The Regulation and Quality Improvement Authority

Regulation and Quality Improvement Authority

The Care of Older People in Acute Hospitals

Unannounced inspection

Ulster Hospital

South Eastern Health and Social Care Trust

24 & 25 February 2014

informing and improving health and social care
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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 inspection was carried out by a team of RQIA inspectors as part of a programme of inspections to inform the RQIA thematic review of the care of older people in acute hospitals. This review was identified and scheduled within the RQIA three year review programme for 2012 to 2015.

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Contents

1.0 Inspection Summary

An unannounced inspection to the Ulster Hospital, South Eastern Health and Social Care Trust (SEHSCT) was undertaken, on 24 and 25 February 2014. The inspection reviewed aspects of the care received by older people in the acute hospital setting within the terms of reference of the review to provide a report of current practice, the following areas were inspected:

- Emergency Department (ED)
- Ward 15 - Medical Admissions Unit (MAU)
- Ward 9 - Respiratory and General Medical
- Ward 18 – Orthopaedic and Trauma
- Ward 23 - Stroke

The inspection team contacted the Patient Flow Coordinator on arrival to obtain information on the number of older people waiting for over six hours in the ED. The inspection team visited the ED as a number of care interventions should commence within in this timeframe.

Inspectors gathered evidence by reviewing relevant documentation, carrying out observations and speaking to staff and patients. 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.

The process was designed to provide a snapshot of what is happening during the inspection in a particular ward or clinical area and 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.

Inspectors felt that ward sisters had demonstrated effective management however had raised concerns with trust senior staff advising that safety could be compromised due to inadequate staffing levels and patient dependency. Ward sisters reported difficulties in balancing their clinical and managerial roles and responsibilities and ensuring staff received appropriate training. The trust has implemented various initiatives to improve patient care and training in customer care is to be commended.

In general all wards were clean and bright. Ward 23, located in a refurbished building was generally clutter free. In contrast, in other wards, the main ward corridor, nurses' station and utility corridors were cluttered and at times congested with equipment. The fabric of the environment in MAU presented was old and tired, with paint and plaster damage throughout.

Although patient bay areas were spatially constrained, staff tried to keep them clean, tidy and free from hazards. However at times, equipment needed at the bed space resulted in a cluttered environment. In some wards sanitary facilities, including bathrooms and showers needed repair.

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**.** Most patient call systems (buzzers) were easily accessible, in Wards 9 and 18, some were out of reach and hanging behind the bed. Call bells were generally answered promptly by staff however in Ward 23, response time varied. In Ward 9, the light diffuser was missing from the call system outside a bay.

Patient personal care was generally of a high standard, although staff needed to ensure that stained clothing was changed. Patients were assisted to the toilet as required, hand hygiene was offered to patients at the bedside after toileting and personal mobility aids were within easy reach. Staff used good communication skills when talking to patients. More attention was needed for those patients with communication difficulties who required aids and pictorial triggers.

Protected meal times were in place although not always adhered to. There was a good variety of meals and these were warm and generally appeared appetising. With the exception of Ward 23, there was enough staff to assist patients with their meals, at lunch time, inspectors observed that there were varying systems in place to identify patients who required assistance with their meal, at times these systems did not appropriately identify patients who needed help. Patients were generally offered hand hygiene before meals and napkins were supplied. The use of plastic cups, flimsy food containers and food wrapped in cling film could pose difficult to open for patients with dexterity or visual problems.

Inspectors observed that in some instances hand hygiene and the use of personal protective equipment could be improved. On two occasions staff did not comply with the trust's administration of medication policy.

RQIA inspectors reviewed 13 patient care records in depth and 23 patient bedside charts were examined. Inspectors found similar inconsistencies in recording in each set of records. None of the care records reviewed 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. Nurse record keeping did not always adhere to NMC and Northern Ireland Practice and Education Council (NIPEC) guidelines. The care records examined failed to demonstrate that safe and effective care was being delivered.

Inspectors and lay reviewers undertook a number of periods of observation in all wards to review patient and staff interactions. The results of these periods of observation indicated that 75 per cent of the interactions were positive and staff demonstrated empathy, support, and provided appropriate explanation where required. The results indicated that a small number of staff did not always speak with patients appropriately, dignity and respect was not evident in these interactions. Inspectors advised ward sisters of any issues they observed.

During the inspection 23 patients and relatives/carers questionnaires and 14 patient interviews were completed. Generally feedback received from patients and relatives or carers was positive. Overall they thought that staff were 'very good' and had a positive experience while in hospital. Areas where patients and relatives felt there could be an improvement related to:

- communication between staff and the patient/carers in relation to involvement in care
- knowing who to speak to when issues with care arise
- acknowledgement of information given to be reflected in care
- not always being able to speak to a doctor
- more information leaflets to be distributed
- rest facilities for relatives could be better

Patients felt that overall meals were good, with a variety of choice. Visiting hours were suitable.

Inspectors visited the ED three times on the first day of the inspection and once on the second day. There has been significant work undertaken by the trust to work to comply with departmental targets for waiting times in ED. More work required to ensure that patients have the appropriate assessments undertaken, particularly if they are waiting for over six hours.

This report has been prepared to describe the findings of the inspection and to set out recommendations for improvement. The report includes a quality improvement plan, submitted by the South Eastern Health and Social Care Trust in response to RQIA's recommendations.

2.0 Introduction

2.1 Background and Methodology

RQIA carries out a public consultation exercise to source and prioritise potential review topics, prior to developing a planned programme of thematic reviews. Through the use of this tool, a need to review the care of older people in acute hospital wards was identified as part of the 2012-2015 Review Programme.

This review was designed to assess the care of older people in acute hospital wards in 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]

Older people admitted to acute hospitals may have multiple and complex physical and mental health needs, with the added challenge in many instances 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 this challenge in isolation. Implementation of improved care for older people requires a whole system approach to ensure that safe, efficient, effective and a high quality holistic care for frail older people is delivered. Staff need to develop their understanding and confidence in managing common frailty syndromes, such as confusion, falls and polypharmacy as well as issues such as safeguarding in older people.

Inspection tools used are 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 have been 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

More detailed information in relation to each of these tools can be found in the RQIA overview report in the care of older people on acute hospital wards[2].

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

[2] RQIA Review of Care of Older People in Acute Hospital Wards: Overview report. (2.0 Background.p7) 2014

2.2 Terms of reference

The terms of reference for this review are:

1. To undertake a series of unannounced inspections of care of older people in acute hospitals, in each of the 5 hospital 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 one overview report.

3.0 Inspection Format

The agreed format the inspection was that inspections would be unannounced. Hospitals were categorised dependent upon the number of beds and specialist areas. The number of inspections and areas to be inspected would be proportionate to the type of services provided and the size of the hospital.

The inspection team would visit a number of wards and the emergency department. The Patient Flow Coordinator would be contacted on arrival and where necessary during the day, to obtain information on the number of older people waiting for over six hours in the Emergency Departments.

The review team would consist of inspectors drawn from RQIA staff who have relevant experience. The team would also include lay assessors.

It is anticipated that the unannounced inspections would take two days to complete.

3.1 Unannounced inspection process (Flowchart Appendix 1)

Organisations received an email and telephone call by a nominated person from RQIA 30 minutes prior to the team arriving on site. For this review the unannounced inspections were generally be within 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 generally met by a trust representative to discuss the process and to arrange any special requirements. If this was not possible the inspection team left details of the areas to be inspected at the reception desk.

The unannounced inspection was undertaken using the inspection tools outlined in section 2.1.

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.

The inspection included taking digital photographs of the environment and equipment for reporting purposes and primarily as evidence of assessments made. No photographs of staff, patients or visitors were taken in line with the RQIA policy on the" Use and Storage of Digital Images".

The second day the inspection concluded with a feedback session to outline key findings, the process for the report and action plan development.

3.2 Reports

An overview report on the care of older people on acute hospital wards in Northern Ireland will be produced and made available to the public on the RQIA website.

In addition, individual reports for each hospital inspected will be produced and published on the RQIA website. The reports will outline the findings in relation each individual hospital and highlight any recommendations for service improvement.

The hospital will receive the draft report for factual accuracy. The Quality Improvement Plan attached to the report will highlight recommendations. The organisation will be asked to review the factual accuracy of the draft report and return the signed Quality Improvement Plan to the RQIA within 14 days of receiving the draft report.

Organisations should, after the feedback session, commence work on the findings of the inspection. This should be formalised on receipt of the inspection report.

Prior to publication of the reports, in line with the RQIA core activity of influencing policy, RQIA may formally advise the DHSSPS, HSC Board and the Public Health Agency (PHA) of emerging evidence which may have implications for best practice.

3.3 Escalation

During inspection it may be necessary for RQIA to implement its escalation policy

4.0 Inspection Team Findings

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

- Emergency Department Ward governance
- Ward observation
- Care records
- Patient/Relative /Carer Interviews and Questionnaires:
- QUIS Observation Sessions

4.1 Ward Governance

Inspectors reviewed the ward governance using the inspection tool developed. The areas reviewed related to, nurse staffing levels and training; patient advocacy; how incidents, serious adverse incidents and complaints are recorded and managed. Some records were also reviewed such as; quality indicators, audits; and relevant policies and procedures.

Inspectors' assessment

Staffing: Nursing

Inspectors were informed by trust representatives that the trust has reviewed staffing levels and carried out a baseline evaluation of the present staffing levels.

As part of the inspection the staffing complement for each ward was reviewed.

Ward 15, Medical Assessment Unit (MAU)

The MAU is a busy 40 bedded medical assessment unit. The unit is divided into two sides, with staff allocated to either side. For continuity of care, the ward sister tries to maintain the same staff on each side of the ward. Inspectors noted that the ward generally has a quick patient turnaround and continually receives admissions from the ED and transfers patients onwards to specialised care wards. This is a 24 hour occurrence. On the second day of inspection the ward had four overnight admissions.

Daily staffing levels for the unit were 10 registered nurses (RNs) and two healthcare assistants (HCAs). On day one of inspection there were; 12 RNs including the ward sister and two HCAs. On day two there were 10 RNs, two student nurses and two HCAs. Student nurses are supernumerary. The ratio of nursing was reviewed and identified that there should be 80:20, RN: HCA split. Staff advised inspectors that this was not achieved and was usually a ratio of 70:30.

Ward 23 Stroke

Ward 23 is a 20 bedded ward for patients with a stroke. Sister advised that staffing levels are higher than in other Care of the Elderly Wards as a bed is always kept for patients requiring lysis. One member of staff can be called to the ED at any time for a lysis patient. There were four RNs, three HCAs and a student nurse in the morning on both days of the inspection, at night there were three RNs and one HCA. Staff advised that staffing at night was normally two RNs and two HCAs.

Ward 18, Orthopaedic and Trauma

Ward 18 is a 20 bedded ward. At the time of inspection there were two medical outliers being cared for in the ward. Inspectors were advised that there were two vacant full time RN posts and there had been a high reliance on bank staff over the last year due to staff turnover. Optimal staffing would have been seven staff for the morning shift; six for the afternoon shift; five for the evening and four for night duty. A minimum of three RNs were to cover each shift however night duty was usually 2:2 RN: HCA ratio. The clinical service manager was supportive in the provision of extra staff for 1:1 nursing for patients with challenging behaviour.

There has been a transitional period for staff in Ward 18. A newly appointed Band 7 came into post and six experienced staff nurses left the ward; replaced with relatively inexperienced staff. Staff reported this had caused ward tensions and subsequently a teamwork workshop was held to discuss staffing and ward issues. Over the two days of inspection, there appeared to be a strong ethos of teamwork among staff members.

Ward 9 Acute Respiratory and General Medical

Ward 9 is a 20 bedded ward. An additional corridor bed is located in the day room bringing the total ward capacity to 21 beds. On the first day of the inspection, Ward 9 was short staffed by one RN. Planned staffing up to 5.00pm was four RNs and two HCAs; evening cover was three RNs and one HCA. There were two RNs and two HCAs on night duty. The night duty cover had been recently increased due to the workload and increased observation required for patients nursed on the ward receiving ‘NIPPV’ ventilation.

General Staffing Issues

All wards could access bank or agency staff for 1:1 nurse to patient observation and when staffing levels fell. In the MAU, there was a higher use of bank staff due to staffing vacancies, sister had block booked bank staff. In Ward 23, management was supportive with requests for extra staff however 1:1 staffing had to be reviewed and booked every 24 hours rather than block booked.

1. **It is recommended that any identified nurse staffing variances are reviewed to ensure that patient care and safety is not compromised due to staffing levels.**

In all wards, staff reported that beds were never closed when wards were short staffed. Ward sisters generally had protected time to carry out their managerial duties and were not included in the staffing levels. However, the ward manager in Ward 9 reported that although her managerial hours were recorded as 'manager hours' and were supernumerary, at busy times she worked as a fifth RN or covered staff vacancy as a result of short notice leave.

2. **It is recommended that ward sisters should have protected time. This is to ensure that there is a balance between clinical and managerial roles and responsibilities.**

Policies, Procedures and Audits

In all wards, the ward sister or deputy was able to provide hard copies or demonstrated intranet site access to policies and procedures. The trust policy/guidance on nutrition or weight loss management was not located in Ward 23.

3. **It is recommended that the trust should ensure all policies/guidance are available to staff.**

Ward sisters and deputies confirmed that audits were carried out and action plans developed. In Ward 18 the ward sisters' assistant conducted audits. This practice is carried out between four surgical wards, allowing ward sisters time to concentrate on nursing and managerial duties. Results were discussed with staff as part of the safety briefing process or at staff meetings. Ward 23 holds a communication book to inform staff of changes in policy/ audit/incidents however a record was not maintained of staff who read this information.

Training

All ward sisters and deputies advised that mandatory training was on-going. Staff booked themselves onto training; attendance could be cancelled due to ward pressures. Staff non-attendance at face to face training is flagged up on the training and administration system (TAS) and followed up by the ward sister.

The ward sister in the MAU confirmed there was no system in place to capture non-attendance at online mandatory training. In the MAU, band 6 nurses have been allocated staff to supervise and manage training issues. The medical clinical coordinator would be emailed quarterly on training figures. There has been recent training for senior nursing staff on navigating the HR, Payroll, Travel and Subsistence (HRPTS) portal which will allow senior nurses to check staff training records. It was hoped the system will roll out in April 2014.

The ward sisters' assistant in Ward 18 has devised a training excel spreadsheet. This demonstrated gaps in the uptake of face to face and online mandatory training. In Ward 9, an over view of completed staff training and planned training was in place and was easily read and accessible. In addition, each staff member had an individual training file.

Ward sisters and deputies have protected time for educational training. Training opportunities were available and taken however had to be balanced against the ward needs to meet the responsibilities of the role.

Inspectors were advised that vulnerable adult training was part of the trust's mandatory training programme. All staff in Ward 23 and 18 had attended training, the Band 6s and 7 in the MAU still needed to attend. In all wards not all staff had received training on dementia care.

4. **It is recommended that mandatory training should be kept up to date and staff should receive training appropriate to the patient's needs.**

Inspectors were informed that in Wards 9, 18 and 23; staff appraisals were generally up to date, however participation in supervision needed improvement. In contrast, appraisals in the MAU were low; participation in supervision was generally good. In the MAU, individual and group supervision were offered to staff. Supervision could be part of the ward meetings which the ward sister confirmed would be recorded. The trust has introduced a new electronic software system, 'quick view', which is used to capture supervision rates.

5. **It is recommended that staff supervision and appraisal should be carried out and up to date.**

Management of SAIs, incidents, near misses and Complaints

Incidents were documented on IR1 forms; a copy is forwarded to the risk management/governance team. In Wards 18 and 23, the Band 6 RNs were unaware if incident data analysis trends were returned to the ward. In Ward 18 information on incidents and action plans were shared at staff meetings, a communication book was used to inform staff in Ward 23.

Staff in the MAU and Ward 9 confirmed that incident data, forwarded from the governance team, was discussed at staff meetings and safety briefings. The ward manager in Ward 9 showed an example of a complaint received. The documentation included the investigation, outcomes, learning identified and a staff meeting to discuss the process and learning, this is commendable.

6. **It is recommended that all ward sisters should be aware of trust and ward incident data trends.**

Trust complaints were submitted, audited monthly and the results correlated by the governance department. Evidence was available to show discussion with ward staff on complaints as part of ward meetings, safety briefings or documented in the communication book in Ward 23. Inspectors were advised that while the governance department gives good feedback on serious adverse incidents, this does not always occur for lesser complaints.

Meetings

Multi-disciplinary team (MDT) meetings were held daily in Ward 9, twice weekly in Ward 18 and weekly in the MAU and Ward 23. Patient and relative meetings with the consultant were facilitated in Ward 9. In the MAU, consultants cover at weekends and carry out ward rounds. All wards had ward meetings and safety briefings for cascading information to staff. There were no records of staff meetings in Ward 23 since August 2012.

The trust has a monthly ward sister meeting/forum to discuss trust and ward issues that impact on service delivery. This forum is also used for share learning and to cascade information to staff.

Ward 23 held a monthly MDT teaching session where each discipline rotated presenting. This is a good example of multi-disciplinary team work. Due to the diverse range of patients with complex needs, staff in the MAU link closely with other wards and allied health professionals to facilitate care and specific patient needs, for example stroke care. Geriatric and psychiatric liaison was accessible for all wards**.**

Projects/ Improvements

The Butterfly scheme has recently been introduced to Ward 23; there were two dementia champions. The trust intends to roll out the scheme in other wards. None of the wards have had a physical environmental audit carried out for dementia patients. There has been improved signage in bays and sanitary areas however the MAU did not have any pictorial signs to aid patients. Inspectors were informed that while a specific project was not carried out throughout the trust on patient dignity, this is emphasised on all wards.

7. **It is recommended that all wards have a physical ward environmental audit carried out for dementia patients.**

In the MAU, an electronic care record (ECR) screen was mounted in sister's office. When the system is fully in place, it will identify by using symbols, patient's infection status, falls risk, feeding assessment and dementia. The ward had its own geriatrician. The psychiatric liaison nurse frequently visited to assess patients and has trained staff to complete the Alcohol Use Disorders Identification Test. After the ward round, a daily risk assessment was completed to identify the right patient for the right area/bed.

A Critical Medication cupboard with emergency medication is located in the MAU. This is for out of hours use for the whole hospital; ward staff advised that other wards felt this was a good initiative. Some new initiatives were to commence in the MAU; trialling an 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 rounds, to facilitate multi-disciplinary team work were also to be introduced.

A number of notice boards in Ward 9 displayed information for staff, patients and visitors regarding hospital services, various respiratory conditions and other illnesses. The ward sister was the lead nurse in the right patient getting to the right bed project.

Approximately five years ago, Ward 18 commenced the "Productive Ward "-Releasing Time to Care initiative. A positive result of this initiative was increasing the time available for staff to spend directly caring for patients. This ethos remains firmly imbedded in current ward practices. New core care plans had been introduced, to promote easier review and updating. The ward has implemented new and improved ward decontamination and cleaning schedules and introduced a snack menu for patients with poor appetite.

ECR was already in place in Ward 23. There was a traffic light discharge guide displaying the stages of discharge and the intervention required by staff. New ward patient/family information packs have been introduced and the ward plans to develop a stroke continence tool. The band 6 and 7 nurses had commenced development of a nurse led stroke ward round. This would address issues such as the malnutrition universal screening tool (MUST), Braden scores, skin integrity, self-retaining urinary catheters, family input and updates.

Quality Indicators

There is more focus than ever 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, use of indicators can help to minimise the risk of a patient getting pressure ulcers or suffering a fall, it can help to reduce the chance of spreading healthcare associated infections, or help a patient to recover more quickly. Measurement can also help inform patients about their own progress, and provide the wider public with information about the impact of nursing care.

The trust has introduced a range of the 26 national Nursing Quality Indicators (NQIs) to include; falls prevention, nutrition, pressure ulcer care, record keeping, national early warning scores, complaints and incident reporting, infection control care bundles. Inspectors noted that all wards were working hard to implement these indicators.

Results of audits from the NQIs were logged onto the trust's new software system, Safety and Quality Experience data. Staff have reported some teething problems with the system and accessing audits. At the feedback,

trust representatives confirmed that the system would be able to facilitate a retrospective review of ward scores and trends analysis which staff could access. If compliance was low an action plan was developed and the frequency of audit increased. Results were circulated to staff either by posting on the ward notice board, discussion at staff meetings or via safety briefings.

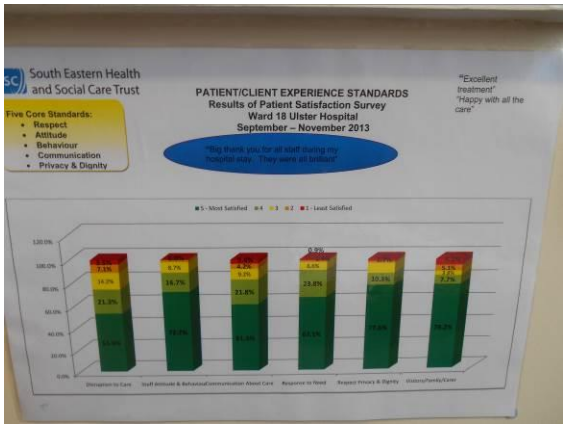
Inspectors were informed that these indicators were subject to continuous review to ensure that measurements of quality of nursing care are robust and in line with regional and national standards.

Staff reported that ward trends were generally satisfactory however inspectors identified in some wards that record keeping and completion of care records, assessment and care planning of need, were areas that required attention.

8. **It is recommended that the trust should continue to introduce and monitor the nursing quality indicators (NQIs), with particular attention given to record keeping.**

Patient Client Experience and Customer Care

The trust carries out an annual "ward experience in-patient satisfaction survey", some wards had yet to receive feedback on the 2013 results. The survey reviews general 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 1).



Picture 1 Patient/ Client Experience Standard Results September/ November 2013

In September/October 2013, the MAU and ED participated in a survey 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 patients were asked to give consent; feedback was positive.

The trust was also participating in the recently launched Public Health Agency (PHA) "10,000 voices" project. [3]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.

The PHA would like patients, families and carers to share their experiences of healthcare and how it has impacted on their lives. They will collect 10,000 stories to inform the commissioning process, enabling the delivery of better outcomes and better value for money in how services are delivered. This will be carried out using a phased approach beginning with unscheduled care.

The ward sister in the MAU confirmed that the trust undertakes customer care training for staff on induction with routine updates. All staff in Ward 23 were trained in 2012, two out of thirty staff were trained in Ward 9.

A range of advocacy services was available in the hospital. In the MAU, the social worker and alcohol liaison nurse could advocate on behalf of the patient. In Ward 18, the social worker acted as a protagonist link for patient advocacy and could network with other services if required. Ward 23 used external groups such as Chest, Heart and Stroke and the Stroke Coordinator would offer support, advice and guidance.

Overall Summary

Overall the inspectors felt that the ward sisters had demonstrated effective management and had raised concerns with trust senior staff advising that safety can be compromised due to staffing levels and patient dependency. However, there were difficulties in balancing their clinical and managerial roles and responsibilities and ensuring staff received the appropriate training. The trust has implemented various initiatives to improve patient care which is to be commended.

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

4.2 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 feeds into 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.

Inspectors' assessment

Ward Environment

In general all wards were clean and bright. Ward 23, located in a refurbished building was generally clutter free. The patient environment was well maintained, fresh smelling and generally clutter free. There was a good sized equipment store. In contrast, in the wards in the main hospital building, the ward corridor and utility corridors were cluttered with equipment such as medicine, phlebotomy, resuscitation and drugs trolleys, computers on wheels (COWS) and transport cages. At meal times, the food trolley added to the cluttered environment.

The fabric of the environment in MAU was old and tired, with paint and plaster damage throughout, notably in the side rooms. A linen trolley blocked access to a fire exit and the day room, which had mail box cabinets to store supplies, was also used as a discharge area.

Although in all wards patient bay areas were spatially constrained, staff tried to keep them clean, tidy and free from any hazards. However at times equipment required at the bed space resulted in a cluttered environment. Wards were busy but calm with welcoming staff. Ward 23 has two single rooms with en-suite facilities which can be used for isolation precautions. The MAU and Wards 9 and 18 have single rooms with hand washing facilities. Some have an en-suite toilet; none have an en-suite shower.

In the MAU and Wards 9 and 18, the clinical work surface was located at the nurses' station. This area could become congested with nursing, medical, allied health professionals and clerical staff and is inadequate for clinical activity; preparing intravenous medication.

There was good signage for visitors to direct them to wards however there was no special signage for patients with sight or orientation difficulties. In Ward 23 there was good pictorial information on stroke, high blood pressure and cholesterol. In contrast, in the MAU there was no pictorial signage on doors and walls to assist patients with reading difficulties or confusion.

9. **It is recommended that the trust ensures that all areas are tidy, in good repair and fixtures and fittings replaced where necessary. The spacing within bays should be reviewed to ensure that they are in line with current recommendations for core clinical space.**

Sanitary Facilities

In all wards, inspectors observed mixed gender sanitary facilities, there was some attempt to label toilets for male or female only use. In Ward 9, communal toilets and showering facilities were provided in the utility corridor with one toilet allocated male, one female and a unisex toilet in the middle of the ward.

In Ward 18, there was a female toilet on the main ward corridor and two male toilets in the ancillary corridor. There was one shower room available; however patients from Ward 17 also used this shower. In the MAU, one of the ancillary corridors had designated male and female toilets, there was only one shower working for 40 patients. One shower was out of use, the shower room was old and tired (Picture 2). The sanitary facilities in Ward 23 were located on the opposite side of the ward and were designated male or female as the gender makeup of the ward changed. They were in good repair (Picture 3)

Picture 2 Old and tired shower room in MAU


Picture 3 Well-presented shower room in Ward 23

A ceiling pull cord and/or push button call system was available for patients in all sanitary areas. Bathrooms and toilets could be locked from the inside and unlocked from the outside. Raised toilet seats, commodes and handrails or grab rails were available in sanitary areas, all within patient reach.

10. **It is recommended that where appropriate the sanitary facilities, including bathrooms and showers, are repaired and appropriate adaptations put in place for disabled patient use.**

Privacy and Dignity

With the exception of Ward 18, mixed gender bays were observed. Inspectors were advised that some wards have a bay allocated for higher dependency patients, admission to this bay was dictated by clinical need and can therefore be mixed gender. Staff advised that at times these bays could be to facilitate patient admission from ED.

Mixed gender wards compromise patient privacy and dignity and when possible staff would move patients and position them appropriately. Inspectors noted the movement of patients within wards to try and alleviate this issue.

In the MAU, side rooms could be locked from the inside but required a key to open from the outside. The key is a master key held only by the nurse in charge. Staff expressed concerns that if the nurse in charge was not easily located, there could be delayed access to the room in an emergency situation.

Inspectors noted that there were no hand rails in corridors and within wards. Mobility aids were positioned near patients, however in the MAU, a physiotherapist took a zimmer frame from one patient to use with another patient. The zimmer frame was not decontaminated before return to the original patient.

Information boards were used to display patient/relative information and information on infection prevention and control. All wards had a good supply of relevant information leaflets. However in Ward 18 the leaflet rack was not easily visible..

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Privacy curtains had ‘do not enter’ labels present and were used well; closed during personal care and during interviews with medical, nursing and allied health professionals. In the MAU, on the second day of the inspection, there was a large blood splatter on a privacy curtain. Staff had reported this at 7.30am and 11am; the curtain was still not changed at 1pm. Staff advised curtain changes fall under the remit of the ‘clean team’. This team is responsible for all the terminal cleans throughout the hospital, there is only one team. In Ward 23 the curtains were stained at touch points.

The environmental layout of all wards was bed bays and single rooms. The use of escalation beds raises issues with patient privacy and dignity. With the exception of Ward 23, wards hold an escalation bed. These are usually located in the main ward corridor however in Ward 9; the escalation bed was in the day room. There was no piped oxygen or suction, designated call bells, arm chairs or bedside cabinets at these escalation beds. Although portable privacy screens were used, these did not provide full privacy for the patient. During the inspection, there were no escalation beds in use in Wards 9 and the MAU. The escalation bed in Ward 18, while not in use, was located beside the emergency exit doors to Ward 19 (Picture 4). Staff reported that patient belongings were kept in plastic bags. Inspectors were informed that patients allocated to the escalation bed are risk assessed as being suitable.

Picture 4 Escalation bed in corridor blocking access to the fire exit

Not all wards have a designated quiet visitor's room. If a patient wished to speak confidentially with staff or relatives they used the ward sisters' office. However, this room was generally in use and could be subject to interruption from staff.

In Ward 18, there was a small interview room with a telephone. The room could be used as a meeting room for more mobile patients and their visitors. It could also be used by medical staff to discuss information about an older person's condition. A private discussion room was available in the ancillary corridor of Ward 9. Ward 23 has a relatives' room containing a television, settee, chairs and shower facilities. Staff reported it could be difficult to facilitate more than one family requesting its use. Occupational therapy staff also used the room when treating patients.

Patients were able to use personal mobile phones; the bedside entertainment system also provided a phone. Unless patients were mobile, there was an issue regarding telephone conversations being overhead or disturbing other patients.

Name badges were not always worn by staff. When present, the badges were worn at waist height and difficult to see.

11. **It is recommended that trust staff wear name badges which are easily seen and denote the staff designation.**

In all wards, the majority of staff observed were courteous and respectful to patients and visitors. During ward rounds medical and nursing staff spoke quietly together before entering the bay to speak with the patient. However, in bays conversations could easily be overheard. This was especially evident in the bay nearest the nurses' station in Wards 23 and 18 as a number of conversations could be heard from the nurses' work station. Nursing handovers were generally conducted quietly close to the patient. In Ward 23, the nursing handover was carried out in the medication room and could not be overheard.

A large wall mounted whiteboard in the MAU displayed information on each patient, staff used codes, symbols and colour coding to maintain patient confidentiality. A similar notice board was positioned in sister's office in Ward 23 however patients' details such as eating and dietary needs were written on a board above the patient's bed.

Staff should be alert to the positioning of computer screens. In Ward 18 patient details on the portable computer terminals were visible in the bays by persons not involved in the patient care.

12. **It is recommended that the trust undertakes further work to ensure that all staff provide the appropriate personal care, privacy is maintained at all times and all patients are treated with dignity and respect.**

Person Centred Care

In acute settings intentional care rounds are used to check key aspects of care and include; making sure the patient is comfortable and assessing the risk of pressure ulcers; scheduling patient visits to the bathroom to avoid risk of falls; asking patients to describe their pain level on a scale of 0 - 10 and making sure the items a patient needs are within easy reach.

During each round the following behaviours should be undertaken by the nurse:

- an opening phrase to introduce themselves and put the patient at ease
- ask about the above areas (from the paragraph above)
- assess the care environment (e.g. fall hazards, temperature of the room)
- ask, 'is there anything else I can do for you before I go?'
- explain when the patient will be checked on again and documenting the round.

All wards carried out a form of intentional care rounding using a modified SSKIN (Surface, Skin, Keep moving, Incontinence, Nutrition) care bundle. Inspectors noted slight differences in the care rounding documentation in use in the hospital. Variance was noted on direction given to staff when they were

recording pain and the inclusion of the question ‘Is there anything I can do?’ for you. The bottom section of some forms had become lost during the photocopying process.

Completion of the documentation could be improved. In Ward 18, five care rounding forms were reviewed and the frequency of the care rounding was not completed. The pain assessment and the National Early Warning Score (NEWS) chart were omitted; this was especially evident for patients with cognitive impairment. The form stated the Abbey pain score was to be used however staff questioned had no knowledge on this scoring system.

13. **It is recommended that staff ensure that care rounding is carried out as per trust protocol and documentation fully completed. Information identified on care rounds should correspond with patient care plans.**

Patient Call bells

A ceiling pull cord and/or push button call system was available for patients in sanitary areas and at the bedside. Most patient call systems (buzzers) were easily accessible, some in Wards 9 and 18 were out of reach and hanging behind the bed. In Ward 9, the light diffuser was missing from the call system outside a bay. Staff generally answered call bells.

In Ward 23, response time varied and was longer over lunch time. There was one instance when a call bell sounded in a bay for several minutes. A visitor answered the patient and went to get help as staff did not respond. Inspectors in the MAU noted that due to staff presence in bays, the call system was minimally used.

14. **It is recommended that call bells are within patients’ reach and answered promptly.**

Personal Care

In all wards, patient personal care was generally of a high standard. Patients appeared clean, comfortable and suitably clothed. In the MAU, one confused patient had a stained nightdress; staff reported that the ward received a limited supply of nightwear. In Ward 18, cloth theatre gowns were the only garments available for patients that had no night wear. A stock of blue disposable theatre gowns was available for patients in Ward 23.

Patients were assisted to the toilet when required and hand hygiene was offered at the bedside after toileting.

Staff used good communication skills when talking to patients. More attention is needed for those patients with communication difficulties. In Ward 23, staff entering a bay failed to engage with a patient with no speech, even though the patient was alert and sitting up in bed. With the exception of Ward 23, there was limited communication aids for those with communication difficulties. The ward manager in the MAU and Ward 18 confirmed that the speech and language therapist could bring aids and pictorial triggers to the ward to assist patients with communication difficulties.

15. **It is recommended that all patients receive the essential care needed at all times.**

Food and Fluids

Ward staff endeavoured to protect meal times for patients and ensure there was minimum interruption. It is acknowledged that in some instances emergency procedures and tests must be carried out, irrespective of protective mealtimes. This was not always feasible due to ward rounds being carried out; not emergencies. In all wards patients ate meals either in the bed or at the bedside as dining rooms were not available.

16. **It is recommended that the trust policy on protected meal times is adhered to by all staff.**

Meals were of good variety, warm and appetising. They were presented to patients on a tray, with a dinner plate and various polystyrene cartons for porridge/soup/custard with lids and cling film wrapped items. Milk was served in plastic cups. This practice could pose problems for patients with dexterity or visual problems. Inspectors were also concerned that hot liquids were served in 'flimsy' containers, increasing the risk of spillage why?

There was a variance in how wards indicated when patients required assistance with meals. In the MAU and Ward 9, information was communicated to staff at handover, in Ward 9 it is also identified on the white board. In all wards nursing staff distributed and collected trays, at times catering staff removed trays. Catering staff advised that they would alert nursing staff to patients who needed further assistance, or who had not eaten.

Patients who were fasting have a nil by mouth sign posted on the wall above the bed. In the MAU, the bedside entertainment system was blocking the sign from the catering assistant's view. The assistant was about to leave fresh water on the table when the inspector pointed out the sign. It was noted that there was a variety of signs in use such as nil by mouth, 'NBM' or fasting. Some were hand written on A4 pages, some were typed and laminated.

Jugs of fresh water were generally within easy reach of patients. The jugs were changed twice daily and had a lid in place. In all wards patient encouragement with oral fluid intake was identified as part of the care rounding and repositioning schedule. Staff were observed cutting up food and encouraging fluids and food, however from observations in Wards 18 and 23, encouraging patients to take fluids could be improved.

With the exception of Ward 23 at lunch time, there were adequate staffing levels to meet the required demand for assistance at meal times. Overall patients requiring assistance at meal times were identified and assisted appropriately. There were a few exceptions.

A coding system was in place in Ward 23 to identify patients requiring assistance with meals however inspectors observed a patient was overlooked at lunch time. The meal sat for 20-25 minutes before an inspector drew a nurse's attention. A second patient in this bay had been assisted by a nurse who had not acknowledged the other patient waiting to be assisted with feeding. At this time there were only three HCAs and one RN on the ward. A new meal was requested from the kitchen. Fluid balance charts were not always completed accurately or by the person assisting the patient. A member of staff filled in the food chart of a patient they had not assisted. The patient had not eaten any food however it was recorded that a quarter of a yoghurt had been taken.

In Ward 18, patients requiring assistance were to be identified on the whiteboard. On one occasion, the inspector observed an agency nurse leaving a breakfast tray with a patient who required assistance. As the nurse did not return, the inspector assisted the patient with their breakfast. A staff nurse entered the room, with the impression the patient had been fed by the agency nurse. The whiteboard in sister's office had not been updated to inform staff who required assistance with meals, the inspector was unsure if the agency nurse had been aware assistance was needed. To rectify this issue, the ward deputy sister updated the nursing handover sheet to inform staff of those patients that require assistance. A patient in this ward, reported that food could be cold at times. This was in contrast to the inspection team's observations as food appeared to be at a suitable temperature.

Patients were generally offered hand hygiene before meals and napkins were supplied. In contrast in Ward 9, staff did not offer patients with limited mobility the facility to wash their hands. Hand wipes were available on the ward, but inspectors did not observe their placement on meal trays.

Staff in Ward 23 advised that adapted cutlery was available from the occupational therapy department if required. Adapted cutlery was not available in the other wards inspected.

17. It is recommended that the trust clarifies the system in place to identify patients who require assistance or encouragement with meals and provide appropriate adapted crockery and cutlery.

It was difficult to assess staff carrying out mouth care on patients as this was carried out during personal care, when privacy curtains were closed. No issues were identified with patients mouth care in any of the wards.

Overall summary

In general all wards were clean and bright. Ward 23, located in a refurbished building was generally clutter free. In contrast, in the other wards, the main ward corridor and utility corridors were cluttered with equipment and at meal times, the food trolley added to the congestion.

Inspectors noted that the spacing within bays was particularly cramped and would not currently be in line with current recommendations for core clinical space. The clinical work surface area in wards 9, 18 and the MAU was located at the nurses' station. This area was congested at times with nursing, medical, allied health professionals and clerical staff and is inadequate for clinical activity; preparing intravenous medication. Wards were busy but calm with welcoming staff.

In some wards, sanitary facilities, including bathrooms and showers were in need of repair.

The majority of staff observed were courteous and respectful to patients and visitors. In some wards inspectors observed that not all staff treated patients with dignity and respect. Not all call bells were within patient reach or answered promptly. In all wards, patient personal care was generally of a high standard, although staff need to ensure that stained clothing is changed and all patients have a drink beside them.

Protected meal times were in place although not always adhered to and there was a good variety of meals. These were warm and generally appeared appetising. At times there was not enough 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 and at times these did not appropriately identify patients who needed help.

Inspectors observed that in some instances hand hygiene and the use of personal protective equipment could be improved. On two occasions staff did not comply with the trust's administration of medication policy.

Other issues identified

- Staff in the MAU and Ward 9 were observed making beds without wearing a plastic apron. In the MAU, gloves were not worn when handling used linen. Medical staff in the MAU and Ward 18 were observed not adhering to the 'bare below the elbow' policy when working in the clinical environment. In Ward 9, visitors and staff were observed sitting on patients' beds.

- Some patients like taking medication with yoghurt. Yoghurt is easy for patients on a modified diet to take however this is not always available in each ward. The policy in the trust is strict in regard to the storage of perishables. At the feedback, trust representatives confirmed yoghurts could be ordered in wards providing they were dated and labelled for the patient.

- In Ward 23, patient wash water was disposed of down the clinical hand washing sink and staff did not always wash hands before donning gloves.

  On the first day of the inspection, patients in Bay 1 stated they had not received their evening medications until midnight the previous night, as staff had been taken to another ward.

  Inspectors noted that patients were not freely able to exit the ward without asking staff to use a swipe card. 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. Inspectors were informed that trust management staff had initiated this practice based on recent patient safety incidents. Whilst RQIA recognise the difficulties in balancing patient safety and security and individual patient rights, the trust needs to ensure that appropriate controls are initiated.

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

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

- In the MAU, a doctor not wearing PPE was observed entering a room with a contact precaution sign in place. The doctor proceeded to take blood from the patient without donning PPE and left the room without washing hands. There was a shortage of pumps for IV infusions. Staff were prioritising therapeutic drips.

- In Ward 9, on the first day of the inspection, staff did not always wash their hands between patients and equipment placed on patient’s beds was not decontaminated between use, for example blood glucose monitoring kit. Two RNs were observed not checking patients ID bands before administering medicines. This was discussed in detail with sister. Many of the clocks in the ward were not working.

18. **It is recommended that if de facto detention is used, local detailed procedures are put in place, including how this is documented.**

19. **It is recommended that staff should adhere to the trust's infection, prevention and control polices in relation to use of personal protective equipment, adherence to dress code policy and disposal of wash water.**

20. **It is recommended that staff should adhere to the trust's administration of medication policy.**

4.3 Review of Care Records

The inspection tool used 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. 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 and finally evaluation and review of the care.

Inspectors' assessment

RQIA inspectors reviewed 13 patient care records in depth and 23 patient bedside charts were examined for specific details. The inspectors found similar gaps in each set of records.

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

Due to the quick turnaround time of patients the sister in MAU advised inspectors that trust management has agreed to review what aspects of the initial nursing assessment plan must be completed on the ward and what aspects of the assessment are not immediately required. It is envisaged that MAU staff will prioritise care and complete the relevant care needs assessment and risk assessment, rather than the whole nursing assessment booklet.

21. **It is recommended that the assessment of patients nursing needs should be patient focused and identify individual needs and interventions required. This should be reviewed and updated in response to changing needs of patients.**

The nursing documentation in use indicated 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 that the initial nursing assessment of patient needs was not always completed within the appropriate time frame. At times notes did not specify the time the patient arrived on the ward.

In all wards there were variations in the quality of the risk assessments undertaken. Inspectors found that generally risk assessments had not been fully completed; some had been left blank. There was minimum recording in the infection prevention and control assessment, the emotional and psychological assessment was left blank and the MUST initial assessments while carried out

were not always acted upon. In a set of records reviewed, the infection prevention and control assessment indicated that the patient was 'currently having diarrhoea'. This did not correspond with the information recorded by the RN in the elimination section.

Regular review of risk assessments did not always occur despite changes in the patient's condition. Identified risks did not always have a plan of care devised to provide instruction on how to minimise the risks.

22. It is recommended that all risk assessments should be completed within the set timescales. These should be reviewed and updated on a regular basis, or when there are changes in the patient's condition. Identified risks should have a plan of care devised to provide instruction on how to minimise the risks.

The SEHSCT nursing assessment booklet does not have prompts to indicate if a care plan is required. Staff use their professional knowledge and experience to determine if a care plan is required.

The care plans reviewed did not always reflect the nursing assessment carried out or the care required for the patient, identified on observation. In some instances, care plans were not always in place for all identified patient needs, individualised care plans were poorly written, with minimal detail and little direction of the care to be implemented for the patient.

In the MAU and Ward 9, nursing daily evaluation notes were recorded within a multi-disciplinary team (MDT) folder. Generally the notes were dated, timed and signed. The method of recording for the MDT notes was not in accordance with Northern Ireland Practice and Education Council (NIPEC) or other professional guidance. For example there were gaps left between entries, and not all professions documented their designation. It was confusing for the inspector to follow the continuity of care and identify staff designated as the recording of daily records commenced in the medical notes and continued into the nursing notes.

One patient had ten identified nursing care needs, this was determined from observation of the patient and review of their nursing assessment. The review of care records indicated that only one care plan was in place.

Another patient had three care plans in place, a mixture of written and core care plans. From the inspector's review of the patient's notes, six additional care plans were needed.

Inspectors took the opportunity to review the notes of a patient who was being discharged on the second day of the inspection. The discharge check list, available at the end section of the nursing assessment and plan of care booklet, had not been completed.

These findings would be reflective of other care records reviewed. None of the care plans reviewed evidenced that nurses 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. Nurse record keeping did not always adhere to the NIPEC and NMC guidelines.

Improvements in record keeping are required in the following areas:

- admission assessment should be fully completed
- assessments were not fully used to inform the subsequent care interventions required
- risk assessments should be fully completed
- if a risk is identified a care plan should be devised to provide instruction on how to minimise the risk.
- care plans should be devised for patients needs
- in the nursing progress notes, entries should be dated and legible They should reference the care plan, and triangulation of care

The care records examined failed to demonstrate that safe and effective care was being delivered.

23. It is recommended that care plans should be devised for all identified patient's needs. These should be reviewed and updated within the set timescale, or in response to changing needs of patients.

24. It is recommended that nurse record keeping should adhere to NMC and NIPEC guidelines.

DNAR (Do not attempt resuscitation)
Background

A trust policy was devised based on the joint guidance. As part of the inspection, DNAR decisions and subsequent documentation were reviewed in both medical and nursing records.

In Ward 9, one DNAR section within the nursing assessment was incomplete; the order had been signed by the doctor and was on file. In another set of notes, the nursing assessment stated there was no DNAR however an order had been signed by the doctor and was on file.

Incomplete forms were noted in Ward 23 where medical staff were writing 'indefinitely' at the review date, not dating a form and not recording in the notes discussion with the family. One form did not have the unit number or address and although it stated the need to discuss the decision with the family, this was not recorded.

In Ward 18, in two out of three nursing assessment booklets reviewed, the section on DNAR was not completed to inform staff.

25. **It is recommended that medical staff comply with the trust's DNAR policy and nursing staff complete the DNAR section of the nursing assessment booklet.**

4.4: QUIS Observation Sessions

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

Inspectors Assessment

Inspectors and lay reviewers undertook a number of periods of observation in the ward which 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 used was the Quality of Interaction Schedule (QUIS). This 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.**

	Sessions undertaken	Observations	Positive (PS)	Basic (BC)	Neutral (N)	Negative (NS)
MAU	**6**	**111**	**96**	**12**	**0**	**3**
Ward 9	**4**	**22**	**13**	**4**	**0**	**5**
Ward 18	**4**	**36**	**34**	**1**	**1**	**0**
Ward 23	**6**	**45**	**18**	**13**	**4**	**8**
Total	**20**	**214**	**161**	**30**	**5**	**16**

The results of the periods of observation indicate that 75 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.

Basic interactions relate to brief verbal explanations and encouragement, but only that the necessary to carry out the task with no general conversation. Neutral interactions are brief indifferent interactions not meeting the definitions of other categories.

Negative interactions relate to communication which is disregarding of the patients' dignity and respect. It was disappointing to note this type of interaction however this was by a small number of staff. The staff involved were made known to the ward sister for the appropriate action to be taken.

The narrative results from the four wards have been combined and listed below.

Positive interactions observed

- Patient was in a side room. The HCA entered and said 'good morning ….' when assisting the patient with breakfast, the HCA put the bed rail down, raised the bed and engaged in conversation
- Good interaction between catering and domestic staff with patients at breakfast time
- Good social interaction, introducing self- 'If you need anything you have your buzzer', 'are you tired?', 'hello, how are you? my name is…I am here to…'
- Staff discreet when behind curtains
- Asking the patient what is their preferred name
- Staff initiated conversation with patients, listened and spoke respectfully
- Generally good communication skills displayed; coming down to patient level, speaking slowly, awareness of hearing difficulties, introduced self, repeating information, ensuring patient understood

Basic interactions observed

- Minimal conversation with a patient on a stand easy when being taken to the toilet.
- Handing out water jugs, no chat however water left within easy reach
- RN assisting patient in side room, minimal conversation
- RN observed feeding a patient standing at the bedside

Neutral interactions observed

- Two nurses moving a bed, caused minor inconvenience to a patient bin the adjacent bed, no comment from staff
- RN at bedside preparing oral medication and having no interaction with the patient
- Staff giving out tea/biscuit without engaging with patient
- A member of nursing staff was taking blood from a patient. There was no interaction with the patient

Negative interactions observed

- Referring to patients as feeders
- Flippant remarks were made in general to a male patient who had been very unsettled the night before

Patients receiving assistance with eating, staff were:

- Standing with hands in pockets
- Staff turning their back to the patient while assisting with eating
- Standing over patient rather than sitting

Events

During observations inspectors noted 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'. For example, a nurse may complete personal care without talking or engaging with a patient.

An example of an omission of care may be:

- a patient repeatedly calling for attention without response,
- a patient left inadequately clothed,
- a meal removed without attempts made to encourage the patient to finish it,
- a patient clearly distressed and not comforted

Events observed by Inspectors/Lay Reviewers

In Ward 23, unless conversations were instigated by other patients, some patients were not engaged with. In one bay, male patients were joking and laughing with HCAs and the RN. In contrast in another bay in the same ward where patients were not initiating conversation, the two RNs, one assisting a patient with food, did not speak to the patients.

A patient with dementia was aggressive. Staff moved away and stopped feeding the patient as they lacked the skills to deal appropriately with the situation. A patient was assisting another patient out of bed while a porter was waiting. The screens were not pulled and the patient's legs were exposed.

Doctor examined a patient without pulling the screens.

Recommendation

26. It is recommended that the trust should develop measures to improve staff to patient interactions, ensuring that patients are always treated with dignity and respect.

4.5 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.

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

Inspectors Assessment

During the inspection 23 patient and relatives/carers questionnaires and 14 patient interviews were undertaken. Following the inspection, an anonymous questionnaire was received by RQIA. The issues highlighted from the questionnaire were forwarded to the SEHSCT for investigation and action.

Generally feedback received from patients and relatives or carers was positive. Overall they thought that staff were 'very good' and had a positive experience while in hospital. Questionnaires indicated that communication between staff and patients/carers could be improved upon in relation to involvement in care, knowing who to speak to and the acknowledgement of information given. In the MAU, three out of four family questionnaires commented on not always being able to speak to a doctor when they wanted to.

Patients felt that overall meals were good, with a variety of choice. Visiting hours were suitable.

Some positive written comments were:

'My mum has been in A&E, wards 15, 9 and now 18 all of which treated her more than well'

'Care consistent and good. Attentive and cannot fault. Staff very friendly'

'All my experience in this admission to hospital was most positive …'

Patient Interviews

Overall patients stated they were happy with the standard of care and had a good relationship with staff. Staff were courteous, respectful, 'explain what is happening' and took time to speak to them. However, not all staff introduced themselves and not all staff names were known to the patients. On some occasions information leaflets had not been given to the patient on admission.

Patients felt that they were kept informed about their care. There was a general understanding from patients that staff were working to the best of their ability given the time and staff available. Patients generally felt that call bells were answered reasonably quickly. One patient stated that on two occasions they had difficulty when summoning assistance at night, they had to wait half an hour.

Patients felt that the meals were generally good, with a variety of choice. One patient commented that 'early morning to breakfast is a bit hectic' as patients are all tired and there is a lot of activity on the ward. Patients were happy with visiting times; one patient commented that public transport from Bangor is not good.

Interview with family members

There was no opportunity during the inspection for inspectors or lay reviewers to interview family members.

Recommendation

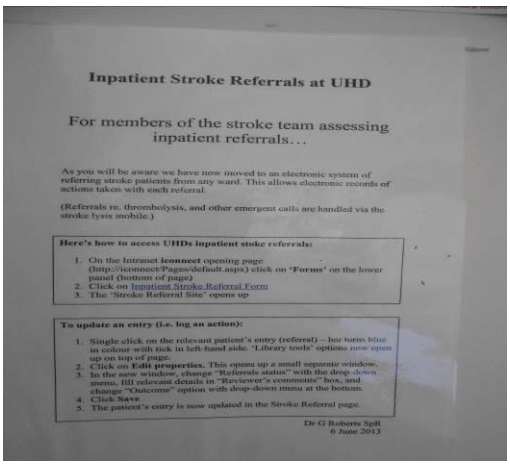
27. **The trust should acknowledge patient, relative, carer comments to improve the patient experience.**

4.6 Emergency Department

Inspectors' assessment

Inspectors visited the ED on the first day of the inspection at 9.30am, 2.30pm and 4pm. At these times there were eight patients over 65 who had been waiting in the ED for more than six hours. On the second day at 8.00am, there were 11 patients over 65; four had been waiting in the ED between 12 – 21 hours. In all cases patient admission was delayed as there was no admission bed available.

In order to improve the ED waiting times and streamline services, inspectors were informed of several patient admission routes/areas which are adjacent to the main ED department, feeding into the ED service. Following triage in the ambulance corridor or Rapid Assessment Treatment Unit (RATU), patients can be transferred to either the ED to wait for an available inpatient bed or admitted to the Ambulatory Ward or Observation Ward for a short, usually 24/48 hour stay. A Stroke Coordinator can assess patients with stroke diagnosis for suitability of admission to Ward 23. They will work with patients in the ED to arrange scans, review appointments and assist with home support if an admission is not required. Patients can be admitted directly to the Care of the Elderly Unit following triage and assessment by a doctor from the Care of the Elderly Unit (Picture 5).



Inpatient Stroke Referrals at UHD

For members of the stroke team assessing inpatient referrals…

As you will be aware we have now moved to an electronic system of referring stroke patients from any ward. This allows electronic records of actions taken with each referral.

(Referrals re. thrombolysis, and other emergent calls are handled via the stroke lysis mobile.)

Here's how to access UHDs inpatient stoke referrals:

1. On the Intranet **Iconnect** opening page (http://iconnect/Pages/default.aspx) click on "**Forms**" on the lower panel (bottom of page)
2. Click on Inpatient Stroke Referral Form
3. The "Stroke Referral Site" opens up

To update an entry (i.e. log an action):

1. Single click on the relevant patient's entry (referral) – bar turns blue in colour with tick in left-hand side. 'Library tools' options now open up on top of page.
2. Click on **Edit properties.** This opens up a small separate window.
3. In the new window, change "Referrals status" with the drop-down menu, fill relevant details in "Reviewer's comments" box, and change "Outcome" option with drop-down menu at the bottom.
4. Click **Save**
5. The patient's entry is now updated in the Stroke Referral page.

Dr G Roberts SpR
6 June 2013

Picture 5 Stroke referral information

Inspectors were informed of a recent initiative with the Northern Ireland Ambulance Service (NIAS) which is providing an onsite member of staff for trust liaison. Staff within the ED were unsure of the responsibilities of this role.

28. It is recommended that the trust and NIAS evaluate the impact of this initiative and agree and inform all staff of defined roles and responsibilities.

Patient Documentation and Assessments

The care patients receive in the ED was recorded on the ED flimsy. This involved completing a form to record details on social history and care needs such as mobility, social history, washing and dressing, feeding and diet and mental state.

The flimsy only allowed for minimal information to be recorded on the patient care delivered, with no obvious intentional care rounding documented. There was limited recording of care given in relation to activities of daily living; only referencing vital signs, medication administered, toileting assistance and food or fluids. There was no full nursing risk assessment carried out for patients who were pending admission and waiting in the majors' area for more than six hours. For example risk assessments such as manual handling, pressure ulcer risk or falls.

The patients admitted to the Observation Ward were under the care of the ED consultant. At the time of inspection there were generally psychiatric crisis response and elderly patients waiting for multi-disciplinary team input. Their stay in ED could be 24/48 hours however waiting on a community placement could delay discharge. The ward was busy with intense input from physiotherapists, occupational therapists and social work staff. On the patient's arrival, an Emergency Department Observation Ward assessment booklet was completed by the RN. The booklet is comprehensive; all members of the multi-disciplinary team have to document assessments, actions and plans of care. It includes a pressure ulcer assessment/risk management guide (Braden). This assessment is to be completed within two hours of admission to the ward if the patient is immobile or 12 hours if mobile.

Ambulatory Ward patients were under the care of medical consultants. The ward was intended for short stays but a delay in bed availability in the main hospital had resulted in longer stays. There were beds for 10 patients with two RNs in attendance. On the second day, there were 10 patients, eight requiring full care and assistance from the two staff. There were no showers or chairs, there was one disabled toilet with a small hand washing sink. Patients sat on the bed all day. A review of patient records evidenced that risk assessments had not been completed for these patients, progress sheets were generally comprehensive. Inspectors were advised that the trust intends to revert back to the original plan for the area with four trolleys and recliners by March 2014.

Patients were 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. There is a need to ensure that the documentation used by all staff takes into account these areas.

The mental state assessment was only a tick box on the flimsy. No recognised assessment tool to recognise dementia/delirium or for cognitive impairment was used. There was no Identification of Seniors at Risk (ISAR) or equivalent screening tool or a screening tool to assess older patients for depression.

29. It is recommended that the trust reviews the current documentation to improve assessments for common frailty syndromes and depression.

The ED staff advised the Integrated Care Pathway for Adults who have self-harmed is a robust pathway. However, inspectors were informed that crisis response for over 65s could be improved. At the feedback, trust representatives confirmed they were piloting the Psychiatric Liaison, Lisburn Model, to look at improving advocacy and support, information system and telephone contact numbers. There were plans to increase the number of community psychiatric nurses (CPNs) for unscheduled care, this should impact positively on the over 65s.

A notice board in the ambulance corridor displayed advice on the Butterfly scheme to patients and carers; there is a Butterfly nurse champion (Picture 6). Dementia training has yet to be rolled out to all staff and not all staff had received vulnerable adult training.

Picture 6 Information on Butterfly scheme in ambulance corridor in the ED

There was access to a physiotherapist, occupational therapist and social worker Monday to Friday, 9.00am to 5.00pm. Social work staff also cover the Observation Ward at weekends. Patient information on local social services, healthy eating, benefits and staying warm was not available. Staff reported that the addition of a pharmacy technician within the department, was invaluable for ordering, locating and managing stock.

Staff were aware of the trust policy on prevention of falls and essential care after a fall; a patient information leaflet on advice to reduce falls was available. Regular meals were provided for patients; out of hours, tea and toast can be made and vending machines were available. Sister advised that some observation equipment was broken and there was no funding for replacement. This had been reported and was documented in safety briefings. Staff could access specialist pressure relieving mattresses when required; the availability of laundry was at times an issue.

30. **It is recommended that sufficient supplies of equipment are available.**

Inspectors were informed by patient flow that there was one porter to cover the whole hospital at night. This could result in ward staff and patient flow staff transferring patients. There is a Repatriation Protocol for transferring Lagan Valley Hospital and Downe Hospital patients back to their original hospital. Staff reported that a hospital doctor must contact a doctor in the receiving hospital, delays in contact or availability of the doctor can result in delayed discharge from the Ulster Hospital.

There was difficulty at times getting NIAS ambulances and a heavy reliance on Red Cross and St. John's ambulances out of hours. Bangor Hospital has step down beds. The lift was broken for six weeks and this had significantly impacted on transfers and discharges to the Bangor Hospital for patients with mobility problems.

There has been significant work undertaken by the trust to work within the departmental targets for waiting times in the ED. Inspectors observed patients treated with privacy and dignity. There was work required to ensure that patients have the appropriate assessments undertaken, particularly if they are waiting over six hours.

31. **All staff should receive training on dementia care and care of the vulnerable adult.**

32. **The trust should review the services available out of hours and information available for patients.**

5.0 Recommendations

1. **It is recommended that any identified nurse staffing variances are reviewed to ensure that patient care and safety is not compromised due to staffing levels.**

2. **It is recommended that ward sisters should have protected time. This is to ensure that there is a balance between clinical and managerial roles and responsibilities.**

3. **It is recommended that the trust should ensure all policies/guidance are available to staff.**

4. **It is recommended that mandatory training should be kept up to date and staff should receive training appropriate to the patient's needs.**

5. **It is recommended that staff supervision and appraisal should be carried out and up to date.**

6. **It is recommended that all ward sisters should be aware of trust and ward incident data trends.**

7. **It is recommended that all wards have a physical ward environmental audit carried out for dementia patients.**

8. **It is recommended that the trust should continue to introduce and monitor the nursing quality indicators (NQIs), with particular attention given to record keeping.**

9. **It is recommended that the trust ensures that all areas are tidy, in good repair and fixtures and fittings replaced where necessary. The spacing within bays should be reviewed to ensure that they are in line with current recommendations for core clinical space.**

10. **It is recommended that where appropriate the sanitary facilities including bathrooms and showers, are repaired and appropriate adaptations put in place for disabled patient use.**

11. **It is recommended that trust staff wear name badges which are easily seen and denote the staff designation.**

12. **It is recommended that the trust undertakes further work to ensure that all staff provide the appropriate personal care, privacy is maintained at all times and all patients are treated with dignity and respect.**

13. **It is recommended that staff ensure that care rounding is carried out as per trust protocol and documentation fully completed. Information identified on care rounds should correspond with patient care plans.**

14. **It is recommended that call bells are within patients' reach and answered promptly.**

15. **It is recommended that all patients receive the essential care needed at all times.**

16. **It is recommended that the trust policy on protected meal times is adhered to by all staff.**

17. **It is recommended that the trust clarifies the system in place to identify patients who require assistance or encouragement with meals and provide appropriate adapted crockery and cutlery.**

18. **It is recommended that if de facto detention is used, local detailed procedures are put in place, including how this is documented.**

19. **It is recommended that staff should adhere to the trust's infection, prevention and control polices in relation to use of personal protective equipment, adherence to dress code policy and disposal of wash water.**

20. **It is recommended that staff should adhere to the trust's administration of medication policy.**

21. **It is recommended that the assessment of patients nursing needs should be patient focused and identify individual needs and interventions required. This should be reviewed and updated in response to changing needs of patients.**

22. **It is recommended that all risk assessments should be completed within the set timescales. These should be reviewed and updated on a regular basis, or when there are changes in the patient's condition. Identified risks should have a plan of care devised to provide instruction on how to minimise the risks.**

23. **It is recommended that care plans should be devised for all identified patient's needs. These should be reviewed and updated within the set timescale, or in response to changing needs of patients.**

24. **It is recommended that nurse record keeping should adhere to NMC and NIPEC guidelines.**

25. **It is recommended that medical staff comply with the trust's DNAR policy and nursing staff complete the DNAR section of the nursing assessment booklet.**

26. **It is recommended that the trust should develop measures to improve staff to patient interactions, ensuring that patients are always treated with dignity and respect.**

27. **The trust should acknowledge patient, relative, carer comments to improve the patient experience.**

28. **It is recommended that the trust and NIAS evaluate the impact of this initiative and agree and inform all staff of defined roles and responsibilities.**

29. **It is recommended that the trust reviews the current documentation to improve assessments for common frailty syndromes and depression.**

30. **It is recommended that sufficient supplies of equipment are available.**

31. **All staff should receive training on dementia care and care of the vulnerable adult.**

32. **The trust should review the services available out of hours and information available for patients.**

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	**Examples include:** Brief verbal explanations and encouragement, but only that the necessary to carry out the task No general conversation

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 • 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 Experience

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	85.7%	14.3%	0.0%	0.0%	0.0%	2	14
I always have access to a buzzer	93.8%	0.0%	0.0%	6.3%	0.0%	0	16
When I use the buzzer staff come and help me immediately	50.0%	12.5%	6.3%	0.0%	31.3%	0	16
When other patients use the buzzer staff come and help them	50.0%	12.5%	0.0%	0.0%	37.5%	0	16
I am able to get pain relief when I need it	64.3%	0.0%	0.0%	0.0%	35.7%	2	14
I am able to get medicine if I feel sick	50.0%	0.0%	0.0%	0.0%	50.0%	2	14
I get help with washing, dressing and toileting whenever I need it	75.0%	0.0%	0.0%	0.0%	25.0%	0	16
Staff help me to carry out other personal care needs if I want them to	81.3%	0.0%	0.0%	0.0%	18.8%	0	16
If I need help to go to the toilet, staff give me a choice about the method I use e.g. toilet, commode, bedpan	62.5%	0.0%	0.0%	0.0%	37.5%	0	16
If I need any help with my glasses, hearing aid, dentures, or walking aid staff will help me with this	43.8%	25.0%	0.0%	0.0%	31.3%	0	16

Questions	Always	Often	Sometimes	Not at all	Don't Know/ Not relevant	Skipped question	Answered question
Staff are aware of the help I need when eating and drinking	43.8%	12.5%	0.0%	0.0%	43.8%	0	16
I enjoy the food I am given on the ward	75.0%	25.0%	0.0%	0.0%	0.0%	0	16
Staff help other patients to eat or drink if they need assistance	62.5%	12.5%	0.0%	0.0%	25.0%	0	16
I have access to water on the ward	100.0%	0.0%	0.0%	0.0%	0.0%	0	16
Staff always respond quickly if I need help	81.3%	0.0%	0.0%	0.0%	18.8%	0	16
The quality of care I receive is good	100.0%	0.0%	0.0%	0.0%	0.0%	0	16
The ward is clean and tidy and everything on the ward seems to be in good working order	87.5%	12.5%	0.0%	0.0%	0.0%	0	16
Staff will give me time to do the things I need to do without rushing me	100.0%	0.0%	0.0%	0.0%	0.0%	0	16
I feel safe as a patient on this ward	91.7%	0.0%	0.0%	0.0%	8.3%	4	12
Are you involved in your care and treatment	43.8%	31.3%	25.0%	0.0%	0.0%	0	16
Staff have talked to me about my medical condition and helped me to understand it and why I was admitted to the ward	50.0%	37.5%	12.5%	0.0%	0.0%	0	16

Questions	Always	Often	Sometimes	Not at all	Don't Know/ Not relevant	Skipped question	Answered question
Staff explain treatment to me so I can understand	75.0%	25.0%	0.0%	0.0%	0.0%	0	16
Staff listen to my views about my care	37.5%	56.3%	0.0%	0.0%	6.3%	0	16
I can always talk to a doctor if I want to	56.3%	43.8%	0.0%	0.0%	0.0%	0	16
I feel I am involved in my care	75.0%	12.5%	12.5%	0.0%	0.0%	0	16
Staff have discussed with me about when I can expect to leave the hospital	53.8%	46.2%	0.0%	0.0%	0.0%	3	13
Staff have talked to me about what will happen to me when I leave hospital	43.8%	37.5%	0.0%	0.0%	18.8%	0	16
Staff always introduce themselves	62.5%	25.0%	12.5%	0.0%	0.0%	0	16
Staff are always polite to me	87.5%	12.5%	0.0%	0.0%	0.0%	0	16
Staff will not try to rush me during meal times	87.5%	0.0%	0.0%	12.5%	0.0%	0	16
Staff never speak sharply to me	87.5%	0.0%	0.0%	12.5%	0.0%	0	16
Staff call me by my preferred name	100.0%	0.0%	0.0%	0.0%	0.0%	0	16
Staff treat me and my belongings with respect	87.5%	12.5%	0.0%	0.0%	0.0%	0	16
Staff check on me regularly to see if I need anything	62.5%	25.0%	12.5%	0.0%	0.0%	0	16
My visitors are made welcome	100.0%	0.0%	0.0%	0.0%	0.0%	0	16

Appendix 3 Relative Survey responses 2014

Patient 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	48.3%	27.6%	13.8%	0.0%	10.3%	2	29
Staff always have enough time to give care and treatment	51.6%	19.4%	19.4%	0.0%	9.7%	0	31
Staff are knowledgeable about the care and treatment they are providing	71.0%	22.6%	0.0%	0.0%	6.5%	0	31
The ward is a happy and welcoming place	62.1%	10.3%	20.7%	6.9%	0.0%	2	29
I am confident that my relative/ the patient is receiving good care and treatment on the ward.	77.4%	9.7%	6.5%	0.0%	6.5%	0	31
Staff never speak sharply to me or my relative/friend	54.8%	6.5%	6.5%	25.8%	6.5%	0	31
Staff include me in discussions about my relative/friend's care	69.0%	3.4%	0.0%	27.6%	0.0%	2	29
Staff treat my relative/friend with dignity and respect	80.6%	6.5%	0.0%	6.5%	6.5%	0	31

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	61.3%	22.6%	3.2%	0.0%	12.9%	0	31
Staff make me feel welcome on the ward	80.6%	0.0%	12.9%	0.0%	6.5%	0	31
I feel confident to express my views on how my relative is being cared for	80.6%	9.7%	6.5%	0.0%	3.2%	0	31
Staff ask me about my relative/friend's needs or wishes	43.3%	23.3%	0.0%	26.7%	6.7%	1	30
When I give information about my relative, it is acknowledged and recorded so I do not have to repeat myself.	51.6%	12.9%	9.7%	6.5%	19.4%	0	31
I know who to speak to about my relative/friend's care	63.3%	0.0%	16.7%	16.7%	3.3%	1	30
I can speak to a doctor when I want to	35.7%	10.7%	21.4%	7.1%	25.0%	3	28
If I chose to be, I am informed if/when my relatives/the patient's condition changes	54.8%	12.9%	9.7%	0.0%	22.6%	0	31

Questions	Always	Often	Sometimes	Not at all	Don't Know/ Not relevant	Skipped question	Answered question
If my relative wants me to, I have been fully involved in the discharge planning for when my relative leaves hospital	42.3%	3.8%	0.0%	7.7%	46.2%	5	26
Staff listen to my views about my relative/friend's care	56.7%	10.0%	6.7%	0.0%	26.7%	1	30

6.0 Quality Improvement Plan

Reference number	Recommendations	Designated department	Action required	Date for completion/ timescale
1	It is recommended that any identified nurse staffing variances are reviewed to ensure that patient care and safety is not compromised due to staffing levels.	ED	All nurse vacancies have been released for recruitment and are in the recruitment process	In recruitment process. Posts held until 30.11.2014 in respect of response to health cuts.
2	It is recommended that ward sisters should have protected time. This is to ensure that there is a balance between clinical and managerial roles and responsibilities	Nursing	Ideally, the ward manager will fulfil the supernumerary shift as per health roster, however, this can be comprised as need to step into clinical duties arise due to staff absence / sickness. The ward manager subjectively uses the shift to deal with managerial responsibilities.	Arrangement in place. Managed as per shift pressures.
3	It is recommended that the trust should ensure all policies/guidance are available to staff.	Nursing	To review provision of / access to (hard copy and electronic) policy / guidelines and ensure that all staff have knowledge of and ability to access all policies / guidance. Ward 23 addressed, completed and continued focus as staff meeting agenda item. Staff instructed to seek manager guidance if any difficulty / need encountered.	Completed. Continuing focus.

Reference number	Recommendations	Designated department	Action required	Date for completion/ timescale
4	It is recommended that mandatory training should be kept up to date and staff should receive training appropriate to the patient's needs.	Nursing	Training is provided and open for all staff and is recorded through e-roster. Quarterly monitoring – figures provide to director. Ward manager responsible to keep up-to-date. Training in specific areas tailored to match specific patient needs (e.g. stroke).	In place pre-review.
5	It is recommended that staff supervision and appraisal should be carried out and up to date.	Nursing	2 x supervisions per year. 1 x appraisal per year. For all staff. Quarterly monitoring in place through directorate office. Trust currently developing a comprehensive clinical supervision management improvement programme to improve recording, compliance with requirements for supervision / appraisal. Detailed information available. To achieve robust recording and reporting. Staff instructed to come to appraisal with supervision requirements met and evidenced.	Standard arrangements in place pre-review. Improvement focus launched and ongoing development.
6	It is recommended that all ward sisters should be aware of trust and ward incident data trends.	Nursing	2 x governance facilitators in post who analyse and focus on trends. Reported directly to ward managers and at quarterly management meetings. Awareness / improvement focus Within Medicine, incidents / IR1s at ward and Trust level focused upon for learning.	In place pre-review. Post review focus completed. Additional improvement

Reference number	Recommendations	Designated department	Action required	Date for completion/ timescale
			Ward sisters/managers are actively involved in completing own IR2s and Root Cause Analysis for learning / improvement. Included as ward meeting content and documented in Ward Communications Book. **Additional improvement focus exploration:** To focus on improvement of shared learning / improvement mechanism on a Trustwide / Directorate basis through Nursing Directorate leadership in connection to Trust Lessons Learnt Committee. To explore integration into Nursing / Midwifery Governance Committee standing business. To focus on through Lunch and Learn Information Session presentation slots. To record same and have podcast access for staff. Developments with ICT re: recording / YouTube access etc.	mechanisms raised and being explored for implementation.
7	It is recommended that all wards have a physical ward environmental audit carried out for dementia patients	Nursing	Ongoing development and training regarding environmental layout (e.g. colour-coding / clocks). Working Group in place led by Assoc Clinical Director for Medicine / Clinical Co-ordinator for Medicine focus on improvement of environment,	Working group in place and will remain as an improvement feature.

Reference number	Recommendations	Designated department	Action required	Date for completion/ timescale
8	It is recommended that the trust should continue to introduce and monitor the nursing quality indicators (NQIs), with particular attention given to record keeping.	Nursing	Nursing KPI's continue to be documented and monitored monthly with corrective action taken if compliance slips below acceptable levels	In place pre-review. Reminder / reinforcement continues.
9	It is recommended that the trust ensures that all areas are tidy, in good repair and fixtures and fittings replaced where necessary; the spacing within bays should be reviewed to ensure that they are in line with current recommendations for core clinical space.	Nursing	Transfer of ward to Phase B will see all patients in new build single rooms. In the interim, a monthly environmental audit takes place. Every ward has a Band 3 Housekeeper in place. Requests made to Estates for repairs as need identified.	In place / planned pre-review.
10	It is recommended that the sanitary facilities, including bathrooms and showers in some wards, are repaired and appropriate adaptations put in place for disabled use.	Nursing Estates	All repairs and adaptations have been completed. Trust capital scheme manages all works to include programme of bathroom / shower equipment / environment maintenance. All showers replaced with CoE during recent months.	System in place pre-review. Needs met through Capital Scheme.
11	It is recommended that trust staff wear name badges which are easily seen and denote the staff designation.	Nursing All	Arrangements in place for all staff to access suitable badges. Ward managers to ensure that all staff are compliant. Nurse-in-charge badge in place. #hellomynameis campaign in place. In place as priority focus through Regional Patient Experience x 4 Priorities. Hotboards design and content has been drafted and consulted upon and undergoing further development.	Focus heightened through implementation of 2014 / 2015 Regional PCE Action Plan.

Reference number	Recommendations	Designated department	Action required	Date for completion/ timescale
12	It is recommended that the trust undertakes further work to ensure that all staff provide the appropriate personal care, privacy is maintained at all times and all patients are treated with dignity and respect	Nursing	Nursing Strategy to provide person-centred care to all patients is in place. Patient experience quality improvement mechanisms support quality improvement focus in this area. Privacy & Dignity Trust Policy in place and adhered to. Element added to Pt Exp bedside satisfaction survey and focused upon through 10,000 Voices. W 23 (Stroke – Specialised Area) always attains consent to place a patient within mixed gender bay – and moves patient to single sex bay at earliest opportunity. Interpreter service used to ensure quality of communication to ensure dignity and respect standards are upheld. Bereavement (last offices) and nutrition arrangements in place to ensure adherence to culture / privacy & dignity requirements. Each ward participates in satisfaction surveys, patient stories, observations of practice, 10k voices, #hellomynameis, web-based etc and any issues or themes are identified and actioned. Reported to Safety & Quality Committee. Comprehensive action programme in place. All staff have been reminded of responsibility to ensure patient / data confidentiality / protection – with direct focus on positioning of	Programmes in place (pre and since review)to focus on maintaining and improving performance. Post review, Staff reminded of responsibilities.

Reference number	Recommendations	Designated department	Action required	Date for completion/ timescale
			computer screens incident. Single sign on protective mechanism in place – locks screen after short period of inactivity.	
13	It is recommended that staff ensure that care rounding is carried out as per trust protocol and documentation fully completed. Information identified on care rounds should correspond with patient care plans	Nursing	Intentional rounding carried out per ward in correspondence with care plan content. A suitable audit tool will be devised to meet this need. To incorporate into pilot of Nurse Led Ward Rounds on UHD Ward 23 – with further cascade.	In place pre-review. To complete review and develop improved arrangement. Under Trust SQE improvement focus. Process started – completion point of development timeframe not definable at this point.
14	It is recommended that call bells are within patients' reach and answered promptly.	Nursing	Actioned. Requirements met. Raised at staff meetings to ensure that checking takes place. Recorded in meeting minutes. Audits carried out..	Completed. Continued audit / checking.

Reference number	Recommendations	Designated department	Action required	Date for completion/ timescale
15	It is recommended that all patients receive the essential care needed at all times	Nursing	Ratio of staff:patient met as per recommendations. Intentional rounding addresses this requirement. Patients encouraged to use buzzer / alert staff when needed. Personalised care planning identifies and plans around individual essential care needs.	In place pre-review and continued focus on maintaining and improving performance.
16	It is recommended that the trust policy on protected meal times is adhered to by all staff.	Nursing	Policy in place and adhered to. December 2014 Patient monitoring exercise to take place through electronic post-mealtime pop-up question set on Hospedia system. Findings and recommendations to be transferred to all areas to support improvement / compliance. Findings to support discussion around protected mealtimes arrangements going forward. To add Protected Mealtimes to ward manager meeting agenda.	In place pre-review. Dec 2014 monitoring exercise to take place to inform ward improvement recommendations and general protected mealtime planning going forward.
17	It is recommended that the trust clarifies the system in place to identify patients who require assistance or encouragement with meals and provide appropriate adapted crockery and cutlery.	Nursing	System in place per area (e.g. red dot / plate / symbol on tray). Cutlery and crockery provided as per Occ Therapy guidance following assessment. Supported through Clinical Nutrition Sub Committee.	In place. Clarified. Ongoing development focus.

Reference number	Recommendations	Designated department	Action required	Date for completion/ timescale
18	It is recommended that if de-facto detention is used, local detailed procedures are put in place, including how this is documented.	Nursing	Current system in place for safety of patients. Cannot action. To consider, high-risk confused patients and site on busy main road. Patients with capacity are free to exit the ward and can be assisted to do so.	To consider further.
19	It is recommended that staff should adhere to the trust's infection, prevention and control polices in relation to use of personal protective equipment, adherence to dress code policy and disposal of wash water.	Nursing All	Trust policies in place and adhered to. IPC Team guidance followed (aprons / masks / gloves / masks). Appropriate PPE for feeding and for IPC. Disposal of wash water in sluice. Sinks used only for hand-washing. Advice reinforced to staff. Laminated notice placed at location – planned introduction. Staff reminded to adhere to Dress Code Policy.	Arrangements in place. Reminder / reinforcement and monitoring continue.
20	It is recommended that staff should adhere to the trust's administration of medication policy.	Nursing	Trust policy in place and adhered to. Staff reminded and reinforced.	In place pre-review. Adherence continually monitored.
21	It is recommended that the assessment of patients nursing needs should be patient focused and identify individual needs and interventions required. This should be reviewed and updated in response to changing needs of patients	Nursing	Handwritten personalised careplans produced. Daily focus, Daily evaluation. All staff have been reminded of the importance of nurse record keeping in	In place pre-review. In development

Reference number	Recommendations	Designated department	Action required	Date for completion/ timescale
			relation to care planning. The Ward Managers continue to work on this to develop 'standardised care plans'.	at present. Completion date not yet definable.
22	It is recommended that all risk assessments should be completed within the set timescales. These should be reviewed and updated on a regular basis, or when there are changes in the patient's condition. Identified risks should have a plan of care devised to provide instruction on how to minimise the risks.	Nursing	MUST, Braden, Falls, Pressure, SKIN, EWS all in place. Individualised with scores determined and appropriate action taken as per scores.	In place pre-review. Remind, reinforce and monitor continually (inc. within timescale).
23	It is recommended that care plans should be devised for all identified patient's needs. These should be reviewed and updated within the set timescale, or in in response to changing needs of patients.	Nursing	Written personalised care plans per patient produced and evaluated daily. All staff have been reminded of the importance of nurse record keeping in relation to care planning. The Ward Managers continue to work on this to develop 'standardised care plans'. Regional instruction awaited on direction in this area. Will comply with regional recommendation when issued.	In place pre-review. In development at present. Completion point not yet definable.

Reference number	Recommendations	Designated department	Action required	Date for completion/ timescale
24	It is recommended that nurse record keeping should adhere to NMC and NIPEC guidelines.	Nursing	Trust Record Keeping Policy in place and adhered to.	Audit tool – legible, dated, signed. NIPEC audit tool
25	It is recommended that medical staff comply with the trusts DNAR policy and nursing staff complete the DNAR section of the nursing assessment booklet.	Medical Nursing	All staff reminded to comply with Trust DNAR Policy. All staff reminded to complete DNAR section of nursing assessment booklet. Added to Clinical Manager meeting agenda and discussed with staff.	In place pre-review. Documentation completion raised with staff.
26	It is recommended that the trust should develop measures to improve staff to patient interactions, ensuring that patients are always treated with dignity and respect.	Nursing Safe and Eff Care	Each ward participates in satisfaction surveys, patient stories, observations of practice, 10k voices, #hellomynameis, web-based etc and any issues or themes are identified and actioned. Reported to Safety & Quality Committee. Comprehensive action programme in place. Trust Privacy & Dignity Policy in place and adhered to.	Programmes in place pre and since review.
27	The trust should acknowledge patient, relative, carer comments to improve the patient experience.	Nursing and Safe Care	Each ward participates in satisfaction surveys, patient stories, observations of practice, 10k voices, #hellomynameis, web-based etc and any issues or themes are identified and actioned. Reported to Safety & Quality Committee. Comprehensive action programme in place. Trust Privacy and Dignity Policy in place and adhered to,	Programmes in place pre and since review.

Reference number	Recommendations	Designated department	Action required	Date for completion/ timescale
28	It is recommended that the Trust and NIAS evaluate the impact of this role and agree clearly defined roles and responsibilities.	ED / Nursing	As per Item 1. Much work has been done with Alamac to reduce 12 and 4 hour waiting times in ED. Bed managers manage direct admissions to Care of Elderly as appropriate. If bed available, Coe will accept direct admissions from ED.	Fuller statement to follow from ED lead.
29	It is recommended that the trust reviews the current documentation to improve assessments for common frailty syndromes and depression.	ED / Nursing	Tool (depression scale) available and used for measuring depression in elderly. Abbey Pain Scale used for non-verbal assessments. OTs use MOCA scale cognitive assessment tool. To review and address staff knowledge on usage of appropriate tools. e.g. training on Abbey Pain Score. Nursing documentation includes section on Emotional and Psychological Needs. Checklist in medical documentation to assess potential cognitive impairment. Pain Review Team established and carrying out baseline work and gathering feedback directly from patients.to work toward improvement in this area.	In place pre-review. Currently being addressed and will be continually monitored / acted upon.

Reference number	Recommendations	Designated department	Action required	Date for completion/ timescale
30	It is recommended that sufficient supplies of equipment are available.	Nursing	All essential equipment is supplied as required, including fully-functional gym for rehab. Equipment made available / ordered to meet need. Charitable Funds accessed to purchase items of equipment. System in place to report / repair / replace / introduce / maintain / manage equipment upon identification of need. Staff reminded of responsibilities to report faulty or broken equipment upon identification.	In place pre-review. System in place. Staff reminded to report early.
31	All staff should receive training on dementia care and care of the vulnerable adult.	Nursing	All staff complete elearning for vulnerable adult training. In-house Butterfly Scheme training delivered for all staff. Clinical Education Centre provides dementia training for all applicable staff. Access to Consultant Nurse for training / advice. Specialist Ward at LVH Ward 11, staff visited for shared learning. Working Group in place to focus on improvement of environment,	In place pre-review. Training in place for all staff. Additional introduction of Butterfly Scheme training.
32	The trust should review the services available out of hours and information available for patients.	Nursing All	ED Quality Improvement Group and Regional Collaborative in place to address ED / Unscheduled Care issues. Bangor Hospital lift has been fixed. Trust has contract in place with Red Cross.	In place pre-review and continuing.

Reference number	Recommendations	Designated department	Action required	Date for completion/ timescale
			Concerted efforts in place to discharge early and before 17:00 to avoid OOH situation.	

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