient services, maternity services, end of life care, diagnostic services and services for children and young people. The trust provides 1,220 inpatient beds and 150 day care beds. There is a 24-hour emergency department at both The Royal Bournemouth Hospital and at Poole Hospital, which is the designated trauma unit for East Dorset.

On 1 October 2020, The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust and Poole General Hospital NHS Foundation Trust merged to form a new organisation. Poole General Hospital is a location within the trust.

The trust provides a wide range of hospital and community-based care; and employs approximately 8,400 members of staff, both clinical and non-clinical.

The trust has not been rated since the merger in October 2020. The hospital's ratings were inherited from the previous provider.

We carried out a focused inspection with a short notice on 28 September 2022. The inspection was carried out because we had concerns about care and treatment in some areas of medical care. We did not look at all key lines of enquiry but limited these to areas where concerns had been raised.

We also inspected maternity services at this location. Please see separate maternity report for further information.

For a focused inspection, ratings can be applied to areas where enforcement action is taken.

Medical care (including older people's care)

Inspected but not rated

The service was inspected but not rated, except for the key question of safe which was rated requires improvement.

We found:

- The service did not always have enough nursing and health care assistants to care for patients and keep them safe. Staff did not always complete and update risk assessments for each patient.
- Patient records were not always stored securely. The service used systems and processes to safely prescribe, administer and record medicines. However, we found the storage of medicines and their use by date was not always safe.
- Patients did not always receive adequate amounts of food and drink to meet their needs and improve their health.
- The service was blocked by patients in beds who were medically fit for discharge due to a lack of community and social care packages in the region.
- Staff morale was low but still focused on the needs of patients receiving care.

However

- Staff understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff mostly identified and quickly acted upon patients at risk of deterioration.
- Staff assessed and monitored patients regularly to see if they were in pain, and mostly gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain. Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- The service was inclusive and mostly took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.
- Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear. Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Is the service safe?

Requires Improvement ➔➔

Our rating of safe stayed the same. We rated it as requires improvement.

Medical care (including older people's care)

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.

Staff understood the different forms of abuse and what action to take to promote patient safety. They knew how to report safeguarding concerns and understood how to identify patients with safeguarding concerns on the IT systems.

The provider had a safeguarding team which staff could approach for additional advice. We observed staff from different professions coming together to discuss plans for a patients discharge to ensure they were safe to return to their usual home.

The provider had an internal target of 90% of staff to be trained to Level 1 and Level 2 Safeguarding Adults. Poole hospital did not meet the trust target for adults safeguarding Level 1 and 2 at 86.8% and 87.7% respectively.

The provider had made the decision to increase the requirement for Level 3 safeguarding children to a wider range of staff and was currently working to train more staff to this level. The current number of staff trained to this level was 67.9%. This item was on its risk register and was being monitored. However, not all trusts train staff to Level 3 for safeguarding children.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

Ward areas were clean and had suitable furnishings which were visibly clean and well-maintained.

The service generally performed well for cleanliness. Poole Hospital performed a monthly audit where cleanliness was monitored. For the three month period from May to July 2022, the service scored on average 98.97% against the set cleaning criterion. Any criterion that were not met were flagged to the cleaning team.

Staff followed infection control principles including the use of personal protective equipment (PPE). The trust participated in the saving lives audit initiative that was launched by the NHS in 2009. This was designed to focus on high impact areas of patient care to help reduce the risk of healthcare associated infections. The trust results for hand hygiene showed an improving picture from July 2022 to September 2022 with the combined sites (Poole Hospital and The Royal Bournemouth Hospital) scoring 96.7% compliance for hand hygiene audits in September 22 for older people's medicine wards.

The trust used isolation bays for patients with COVID-19 and where there were outbreaks, patients were co-horted together in bays. Patients were tested if they showed signs of having COVID-19 or they had been in contact or near to another patient with COVID-19. At the time of inspection, the trust had an increase in patients with COVID-19. At the time of inspection some older people medicine wards were closed as a result of COVID-19 and we were unable to inspect these wards.

Assessing and responding to patient risk

Staff did not always complete and update risk assessments for each patient. Staff mostly identified and quickly acted upon patients at risk of deterioration.

Medical care (including older people's care)

Staff used a nationally recognised tool to identify deteriorating patients and mostly escalated patients within the specified time scales. The tool included recording physical observations; for example, blood pressure, pulse and respirations. Staff told us they knew when they had to call for medical review.

Patients were not always reviewed by a consultant within 14 hours of being admitted to the trust as per NHS England Clinical Standard Two. The trust had systems to monitor the time to first consultant review and to see if patients had regular ongoing review. We received trust level, site specific, data which indicated 63% of patients were reviewed within 14 hours during Monday to Friday with a lower percentage of patients reviewed on Saturday and Sunday. The data was taken between 28 March and 3 April during a 4-hour sample period. However, from the five files we sampled on the medical wards, we saw that 100% of patients were seen in a timely manner; although we were told this was not always the case for medical outliers. Medical outliers are patients who may be on another speciality ward due to high occupancy levels within the trust. There is a risk to patients' ongoing care needs and plans if they are not reviewed in a timely manner.

Staff shared key information to keep patients safe when handing over their care to others. Patients were reviewed daily during the week by a mixture of board rounds and multi-disciplinary team meetings. At weekends patients were risk assessed as to whether they required a daily review and any deteriorating patients were escalated for doctor / consultant review by nursing staff.

There was not always enough staff to meet the fundamental care standards for patients or ensure that patients at high risk of falls were monitored. Staff knew about and tried to deal with any specific risk issues for patients to the best of their ability. Staff told us that patients did not always receive the care that was required. We were told patients were not always repositioned the optimal number of times during a working shift. However data from the trust indicated a decrease in Category 3 and Category 4 pressure ulcers from the same period the previous year. Patients who are not repositioned at regular intervals could develop pressure ulcers. Staff did have access to pressure relieving equipment for patients assessed as being at high risk of pressure ulcers and falls risk assessments were completed. The trust had responded to the falls risk by trying to increase staff knowledge around what they could do to minimise the risk to patients.

The service had 24-hour access to mental health liaison and specialist mental health support. However, the trust reported a significant increase in the number of patients being admitted with mental health issues and this was confirmed by staff on the wards. Some of these patients did not have any medical reasons for being in hospital, for example, dementia patients. However, a suitable placement could not be found for them in an appropriate setting elsewhere. This was also a national problem. These patients sometimes required specialist support such as one to one support by a registered nurse which increased the overall pressure on nursing establishment levels and often required agency and bank nurses which increased agency expenditure for the organisation. Some nurses felt they required additional training in order to provide this specialist support. The Trust had limited access to external mental health beds and continued to work closely with external partners for timely access.

There was an electronic prescribing and medicines administration system where medical staff completed all prescriptions. Medical staff told us the system would not allow them to proceed to any prescribing of medicines unless a Venous Thromboembolism (VTE) risk assessment had been completed and information about patient allergies had been recorded.

Medical care (including older people's care)

We spoke with staff in oncology services to ask about the safe care and treatment of patients who received brachytherapy (a type of internal radiation therapy). Some of these patients required a general anaesthesia to ensure effective treatment could be delivered. Staff from the main operating theatre were allocated to support the oncology staff with these procedures. We were told an anaesthetist and a nurse would attend to provide the anaesthesia. The anaesthetist would only leave the unit when the patient had recovered, and it was safe to do so.

Nurse staffing

The service did not always have enough nursing and non-nursing staff to care for patients and keep them safe. Managers regularly reviewed and adjusted staffing levels and skill mix, however the lack of staffing meant that it was often difficult to safely staff wards. Bank and agency staff received a full induction. Some staff were moved to wards they were not familiar with, to help maintain safer staffing levels.

The service had a significant level of vacancy within the health care assistant (HCAs) band. There was also a high level of vacancies for registered nurses (RNs). In older people services there were approximately 70 HCA vacancies and 42 RN vacancies across both The Royal Bournemouth Hospital and Poole Hospital as at July 2022. This impacted negatively on patient care. As stated previously in assessing and responding to risk section, there was not always enough staff to provide one-to-one care for those patients requiring this. Staff talked about having to prioritise the care provided to patients in terms of what they could achieve, due to the staffing levels and the needs of the patients that day.

Nationally there is a shortage of both HCAs and RNs. The trust was aware that lack of RN and HCA staffing was an issue and it was recorded on the corporate risk register. The lack of staffing problem was compounded by issues with staff retention. Existing staff were working in difficult conditions, where there was not always enough staff for the wards and therefore the job was more stressful. Staff reported they did not always feel supported as they were sometimes moved to unfamiliar wards where they did not have the support of regular colleagues. Staff were moved to ensure safer staffing levels across the wards. This was not good for staff retention. Trust level data stated turnover for staff was regularly between 12% and 14% between August 2021 and May 2022.

Managers regularly reviewed and adjusted staffing levels and skill mix however this was often challenging. Fundamental care standards were not always being met. Matrons and directors of nursing had meetings at least twice daily to review nurse staffing across all hospital sites. The assessment of safe nurse staffing levels was carried out using a national tool. This information was reviewed alongside an assessment to ensure nursing staffing levels met patients' nursing needs. The trust used reported incidents as one way to assess if fundamental standards were met, including those incidents considered as a 'red flag'. During the period from March to June 2022, data for older people wards showed there were 43 red flags raised for omission in fundamental care and 30 red flags raised for patient at risk as unable to provide enhanced care (such as one-to one). However, staff has told us they did not always report incidents due to pressures on their time and the fact that they were short staffed.

Matrons used their professional judgement to make decisions about the level of staffing at any given time. At the daily staffing meeting each care group matron discussed the staffing in their clinical area and highlighted the clinical reasons behind the score given to their area. We were told there was an element of subjectivity in making these assessments and it was not always clear to staff how patients' acuity (how clinically unwell patients were) or the need for one- to-one nursing were taken into account. Some of the ways matrons addressed issues of safe staffing on wards was by asking non rostered staff to work clinically, moving staff to support areas that have safety concerns and authorising agency staff. When the trust was working at OPEL 4, staff whom were on internal study leave could be requested to work clinically.

Medical care (including older people's care)

The trust were trying to find innovative ways to attract staff, alongside running recruitment fairs. They had various initiatives to attract candidates such as the Trainee Nurse Associate programme, which was designed to enable the growth of the band four workforce to registered nurse level. There was a scholarship programme for people with experience of unemployment and young people leaving school and college with an interest in a career in healthcare. The Trust had successfully recruited 200 internationally educated nurses and was looking to employ a further 140 nurses during 2022, which it was on track to meet.

There were processes for ward managers to request bank or agency staff to improve staffing levels. These requests were signed off by senior leaders. The service used bank and agency nurses on the wards but requested staff who were familiar with the service. One ward, an escalation ward, was staffed by regular bank and agency nurses.

It was not always clear to patients and visitors how well the ward was staffed as not all wards displayed this data.

Sickness rates were relatively high, due in part to COVID-19. The trust wide sickness figure as at August 2022 was 4.7%.

Medical staffing

The service did not always have enough medical staff with the right qualifications, skills, training and experience. The service had implemented measures to keep patients safe from avoidable harm and to provide the right care and treatment. Managers had reviewed staffing levels and were actively looking to recruit more medical staff.

The service did not always have enough consultants to provide daily ward rounds in older people's medicine. The service mitigated this risk by holding multi-disciplinary meetings daily and ward rounds every other day. Junior doctors were made aware of the wards where there was consultant cover. Junior doctors stated they were able to access consultant advice if required.

Managers made sure locums had a full induction to the service before they started work.

The service had a consultant on call during evenings and weekends.

Records

Patient records were stored securely. Records of patients' care and treatment were not always fully completed. Records were easily available to all staff providing care.

Patient records were not always fully completed. An audit of patient records for 2021/22 in Poole Hospital for the older person medicine neurosciences (nursing notes) showed the quality of record keeping was poor and had deteriorated from the previous year. In particular 48% of nursing entries included the time and 53% of nursing entries were considered legible. One of the audit criteria was for all notes to include a clearly written plan of care with goals, for example a care plan and 52% of notes complied with this, versus 100% from the audit the previous year. From the five sets of notes reviewed on the day of inspection, the majority of documentation was complete.

Patient records we reviewed did not consistently demonstrate patients' communication needs were assessed in line with national guidance.

When patients transferred to a new team, there were no delays in staff accessing their records.

Medical care (including older people's care)

Medicines

The service used systems and processes to safely prescribe, administer and record medicines. However, we found the storage of medicines was not always safe.

We found the storage of medicines was not always safe. We saw that the temperature of fridges used to store medicine was not always recorded regularly. If fridge temperatures are above or below specified limits, then the efficacy of the medicine can be affected. At Poole hospital we saw medicines which should be stored in a locked cupboard, left out on the side counter. We observed some medicine storage cupboards had broken locks, although the controlled medicines were securely stored.

The trust undertook regular medicine audits and the last audit identified issues around out-of-date controlled drugs. We understand the trust was working on improving communicating and following up actions from the medicine audit.

Staff followed systems and processes to prescribe and administer medicines safely. Staff reviewed each patients' medicines regularly and provided advice to patients and carers about their medicines.

Incidents

The service managed patient safety incidents well. Staff recognised what constituted an incident and near miss, however stated they did not always have time to report incidents due to staff shortages. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. Staff mostly raised concerns and reported incidents and near misses in line with trust policy. The service used an electronic record system to report incidents. Incidents were escalated depending on the level of harm that had occurred. There were forums where learning from incidents were discussed and learning shared. Staff stated they did not always report incidents due to not having time to complete the documentation.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong.

Staff learned from safety alerts and incidents to improve practice.

Is the service effective?

Inspected but not rated

Nutrition and hydration

Patients did not always receive adequate amounts of food and drink to meet their needs and improve their health.

Staff reported patients did not always receive optimal nutrition and hydration levels due to a lack of staffing. At the time of inspection there was a national shortage of health care assistants and registered nurses and the trust was struggling to fill the vacant health care positions despite running numerous employment campaigns. The trust had created a role

for ward host and hostesses on the wards to ensure patients were offered tea, coffee, water and other beverages at regular intervals. The wards which had these staff reported a positive impact on patient care. Ward host / hostesses also helped patients with ordering food and some could assist with helping patients eat their food dependant on their training. Ward host and hostesses were more established at The Royal Bournemouth Hospital and were in the process of being rolled out to Poole Hospital. If patients do not receive adequate amount of food and drink, this could be detrimental to their recovery and could lead to additional health issues.

We reviewed fluid and nutrition charts on the ward and found there were instances where some had not been fully completed.

Specialist support from staff such as dietitians and speech and language therapists, was available for patients who needed it.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain, and mostly gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed patients' pain using recognised tools and gave pain relief in line with individual needs and best practice. This included tools to assess pain in those unable to communicate. However, due to staffing and resourcing issues staff said some patients did not receive pain relief in a timely manner.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. We observed planned multidisciplinary meetings on an older people's ward, which was attended by nurses and doctors. Staff were engaged and worked together to ensure safe discharges of patients as soon as this was possible. When delays were identified, actions were identified to solve barriers to getting patients home. This included writing to patients' relatives to explain the urgency of arrangements being agreed so that discharge was not delayed.

Staff worked across health care disciplines and with other agencies when required to care for patients. Patients had their care pathway reviewed by relevant consultants.

Staff referred patients for mental health assessments when they showed signs of mental ill health, depression. There were patients who required a mental health placement bed in a hospital or in the community, however these patients were waiting, residing at the hospital.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They mostly used measures that limit patients' liberty appropriately.

Staff understood how and when to assess whether a patient had the mental capacity to make decisions about their care.

Medical care (including older people's care)

The provider used measures that limit patients liberty in line with the Mental Capacity Act and Deprivation of Liberty Safeguards.

Staff received basic training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Due to the high number of patients that were on wards with mental health issues, some staff wanted to receive further training in order for them to feel safer when dealing with this cohort of patients.

Is the service caring?

Inspected but not rated

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We witnessed staff supporting a patient in a quiet and calm manner, speaking in a tone that was calming and patient.

We witnessed staff supporting a patient on a one-to-one basis ensuring they remained safe while mobilising around the ward, using redirection techniques when needed.

We witnessed staff responding to confused patients in a caring manner using appropriate language that met the needs of the individual.

Patients said staff treated them well and with kindness. We spoke with 9 patients who all said that staff were kind, caring and responded quickly when they called for support. Most of the patients spoken with said staff were rushing around that there were not enough of them and that they were doing their best despite this. We observed staff speaking to patients kindly. Patients said that staff were kind and kept them up-to-date with their treatment and discharge plan. Patients recognised how hard staff were working and appreciated their effort to make them as comfortable as possible

Staff followed policy to keep patient care and treatment confidential.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

Is the service responsive?

Inspected but not rated

Meeting people's individual needs

The service was inclusive and mostly took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Medical care (including older people's care)

Staff mostly made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. However, not all wards were designed to meet the needs of patients living with dementia. On some wards we saw that there were large clocks and information about the date and day of the week as well as information about the weather displayed. However, this was not consistent across all wards in older people's medicine.

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports. The service had dementia champions and a dementia team. The dementia team were able to input into the patients care as well as take patients to the dementia garden and run events such as 'Bingo'.

The service had information leaflets available in languages spoken by the patients and local community.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed.

Patients were given a choice of food and drink to meet their cultural and religious preferences.

Staff had access to communication aids to help patients become partners in their care and treatment.

Access and flow

The service was blocked by patients in beds who were medically fit for discharge, due to a lack of community and social care packages in the region. People could mostly access the service when they needed it and received the right care promptly.

The trust had problems maintaining flow from admission to timely discharge. In August 2022 the average number of beds per day occupied by patients with stays over seven and 14 days had been at its highest level in the past three years. The average number of patients who were ready to leave / had no reason to reside in hospital was 237 patients. In real terms this was the equivalent of nine wards (with capacity of 25 patients) being used for patients that had no medical reasons to be in hospital. These patients still required care from medical, nursing and health care staff. Long hospital stays can be linked to negative outcomes such as a decline in physical ability as well as an increased risk of picking up a hospital-acquired infection for frail elderly people. The trust monitored the impact on those patients who did not need to be in hospital in terms of falls. They found in Poole Hospital from January 2022 to July 2022, the patients without criteria to reside accounted for 22% of all hospital falls.

People could mostly access the service when needed but did not always receive the right care promptly due to pressures on bed capacity. Patients were being moved sometimes multiple times and sometimes at night, in order to admit them to the right place once a bed became available. Some staff stated that the movement of patients was not always suitable or appropriate. The hospital had seen an increase of patients suffering mental health disorders who were residing in the hospital, because there was a lack of mental health provision elsewhere and in the community. This coincided with an increase in violence and aggression incidents towards staff.

The trust used an established tool to identify the capacity of wards and assessment units at any point in time. The Trust tried to use these tools to best meet the needs of the patients. The Trust had been consistently over 93% bed occupancy for the last six months. This made flow throughout the hospital difficult to manage. The National Institute for Health and Care Excellence Guideline 94 talks about 85% bed occupancy being recognised in literature as the ideal occupancy rate and states "high levels of bed occupancy may affect patient care as directing patients to the bed most suitable for their care is less likely to be possible".

Medical care (including older people's care)

The hospital monitored the demand on its service. The Operational Pressures Escalation Framework (OPEL) detailed how the trust identified and responded to pressures within its system daily, as well as at times of extraordinary pressure. The service had been at OPEL level three and four for the last six months. Level four is the highest OPEL level and means the trust is at high pressure. Each day bed meetings took place at 8.30am and 4pm, to review the flow of patients through the hospital. Those meetings were attended by bed managers and department nurses in charge at both sites. Some staff attended virtually.

The trust had some issues with discharging patients safely, for example some patients had been discharged home without the relevant equipment ready in their homes to help with care. There had also been instances where the relevant discharge paperwork had not been provided to the patient's general practitioner, which could impact on patients' medicines and follow up appointments. The Integrated Care System was due to work on reviewing its discharge policies in the following months. A focus on discharge was required by the whole integrated care system in order to tackle the number of people who were being looked after in hospitals without any medical requirements and addressing the issues around hospital discharge.

The trust had a Same Day Emergency Care (SDEC) centre especially designed for patients aged 75 and over to avoid admission and to help the patient to remain at home. There has been positive feedback from both patients and staff on this service. There was however a barrier to accessing this service in terms of patient transport. Patient transport was commissioned in this area requiring a lead in time of four to six hours. This meant a patient in emergency department without any relatives to transport them home following treatment would sometimes not be considered for this service if they arrived in the emergency department during the afternoon period.

Is the service well-led?

Inspected but not rated

Leadership

Leaders mostly had the skills and abilities to run the service. They understood and attempted to manage the priorities and issues the service faced. Some of the issues faced in terms of staffing and hospital flow were mostly connected to recognised national issues. Leaders were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The Older People Medicine management team were visible and approachable for patients and staff. Staff told us they received strong leadership from their direct managers, matrons, ward managers and the heads of nursing. Nursing staff told us matrons had based themselves on wards to provide additional support to staff, which was appreciated. Medical staff felt the clinical director and medical director were approachable and supportive. Leaders supported staff to develop their skills and take on more senior roles.

Culture

Staff morale was low but still focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff told us morale was low. Staff explained they were passionate about the work they carried out, however working with too few staff was stressful and led to low job satisfaction. Due to low numbers, staff had to work in wards which they were unfamiliar with and this also negatively impacted staff morale.

Medical care (including older people's care)

Staff told us they felt supported by their colleagues and worked as teams to deliver care. However, staff told us they could not always meet patients' fundamental care needs and this was difficult to cope with. Staff said they were passionate about delivering compassionate care for all patients and found it hard when this was not possible because of staff shortages. We saw that staff were kind and compassionate towards patients and supportive of each other.

Senior nursing staff we spoke with discussed the impact on staff morale mainly caused by staff shortage. They explained they understood staff were concerned about being moved to areas they were not familiar with and acknowledged this happened most days. They spoke of the high number of healthcare assistants that had left the hospital. Information obtained from exit interviews suggested difficult working conditions, as well as the need to have a better work life balance. Senior leaders spoke of the difficulties in the recruitment of new staff in a competitive market and the initiatives they took to attract new employees. The trust had ongoing recruitment initiatives to attract more staff from the local area, as well as from international recruitment.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Poole Hospital and Royal Bournemouth and Christchurch Hospitals merged to form University Hospitals Dorset NHS Foundation Trust on 1st October 2020. The trust was going through an extensive building and reconfiguration programme at all sites, which has seen a number of changes to the existing way of working. Most staff we spoke with felt the trust had engaged well with them regarding the plans. The Older Peoples Medical team were already working at both Poole and Bournemouth sites and we saw good examples of shared learning bringing positive improvements to both sites; such as Ward Hosts which was an idea originating from the Bournemouth site but now also in place at Poole hospital.

The trust collaborated with partner organisations to help improve services for patients. The trust was part of the Dorset Integrated Care System (ICS). An Integrated Care System brings NHS organisations, councils, public services and voluntary and community partners together to improve the health and wellbeing of everyone in their area. Dorset was part of the first pilot of integrated care systems in 2018. It was a government proposal for all areas across England to become integrated care systems by July 2022. One of the aims of the ICS is to tackle inequalities in outcomes, experience and access.

The trust continued to work as part of the Dorset Cancer Partnership and Wessex Care Alliance to ensure cancer treatment was prioritised. The trust worked in partnership with Bournemouth University which had amongst its aims to develop training opportunities and meet future workforce training needs.

The trust engaged with patients and staff via its website and email bulletins. It also had an on-line social media channel and monthly staff digital and printed publications. Some staff said due to staff shortages, relatives and carers were not always kept up-to-date with patients care.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Medical care (including older people's care)

MUSTS

Medicine core service

- The trust must continue to act to recruit to vacant roles and retain staff across the organisation to ensure there are sufficient staff deployed to meet the needs of patients and ensure the fundamental standards of care are met for all patients. (Regulation 18 (1) 2 and Regulation 14 (1) (b)).
- The trust must ensure the management of outlier patients are effective and all staff are clear on the process to follow when patients require urgent or non urgent review. (Regulation 12 (2) (b)).
- The trust must ensure that patients records and assessments are fully completed. (Regulation 12 (2) (b)).
- The trust must ensure the safe storage of medicines and ensure that they are within their use by date. (Regulation 12 (2) (g)).

SHOULDS

Medicine core service

- The trust should consider improving training compliance for safeguarding adults.
- The trust should continue to work with all system partners and implement actions to address the capacity pressure in the hospital.

Surgery

Requires Improvement 

In the 12 months before our inspection, the Poole Hospital carried out 4541 day case operations, 1869 elective (pre planned) and 8978 emergency operations. There were 7 surgical wards with 145 beds.

We rated the service requires improvement in safe and effective. The service was inspected but not rated in caring, responsive and well-led.

We found:

- The service did not always have enough staff to care for patients and keep them safe.
- The service did not always manage safety incidents well.
- The service did not always plan care to meet the needs of local people. Patients on a fractured neck of femur pathway mostly did not receive treatment within recommended timescales in line with NICE guidance. Delays for these patients led to worse outcomes and longer recovery times.
- The service was blocked by patients in beds who were medically fit for discharge due to a lack of community and social care packages in the region.
- Staff did not always feel supported and valued. They described the challenges of working with not enough staff and how that affected them.

However:

- Staff assessed risks to patients, acted on them and mostly kept good care records.
- Staff treated patients with compassion and kindness, respected their privacy and dignity.
- Staff were focused on the needs of patients receiving care.

Is the service safe?

Requires Improvement 

Our rating of safe stayed the same. We rated it as requires improvement.

Assessing and responding to patient risk

Staff identified and quickly acted upon patients at risk of deterioration. However, there was not always enough staff to complete and update risk assessments for each patient to remove or minimise risks.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. They used the National Early Warning Score 2 (NEWS2) to monitor and identify the acute deterioration of patients, including sepsis, and Situation Background Assessment Recommendations to ensure clear transfer of information between staff. Treatment was delivered to patients with presumed sepsis within recommended Sepsis Six pathway timelines. However, we were told staff were not always able to get a doctor to assess a deteriorating patient, especially if the patient was a medical outlier (a non-surgical patient bedded on a surgical ward). For example, we saw an incident report about a poor

outcome for a medical outlier on a surgical ward. Staff had been unable to escalate their concerns when the patient began to deteriorate. The ward team felt the patient may have had a different outcome if they had more regular consultant review and a named medical team to act as a clear point of escalation. The report concluded that despite asking for support, there was not enough provision for care of medical outliers on orthopaedic wards and earlier input from the medical care team may have changed the patient outcome. We were told about another example when staff were unable to contact the doctor for medical outlier patient with a NEWS2 score of 16 (very unwell). The nurse put out a medical emergency alert to get doctors from the medical team to visit the ward.

Senior staff told us they were confident to challenge the decision if outlying was not appropriate for a patient, and they could escalate to the surgical team on call. However, staff told us patients were moved frequently at night and at weekends, when there were fewer senior staff to prevent this.

Staff completed risk assessments for each patient on admission, using recognised tools, and mostly reviewed them regularly, including after any incident. Some ward staff told us they were sometimes so short of staff on the ward, risk assessments were not always completed. Staff told us they mostly completed a falls risk assessment for each patient and completed body maps to detect and assess tissue viability including pressure sores.

Staff assessed new patients for their risk of developing venous thromboembolism (VTE). We requested the outcome of a VTE assessment tool audit. However, we were told this was not available as data was still being collected. The trust had introduced a system for ward staff to ensure a VTE risk assessment was completed for each new patient and for patients following a change in their clinical situation. A daily email was sent to Band 6 nurses flagging patients whose VTE risk assessment had not been recorded, to ensure these were completed. In theatre, we saw staff check VTE assessment outcomes as part of their patient pre and post-surgery checks to ensure the correct prophylaxis was administered. There was an electronic prescribing and medicines administration system where medical staff completed prescriptions. Medical staff told us the system contained a failsafe mechanism that would not allow them to proceed prescribing medicines, unless a VTE assessment had been completed and information about patient allergies had been recorded.

According to the National Institute for Health and Care Excellence (NICE) quality statement, consultants must assess adults with a medical emergency as soon as possible and always within a maximum of 14 hours from the time of hospital admission (QS174). The trust gave us information, which showed this target had been met for 85% of patients admitted during the week and for 77% of patients admitted during the weekend (patients admitted between 28 March 2022 and 3 April 2022).

Staff in theatre completed the World Health Organization (WHO) surgical safety checklist. The checklist contains important safety checks that need to be performed before and after a surgical procedure to increase the safety of patients and reduce adverse events such as surgical site infections or retained instruments. The audit of the WHO checklist showed an average compliance rate of 93% from October 2021 to September 2022.

Patients waiting for surgery were talked through the procedure they were due to undergo. We saw theatre staff checking the patient care plans and ensuring patient information was up to date. We observed the safety check of surgical instruments. We saw good communication between staff throughout the operation. At the end of the operation we saw staff reassess the clinical dependency of patients.

The service had 24-hour access to mental health liaison and specialist mental health support if staff were concerned about a patient's mental health, including those thought to be at risk of self-harm or suicide.

Staff mostly shared key information to keep patients safe when handing over their care to others. For example, when patients were transferred to other wards, up-to-date risk assessments and body maps were completed and handed over to the receiving ward. However, staff told us patients were sometimes moved at short notice during the night and up-to-date assessments were not always completed for these patients.

Shift changes and handovers included necessary key information to keep patients safe. Handovers took place at the beginning and end of each shift. However, staff on larger wards told us that attending handover at the end of their shift was problematic when they were short staffed as they needed to provide nursing care to patients.

We spoke with staff in Oncology services to ask about the safe care and treatment of patients who received brachytherapy (a type of internal radiation therapy). Some of these patients required general anaesthesia to ensure effective treatment could be delivered. Staff from the main operating theatre were allocated to support the oncology staff with these procedures. We were told an anaesthetist and a nurse would attend to provide the anaesthesia. The anaesthetist would not leave the unit until the patient had recovered, and it was safe to do so.

Nurse staffing

The service did not always have enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels.

The service had a significant level of vacancies for health care assistants. There was also a high level of vacancies for Registered Nurses. In addition to staff vacancies there was a general trend across the service of increased staff sickness rates. Sickness rates for nursing staff increased by around 1% in the 12 months before we inspected. In July 2022 the vacancy rate was 6.2% and turnover 14.6% with sickness absence at 5.6% across the trust.

High vacancy rates were discussed by senior leaders and hospital leaders at meetings. Minutes from meetings record there was a lack of healthcare support workers, and significant vacancies (240 across the trust) were having a negative effect on the care given to patients. For example, information from the trust showed there was a 20% vacancy rate (12.8 whole time equivalent posts) for health care assistants on the trauma wards, leading to risks to the quality of care to patients. In addition to this, the nursing bank office was unable to provide substantive replacement staff for each vacant shift, resulting in agency staff being employed. According to the ward nursing staff report, this led to an increased workload and delays in care delivery. Senior trust leaders spoke of the difficulties in the recruitment of new staff in a competitive market and the initiatives they used to attract new employees. However, the trust had ongoing recruitment initiatives to attract more staff from the local area as well as from overseas recruitment.

Most staff told us the general level of care was lower than before the pandemic because they were trying to care for too many patients at once. They said this impacted on their wellbeing and work home balance. They described feeling “shattered” and ”broken” and said after shifts and on days off they were too tired to spend quality time with family and friends.

Hospital systems were increasing the workload for staff**.** Ward staff described a system developed by the hospital to improve flow by the introduction of admission, acute, and discharge wards that had significantly increased their workload. They said the increased frequency of patient bed moves from one ward to another, meant they were updating risk assessments and completing other paperwork more than if the patient remained on one ward for the duration of their stay. One member of staff told us when they raised concerns about this, they were told they were a troublemaker.

Surgery

The gaps in staffing was leading to a loss of time in which staff were able to perform their core role. Some staff expressed particular concern about the low numbers of Health Care Assistants (HCAs), and ward clerks, and housekeeping staff on some wards. We saw a junior doctor answering the phone to relatives, making cups of tea for patients, and completing other tasks (searching for printer paper) because of a lack of support staff. They told us these additional tasks were preventing them from completing their core medical duties. The trust acknowledged at the time of inspection there was a shortfall in support staff owing to vacancies (12%), sickness (6%) and planned leave (18%).

The trust told us about a number of processes that were being used to monitor staffing levels. The processes used at the weekend varied slightly to those used Monday to Friday. At the start of each day matrons performed a quality and safety check on each ward, the check included understanding staffing levels and the acuity and dependency levels of patients on the ward. Each ward leader submitted an audit twice a day (6am and 6pm) that reflected staffing levels and patient acuity and dependency. The audit data was fed into a system that mapped staffing levels across the trust to ensure they matched the acuity and dependency of patients. Hospital leaders, and department leaders, including matrons, held a number of meetings throughout the day that focused on safe staffing levels.

If a ward was identified as having unsafe staffing levels, staff were moved there from areas of the hospital identified as having more staff. If wards or other areas had lower than safe levels of staff they escalated this using a system called a red flag. Red flags indicated that patient needs were not being met, for example, omissions in medicines being administered, omission to assess and record vital observations, and not meeting patients' fundamental needs (pain relief, repositioning, hydration and risk assessments).

Trust wide data for surgical wards showed 57 reported red flags from April to July 2022. The most commonly reported red flags were for a lack of health care assistants and other unfilled shifts requested through temporary staffing.

Staff told us the tool they used at the start of every shift to calculate how many patients were on each ward and how many nurses were required to care for them did not calculate the acuity of patients. This tool was used to feed into a second tool used by senior leaders to identify the areas of the hospital with the most patient need, so that staff could be moved from areas with higher staff ratios to avoid patient harm. They said the use of these tools meant they often worked in unsafe situations. Staff told us when they voiced their concerns over the continued use of these tools, they did not feel like they had been heard at the trust's executive level. They said this left them feeling unvalued.

Staff were not always experienced, qualified or held the right skills and knowledge to meet the needs of patients. Matrons and directors of nursing met at least twice daily to review nurse staffing and skill mix across the hospital sites. Due to the trust's chronically low staffing levels, staff were often moved to work on wards outside of the specialism to cover areas of the hospital with the lowest staffing levels. This meant staff were not always competent to carry out their role as effectively in these settings

Senior nursing leaders told us they were mindful about moving staff to ensure they were not moved to areas where they did not feel competent to carry out their role. They told us staff were asked before they were moved and if staff did not feel they were able to work safely in another area, this would be respected. Some nursing staff told us they felt unable to refuse when asked to work on other wards for fear of reprisals. When staff were moved, senior nursing staff told us they tried to introduce staff to the ward manager of the ward, as they recognised walking on to a new ward and a new team could be daunting. Matrons and leaders recognised the challenges of ensuring safe nursing levels and the impact moving staff around had on morale. They expressed their concerns about health care assistants, nurses, and junior doctors being moved to cover absence on other wards, especially to cover areas outside of their speciality. Staff told us,

not knowing where in the hospital you would be working before you went to work was stressful, as was working in areas of the hospital outside their specialism. They said this caused them stress because they did not have the skills and experience to deliver the care and treatment required. They also said this had an impact on continuity of care for patients.

Nurse to patient ratios did not always meet hospital standards. We looked at average staffing rates on wards for August 2022. On ward C3 the percentage of qualified nurses for day shifts was 99.1%. However, the percentage of HCAs was 73.2%. On ward B4 there was an average 116.5% of qualified nurses and 57.6% of HCAs.

Staff told us supernumerary staff, for example student nurses and nurses still on induction, were frequently used to provide patient care when wards were short staffed. This did not ensure staff with the right skills and competency were deployed consistently to meet the needs of patients.

Staff said that since the end of the second wave of the pandemic, a high percentage of patients had an increased clinical complexity, and that wards were consistently full and or had higher than planned bed occupancy. They said when they started a shift, if the staffing numbers matched the current template, one or more member of staff would inevitably be moved to other wards to cover, leaving them short staffed in an already challenged environment. In minutes of a governance meeting, from September 2022, shown to us by the trust we saw a shortfall of 50 staff hours on one ward and a HCA was moved to work on another ward. The discussion highlighted low staffing levels contributed to a patient falling resulting in a fracture to their neck of femur.

Low staffing numbers had a negative impact on all aspects of patient care. Staff told us due to low staffing levels areas of patient harm included: medicine being given late and medicine errors, poor pressure area assessment and care, risk assessments not always up to date, and personal hygiene needs being met only when there was enough time. The hospital told us on the surgical wards October 2022 there were 23 incidents relating to pressure ulcers, 20 patient accidents / falls, and 8 incidents relating to medicines management. However, staff said they did not always have the time to record incidents on the electronic incident recording system, including fundamental standards not being met.

Since our inspection, we have received two complaints from members of the public about patient care. They included information about a patient left in soiled clothes for two days, a relative having to ask for a catheter to be removed, a lack of staff to mobilise patients after surgery, symptoms of delirium not being addressed, a lack of communication with relatives, bed pans left on tables next to food and water, a strong smell of faeces, call bells out of reach of patients, and a lack of staff available to help patients.

Ward staff told us they often missed breaks or cut breaks short to help alleviate pressure on other staff. Senior staff told us they were stretched too thin to provide clinical guidance to more junior staff. They described huge volumes of unanswered emails and completing staff rotas in their own time. One nurse said, “you question your decision to be a nurse. You work so hard and don’t get a break, don’t get a wee or a drink and you don’t even get thanked. If you do something wrong you get pulled up on it, no one says ‘you have had a hard day do you want to talk about it?’”.

In the 2021 staff survey results, 56% felt they could not meet the conflicting demands on their time at work and 75% said there was not enough staff in the organisation for them to be able to do their job properly. Also, 36.8% said they felt valued by the organisation and 36.6% said they felt the trust was committed to helping them achieve a good work life balance. Over half of responders (57.2%) said they did unpaid work in addition to their contracted hours each week. Half of the staff group (53.1%) said they had felt unwell due to work related stress in the 12 months before the survey and most (85.4%) said they feel worn out at the end of a shift, with 71.7% saying they lacked energy to see family and friends. However, 89.6% of staff felt their role made a difference to patients.

Surgery

Medical staffing

The service did not always have enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

The service did not always have enough medical staff to keep patients safe. Nursing staff told us they were not always able to access medical advice for patients who were medical outliers because there were not enough doctors to cover the volume of patients. At times, this caused long delays in patients receiving urgent treatment, for example, patients being started on intravenous antibiotics. We saw an incident report for a patient who was nil by mouth who was not written up for an intravenous version of their medication, despite this being the plan devised at ward round, so did not get all their medicine and subsequently became very unwell. This patient was under the care of the medical team but was bedded on the surgery ward because the medical wards were full.

Most but not all junior doctors said they were able to take lunch breaks and they did not work additional unpaid hours.

We requested details for medical staffing levels for surgical services. However, this was not provided.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Patient notes were comprehensive and staff could access them easily. Most notes were paper-based, although vital observations were recorded using a digital recording system. There were back up processes to revert to recording these on paper templates in the event of computer failure.

We reviewed 12 patient records and found these were mostly completed in a timely way. However, we saw that information about patients' social situations was not always completed as part of the admission process. This information was important to enable staff to start discharge planning as soon as possible, including considerations about potential adjustments or packages of care that may be needed.

The trust performed regular internal audits of the legibility and completeness of documentation in the trust's orthopaedic operation notes. This is because historically operations notes were found to be illegible, lacked complete intraoperative events and procedures with unclear post-operative instructions, which led to confusion and delays in post-operative care. The purpose of the audit was to implement change in practice when need for improvement was identified. In the most up to date audit supplied by the trust 96 sets of notes for patients who underwent surgery in February and March 2021 had been reviewed. The outcome of this audit showed details of problems and complications were recorded for 58% of patients, and details of antibiotic prophylaxis (where applicable) for 28% of patients. This was an improvement from the previous audit which found only 15% of problems and complications had been recorded, and details of antibiotic prophylaxis (where applicable) had been recorded for 27% of patients.

We saw that notes were stored securely on the wards we visited. Notes were stored in designated locked trolleys and staff took care to return notes when they had completed their documentation of care and treatment they had delivered.

Incidents

The service did not always manage patient safety incidents well. Staff recognised but did not always report incidents and near misses. Managers ensured that actions from patient safety alerts were implemented and monitored.

Surgery

Staff knew what incidents to report and how to report them. Ward staff told us because they were short staffed they did not always have enough time to complete incident forms. However, staff said they would always report a serious incident, for example a patient fall. Staff did not always receive feedback from investigation of incidents they had reported.

The trust used reported incidents as one way to assess if fundamental standards were met, including incidents considered as a 'red flag'. Ward staff said they did not always have time to report incidents, including when patients fundamental standards of care were not met, and some senior staff told us they were too 'stretched' in their role to review all incidents forms. One band 6 nurse had been allocated an incident to review but had not been given training to investigate incidents. Information from the trust showed that the number of incidents reported by staff was in decline. For example, across the trust reporting rates fell from 1145 in May 2021 to 935 in May 2022.

We saw evidence of learning from some incidents. There was a process for a rapid review of some incidents, and these were discussed at weekly meetings for ward leads. Information from these meetings was cascaded down to junior staff along with actions from patient safety alerts. As a direct result of incidents that occurred we saw evidence that staff received training in falls prevention, which included exploring themes of historic falls incidents to mitigate risk of future patient falls. We were shown a ward newsletter that contained details of incidents that had occurred on the ward and learning from these. The newsletter contained reminders for staff to complete pressure sore audits and body maps, as well as information about the adoption of a new transfer letter to be used for patient discharges.

In the 12 months before our inspection there was one never event (a never event is a serious incident or error that should not have occurred if proper safety procedures were followed) reported in surgery, which was a wrong site surgery. We saw evidence of learning being shared to reduce the likelihood of future avoidable harm. Managers shared learning about never events with their staff and across the trust.

Is the service effective?

Requires Improvement 

Our rating of effective went down. We rated it as requires improvement.

Patient outcomes

Staff monitored the effectiveness of care and treatment. The trust did not always used this information to make improvements and achieve good outcomes for patients.

The service participated in relevant national clinical audits, including to the National Hip Fracture Database (NHFD) for patients on a fractured neck of femur pathway. Information for 2021 from the NHFD showed that the trust had the highest number of patients admitted with a fractured neck of femur in England (891) and the lowest number of patients receiving surgery within 36 hours of admission to hospital (27.2%). Evidence from the National Institute for Health and Care Excellence (NICE) shows if patients wait more than 36 hours after admission for surgery for a fractured neck of femur they will have a worse outcome and longer recovery. The information submitted to the NHFD could not always be used to improve patient outcomes because the trust did not have enough operating theatres with laminar flow or enough staff to work in theatres (laminar flow is a type of ventilation used for orthopaedic surgery as it reduces airborne contamination and thus the chance of a surgical site infection).

Surgery

NICE recommends that patients with a fractured neck of femur (the top part of the femur is broken, just below the ball of the bone that sits in the hip socket joint) have surgery within 36 hours of admission to hospital (CG124). However, not all patients are medically fit for surgery within this timescale, for example patients on anticoagulant medication or patients with COVID-19. Considering this NHFDs Best Practice Tariff Target is for 85% of fractured neck of femur patients to be operated on within 36 hours of admission. Compliance with this target in 2022 was between 2% (June) and 32% (February). If treatment of a femoral neck fracture is delayed, avascular necrosis can occur causing longer recovery, severe, lasting disability, the need for a total hip replacement, or in some cases lead to death.

Data from NHFD showed mortality for patient on a fractured neck of femur pathway was in line with the national average. Data produced by the trust in August 2022 showed the average length of length of stay for these patients was 17.5 days, which was above the national average of 15 days. Trust data also showed 9.2% of patients developed a pressure ulcer during their inpatient stay, and there was a higher rate of patients developing acute renal failure when their surgery was delayed. There was also a higher rate of patients requiring a full hip replacement than the national average, however, the number of patients requiring a return to theatre was below the national average.

The risk to patients on a fractured neck of femur pathway who had their surgery delayed was discussed by senior managers at surgical care group meetings, quality committee meetings and escalated to board meetings. A review of the early post-operative care of 50 fractured neck of femur patients was undertaken in 2021. This review highlighted that a higher than expected number of patients went into renal failure during the post-operative period with 30% found to have an acute kidney injury (AKI). Fluid management was reviewed in detail and was found to be appropriate but with some room for improvement. Pre-op medication reviews were also completed. However, 50% to 65% of patients had to some degree a renal impairment post-operatively with approximately 70% having hypotension peri-operatively. Peri-operative hypotension is associated with major postoperative complications including AKI, myocardial injury and death.

The review concluded patients could be provided with better care while waiting for surgery to improve their outcomes. It also recommended that a workforce plan for a dedicated service which operated 7 days a week be introduced to reduce delays to surgery. The 7 day service was trialled in August 2022 and was reported to be successful. However, this was not continued following the trial. There was no evidence that this pattern of working was going to be introduced as a permanent solution to reducing waits for surgery for this patient group. Since the inspection senior hospital managers told us workforce plans were in place to introduce a 7-day work plan for patients on a fractured neck of femur pathway.

The trust had lower than the national average number of consultant surgeons and anaesthetists performing or supervising operations for patients on a fractured neck of femur pathway. In July 2021, 8.2% of orthopaedic surgery was supervised by consultant surgeons and anaesthetists against a national average of 65.8%.

The geographical area covered by the trust had the highest percentage of elderly people in the county, which was reflected in the high incidence of patients being admitted to on a fractured neck of femur pathway. We found complex, overlapping, and compounding issues that contributed to the trust's failure to meet NICE guidelines. Notably, problems with patient flow throughout the hospital, but also a lack dedicated theatre time, a lack of laminar flow theatres, a lack of diagnostic imaging staff, and high vacancy rates for medical, nursing and support staff. Hospital managers said teams worked together to deliver dedicated trauma care. However, a senior manager told us there was a lack of designated trauma teams specifically for patients on a fractured neck of femur pathway, and this contributed to the difficulty of operating on these patients within safe timescales.

Problems with hospital flow were complex but were significantly impacted on by a shortage of staffing capacity in social care services, including domiciliary care. This meant that many people could not be safely discharged from hospital, resulting in a lack of bed space for new patients being admitted to the hospital. Some medical staff told us there was a

culture of accepting patients were left at home or on the wards waiting for surgery. We were told other factors impacting on the trust's ability to meet 36 hour targets for patients on a fractured neck of femur pathway included, only having two laminar flow theatres at the hospital, and the unpredictability of patients accessing the service, which meant it was not possible to predict how many theatre slots would be required.

The trust held regular meetings to discuss the safety and risk to patients on a fractured neck of femur pathway including at board level. Harm to this patient group was also on the trust's risk register. Senior hospital leaders acknowledged the failings in this treatment pathway and said there were plans to improve it. The trust had a long-term improvement plan that focused on the ongoing building of a new theatre complex. Due for completion in May 2023, the opening of the theatre complex would increase laminar flow capacity on the site from 2 to 6 theatres. However, in the quality committee meeting minutes from August 2022 it was recognised by senior trust leaders that the opening of the new theatres might not be a complete solution to improving the outcomes for this patient group.

The hospital did not conduct harm reviews so there was no evidence of what harm patients who had waited longer than 36 hours for surgery may have sustained. The data submitted to NHFD reflected the number of patients who had undergone a full hip replacement or had been returned to theatre for further surgery but this was not triangulated with the number of hours a patient had waited for surgery. For example, in August 2022, 80 patients waited longer than 36 hours for surgery on a fractured neck of femur. The average wait for surgery during that month was 78 hours.

Short term plans to improve outcomes included; working with the wider system of Dorset health and social care providers to improve flow through the hospital to speed up patient admissions, and working with high performing services to explore how different ways of working could be utilised to improve patient outcomes for patients on a fractured neck of femur pathway. Also, recruitment to consultants' vacancies to reduce the number of operations carried out by middle grade doctors.

To mitigate risks when surgery was delayed, the trust had introduced and embedded processes to review each patient waiting for surgery. There was a daily report between the trauma admission team and the ortho-geriatrician, which included monitoring of complications. In September 2022, it was reported that matrons were seeing patients on this pathway a minimum of twice weekly to assess their skin viability and this had resulted in a reduction of pressure ulcers being reported throughout August and September 2022. A patient safety group had also been convened, and was agreeing its terms of reference, which aimed to provide greater oversight of the outcomes for this group of patients.

Competent staff

The service could not always ensure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support.

Managers tried to give all new staff a full induction tailored to their role before they started work. However, we were told that staff who were supernumerary because they were still on induction were sometimes counted in ward staffing numbers due to low staffing levels.

Managers supported staff to develop through yearly, constructive appraisals of their work. Senior hospital leaders said all staff receive an annual appraisal and there were systems to monitor compliance and remove obstacles preventing staff from participating in this process. In the 2021 staff survey 84.2% of trust wide surgical ward and theatre nursing staff said they had received an appraisal in the last 12 months. Although only 16.5% felt their appraisal helped them improve how they did their job.

Surgery

Outside of the annual appraisal process, managers could not always support nursing staff to develop through regular, constructive clinical supervision of their work. For example, matrons told us they did not always have time to support Band 6 and 7 nurses to develop in their roles because they were too stretched in their own role.

Managers could not ensure staff always received specialist training for their role. Clinical educators supported the learning and development needs of some staff. However, not all wards were allocated funding for clinical educators and sometimes clinical educators had to provide nursing care rather than support the learning needs of others.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. We saw important staff messages on staff notice boards and staff told us they received emails about important information. Theatre and recovery staff were updated in daily safety briefings and in regular bulletins known as 'SPOTTED' (safety, patients, optimise, time, tissue, education and incidents).

Some junior doctors told us there was not always enough training or practical support to enable them to progress to become a surgeon. However, they told us this concern had been raised with the deanery and the trust were looking at ways this could be improved.

Overall compliance with mandatory training was 77.8%, with trust overall compliance standing at 83.7%.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients' liberty.

Staff mostly gained consent from patients for their care and treatment in line with legislation and guidance. When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions. Staff made sure patients consented to treatment based on all the information available. Consent for surgical procedures was confirmed as part of the safer surgery check and staff felt this process was well embedded. Staff clearly recorded consent in the patients' records in all of the records we reviewed. However, an audit of consent forms from November 2020 to December 2020 showed that none of the consent forms reviewed included all relevant risks of surgery. However, all other parts of the consent form were correctly completed. A re-audit in of consent forms from 1 March 2021 to 15 April 2021 saw an improvement of risks of surgery being documented (66%). There were no plans shared about repeating this audit.

Staff could describe and knew how to access the policy to get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. They understood how and when to assess whether a patient had the capacity to make decisions about their care. We saw patient files that showed the correct processes for assessing capacity had been followed and staff implemented Deprivation of Liberty Safeguards (DoLS) in line with approved documentation. However, each ward had a separate method of communicating DoLS authorisation to other members of their staff team. For example, on one ward they communicated patients' DoLS status into the ward handover book, on another staff copied all senior nurses on the ward into the DoLS authorisation email. A lack of cohesion in communicating important legal information could result in a patient being detained unlawfully.

Surgery

Seventy sets of notes for patients with a DoLS from across the trust who were an inpatient between 15 March 2021 and 16 April 2021 were reviewed. The audit showed there were gaps in documentation relating to DoLs and 'Best Interest Decision' making in documentation. The action plan for the audit was to discuss the findings at the mental health steering board meeting in October 2022.

Audits of the use of the Mental Health Act for detaining patients were carried out to ensure documentation had been completed lawfully and learning could be shared when things went wrong. We looked at patient files and saw that do not attempt cardiopulmonary resuscitation (DNACPR) to allow a natural death forms had been completed in collaboration with patients and or their relatives and using advanced decisions to refuse treatment. The DNACPR forms we looked at were completed correctly and signed by the consultant who the decision had been made with. However, an internal 2021 audit of DNACPR and Allow A Natural Death (AAND) forms showed that these forms had not always been completed in line with hospital protocol for patients who lacked capacity. In 75% of these cases Mental Capacity Assessment form had not been completed and in 79% of all cases the DNACPR or AAND form had not been signed by the consultant with overall responsibility for the patient within 48 hours.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong.

Is the service caring?

Inspected but not rated

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. We saw staff take time to interact with patients and those close to them in a respectful and considerate way. We saw staff caring for patients, checking if they were cold and wanted extra blankets, checking their temperature, and speaking with a caring tone. We saw them introducing themselves to patients and explaining the care they were going to be giving. Patients told us staff were discreet, for example, drawing privacy curtains and softly inquiring if they had finished with bedpans or urinal bottles.

Feedback from the trust wide Friends and Family Test for August 2022 showed that 89.7% of patients thought the care they received was either very good or good. Patients left comments like “I thought all the staff were wonderful despite working under very challenging circumstances” and “all staff were very pleasant and helpful”.

Staff told us they understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. We saw and heard nurses asking patients about their preferences.

Staff followed policy to keep patient care and treatment confidential whenever they could.

Is the service responsive?

Inspected but not rated

Surgery

Service delivery to meet the needs of local people

The service did not plan and provide care in a way that met the needs of local people and the communities served.

The geographical area the trust served had a higher proportion of older people than the national average. This applied to both the over 65 and over 85 populations. Femoral neck fractures are commonly seen in the elderly population after a trivial fall as a result of osteoporosis. Consequently, the trust had the had the highest number of patients admitted with a fractured neck of femur in England, 891 in 2021. The National Hip Fracture Database (NHFD) Best Practice Tariff Target is for 85% of fractured neck of femur patients to be operated on within 36 hours of admission. In 2021 only 27.2% of patients had surgery within this timescale. The trust had an internal target to get 95% of trauma patients deemed fit for surgery (apart from those on a fractured neck of femur pathway) to theatre within 48 hours of admission to hospital. In August 2021 87.2% of patients were admitted to theatre within 48 hours and in August 2022 this target was met.

Meeting people's individual needs

The service was not always inclusive as it did not always take account of patients' individual needs and preferences. Staff did not always make reasonable adjustments to help patients access services.

We spoke with a patient with a profound learning disability and autism, and their parent. The parents were taking it in turns to provide round the clock care and supervision for their son in a side room. The patient had not been visited by a learning disability nurse and he did not have a named nurse. The parents did not get breaks from providing care, and they told us there had been no attempt by staff to assess the communication needs of their son. Some of the nurses we spoke to did not know there was a specialist team to work with patients with learning disabilities and autism.

Feedback from the Friends and Family Test for August 2022 showed staff did not wear a face covering with transparent mouth to communicate with a patient who lip read. Staff normally supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports. The service had dementia champions and a dementia team.

The service had information leaflets available in languages spoken by the patients and local community.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed.

Access and flow

The service was gridlocked by patients in beds who were medically fit for discharge. People could not always access the service when they needed it and receive the right care promptly.

It was recognised nationally that the health and care system was in gridlock. Large numbers of people were stuck in hospital longer than they need to be, due to a lack of available social care. The trust was experiencing significant problems with access and flow because of delays in discharging a large population of patients with no criteria to reside (medically fit and well). The month before we inspected, the average number of patients with no criteria to reside in the trust was 237. This was equivalent to 9 wards. Most of the patients with no criteria to reside on surgical wards. were medical outliers. Following our inspection, we requested information from the Trust about the number of medical outliers on surgical wards. We were given information for 4 October 2022 which showed 56 patient outliers bedded on surgical wards. This equated to 18.8% of the trusts' surgical beds.

The reasons for delayed discharges were complex. For example, we attended a meeting about bed capacity (board meeting) where we heard about a patient who had stayed at the hospital for 55 days after being declared medically fit

for discharge because a rehabilitation placement could not be found. Other patients needed domiciliary care packages or places in residential homes that were not available. Patient flow across the system in Dorset was significantly impacted by a shortage of staffed capacity in social care services. Senior trust managers told us they worked with their system partners to try and find solutions to delayed discharges for medically fit patients.

People could mostly access the service when they needed it but they experienced long waits to be admitted due to pressures on bed capacity. For example, in 2021 81.9% of patients on a fractured neck of femur pathway were not admitted to an orthopaedic ward within 4 hours. Admission to a ward within 4 hours of arriving at hospital is a best practice standard measured by the National Hip Fracture Database. However, 100% of patients received orthogeriatrician assessment within 72 hours of admission indicating prompt care despite bed pressures.

Some patients were being moved multiple times and sometimes at night, in order to place them on the right ward when a bed became available. Information from the trust showed from April 2021 to March 2022, 30 surgery patients had been moved onto 3 or more wards. Staff told us they did not have a tool to assess the clinical appropriateness of moving patients and sometimes felt these moves, especially at night, were unsafe. From April 2022 to September 2022, there were 231 patients from across the trust that were moved during the night time (between 10pm and 6am), recorded on the trust's system. The inability to effectively place patients in the right bed at the right time was on the trust's risk register.

NICE guidance (NG 94) refers to hospitals being at 85% capacity as ideal to maintain access and flow. The trust had been consistently over 93% occupancy for the six months before we inspected. The trust used an established tool to monitor the capacity of wards and tried to use it to meet the needs of the patients but were overwhelmed by the number of patients in the hospital. Trust managers told us the situation had led to an increase in patient harm and poor patient outcomes. They were holding talks with their system partners to look at how they could safely discharge patients with no criteria to reside.

Managers and staff started planning each patient's discharge as early as possible. The trust's discharge team were working hard to try and get patients without criteria to reside discharged but said the 'system' was not able to take them. They said due to delays in discharging patients some patients, at the end of their life, were being left to die in the side rooms of busy hospital wards instead of with dignity at home/in a residential home surrounded by their loved ones.

Problems with access and flow had an impact on patients waiting for elective surgery. There were sometimes no beds available for patients before or after surgery. Theatre recovery staff told us it was often quite difficult to transfer patients who had been admitted for emergency surgery to wards once they were recovered from their anaesthetic.

Initiatives had been introduced to reduce the length of time patients needed to stay in the hospital following surgery. For example, patients that needed toilet risers (a device that raises the height of the toilet to improve the accessibility of toilets to older people or those with disabilities. They can aid in transfer from wheelchairs and may help prevent falls) after surgery, were being assessed prior to surgery instead, to speed up the discharge process.

The hospital monitored the demand on its service using the Operational Pressures Escalation Framework (OPEL). The service had been at OPEL level three and four for the last six months before our inspection. Level four is the highest OPEL level and means the trust was at high pressure.

Managers worked to keep the number of cancelled operations to a minimum but were challenged by the chronically low staffing levels. Some staff told us theatre efficiency was not well managed. They told us that even if more operations took place, there was an issue with discharging patients back to surgical wards in a timely way.

Surgery

Is the service well-led?

Inspected but not rated

Leadership

Surgery leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced within their remit. They were mostly visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles when they were able to.

Surgery care leaders had the skills, knowledge, and experience to run the service. They understood the challenges and issues faced by the surgical wards and theatres service. Staff told us their leaders were visible and approachable. However, some nursing staff told us they rarely saw senior leaders, apart from when they were being told they have done something wrong. They said no thought was given to when they were told they had done something wrong or why something might not have been done or done incorrectly. They were sometimes "told off" as they were leaving the hospital for the day or about to go on annual leave, and that consideration of the impact of the extremely understaffed shifts on the issues were not considered.

Ward and theatre staff received strong leadership from their direct managers, ward managers, matrons, and department leaders. They described their leadership team as approachable but not always visible, due to their high workloads.

Some of the senior ward and theatre staff told us that senior hospital leaders did not listen to their concerns and did not understand the challenges they faced in maintaining patient safety. Many senior nurses told us they could not provide safe or effective patient care because of chronically short staffing levels and this was contributing to low staff morale.

The visibility of executive leaders on inpatient wards we visited, was mixed. Some staff told us they saw executive leads while other were not sure they would recognise them if they turned up on their ward.

Some matrons said they did not have time to support the development of Band 6 and 7 nurses. However, some staff told us about opportunities for personal and professional development. The theatre department were developing progression pathways for staff. We spoke with staff who were being supported to complete their nurse training through an apprenticeship programme. Students felt well supported in their placements.

Culture

Staff did not always feel respected, supported and valued. Staff morale was low but still focused on the needs of patients receiving care.

Staff told us morale was low. They said pressures from working with too few staff, staff leaving, cancellation of training and working in wards in which they were often unfamiliar, affected morale every day. Some of the conversations we had with staff were difficult to hear. Staff often became tearful or visibly upset when they were describing the way the hospital has changed since the pandemic and the conditions in which they were now working. They used words like "unvalued", "broken" and "exhausted" to describe how they felt.

Surgery

Staff at all levels told us they felt supported by their colleagues and worked as teams to deliver care. However, staff told us they could not always meet the fundamental care needs of patients and this was difficult to cope with. Staff were passionate about delivering compassionate care for patients and found it hard when this was not possible because of staff shortages. We saw that staff were kind and caring towards patients and supportive of each other.

During the pandemic staff felt valued for working with low staffing numbers because it was recognised how much extra effort was exerted to cover absent staff, and if they worked additional shifts, they would receive a financial incentive. However, they said they were no longer thanked for consistently working with low staff numbers and the financial incentive to work extra shifts had been severely curtailed. They said hospital leaders did not listen to their concerns about patient safety and their own wellbeing and they feared working on wards below the staff template had become the 'new normal'.

Senior nursing staff said they were losing staff because of the culture that normalised working with low staffing numbers and moving staff to different departments. For example, one health care assistant was moved to work on different wards eight times in a three-week period. They told us the stress and anxiety caused by staff not knowing where they would be working and or feeling they did not have the skills required to work on other wards was causing them distress. They said when they had raised this issue with senior hospital managers, they were made to feel like they were "causing trouble" or were "shot down in front of other staff". One senior nurse said, "the hospital don't care, we are just numbers, there's no recognition of the circumstances we are working in, we are told you just need to get on with it".

Other staff said they were fearful of repercussions if they spoke out about their working conditions. One member of staff said, "if you raise your head above the parapet you are bullied, told you are a troublemaker". However, one senior leader told us that they did not believe that there was a feeling that staff were fearful of reprisals.

Staff said some of the culture problems developed during the pandemic when ward changes were made due to the unprecedented National healthcare emergency. Nursing and medical staff were not consulted or involved in the process, and staff began to be moved to other areas of the hospital. Some staff reported being forcibly moved to a specialist area without the required competencies to care for patients without adequate training and support.

Senior staff told us they used to have direct access to the hospital directors and could affect change, but a layer of management had been created because of the merger, that prevented these lines of communication and they no longer felt listened to. One person said they "do feel respected and listened to but don't feel heard". Some senior staff described hospital leaders as not having an ethos of listening to concerns about patient safety. They said the trust put financial constraints above patient safety and staff wellbeing

Most staff did not talk about the merger favourably. Staff said things like, "since the merger the hospital has lost its vision" and "we are forced to do things in a new way, but the old way kept our patients safer".

Some staff said doctors did not understand the pressure nursing staff were under. However, some doctors told us they could see nurses were struggling to cope with their workload and they offered support when they could. They could also see nurse's wellbeing suffering.

Senior leaders told us about work they had done to improve culture by asking staff their thoughts on what changes they felt were needed within the trust. Some changes were introduced as a direct result of these listening events. For

example, some staff were concerned about their shift patterns. As a consequence rotas were changed to fit in with staff preference, so rotas that did not contain night or weekend shift for people that wanted work to fit in with their family life. However, managers had not been able to make all of the requested changes, for example providing areas for staff to take breaks in.

New members of staff said trust was friendly place to work.

Management of risk, issues and performance

Surgery leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact.

The service had assurance systems and performance issues were escalated through clear structures and processes. There were processes to manage most current and future performance which were reviewed and improved through a programme of clinical and internal audit. Leaders monitored quality, operational and financial processes and had systems to identify where action should be taken. However, the fractured neck of femur pathway was an exception. There was an expectation that the redevelopment of the theatres which began in 2018 and was expected to reach completion in 2023, would resolve the poor outcomes for patients on this pathway. We did not see evidence of shorter-term improvements to theatres that could have improved performance.

There were arrangements for identifying, recording and managing risks, issues and mitigating actions. There was alignment between recorded risks and what staff said was 'on their worry list'. The risk register reflected the fractured neck of femur pathways was one of the trusts highest risks, this risk was reviewed regularly and had oversight from the board of directors. Plans to improve patient safety and patient outcomes were high on the agenda for senior staff and the frustrations about delays to theatre for patients on a fractured neck of femur pathways were discussed frequently and regularly escalated to the executive board.

Staff in the brachytherapy unit described the progress in the delivery of low dose radiation for some cancer conditions and that there was scope to increase the number of procedures, although this was impacted by staff shortages. The service had a vacancy rate of 25% but had been successful in recruiting radiographers and apprentices.

Staff in the brachytherapy unit described the challenges around airflow in the operating theatres where brachytherapy was carried out and the impact this had on capacity. This was a recognised risk on the trust's risk register.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the trust MUST take to improve:

Surgery

- The trust must continue to act to recruit to vacant roles and retain staff across the organisation to ensure there are sufficient staff deployed to meet the needs of patients. Regulation 18 (1)(2)(a).

Surgery

- The trust must consider all options available for reducing delays to surgery for patients on a fractured neck of femur pathway. Regulation 12 (2)(b).

Action the trust SHOULD take to improve:

Surgery

- The trust should introduce a universal system for communicating DoLS authorisation to staff to avoid patients being detained unlawfully.
- The trust should continue to provide training to staff on gaining consent that includes informing patients of all of the risks of surgery.
- The trust should raise the profile of their learning disabilities and autism team to improve the inpatient experience for all patients and their relatives.
- The trust should develop systems so DNACPR forms are accompanied by a mental capacity assessment for patients who lack capacity.
- The trust should develop systems so DNACPR and AAND forms are completed by the responsible consultants within 48 hours.
- The trust should continue working with system partners to resolve problems with access and flow.
- The trust should continue to explore how culture can be improved.

Our inspection team

The inspection team comprised of four inspectors and three Specialist Advisors. We spoke to 64 members of staff, 16 patients, and 2 relatives. We looked at patient notes and observed patient operations. We attended staff meetings. This was followed by interviews with key people using MS Teams. We also reviewed documentation, policies and procedures.

The inspection was supported by an inspection manager and overseen by Catherine Campbell, Deputy Director.

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
	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity	Regulation
Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing