The Regulation and Quality Improvement Authority

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Review of the Care of Older People in Acute Hospitals

Overview Report

March 2015

Assurance, Challenge and Improvement in Health and Social Care

www.rqia.org.uk

The Regulation and Quality Improvement Authority

The Regulation and Quality Improvement Authority (RQIA) is the independent body responsible for regulating and inspecting the quality and availability of health and social care (HSC) services in Northern Ireland.

RQIA's reviews and inspections are designed to identify best practice, to highlight gaps or shortfalls in services requiring improvement and to protect the public interest.

This review was identified and scheduled within the RQIA three year review programme for 2012 to 2015.

The review was carried out through a programme of inspections of hospitals across Northern Ireland. Separate reports have been prepared on each individual hospital inspection and are available on the RQIA website at www.rqia.org.uk

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1.0 Executive Summary

This review was designed to assess the care of older people in acute hospital wards in health and social care (HSC) trust hospitals across Northern Ireland. The review has been undertaken with due consideration to some of the main thematic findings of the report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, as they are directly relevant to older people in acute settings.[1]

Evidence was collected for the review using a range of methodologies including:

- unannounced inspections of 11 hospitals
- inspection tools based on those currently in use by Healthcare Improvement Scotland(HIS) and Healthcare Inspectorate Wales (HIW)
- patient, relative/carer interviews and questionnaires
- quality of interaction schedule (QUIS) observation sessions
- review of patients' notes and relevant documentation

This information was used to assess the degree to which older patients on the wards were being treated with dignity and respect, and that their essential care needs were being met.

For the purpose of this report the findings have been presented in six sections related to:

- ward governance
- ward observation
- care records
- patient/relative/carer interviews and questionnaires
- QUIS observation sessions
- emergency department

This overview review report highlights areas of strengths and sets out 14 strategic recommendations for improvement across Northern Ireland.

The hospitals inspected have been given recommendations, which are included in individual hospital inspection reports published separately.

The process was designed to provide a snapshot of the care provided during the inspection in a particular ward or clinical area. This must be considered against the wider context of the measures put in place by trusts, to improve the overall care of older people in acute care settings.

[1] Mid Staffordshire NHS Foundation Trust Public Inquiry. http://www.midstaffsinquiry.com/pressrelease.html

Nurse Staffing

HSC trusts have been actively involved in phase one of the normative staffing work stream, commissioned by the Department of Health, Social Services and Public Safety (DHSSPS), led by the Public Health Agency (PHA) and supported by Northern Ireland Practice and Education Council (NIPEC). In September 2014 the DHSSPS published 'Delivering Care: Nurse Staffing in Northern Ireland. Delivering Care[2] supports the provision of safe, effective, person-centred care in hospital and community settings through a framework to determine staffing ranges for the nursing and midwifery workforce in a range of major specialities. The paper promotes a shared understanding of the essential components to set and review staffing levels to enable conversations between a range of individuals across organisations, such as commissioners, finance officers, human resource officers, nurses, midwives and senior managers.

At the time of the inspections all trusts had been reviewing the acute nursing workforce across general medical and surgical wards. In several trusts these workforce reviews indicated that there were variances between the current funded staffing levels (FSL) and the normative staffing ranges (NSR). Some trusts had submitted a report or were in discussion with the Public Health Agency (PHA) and the Board regarding these variances. Discussions are ongoing. In the interim, some trusts had taken the decision to recruit additional nurses.

Generally, inspectors considered that ward sisters had demonstrated effective management practices and leadership skills to support the service they deliver. When necessary ward sisters raised concerns about staffing levels with senior trust staff to advise them that safety could be compromised due to inadequate staffing levels and patient dependency. In all hospitals ward sisters rely on bank and agency staff to cover staff shortages, and some wards reported a heavy reliance on these staff. Inspectors were informed that there has been ongoing funding issues regarding staffing, which has impacted on the running of the wards.

In most, but not all, hospitals, ward sisters generally had some protected time, and were not included in the staffing levels. However, some ward sisters reported that although their managerial hours were recorded as management hours, they could frequently be required to provide cover for short notice leave or when the ward was very busy.

Ward managers reported that, at times they had difficulties in balancing the clinical and managerial role of the position when protected time for managerial duties was insufficient or not provided. There were also difficulties in maximising staff attendance at mandatory training with balancing the clinical needs of the ward.

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[2] Delivering care: Nurse Staffing in Northern Ireland http://www.dhsspsni.gov.uk/dc

In all wards inspected there were a range of meetings held to cascade information to staff. In all hospitals, ward sisters gather daily data on admissions and discharges for patient flow coordinators. The information is required to review actual and predicted admissions and discharges, bed capacity and demand to assist in creating an action plan to address bed needs. However ward sisters stated that the demand for beds often exceeded capacity and this remains an ongoing challenge.

HSC Trust Initiatives

Trusts have implemented a range of initiatives to improve the environment and patient care such as:

- LEAN methodology and management system provides a number of approaches for improving quality and patient safety in very practical ways.
- The Productive Ward - Releasing Time to Care.
- The Butterfly scheme.
- All hospitals were in the process of improving their electronic care record (ECR) display screen.
- In most wards, there were good link nurse systems in place to assist with care and offer advice, examples include: infection prevention and control, pain management, nutrition and tissue viability.

All trusts have introduced nursing quality indicators (NQIs). There are 26 quality national indicators available; the number of quality indicators introduced varied from ward to ward and across trusts. Inspectors noted that all wards were working to implement these indicators; these are audited by senior staff.

Listening to Patients

All trusts were participating in the recently launched PHA 10,000 Voices project.[3] Inspectors found evidence that all trusts had introduced some form of in-patient satisfaction survey, and regionally there were various initiatives being taken forward to improve patient experience.

The Ward Environment

In general, wards were clean, bright and well maintained, and although staff were busy the atmosphere was generally calm and welcoming. Ward clutter presents an issue for all trusts, as in many facilities the storage areas provided for patient equipment was limited. Sanitary facilities were located conveniently for patients, however, some were not for single gender use.

Most of the wards inspected had not undertaken a physical audit of the environment using the dementia checklist. However, there had been improved signage in ward bays and sanitary areas.

[3] http://www.publichealth.hscni.net/publications/10000-voices-improving-patient-experience

In all hospitals, ward bays were generally dedicated for single sex use. On occasions, either due to patient flow requirements, or the individual needs of patients, inspectors observed mixed gender bays. The use of escalation beds presented a particular challenge for staff in maintaining patient dignity and privacy. Escalation beds were used within a number of trusts to increase bed capacity at times of intensified demand on their services.

Privacy and Dignity

In all wards during observation the majority of staff were courteous and respectful to patients and visitors. Generally patients' privacy and dignity were maintained. Improvement was required by some staff. In some wards, the patient call systems were old and needed to be replaced. Inspectors observed that not all call bells were within patients reach, or answered promptly. In all wards, patient personal care was generally of a high standard. On most occasions privacy curtains were used effectively. Inspectors observed occasional lapses in privacy when curtains were not fully drawn during personal care activities.

Nutrition and Fluid Balance

Protected mealtimes had been implemented in most hospitals. Although protected meal times were in place across all hospitals, inspectors observed unnecessary breaches in this protocol.

Inspectors noted there was a good choice of meals, which were warm and generally appeared appetising. At times there were insufficient staff to assist patients with their meals and some patients were not provided with appropriate crockery and cutlery. Inspectors observed that there were varying systems in place to identify patients who required assistance with their meal. At times patients who needed help were not identified.

Most trusts had implemented the new regional fluid balance and prescription charts. These charts reflect the range of developments in fluid therapy and the regional approach supports safe and effective practice across Northern Ireland. Therefore it was of particular concern that inspectors observed that a large number of fluid balance and food intake charts were inadequately and inaccurately completed.

Patient Records

A review of patient care records was carried out as part of the inspection process. Inspectors found similar inconsistencies in recording. The care records did not evidence that nurses demonstrated they had adequately carried out assessment, planning, evaluation and monitoring of the patients' needs. Nurse record keeping did not always adhere to Nursing and Midwifery Council (NMC) and NIPEC guidelines. Frequently care records failed to demonstrate that safe and effective care was being delivered.

Patient – Staff Interaction

Inspectors and lay reviewers undertook a number of periods of observation in all wards to review patient and staff interactions. A total of 233 observation sessions were undertaken across the 11 hospitals resulting in 1836 interaction observations recorded.

The overall findings for Northern Ireland evidenced that 67 per cent of the interactions were positive. Generally, staff demonstrated empathy, support, and provided appropriate explanation of care when required. The results indicated that a small number of staff did not always speak with patients appropriately, and dignity and respect were not evident in these interactions. Inspectors advised ward sisters of any concerns they observed during observations.

Feedback from Patients, Relatives and Visitors

The RQIA inspections included obtaining the views and experiences of people who use services. A number of different methods were used to allow patients, relatives and visitors to share their views and experiences with the inspection team. During the inspection a total of 216 patient and relatives/carers questionnaires and 139 patient interviews were undertaken.

Generally, feedback received from patients and relatives or carers was good. Overall, patients were satisfied with the standard of care they received; they thought staff were polite, courteous and compassionate, and generally felt that they had received a good standard of care during their stay. Some areas for improvement are noted in section 5.5 of this report.

Emergency Departments

Members of the inspection team visited the emergency department (ED) in the hospitals that provided the service. Inspectors visited ED departments on a number of occasions throughout the two days of the inspections to ensure that patients of 65 years and over, who had waited within EDs over six hours, had the appropriate care interventions commenced.

In order to improve ED waiting times for elderly patients, trusts have implemented a range of initiatives. More work is required to ensure that patients have the appropriate assessments undertaken, particularly if they are waiting in ED for over six hours.

The care patients received in the EDs was generally recorded on the ED patient record; commonly known as a flimsy. These flimsies provided only limited reference to the delivery of care. Risk assessments were not routinely completed for patients that had waited over six hours in EDs. Elderly patients were not automatically fully assessed for all common frailty syndromes, and some areas were unfamiliar with any recognised cognitive impairment pain assessment tools. On most occasions, mental health assessment tools did not form part of assessment documentation; many ED nursing staff have not had training in managing patients with dementia.

Access to multidisciplinary services was generally available, but could be limited outside core working hours. Improvement is required in the provision of relevant information leaflets for elderly patients.

This report makes 14 recommendations, which are required to be addressed by HSC trusts across Northern Ireland.

2.0 Background

RQIA carries out a public consultation exercise to source and prioritise potential areas for review. A need to review the care of older people in acute hospital wards was identified as part of the 2012-2015 Review Programme.

Older people admitted to acute hospitals may have multiple and complex physical and mental health needs, and in many instances the added challenge of adverse social circumstances. Hospitals need to be supported to deliver the right care for these patients, as no one component of the health and social care system can manage these challenges in isolation. Implementation of improved care for older people requires a whole system approach to ensure that safe, efficient, effective and high quality holistic care is delivered. Staff need to develop their understanding and confidence in managing common frailty syndromes, such as confusion, falls and polypharmacy, as well as managing issues such as safeguarding older people.

During this review an unannounced inspection was undertaken to 11 acute hospitals across Northern Ireland. The inspection tools used were based on those currently in use by Healthcare Improvement Scotland (HIS) and Healthcare Inspectorate Wales (HIW). They have been adapted for use in Northern Ireland. The following inspection tools were developed by RQIA.

- ward governance inspection tool
- ward observational inspection tool
- care records inspection tool
- patient/relative /carer interviews and questionnaires:
- quality of interaction schedule (QUIS) observation sessions
- emergency department inspection tool [i]

2.1 Ward Governance Inspection Tool

This inspection tool reviews ward governance in relation to leadership, nurse staffing levels and training, multidisciplinary working; patient advocacy; how incidents, serious adverse incidents and complaints are recorded and managed. Other information reviewed included: quality indicators, audits, and relevant policies and procedures.

In 2009, the NMC[4] issued Guidance for the Care of Older People. The guidance states that effective managers and nurse leaders should be good role models and lead by example, making explicit the standard of care that they expect to be delivered within their area of responsibility. They should ensure that their staff can see their commitment to providing excellence in the care for older people. This should include acknowledging circumstances such as poor staffing levels, which prevent staff from delivering safe and effective care. They are accountable for the delivery of care in their area of responsibility and take steps to address any identified issues.

[4] Nursing and Midwifery Council - http://www.nmc-uk.org/

The guidance outlines the need for commitment from management at all levels, to support nurses, to enable them to adhere to the principles of care for older people. Managers should motivate, influence and develop members of their team, to ensure that they have the necessary skills and abilities to care for older people. Training needs of staff should be identified and training opportunities provided.

Nurse staffing levels have been a topic of debate and discussion for a number of years. Many inquiries and investigations reference inappropriate staffing. Staffing levels are documented in research evidence, and the number of nurses on a ward is viewed by patients and their carers as a key element in influencing the quality of care.

The first phase of "Delivering *Care:* A Framework for Nursing and Midwifery Workforce Planning to Support Person Centred Care in Northern Ireland has been introduced."[5] The draft framework was developed in a phased approach, to include nursing and midwifery workforce levels across hospital and community settings, in all programmes of care. The framework was subsequently endorsed by the Minister for Health, Social Services and Public Safety in January 2014.

The framework sets out a guide for commissioners and providers of HSC services, for planning and discussing of nursing and midwifery workforce requirements. Securing sufficient numbers of staff with the appropriate skills and deploying them effectively is a highly complex challenge. The publication of this first phase of work around normative staffing ranges (NSR) is intended to stimulate conversations around workforce planning.

2.2 Ward Observational Inspection Tool

This inspection tool reviews:

- organisation and management of patient environment
- privacy and dignity afforded to patients
- person centred care to ensure that older patients are treated with respect and compassion
- management of food and fluids

The NMC Guidance for the Care of Older People (2009)[6] states that the essence of nursing care for older people is about getting to know and value people as individuals through effective assessment, finding out how they want to be cared for from their perspective, and providing care which ensures that respect, dignity and fairness are maintained.

[5] Delivering Care: A Framework for Nursing and Midwifery Workforce Planning to Support Person Centred Care in Northern Ireland - http://www.hscboard.hscni.net/board/meetings/Meetings%202013/20130509%20May%202013/Item%2015%20-%2010%20-%20HSCB%20Delivering%20Care%20May%202013%20PDF%20769KB.pdf

[6] Guidance for the care of older people .Published 2009. http://www.nmc-uk.org/Documents/NMC-Publications/NMC-Guidance-for-the-care-of-older-people.pdf

The organisation and management of the ward environment should allow for care to be delivered in a dignified and safe way. If the care environment lacks cleanliness, is untidy or noisy, this can give the impression that there is a general lack of control and that important things may be overlooked. It can also raise concerns that there may be an increased risk of infection.

What older people, and some nurses, describe as basic care is in fact fundamental or essential care that is the foundation of the healing and therapeutic process. Care such as receiving food and fluids, having hygiene and continence, sexual, spiritual and relationship needs identified and met, building relationships with the nurses caring for them and being communicated with are all important in the delivery of essential care.

In Northern Ireland, the Patient and Client Experience Standards (DHSSPS,2008) outlined the following five standards.[7]

- Respect – Being valued as a unique individual
- Attitude - Feeling cared for as an individual
- Behaviour – Feeling valued and safe
- Communication - Understanding and feeling understood
- Privacy and Dignity - Protected and treated with due respect and consideration

The DHSSPS Priorities for Action state that:[8]

> "By September 2009, Trusts should adopt Patient and Client Experience Standards in relation to Respect, Attitude, Behaviour, Communication, and Privacy and Dignity, and have put in place arrangements to monitor and report performance against these standards on a quarterly basis"

2.3 Care Records Inspection Tool

This inspection tool reviews the patient care records in relation to the management of patients with cognitive impairment; food, fluid and nutritional care; falls prevention; pressure ulcer prevention; medicine and pain management.

In line with the terms of reference agreed by the DHSSPS the review of care records primarily focused on nursing records. Inspectors viewed medical and allied health professional records where more detail or clarification was required, however, these records were not subject to an in-depth review.

Record keeping is an essential aspect of clinical practice. It protects the welfare of patients by promoting high standards of care, is an essential communication tool for the healthcare team, and should facilitate the detection of early warning triggers.

[7] Patient & Client Experience Standards 2008 - http://www.dhsspsni.gov.uk/improving_the_patient_and_client_experience.pdf
[8] DHSSPS Priorities for Action - http://www.dhsspsni.gov.uk/microsoft_word_-_priorities_for_action_2010-11.pdf

Patient records should accurately reflect the details of the care provided, enable continuity of care between practitioners and reinforce standards of care. Good records are essential for high quality care.

The principles of good record keeping are set out by the General Medical Council (GMC) and the NMC and apply to all types of records, regardless of how they are held. Records must be accurate and recorded in such a way that the meaning is clear. Records should be factual and not include unnecessary jargon. The record should provide clear evidence of the arrangements that have been made for future ongoing care.

On admission, the assessment of the patient is the process by which nurses gather information from a variety of sources. This is then reviewed and analysed to collectively identify the care needs of individual patients. Thereafter, the care should be reviewed, or new assessments undertaken, if the patient's condition changes.

There are NMC [9] guidelines on assessment of health care needs and risk assessment and requirements, in accordance with the The Health and Safety at Work (Northern Ireland) Order 1978 that should be followed. If risks are identified through assessment and an action plan (care plan) is not completed to minimise those risks, this would not comply with the requirements of health and safety legislation.

A care plan is the nursing prescription of the care to be delivered to patients. The care plan contains the set of actions a nurse will implement to resolve or support the nursing needs that were identified for a patient during assessment[10].

A nursing care plan is important in the management of any patient, as the written record of planned care, individual to that patient, is crucial in monitoring progress and evaluation of care and communicating concerns.

The style of care plans may vary. They may be individually written for specific patients, multidisciplinary care pathways, or core care plans. Core care plans are a method of streamlining and augmenting care planning. These are not meant to replace the nursing care process, but assist nurses if they have to write the same generalised plan for a number of patients. There are advantages and disadvantages in their use. The advantages are that they establish clinically sound standards of care for similar conditions/patients; they can help inform nurses of accepted requirements of care. The disadvantages are that there is a risk that care plans are not sufficiently individualised by nurses, to identify the individual care needs of patients.

Care plans must be updated on a regular basis, to ensure that their content is current and appropriate, and reflect changes in patients' conditions. The key is that they are accurate, up- to-date and are used to direct the care required[11]. Progress notes should be completed any time a nursing intervention is undertaken and at least daily to report on the patient's condition.

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[9] http://www.nmc-uk.org/

[10] Guidance for the care of older People. Nursing and Midwifery Council. 2009

[11] Record keeping: Guidance for nurses and midwives. Nursing and Midwifery Council. 2009

2.4 DNAR (Do Not Attempt Resuscitation)

As part of the inspection, DNAR decisions and subsequent documentation were reviewed in both medical and nursing records.

In October 2007, joint guidance was issued by the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing on decisions in relation to cardiopulmonary resuscitation.[12]

A do not attempt resuscitation decision would be discussed with the patient or their family by the doctor. Such a decision should only be taken if there are clear reasons why active attempts to resuscitate would, on the balance of probability fail; if the quality of life would be severely affected by such an attempt; or if the person themselves has stated they do not want such an intervention.

If the person lacks the capacity to make such a decision, the family should be involved in giving their views about what the patient would have wanted. The decision is made, based on what is considered to be in the best interest of the patient, but the decision remains with the doctor.

The nurse has an integral role to play in informing and being part of the decision making process. All staff should be aware of the patient's wishes or any DNAR decision. All DNAR decisions should be reviewed regularly, and should not be routinely signed, based simply on a diagnostic label or age of a person.

2.5 Quality of Interaction Schedule (QUIS) Observation Sessions

Observation of communication and interactions between staff and patients or staff and visitors formed part of the inspection. This was carried out using the quality of interaction schedule (QUIS).

QUIS is a method of systematically observing and recording interactions, without becoming involved (non-participant observation). This technique was first developed for use in long-term mental health settings, but has since undergone many refinements and has been adapted for general use in care homes and hospital settings (Dean, Proudfoot, & Lindesay 1993)[13].

Communication and behaviour of staff are vital components of dignified care. The quality of interaction schedule is a tool designed to help evaluate the type and quality of communication that takes place on wards. It can be used as both a qualitative and quantitative tool to provide a measure of the quality of interaction between staff, patients and visitors.

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[12] Decisions Relating to Cardiopulmonary Resuscitation: A Joint Statement from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing, October 2007.

[13] Dean**,** R**.,** Proudfoot**,** R**.** and Lindesay**,** J**. (**1993), The quality of interactions schedule (QUIS): Development, reliability and use in the evaluation of two domus units. International Journal of Geriatric Psychiatry. Volume 8, Issue 10, pages 819–826, October 1993

The main focus of the observation is to review the way that staff respect and interact with older people and their visitors. Inspectors and lay reviewers were informed that if they observed practice that may put the patient at risk, the observation should stop and the observation immediately reported to the person in charge. If any team member saw that a patient was in danger, they should immediately call for help from staff.

On the inspection team's arrival on the ward, a notice was given to the person in charge for dissemination to staff. Observations were generally carried out at times of day when speaking with older patients, or handing out questionnaires, would have been inappropriate or obtrusive.

2.6 Patient/Relative/Carer Interviews and Questionnaires

In April 2009, the DHSSPS published the Improving the Patient and Client Experience Standards. The development of the standards incorporated significant consultation and involvement of patients, carers and service users or their representatives. Patient experience is a recognised component of high quality care. Within the six HSC trusts, there is a comprehensive programme of work in place to support the implementation of the Patient and Client Experience Standards.

Trusts use various methods and tools such as current and retrospective patient and client surveys, patient and client structured interviews, staff surveys, analysis of patient and client stories, observational techniques and use of indicators to collect information on the patient's experience.

A number of different methods were used to allow patients and visitors to share their views and experiences with the inspection team.

- patient/relatives/carers interviews
- patient questionnaires
- relatives/carers questionnaires

Patient/relatives/carers' interviews were based on a number of discussion prompts, which formed the basis of face-to-face discussions with older people (or their relatives or carers) during inspection visits. The interviews were used for those who did not feel able to complete the questionnaire but were willing and able to take part in a face-to-face interview.

The interview template used was not prescriptive, and additional questions were included as required.

Templates were also used for patient and relatives/carers questionnaires.
Views on the care received while in hospital can help identify areas for service improvement. The information obtained was anonymous and patients could ask a family member, carer or visitor to help them complete the form. When required, a member of the RQIA inspection team also helped patients to complete the questionnaire.

2.7 Emergency Department Inspection Tool

This inspection tool reviews the patient documentation, risk assessment used; multidisciplinary team working; and the environment. The ED was included in the inspection to ensure that older people waiting for over six hours had the appropriate care interventions commenced.

An increasing number of older people are attending EDs and accessing urgent health and social care services. EDs need to be supported to deliver the right care for these patients. Attendance at the ED is associated with a high risk of admission for older people, so the nature of the service and the environment in which it is provided requires to change to meet the needs of an ageing population.

3.0 Terms of Reference

The terms of reference for this review were:

1. To undertake a series of unannounced inspections of care of older people in acute hospitals, in each of the five HSC trusts, between September 2013 and April 2014.

2. To undertake inspections using agreed methodologies i.e. validated inspection tools, observation approaches, meeting with frontline nursing and care staff.

3. To carry out an initial pilot of agreed inspection tools and methodologies.

4. To review a selection of patient care plans for assurances in relation to quality of patient care.

5. To obtain feedback from patient/service users and their relatives in relation to their experiences, according to agreed methodology.

6. To provide feedback to each trust after completion of inspections.

7. To report on findings and produce and publish individual trust reports and a single overview report.

4.0 Inspection Methodology

Inspection teams visited the following acute hospitals within each trust.

Table 1 Hospitals Inspected

Health and Social Care Trust	Acute Hospital	Number of wards inspected
Belfast	Royal Victoria Hospital	4
	Belfast City Hospital	3
	Mater Hospital	3
Northern	Antrim Area Hospital	4
	Causeway Hospital	3
South Eastern	Ulster Hospital	4
	Lagan Valley Hospital	2
Southern	Craigavon Area Hospital	4
	Daisy Hill Hospital	3
Western	Altnagelvin Hospital	4
	South West Acute Hospital	3
Total	**11**	**37**

Inspections were unannounced and hospitals categorised dependent upon the number of beds and specialist areas. The number of inspections and areas to be inspected was proportionate to the range and type of services provided and the size of the hospital.

In each hospital the inspection team visited a number of wards and the ED. The patient flow coordinator was contacted on arrival, and, where necessary, during the inspection, to obtain information on the number of older people waiting for over six hours in the EDs.

The inspection team was comprised of inspectors drawn from RQIA staff with relevant experience, and lay assessors.

Each unannounced inspection was undertaken over a two day period.

Unannounced inspection process

Trusts received an e-mail and telephone call from RQIA 30 minutes prior to the team arriving on site. For this review, the unannounced inspection was normally conducted during working hours, including early mornings.

The first day of the inspection was unannounced; the second day facilitated discussion with the appropriate senior personnel at ward/unit level.

On arrival, the inspection team were met by a trust representative to discuss the process and to arrange any special requirements.

The unannounced inspection was undertaken using the inspection tools outlined in section 2.0.

During inspections the team required access to all areas outlined in the inspection tools, and to the list of documentation given to the ward manager on arrival.

During inspections photographs were taken of the environment and equipment, for reporting and as evidence of assessments made. In line with the RQIA policy on the Use and Storage of Digital Images no photographs were taken of staff, patients or visitors.

The second day of inspection concluded with a feedback session, to outline key findings, the process for the report and action plan development. Trusts were asked to commence work on the findings of the inspection prior to the receipt of the inspection report.

Trusts were informed that an individual report would be produced for each hospital on completion and published on the RQIA website. These reports outlined the findings and gave recommendations for service improvement.

Trusts received a draft report for factual accuracy checking and were asked to sign and return a completed quality improvement plan to RQIA.

5.0 Summary of Findings

The findings have been presented in six sections:

- ward governance
- ward observation
- care records
- patient/relative/carer interviews and questionnaires
- QUIS observation sessions
- Emergency Department

5.1 Ward Governance

Inspectors reviewed ward governance, using the inspection tool developed for this purpose. The areas reviewed included: ward improvements, nurse staffing levels and training, patient advocacy and how incidents, serious adverse incidents and complaints are recorded and managed. Further information was reviewed including quality indicators, audits and relevant policies and procedures.

Staffing: Nursing

Trusts have been actively involved in phase one of the normative staffing work stream, commissioned by the DHSSPS, led by the PHA and supported by NIPEC.

The staffing complement for all wards in the hospitals inspected was reviewed. Generally, inspectors considered that ward sisters had demonstrated effective management practices and leadership skills to support the service they deliver. When necessary, ward sisters raised concerns about staffing levels with trust senior staff to advise them that safety could be compromised due to inadequate staffing levels and patient dependency.

Inspectors found that trusts had been reviewing the acute nursing workforce across general medical and surgical wards. In some trusts these workforce reviews indicated that there were variances between the current funded staffing levels (FSL) and the normative staffing ranges (NSR). Some trusts had submitted a report or were in discussion with the PHA and the HSC Board regarding these variances. Discussions are ongoing. In the interim, some trusts had taken the decision to recruit additional nurses.

In all hospitals the ward sisters rely on bank and agency staff to cover staff shortages. Generally, they reported that they were supported by their immediate line manager when requesting bank staff to increase the ratio of staff. Inspectors were advised that there have been ongoing funding issues regarding staffing, which has impacted on the running of wards. Some medical assessment units (MAU) reported that they relied heavily on bank or agency nursing staff to cover weekly duty rotas.

Inspectors were informed that some bank staff did not have the appropriate experience, and at times there can be a lack of continuity with regard to the deployment of agency staff. Staff also confirmed that agency and bank staff can frequently cancel shifts at the last minute, and staff who were not busy in one ward may be redeployed to a another ward to augment staffing levels.

Most hospitals used escalation beds (extra beds, above the ward bed capacity) when there are bed pressures for admissions from ED. A risk assessment is carried out prior to placing a patient in an escalation bed to ensure the patient suitability for this bed. The use of escalation beds can be challenging for staff, due to the increased workload. Inspectors were told that bed pressures, bed management targets and moving patients, can all impact on quality of care.

Ward sisters reported that, at times, they had difficulties in balancing the clinical and managerial role when protected time for managerial duties was insufficient, or not provided. Ward managers also reported difficulties in maximising staff attendance at mandatory training with balancing the clinical needs of the ward. In some wards there were a number of governance deficits, such as recording of care records, audit and staff supervision. Inspectors were informed that this was in part due to staffing constraints, which have given rise to the dilemma of either delivering good care or maintaining good care records.

Inspectors noted that in the latter set of inspections there had been some recent improvement in staffing levels, in particular at the Royal Victoria Hospital.

In most, but not all, hospitals, ward sisters had some protected time and were not included in the staffing numbers. This provided time for them to carry out managerial duties. However, some ward sisters reported that although their managerial hours were recorded as management hours, and were supernumerary, they could frequently be covering short notice leave, or working on the ward when it was very busy.

Policies, Procedures and Audits

Ward sisters provided either hard copies or access to policies and procedures on the intranet site. In some hospitals, wards had prepared an Older Peoples Resource Folder, which included policies, procedures, and guidelines for the care of older people, based on the RQIA inspection tool.

Inspectors found that in most hospitals, a number of policies and procedures or guidance documents, relevant to the care of older people, were not available.

The majority of ward sisters or deputies confirmed that audits carried out have an action plan developed. Results are discussed with staff as part of the safety briefing process, or at staff meetings.

Training

In all hospitals ward sisters discussed the difficulties they experienced in ensuring that staff receive the required training. At times, work pressures have limited staff ability to avail of educational opportunities, and it could be difficult for staff to access training opportunities that are outside mandatory training requirements.

Some ward sisters reported that training opportunities to fulfil the responsibilities of the post were available. However, such opportunities had to be balanced against the needs of the ward.

Mandatory training records for nursing and healthcare assistants highlighted that there were variations in attendance across the hospitals inspected. Inspectors were informed that training can be cancelled if the ward is busy.

There were computer- based training records; the systems in place flag up non-attenders, these were followed up by the ward sisters.

In some hospitals, inspectors were informed that while staff appraisals and supervision were being carried out, this was not always up to date.

Nursing staff across all hospitals stated that they received training in a number of areas. The training varied dependent on what was available in each trust. Some training included the use of patient assessment and monitoring tools which include: pressure ulcer risk assessment (Braden) falls risk assessment, malnutrition universal screening Tool (MUST) SKINN (surface, skin, keep moving, incontinence, nutrition) care bundle, and the identification of the deteriorating patient.

Most staff reported that they have had no specific training on continence promotion and incontinence management, although some training on continence aids has been provided by various companies. In some hospitals there has been limited training in the management of dementia, delirium and challenging behaviour. Where training on dementia care had been carried out within wards, not all staff had attended. Inspectors noted that most trusts were commencing or had planned to introduce this training in the near future.

Safeguarding vulnerable adult training is part of all trusts' mandatory training programme, inspectors noted in some hospitals that attendance at this training had been poor.

Management of SAIs, Incidents, Near Misses and Complaints

HSC Trusts use a web-based system for incident and complaint reporting. This system allows reporting, review and recording of action taken, to allow learning from the incident to be disseminated to staff. Reports can be generated for trend analysis, which were reviewed at the monthly local governance and quality meetings.

Some ward sisters reported that they receive no formal reports on incident trends from the risk and governance team. In other hospital wards, feedback to staff occurred at ward safety briefings and staff meetings.

In some areas there was evidence of incident and complaint feedback to staff and action plans developed to address any issues identified.

In some hospitals ward managers reported that they record verbal complaints within patient notes. Verbal complaints should be recorded on the ward to allow any trends or patterns to be identified.

The inspections did not review the incident and complaint reports generated for trend analysis; this will be included in RQIA forthcoming hospital inspection programme to commence in 2015.

Meetings

In all wards inspected there was a variety of meetings held to cascade information to staff. In most wards staff meetings occurred every six to eight weeks, staff members unable to attend are updated by the nurse manager, or can access the minutes of meetings.

In all hospitals, ward sisters gathered daily data on admissions and discharges for patient flow coordinators. The information is required to review actual and predicted admissions and discharges, bed capacity and demand, to assist in creating an action plan to address bed needs. Despite this planning, ward sisters stated that the demand for beds, above capacity remains an ongoing challenge.

In all hospitals local governance and quality meetings were held, the title of these meetings varied across the trusts. These meetings were used to review the key performance indicators, care bundles and audits for each ward; to discuss complaints and incidents and review trends; and to review mandatory training attendance. In most instances this information was cascaded to the wards and subsequently disseminated to ward staff at team meetings and at safety briefs.

Multidisciplinary team meetings were held and attended by members of the medical and nursing teams, and other specialist disciplines such as: physiotherapist, occupational therapist, and pharmacist. The frequency of these meetings varied, dependant on the type of ward and patients' needs.

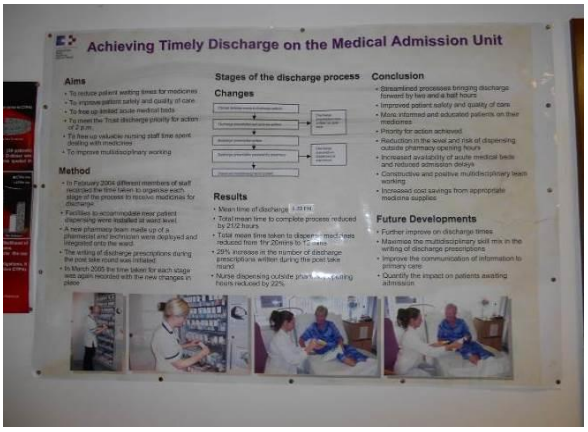
In some MAUs a variety of ward rounds are held each morning, which link with allied health professionals. Due to the diverse range of patients admitted from ED, ward staff link with specialists if advice is needed to facilitate care and meet specific patient needs. Geriatric and psychiatric liaison was available every day**.**

Projects/Improvements

In the hospitals inspected there were a variety of initiatives that had been undertaken or were in the process of being introduced such as:

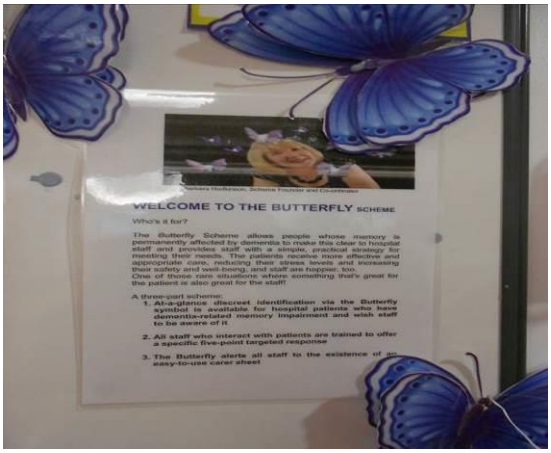
The Productive Ward - Releasing Time to Care. This project focuses on improving ward processes and environment to help staff spend more time on patient care and at the same time improve levels of safety and efficiency.

LEAN methodology and management systems, which provide a number of approaches for improving quality and patient safety in very practical ways. LEAN improvement methodology had been undertaken in one ward and the ward sister had been a LEAN Healthcare Academy Awards UK finalist. The project related to achieving timely discharge in MAU (Picture 1).



Picture 1: Achieving timely discharge in MAU

The Butterfly Scheme (Picture 2), is a simple, practical way of alerting staff to people whose memory is permanently affected by dementia. Wards which had introduced this scheme had nominated staff as butterfly champions who cascade training to other members of the clinical team within their respective areas. One trust was in the process of introducing a purple folder scheme throughout its wards and departments.



Picture 2: Poster highlighting the Butterfly Scheme

Some hospitals had initiated an electronic wander guard system. The system was designed to assist staff, where care is provided to people who may present wandering risks. A signalling bracelet is placed on the wrist of those patients that present a wandering risk. If the patient passes through a monitored area, an alarm sounds to alert staff of their attempt to exit the ward without an escort.

Most of the wards inspected had not undertaken a physical audit of the environment using the dementia checklist. However, there had been improved signage in bays and sanitary areas.

All hospitals were in the process of improving their electronic care record screen. This will help manage the patient journey within the hospital. In trusts this was being taken forward in a range of ways.

In the Western Trust some of the anticipated benefits included; real time view of the live bed state, electronic bed requests, user update with interactive whiteboards, which offered a faster way to update patients' status and track patients in real time. In the Western Trust staff members in one ward had introduced a traffic light rating system for ward rounds. Those patients categorised as red, were assessed as a higher priority, and were seen first by medical staff on the ward round.

In the Northern Trust the system identifies, using symbols on a wall mounted screen, patient's infection status, falls risk, feeding assessment and dementia. The screen can be used in a way that patient names are hidden from view, with only ward staff able to access. When embedded it is planned to use this system to print out information as part of nursing handovers.

In the Southern Trust a new information system called Hub had just commenced. This system holds patient information provided by the community such as social workers, key workers and district nurses. This system is also linked to the patient system. It is updated daily and the information is used to inform decisions on discharge.

In the South Eastern Trust a number of new initiatives were to commence in the MAU: trialling arterial blood gas equipment, a LEAN project for medicine management and an information page for patients on the MAU, written in layman's terms. Schwarz centre rounds were to be introduced. This is a multiprofessional forum to enable discussion of emotional and social issues arising from patient care.

Rounds provide a forum for staff from a range of disciplines to meet once a month (or every other month) to explore together some of the challenging psychosocial and emotional issues that arise in caring for patients.

In the Belfast Trust occupational therapy and neuropsychology staff had put forward an entry to the Chairman's Award entitled, 'Mindfulness Based Stress Reduction in Acute Stroke Care'. The Belfast Trust stroke service provides a trust educational initiative 'Core Skills for Stroke Care' which is open to all staff members within the trust.

In the Southern Trust one ward had carried out a nurse harmonising project entitled A Review of the Patient Day. This project changed the times that breakfast and dinners were served to provide more support to patients who require assistance with their meals.

In most wards, there were good link nurse systems in place to assist with care and offer advice, examples include: infection prevention and control, pain management, nutrition and tissue viability.

Quality Indicators

There is an increased focus on measuring outcomes of care, including documenting how nursing care is provided. Measuring quality and maintaining a quality workforce are daily challenges. In practical terms, the use of indicators can help to minimise the risk of a patient getting pressure ulcers, suffering a fall or acquiring a healthcare associated infection. Measurement can also help inform patients about their own progress, and provide the wider public with information about the impact of nursing care.

All trusts have introduced nursing quality indicators (NQIs). There are 26 quality national indicators available; the number of quality indicators introduced varied from ward to ward and across trusts.

These include falls prevention, nutrition, pressure ulcer care, record keeping, national early warning scores, complaints and incident reporting, infection control and care bundles. Inspectors noted that all wards were working to implement these indicators.

Inspectors were informed that these indicators were still subject to continuous review and refinement, to ensure that measurements of quality of nursing care are robust, and in line with regional and national standards.

A range of validation audits was carried out by senior nurses across wards and if compliance is low the frequency of audit is increased. Results were circulated to staff either by posting on the ward improvements board, discussion at staff meetings or via safety briefings. Inspectors noted that ward trends in relation to indicators were generally improving; however, the results for record keeping could be low.

Patient Client Experience and Customer Care

All trusts were participating in the recently launched PHA 10,000 voices project.[14] This is a unique project that offers people the opportunity to speak about their experiences as a patient, or as someone who has experienced the health service, and to highlight the things that were important to them, which will help direct how care is delivered in Northern Ireland.

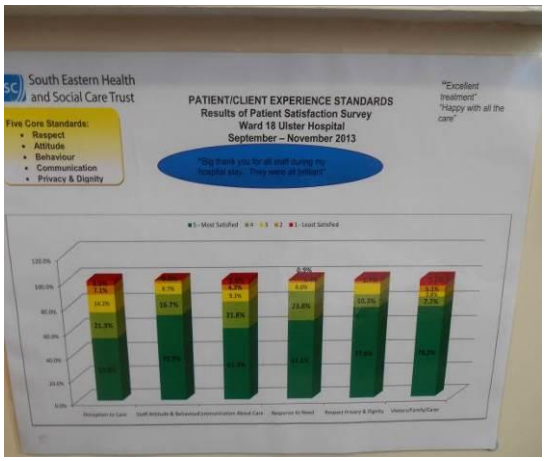
In the Southern Trust a customer care satisfaction survey had recently been undertaken within the wards inspected. The patient questionnaire was analysed and results were forwarded to ward sisters. The results were shared with ward staff and all members of the multidisciplinary team. In one ward, mealtime volunteers had been introduced as part of feedback from the survey.

[14] http://www.publichealth.hscni.net/publications/10000-voices-improving-patient-experience

Access to mobile phones and sometimes poor communication with patients were other issues identified for improvement. Staff did not always fully explain what was happening to patients. Feedback indicated that there was limited or poor signage in the hospital, and staff did not wear name badges.

The Southern Trust had undertaken customer care training for nursing/domestic staff. Customer care is part of the trust's work to promote privacy and dignity awareness. This training discussed staff self-awareness and attitudes to patients and family members, and staff also received feedback relating to patient views. Feedback on customer care training was given at the sisters meeting and as part of a safety briefing for staff.

In the Southern Trust an annual ward experience in-patient satisfaction survey, is undertaken, although some wards had yet to receive feedback on the 2013 survey. The survey includes issues such as cleanliness; meals and beverages; portering; laundry; security; car parking and travelling to hospital. This can also incorporate: respect; behavior; communication; response to need and privacy and dignity (Picture 3).



Picture 3: Patient/ Client Experience Standard Results September/ November 2013

In September/October 2013, the South Eastern Trust carried out a survey, in the MAU and ED on the patient flow journey. This involved managers in the ED, the MAU and clinical managers carrying out observations of nursing staff delivering care, throughout the patient's journey. Staff reported that the feedback received from patients who participated within the survey was positive.

Patients in the Western Trust admitted to the GP assessment area of AMU were asked to complete a questionnaire in relation to the cleanliness of the facility, ease of referral to the unit, the waiting area facilities and the standard of nursing and medical staff engagement. Results of this survey had not been collated at the time of the inspection.

A Western Trust leaflet, entitled 'Get Help for the Person' was available in each area. The leaflet is a resource to guide the public on local and regional support services. The leaflet contained useful contacts for the older person such as: Age NI; Alzheimer's Society; Help the Aged and HOPE (help on pension entitlements).

The social workers on each ward act as the protagonist link for patient advocacy and could network with older person's services on behalf of the patient.

The Belfast Trust has recently carried out a patient experience survey however wards have yet to receive feedback on the results. A patient food satisfaction survey had recently been undertaken. The results from this survey were not available at the time of the inspection.

In the Northern Trust one of the wards had carried out work on the Patient Client Experience and the Journey (2012). A patient experience questionnaire on discharge, has been devised to seek views after discharge, but not yet implemented. In two other wards inspectors were informed that as an action from visitor's complaints, the ward had placed a table in the bays for staff to use to facilitate visitor's questions during visiting time.

Regionally there are various initiatives being taken forward to improve patient experience such as:

- A joint, HSCB/PHA newsletter has now been developed entitled Learning Matters. This is issued bi-annually and involves learning from complaints, as well as learning arising from other areas such as, serious adverse incidents, safety and quality issues and medicines alerts.

- The Regional Complaints Sub-Group monitors trends in complaints concentrating on what and how HSC organisations have learned from complaints, changes in practice and protocol that have been implemented and how this has been cascaded to relevant staff throughout the organisation.

- An annual regional complaints workshop for all HSC organisations which will focus on the findings and recommendations of the Francis Report, and involve input from service users as to their experiences of the HSC complaints procedure will be held.

- A further workshop, involving direct engagement with service users who have complained, and also those who had a negative experience but chose not to complain is to be held. The workshop will be publicly advertised through various press and media forums and also within the HSC itself. This is to ensure maximum exposure of patient experiences and endorse the commitment to Personal and Public Involvement (PPI)

- June 2014 was Complaints Awareness Month. This was advertised extensively through local media, and a new leaflet designed to highlight the contact points for members of the public to address complaints. This leaflet was distributed province-wide through various local facilities such as shopping centres, transport stations and leisure facilities.

- Collaboration with the Quality 2020 steering group regarding the volume of complaints specifically in relation to staff attitude and behaviour, communication and the provision of information for patients and clients.

5.2 Ward Observation (Treating Older People with Compassion, Dignity and Respect)

This inspection tool reviewed; the organisation and management of patient environment; the privacy and dignity afforded to patients; person centred care to ensure that older patients are treated with respect and compassion; and the management of food and fluids.

The objective of this exercise was to gather evidence by carrying out ward observation and speaking to staff and patients. This evidence informs the overall information gathered to identify whether older patients on the ward are being treated with dignity and respect, and their essential care needs are being met.

Ward Environment

All patients including the older patient in the Western Trust had benefitted from an improved hospital environment, with the new facilities at the South West Acute Hospital and the completion of the new wing of Altnagelvin Hospital. New inpatient facilities are currently being built at the Ulster Hospital to replace the main ward block, which inspectors noted was old and worn and not conducive to a modern therapeutic patient environment.

In general, wards were clean, bright and well maintained, and although staff were busy, the atmosphere was generally calm and welcoming.

Wards consisted of bed bays and en-suite side rooms for isolation purposes if required. On most occasions, wards appeared to provide sufficient space to enable the activities of clinical and personal care to be carried out comfortably, easily and safely (Picture 4). In contrast, spacing within some patient bays within Craigavon Hospital was particularly cramped. The limitations in clinical space affected staff members' ability to safely manoeuvre patients and equipment.

Picture 4: Spacious core clinical bed space

Most of the wards inspected had not undertaken a physical audit of the environment using the dementia checklist. However, inspectors noticed improved signage in bays and sanitary areas. However, further work is needed to make the wards more suitable and supportive for people with dementia or a cognitive impairment.

Ward clutter presents an issue for all trusts, facilities for the storage of patient equipment was limited. Patient equipment was observed stored in central ward thoroughfares, ward corridors (Picture 5), within patient bays and, on one occasion, blocking the ward fire escape. In some wards patient property bags were observed tied to bedside lockers and on the floor at the patient bedside, which presented trip hazards for elderly patients (Picture 6). Overall ward clutter had presented a safety risk for patients and had taken away from the overall aesthetic appearance of wards.

Picture 5: Cluttered corridor

Picture 6: Patients clothes in a carrier bag, detergent wipes on the floor

Sanitary Facilities

Generally sanitary facilities were located conveniently for patients, either within ward bays or along the ward corridor. On most occasions there was an adequate ratio of facilities per patient. However, the number of facilities within wards in the Ulster, Daisyhill and Antrim Area hospitals were limited. In some hospitals a number of side rooms did not have ensuite facilities. In the MAU in the Ulster Hospital, there was only one working shower in use for 40 patients.

Sanitary areas ranged from the very modern facility (Picture 7) to facilities that were worn, outdated and in need of upgrading (Picture 8).

Picture 7: Modern sanitary facility

Picture 8: Old shower room

The spatial constraints of a small number of toilet facilities would present difficulties for independent and assisted wheelchair use or allow for appropriate assistant to be given. The majority of facilities were equipped with specialised adaptions including raised toilet seats, commodes, and hand rails to support the needs of patients with impaired mobility. There were exceptions in some hospitals where fully adapted facilities were not available.

Sanitary facilities in a number of wards had been used as equipment storage areas (Pictures 9 and 10). These facilities still had water outlets present; the flushing of water outlets was inconsistently carried out. All toilet and shower facilities could generally be locked from the inside and, if required, be unlocked by staff from the outside in the event of an emergency. Inspectors found that in a number of wards staff did not have an appropriate tool readily available to open doors in the event of an emergency.

Picture 9 and 10: Shower room and bathroom used to store equipment

Picture 11: Clear Pictorial Signage

Generally, toilet and shower facilities were designated for single gender use, with clear pictorial signage (Picture 11). However, there were a few exceptions. In one ward a female bay had no attached toilet/shower facility; female patients had to travel to an adjoining male bay to use the toilet/wash room.

Privacy and Dignity

In all hospitals, ward bays were generally dedicated for single sex use. On occasions, either due to patient flow requirements or the individual needs of patients, inspectors observed mixed gender bays.

The use of escalation beds presented a particular challenge for staff in maintaining patient dignity and privacy. Escalation beds were used within a number of trusts to increase bed capacity at times of intensified demand on their services. Inspectors observed patients nursed in escalation beds. These beds could be located in ward corridors (Picture 12), beside nursing stations. Some beds had been placed into patient bays bringing the bed numbers above normal configured capacity. A number of these escalation beds had no or limited bedside furnishings; staff reported that patient belongings were kept in plastic bags at the bedside. Patients did not have access to a nurse call system and there was no piped oxygen or suction at these bed spaces. Staff did inform inspectors that patients were risk assessed prior to being placed in these beds. In some wards the use of portable screens was not sufficient to maintain the privacy and dignity of patients.

Picture 12: Escalation bed in corridor blocking access to the fire exit

Disposable privacy curtains were used in most wards. They were of adequate length and appeared fresh and clean. In some hospitals, fabric privacy curtains continued to be used. Some of these curtains did not fit around the patients' bed space and some were of differing lengths which resulted, at times in patients' dignity and privacy being comprised.

On most occasions, privacy curtains were used effectively when patients were receiving personal care; and during interviews with medical and allied health professionals. In all trusts inspectors observed occasional lapses in privacy when curtains were not fully drawn during personal care activities.

In some hospitals disposable privacy curtains had a "do not enter" label present; staff were generally compliant with this request during care activities. In most instances staff were discreet and hesitated before entering the patient bed space.

In over half of the wards inspected, patients did not have access to a quiet room that could be used if they wished to use the phone or speak confidentially with staff or relatives. In general, the ward sister's office was used. When these rooms were present, not all patients were made aware of their availability within wards.

Most wards had no trolley phones, but patients could, if they were able, use the ward telephone to receive calls from relatives. Ward reception staff delivered messages to and from patients and relatives.

In all trusts, not all staff wore name badges; badges when worn were at waist height on the uniform pocket and it was not easy to identify the staff member. It was also noted that not all staff introduced themselves to patients on first interaction.

Inspectors noted that some wards did not have a sufficient number of patient dignity gowns for those patients that do not have their own night attire. Staff found it difficult to maintain the privacy and dignity of some confused and restless patients when they constantly removed their bedclothes.

Within all trusts, staff were generally courteous and respectful to patients and visitors. The vast majority of staff were caring, sensitive, insightful and anticipated the care needs of patients. However, inspectors observed some incidents when patients were not treated in a dignified manner:

- A member of staff asked a patient to go back into the bathroom and make sure that he washed under his arms so that he did not smell. This happened in the presence of other patients.
- A patient in a side room sitting on a commode with their back and bottom exposed as the side room door had not been closed fully.
- A patient was scolded by two members of staff present during the delivery of care.
- Inspectors overheard some patients being referred to as feeders and strokes.

On most occasions the privacy of information was maintained within wards. Most staff endeavoured to speak with discretion when discussing patient information. However, during ward rounds in multi-bedded areas this presented a particular challenge for staff. Staff in all trusts should be mindful of the ward physical environment, including displaying patient information behind bed spaces, the location of computer display units, telephones and seating, all of which may contribute to breaches in patient confidentiality.

Patient Call Bells

The call bell is a vital communication link during a patient's hospital stay. It is the mechanism by which patients can alert a healthcare worker to provide help. It is vital these are within easy reach and that staff respond quickly and promptly to the patient's concern.

Patient call bell systems ranged from modern efficient systems to older systems, which needed to be upgraded or suffered from continued maintenance issues. In one ward the call bell was located in a patient toilet behind a hot radiator making it extremely difficult for patients to access and obtain assistance. The position of this call bell created the risk of a burn injury (Picture 13).

Picture 13: Patient call bell behind radiator

On entering some wards, inspectors noted that patient call bells were out of the reach of patients. This was not an isolated issue, and was observed on a number of wards and trusts. (Pictures 14 and 15).

Pictures 14 and 15: Call bells out reach of patients

Overall, inspectors observed that call bell requests from patients were answered promptly. At times, in some wards, it was difficult to hear the call bell as the system was old or due to the level of noise in the ward. On some occasions staff were observed demonstrating the system to patients. Inspectors noted in some instances that call bells could have had a speedier response. On one occasion a patient waited approximately 30 minutes for assistance with their toileting needs after a call request.

Person Centred Care

Patients have a right to a high standard of personal care; this is an important factor for all patients but significantly so for older patients. Meeting the personal care needs of patients is a fundamental aspect of care provision. It is the responsibility of staff to provide patients and clients with compassionate, considerate assistance with their personal care needs.

Many of the wards inspected have adopted a form of intentional care rounding. Intentional care rounding is a structured process where nurses carry out scheduled tasks or observations with patients' to meet and anticipate their fundamental care needs. Typical care needs include: addressing patient's pain, hydration and nutrition, continence, positioning; assessing and attending to the patient's comfort; and checking the environment for any risks to the patient's comfort or safety. Elements of intentional care rounding can reduce adverse incidents such as falls and pressure sores, offer patients greater comfort and ease their anxiety.

Trusts used a variety of charts to capture scheduled interventions and observations. Many trusts have linked elements of intentional care rounding with the development of trust SKINN (surface, skin, keep moving, incontinence, nutrition) care bundles and repositioning charts. Some trusts complete these scheduled interventions and observations for all patients. However, in other trusts these are only completed for patients dependent upon their risk status, for example, risk of pressure sores.

In all hospitals inspectors reviewed a number of these documents to assess if planned care interventions and observations had been undertaken. In all hospitals there were inconsistencies in the completion of these documents. Not all elements of the tools were completed, and the required care was not always carried out at the planned time. In some instances inspectors observed these being marked as complete when no care had been delivered; some staff seemed to regards these as a tick box exercise.

In all trusts, inspectors observed that patient personal care was generally of a high standard. Patients appeared clean, comfortable, warm and suitably clothed. Patient personal mobility aids, hearing aids and glasses were generally within easy reach of the patients, and assistance was provided as appropriate.

Of particular note was how staff managed elderly patients with symptoms of confusion and sensory impairments. A confused patient within a ward in the Belfast Trust liked to walk and move around the ward. The patient was accompanied at all times by nursing staff and they managed his behavior in a calm, gentle and appropriate manner. In the Northern Trust staff used excellent communication skills in conversing with a patient who had a hearing impairment.

Patients generally did not appear to be in pain or distress, however, on one instance a patient had to wait a period of approximately 30 minutes before a nurse administered pain relief.

Inspectors observed that most patients were assisted to the toilet as and when required. However, on a small number of occasions the over usage of commodes at the patient bedside was observed. Staff reported that this was due to the availability and spatial constraints of some toileting facilities. In one area there was a limited number of commodes, which resulted in a delay in patient toileting needs being met.

In most wards staff hand hygiene practice was good, however, on a number of occasion's inspectors observed that hand hygiene was not facilitated, or routinely offered to patients, before and after meals.

In some hospitals, inspectors were concerned about timing of the delivery of personal care. On the second day of the inspections, inspectors arrived in the wards from 07.30 to observe care practices and the serving of breakfast. On one occasion, there was a lack of evidence either through observation or within care records to support the delivery of morning personal care for a number of vulnerable elderly patients. During discussion with a staff member, it was stated that the patients were assisted to wash by night staff. As restful sleep is an important aspect of care, it was concerning that patients sleep is being disturbed for personal care interventions to facilitate task orientated ward care routines.

Food and Fluids

Protected mealtimes had been implemented in most hospitals. The aim of this initiative is to allow patients to eat their meals in calm and relaxing environment, without unnecessary interruption; enhance the patients' experience of hospital food; and allow nursing staff to monitor and help patients meet their nutritional needs (Picture 16).

Picture 16: Protected meal time poster

Although protected meal times was in place in the majority of hospitals, on some necessary circumstances patients were away from their bedside during meal times. This included when patients attend therapy sessions, have tests or x-rays, recovering from surgery. However, across all hospitals inspectors observed unnecessary breaches in this protocol. Inspectors found that in many wards phlebotomists disturbed patients' meal times despite being asked not to disturb the patients by nursing staff.

Meals were generally of a good variety, warm, nutritious and appetising. Most meals were of a good portion size. Some of the hospitals are moving towards providing one cooked meal a day, the other meal being a soup and sandwich option. In many cases elderly patients are unable to or do not wish to eat two main meals each day. In a specific area that was serving two main meals for patients a day, this resulted in a considerable amount of food wastage.

Patients generally had a choice, either to remain in bed and eat their meal or have their meal at the bedside; ward dining rooms were generally not available. On occasions, the available cutlery and glassware at mealtimes was of poor quality. Inspectors observed patients using disposable plastic cutlery and plastic disposable cups (Picture 17). Some areas did not have the availability of feeding aids for patients with flexibility, mobility or physical dexterity issues.

Picture 17: Disposable plastic cups

Picture 18: Red napkins on trays

The systems in place to identify patients who required assistance with their meals varied across trusts and between wards. Some wards had this information recorded on staff handover sheets, ward white boards or on symbols behind patients' bed spaces. The information was not always accurate or complete.

In some trusts a red tray or napkin had been introduced as a visual indicator for nursing staff to identify those patients who require assistance (Picture 18). Inspectors noted that even when this had been introduced there was variation in the implementation of this at ward level.

There was poor coordination and minimal nursing staff input into the planning and coordinating of the meal service in some wards. Not all staff had been kept updated regarding the assistance or special dietary requirements of some patients. Inspectors noted that patients were not always positioned or prepared for their meals, and the availability of staff to provide assistance was at times limited. These factors ultimately resulted in a poor quality service in some wards.

In some wards, some meals were left on bedside tables for at least 10-15 minutes before assistance was provided. As a result, the meals had become cold. Inspectors requested that the meals be reordered to ensure patients received hot meals.

Patients were provided with jugs of fresh water unless contraindicated. Jugs and glasses were generally within the reach of patients and changed two to three times daily. On a number of occasions inspectors observed staff proactively encouraging patients with food and fluids.

Most trusts had implemented the new regional Fluid Balance and Prescription Chart. These charts reflect the range of developments in fluid therapy and the regional approach supports safe and effective practice across Northern Ireland. Therefore, it was concerning that inspectors observed a large number of fluid balance and food intake charts inadequately and inaccurately completed.

Additional Issues

In a small number of hospitals inspectors observed IV medication had been drawn up and left sitting in trays in the open clinical room. This is unsafe practice which allows for unauthorised access (Picture 19).

Picture 19: Pre-prepared, unattended IV medication

De-facto detention

Inspectors noted that on a small number of occasions patients, relatives or visitors were not able to exit wards without asking staff to trigger the exit doors to open. This practice is classed as de-facto detention, which includes any situation where an individual is not formally detained but may nevertheless be deprived of liberty. While RQIA recognise the difficulties in balancing patient safety and security and individual patient rights, trusts must ensure that appropriate controls are initiated.

The management, security, and safety of patients should, where practicable, be ensured by means of adequate staffing. To maintain a safe environment it may be necessary to lock ward doors, there should be detailed procedures for this practice, which include:

- Informing all staff of the reason why the action has been taken and how long it will last.
- Informing all patients for the reason behind locking ward doors, including those whose behaviour has led to this action.

- Inform line management of the action taken
- Inform the medical consultant or deputy of the action taken

It is therefore recommended that local detailed procedures are put in place.

5.3 Review of Care Records

An inspection tool was used to review patient care records in relation to: the management of patients with cognitive impairment; food, fluid and nutritional care; falls prevention; pressure ulcer prevention; medicine and pain management.

In line with the terms of reference agreed by the DHSSPS, the review of care records mainly focused on nursing records. Inspectors viewed medical and allied health professional records where more detail or clarification was required, however, these records were not subject to an in-depth review.

Care records should build a picture of why the patient has been admitted; what their care needs are; desired outcomes for the patient; nursing interventions; evaluation and review of the care required.

A nursing booklet had been regionally agreed to record nursing care, trusts had adapted this booklet for local use.

Inspectors reviewed 121 patient care records. Patient bedside charts were also examined for specific details relating to the delivery of care. Inspectors found similar gaps in the recording of care records in all hospitals inspected.

Only a small number of the care records evidenced that nurses demonstrated by their recording that they had adequately carried out assessment, planning, evaluation and monitoring of the patient's needs. This is vital to provide a baseline for the care to be delivered, and to show if a patient is improving, or if there has been deterioration in their condition.

Patient information, sourced by nurses, was not always reviewed, or analysed collectively to identify the care needs of individual patients. The initial assessments were not always fully completed, or used to inform subsequent care interventions required.

The nursing documentation in use indicates that there are a variety of risk assessments that should be undertaken. Some examples of these include risk assessments on nutrition, falls, and pressure ulcer risk. If a risk has been identified, a care plan should be devised to provide instruction on how to minimise the risk.

Inspectors noted variations in the recording and completion of risk assessments in all wards. Generally, risk assessments were completed within the appropriate time frame; however, a significant number of risk assessments were not always fully completed. Regular review of risk assessments did not always occur, despite changes in the patient's condition. Identified risks did not always have a care plan devised to provide instruction on how to minimise the risks.

Patients' care records reviewed did not always have appropriate care plans in place and in many patient care records; no care plans had been devised.

If care plans were in place, these did not always reflect the nursing assessment, or the care required for the patient, identified on observation. The majority of care plans devised contained inadequate detail, and little direction of the care to be implemented for the patient.

In some hospitals preprinted care plans were used, however, these were not always individualised to the patients' needs.

The nursing progress notes did not always reflect the nursing assessment or any care plans that were in place. Within the progress notes there was some narrative of the delivery of care, although in most occasions this did not relate to the care plans in place. Additionally, nurses did not always provide ongoing assessment or triangulation of care in the progress notes. For example, if nurses on night duty identified that a patient's sacrum was red, the progress notes may not have recorded a comment about this for two days or more. This issue was not isolated to pressure area care. Inspectors also noted that care charts maintained at the bedside were not always completed and contemporaneously maintained.

Inspectors found that nurse record keeping did not always adhere to NMC and NIPEC guidelines.

Overall, the patient care records failed to demonstrate that safe and effective care was being delivered. Improvements in record keeping are required in all hospitals inspected.

The inspections highlighted that all trusts had identified this as a problem and were working to improve recording. Regionally work is ongoing by the Chief Nursing Officer and NIPEC to identify ways of improving the recoding of patient care. Inspectors identified that nurses in wards with a high turnover of patients, such as ED and MAUs, have challenges in the completion of the nursing booklet, as some patients may only be in the ward or department for a short time.

Nurses reported that, at times, they had difficulties in balancing the dilemma of either delivering good care or maintaining good care records. Ward managers also reported difficulties in ensuring that staff recording was appropriate with balancing the clinical needs of the ward.

DNAR (Do Not Attempt Resuscitation)

As part of the inspection, DNAR decisions and subsequent documentation were reviewed in both medical and nursing records.

Inspectors observed inconsistencies in the completion of the DNAR documentation, in both nursing and medical records throughout all trusts. The DNAR section in the nursing assessment and plan of care booklet was often not completed by nursing staff. In one set of nursing records that had the DNAR section completed, it referenced that there was no DNAR decision. However, a DNAR order was present and signed by a doctor within the medical records. In another ward the nursing assessment at the section on DNAR stated "do not discuss with relatives".

This patient was confused, therefore, would not have had the capacity to make a decision in this respect. No DNAR form could be found in the medical notes by inspectors or the nursing staff.

Although many of the DNAR orders were fully completed, a number of signed orders failed to highlight that there had been discussion with the patient, family or carers.

5.4: Quality of Interaction Schedule (QUIS) Observation Sessions

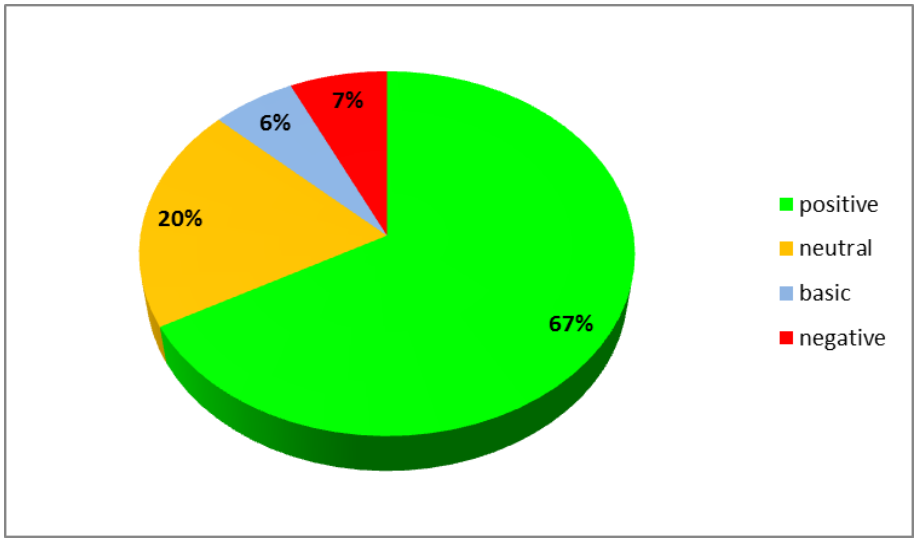
Observation of communication and interactions between staff and patients or staff and visitors was included in the inspections. This was carried out using the Quality of Interaction Schedule (QUIS).

Inspectors and lay reviewers undertook a number of periods of observation in each hospital ward inspected. Each session lasted for approximately 20 minutes.

Observation is a useful and practical method that can help to build up a picture of the care experiences of older people. The observation tool uses a simple coding system to record interactions between staff, older patients and visitors. Details of this coding have been included in Appendix 1

A total of 233 observation sessions were undertaken across the 11 hospitals resulting in 1836 interaction observations recorded. The overall findings for Northern Ireland are detailed in figure 1.

Figure 1 Overall Findings



67 per cent of the interactions were positive. Positive interactions relate to care which is over and beyond the basic physical care task, demonstrating patient centred empathy, support, explanation, socialisation etc.

6 per cent were basic interactions. These relate to brief verbal explanations and encouragement, but only that necessary to carry out the task, with no general conversation.

20 per cent were neutral interactions. These are brief indifferent interactions, not meeting the definitions of other categories.

7 per cent were negative interactions. These relate to communication which is disregarding of the patients' dignity and respect.

It was disappointing to note any negative interactions; however, these involved a small number of staff. The staff involved were made known to the ward sisters for the appropriate action to be taken.

The findings varied with hospitals and across trusts as represented in Table 2

Table 2 Individual Hospital Findings

HSC Trust	Hospital	Positive (PS)	Basic (BC) %	Neutral (N) %	Negative (NS)
Belfast	Belfast City	74%	19%	3%	4%
	Mater	63%	25%	7%	5%
	Royal Victoria	57%	29%	7%	7%
Northern	Antrim Area	60%	17%	13%	10%
	Causeway	54%	24%	13%	9%
South Eastern	Ulster	76%	14%	2%	8%
	Lagan Valley I	74%	20%	1%	5%
Southern	Craigavon Area	68%	15%	10%	7%
	Daisy Hill	65%	22%	3%	10%
Western	Altnagelvin	81%	16%	2%	1%
	South West Acute	63%	24%	1%	12%
Total		67%	20%	6%	7%

The findings indicate that the highest number of positive and lowest number of negative interactions was observed in Altnagelvin Hospital. Causeway Hospital had the lowest number of positive interactions, whilst the South West Acute hospital had the highest level of negative interactions.

The narrative results from all the hospitals have been noted in the individual reports; the most frequent interactions are detailed below. The interactions observed relate to all disciplines of staff, nurses, healthcare assistants, doctors and allied health professional such as physiotherapist, occupational therapists and assistants.

Positive Interactions

Evidenced by:

- Generally good communication skills displayed by staff; coming down to patient level, speaking slowly, awareness of hearing difficulties, introduced themselves, repeating information to ensure the patient understood.
- Staff members observed encouraging patients to eat, sitting facing a patient when assisting them with their meal, good conversation during assistance.
- Encouragement, comfort and reassuring behaviour from staff when care was being given to the patient. Ensuring patients were comfortable before leaving the bedside.
- Staff took into account patient's wishes, initiated conversation with patients, listened and spoke respectfully and politely, showed an interest in the patient.
- Staff responding warmly to visitors questions.
- Good explanation of care and changes in medications prescribed.
- Staff were observed asking patients preferences regarding food choices, salt, sugar and milk at breakfast service. "Good morning, what would you like for breakfast", and checking on patient progress during meals.
- Personal care given, quiet tone when communicating behind bed screens
- Asking the patient what is their preferred name.

Basic Interactions

Evidenced by:

- Limited engagement by staff when making patient comfortable, assisting with personal care or carrying out observations.
- Engagement and conservation with patients during care was only what was necessary to complete the task: venepuncture, clinical observations, assisting patient to eat, getting patient into bed, dispensing medications.
- Minimal conversation when being taken to the toilet. No reassurance given.
- Working behind patients in silence, only responding when patient spoke.
- Asking patients questions, not looking at patient.

Neutral Interactions

Evidenced by:

- No conversation when attending to patients care, serving and assisting with meals.
- Leaving equipment at bedside, no interaction with patient.
- Hoisting patient from bed to chair, no interaction with patient.
- Carrying out personal care to confused patient, no interaction with patient.
- Taking a blood sample from a patient. There was no conversation during the clinical practice.
- Sorting drugs at the bedside locker, no conversation.
- Assisting patient with shaving, no communication with patient.

- Carrying out personal care with patients and did not speak, except to say good morning. Some patients unresponsive, so no further engagement or personal care carried, only addressing patient once on one occasion when care was delivered for over 15 minutes.

Negative interactions

Evidenced by:

- Referring to patient by bed space position rather than name.
- General overuse of colloquial terms such as darling, sweetheart, only with older patients.
- Referring to patients as feeders.
- Flippant remarks were made in general to a male patient who had been very unsettled the night before.
- A patient was in bed was calling out, leaning over bedrails towards staff. Staff initially engaged “what’s wrong darling”, “what do you want”. However, the patient did not settle and continued to call out, staff then ignored the patient. On observation, this patient was settled quite easily by nursing staff.
- A patient informed night staff they needed to use the bedpan. A member of staff acknowledged the request, however, went off duty without assisting the patient. Day staff appeared unaware of the request, and did not attend to the patient until intervention by the inspector.
- A specialist nurse could be overheard by inspectors discussing a patient’s post-operative care in a bay, there had been no attempt by staff to take the patient to a more private area as the discussion could have been embarrassing for the patient due to the nature of the procedure.
- Staff nurse greeted patients with “are you not washed yet?”, scolding manner
- Scolding a patient “Don’t do that” when the patient was attempting to lift the breakfast bowl.
- A nurse at the bottom of the bed serving breakfast on a tray asked a female patient “How’s your rash?” This was heard by all in the bay.

Events Observed by Inspectors/Lay Reviewers

During the observations sessions the following events or important omissions of care, which are critical to quality of patients care but which do not necessarily involve a direct interaction were observed.

- A patient was observed attempting to climb around the bed rails. Three nurses had walked past the patient’s bed space without action to assist and maintain the patient’s safety. Action was taken by a member of the nursing staff after being prompted by an inspector.
- Staff working at the patients locker to administer medication. Patient immobile/poor eye sight. Patient had to ask what was going on as heard staff but could not understand what they were doing.
- Patient, arrived in the ward on a trolley, placed at nurses’ station. Left eating lunch in twisted position, with meal tray at side on top of station.

- Patients required assistance with feeding; this was not always readily available. Patients waited five minutes and 10 minutes.
- A syringe pump alarmed; care staff member ignored the alarm event.
- A patient was distressed, shouting out and trying to get up from the bed, the patient's call bell was not within easy reach.
- Breakfast served to patients before the patient was sitting up and ready.
- Medical staff entering a screened bed area (where personal care was being delivered) without checking before they opened the curtain. Did not fully close the curtain on exiting the area.
- A patient was observed lying flat on their back in a side room. The inspector observed a lapse of at least 10 minutes and two requests from PCSS staff to nursing staff and a request from the inspector, before the patient was attended to.
- Inspectors had to ask staff to attend to buzzers.

The findings indicate that many staff had demonstrated by the interactions patient centred empathy, support, explanation and socialisation. The findings also indicate that there was further work required to ensure that all staff respond and interact with patients in a caring and compassionate manner.

5.5 Patient and Relative Interviews/ Questionnaires

The RQIA inspection included obtaining the views and experiences of people who use services. A number of different methods were used to allow patients and visitors to share their views and experiences with the inspection team. The findings are presented from a composite perspective combining the patient and relative perceptions.

- Patient /Relatives/Carers Interviews
- Patient Questionnaires
- Relatives/Carers Questionnaires

During the inspection a total of 216 patient and relatives/carers questionnaires and 139 patient interviews were undertaken. The overall results are detailed in the charts at Appendix 2.

Generally, feedback received from patients and relatives or carers was good. Overall patients were satisfied with the standard of care they received; they thought staff were polite, courteous and compassionate, and generally felt that they had received a good standard of care during their stay. Questionnaires indicated that staff introduced themselves to patients and included them in conversation. Patients generally felt that meals were enjoyable and of good quality, although some patients thought that the portion size was too big, and the food could be repetitive.

Positive Comments:

"I have received the most excellent care during my stay in hospital, including the right positive approach and response from staff nurses and all investigative staff."

"We are very content with my mother's hospital experiences, care and medical attention."

"Although staff finish at 8pm they are here until sometimes 10pm due to dedication and commitment."

"My mother has been well looked after and is happy with her care. Staff have noticed when she is in pain and have given pain relief before moving/dressing etc. My daughters and I have been kept fully informed of her treatment and condition."

"I often feel the nurses are under pressure to try and assist all the patients that need help eating. They work very hard under increasing pressure and still manage to do it cheerfully and caringly."

"Overall good involvement in relatives care, confident getting the best care".

‘‘The care is first class; my father is 87 years and has been cared for with respect, empathy and in a highly professional way.”

“Outstanding care from both medical and non-medical personnel in relation to communication about relative’s condition.”

“This is the first long term stay my husband has had, I am happy with the care from he was admitted. Great caring staff.”

“They washed me and I dirtied the bed and they never said anything and took me to bathroom and came back and the bed was made and its part of their job. It’s the wee things that matter.”

“Staff include me in the care and treatment. Don’t look down on you. Speak to you at your level.”

“I would like to praise the attitude and treatment received from the ambulance men and paramedics, they were truly excellent. I also appreciate the wonderful care given by all staff.”

Some patient questionnaires indicated that communication between staff and patients could be improved in relation to involvement in care and knowing who to speak to. Some questionnaires identified that relatives did not feel confident to express views on how their relative is being cared for; they are not asked their relative’s needs or wishes and they do not know who to speak to about their relatives care.

Overall patients felt that visiting hours were suitable. When questioned patients informed the inspection team that they had not received information leaflets.

Comments where improvements could be made:

“Unaware of whom to speak to about relatives care, not asked about relatives wishes.”

“I witnessed an elderly woman being given her lunch but she obviously could not feed herself. Her lunch was left sitting for at least half an hour before a relative came to feed her.”

“I feel that the majority of nursing staff can do their jobs effectively. There have been issues however with moving my relative to different floors and wards, this caused major confusion and extreme anxiety and annoyance.”

“Not a lot of information was given to me about what was going on with my granddad. Other patients in the ward kept the TV on to 12.00am and were shouting, this upset my granddad because it was his first stay.”

“It would be helpful if a staff member (doctor or nurse) would meet with a family member regularly to update plan of care/treatment.”

“Don’t always provide sufficient information.” “Not always included in discussions about relatives care.”

“Would like to know staffs names, would like if nurses had more time for general chat. “

“Some staff are nice, others not so, but that’s life.”

“Sometimes busy and it can be a while for buzzer to be answered.”

“It was difficult to speak to nursing staff in private - too many patients in bay all listening.”

“Some nurses excellent, suited to care, for some just a job or routine.”

“Breakfast and early morning wash frequently conflict- this means breakfast sits in the corridor for longer periods than necessary. Porridge and toast suffer accordingly.”

“Meals are ok but repetitive; reasonable choice I am on a low sodium diet and suspected diabetic which limits my real choice.”

“We have given multiple explanations about relatives past medical history surely this could be written down in one place for the basics.”

Patient Interviews

Overall, there was good feedback from patient interviews. Patients were generally happy with the standard of care that they had received and had a good relationship with staff. Patients indicated that they were kept informed about their care although one patient, who was not allowed out of bed and didn’t know why, stated that staff ‘don’t tell you too much’. There was a general understanding from patients that staff were working to the best of their ability, given the time and staff available.

Most patients indicated that staff took the time to chat with them, although not all staff introduced themselves and not all staff names were known or visible on badges.

Most patients indicated that call bells were answered reasonably quickly, however some felt that they might have to wait if staff were attending to another patient.

One patient commented that it was difficult to speak privately with a nurse as there were too many patients in the bay listening.

Most patients indicated that meals were of a good quality and variety of choice although a patient commented that meals were not satisfactory for coeliac patients.

Patients were happy that family members are able to visit outside visiting times.

6.0 Emergency Department ED

Increasing numbers of older people are attending EDs and accessing urgent health and social care services. EDs need to be supported to deliver the right care for these patients. Attendance at the ED is associated with a high risk of admission for older people, so the nature of the service and the environment in which it is provided needs to meet the needs of an ageing population.

Members of the inspection team visited the ED of each hospital included within this review. Inspectors visited ED departments on a number of occasions throughout the two days of the inspections to ensure that patients of 65 years and over who had waited within EDs over six hours had the appropriate care interventions commenced.

The four hour target for treatment in EDs aims to improve the patient journey by emphasising the length of time it takes for a patient to be seen, assessed, treated, and either discharged home or admitted to the hospital. In seven of the ten EDs older patients had to wait for more than four hours; on most occasions waiting times ranged from six hours to 12 hours. However, in one specific hospital the 12 hour target had been breached for four elderly patients, who had been waiting in ED between 12 hours to 21 hours. In the vast majority of these cases admission was delayed as there were no admission beds available.

In order to improve ED waiting times for elderly patients, trusts have implemented a range of initiatives.

Within the Northern Trust and South Eastern Trusts, elderly care patients can be admitted directly to the elderly assessment units.

The Western Trust commissioned a team from the Greater Manchester Commissioning Support Unit to carry out a review of the trust ED services. One of the pertinent findings of this report was that frail elderly patients tended to spend a longer time within the ED. To address this issue, the patient flow team adopted a policy of positive discrimination for older patients within the ED who are waiting for a bed.

In the Southern Trust, ‘Oracle’ display monitors in the ED gave information on patient waiting times, prioritising patients with red, amber, green colours. This screen could be viewed by the hospital patient flow, and was computer linked to the head of service, lead nurses and managers off site, to allow the trust to monitor patient waiting times.

The Belfast Trust is establishing a direct assessment and admission facility (Picture 20) for frail elderly patients in the Belfast City Hospital who require assessment and treatment by a geriatrician and care of the elderly care team. The primary goal is for frail older people who may require admission to come directly to the older peoples services rather than to the EDs.

Picture 20: Optimal 7 Unit

A number of trusts have engaged in a pilot initiative with the Northern Ireland Ambulance Service (NIAS) who are providing an onsite member of staff as a trust liaison. Inspectors were informed that this is proving beneficial with pending admissions and discharge of patients.

Patient Documentation and Assessments

The care patients receive in the EDs was generally recorded on the ED patient record commonly known as a flimsy. These forms allowed for only minimal information to be recorded such as social history and next of kin details, and for the following care needs: mental state; washing and dressing; mobility; diet; and assistance required. There was no, or only limited, reference to the delivery of care, and the forms are not structured to take into account the activities of daily living. Recording details generally referenced vital signs, medication administered, toileting assistance and food or fluids.

Throughout all trusts, regional nursing plan of care booklets stipulated that a number of patient risk assessments are to be completed within six hours of admission Examples include: infection prevention and control risk assessment: falls risk assessment; moving and handling risk assessment; and pressure development risk assessment. Through a review of documentation, inspectors observed that risk assessments were not routinely completed for patients that had waited over 6 hours in EDs.

Patients were also not automatically fully assessed for all common frailty syndromes. Older people tend to present to clinicians with non-specific presentations or frailty syndromes. The reasons behind these non-specific presentations include the presence of multiple comorbidities, disability and communication barriers. The ability to recognise and interpret non-specific syndromes is key, as they are markers of poor outcomes. The documentation used by staff should cover these areas.

Patients were generally assessed for pain as part of the triage assessment. The 1-10 ruler was a commonly used tool. Some trusts use cognitive impairment pain assessment scales for patients that are unable to articulate their pain. However, some areas were unfamiliar with any recognised cognitive impairment pain assessment tools.

In one specific area a patient with dementia admitted with a possible fracture from a fall was not regularly assessed for pain or prescribed pain relief.

On most occasions, mental health assessment tools to recognise dementia and delirium, did not form part of assessment documentation. Inspectors were informed by a number of medical staff that their inclusion would be beneficial.

Many staff working within the EDs throughout trusts have not had training in managing patients with dementia although many agreed during the inspections that this would be beneficial. Many EDs have commenced introducing practical methods of alerting staff to people whose memory is permanently affected by dementia. However, it is most important that this is balanced by equipping staff with the necessary skills to manage the challenges of this condition.

Elderly patients could access a range of multidisciplinary services while in the ED. These include physiotherapy; occupational therapy; social work; falls prevention teams, and mental health specialists. Access to these services was generally available, but could be limited outside core working hours.

Information leaflets for elderly patients that offer advice on accessing local social services, healthy eating, financial benefit entitlements and staying warm were generally not available within EDs.

7.0 Conclusion and Recommendations

RQIA's series of unannounced inspections reviewed the care experienced by older people in acute hospital settings. There were many examples of good practice and initiatives that had been implemented to improve the overall care of older patients. RQIA's inspections indicate that there is still work required to improve the overall experience of older people in our acute hospitals.

Each hospital inspected received an individual report with recommendations for improvement. This report gives fourteen recommendations for improvement across Northern Ireland.

Recommendation 1:
Nurse staffing levels should be progressed in line with normative staffing ranges to ensure safe staffing levels, and a reduction on the reliance of bank and agency staff.

Ward sisters demonstrated effective management practices and leadership skills. When necessary they raised concerns about staffing levels with senior staff to advise that safety could be compromised due to inadequate staffing levels and patient dependency. In all hospitals, bank and agency staff were used to cover staff shortages, and some wards reported a heavy reliance on these staff. Inspectors were informed that there has been ongoing funding issues regarding staffing, which has impacted on the running of the wards.

Recommendation 2:
Ward sisters should be provided with protected time to undertake managerial duties.

In most, but not all hospitals, ward sisters generally had some protected time and were not included in the staffing levels. However, some ward sisters reported that although their managerial hours were recorded as manager hours, they could frequently be covering short notice leave, or when the ward was very busy.

Ward managers reported that, at times, they had difficulties in balancing the clinical and managerial role of the position, when protected time for managerial duties was insufficient or not provided.

Recommendation 3:
It is recommended that, staff appraisals and supervision and mandatory training should be kept up to date especially in relation to areas such as safeguarding vulnerable adults.

In all hospitals ward sisters discussed the difficulties in maximising staff attendance at mandatory training with balancing the clinical needs of the ward.

Mandatory training records for nursing and healthcare assistants highlighted that there were variations in attendance across the hospitals inspected. Inspectors were informed that training can be cancelled if the ward is busy. Safeguarding vulnerable adult training is part of all trusts' mandatory training programme; inspectors noted in some hospitals that attendance at this training had been poor.

In some hospitals, inspectors were informed that while staff appraisals and supervision were being carried out, this was not always up to date.

Recommendation 4:
Staff should receive additional training appropriate to the patient's needs such as delirium, dementia and challenging behavior.

At times, work pressures have limited staff ability to avail of educational opportunities, and it could be difficult for staff to access training opportunities that are outside mandatory training requirements.

Some ward sisters reported that training opportunities to fulfil the responsibilities of the post were available. However, such opportunities had to be balanced against the needs of the ward.

Nursing staff across all hospitals stated that they received training in a number of areas. The training varied dependent on what was available in each trust.

Recommendation 5:
Ward sisters should receive formal reports on incident trends

HSC Trusts use a web-based system for incident and complaint reporting. This system allows reporting, review and recording of action taken, to allow learning from the incident to be disseminated to staff. Reports can be generated for trend analysis, which were reviewed at the monthly local governance and quality meetings.

Some ward sisters reported that they receive no formal reports on incident trends from the risk and governance team.

Recommendation 6:
Further work is required by all trusts to ensure that ward environments are more suitable and supportive for older people, taking into account the issues raised in this report and individual hospital reports.

Cluttered ward environments was an issue for all trusts, in many facilities the storage areas provided for patient equipment was limited. Ward bays and sanitary facilities were not always for single gender use.

In most hospitals some steps were being taken to improve the ward or hospital environment for people with dementia or a cognitive impairment.

This can help to limit the confusion and distress which may be experienced by people with dementia or a cognitive impairment. The inspection teams concluded that there is still work to be done to make the wards more suitable and supportive for people with dementia, or a cognitive impairment.

Recommendation 7:
Trusts should regularly review and update their procedure for the use of escalation beds, taking into account the clinical needs of the patient, and their privacy and dignity.

The use of escalation beds presented a particular challenge for staff in maintaining patient dignity and privacy. Escalation beds were used within a number of trusts to increase bed capacity at times of intensified demand on their services. These beds could be located in ward corridors, beside nursing stations or placed into patient bays bringing the bed numbers above normal configured capacity.

A number of these escalation beds had no or limited bedside furnishings; staff reported that patient belongings were kept in plastic bags at the bedside. Patients did not have access to a nurse call system and there was no piped oxygen or suction at these bed spaces. Staff did inform inspectors that patients were risk assessed prior to being placed in these beds. In some wards the use of portable screens was not sufficient to maintain the privacy and dignity of patients.

Recommendation 8:
Further work is required in all trusts to improve person-centred care, and to ensure that all staff understand and demonstrate that older patients are treated with compassion, dignity and respect, and that privacy is maintained at all times.

The series of inspections demonstrated that the majority of staff were courteous and respectful to patients and visitors, and generally patients' privacy and dignity was maintained. Improvement was required by some staff. In some wards, the patient call systems needed to be replaced, and not all call bells were within patients reach, or answered promptly. In all wards, patient personal care was generally of a high standard. On most occasions privacy curtains were used effectively, occasional lapses in privacy were observed.

Most hospitals had introduced intentional care rounding, or a similar system. This is when staff check on individual patients at defined regular intervals to anticipate any care needs they may have, for example, pain relief or needing the toilet. However, inspectors found that these were not always fully or consistently completed.

Recommendation 9:
Protected meal times should be respected and the serving of meals improved to ensure patients are supported to eat and receive the appropriate nourishment.

Inspectors found that in most hospitals protected mealtimes had been introduced. This aims to reduce non-essential interruptions during meal times, however, inspectors observed variations in practice across the hospitals inspected. There were many times inspectors observed patients being helped or encouraged to eat and drink in a caring and attentive manner, where meals were provided in a relaxed environment.

At times the serving of meals appeared to be poorly organised, which on occasion resulted in patients who needed help to eat and drink having to wait for a long time before that help was provided.

Recommendation 10:
Regional fluid balance and prescription charts should be consistently and accurately completed in line with regionally agreed protocols.

Most trusts had implemented the new regional fluid balance and prescription charts. These charts reflect the range of developments in fluid therapy and the regional approach supports safe and effective practice across Northern Ireland. It was therefore of concern that inspectors observed that a large number of fluid balance and food intake charts were inadequately and inaccurately completed.

Recommendation 11:
It is recommended that if de facto detention is used, local detailed procedures are put in place.

Inspectors noted that on a small number of occasions patients, relatives or visitors were not able to exit wards without asking staff to trigger the exit doors to open. This practice is classed as 'de-facto detention' which includes any situation where an individual is not formally detained but may nevertheless be deprived of liberty. While RQIA recognise the difficulties in balancing patient safety and security and individual patient rights, trusts need to ensure that appropriate controls are initiated and local detailed procedures put in place.

Recommendation 12:
There should be a regional approach taken to improving the recording of patient care in line with regional and professional guidelines.

Inspectors found similar inconsistencies in recording. The patient care records did not evidence that nurses demonstrated by their recording that they had adequately carried out assessment, planning, evaluation and monitoring of the patient's needs. Nurse record keeping did not always adhere to NMC and NIPEC guidelines. Care records examined frequently failed to demonstrate that safe and effective care was being delivered.

Do not attempt cardiopulmonary resuscitation (DNACPR) relates to the emergency treatment given when a patient's heart stops or they stop breathing. In three hospitals, RQIA found examples when clinical staff were not always complying with the national DNACPR policy, and were not completing the appropriate documentation correctly. This has the potential impact on a patient's specific wishes about resuscitation.

Recommendation 13:
Trusts need to ensure that verbal and nonverbal communication with patients is improved and confidentiality respected.

On most occasions inspectors and lay assessors observed that staff treated older people with compassion, dignity and respect. The inspection teams saw many examples of warm, caring interactions between staff and patients. Feedback from interviews with patients and from the questionnaires indicated that patients were mostly satisfied with the care they were receiving. There were some instances where staff did not use the appropriate language, and when patient confidentiality was not always fully respected. Staff interaction with patients is a vital element of their overall care, which can improve a sense of wellbeing and overall perception and satisfaction with the care received.

Recommendation 14:
Regionally more work is required in all emergency departments to improve recording of patient care, and in identifying and managing frailty and cognitive impairment.

In ED more work is required to ensure that patients have the appropriate assessments undertaken, particularly if they are waiting in ED for over six hours.

Inspectors found that risk assessments were not routinely completed and older patients were not automatically screened for common frailty syndromes or cognitive impairment. On most occasions, mental health assessment tools did not form part of assessment documentation; many ED nursing staff have not had training in managing patients with dementia. Access to multidisciplinary services was generally available; but could be limited outside core working hours.

Significant work has already been carried out across Northern Ireland to improve the care of older patients in acute hospitals. A key message is that all staff have their part to play to take forward these recommendations and ensure that these improvements are sustained in the future.

Appendix 1 QUIS Coding Categories
The coding categories for observation on general acute wards are:

Examples include:

Positive social (PS) – care over and beyond the basic physical care task demonstrating patient centred empathy, support, explanation, socialisation etc.	**Basic Care: (BC) –** basic physical care e.g. bathing or use if toilet etc with task carried out adequately but without the elements of social psychological support as above. It is the conversation necessary to get the task done.
• Staff actively engage with people e.g. what sort of night did you have, how do you feel this morning etc (even if the person is unable to respond verbally) • Checking with people to see how they are and if they need anything • Encouragement and comfort during care tasks (moving and handling, walking, bathing etc) that is more than necessary to carry out a task • Offering choice and actively seeking engagement and participation with patients • Explanations and offering information are tailored to the individual, the language used easy to understand ,and non-verbal used were appropriate • Smiling, laughing together, personal touch and empathy • Offering more food/ asking if finished, going the extra mile • Taking an interest in the older patient as a person, rather than just another admission • Staff treat people with respect addressing older patients and visitors respectfully, providing timely assistance and giving an explanation if unable to do something right away Staff respect older people's privacy and dignity by speaking quietly with older people about private matters and by not talking about an individual's care in front of others	**Examples include:** Brief verbal explanations and encouragement, but only that the necessary to carry out the task No general conversation

• Staff use of curtains or screens appropriately and check before entering a screened area and personal care is carried out with discretion	

Neutral (N) – brief indifferent interactions not meeting the definitions of other categories.	**Negative (N) –** communication which is disregarding of the residents' dignity and respect.
Examples include: • Putting plate down without verbal or non-verbal contact • Undirected greeting or comments to the room in general • Makes someone feel ill at ease and uncomfortable • Lacks caring or empathy but not necessarily overtly rude • Completion of care tasks such as checking readings, filling in charts without any verbal or non-verbal contact • Telling someone what is going to happen without offering choice or the opportunity to ask questions. • Not showing interest in what the patient or visitor is saying.	**Examples include:** • Ignoring, undermining, use of childlike language, talking over an older person during conversations. • Being told to wait for attention without explanation or comfort • Told to do something without discussion, explanation or help offered • Being told can't have something without good reason/ explanation • Treating an older person in a childlike or disapproving way • Not allowing an older person to use their abilities or make choices (even if said with 'kindness'). • Seeking choice but then ignoring or over ruling it. • Being angry with or scolding older patients. • Being rude and unfriendly • Bedside hand over not including the patient

Events

You may observe event or as important omissions of care which are critical to quality of patients care but which do not necessarily involve a 'direct interaction'. For example a nurse may complete a wash without talking or engaging with a patient (in silence).

Appendix 2 Patient Overview Responses 2013/14

Patient Experience questions	Always	Often	Sometimes	Not at all	Don't Know/ Not relevant	Skipped question	Answered question
I have been given clear information about my condition and treatment	68.9%	11.8%	8.4%	6.7%	4.2%		
Number of responses	82	14	10	8	5	5	119
I always have access to a buzzer	83.6%	2.5%	4.1%	7.4%	2.5%		
Number of responses	102	3	5	9	3	2	122
When I use the buzzer staff come and help me immediately	58.3%	13.3%	8.3%	2.5%	17.5%		
Number of responses	70	16	10	3	21	4	120
When other patients use the buzzer staff come and help them	45.5%	10.7%	6.3%	0.9%	36.6%		
Number of responses	51	12	7	1	41	12	112
I am able to get pain relief when I need it	65.5%	7.8%	2.6%	0.9%	23.3%		
Number of responses	76	9	3	1	27	8	116
I am able to get medicine if I feel sick	55.2%	7.8%	1.7%	2.6%	32.8%		
Number of responses	64	9	2	3	38	8	116
I get help with washing, dressing and toileting whenever I need it	72.3%	3.4%	1.7%	0.8%	21.8%		
Number of responses	86	4	2	1	26	5	119
Staff help me to carry out other personal care needs if I want them to	81.9%	1.7%	1.7%	0.9%	13.8%		
Number of responses	95	2	2	1	16	8	116
If I need help to go to the toilet, staff give me a choice about the method I use e.g. toilet, commode, bedpan	68.1%	4.4%	0.9%	0.9%	25.7%		
Number of responses	77	5	1	1	29	11	113
Staff are aware of the help I need when eating and drinking	40.7%	6.2%	2.7%	0.9%	49.6%		

Number of responses	46	7	3	1	56	11	113
I enjoy the food I am given on the ward	56.9%	18.1 %	15.5%	6.0%	3.4%		
Number of responses	66	21	18	7	4	8	116
Staff always respond quickly if I need help	80.9%	8.7%	3.5%	1.7%	5.2%		
Number of responses	93	10	4	2	6	9	115
The quality of care I receive is good	88.3%	11.7 %	0.0%	0.0%	0.0%		
Number of responses	106	14	0	0	0	4	120
The ward is clean and tidy and everything on the ward seems to be in good working order	90.9%	8.3%	0.8%	0.0%	0.0%		
Number of responses	110	10	1	0	0	3	121
Staff will give me time to do the things I need to do without rushing me	90.7%	5.9%	1.7%	0.0%	1.7%		
Number of responses	107	7	2	0	2	6	118
I feel safe as a patient on this ward	90.4%	8.7%	0.0%	0.0%	0.9%		
Number of responses	104	10	0	0	1	9	115
Are you involved in your care and treatment	67.6%	13.9 %	8.3%	6.5%	3.7%		
Number of responses	73	15	9	7	4	16	108
Staff have talked to me about my medical condition and helped me to understand it and why I was admitted to the ward	68.7%	16.5 %	5.2%	7.8%	1.7%		
Number of responses	79	19	6	9	2	9	115
Staff explain treatment so I can understand	77.7%	11.6 %	2.7%	7.1%	0.9%		

Number of responses	87	13	3	8	1	12	112
Staff listen to my views about care	68.5%	18.9 %	5.4%	2.7%	4.5%		
Number of responses	76	21	6	3	5	13	111
I can always talk to a doctor if I want to	73.5%	12.4 %	9.7%	2.7%	1.8%		
Number of responses	83	14	11	3	2	11	113
I feel I am involved in my care	74.5%	11.3 %	6.6%	3.8%	3.8%		
Number of responses	79	12	7	4	4	18	106
Staff have discussed with me about when I can expect to leave the leave hospital	49.0%	9.8%	5.9%	23.5%	11.8%		
Number of responses	50	10	6	24	12	22	102
Staff have talked to me about what will happen to me when I leave hospital	42.3%	11.3 %	6.2%	20.6%	19.6%		
Number of responses	41	11	6	20	19	27	97
Staff always introduce themselves	76.9%	12.0 %	8.5%	1.7%	0.9%		
Number of responses	90	14	10	2	1	7	117
Staff are always polite to me	91.5%	8.5%	0.0%	0.0%	0.0%		
Number of responses	107	10	0	0	0	7	117
Staff will not try to rush me during meal times	80.9%	7.0%	0.0%	8.7%	3.5%		
Number of responses	93	8	0	10	4	9	115
Staff never speak sharply to me	81.2%	2.6%	1.7%	13.7%	0.9%		
Number of responses	95	3	2	16	1	7	117
Staff call me by my preferred name	90.6%	4.3%	1.7%	0.9%	2.6%		
Number of responses	106	5	2	1	3	7	117
Staff treat me and my belongings with respect	89.1%	8.4%	0.8%	0.0%	1.7%		
Number of responses	106	10	1	0	2	5	119
Staff check on me regularly to see if I need	78.0%	14.4 %	4.2%	1.7%	1.7%		

anything							
Number of responses	92	17	5	2	2	6	118
My visitors are made welcome	95.7%	2.6%	0.9%	0.0%	0.9%		
Number of responses	112	3	1	0	1	7	117

Appendix 3 Relative Survey Overview responses 2013/14

Relative Experience questions	Always	Often	Sometimes	Not at all	Don't Know/ Not relevant	Skipped question	Answered question
Staff take time to get to know my relative/friend	48.9%	28.1%	16.3%	2.2%	4.4%		
Number of responses	66	38	22	3	6	8	135
Staff always have enough time to give care and treatment	51.4%	21.7%	21.0%	1.4%	4.3%		
Number of responses	71	30	29	2	6	5	138
Staff are knowledgeable about the care and treatment they are providing	69.3%	22.6%	4.4%	0.0%	3.6%		
Number of responses	95	31	6	0	5	6	137
The ward is a happy and welcoming place	58.5%	23.0%	13.3%	3.0%	2.2%		
Number of responses	79	31	18	4	3	8	135
I am confident that my relative/ the patient is receiving good care and treatment on the ward.	71.7%	16.7%	8.7%	1.4%	1.4%		
Number of responses	99	23	12	2	2	5	138
Staff never speak sharply to me or my relative/friend	40.6%	8.3%	7.5%	38.3%	5.3%		
Number of responses	54	11	10	51	7	10	133
Staff include me in discussions about my relative/friend's care	55.1%	17.6%	13.2%	11.0%	2.9%		
Number of responses	75	24	18	15	4	7	136
Staff treat my relative/friend with dignity and respect	75.2%	14.9%	3.5%	2.8%	3.5%		
Number of responses	106	21	5	4	5	2	141

Questions	Always	Often	Sometimes	Not at all	Don't Know/ Not relevant	Skipped question	Answered question
Staff provide me with sufficient information when I need it/ask for it	68.3%	16.9%	9.2%	1.4%	4.2%		
Number of responses	97	24	13	2	6	1	142
Staff make me feel welcome on the ward	72.3%	16.8%	6.6%	1.5%	2.9%		
Number of responses	99	23	9	2	4	6	137
I feel confident to express my views on how my relative is being cared for	70.8%	15.3%	8.8%	2.2%	2.9%		
Number of responses	97	21	12	3	4	6	137
Staff ask me about my relative/friend's needs or wishes	44.0%	20.9%	13.4%	17.9%	3.7%		
Number of responses	59	28	18	24	5	9	134
When I give information about my relative, it is acknowledged and recorded so I do not have to repeat myself.	49.3%	16.7%	15.2%	7.2%	11.6%		
Number of responses	68	23	21	10	16	5	138
I know who to speak to about my relative/friend's care	60.0%	14.8%	15.6%	6.7%	3.0%		
Number of responses	81	20	21	9	4	8	135
I can speak to a doctor when I want to	35.1%	16.4%	31.3%	6.0%	11.2%		
Number of responses	47	22	42	8	15	9	134
If I chose to be, I am informed if/when my relatives/the patient's condition changes	59.7%	15.7%	7.5%	6.7%	10.4%		
Number of responses	80	21	10	9	14	9	134
If my relative wants me to, I have been fully involved in the discharge planning for when my relative leaves hospital	53.2%	8.9%	4.0%	5.6%	28.2%		
Number of responses	66	11	5	7	35	19	124

Staff listen to my views about my relative/friend's care	63.7%	15.6%	8.9%	0.7%	11.1%		
Number of responses	86	21	12	1	15	8	135

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