# Plymouth Community Healthcare CIC

1-271962340

# Urgent care services

## Quality Report

Local Care Centre
Mount Gould Hospital
Plymouth
Devon
PL4 7PY
Tel: 08451 558100
Website: www.livewellsouthwest.co.uk

Date of inspection visit: 21 - 24 June 2016
Date of publication: 19/10/2016

# Summary of findings

## Locations inspected

| Location ID | Name of CQC registered location | Name of service (e.g. ward/ unit/team) | Postcode of service (ward/ unit/ team) |
|---|---|---|---|
| 1-297634914 | Cumberland Centre | Cumberland Centre Minor Injuries Unit | PL1 4JZ |
| 1-2078154330 | Tavistock Hospital | Tavistock Hospital Minor Injuries Unit | PL19 8LD |
| 1-2078169826 | South Hams Hospital | South Hams Hospital Minor Injuries Unit | TQ7 1AT |

This report describes our judgement of the quality of care provided within this core service by Plymouth Community Healthcare CIC, also known as Livewell Southwest. Where relevant we provide detail of each location or area of service visited.

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

Where applicable, we have reported on each core service provided by Plymouth Community Healthcare CIC and these are brought together to inform our overall judgement of Plymouth Community Healthcare CIC.

# Summary of findings

## Ratings

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

# Summary of findings

## Contents

# Summary of findings

## Overall summary

Overall, we rated the urgent care service as good because;

- Safety performance and risks were assessed, managed and monitored. Quality and safety reports were sent to senior managers on a monthly basis. Openness and transparency about safety was encouraged.
- Practitioners were well qualified and demonstrated the skills that were required to carry out their roles effectively and according to best practice. They worked collaboratively with multidisciplinary teams from community services and acute services at neighbouring hospitals
- Staff used evidence-based guidelines in order to ensure effective treatment was delivered.
- The learning needs of staff were identified at regular clinical supervision sessions and at annual appraisals.
- We observed staff taking trouble to maintain people's privacy, dignity and confidentiality. They demonstrated empathy towards people who were in pain or distressed and were skilled in providing reassurance and comfort.
- Feedback from patients and those close to them confirmed that staff were caring and kind.
- There were relatively few delays for treatment. The average wait across all units was 42 minutes. Ninety nine per cent of patients were treated, discharged or transferred within four hours.
- The needs of people with complex needs were well understood and addressed appropriately.
- Clinical leaders were respected by staff. They were knowledgeable about quality issues and priorities, understood what the challenges were and took action to address them.
- Integration of the three units was at an early stage but obvious progress had already been made.
- There was a strong sense of teamwork between all staff. There were shared values of delivering high quality patient care

However:

- There was no record of how many staff had received training in life support for children.
- There was no risk assessment of resuscitation facilities at isolated units.
- Healthcare assistants carried out initial clinical assessment of patients before being assessed as competent to do so. If a unit closed at short notice they would assess the seriousness of injuries and advise patients on treatment. They had not been trained to do this.
- There was no x-ray service at South Hams and Tavistock during weekends and bank holidays.
- Plymouth Healthcare did not have a strategy for the integration of Tavistock and South Hams hospitals. As a result, there was no agreed plan for the integration of the three minor injuries units.

# Summary of findings

## Background to the service

The urgent care service consists of three minor injuries units located at the Cumberland Centre in Devonport, South Hams hospital in Kingsbridge and Tavistock hospital. They are nurse-led units staffed by emergency nurse practitioners and minor injury practitioners. These are experienced and specially trained nurses who are qualified to diagnose and treat injuries and conditions within the scope of practice of a minor injury unit. These include minor head injuries, bone and joint injuries, infected wounds and small burns. The Cumberland Centre also has paramedics who have gained further qualifications to become emergency care practitioners

South Hams and Tavistock minor injuries units become part of Plymouth Community Healthcare in July 2015. Since April 2016 they have been managed by the same service manager as the Cumberland Centre minor injuries unit. In November 2015 the units were linked by a new clinical computer system that allowed up-to date clinical guidance to be shared by all three units. Between them the minor injury units saw almost 46,000 patients in the year ending March 2016. The Cumberland Centre was the biggest of the three, seeing nearly 34,000 patients a year. 9,000 patients attended Tavistock minor injuries unit and there were 3,6000 at South Hams.

## Our inspection team

Our inspection team was led by:

**Chair**: Andy Brogan, Director of Nursing, South Essex Partnership Trust

**Head of Hospital Inspections**: Pauline Carpenter, Care Quality Commission

**Inspection Manager**: Nigel Timmins

The inspection team comprised one CQC inspector and one specialist advisor who had experience as an emergency nurse.

## Why we carried out this inspection

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

## How we carried out this inspection

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

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

We visited between 21 and 24 June 2016. During this inspection we observed care and treatment of patients, looked at 11 patient records and reviewed performance information about the department. We spoke with patients and their families and approximately 20 members of staff including nurses, receptionists, managers and support staff.

# Summary of findings

## Areas for improvement

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

**Action the provider must take:**

- The provider must ensure that healthcare assistants have been assessed as competent before carrying out initial clinical assessment of patients.
- The provider must ensure that healthcare assistants do not re-direct patients to other services before the patients have been assessed by a registered practitioner.
- The provider must ensure that all practitioners have been trained in immediate life support for adults and children.
- The provider must carry out a risk assessment of child and adult resuscitation facilities at South Hams and Tavistock to ensure they are suitable for an isolated unit.
- The provider must ensure that patients in waiting areas can be observed by staff at all times.

# Summary of findings

**Action the provider should take:**

- The provider should appoint a lead nurse for children in the minor injuries units to ensure that their needs are met.
- The provider should introduce a more rapid assessment by a competent member of staff, within 15 minutes of arrival at the MIU.
- The provider should provide enough practitioners to ensure that units do not have to close at short-notice.
- The provider should improve consistency in the recording of clinical details across all three units.
- The provider should ensure that there is strategic oversight of the MIUs to support the integration of these services.
- The provider should include the minor injuries units in wider organisational governance arrangements.
- The provider should review all clinical guidelines to ensure that they reflect the most recent national guidance.
- The provider should consider the use of paediatric and adult pain scores to ensure consistency of treatment.
- The provider should ensure that X-ray equipment at South Hams hospital is appropriate for the accurate diagnosis of suspected broken bones.
- The provider should ensure that is makes the availability of x-ray facilities clear to the public and that patients may be advised to attend the nearest acute trust for x-ray.

Plymouth Community Healthcare CIC

# Urgent care services

**Detailed findings from this inspection**

Requires improvement

## Are services safe?

By safe, we mean that people are protected from abuse

**Summary:**

We rated as safe as requires improvement because:

- There were long waits for the initial clinical assessment (triage) of patients at the Cumberland Centre. There was a risk that a patient's condition could deteriorate during that time.
- Triage was performed by healthcare assistants but there was a risk that they did not have the skills to do this because there was no competency framework for, or formal assessment of, staff in the initial clinical assessment of patients.
- If a unit was closed at short notice, it was accepted practice for health care assistants to assess and advise people regarding the seriousness of their injury. They had not received appropriate training to enable them to do this.
- Although all practitioners had received recent training in immediate life support for adults, there was no record of how many had received training in life support for children.
- There was no risk assessment of resuscitation facilities at isolated units.

However:

- Openness and transparency about safety was encouraged. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. Lessons were learned from incidents and were shared with all staff.
- Safety performance was monitored and reported to senior managers on a monthly basis.
- Safeguarding of children and adults was well understood and implemented.
- There was some variation in the standard of clinical record-keeping but there were plans to address this by extending existing clinical pro-formas to all units.
- Medicines were stored and administered correctly.
- The units were visibly clean and well maintained. Infection control measures had been implemented.
- Risks to people who used the centres, including staffing levels, were assessed, managed and monitored.

**Detailed Findings:**

**Safety performance**

- Safety performance was monitored using a Quality, Effectiveness and Safety Trigger Tool (QuESTT). Examples of triggers that were monitored monthly included staff vacancy rates, patient waiting times,

complaints trends and patient feedback. Reports from the previous six months showed that quality was good in all the units. Staff told us that QuESTT reports were reviewed monthly by the organisation's Board.

### Incident reporting, learning and improvement

- All staff that we spoke with were aware of their responsibilities in reporting incidents and we saw examples which had been submitted. Staff told us they would report incidents such as medication errors, incidents of aggression or faulty equipment.
- Incidents and accidents were reported using an organisation wide electronic system. All staff had access to this and knew which incidents required reporting.
- None of the incidents reported in the year ending May 2016 had been assessed as serious. We looked at a random sample and found the incidents had been logged appropriately, were clearly described and appropriate remedial action had been taken when necessary. For example, changes had been made to X-ray referral forms to make them more easily understood.

### Duty of Candour

- Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 was introduced in November 2014. This Regulation requires the organisation to be open and transparent with a patient when things go wrong in relation to their care and the patient suffers harm or could suffer harm which falls into defined thresholds. This is known as the duty of candour. Any reportable or suspected patient safety incident falling within these categories must be investigated and reported to the patient, and any other 'relevant person', within 10 days.
- Staff that we spoke with understood the principles of openness and transparency that are encompassed by the duty of candour.

### Safeguarding

- Staff that we spoke with were familiar with processes for the identification and management of children and adults at risk of abuse. They understood their responsibility to report concerns.
- Children who had been identified as 'At risk' were automatically flagged by the computer system.
- The clinical computer system ensured that a child's attendance record could not be completed until consideration had been given to safeguarding issues. There was a risk assessment available if there was a possibility that a child was at risk.
- Records showed that all staff had received safeguarding training in the last year. However, at Tavistock only two of the four practitioners had undertaken the more advanced level three child safeguarding training.

### Medicines

- Medicines were stored correctly in locked cupboards or fridges. Controlled drugs and fridge temperatures were regularly checked by staff working in the department and seen to be within required parameters.
- Unused drugs were disposed of in accordance with local policy.
- Allergies were clearly recorded and antibiotics were prescribed according to local protocols.
- Five members of staff were trained as nurse prescribers so that they could prescribe and administer certain medicines. There were also Patient Group Directions (PGDs) in place. PGDs are agreements which allow some registered nurses to supply or administer certain medicines to a pre-defined group of patients without them having to see a doctor. We saw that the PGDs were up-to-date and there was evidence that staff had been appropriately assessed and signed off as competent to use them.

### Environment and equipment

- The minor injuries units were located in buildings that varied from Victorian to relatively modern. The fabric of the buildings was well maintained. Reception facilities at Tavistock and South Hams were shared with the main hospital. They were easily accessible although Tavistock did not have a lowered reception desk to assist people in wheelchairs. Reception facilities at the Cumberland Centre were in a small room with a glass window. They were not well sign posted and it was not immediately clear where people should register.
- The design of the buildings at Tavistock and South Hams meant that patients in the minor injury unit waiting rooms could not be observed by staff. This meant that a patient's condition could deteriorate without staff being aware.
- The waiting rooms at the Cumberland Centre and South Hams had separate waiting areas for children. There

were entertaining pictures on the walls and easily cleaned toys for a variety of age ranges. However, these areas were part of the main waiting room and children could not be separated from the potential stress caused by injured adults. Staff told us that they would move any adults who were like to cause distress to waiting children.

- The clinical environment at South Hams and the Cumberland Centre was spacious, modern, light and well ventilated. Each had a designated room containing resuscitation equipment and an ECG machine where the sickest patients were treated. Patients at the Cumberland Centre were treated in individual consultation rooms all of which were child-friendly and easily accessible by wheelchair.
- The clinical area at Tavistock consisted of two trolley cubicles and one cubicle with a reclining chair which was used for initial clinical assessment. Privacy was maintained by means of curtains. There was very little circulation space around the cubicles which caused difficulties when more than two members of staff were present.
- There was a small amount of resuscitation equipment available in line with the scope of practice of minor injuries units. It was contained in a tamper-proof trolley and was checked regularly to ensure that it was ready to use.
- There was no equipment available at Tavistock or South Hams to set up an intravenous infusion in infants or small children. This is contrary to the Intercollegiate Standards for Children in Emergency Care Settings.
- All the units were well equipped and the equipment was checked regularly to ensure that it was ready for use. We saw maintenance records showing a regular programme of maintenance and servicing.
- X-ray facilities available for patients at South Hams consisted of a single portable X-ray machine. This meant that the quality of some X-rays was not always good enough for an immediate diagnosis and that the X-ray sometimes had to be repeated at another hospital. X-ray facilities at Tavistock and the Cumberland centre were satisfactory.

### Quality of records

- Patient records were fully computerised. Access to the system was controlled by individual passwords. This helped to ensure that the name of the practitioner and the time that they saw each patient was accurately recorded.
- The registration screen alerted staff if there were two patients in the unit with similar surnames. This helped to ensure that the right patients were seen at the right time.
- Computer screens were arranged so that only healthcare professionals could see them. If a screen was inactive for more than a minute a screensaver appeared. This helped to ensure that unattended screens could not be viewed by unauthorised individuals.
- We reviewed 11 random patient records from the previous week and found them all to be clearly laid out and easy to read. However, the detail recorded was variable. We compared the records of two children with head injuries who had been seen at different minor injury units. One contained a detailed account of how the head injury had occurred and what had happened immediately afterwards. It went on to record the results of a thorough neurological examination. The second had no details of the mechanism of injury and no account of any neurological examination
- We showed these records to the service manager who explained that the first child had been seen at the Cumberland centre which uses a proforma for the examination and treatment of certain injuries. There had not yet been time to implement these proformas at the other two units but plans had been made to do so in the near future.

### Cleanliness, infection control and hygiene

- The centre appeared clean and tidy. Hand washing facilities were readily available and we observed staff clean their hands before and after patient contact. This helped to prevent the spread of infection and complied with National Institute for Health and Care Excellence (NICE) quality standards. The “bare below the elbow” policy was adhered to.
- Recent hand hygiene audits showed good compliance with infection control measures.

Requires improvement

# Are services safe?

## Mandatory training

- There were a wide range of topics included in mandatory training. For example, customer care, fire awareness, record keeping, infection control and manual handling.
- Some of the topics were covered by e-learning and others took place during mandatory training sessions which were tailored to the specific needs of the staff attending.
- At the time of our inspection 98% of staff working in the units had completed training in the last year. The provider's target was 95%.
- Staff had been trained to treat people with life threatening emergencies. All practitioners had a current immediate life support qualification and healthcare assistants had undertaken basic life support training in the last year.
- Some staff told us that they had received recent resuscitation training for children. We asked Plymouth Community Healthcare for evidence of this training but they were not able to supply it.

## Assessing and responding to patient risk

- Currently there is no set national standard by which MIUs should assess patients when they arrive. However, considering the nature of these services, we would expect, where possible, patients to be rapidly assessed on arrival to identify serious or life threatening conditions. This will help ensure that patients are directed to the appropriate clinician and can receive immediate treatment if necessary. Where patients are routinely waiting long periods for assessment by a clinician, we would expect appropriate steps to be taken to ensure they are safe to wait.
- Waiting times for triage were monitored and showed that, at Tavistock and South Hams, the average time from arrival to triage was less than seven minutes. (for the year ending May 2016). At the Cumberland Centre for year ending May 2016, patients waited an average of 25 minutes to be triaged. There was a risk their condition could deteriorate during that time.
- During our inspection most patients were triaged by an experienced healthcare assistant, not a registered clinician. The nurse manager told us that healthcare assistants were trained by registered practitioners. However, there was no structured competency framework for this training and no formal competency assessment. No patient assessment framework was used in order to guide the healthcare assistants. One of the healthcare assistants at Tavistock told us that she had received no training in the initial assessment if patients. This lack of competency assessment meant that there was a risk of some healthcare assistants having incomplete knowledge and skills when triaging patients.
- We were told that immediate feedback was given to triage staff if there were any shortcomings in their assessments. In this way, any mistakes were corrected and learning enhanced.
- We reviewed the triage notes of nine patients from the previous week. Although the assessments appeared appropriate for the presenting complaint the detail that had been recorded varied considerably.
- Reception staff were aware of "red flag" presenting complaints such as chest pain, shortness of breath and severe bleeding. They told us that they would contact a nurse immediately, rather than delaying treatment by registering the patient on the computer system first. Basic registration details would be taken while the patient was being assessed and further details obtained when the patient's condition had stabilised.
- Early warning scores were not used to identify patients whose condition was at risk of deteriorating. Staff felt that they were not necessary because there were few delays in patients being treated.
- We were concerned that the risk of adults or children requiring resuscitation had not been fully assessed at South Hams. Although cardiac and respiratory arrest was a rare occurrence it could take 40 minutes for help to arrive via the ambulance service. Resuscitation equipment had recently been standardised across the whole hospital which meant that it was suitable for immediate life support procedures, but not advanced life support. In addition, there was no equipment available to set up an intravenous infusion for a child. This is a requirement of the Intercollegiate Standards for Children in Emergency Care settings.
- Seriously ill or injured patients were always escorted to the X-ray department by a clinical member of staff.
- Patients who were seriously ill or injured were transferred by ambulance to the emergency department at nearby hospitals according to local protocols.

Requires improvement

# Are services safe?

### Staffing levels and caseload

- A review of staff rotas for May 2016 showed that units had a minimum of one nurse practitioner or minor injury practitioner on duty at all times. Cumberland Centre, the largest of the units, had at least three practitioners present at all times. Numbers of staff increased to match predicted increases in patient attendance. Although there were no current staff vacancies the service manager had identified that the nursing establishment at South Hams was not sufficient to provide a 365 day service. This had led to the unit closing twice since April 2016, due to staff sickness. The service manager told us that other short-term closures had been prevented by rotating staff from other units. A proposal had recently been submitted to senior managers to increase the number of nursing hours at South Hams.
- South Hams was closed for two days during our inspection due to a lack of registered nurse practitioners. We visited when it re-opened and were told that a healthcare assistant had assessed patients when they arrived and advised them about the most suitable alternative healthcare provision. It appeared that this way of working had been a practice of long-standing. We overheard one patient saying they had been advised that their condition was not serious and that they could wait until the following day when the unit would be open. Although people thought this was helpful, healthcare assistants had not been trained to make such decisions and there was a risk of people being given the wrong advice. .
- The service manager told us that it was difficult to fill vacancies with agency staff as there were very few agency nurse practitioners in the area. It was also difficult to find another registered member of staff at short notice to orientate someone new.
- Although 27% of patients were children less than 17 years there were no registered children's nurses at the centre and no lead nurse for children. However, all practitioners had been trained to assess and treat children and to decide which services would best meet their needs.
- There were several occasions each week when a practitioner would be working alone at Tavistock and South Hams. Although there were other staff in each hospital they were often on different floors and would not always know if someone in the minor injury unit needed help. A risk assessment had recently been carried out and individual safety alarms had been provided to staff. A proposal was being drafted for an additional healthcare assistant at Tavistock.

### Managing anticipated risks

- There were plans in place to deal with possible disruptions to services such as computer failure, power cuts and flood.
- Staffing levels were managed to ensure sufficient staff were available during busy periods such as holiday seasons.
- There were emergency call bells throughout the units should staff need to summon assistance. Staff at South Hams and Tavistock had individual security alarms. They had been trained in conflict resolution and felt confident in diffusing aggressive situations. Should there be the risk of violence towards patients or staff the police would be called. Staff told us that this happened rarely but that local police responded quickly when called.

Good

# Are services effective?

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

## Summary

We rated effective as good because;

- Nurses and paramedics were well qualified and demonstrated the skills that were required to carry out their roles effectively and according to best practice. They worked collaboratively with multidisciplinary teams from community services and acute services at neighbouring hospitals
- Evidence-based guidelines and protocols were easily available although a small number did not include the most recently published evidence.
- Pain relief was administered quickly and effectively.
- X-ray results were reviewed by a specialist radiology doctor within 48 hours. Any discrepancies were follow-up by senior staff.
- There was a low rate of unplanned re-attendances.
- Clinical audits took place and the information gained was used to improve care and treatment.
- The learning needs of staff were identified at regular clinical supervision sessions and at annual appraisals.
- Staff had a sound knowledge of consent from children and adults.

## Detailed Findings:

### Evidence based care and treatment

- There were treatment guidelines based on guidance from the National Institute for Health and Care Excellence (NICE) and Royal College of Emergency Medicine (RCEM). They included topics such as lower limb fractures, sepsis and head injuries.
- We were shown weekly updates that were sent to staff regarding the latest guidance from NICE.
- We noted that some departmental guidance was not up-to-date. Resuscitation algorithms displayed next to resuscitation equipment had been published in 2010 and 2011, not the most recent version published in 2015. Reference material for the meningitis protocol was from 2002 and 2007. NICE had updated their guidance in February 2015 but it was unclear whether this had been included in the protocol.
- Staff were familiar with the use of the guidelines and they were easily available on the computer system or in hard copy. Most local guidelines were updated when new national guidance was received. For example, the treatment of non-complex fractures had recently been reviewed.
- Records that we saw showed that clinical assessment was methodical, appropriate and clearly documented in the majority of cases.
- All x-rays were reviewed by a specialist radiology doctor within 48 hours. This ensured that, if there were any discrepancies in diagnosis, the patient would be recalled and re-assessed in a timely manner.
- Records showed that, where appropriate, patients were referred back to their own GP once their urgent care needs had been met.
- There was a wide range of information leaflets available to help patients manage their injury or illness. We reviewed a random sample of these and found that they followed current national guidance.

### Pain relief

- Patient records showed that pain was always assessed and appropriate pain relief was given. However pain scores were not always used which meant that monitoring the effects of pain was sometimes inconsistent.
- During our inspection we observed timely pain relief administered to children. The results of the pain relief were monitored and additional treatment given if necessary.

### Patient outcomes

- Plymouth Community Healthcare did not have a clinical audit team and so audits of patient assessment and treatment were carried out by staff in the minor injury unit. The two current audits were investigating the reasons behind undiagnosed fractures and the effectiveness of pain assessment.
- The last audit looked at the accuracy of safeguarding assessments. It found that, occasionally, some of the information included in the assessment had not been recorded on the electronic patient record. As a result a proposal had been put forward to make the assessment a mandatory part of the computer records.

Good

# Are services effective?

- There was real-time peer review of the effectiveness of care and treatment. We observed a number of discussions between staff regarding diagnosis and treatment. If necessary, further advice could be sought from specialists at Derriford Hospital in Plymouth.
- No national organisations had arranged audits specific to minor injuries or illnesses in the last year and so it had not been possible for the units to compare their outcomes with other similar services.
- A low rate of unplanned re-attendances is often used as an indicator of good patient outcomes. The national average for urgent and emergency care is 7.5%. The rates locally were 3.3%.

### Competent staff

- Staff who were new to the department took part in a structured orientation programme. This was accompanied by a detailed competency assessment for skills such as wound assessment and treatment, bandaging techniques and application of plaster casts.
- The orientation programme for nurse practitioners and emergency care practitioners lasted for a minimum of four weeks and practice during this time was always supervised.
- There were no competency assessments for healthcare assistants before they undertook initial patient assessments.
- There were regular individual clinical supervision sessions where staff could discuss any difficulties that they might have experienced.
- Specific learning needs for all staff were identified at a yearly appraisal meeting. Records showed that all staff had received an appraisal in the last year. Each member of staff had a minimum of three days protected learning time for professional development.
- At the Cumberland Centre in-house teaching was run by senior staff and included topics such as wound care, lower limb fractures, treatment of burns and resuscitation scenarios. In-house teaching at South Hams and Tavistock was rarely possible due to the small number of staff. The service manager told us that she hoped to improve training opportunities by rotating staff between the three units.
- One practitioner at Tavistock told us that she had no professional training specific to minor injuries in the last four years. (Tavistock minor injuries unit had been run by a different organisation until in July 2015 and different managers until April 2016). However, an appraisal was planned and a learning needs assessment anticipated.

### Multi-disciplinary working and coordinated care pathways

- There were good working relationships with community services, such as district nurses and health visitors, and with the emergency department at Derriford Hospital.
- If patients needed urgent hospital treatment they could be referred directly to specialist doctors such as orthopaedic surgeons and burns specialists. A referral letter was always sent with the patient in order to confirm information discussed with the specialist at the time of the referral.
- Practitioners could discuss complicated injuries or X-rays with a senior doctor at the emergency department at Derriford Hospital.
- If patients presented with long-term health conditions they were assessed by a practitioner and then referred back to their GP in order to provide continuity of care.

### Referral, transfer, discharge and transition

- Letters were sent to GPs after each attendance. We reviewed ten letters and found clear and comprehensive descriptions of diagnosis, treatment and advice.
- Practitioners told us that, if people were likely to have difficulty making follow-up appointments with their own GP (for example, those with communication difficulties or dementia), staff would make them on their behalf before they left the unit.

### Access to information

- Information needed to deliver effective care and treatment was well organised and accessible. Clinical guidelines were computer based and we observed staff referring to them when necessary.
- The minor injuries units used the same computer system as many local GPs. This meant that staff had access to patients' previous medical history and medication records and that discharge summaries could be sent electronically.
- If a patient's GP used a different computer system discharge letters would be sent within 24 hours.
- Previous X-rays and their results were always available via computer.

Good

# Are services effective?

### Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- We observed that verbal consent was obtained for any procedures undertaken by the staff.
- Consent forms were available for people with parental responsibility to consent on behalf of children. The nursing staff that we spoke with had a good working knowledge of the guidance for gaining valid informed consent from a child. They were aware of the legal guidelines which meant children under the age of 16 were able to give their own consent if they demonstrated sufficient maturity and intelligence to do so (known as the Gillick competencies). Otherwise, consent would be sought from the child's parent or guardian. If a child attended without a person who was able to provide consent, staff would attempt to contact an appropriate adult.
- The staff we spoke with were aware of issues surrounding consent and mental capacity but they told us that they had not received training in mental capacity assessments. They did not have access to pro-formas that would assist them in assessing a patient's capacity to consent to, or refuse treatment.
- Staff were able gain telephone advice from local psychiatric crisis teams but patients would have to be taken to the nearest emergency department in order to be assessed by a mental health professional. This posed logistical problems if a patient was unaccompanied and did not want to wait for up to two hours for an ambulance to convey them to the psychiatric team.

Good

# Are services caring?

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

## Summary

We rated caring as good because:

- Feedback from patients and those close to them confirmed that staff were caring and kind.
- We observed staff taking trouble to maintain people's privacy, dignity and confidentiality. They demonstrated empathy towards people who were in pain or distressed and were skilled in providing reassurance and comfort.
- People were kept informed and given information about their condition and their care and treatment. Their social and cultural needs were taken into account and they were helped to maintain their independence whenever possible.
- Communication with children and young people was age-appropriate and effective.

## Detailed Findings:

### Compassionate care

- Confidentiality was maintained at the reception desks by means of signs asking people to stand back from the desk when someone was being registered.
- The Cumberland Centre and South Hams had examination and treatment rooms with doors to ensure privacy when patients were being examined. We saw that staff knocked and waited to be called before entering. Tavistock divided patient cubicles with curtains. Staff tried, wherever possible, to hold confidential conversations in quieter areas of the unit, but at busy times this was not always possible.
- We observed staff introducing themselves and explaining what was about to happen before examining patients.
- All staff wore name badges which clearly stated their name and role. This helped to ensure that patients were aware of the professionals involved in their care.
- We saw several examples of patients being treated with compassion, dignity and respect. Staff spoke in a respectful but friendly manner and made allowances when people were stressed or worried. We observed a nurse putting their arm around a patient's shoulders when they became upset about being transferred to another hospital.
- Practitioners took time to distract and comfort children during examinations and wound cleaning. Parents were involved in the assessment and treatment of their children and clear explanations were given.
- We spoke with eight patients and their families. They all reported a positive experience. One parent at Kingsbridge told us: "They are my saviours. Whatever I come with, they know what to do." A patient at the Cumberland Centre said, "They are very patient-friendly here. I felt very at ease". At Tavistock we were approached by a couple who wanted to tell us how impressed they were with the high standards of care that they had received.
- We were shown written feedback from patients. One wrote "Fantastic welcome. Very caring and attentive. I would recommend to anyone." Another wrote "Excellent, kind and caring staff. They went out of their way to sort out my problem."
- Results from the Friends and Family test for the year ending May 2016 were consistently good across all the units. They showed that between 96% and 99% of people would recommend them.

### Understanding and involvement of patients and those close to them

- We spoke with eight patients and families whose care and treatment we followed. They all told us they were satisfied with the care they received and the staff who provided it. They had been involved in how and where their ongoing treatment took place.
- We observed staff interacting with patients and family members. Staff talked to them in a way that patients could understand and described what they were going to do.
- Staff had identified that many people had difficulty understanding the details of broken bones and joint injuries. To assist with this a skeleton had been purchased so that staff could demonstrate how an injury would affect the limb or joint in question. They told us this had helped patients' understanding of the injury and the treatment that was necessary. The skeleton was particularly popular with children.
- Staff also checked that people had understood what they had been told and what needed to happen next.

Good

# Are services caring?

**Emotional support**

- We observed reassurance being given to patients and staff offering emotional support. Relatives were able to remain with patients throughout their time in the centre to ensure they were supported.
- Staff took account of people's social needs when deciding on treatment options. We observed one practitioner helping a parent to decide whether a child should return to school or not.
- Communication with children was thoughtful and age-appropriate.
- The wife of one patient told us "The nurse spent as much time looking after me as she did my husband. She was very reassuring and made me feel a lot better".
- Staff were aware of local counselling services and would refer patients when appropriate.

Good

# Are services responsive to people's needs?

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

## Summary

We rated responsive as good because:

- The average time to treatment across all the units was 42 minutes. Waiting times were constantly monitored in real-time by clinical staff.
- 99% of patients were treated, discharged or transferred within four hours in the year ending May 2016. This was as good as, or slightly better than, most other urgent care centres nationally.
- The needs of people with complex needs were well understood and addressed appropriately. People with dementia or learning disabilities received care and treatment that was sympathetic and knowledgeable. Complaints were responded to in a timely manner and improvements were made to the quality of care as a result of complaints and concerns

However:

- X-ray services were not always available when patients needed them.
- There had been a number of short-term closures of Tavistock and South Hams in the last year. Solutions were already in place, or had been proposed, to avoid a recurrence.

## Detailed Findings:

### Planning and delivering services which meet people's needs

- The management of the three units had merged two months prior to our inspection and planning was underway to align services and share best practice.
- Many patients during the summer were holiday makers who would not know how to get to the minor injuries units. Road signs to the units at Tavistock and the Cumberland Centre were clear and helpful. However, it was difficult to find the unit at South Hams from the centre of Kingsbridge.
- X-ray services were not always available. Patients who needed an X-ray at Tavistock and South Hams were sent to the main hospital X-ray department. These closed at 5pm during the week and were not open at all at weekends or bank holidays. Patients with suspected fractures had to be sent on a journey of 50-80 minutes to the X-ray department at Derriford Hospital.
- The waiting room at Tavistock was very small with bare walls and no toys. There were children's books but only for limited age ranges.
- Patients told us that they appreciated the short waiting times in comparison to local accident and emergency departments.

### Equality and diversity

- At South Hams and the Cumberland centre there were a drop-off points close to the entrance of the minor injuries units to assist people with disabilities or mobility problems. There were ample disabled parking spaces close to the entrance. There were always empty spaces throughout our inspection. At Tavistock parking was very limited, leading to traffic jams. It was difficult to drop off an injured person at the entrance and walking to the entrance was often hazardous if people were frail or had impaired vision. There were no available disabled parking spaces during our inspection.
- Equality and diversity training was delivered at induction and then on a yearly basis.
- Translators could be accessed via the telephone translation system provided by the hospital.
- Senior staff were aware of the Accessible Information Standard which had recently been introduced by the NHS. However, they did not know how the computer system would be adapted to comply with it.

### Meeting the needs of people in vulnerable circumstances

- Staff that we spoke with demonstrated a good understanding of the requirements of patients with complex needs. There were close links with community services to provide support.
- The majority of staff had undertaken training in the specific needs of people with dementia and learning disabilities and the involvement of families was encouraged.
- The clinical computer system alerted staff to patients with learning disabilities who had been identified as having special needs.
- We were told that care and treatment of people with dementia would be provided in a quiet part of the centre so that their exposure to the unfamiliar and

Good

# Are services responsive to people's needs?

confusing environment of a hospital was kept to a minimum. Their particular needs would be discussed with them and their carers and treatment adapted if necessary.

### Access to the right care at the right time

- The minor injuries units consistently exceeded the national standard which requires that 95% of patients are discharged, admitted or transferred within four hours of arrival at urgent care and emergency departments. We were shown monthly monitoring reports demonstrating that no patients had stayed in the units for more than four hours since April 2016.
- The service manager told us that, in the previous year, 99% of patients had been treated within four hours. The only exception were those who had had to wait for an ambulance or other transport to take them to another hospital for further treatment.
- While waiting no more than four hours from arrival to departure is a key measure of urgent care performance, there are other important indicators, such as how long patients wait for their treatment to begin. A short wait will reduce patient risk and discomfort. The national target is a wait of below 60 minutes. The units consistently achieved this target. The average time to treatment for year ending May 2016 was 12 minutes at Tavistock and South Hams and 49 minutes at the Cumberland Centre.
- We observed the nurse in charge of the Cumberland Centre monitoring the waiting times throughout the day. If delays in treatment were growing staff could be redeployed to improve the situation.
- If there were any doubts about X-ray results they could be immediately reviewed electronically by a senior doctor at the emergency department at Derriford Hospital. This reduced any delays in accurate diagnosis and appropriate treatment.
- Tavistock closed early at short notice on thirteen occasions during November and December 2015 because of a staff vacancy. The vacancy had been filled in 2016 and the unit had been fully open since. South Hams had closed for three days on two occasions this year due to staff sickness. A proposal had recently been submitted to increase staff hours in order to prevent this happening in future.

### Learning from complaints and concerns

- There had been few complaints about the minor injuries units with only nine received in the year ending May 2016. These had been handled in line with the the organisation's policy. If a patient or relative wanted to make an informal complaint they were directed to the person in charge of the department. If the concern was not able to be resolved locally, patients were referred to the Customer Services department that would formally log their complaint and attempt to resolve their issue within a set period of time. Information about how to make a complaint was displayed on noticeboards in public areas and was included in patient information leaflets.
- Formal complaints were investigated by senior staff in each unit. Replies were sent to the complainant in an agreed timeframe. Where possible, action was taken to prevent similar complaints. For example, chairs in the waiting room at the Cumberland centre had been moved away from the reception desk so that confidential information could not be overheard.
- We saw that learning from complaints was discussed at team meetings.

Good

# Are services well-led?

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

## Summary

We rated the minor injuries service as good for well-led because;

- Clinical leaders were respected by staff. They were knowledgeable about quality issues and priorities, understood what the challenges were and took action to address them.
- Integration of the three units was at an early stage but obvious progress had already been made.
- There was a strong sense of teamwork between all staff. There were shared values of delivering high quality patient care.
- Quality monitoring was well structured with risks and quality being regularly monitored and action taken if necessary. The Quality, Safety and Effectiveness Trigger Tool provided consistency and ensured that performance and quality was understood by senior the managers.
- Work had started to develop an integrated governance structure for the three units.

However,

- The minor injuries units were not included in the wider governance meetings held within the organisation.
- Plymouth Community Healthcare did not have a strategy for the integration of services at South Hams and Tavistock hospitals. As a result, there was no agreed plan for the integration of the minor injuries units.

## Detailed Findings:

### Service vision and strategy

- The service manager told us that the strategy for the minor injury units was to act cohesively in order to provide safe and effective urgent care to local people. Integration was at an early stage (having started 10 weeks prior to our inspection) but progress had already been made in the sharing of clinical guidelines and standardisation of medication.
- Staff that we spoke with in all units identified with these strategic aims. They thought that progress had already been made in the short time that the units had been working together.
- Plymouth Community Healthcare did not have a strategy for integration of South Hams and Tavistock Hospitals into the existing organisation. As a result, there was no documented or agreed plan for the integration of the minor injury units.

### Governance, risk management and quality measurement

- There were effective processes in place to identify, understand, monitor and address current and future challenges to high quality care and treatment.
- The service manager maintained a risk register, which defined the severity and likelihood of risks in the department causing harm to patients or staff. We reviewed the risk register and found risks to be clearly described and appropriate action taken. The risks reflected worries that had been described to us by staff. For example, aggressive behaviour from patients or those who accompany them.
- Any risks that had been assessed as moderate or serious were discussed with senior managers at monthly risk moderation meetings. Additional mitigating action was discussed and agreed. All serious risks were reported at monthly Board meetings.
- A recent example was an increase in referrals of patients with serious and complex medical problems that were outside the scope of practice of a minor injuries unit. There was a risk that seriously ill patients would not receive medical treatment quickly enough. A meeting with the organisation responsible had taken place and improvements had resulted and therefore the risk reduced. The risk continued to be monitored.
- Quality and performance was monitored by means of the Quality, Effectiveness and Safety Trigger Tool (QuESTT). Examples of triggers that were monitored monthly included staff vacancy rates, patient waiting times, complaints trends and patient feedback. Reports from the previous six months showed that quality was good in all the units.
- QuESTT reports were sent monthly to the Plymouth Community Healthcare Board. However, there were no structured locality governance arrangements that included the minor injuries units.

Good

# Are services well-led?

- In order to implement a governance structure for the three minor injuries units the service manager had attended a meeting with the governance lead at Derriford Hospital Emergency Department. It was hoped to adapt their existing structure so that it was suitable for a minor injuries service within a community healthcare organisation.

### Leadership of this service

- Managerial and clinical leadership of the minor injury units was provided by the service manager who in turn reported to the deputy locality manager.
- The service manager was supported by the clinical lead. Both worked clinically in the Cumberland Centre and had a full understanding of the caseload and issues experienced by staff. They had started to work at Tavistock and South Hams in order to understand the differences in case mix and activity.
- Staff told us that the leadership had the knowledge, skills and integrity required to lead the service. They trusted the leadership team and knew that they would be listened to if they raised concerns. They told us that there was a 'no blame' culture that made it easier to admit mistakes and to learn from them.
- Staff were aware of visits from the Chief Executive who was regarded as approachable and supportive. However, there were no specific senior manager meetings where help and support could be gained for the integration of the three minor injuries units.

### Culture within this service

- The culture in the service was positive. All the staff we met told us they enjoyed their work and described working in an open and progressive environment. They demonstrated support for the service and one another.
- There was a low sickness rate and most unplanned vacant shifts were filled by existing staff.
- Staff told us that they felt respected and valued by their colleagues and the leadership team within the minor injuries units. One practitioner said "We are a strong team here". They felt well supported by their manager, both professionally and operationally.
- The culture within the units gave priority to the needs and experience of people who used the service. Staff in two units told us "It's the patient who's important". Others voiced similar sentiments.

### Public engagement

- There was a good response rate for the Friends and Family test with 17.5% of people completing a form. This exceeded the Plymouth Community Healthcare target of 15%. In addition, people who attended the units were encouraged to complete a more detailed questionnaire which asked why they would recommend the service. It also asked if anything could be improved. The answers to these questions were used to ensure responsiveness to people's changing needs.
- The service manager kept copies of patient feedback and letters of comment or complaint. Both were included in monthly performance reports. We were told there were many more compliments than complaints.

### Staff engagement

- Plymouth Community Healthcare ran a staff survey each year and we were told that early results from the minor injuries units were positive. However, detailed results had not yet been shared with staff.
- Staff that we spoke with said that they felt actively engaged in the running of the units and that their views were taken into account when decisions were made about the service. For example, there had been staff involvement in the types of wound dressings that were now used.
- The Cumberland Centre held monthly team meetings which were well attended. Discussions were being held regarding the best way to include staff at Tavistock and South Hams.

### Innovation, improvement and sustainability

- In the last two years South Hams had experienced an increasing frequency of short-notice closures. Senior staff had recognised the threat to sustainability and had put forward a proposal for a new staffing structure that would allow the unit to be fully open throughout the year.
- There was a shortage of nurse and paramedic practitioners in the southwest. In order to improve the flexibility of staff the Cumberland Centre had taken part in training staff for the new role of assistant practitioner. They were experienced healthcare assistants who had undertaken further specialist training at the local University. They were able to assess and treat simple lacerations and ankle and foot injuries when the patient was weight-bearing.

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 |
|---|---|
| Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 18 HSCA (RA) Regulations 2014 Staffing<br>**18(2) Persons employed by the service provider in the provision of a regulated activity must –**<br>**(a) receive such appropriate support, training,**<br>**professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform.**<br><br>Healthcare assistants had not been fully trained, or assessed as competent, to undertake clinical assessment of patients.<br>Appropriate resuscitation training had not been provided for all staff. |

| Regulated activity | Regulation |
|---|---|
| Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br>**12(2 (a) (b) Assessing the risks to the health and safety of service users of receiving the care or treatment. Doing all that is reasonably practicable to mitigate risk**.<br><br>Healthcare assistants were permitted to assess injuries and advise patients regarding treatment when a registered practitioner was not available.<br><br>A risk assessment of resuscitation facilities had not been carried out at Tavistock or South Hams minor injuries units to ensure they were appropriate for geographically isolated locations. |

This section is primarily information for the provider

# Requirement notices

Patients waiting at the minor injuries units at Tavistock and South Hams hospitals could not be observed by staff in order to identify if there clinical condition was deteriorating.