Leeds Teaching Hospitals NHS Trust

Chapel Allerton Hospital

Quality Report

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

Ratings

Overall rating for this hospital	Good
Surgery	Good

Summary of findings

Letter from the Chief Inspector of Hospitals

Leeds Teaching Hospitals NHS Trust is one of the largest trusts in the United Kingdom and serves a population of around 780,000 in Leeds and up to 5.4 million in surrounding areas, treating around 2 million patients a year. In total the trust employs around 15,000 staff and provides 1785 inpatient beds across Leeds General Infirmary, St James's University Hospital, Leeds Children's Hospital and Chapel Allerton Hospital. Day surgery and outpatient services are provided at Wharfedale Hospital and outpatients services are also provided at Seacroft Hospital. The Leeds Dental Institute, although part of the trust, was not inspected at this inspection.

We carried out a follow up inspection of the trust from 10 to 13 May 2016 in response to the previous inspection as part of our comprehensive inspection programme in March 2014. We also undertook an unannounced inspection on 23 May 2016 to follow up on concerns identified during the announced visit.

Focussed inspections do not look across a whole service; they focus on the areas defined by information that triggers the need for an inspection. Therefore, we did not inspect all the five domains: safe, effective, caring, responsive and well led for each core service at each hospital site. We inspected core services where they were rated requires improvement. We also checked progress against requirement notices set at the previous inspection due to identified breaches in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. As a result of the March 2014 inspection, we issued a number of notices, which required the trust to develop an action plan on how they would become compliant with regulations. We reviewed the trust's progress against the action plan as part of the inspection.

We inspected the following locations:

At Leeds General Infirmary (LGI), we inspected the following domains:

- Urgent and emergency care (A&E) - safe and effective
- Medicine - safe, effective, responsive and well-led
- Surgery - safe, responsive and well-led
- Critical care - safe, responsive and well-led
- Maternity and gynaecology - safe
- End of life care - safe

We inspected the following domains for children's and young people's services at the Children's Hospital, which is reported in the LGI location report – safe, responsive and well-led.

At St James's University Hospital (SJUH), we inspected the following domains:

- Urgent and emergency care (A&E) – effective
- Medicine – safe, responsive and well-led
- Surgery - safe, responsive and well-led
- Critical care - safe, responsive and well-led
- Maternity and gynaecology - safe
- End of life care - safe

At Chapel Allerton and Wharfedale Hospitals, we inspected the safety domain within surgery.

We did not inspect the Leeds Dental Institute and we did not inspect the outpatients' services across the trust as these had previously been rated as good.

We did not inspect the caring domain across the trust as this was rated as good across all trust services at the previous inspection.

Summary of findings

Overall, we rated the trust as good. We rated safe as requires improvement, effective, responsive and well-led as good. We rated Leeds General Infirmary and St James's University Hospital as requires improvement, Chapel Allerton Hospital as good and Wharfedale Hospital as good.

Our key findings were as follows:

- Since the last inspection, the trust had invested time, effort and finances into developing a culture that was open, transparent and supported the involvement of staff, and reflected the needs of the people who used the services.
- Changes such as the development of clinical service units and governance arrangements that were in their infancy at the last inspection had been further embedded and embraced by staff in the organisation.
- Each clinical service unit had clear direction and goals with steps identified in order to achieve them.
- The leadership team had remained stable. Staff across the organisation were positive about the access and visibility of executives and non-executives, particularly the Chief Executive. There had been improvements to services since the last inspection.
- The leadership team were aware of and addressing challenges faced with providing services within an environment that had increasing demand, issues over patient flow into, through and particularly out of the organisation, including the impact this had on service provision; and the recruitment of appropriately skilled and experienced staff.
- The trust values of, 'The Leeds Way' were embedded amongst staff and each clinical service unit had a clear clinical business strategy, which was designed to align with the trust's 'Leeds Way' vision, values and goals. This framework encouraged ownership from individual CSU's.
- We saw strong leadership of services and wards from clinicians and ward managers. Staff spoke positively about the culture within the organisation.
- Staff reported across the trust that they were proud to work for the organisation and felt that they worked well as a team across the different sites.
- The trust invited all 15,000 staff to participate in the national staff survey, with a response rate of over 8,000 staff across the organisation. The survey showed that there was continuous improvement. The response rate for the NHS Staff Survey 2015 was 50%, this was better than the England average of 41%.
- At service level there were governance processes and systems in place to ensure performance, quality and risk was monitored. Each CSU met weekly and used the ward health check to audit a range of quality indicators including the number of falls, complaints, pressure ulcers, staffing vacancies and staff sickness. This information was then escalated to senior staff and through the trust's governance structure.
- There was a positive culture around safety and learning from incidents with appropriate incident reporting and shared learning processes in place. However, learning from Never Events was not consistent amongst all staff within theatres. All steps of the World Health Organisation (WHO) safety checklist were not consistently taking place: audit data and our observations supported this. The audit data provided by the trust did not assure us that national early warning score (NEWS) and escalation was always done correctly.
- There were occasions when nurse and care support worker staffing levels were below the planned number. Despite having a clear escalation process, non- qualified staffing levels did not always mitigate for the reduction in qualified nursing levels. Nursing, midwifery and medical staffing levels did not meet national guidelines in some areas, particularly surgery, theatres, critical care, maternity and children and young peoples' services. The trust was actively recruiting to posts and supporting a range of role development programmes to diversify the staff group, including supporting advance roles and role specific training for non-qualified staff.
- Arrangements and systems in place were not sufficiently robust to assure staff that the maintenance of equipment complied with national guidance and legislation.
- There were arrangements in place for assessing the suitability of patients who were appropriate to wait on trolleys on the assessment ward. However, these were not consistently applied, or risk assessments undertaken. There was a lack of robust assurance over the oversight of patients waiting on trolleys.

Summary of findings

- Adherence to General Medical Council (GMC) guidance and the trust consent policy was not consistently demonstrated in patient records. In accordance with trust policy, a two stage consent process including two patient signatures was not consistently evidenced in patient records. However, we were assured that patients were well informed about their surgical procedure and had time to reflect on information presented to them at the pre-assessment clinic.
- There was a much improved mandatory training programme. However, there were still low completion levels in some training, particularly resuscitation and role relevant safeguarding.
- The Summary Hospital-level Mortality Indicator (SHMI) and the Hospital Standardised Mortality Ratio (HSMR) indicated there was no evidence of risk compared to the England average.
- There were suitable arrangements in place for the prevention and control of infections, including policies, procedures and a dedicated infection prevention control team. Areas visited were clean and staff generally adhered to good infection control practices.
- The trust responded to complaints and concerns in a timely manner. Improvements were made to the quality of care as a result of complaints and concerns.
- The trust took into consideration the needs of different people when planning its services and made reasonable adjustments for vulnerable patient groups.
- There was clear guidance for staff to follow within the care of the dying person's individual care plan when prescribing medicines at the end of their life. Patients' individual needs and wishes at the end of their life were represented clearly in the documentation.
- Policies and guidelines were based on the latest national and international guidelines such as from the National Institute for Health and Care Excellence (NICE) and Royal College of Emergency Medicine.
- On the whole, patients received pain relief in a timely manner and were able to access food and drinks as required.
- Arrangements were in place to alert staff when patients were in receipt of treatment or admitted with special needs or were vulnerable, including living with dementia and learning disabilities. Staff had received training on how to support patients and individualise care to meet specific needs.
- Staff understood their responsibilities in relation to the Mental Capacity Act (2005), restraint of patients and the treatment of detained patients, although there was some inconsistent practice over care of patients receiving rapid tranquilisation treatment.

We saw several areas of outstanding practice including:

- There were outstanding examples of record keeping in the care of the dying person care plan. We saw that staff recorded sensitive issues in a clear comprehensive way to enable safe care to be given.
- The development of Leeds Children's Hospital TV allowed families to explore the wards and meet the teams.
- Organ transplantation which included a live liver donation and transplant programme had been undertaken, which was the largest in the UK. Other aspects of the transplantation programme included Neonatal organ retrieval and transplantation, Life Port Trial, Kidney Transplantation, QUOD Trial, Quality in Organ Donation National Tissue Bank, Revive Trial, Organ Care System and Normothermic perfusion, Support for Hand Transplantation.
- Procedures such as minimally invasive oesophagectomies were being performed. The colorectal team were using sacral nerve stimulation for faecal incontinence.
- There is a consultant led virtual fracture clinic. This allows patients to be assessed without attending the hospital and then have the most appropriate follow up. This reduces unnecessary hospital attendances.
- Revolutionary hand transplant surgery had taken place within plastic surgery.
- Nurse-led wards for patients who were medically fit for discharge had been introduced to allow the service to adapt their staffing model to meet the needs of patients.
- In response to patient carer feedback the acute medicine Clinical Service Unit had introduced John's campaign. This allowed carers to stay in hospital with patients with dementia.

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

Summary of findings

Importantly, the trust must:

- The trust must ensure at all times there are sufficient numbers of suitably skilled, qualified and experienced staff in line with best practice and national guidance taking into account patients' dependency levels.
- The trust must ensure all staff have completed mandatory training and role specific training.
- The trust must ensure staff have undertaken safeguarding training at the appropriate levels for their role.
- The trust must review the admission of critical care patients to theatre recovery areas when critical care beds are not available to ensure staff are suitably skilled, qualified and experienced.
- The trust must review how learning from Never Events is embedded within theatre practice.
- The trust must review the appropriateness of out of hours' operations taking place and take the necessary steps to ensure these are in compliance with national guidance.
- The trust must review the storage arrangements for substances hazardous to health, including cleaning products and sharps disposal bins to ensure safety in line with current procedures.
- The trust must review and address the implementation of the WHO Five Steps to Safer Surgery within theatres.
- The trust must ensure that physiological observations and NEWS are calculated, monitored and that all patients at risk of deterioration are escalated in line with trust guidance.
- The trust must ensure that all equipment used across core services is properly maintained and serviced.
- The trust must ensure that staff maintain patient confidentiality at all times, including making sure that patient identifiable information is not left unattended.
- The trust must ensure that infection prevention and control protocols are adhered to in theatres.

In addition the trust should:

- The trust should review and improve the consent process to ensure trust policies and best practice is consistently followed.
- The trust should review the availability of referral processes for formal patient psychological and emotional support following a critical illness.
- The trust should review the provision of post-discharge rehabilitation support to patients discharged from critical care.
- The trust should ensure that appropriate staff have access to safeguarding supervision in line with best practice guidance.
- The trust should continue to monitor the safe and correct identification of deceased patients before they are taken to the mortuary and take necessary action to ensure this is embedded in practice.
- The trust should continue to work towards improving the assessment to treatment times within the ED department. The trust should also continue to work towards improving ambulance handover times and reduce the number of handovers that take more than 30 minutes.
- The trust should ensure that systems and processes are in place and followed for the safe storage, security, recording and administration of medicines including controlled drugs.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Surgery	Good 	We rated surgical services as good because: • We found that the concerns raised from the previous inspection which resulted in a 'requires improvement' rating had been fully addressed. • We found that there were appropriate incident reporting arrangements and there were suitable processes in place to support learning from incidents; this included dissemination of learning across the hospital and more widely across the trust. • The ward performed well against performance measures including safety thermometer and ward health checks. The ward and theatre environments were in a good state of repair and the general environment in these areas was clean and free from clutter. Compliance with mandatory training for ward and theatre staff was above the trust target of 80% and the processes for monitoring mandatory and appraisal worked well. Nurse staffing levels for both theatres and the ward were in-line with the assessed levels of safe staffing. Staff understood the early warning score process and how to escalate concerns appropriately and there were specific patient transfer guidelines for the transfer of the deteriorating patient to another hospital site.

Chapel Allerton Hospital

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Detailed findings

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Background to Chapel Allerton Hospital

Chapel Allerton hospital is a peripheral site of Leeds Teaching Hospitals NHS Trust. The hospital was recently established as a separate clinical service unit within the trust. Surgical services at Chapel Allerton Hospital are supported by three wards, which support neuro-rehabilitation, rheumatology, dermatology and orthopaedic services. The hospital operates two day services units, the first with four procedure rooms for dermatology and the second for rheumatology. Four theatres provide elective orthopaedic and dermatology surgical procedures. A pre-admissions unit supports elective orthopaedics and there are 16 post-operative beds.

Services at Chapel Allerton Hospital comprised of three inpatient wards, which supported neuro-rehabilitation (Ward C1), rheumatology and dermatology (Ward C2) and orthopaedic surgery (Ward C3). The hospital operated four theatres, which undertook elective orthopaedic and dermatology surgical procedures. A pre-admissions unit supported elective orthopaedic procedures with 16 post-operative beds.

Our inspection team

Our inspection team was led by:

Chair: Diane Wake, Chief Executive of Barnsley Hospital NHS Foundation Trust

Head of Hospital Inspections: Julie Walton, Care Quality Commission

The team included CQC inspectors and a variety of specialists including medical, surgical and obstetric consultants, a junior doctor, senior managers, nurses, a midwife, a palliative care specialist and children's nurses.

How we carried out this inspection

To get to the heart of patients' experiences of care, we routinely ask the following five questions of services and the provider:

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

As this was a focused inspection we did not look across the whole service provision; we focussed on the areas

Detailed findings

defined by the information that triggered the need for the focused inspection. Therefore not all of the five domains: safe, effective, caring, responsive and well led were reviewed for each of the core services we inspected.

Prior to the announced inspection, we reviewed a range of information that we held and asked other

organisations to share what they knew about the trust. These included the clinical commissioning

groups (CCG), Monitor, NHS England, Health Education England (HEE), the General Medical Council (GMC), the Nursing and Midwifery Council (NMC), and the local Healthwatch organisation.

We carried out the announced inspection visit from 10 – 13 May 2016. During the inspection we held focus groups with a range of staff including nurses, consultants, allied health professionals (including physiotherapists and occupational therapists) and administration and support staff. We also spoke with staff individually as requested. We talked with patients and staff from ward areas and outpatient services. We observed how people were being cared for, talked with carers and/or family members, and reviewed patients' records of personal care and treatment. We also held focus groups with community groups who had experience of the trust services.

Facts and data about Chapel Allerton Hospital

Budget: £1 billion

Staff: employs over 15,000 staff

Specialist services: The trust is one of the largest providers of specialist hospital services in the country, with almost 50% of the overall income from specialist commissioners, NHS England. Specialist services generally fall into five groups – specialist children's services, cancer, blood and genetics, neurosciences and major trauma, cardiac services and specialised transplantation and other specialised surgery.

Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Good	N/A	N/A	N/A	N/A	Good
Overall	Good	N/A	N/A	N/A	N/A	Good

Surgery

Safe	Good
Overall	Good

Information about the service

Chapel Allerton Hospital is a peripheral site and is one of seven hospitals that form part of Leeds Teaching Hospitals NHS Trust. Surgical services at the hospital are supported by three wards including neuro-rehabilitation, rheumatology, dermatology and orthopaedic services. The hospital operates two day services units; one unit has four procedure rooms for dermatology and the other for rheumatology. Four operating theatres provide elective orthopaedic and dermatology surgical procedures. A pre-admissions unit supports elective orthopaedic surgery and there are 16 post-operative beds.

In March 2014 the Care Quality Commission (CQC) carried out an announced comprehensive inspection and overall we rated surgical care across the trust as requires improvement. For Chapel Allerton Hospital, we rated the domains effective, caring, responsive and well led as good; safety was rated as requires improvement.

This inspection took place on the 10, 11 and 12 May 2016 and was part of an announced focused inspection to follow up the outstanding requirements from the previous inspection. During our inspection we visited ward C3 and operating theatres.

We spoke with staff of various grades including doctors, nurses and service managers. We also reviewed patient care records and medication charts. In addition, we observed care and the environment, handovers and safety briefings. Prior to the inspection we reviewed the hospital's performance data.

Summary of findings

We rated surgical services as good overall because:

- We found that the concerns raised from the previous inspection which resulted in a 'requires improvement' rating had been fully addressed.
- We found that there were appropriate incident reporting arrangements and there were suitable processes in place to support learning from incidents; this included dissemination of learning across the hospital and more widely across the trust.
- The ward performed well against performance measures including safety thermometer and ward health checks. The ward and theatre environments were in a good state of repair and the general environment in these areas was clean and free from clutter. Compliance with mandatory training for ward and theatre staff was above the trust target of 80% and the processes for monitoring mandatory and appraisal worked well. Nurse staffing levels for both theatres and the ward were in-line with the assessed levels of safe staffing. Staff understood the early warning score process and how to escalate concerns appropriately and there were specific patient transfer guidelines for the transfer of the deteriorating patient to another hospital site.

Surgery

Are surgery services safe?

Good

We rated safe as good because:

- There was a positive culture around safety and learning from incidents.
- The ward performed well against certain performance measures including safety thermometer and ward health check measures.
- The ward and operating theatre environments were clean and there were suitable arrangements in place for maintaining a clean and safe environment.
- Compliance with mandatory training for ward and theatre staff was above the trust target of 80%. The processes for monitoring mandatory and appraisal worked well.
- Staff understood the early warning score process and how to escalate concerns appropriately.
- Nurse staffing levels for both theatres and the ward were in-line with the assessed levels of safe staffing.

However:

- Adherence to General Medical Council (GMC) guidance and the trust consent policy was not consistently demonstrated in patient records. However, we were assured that patients were well informed about their surgical procedure and had time to reflect on information presented to them at the pre-assessment clinic.

Incidents

- Never events are serious, largely preventable patient safety incidents which should not occur if proper preventative measures are taken. Although each never event type has the potential to cause serious potential harm or death, harm is not required to have occurred for an incident to be categorised as a Never Event.
- Between October 2014 and September 2015 there had been three Never Events within surgery at the trust. None were attributable to the LGI site. Two occurred at the St. James's University Hospital (SJUH) site, one related to a retained swab following surgery and one related to a wrong site anaesthetic block. A second incident of wrong site anaesthetic block occurred within six months at Chapel Allerton Hospital. We reviewed the investigation reports and related action plans for the three Never Events.
- In reaction to the wrong site block never events the trust launched a specific safety campaign called 'stop before you block.' The concept was that clinicians, just before injecting an anaesthetic block, conducted a set of checks about the patient, intended operation site and required block site.
- The trust conducted a two week 'stealth audit' audit around compliance with 'stop before you block' and presented results in March 2016. The audit ran across three sites between February and March 2016, one site included Chapel Allerton operating theatres.
- During the audit at Chapel Allerton, 19 blocks were performed by consultant doctors. The necessary checks were competed in 16 out of the 19 cases. The compliance was 84%.
- The compliance across all three sites taken together was 80%.
- Conclusions drawn from this were that compliance should be 100% and staff needed to be much more conscientious when confirming correct site. A formal policy change regarding the procedure leading up to an anaesthetic block was being considered.
- The senior charge nurse stated that incidents, including serious incidents, never events and incidents, were openly reported by staff and discussed in appropriate detail at governance meetings and team briefs.
- From April 2015 to March 2016 there were two reported incidents; these were incidents recorded by staff via the trust's electronic incident reporting system.
- One incident (21.12.15) related to an out-of-hours discharge on ward C3 and the second incident (21.8.15) was in the operating theatres and related to lack of clinical assessment.
- The number of incidents classified as serious for Chapel Allerton Hospital for the previous 18 months was one. This related to a patient fall in a surgical ward area. The incident was fully investigated and there has been an overall drive across the hospital, and trust, to reduce patient falls.
- We spoke with the senior charge nurse for ward C3 and it was evident processes were in place for monitoring incidents and cascading information to staff within the department and more widely across the trust.

- The senior charge nurse stated that two senior nursing staff members 'took ownership' for reviewing reported incidents and an e-mail was automatically sent to a 'reviewer' once an incident report had been completed.
- All reported incidents were fed back and discussed at clinical governance meetings for the Chapel Allerton clinical service unit (CSU).
- The reviewer rated incidents and decided on the level of investigation required. Guidance was available to support the decision-making process in terms of when an incident should 'trigger' a root cause analysis review and/or a serious incident investigation.
- Themes from incidents were discussed at weekly staff meetings and information was presented in newsletters including the trust wide quality and safety newsletter.
- We spoke with nursing ward staff about incidents, reporting of incidents and learning. Staff we spoke with confirmed what had been relayed to us from discussions with senior staff; staff were aware of the electronic system and how to report incidents and described examples of feedback from incidents.
- There were appropriate processes in place for reviewing incidents and escalating which incidents were classed as serious and requiring more detailed investigates and root cause analysis. We saw evidence of serious incident and root cause analysis investigations and related action plans for disseminating learning and altering processes to reduce the likelihood of re-occurring incidents.
- On a monthly basis, the matron reviewed all recorded incidents and ensured incidents had been graded accurately in terms of harm and if appropriate action had been taken. Any themes or trends with the data were highlighted and appropriate action taken.
- Reviews were undertaken for patient mortality and morbidity and findings were discussed at clinical governance meetings.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) ofcertain 'notifiable safety incidents'andprovide reasonable support to that person.
- We reviewed examples where patients had been spoken with about an incident and it was evident how the trust were being open and honest and providing/offering any necessary support to the patient.
- In one example, a patient had fallen and the trust spoke with the patient directly to offer support and apologise and also wrote to the patient formally detailing the results of the investigation of the incident.
- All staff were trained in the process of investigating incidents and were involved in incidents investigations and root cause analysis.

Safety thermometer

- The NHS Safety Thermometer is an improvement tool used for measuring, monitoring and analysing patient harms and 'harm-free' care. We observed that the unit's Safety Thermometer was on display in the main corridor of the unit; it was clearly visible to staff, patients and visitors.
- Included in the display was data on pressure ulcers, falls, venous thromboembolism (VTE) and urine infections.
- On the safety information display board in the corridor, data was displayed on the number of falls and the overall trend over time. The overall trend for falls was on a downward trajectory and there had been no falls in the previous three months.
- The harm free care percentage for April 2016 was 93.76% for the hospital; the previous six months had all been above 90%.
- It had been nine months since a patient had been reported as having a moderate injury.
- All safety thermometer data was reviewed and discussed and clinical governance meetings; we saw evidence of this from meeting minutes.

Cleanliness, infection control and hygiene

- The general environment of the admission unit, recovery ward, rehabilitation ward and operating theatres appeared visibly clean and tidy.
- The ward areas and operating theatres had designated cleaning staff and cleaning schedules were in place and followed. Nursing staff also had a responsibility to clean and disinfect the environment and staff we spoke with accurately described their responsibilities in relation to environmental cleaning.
- The hospital participated in the annual Patient Led Assessments of the Care Environment (PLACE).
- We noted that staff followed the trust policy regarding dress code and being bare below the elbow; being bare below is a best practice standard for hand hygiene.

Surgery

- Methicillin-resistant Staphylococcus aureus (MRSA) and Clostridium difficile rates were displayed on the ward and we spoke with the senior charge nurse about the ward's infection control data. The last recorded Clostridium difficile infection was 1 August 2011 and the last recorded MRSA blood stream infection was 21 April 2009.
- We noted there was good access to a range of cleaning products including easy to use service wipes, sporicidal solution and chlorine-based products.
- The 26 bedded rehabilitation ward had a total of eight isolation rooms. These were primarily used for patients requiring isolation for infection control reasons.
- There had been no recorded incidents in the previous 12 months of patients requiring isolation not having been isolated within two hours.
- The ward monitored compliance with certain key trust policies including hand hygiene. Hand hygiene compliance for April was 80%, March 100% and February 100%.
- The observer during hand hygiene audits was not visible to staff and audits were conducted at varying times; this helped ensure that staff were not changing behaviours because they knew they were being observed.
- We spoke with the head of nursing about national data and surgical site infection rates at the hospital; the infection rates were better than the national average.

Environment and equipment

- The general layout of the admission unit, recovery ward and rehabilitation ward was relatively spacious and a suitable environment for patients, visitors and staff.
- From the previous inspection, in relation to the layout of the environment, comment had been made about male and female patients sitting together in their theatre gowns in the pre-operative area; this was not ideal in terms of privacy and dignity.
- On this inspection, we observed the changes that had been implemented and there were separate pre-operative waiting areas for male and female patients.
- The operating theatre environment was relatively spacious and space was utilised in a pragmatic and safe way. The overall theatre environment was fit for purpose and in a good state of repair.
- We spoke with the senior charge nurse about equipment in the ward and recovery areas. All the beds on the unit were new from when the unit was first opened; there were no beds over 11 years old; beds were regularly maintained and were fully functional.
- We were informed that mattresses were also in a suitable condition and were supplied from a trust wide central store. Mattresses were checked periodically for damage and replaced if necessary.
- A clinical support worker on the ward had a responsibility to oversee beds and mattresses and ensure such equipment remained fit for purpose.
- Other key equipment included the resuscitation trolleys. We checked two resuscitation trolleys and all necessary equipment was present and in working order. Daily checks were completed on resuscitation trolleys and we saw evidence such checks were taking place.
- In relation to operating theatre equipment, the hospital had a specific theatre policy stating that equipment in theatre should be checked daily.
- We saw evidence of daily checks on vital equipment, this included anaesthetic machines.
- Both on the ward and in the theatre department we observed some equipment where the portable appliance testing (PAT) was out-of-date. In the recovery area in particular there were several syringe driver pumps with out-of-date appliance testing; we informed the senior nursing team about this for prompt action to be taken. .
- From the previous inspection it was noted that equipment was stored in a corridor area at the back of theatres, a portion of which was a fire exit. We observed the same area and equipment remained in the path of the fire exit; it was promptly removed on the afternoon of the inspection.
- For new equipment, in the majority of cases, training was provided by the equipment supplier. For other items of equipment, specific staff with the necessary experience trained and supported others on how to use equipment safely.

Medicines

- Pharmacists provided support for the ward Monday to Friday and there was an on-call pharmacy service for out-of-hours and at weekends.
- Staff we spoke with felt the support provided by the pharmacy service was sufficient.

- The ward had access to what was described as a 'robotic' dispenser; this complimented the existing drug dispensing processes.
- Quarterly pharmacy audits were completed by junior doctors and these involved drug chart audits and antibiotic prescribing.
- An orthopaedic surgeon oversaw the quarterly pharmacy audit programme and results were reported to clinical governance meetings and trust wide audit committee.
- We assessed four sets of patient records including four drug charts; the drug charts we observed were completed accurately.

Records

- Patient records were predominately paper-based with patients having their own set of patient notes.
- Patient notes were stored in a recently converted designated notes store room named 'the hub'.
- Medicine trolleys were also kept in 'the hub'.
- The room itself was not locked but situated directly opposite the nurses' station.
- Some aspects of patient records were recorded electronically including operation notes and some medicines prescribing.
- The ward was one of the first in the trust to trial eMedicines which is an electronic prescribing and medicines management system which provides clinical staff with an integrated view of a patient's medication history.
- At the start of a patient's surgical pathway, a surgical 'pack' was compiled which had all the necessary documentation for their full surgical process; this was done at the pre-admission clinic.
- This included all the necessary risk assessment documentation and related pre-operative assessments including venous thromboembolism (VTE), pressure ulcers, nutrition, falls and dementia screening.
- We reviewed four sets of patient records and all necessary risk assessments were complete and up-to-date.
- We also reviewed the processes in place around consent, particularly consent to surgery.
- We observed four sets of patient records and the consent forms within. In each set of notes there were three copies of the consent form; one of the three copies should have been offered / handed to the patient. Patients were not being routinely offered a copy of their consent which was not in line with trust policy or national guidance.
- Of the consent forms we reviewed, all had been signed by the patient but, on each occasion, this was done on the day of surgery. According to trust policy, and national guidance, consent to surgery should ideally be a two-stage process whereby the patient signs consent several weeks before their elective procedure and again on the day of surgery.
- The time in-between signing the first and second stage consent allows the patient time to reflect and consider the information provided at their initial assessment with the medical and nursing team; signing consent on the day of surgery does not provide time for reflection.
- We were informed that patients were provided with adequate amounts of information about their procedure at pre-assessment and all patients received a follow-up letter explaining what was discussed at the pre-assessment meeting. This information could then be considered carefully by the patient before their procedure; the patient would then sign on the day of surgery.
- Trust policy in relation to consent was not being accurately followed but patients were well informed about their surgery, did have time to reflect and did sign a consent form in agreement prior to surgery.

Safeguarding

- We spoke with the senior charge nurse about the processes in place around safeguarding people. There was a specific safeguarding policy for staff to refer to and this was on the trust's intranet site.
- There was a specific process to follow in order to raise concerns and/or get advice if there were safeguarding concerns.
- The trust had a designated safeguarding team who were available to support and advise staff in relation to safeguarding.
- Staff we spoke with were aware of how to access the safeguarding policy and how to request support if they had concerns about someone's welfare.
- Staff received specific safeguarding training in relation to adults and children, compliance with such training, from the records we reviewed, were up-to-date.

- The percentage compliance figure for safeguarding vulnerable adults and children Level 1 training was 93%; for Level 2 training the figure was 100%.

Mandatory training

- At the previous inspection we noted that the percentage completion of some mandatory training courses was comparatively low, this included fire safety (44%), resuscitation (31%) and blood transfusion and competence assessment (31%).
- At this inspection we noted that steps had been taken to improve the way in which mandatory training was organised and monitored; it was all done via a relatively new electronic training records database accessed via a training interface.
- Previously, departments were sent an Excel spreadsheet highlighting what training staff required and when staff needed refresher sessions. This was replaced with the electronic training interface which also included staff appraisal monitoring.
- There was a list of mandatory training (16 courses, excluding appraisal) and a list of priority training (16 courses).
- Staff we spoke with said the new system was user friendly and effective in monitoring attendance and updates with mandatory training.
- We reviewed four staff training records and all training was up-to-date. Compliance with mandatory training across the department was above the trust's target of 80%.

Assessing and responding to patient risk

- The senior charge nurse we spoke with stated that the unit used any early warning score system to help determine possible deterioration of patient's health; this was the same system as used across the trust.
- A policy was available for staff on the intranet around early warning scores and the processes for escalation.
- Staff we spoke with understood the early warning score process and how to escalate concerns appropriately.
- Patients returning from the operating theatre were 'recovered' in a designated ward recovery area by ward staff; patients were closely monitored in the recovery area immediately following surgery.
- Ward staff would then monitor patients following their stay in the recovery area and there were specific pathways to follow in order to alert medical staff if a patient's condition appeared to be deteriorating.
- The unit, because of it being a peripheral site, did not have input from an outreach team; if there were concerns about a patient's condition there was a fast-track process whereby patients were taken to one of the main hospital sites for assessment and/or treatment.
- There were specific patient transfer guidelines for the transfer of the deteriorating patient to another hospital site, this included guidance for transfers in usual working hours and out-of-hours.
- If patients scored an early warning score of three or above, nursing staff were required to escalate concerns to medical staff.
- We spoke with one junior doctor about medical support, the deteriorating patient and potential patient transfers.
- For patient transfers they stated that it wasn't always a straight forward process and could be relatively time consuming. They commented that, on occasion, finding a bed was a challenge and sometimes they needed to speak with a range of staff to help facilitate a patient transfer; this often took a disproportionate amount of time to arrange.
- They stated that, on a number of occasions, because of the delays in transferring some patients, an emergency ambulance was called to transport the patient to one of the larger hospital sites via the Accident and Emergency department. We did not have exact figures on how often this had occurred.
- They also described how the management of a deteriorating patient on the ward was challenging because they were not always supported by nursing staff with such things as cannulation, taking bloods and conducting ECGs.
- Some of the above challenges were recognised and plans were in the early stages for employing two advanced nurse practitioners to support the nurses and medical staff on the ward, including assessment and management of the deteriorating patient.
- All nursing staff on the ward were trained in intermediate life support; this provided staff with advanced skills in managing the deteriorating patient and recognising signs of concern.
- In the operating theatres, we observed surgical procedures and the safety checks used prior to an operation starting. Theatres used the '5 steps to safer surgery' and we observed the first four steps being consistently followed.

- From our observations, and review of patient notes, step five was not consistently done. Step five is the 'debriefing' stage and centres on the full theatre team discussing any problems and potential learning immediately after each operating list.
- Staff we spoke with acknowledged that stage 5 was not consistently done but they stated that debriefs did occur if there had been any distinct problems.

Nursing staffing

- Senior nursing staff we spoke with said staffing levels was adequate and vacancy rates were low. There was less than one whole time equivalent qualified nurse vacancy.
- For any short term short falls in staffing particular shifts, permanent nursing staff usually covered these by working extra hours; nurse agency were not used.
- One bank nurse was used relatively frequently; the nurse used was familiar with the ward and working practices.
- The trust conducted periodic assessments around patient acuity and staffing levels, the ward last had such an assessment in February 2016 and staffing levels were seen as safe.
- Staff retention rates were good and staff sickness was 1.5% which was below the trust average.
- Staff we spoke with did not raise concerns about staffing levels, or skill mix, and from our patient care observations; patients' needs were being met in a timely way.
- There were nursing handovers at 7am, 11.30am and 7pm. The information shared was suitably detailed and accurate.
- There was a 'board round' at 8.45am and this was a multidisciplinary meeting including nursing and medical staff and allied healthcare professionals. Information shared was accurate and effectively managed.

Surgical staffing

- There was a resident junior doctor overseeing the ward overnight from 6pm onwards, which was the time when operating lists finished.
- No anaesthetist was available on-site once the operating lists had finished and there was no outreach team.
- The junior doctor we spoke with was part of a 1:9 on call shift system; they stated two to three 'slots' often remained unfilled. Locum doctors or medical staff from Leeds General Infirmary were used to fill any gaps in the on-call rota.
- The junior doctor stated that there was no consultant led ward rounds at weekends and they themselves sometimes struggled to conduct a formal ward round at weekends because they were too involved in completing routine work.
- The challenges around completing ward rounds were reported by one doctor; we were unable to speak with other medical staff about this. The head of nursing had not received comments about this from other medical colleagues.
- There was no specific consultant on-call service for the hospital but junior medical staff could be contacted via an on-call rota.
- In terms of medical handover, the 'bleep' was handed over to the receiving doctor at 5pm; there was no formal handover process.
- Their ward did receive 'step down' patients (medical outliers) from other sites across the trust. The junior doctor stated that such patients often lacked 'ownership' and it was difficult to know who to contact if there were any problems or issues to discuss. It was reported that this caused delays which impacted the timeliness of patient treatment.

Major incident awareness and training

- There was a trust wide major incident policy; the policy was formed by amalgamating the preparing for emergencies policy with the previously separate major incident policy; it was accessible to all staff via the trust's intranet site.
- The policy covered major incidents, MAJAX, emergency planning and business continuity.
- Chapel Allerton Hospital had been designated as a 'receiving centre' for patients in the event of a major incident.
- Aspects of the policy were recently referred to during medical staff strikes and elective surgical activity was reduced to manage the situation.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital SHOULD take to improve
Action the hospital should take to improve

- The trust should review and improve the consent process to ensure trust policies and best practice is consistently followed.