The Regulation and Quality Improvement Authority

Unannounced Inspection Report
16 & 17 October 2018

Belfast City Hospital
Belfast Health and Social Care Trust

Type of Service: Outpatient Departments
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Abbreviations

IPC	**Infection Prevention and Control**
QIP	Quality Improvement Plan
RQIA	Regulation and Quality Improvement Authority
QUIS	Quality of Interaction Schedule
BCH	Belfast City Hospital
OPD	Outpatient Department
BHSCT	Belfast Health and Social Care Trust

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service. The findings reported on are those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not exempt the service from their responsibility for maintaining compliance with legislation, standards and best practice.

1.0 What we look for

2.0 Profile of service

The Belfast City Hospital (BCH) is a 900-bed university teaching hospital providing local acute services and key regional specialties, including renal medicine and transplantation and a comprehensive range of cancer services.

The hospital's Outpatients Department is located on the ground floor of the main hospital building and comprises of a reception, waiting areas, a blood room and consultation rooms. The department is separated into wings, each designated for the treatment of patients with a range of different conditions. Wings A to C are used for clinics such as general surgery, urology, diabetes and wings E to G are used for clinics such as gynaecology, neurology and general medicine.

3.0 Service details

Responsible person: Mr Martin Dillon (BHSCT)	**Department Manager:** Amanda Tuckey/Bernadette Fitzmaurice
Person in charge at the time of inspection: Bernadette Fitzmaurice, Outpatient Department Manager Nikki Barr and Ashley McGuinness, Deputy Outpatient Manager	

4.0 Inspection summary

An unannounced inspection of the Outpatients Department (Wings A to C and E to G) in BCH took place over a period of two days from Thursday 18 October to Friday 19 October 2018.

This inspection was underpinned by The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, and The Quality Standards for Health and Social Care DHSSPSNI (March 2006).

For the purposes of this inspection, an outpatient service was considered as one which enables patients to see a consultant, their staff and/ or associated health professionals for assessment or review in relation to a specific condition, but where patients are not admitted into hospital.

The inspection was completed as part of Phase 3 of the Regulation and Quality Improvement Authority's (RQIA's) Hospital Inspection Programme. It was one of five unannounced inspections carried out in the Belfast Trust during October 2018. Inspections were undertaken across 60 specialities and 5 hospital outpatient departments. The other sites inspected were: Mater Infirmorum Hospital, Musgrave Park Hospital, Royal Victoria Hospital and Royal Belfast Hospital for Sick Children. Reports of these inspections are available on our website https://www.rqia.org.uk.

These inspections also formed part of RQIA's Review of Governance Arrangements in Outpatients Services in the Belfast Trust, with a Particular Focus on Neurology and Other High Volume Specialties. This review was announced by the Department of Health in May 2018 following the announcement of a recall of patients under the care of a Consultant Neurologist in Belfast Trust.

We employed a multidisciplinary inspection methodology during this inspection. A Lay Assessor supported the inspection in respect of patient feedback. Our Lay Assessor engaged directly with patients and their relatives to gather feedback on their experiences in relation to their outpatient appointment.

Our multidisciplinary inspection team examined a number of aspects of the department, from front-line care and practices, to management and oversight of governance across the organisation. We met with various staff groups, spoke with patients and their relatives, observed care practice and reviewed relevant records and documentation used to support the governance and assurance systems.

We identified good front line care within the Outpatients Department in BCH.

Patients and their relatives advised us they were happy with their care and spoke positively regarding their experiences and interactions with all staff. We observed staff treating patients and their relatives with dignity, staff were respectful of patients' right to privacy and to make informed choices.

We found that staffing levels and morale in the department were good with evidence of good multidisciplinary team working and open communication between staff. Overall staff feedback was positive; they told us that they were happy, well supported and that there were good working relationships throughout the hospital.

We undertook a review of the current arrangements for governance and managerial oversight within the Outpatients Department in BCH. We identified concerns in relation to information and learning shared between outpatient managers, the oversight or assurance arrangements for specialist nurses, the fabric of the environment and facilities for patients, infection prevention and control, and the risk assessment related to the placement of resuscitation equipment.

We also identified concerns in relation to staff knowledge, training and audit in relation to adult and child safeguarding and the display of safeguarding information for staff, patients and relatives.

4.1 Inspection outcome

Total number of areas for improvement	7

Seven areas for improvement were identified, these related to:

- sharing of information and learning between outpatient managers;
- governance arrangements for specialist nurses;
- fabric of the environment and facilities for patients;
- infection prevention and control;
- risk assessment related to placement of resuscitation equipment;
- Safeguarding; and
- availability and display of safeguarding information for staff, patients and relatives.

This report sets out findings which are specific to our inspection of the Outpatients Department in BCH. Recommendations relating to wider issues across the Trust's outpatients services will be presented in the report of RQIA's Review of Governance Arrangements in Outpatients Services in the Belfast Trust, with a Particular Focus on Neurology and Other High Volume Specialties.

On 29 January 2019, we provided local feedback to Joanne Quinn, Service Manager and Ms Tuckey Manager, Outpatients Department in BCH and a number of representatives from the management team regarding the inspection findings. During the meeting we discussed the Outpatients Department in BCH strengths and the areas identified for improvement identified during our inspection.

The areas for improvement arising from this inspection are detailed in the Quality Improvement Plan (QIP). The timescales for completion of these actions commence from the date of our inspection.

4.2 Enforcement action taken following our inspection

We were concerned about the safeguarding arrangements within the Outpatients Departments within the Belfast Trust.

We identified concerns relating to staff knowledge, awareness and understanding of safeguarding issues within outpatient departments/services and the ability of staff to recognise such issues and respond appropriately to ensure vulnerable patients and service users are protected.

This issue was escalated by RQIA's Director of Improvement/Medical Director directly to the Trust's Chief Executive and relevant Executive Directors and three escalation/update meetings were held with the Trust (13 March, 25 July, and 3 September 2019) to discuss implementation of a targeted action plan to address these findings.

Following these meetings, and on review of additional evidence submitted by the Trust, RQIA determined that the Trust has carried out significant work to address our concerns relating to safeguarding within the outpatients department setting. The effectiveness and impact of these actions in relation to Safeguarding will be kept under review, with a progress meeting between RQIA and the Trust planned for March 2020.

5.0 How we inspect

RQIA inspects quality of care under four domains:

- Is the Service Well- Led?
  Under this domain we look for evidence that the ward or department is managed and organised in such a way that patients and staff feel safe, secure and supported;
- Is Care Safe?
  Under this domain we look for evidence that patients are protected from harm associated with the treatment, care and support that is intended to help them;
- Is Care Effective?
  Under this domain we look for evidence that the ward or unit or service is providing the right care, by the right person, at the right time, in the right place for the best outcome; and
- Is Care Compassionate?
  Under this domain we look for evidence that patients, family members and carers are treated with dignity and respect and are fully involved in decisions affecting their treatment, care and support.

Under each of the above domains and depending on the findings of our inspection, we may recommend a number of actions for improvement that will form the basis of a QIP. Through their QIP the hospital and Trust will put in place measures to enhance the quality of care delivered to patients and to address issues and/or challenges we have identified during inspection.

The standards we use to assess the quality of care during our inspections can be found on our website[1]. We assess these standards through examining a set of core indicators. Together these core indicators make up our inspection framework, and this framework enables us to reach a rounded conclusion about the ward or unit or service we are inspecting.

During inspections the views of, and feedback received from, patients and service users is central to helping our inspection team build a picture of the care experienced in the areas inspected. We use questionnaires to facilitate patients and relatives to share their views and experiences with us. Our inspection team also observes communication between staff and patients, staff and relatives/family members, and staff and visitors. Members of our inspection team use the Quality of Interaction Schedule (QUIS) observation tool to carry out observation. This tool allows for the systematic recording of interactions to enable assessment of the overall quality of interactions.

We also facilitate meetings and focus groups with staff at all levels and across all disciplines in the areas or services we inspect. We use information and learning arising through these discussions to inform the overall outcome of the inspection and the report produced following our visit.

[1] https://www.rqia.org.uk/guidance/legislation-and-standards/standards/

6.0 The inspection

6.1 Is the service well led?

Effective leadership, management and governance which creates a culture focused on the needs and experience of service users in order to deliver safe, effective and compassionate care.

During this inspection we examined if the Outpatients Department in BCH was managed and organised in a way that patients and staff are safe, secure and supported. The Belfast Trust organisational leadership, management and governance is addressed in RQIA's Review of Governance Arrangements in Outpatients Services in the Belfast Trust, with a Particular Focus on Neurology and Other High Volume Specialties report.

6.1.1 Departmental oversight and management

We reviewed a sample of records and minutes of meetings and discussed the outpatient department's governance arrangements and managerial oversight with a number of staff. This included meeting the outpatient managers, deputies and the service manager for the department. We found evidence of professional leadership and support provided by the managers.

The managers were able to describe sufficiently effective governing systems to monitor quality, identify emerging risks and assure themselves that high quality care and treatment was being provided. We found evidence of audits in respect of hand hygiene and environmental cleanliness.

There was evidence of staff attending a daily safety brief and regular staff meetings, during which learning is shared. We found that the safety brief included discussion on a range of key issues including daily staffing levels.

Through our inspections to other outpatient departments within the Trust we were informed of an outpatient managers' forum which meets regularly to share information and learning. We did not find a system for regular meetings within the BCH. We would encourage BCH outpatient managers' attendance at this forum and the introduction of regular meetings to share information and learning and strengthening oversight arrangements for outpatient services.

Specialist nurses were observed practicing autonomously; there was no evidence of system level oversight or assurance arrangements for specialist nurses. The safety and quality of care delivered by these professionals is the responsibility of individual line managers rather than the nurse in charge of the department. However, the outpatients' manager outlined how they would address concerns directly with their line manager.

6.1.2 Organisation

We examined pathways and process for the assessment and treatment of patients within the department and were informed of new service models to deliver outpatient services in place. In the upper gastrointestinal surgical outpatient's service a pre-assessment clinic had been established to run parallel with the surgical clinic. Following an initial consultation patients are assessed at the pre-assessment clinic by a multi-disciplinary team where all required investigations are carried out during a single visit. A meeting is held prior to clinics to identify and anticipate specific individual patient needs in advance in order to prepare and plan for the visit.

We observed the use of a new outcomes form that had been developed to record the next steps following an attendance. This had been developed in response to learning from an adverse incident. We noticed this has been implemented in a number of areas and would encourage its use across all areas within the outpatients department.

The aim of these service initiatives was to improve efficiency and reduce waiting times for patients accessing the services and staff stated this had a positive effect on patients. We observed that the clinics were organised and functioning efficiently.

6.1.3 Staffing

We reviewed staffing arrangements in the department and found there was a multi-professional team appropriate to support the delivery of patient care. We found that there were appropriate medical staffing levels throughout the department and junior medical staff reported having a good induction and training in the department.

We found that staff morale throughout the department was good, with evidence of multidisciplinary working and good communication between staff. Staff told us that they were happy, felt supported and engaged, and that there were good working relationships throughout the department. They also reported feeling safe on site, including at evening and weekend clinics.

Our review of staff rotas and discussion with managers noted significant use of nursing bank staff. We were satisfied that these bank staff were block booked and sufficient in number to deliver and promote consistency of care.

We observed nursing staff delivering care to patients and determined that the team was sufficiently experienced and skilled to carry out their role. We found that senior nursing staff were highly visible and approachable within the department. We observed staff working well together and noticed good communication between staff in respect of information sharing and care delivered. We evidenced an effective morning safety brief and regular team meetings.

We reviewed records relating to supervision and appraisal of staff working in the department. We found these were up to date. We were told of a system in place whereby link nurses are identified to provide expert advice as part of ongoing support for staff in the areas such as of IPC. Managers reported that training was available to meet the needs of staff and there was a monitoring system in the department to evaluate staffs' compliance with mandatory training requirements. Nursing staff reported having received good inductions to the department.

Areas of good practice - Is the service well Led?

We identified areas of good practices in relation to the induction, training and support of staff, the practice of safety briefings, the parallel scheduling of surgical and pre-assessment clinics and multi-disciplinary team meetings.

Areas for improvement – Is the service well led?

We identified an area for improvement in relation to sharing of information and learning between outpatient managers and the governance arrangements for specialist nurses.

Number of areas for improvement	2

6.2 Is care safe?

Avoiding and preventing harm to patients and clients from the care, treatment and support that is intended to help them.

6.2.1 Environmental cleanliness and facilities

We observed overall the environment was clean and tidy. However, there was some evidence of wear and tear in areas of high usage. We did not observe any specific dementia-friendly communication equipment such as large clocks or a hearing aid loop system within the Ear Nose and Throat clinic to enhance the experience of people with hearing aids.

We observed that signage to direct patients was inadequate resulting in confusion for patients trying to locate specific clinic areas. There is one reception desk in the main department foyer and we observed staff frequently being helpful and re-directing patients. Several members of staff suggested that a volunteer system could help patients to find their way around the department.

We observed that storage space throughout the department was limited and as a result some areas were cluttered however we noted staff made significant efforts to efficiently use the limited space. We learned that plans were being developed to enhance the physical space of the department such as widening doors to improve disabled access and refurbishment of handwashing facilities.

Cleaning schedules were in place, although we found gaps in the completion of the schedule in one room.

We noted only one disabled accessible toilet for the entire outpatient department. Given the profile and volume of patients attending the department, this would not be adequate and would not promote a positive patent experience. In Wings E- G the treatment room did not meet required standards in relation to infection prevention and control and handwashing and we also noted no dedicated room to break bad news to patients. These issues were identified on the department risk register.

We found inadequate facilitation for patients with additional physical needs. The physical make-up of the environment did not easily accommodate larger wheelchairs in some clinics such as neurology, with large numbers of wheelchair users. We did not find evidence of patient call bells in all spaces were patients may be left alone temporarily such as consultation rooms and treatment rooms in line with Health Building Note 12 – Outpatients Department.

6.2.2 Infection prevention and control (IPC)

We observed working practices to ensure staff minimised the risk of infection. We observed good standards in hand hygiene and compliance with the Trust's uniform policy.

We confirmed staff had undertaken IPC training commensurate with their role. Staff who spoke with us had good knowledge on matters relating to IPC and good compliance with best practice was evident.

Performance indicators for audits relating to best practice for hand hygiene and environmental cleanliness were displayed in the department good compliance was evident.

We found that the manual decontamination of probes in the department was recorded on the department risk register as ideally this would be completed in a central sterile services department and we understand that the Trust is represented on a regional decontamination group where work is ongoing to resolve this issue.

We observed the blood room for taking blood had no aprons available for staff to use while carrying out their duties, to protect their clothes from potential risk of contamination from blood or chemical splashes during cleaning. The dirty utility room in Wings A-C (which held sharps boxes/used needles) was open and easily accessible to the public, presenting a potential risk of needle diversion.

6.2.3 Patient safety

We observed department staff practice and reviewed policies and procedures to ensure the delivery of care is safe and effective practice. Staff within the department were knowledgeable and able to access policies and procedures to support patient care.

We identified that in Wings A-C, there were no staff trained in paediatric life support and that at times children do attend the department. We welcomed plans to train one member of staff during December 2018; however we determined this was likely to be insufficient given the numbers of patients and relatives attending.

We observed that there was only one resuscitation trolley in use for the entire department. Given the size of the department and the numbers of patients we were concerned this was not sufficient and would expect to see a detailed resuscitation risk assessment to specify what equipment is required and where is should be located. We did not find evidence that this had taken place.

Point of care blood testing equipment allows accurate and immediate test results for specific groups of patients. Nursing staff identified they would benefit from point of care blood testing in the diabetic clinic. Patient blood results were not available during the clinic and therefore staff have to contact patients after their appointment with revised treatment plans in view of their blood result. We would encourage the Trust to consider if introducing this equipment could improve the efficiency of the service delivered to patients.

6.2.4 Medicines management

We reviewed arrangements for the management of medicines within the department to ensure medicines are safely, securely and effectively managed in compliance with legislative requirements, professional standards and guidelines.

Systems were in place to manage and oversee ordering and stock control, to ensure adequate supplies were available and to prevent wastage. We found medications were appropriately managed within the department. We identified that pharmacists were available to give advice to clinics when needed. There were very few medicines stored in the department, but those that were present were stored securely. Oxygen cylinders were stored correctly, i.e. upright and with signage in place to denote their presence in the event of a fire.

There were no controlled drugs in the department and following a risk assessment, there was a system for the weekend storage of Botulinum Toxin whereby it was removed and stored in the pharmacy department, outside the clinic.

6.2.5 Safeguarding

We reviewed arrangements for safeguarding of children and adults in accordance with the current regional guidelines. We confirmed policies and procedures were available in relation to safeguarding and protection of children at risk of harm. We found that a planned update review of the Trust's Adult Protection Policy and Procedures (2013) which was due in 2015 had not been carried out despite the subsequent issue of a new regional policy, Adult Safeguarding: Prevention and Protection in Partnership Policy (2015) and Adult Safeguarding Operational Procedures (2016).

We spoke to medical and nursing staff to confirm knowledge and understanding of their roles and responsibilities in safeguarding. Some staff indicated that they had undertaken safeguarding training and we found inconsistencies in the level of knowledge across medical and nursing staff. We noted limited awareness across staff groups of their responsibilities for safeguarding of both children and adults and we were concerned that staff were unclear of their roles and/or triggers to escalate safeguarding concerns.

We reviewed a number of training records and asked managers to supply information about which staff had completed safeguarding training. We found it difficult to obtain information and though some managers had some information we did not find a system in place to monitor which staff had and been trained across all areas.

The levels of training and knowledge and awareness of staff in relation to safeguarding were of significant concern. We could not be confident that safeguarding matters would be recognised or actioned appropriately in the context of outpatient services delivered across the Trust.

We did not see information/posters about safeguarding displayed in any outpatient departments we visited. Such information is essential to guide patients, their relatives/carers and as an aide memoire for staff. This information should encourage disclosures of a safeguarding nature within the safe environment of a consultation with health care professionals.

We could not find evidence of audits being carried out in relation to adherence to Trust Policies.

Due to our concerns in relation to Safeguarding we escalated these matters to the Trust's Chief Executive and relevant Director for action.

Areas of good practice - Is care safe?

We identified areas of good practice in relation to patients treated safely and supported during the delivery of care, cleaning and medicines management.

Areas for improvement - Is care safe?

We identified areas for improvement in relation to fabric of the environment and facilities for patients, IPC, risk assessment related to placement of resuscitation equipment, staff knowledge, training and audit in relation to child and adult safeguarding and the display of safeguarding information for staff, patients and relatives.

Number of areas for improvement	5

6.3 Is care effective?

The right care, at the right time in the right place with the best outcome.

6.3.1 Meeting patients' individual needs

During this inspection we observed the care and treatment provided to patients to ensure that their individual care needs were met. We observed staff responding to patients in a compassionate and timely manner. Many areas of good practice were identified with respect to care delivered. We spoke to patients and relatives who were complimentary of the quality of care and services received.

We observed the use of a pain scale available for staff to reference when assessing patient pain level and were told that whilst paracetamol is available in the department other pain medication could be ordered from the hospital pharmacy if required. The patients we spoke to reported they were comfortable and not in pain.

At times patients attending clinics may require input from specialist staff. We observed and are pleased to note staff being able to contact specialists such as tissue viability for advice to augment holistic patient care.

Patients attending the diabetic clinic may require specialist medication in the event of a medical emergency. We observed that the diabetes emergency kit was stored in a treatment room and would suggest relocation to ensure it is easily available in an emergency situation

6.3.2 Record keeping

We reviewed clinical records and other documentation to ensure record keeping was completed in line with best practice standards. In respect of medical records we identified good record keeping practices, although a small number had legibility issues. There was evidence in the notes of patients being involved in decisions about their care. With the exception of recording patient clinical observations, nursing staff do not to write in patient notes.

6.3.3 Communication

We reviewed the systems and processes supporting effective communication within the department and found examples of good multidisciplinary working, effective lines of communication and supportive structures in place.

We confirmed that nursing and care staff attend a daily safety brief at the beginning of each shift and that a written record is retained to evidence the content and format of the safety brief.

Relatives and carers indicated that their interactions with all grades of staff were positive and they received the necessary information in relation to the patients care and treatment.

6.3.4 Nutrition and hydration

We reviewed the arrangements to ensure patients had access to appropriate food and water and their nutritional needs met. Staff were able to order a lunchbox for patients who are diabetic or became unwell and required longer stay in hospital. Facilities were available during clinics and into the evening for patients attending late clinics.

Areas of Good Practice- Is care effective?

We identified areas of good practice in relation to delivery of care, provision of nutritional support the communication between patients, relative/carers and staff.

Areas for Improvement - Is care effective?

No areas were identified for improvement.

Number of areas for improvement	0

6.4 Is care compassionate?

Patients and clients are treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support.

6.4.1 Person-centred care

We spoke to patients and relatives, observed care delivery, looked at care records and met with various grades of staff to understand how the outpatients department ensures that patients receive person centred care. We observed staff at all levels treated patients with compassion, dignity and respect whilst delivering care and treatment. Conversations were discreet and could not be overheard. Patient details and records were stored appropriately so that confidential and private information was not compromised and privacy was maintained.

During the inspection we observed how staff engaged with patients and relatives to promote high quality care and a positive patient experience. We observed compassionate interactions between staff and patients in all clinics. Most staff wore name badges that made them easily identifiable.

We found staff had access to the interpreting services and staff described how they supported patients with a hearing impairment which involved providing a quiet environment.

We noted the display of general information and notice boards, with information leaflets available in different languages and formats if required.

6.4.2 Patient and staff views

During our inspection, we spoke with patients and relatives, distributed questionnaires to relatives and encouraged them to complete questionnaires during the inspection. Patients also had access to an electronic questionnaire for completion and return to RQIA. We spoke to patients and relatives to obtain feedback about their experience of attending the outpatients department. Those we spoke to during our inspection reported feeling content and positive about their experience however commented on the length of waiting time in the department (which was not always explained), the confusing layout of the department and difficult access to car parking.

Areas of good practice - Is care compassionate?

We identified areas for good practice in relation to patient privacy, dignity and respect, interaction with staff and confidentiality of records.

Areas for improvement – Is care compassionate?

We did not identify any areas for improvement during this inspection in relation to compassionate care.

Number of areas for improvement	0

7.0 Quality improvement plan (QIP)

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Joanne Quinn, Service Manager and Ms Tuckey Manager Outpatients Department in BCH and a number of representatives from the management team as part of the inspection process. The timescales for implementation of these improvements commence from the date of this inspection.

The Trust should note that if the action outlined in the QIP is not taken to comply with regulations and standards this may lead to further action. It is the responsibility of the Trust to ensure that all areas for improvement identified within the QIP are addressed within the specified timescales.

7.1 Areas for improvement

Areas for improvement have been identified and action is required to ensure compliance with The Quality Standards for Health and Social Care DHSSPSNI (March 2006).

7.2 Actions to be taken by the service

The QIP should be completed and detail the actions taken to meet the areas for improvement identified. The Trust should confirm that these actions have been completed and return the completed QIP to BSU.Admin@riqa.org.uk for assessment by the inspector by **5 March 2020**.

Quality Improvement Plan

The Trust must ensure the following findings are addressed:

Departmental oversight and management

Area for Improvement 1 **Ref**: Standard 4.3 (b) **Stated:** First **To be completed by:** 5 March 2020	The Trust should develop a formal mechanism for managers across various outpatient services to share learning, identify common issues or risks and ensure consistency in service development and improvement. **Ref:** 6.1.1
	Response by the Trust detailing the actions taken: Outpatient sisters meet monthly to share learning, identify common issues or risks and ensure consistency in service development and improvement. We are in the process of establishing a forum for the Assistant Service Managers with responsibility for outpatient services across all sites to meet formally on a regular basis. A Trust oversight group focusing on safeguarding in outpatient departments was established to respond to the immediate concern raised by RQIA in November 2018. It is anticipated that the membership of this forum will also be used to provide the mechanism for managers across all outpatient services to share learning and ensure standardisation of processes.
Area for Improvement 2 **Ref**: Standard 4.3 (b) **Stated:** First **To be completed by:** 5 March 2020	The Trust must strengthen arrangements for oversight and monitoring of specialist nurses in Belfast City Hospital, Outpatients Department. **Ref:** 6.1.1
	Response by the Trust detailing the actions taken: Line management structures are in place for all specialist nurses through their specialty teams. A scoping exercise is being carried out via the Senior Nursing and Midwifery Team to identify the specialist nurses who contribute to outpatient services with the with the intention of developing a standard operating protocol (SOP). This will include peer review and governance arrangements.

Environmental cleanliness and facilities and Infection Prevention and Control	
Area for Improvement 3 **Ref**: Standard 5.3.1 (a,e,f) **Stated:** First **To be completed by:** 5 March 2020	The Trust should improve the fabric of the environment and facilities for patients during refurbishment or building work, to include: • maintenance to areas of wear and tear; • introduction of a patient call bell and hearing aid loop system; • improved disabled/wheelchair access; • increase availability of disabled toilets; • designate quiet/breaking bad news area; • treatment room upgrade; and • improved signage throughout the department. **Ref:** 6.2.1
	Response by the Trust detailing the actions taken: • Requests are submitted to estates department for wear and tear as required, and are prioritised as necessary. In addition, monthly environmental audits are carried out and any identified estates issues are addressed as appropriate. • An audit was undertaken of BCH outpatients to identify specific areas where a call bell system would be necessary to ensure patient safety. As result, Wing G have ordered a call bell and are awaiting installation. • The Equality and Diversity team have been asked for their support and advice in relation to the hearing aid loop system in outpatients. The outcome of this review will be actioned as appropriate. • The Equality and Diversity team have been asked for their support and advice in relation to improving disabled/wheelchair access in outpatients. The outcome of this review will be actioned as appropriate. • The Equality and Diversity team have been asked for their support and advice in relation to increasing availability of disabled toilet in outpatients. The outcome of this review will be actioned as appropriate. • The service will liaise with estates and capital redevelopment to explore the possibility of creating a designated quiet/breaking bad news area. • An estates work request has been submitted to upgrade treatment rooms. This will be followed up and actioned accordingly. • The implementation of a new signage system in BCH has been partially implemented within the department. This work is ongoing.

Area for Improvement 4 **Ref**: Standard 5.3.1 (f) **Stated:** First **To be completed by:** 5 March 2020	The Trust should ensure IPC best practice is adhered to in order to negate potential risk of contamination and injury. This should include: • aprons available for all staff carrying out procedures were there is potential for splashes from blood/body fluids or chemicals; and • dirty utility rooms are designated unauthorised access and inaccessible to the public. **Ref:** 6.2.2
	Response by the Trust detailing the actions taken: Aprons are widely available within all departments as per trust policy. Staff have been advised of their responsibilities to be complaint with Infection Prevention Control and Personal Protective Equipment (PPE) policies. The dirty utility room door has now been altered so that it is self-closing and a new sign indicating 'staff only' is now in place. Due to high usage it is not feasible to lock this door.
Patient safety	
Area for Improvement 5 **Ref**: Standard 4.3 (i) **Stated:** First **To be completed by:** 5 March 2020	The Trust must carry out a risk assessment in respect of the availability of resuscitation equipment and the level of training provided for staff within the outpatient department. Recommendations made as a result of this should be implemented. **Ref:** 6.2.3
	Response by the Trust detailing the actions taken: A risk assessment has been carried out as recommended and, following a meeting with the resuscitation team, a second adult trolley has been purchased and is in use. A separate paediatric trolley is available and located in wing G.

Safeguarding	
Area for Improvement 6 **Ref**: Standard 5.3.1 (c) **Stated:** First **To be completed by:** 5 March 2020	The Trust must implement a system to provide assurance that staff have the appropriate knowledge, skills and training in Adult and Child Safeguarding. Actions should include: • updating Adult Protection Policy and Procedures in line with regional guidance; • updating the Trust Safeguarding training programme (to include all disciplines); and • introducing audit and reporting mechanisms to ensure adherence to the Trusts Safeguarding training programmes and to assess staff knowledge in relation to the effectiveness of that training (for all disciplines). **Ref:** 6.2.5
	Response by the Trust detailing the actions taken: As RQIA will be aware, the Trust has already submitted a separate action plan specifically focusing on the safeguarding of adults and children in outpatient settings. This was in response to the immediate concern raised in November 2018. We would therefore reference you to this action plan which will detail the actions as agreed with RQIA.
Area for Improvement 7 **Ref**: Standard 6.3.2 (b) **Stated:** First **To be completed by:** 5 March 2020	The Trust must ensure that the relevant information on Adult and Child Safeguarding is available and displayed for staff, patients and relatives. **Ref:** 6.2.5
	Response by the Trust detailing the actions taken: A concerted effort has been made over the last 12 months to ensure that staff, patients and relatives have access to the appropriate safeguarding documentation in outpatient department across the Trust, in keeping with the action plan in respect of safeguarding already shared with RQIA. Notice boards are available and routinely updated in individual outpatient wings with a variety of safeguarding posters. A new Safeguarding notice board has also been installed in the main waiting area of the department..

The Regulation and Quality Improvement Authority

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