



Acute Hospital Inspection: Antrim Area Hospital, October 2015

(Ward B2 Medical, Ward C6 Surgical,
Emergency Department)

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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.

Our Acute Hospital Inspections are carried out by a dedicated team of inspectors, from our Healthcare Team supported by lay assessors and peer reviewers from all trusts who have the relevant experience and knowledge. Our reports are available on the RQIA's website at www.rqia.org.uk.

RQIA wishes to thank those (including patients, their families and HSC staff) who facilitated this inspection through participating in interviews, or providing relevant information.

Background

In April 2014, the Minister for Health asked RQIA to put in place appropriate arrangements to deliver a rolling programme of unannounced inspections of the quality of services in acute hospitals in Northern Ireland to commence in 2015.

In a statement to the Northern Ireland Assembly on 1 July 2014, the Minister indicated that the programme of inspections would focus on a selection of quality indicators that would not be pre-notified to the trusts. No advance warning is provided to trusts as to which sites, or services within a hospital, will be visited as part of an unannounced inspection.

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Inspection Summary

This is the report of an Acute Hospital Inspection undertaken by RQIA as part of a new programme of inspections which commenced in 2015. The inspection process is designed to provide a detailed overview of care provided in three areas in an acute hospital.

An unannounced inspection was undertaken over three days from 21 October to 23 October 2015, at Antrim Area Hospital. The following areas were inspected:

- Ward B2 Medical
- Ward C6 Surgical
- Emergency Department (ED)

In these areas the four domains examined were:

- Is the clinical area well led?
- Is care safe?
- Is care effective?
- Is care compassionate?

The hospital was assessed using an inspection framework. The approaches used included; observation of practice; focus groups with staff; review of documentation and discussion with patients and relatives. A theme is identified for each inspection which at Antrim Area Hospital focused on handover arrangements.

The overall inspection framework enabled RQIA to reach a rounded conclusion as to the performance of the wards or departments inspected. The findings for each area are detailed in the body of the report and recommendations for each area follow the findings.

This report makes a number of recommendations in aspects where further change and improvement are required. The number of recommendations reflects the detailed nature of the inspection. The report should be used by the Northern Health and Social Care Trust (Northern Trust), as a vehicle to promote and facilitate further improvements in service delivery.

We identified good governance arrangement, systems and processes within the wards inspected. However, issues were identified in the ED which require improvement. These matters have already been brought to the attention of those with responsibility for oversight of the service.

Senior staff from the Northern Trust advised that the ED was particularly busy prior to and during the period of inspection.

We recognise that this increase in the number of admissions placed additional pressure on staff in ensuring the provision of effective care for patients.

Ward B2 Medical

Is the Area Well Led?

Throughout the inspection of Ward B2 Medical, there was evidence of strong leadership, effective governance and dissemination of information to staff. There was an open and transparent culture regarding incident and complaint management and staff felt empowered to raise concerns. Normative staffing had been agreed for the ward; staffing levels and retention of staff were good; and there was evidence of strong multidisciplinary teamwork.

Staff had received the necessary training to enable them to carry out their roles effectively. Ward staff closely monitored performance against a range of clinical indicators and presented a monthly trust report in a dashboard format. There were systems to protect patients from the risk of abuse and to maintain patient safety in line with current best practice guidelines.

Is Care Safe?

The ward environment had some adaptations to meet the needs of patients with dementia or a disability. Limited storage facilities were available and patient equipment and chairs blocked some fire exits.

The number, and specification of clinical hand wash sinks and taps did not comply with local or regional guidance. Although most staff complied with trust policies in relation to infection prevention and control (IPC), documentation in regard to IPC, Aseptic Non-Touch Techniques (ANTT) and care bundle needed improvement.

Patient safety performance indicators/bundles should continue to be analysed to assess the effectiveness of care received by patients. The Sepsis Six bundle should be introduced for the early recognition and management of sepsis.

All medicines were stored safely and securely, and staff knowledge of storage requirements was good. However, at times there were inconsistencies in documentation for prescription and administration of medication. In the administration of intravenous medicines we observed practices that did not comply with trust policy. We also noted that a list of critical medicines, where timeliness of administration is crucial, was not available for staff guidance.

Is Care Effective?

There were inconsistencies in the recording and completion of the various core sections of nursing documentation.

Nursing assessments and risk assessments were not always fully or comprehensively completed and reviewed.

Pre-printed care plans were in use; however, they were not always individualised to meet the needs of the patient. Nursing records did not always adhere to best practice standards of documentation.

Protected meal times were generally well adhered to by staff. A varied menu choice and specialised diets were available. Trained staff supervised the coordination of meal service and effective mechanisms were in place to identify patients who required assistance at mealtimes.

A review of fluid balance charts and food charts demonstrated that not all charts were fully completed, reconciled and signed.

Patients' Early Warning Scores were, at times, completed outside the set timescales. In one example staff did not follow the correct algorithm, or record the result of a significant escalation in the scoring in the patient's nursing notes.

Staff were knowledgeable, and good practices were observed in pressure ulcer care. Medical patient records were generally legible, dated, and had clear evidence of direct senior review.

Is Care Compassionate?

The ward was clean, bright and welcoming and, although busy, the atmosphere was generally calm. We observed staff that were caring, sensitive, and insightful and anticipated the care needs of patients. Call bells and requests for assistance from patients were responded to promptly.

The dignity and privacy of patients was generally maintained throughout the inspection. We observed that on occasions, bed bays and sanitary areas were mixed gender. The use of escalation beds presented a particular challenge to staff in maintaining the privacy and dignity of the patient.

Staff demonstrated discretion when using the open ward Information Technology (IT) system. Information was displayed through the use of symbols and the screen could be anonymised.

Surgical Ward C6

Is the Area Well Led?

Strong leadership, governance and dissemination of information to staff was evident within the ward. There was an open and transparent culture regarding incident and complaint management, and staff felt empowered to raise concerns.

Staffing was below the recommended levels; however, the trust has been actively working to address current staffing deficits. Staff received the necessary training to enable them to carry out their roles effectively. The ward closely monitored its performance against a range of clinical indicators and presented a monthly report in a dashboard format.

There were systems to protect patients from the risk of abuse and to maintain their safety, in line with current best practice guidelines. The timing of ward rounds was a concern. Ward rounds were unscheduled, ad hoc processes that did not always involve nursing staff. This presented a barrier to effective communication between medical and nursing staff.

Is Care Safe?

The ward environment was clean and in a good state of repair. Equipment, including emergency resuscitation equipment, was well maintained, clean and accessible in the event of an emergency. Fire safety and life support training were part of the ward staff mandatory training programme.

Further refurbishment work is required within the clean utility room to improve space for the preparation of clinical procedures.

Although most staff complied with the trust policies in relation to infection prevention and control, some medical staff were not compliant with bare below the elbow in the clinical environment.

Patient safety performance indicators/bundles should continue to be used and analysed to assess the effectiveness of care patients receive. The Sepsis Six bundle should be introduced for the early recognition and management of sepsis.

We saw that all medicines were stored safely and securely. We saw medicine administration rounds taking place on wards and noted staff were undertaking their duties on most occasions to the expected standards of practice. However, in the administration of intravenous medicines we observed practices that did not comply with trust policy. We also noted that a list of critical medicines where timeliness of administration is crucial was not available for staff guidance.

Is Care Effective?

We reviewed a number of nursing care records. We noted variations in the recording and completion of the core sections of nursing process to ensure the quality of patient care. Nursing assessments and risk assessments were not always fully or comprehensively completed, pre-printed care plans were in use within the ward. However these were not always individualised to meet the needs of the patient and the records did not always adhere to best practice standards of documentation.

We reviewed a number of medical notes. Generally entries were legible, dated and clear, with evidence of direct senior review from middle grade and consultant staff.

A protective meal service was in place to allow patients to eat their meals in a calm and relaxing environment, without unnecessary interruption. There was a good menu choice that included specialised diets. Effective mechanisms were in place to identify patients that require assistance at mealtimes. However, we observed that when meals are being served there was little trained nursing staff input into the supervising and coordination of tasks.

Throughout the inspection, patients appeared comfortable and adequate pain relieving measures were available. Staff responded promptly to requests for pain relief. We note that some staff were unfamiliar with the use of pain assessment scales for those patients who cannot verbalise.

Staff were knowledgeable in regard to pressure ulcer care. Staff have access to adequate support and resources for patients with pressure ulcers. Appropriate assistance to promote continence and care for patients with incontinence was observed.

Is Care Compassionate?

The ward was bright and welcoming, and although staff were busy, the atmosphere was generally calm. There was good signage to direct visitors to the ward, and within the ward. We observed staff that were caring, sensitive, and insightful and anticipated the care needs of patients. Requests for assistance from patients were met promptly by staff.

A mechanism was in place to ensure that the fundamental aspects of patient care were being delivered reliably. On most occasions, the dignity and privacy of patients was maintained throughout the inspection. At times we observed mixed gender use of bed bays.

When escalation beds are used, staff reported that it presents a challenge in maintaining the privacy and dignity of patients. We observed times when staff conversation could be overheard by patients.

Emergency Department

Is the Area Well Led?

The inspection identified areas for improvement in the systems and processes which impact on the delivery of care in the ED.

We observed that when the department was busy the processes to promote flow of patients throughout the ED did not work effectively. We did not observe proactive leadership during times of escalation, with limited use of walk rounds to assess the situation across the department.

Staff advised that when they raised concerns there was a lack of a timely response.

At busy times nurse staffing levels were concerning, with areas within the department not staffed adequately to ensure appropriate patient care. Nurse staff training was not up to date. Additional training sessions for nursing staff were not well attended. Staff raised concerns with us about personal security.

The trust advised us that it is actively working to review nurse staffing levels and address current deficits. ED medical cover is good, with medical staff feeling supported. Work is ongoing to improve access to allied health professionals.

Nursing quality performance indicators, to monitor and improve patient care, were not fully implemented within the observation ward.

Communication with staff to improve practice was not always effective. The dissemination of reports to staff which identify trends and patterns with regard to incidents or complaints needs to be improved.

Governance meetings were in place. Support is easily accessible from the infection prevention and control team. The ED is taking part in a regional initiative to improve patient experience.

Is Care Safe?

The environment was clean, bright and free from hazards. Generally staff maintained visual contact with high risk vulnerable patients. However, during times of increased patient numbers, inadequate staffing levels affected observation of patients throughout the ED, particularly in the ambulance triage and resuscitation areas. Crowding and lack of space in ambulance triage can be an issue.

Generally staff carried out hand hygiene and adhered to the principles of ANTT for clinical procedures. We observed some occasions when staff did not carry out best practice.

Patient early warning scores, to detect deterioration in a patient's condition, were generally totalled or completed within the set timescales. However, any escalation and actions taken following elevated national early warning scores (NEWS) scores were not always recorded.

Not all staff were competency assessed in haemovigilance. During times of increased patient numbers, additional essential patient equipment was not always available. Designated rooms to care for vulnerable patients, for example those presenting with a mental health illness or an overdose could not be guaranteed.

We observed patient flow through the ED was at times ineffective, routine safety rounds and patient review was not carried out. Older people are not automatically assessed for all common frailty syndromes.

Clinical standards for ED are being implemented. Three audits in line with ED clinical standards are carried out per year. Once audits are completed, medical staff advised that there is no re-audit programme in place.

The safe storage, security, administration and documentation of medication require improvement. Insufficient ED pharmacist cover did not facilitate effective integrated medicines management.

Spacious single room facilities, throughout the ED, promote good infection control practices. Safeguarding information and support is available for staff, patients, and family/carers. The rapid assessment interface discharge (RAID) service is operated by the mental health team, seven days a week.

Is Care Effective?

Nursing documentation was reviewed throughout the ED including ED flimsys, Majors documentation booklet, nursing admission assessment booklet, risk assessments and a range of observation charts. Nursing assessments, risk assessments, care plans and charts were not always fully completed; up to date; or reviewed regularly. Records did not demonstrate assessment, planning, evaluation and monitoring of the patient's needs. Nursing records were not completed in line with Northern Ireland Practice and Education Council for Nursing and Midwifery (NIPEC) best practice guidelines. Patients and relatives were not routinely involved in planning patient care.

The system in place for ordering, delivery and service of patients' meals requires immediate review and improvement to ensure patients' nutrition and hydration needs are met.

We retrospectively reviewed some documentation. Not all patients attending triage were assessed for pain and pain scores were not always completed. Staff told us that they were not familiar with the Abbey pain score, for the assessment of patients with communication difficulties. A Braden risk assessment tool, for predicting pressure ulcer risk, was not completed for every patient, who had been in the ED more than six hours.

Medical records were well completed. Patients appeared comfortable, pain relieving measures were available and in place. Staff responded promptly to patients' requests for pain relief. Pain medication was administered as prescribed, with its effectiveness reviewed. Staff provided patients with assistance to promote continence and care for incontinence. Specialist nurse advice was available.

Is Care Compassionate?

Staff observed were compassionate, showing empathy to patients, and positive interactions were noted. Staff were courteous to patients and relatives, providing clear, easily understood information.

Documentation to evidence patient care was not always fully completed. On occasion, nurse call bells were not positioned within patient reach. Equipment alarms were not always silenced in a timely manner.

In general, patient's privacy and dignity was maintained; however, within the triage area, patient privacy curtains were not always in use or fully closed. Patients waiting in the corridor of the triage area could not be assured of privacy and dignity.

Staff did not always communicate with patients in a volume and tone that ensured patient privacy. Patient confidentiality was not always maintained, with records easily viewed, or left unattended. Adequate linen supply can be an issue during times of increased patient numbers.

There was good signage throughout the ED. A rolling information board is in place for the public. Staff had access to aids and services for patients with language barriers.

Facilities and information are available for bereaved families. Staff required updated training in end of life care.

Overall, patients and relatives were satisfied with the care they or their relative had received. Some issues were identified in relation to communication, staff shortages and waiting times.

Focus Groups

On the second day of the inspection five focus groups were held with:

- nursing staff
- allied health professionals (AHPs)
- medical staff
- senior managers
- support staff

We found those staff who took part in these groups to be open, transparent and willing to discuss both strengths and challenges within their areas of work.

All staff told us they would be happy for their family to be cared for in the hospital and were aware of the trust's vision and strategy. However, some felt that they do not always have the resources to deliver it. Some staff told us about staffing concerns and the difficulties with the lengthy recruitment process.

Support staff told us that they are integral to the team and training is good. AHP staff told us they are worried about staffing levels and fulfilling the demands of their service.

Senior Managers also spoke about difficulties in achieving all their planned work; with too much undertaken outside of their normal working hours. Some senior posts were vacant, acting or temporary, as a planned restructuring which had been going on for a year, had not yet been implemented in full. This unstable position was affecting morale.

Handover

There are several handovers within and between nursing and medical teams throughout the day. These are well structured and focused, with good examples of multi-professional working being observed.

At the daily 8.30am hospital safety briefing, the main issues relating to patient safety and staffing levels are concisely reviewed for each ward, however, no medical staff are in attendance at this specific briefing. There were no clear or consistent mechanisms for ensuring that the safety briefing influenced consultant ward rounds, nor how potential ward discharges were prioritised and actioned.

The 8.00am medical take handover was concise, but was not being used as an opportunity for education. For example, review or discussion of significant cases or x-rays was not observed. The manual paper-based system for recording individuals admitted under the medical take had the potential for inaccuracy and error.

Summary

The first RQIA inspection under the new programme for acute hospitals took place in three clinical areas of Antrim Area Hospital. Inspection of two wards identified good adherence to best practice in the delivery of patient care, with some areas noted for improvement. Inspection of the ED identified a range of areas for improvement.

Focus groups highlighted some trust wide and regional issues. The handover theme identified good examples of multi-professional working with areas for improvement.

Following the inspection, the Northern Trust received feedback on the findings to enable to facilitate action against identified areas for improvement.

Following publication of the report the Northern Trust should complete a quality improvement plan within four weeks to set out how the recommendations of the inspection will be addressed.

RQIA will review progress at subsequent inspections. The final report and quality improvement plan (QIP) will be available on the RQIA website.

The RQIA inspection team would like to thank the staff of the Northern Trust for their assistance during this inspection.

1.0 Introduction

The aim of the Acute Hospital Inspection Programme is to:

- provide public assurance, and to promote public trust and confidence
- contribute to improvement in the delivery of acute hospital services
- support RQIA's agenda of improvement across health and social care in Northern Ireland

The hospital inspection programme is subject to ongoing review and will be adapted further as it develops.

1.1 Inspection Framework

RQIA's acute hospital inspection programme is designed to support HSC trusts in understanding how they deliver care and to identify what works well and where further improvements are needed. The four domains assessed are:

- Is the clinical area well led?
- Is care safe?
- Is care effective?
- Is care compassionate?

An inspection framework has been designed to support the core programme of acute hospital inspections and to assess key stakeholder outcomes (see Section 3 of the ¹Inspection Handbook).

The inspection framework includes:

- the use of data, evidence and information to inform the inspection
- core indicators
- feedback from patients, relatives/carers
- feedback from staff
- direct observation
- observation sessions - Quality of Interaction Schedule (QUIS)
- the review of relevant documentation and patients care records

The inspection process is supported by:

- the use of peer reviewers (staff who are engaged in the day to day delivery of health and social care)

¹ <http://www.nursingtimes.net/nursing-practice/specialisms/wound-care/what-is-the-skin-care-bundle/5076722.article>

- the use of lay assessors (service users and members of the public and who bring their own experience, fresh insight and a public focus to our inspections)
- consideration of particular focused themes

Core Indicators

Core indicators are designed around 14 areas for inspection. Each area is underpinned by relevant criteria. Each indicator correlates to one aspect of the four domains of safe, effective, compassionate care, and leadership and management of the clinical area as outlined below.

Is the ward/department/area well led?

Leadership and management of the clinical area

Is care safe?	Is care effective?	Is care compassionate?
Environmental safety	Nursing and medical patient records	Person centred care communication
Infection Prevention and Control	Nutrition and hydration	End of life care
Patient safety	Pain management	This section includes the outcomes of patient and relative questionnaires' and observation sessions
Medicines management	Pressure ulcers	
	Promotion of continence and the management of incontinence	

The inspection framework draws from a range of sources, including Department of Health (DoH) standards and guidelines, National Institute for Health and Care Excellence (NICE) Guidelines and other standards relevant to the delivery of safe, high quality care and treatment in a hospital setting. In addition, the inspection teams rely on other sources of published information such as HSC trust quality reports. The framework for the inspection is explained more fully in RQIA's inspection handbook.

The framework enables RQIA to reach a rounded conclusion as to the performance of the wards or departments inspected.

Our inspections can result in one or more of the following:

- **Recommendations:** where performance against indicators or standards is found to be partially or minimally compliant. Significant change and/or improvement will be required and performance will be reviewed at future inspections.
- **Housekeeping points:** improvement is achievable within a matter of days, or at most weeks, through the issuing of instructions or changing routines.
- **Examples of good practice:** impressive practice that not only meets or exceeds our expectations, but could be adopted by similar establishments, to achieve positive outcomes for patients.

This inspection report should not be regarded as a comprehensive review of all strengths and weaknesses that exist across the hospital. The findings are informed only by the information which came to the attention of RQIA during the course of this inspection.

Learning from this inspection should be disseminated where applicable, throughout Antrim Area Hospital and where appropriate, across the trust.

2.0 Background information on the Northern Health and Social Care Trust and Antrim Area Hospital

Antrim Area Hospital

Antrim Area Hospital is the largest acute hospital in the Northern Trust providing a range of inpatient and outpatient services, including a 24 hour emergency department. The hospital has 16 wards; and Laurel House and the Macmillan Unit provide specialist palliative and oncology services. Allied health service provision is available throughout the hospital. The main hospital is on three levels, with separate renal and rheumatology units, and laboratories.

The Northern Trust Annual Quality Report for 2013-14 centres on five key themes. These are:

- effective health and social care
- delivering best practice in health and social care settings
- protecting people from avoidable harm
- ensuring people have positive experiences from services
- staff health and wellbeing

Reform and Modernisation Programme

The vision of the Northern Trust is to deliver excellent, integrated services in partnership with the community. Reform and Modernisation Programme (RAMP) sets out the trust's strategic framework to deliver its vision and outlines a five year strategic plan to help address the following challenges:

- an ageing population
- an extensive and aging estate
- financial constraints
- increasing service demand
- workforce
- maintaining quality and standards

Unscheduled Care Action Plan and Preparations for Winter 2015-16

RQIA was informed of the challenges placed on the trust during the winter period, and the effects on its unscheduled care performance. The increased demand in particular relates to elderly patients, who tend to have a longer length of stay and require more complex community support to facilitate discharge. A range of service development measures have been outlined within the trusts, Unscheduled Care Action Plan and Preparations for Winter 2015-16. The document outlines plans to manage service demands, workforce planning and finance over the winter months.

Trust performance is measured across a range of areas using a range of indicators set by the DoH.

In 2013-14 the trust quality improvement plans included:

- pressure ulcer prevention
- falls prevention in hospitals
- the World Health Organization (WHO) surgical checklist
- preventing harm from venous thromboembolism (VTE)
- cardiac arrest rates
- monitoring and reducing healthcare associated infections

The Northern Trust reports to the Public Health Agency (PHA) and Health and Social Care Board (HSC Board) quarterly on progress against each indicator. Examples of progress include:

- The spread of the ²SSKIN bundle to 98 per cent of required areas, exceeding the target of 80 per cent.
- Falls Safe Bundle- overall compliance with nine elements of Part A is 88.2 per cent.
- WHO surgical checklist end of year compliance achievement was 100 per cent which exceeded the regional target of 95 per cent.
- VTE risk assessment end of year compliance achievement was 61 per cent significantly below the regional target of 95 per cent.
- VTE prophylaxis prescribing compliance achievement of 95 per cent reaching the regional compliance rate.
- NHSCT reduction in cardiac arrest rates (per 1000 deaths) at end of year was 1.3. However, this reduction was not great enough to reach the regional target of 2.25 reduction.
- For 2015-16, the trust target for methicillin-resistant staphylococcus aureus (MRSA) bacteraemia was set at 10 cases; at the end of October 2015 the trust breached this target with a total of 16 cases of MRSA bacteraemia detected.

² <http://www.nursingtimes.net/nursing-practice/specialisms/wound-care/what-is-the-sskin-care-bundle/5076722.article>

- For 2015-16 the set target for *Clostridium difficile* was 59 cases. By the end of October 2015, 42 cases had been detected.
- The Northern Trust won the Caspe Healthcare Knowledge Systems (CHKS) patient safety award 2015: Working with hearts and minds at the Northern Health and Social Care Trust.³ The patient safety award recognises outstanding performance in providing a safe hospital environment for patients.

The CHKS Top Hospitals awards celebrate excellence throughout the United Kingdom and are given to acute sector organisations for their achievements in healthcare quality and improvement.

³ <http://www.chks.co.uk/admin/Award-Categories-2015>



Inspection Findings Ward B2 Medical/Endocrine

3.0 Inspection Team Findings: Ward B2 Medical/Endocrine

Ward B2 is a 27 bed medical ward which also specialises in endocrinology. The ward has four, six bedded bays and three single rooms, one with an ensuite.

3.1 Is the Area Well Led?

Governance

Throughout the inspection, there was evidence of strong leadership, effective governance and the dissemination of information to staff. Staff had access to a range of policies and procedures to facilitate learning, and, when required, affect change. This was supported by twice daily safety briefings and handovers and regular staff meetings. Mechanisms were in place to ensure that staff demonstrated knowledge of the complaints procedure and the reporting of incidents and serious adverse incidents (SAIs). The ward sister demonstrated how trends and patterns in the ward are identified through effective use of the ALAMAC system.

The ward sister updates the IT system which identifies trends or patterns and provides information in relation to complaints, audit results and key performance indicators (KPIs); however, this information was not readily available for staff. The ward sister was not aware of any issues occurring on the ward that necessitated being placed on the trust's risk register.

We were informed that the ward sister attends monthly morbidity and mortality meetings, and the daily hospital safety briefing. Audits of practice and documentation were carried out routinely. These included audits of compliance with key performance indicators, such as falls, skin (pressure ulcers), nursing care records, NEWS, environmental, hand hygiene, food and fluid intake, care bundles, and CDI and MRSA levels.

Trust patient environment/leadership walkabouts were carried out regularly and the IPC team independently audited care bundles. Action plans were compiled following poor compliance results, and we noted that repeat audits evidenced improvement.

On the first day of the inspection, the band 6 nurse in charge was not easily identifiable by uniform or badge. This issue had been identified in a Care Quality Assurance audit carried out in October 2015. During feedback, trust representatives advised that measures were being put in place to change senior staff uniforms to make them easily recognisable.

The name of the ward sister and nurse in charge were displayed on a notice board; however agreed and actual nurse staffing levels for each shift, and the designation of all staff, were not displayed.

Housekeeping Point: Staff should display agreed and actual staffing levels for each shift.

Housekeeping Point: Badges to denote designation of staff should be supplied and worn.

Staffing and Supervision

Normative staffing levels had been agreed for Ward B2. Staffing levels were continually reviewed, with bank staff being used when required. Beds were not closed due to staff shortage. Retention of staff was good; there was a registered nurse (RN) vacancy of whole time equivalent (WTE) 1.62 at the time of inspection.

The ward sister had sufficient time to undertake managerial duties and provide effective clinical leadership, with good support being provided by a band 6 RN and a nurse practitioner. Mentor and preceptor nurses support junior staff and nursing students to fulfil their roles and responsibilities. The vast majority of nursing staff had received an appraisal and a system of supervision was in place. A positive organisational culture was observed during the inspection, with good support from AHPs within the ward. Multidisciplinary team (MDT) meetings were held every Monday, Wednesday and Friday to discuss and agree patient care.

Medical staffing levels did not compromise patient care and there was a system in place to ensure that ward inliers/outliers are reviewed promptly by medical staff.

We were informed that consultant medical staff were directly involved on the ground with patient care, teaching and supporting other staff members. There was a substantial consultant presence during the weekend to review medical patients and consultants were present at each morning hand over.

The morning safety huddle provided a forum to highlight staffing and safety issues on each ward, as well as providing an update on the current position as to the number of vacant beds and expected discharge numbers.

Staff Training

New staff had the support of a buddy during their settling in period. There was a comprehensive ward induction pack and a separate corporate induction, which consists of two days mandatory training. The majority of staff had either received, or are booked to attend, mandatory training and had already received on going, role-specific training. Additional training had been provided for staff. For example, two RNs were completing a postgraduate course on diabetes care and another RN had recently commenced this course. A new healthcare assistant (HCA), had completed the trust First Steps course to prepare for their role as a HCA.

Patient Flow

The ward sister, nurse practitioner or band 6 took part in daily consultant ward rounds. This facilitated communication, early transfer and discharge. Patients at the end of their acute phase of care, who needed additional support following discharge, were referred to an appropriate social worker for a care package. Ward rounds/whiteboard meetings were timed to facilitate early transfer or discharge.

Communication

Inspectors saw examples of effective communication and dissemination of information to staff. These included safety briefings, handovers, ward meetings, ward rounds and multi-professional meetings. There were also link nurse meetings.

Staff have access to a personal email account. The ward displayed audit results on environmental cleanliness. However, results of other audits such as care bundles, falls and comments concerning the PHA's 10,000 voices project were not displayed.

Housekeeping Point: Current results of ward audits and patient experience data should be displayed on the ward.

Safeguarding

Arrangements were in place to safeguard patients from abuse including additional safeguards required for under 18s on the ward. Staff were aware of trust safeguarding communication arrangements.

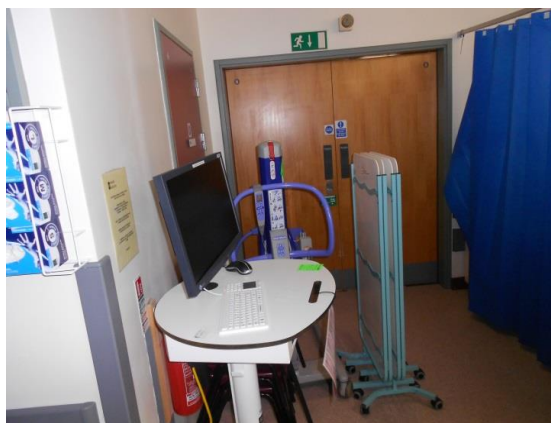
In the event of a safeguarding risk being identified, the ward sister would make a referral through to the hospital social work team responsible for gathering all evidential information. The social work team would subsequently make a referral to the designated officer, who decides if the referral will be managed under vulnerable adult procedures. The ward sister was aware that best interest case conferences were held, if required.

The inspection team found that the ward was well led and some examples of excellence in practice were noted.

3.2 Is Care Safe?

Environmental Safety

The ward environment was generally in good repair and free from trip hazards. Limited storage facilities had contributed to patient equipment and the portable linen pod being stored in the corridor and visitors' chairs and a hoist being placed in front of fire exit doors (Picture 1).



Picture 1: Patient equipment blocking emergency exit

Recommendation: The trust should review storage facilities in the ward to reduce the risk of trips and falls and ensure that fire exits are not blocked.

The layout of the ward was challenging, however staff had endeavoured to maintain a level of visual contact with higher risk patients; call bells were answered promptly. There had been some adaptation to the ward to meet the needs of dementia patients and patients with a disability. Examples included: pictorial signs on doors, clocks in bays and hand and grab rails in sanitary areas.

Some risk assessments had been undertaken for environmental hazards; not all had been completed.

Housekeeping Point: All identified environmental hazards within the ward should be risk assessed, analysed and control measures implemented.

Infection Prevention and Control

Environmental audits demonstrated compliance with trust target levels. Patient equipment was clean and in good repair. Work is needed to ensure nursing cleaning schedules are consistently completed. A range of personal protective equipment (PPE) was available and worn appropriately. Some empty alcohol rub containers were noted at a number of bed spaces. The water in the hot tap in the clinical room was extremely hot; the taps were not mixer or automated and signage was not posted to advise staff of this hazard.

Housekeeping Point: Staff should ensure cleaning schedules are completed and all dispensers have sufficient content.

Recommendation: The hand wash sink and taps in the clinical room should be replaced and hot tap signage displayed where required.

Inspectors observed good hand hygiene practice; hand hygiene audits were carried out in line with trust policy. Good documentation was noted in medical notes reviewed for a patient who had a blood culture carried out.

Staff observed were compliant with ANTT practices for the administration of IV medication and insertion of a cannula. Documentation by a junior doctor following cannula insertion was poorly completed, and some visual infusion phlebitis (VIP) scores were absent. Inspectors noted that these issues were highlighted in the IPC team validation audits and referred to in ward safety briefings; action plans had been commenced and corrective action was being taken. The ward had IPC link nurses who cascaded information to staff; MRSA care pathways were in place where required.

Recommendation: Medical staff should complete all documentation relating to all care bundles and ANTT practices.

Patient Safety

On day one of the inspection, we noted that a patient with dementia did not have an identity band on their arm. We were informed by staff that the patient had removed the identity band. A replacement identity band was immediately reapplied.

We found that at times patients' NEWS were completed outside the set timescales, and in one set of notes staff did not follow the correct algorithm or record a significant escalation in the scoring. We found similar findings in the ward's audits of this documentation. Action is required to ensure compliance in this area.

Recommendation: Staff should receive update training on NEWS and adhere to guidelines when completing documentation.

There were some deficiencies identified in the use and knowledge of sepsis bundles. A sepsis bundle to ensure the recognition and timely management of sepsis was not in place; however documentation evidenced that appropriate measures had been taken that were in line with the care bundle. Key investigations to aid clinical diagnosis were available for inpatients, 24 hours a day.

Recommendation: The Sepsis Six bundle should be implemented for use within the ward.

A falls safe bundle was in place and the ward monitors falls and trends. Improvement in carrying out and recording elements within the care bundle was required. For example, a urinalysis was only carried out for 60 per cent of patients, and recording supine and standing BP on 50 per cent of occasions.

Housekeeping Point: Staff should complete all elements of the fall safe bundle.

VTE risk assessments were generally well completed, however, there was one instance where the assessment was not dated or signed. VTE prophylaxis was administered where required.

The type and occurrence of pressure ulcers were monitored. Staff were compliant with blood transfusion competency assessments and aware of their responsibility to complete blood transfusion record sheets. Patient safety/medical alerts were cascaded to staff by email and/or safety briefings, and posted on the notice board in the ward office.

Inspectors noted the six bedded bays only had four oxygen points. The use of portable oxygen in bays, where there is an escalation bed, raises concerns with regard to trips and patient safety.

Recommendation: The trust should review the supply of piped oxygen points in the ward.

Medicines Management

All medicines, including IV infusions and controlled drugs (CDs) were stored safely and securely. CDs were administered safely, with a second signatory present and administered at the bedside by two RNs. The drug preparation area was in the clinical room. We observed that IV medication prepared and signed for in the medicine Kardex by two RNs, was administered at the bedside by only one RN.

Recommendation: Staff should adhere to trust policy in the administration of medicines and ensure that the reason, for any omission of medication is documented correctly.

The delay or reason for omission for some medication was not clearly and accurately recorded in the medicine Kardex.

Some patients reported that they self-administered medication; however, this was not always recorded on the medicine Kardex. A trust policy or guidance was not available. A robust system should be in place to ensure all self-administered medication is recorded in the Kardex.

Recommendation: The trust medicines management policy should be updated to clearly guide staff on patient self-administration of medicine.

The ward has a full time pharmacist and pharmacy technician; staff had access to pharmaceutical advice at all times. There was evidence of integrated medicines management (IMM) being implemented on the ward, with pharmacy involvement in the completion of medicines reconciliation on admission and discharge. On one occasion, we observed that complete medicines reconciliation did not always occur during the inpatient stay.

When questioned about prescribed patient medications not normally stocked on the ward, staff were unaware of the absence of critical medications and omitted doses not being recorded in the patient Kardex. They reported they would seek advice from medical staff in regard to the urgency of the dose. However, the ward has recently commenced an additional, good practice, quarterly care quality assurance audit, to be completed over a meal time. This includes a review of two medication charts for instances of failure to record medication and the number of instances of failure to record a critical medicine. On completion of the audit, verbal feedback will be provided to the nurse in charge for dissemination to staff.

Recommendation: A list of critical medicines where timeliness of administration is crucial should be available for staff.

There was one instance where a pain score was not completed for a confused patient, however, documentation indicated that necessary analgesia, was prescribed and administered. There were also instances where oxygen prescription and administration and patient weights on admission were inconsistently completed.

Recommendation: All staff should correctly document the prescription and administration of oxygen therapy.

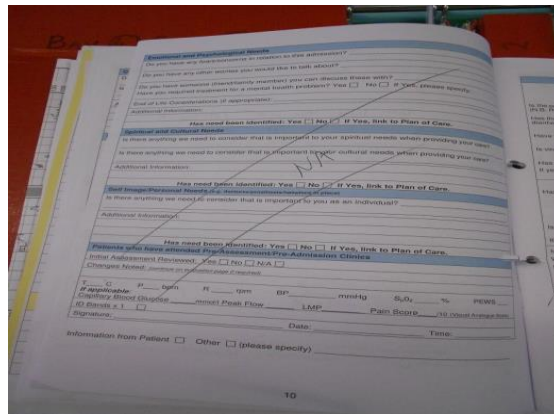
On discharge, patients are given a green bag to take home containing their prescribed medication. Patients on CD medication are provided with a CD bag to bring their own prescribed CD medication with them on admission. This is to ensure that prescribed medication is not missed if unavailable within the ward. Unused CD medication is returned home with the patient.

The inspection team found some examples of good practice however improvement was needed in some areas.

3.3 Is Care Effective?

Nursing Care Records

Some nurses gathered information from a variety of sources to complete their nursing assessments. However assessments were not always subsequently reviewed and analysed to collectively identify the care needs of individual patients. Assessments were not fully used to inform subsequent care interventions and some assessments and risk assessments were not fully completed (Picture 2). As a result of lack of reviews identified risks did not always have a care plan developed to minimise these risks.



Picture 2: Nursing assessments not completed

Care plans did not always reflect the nursing assessment or the care required for the patient, identified by the inspector during observation. Some care plans were poorly written, with minimal detail and little direction of the care to be implemented for the patient. Core care plans were not always individualised. Not all care plans had adequate assessment, planning, evaluation and monitoring of the patient's needs. This is vital in providing 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 Nursing and Midwifery Council (NMC) and NIPEC guidelines; some had illegible signatures, and use of jargon.

Multidisciplinary team involvement was well documented; however, not all records included evidence of involvement of the patient and families in planning aspects of patient care or discharge planning. These findings correspond with the trust's September audit of key performance indicators in relation to record keeping (care plans). During the feedback session, trust representatives advised that they are working proactively to address the deficits in nursing documentation. New care plans, devised by registered nurses in the Northern Trust are to be piloted on some wards.

Recommendation: The recording in nursing care records should be improved to accurately reflect patients' needs, their involvement in their care, and be in line with NIPEC best practice guidelines.

Medical Care Records

Three medical care records were examined. In general, entries were legible, dated and clear, with evidence of direct senior review from middle grade and consultant staff. The times entries were made were much less frequently recorded. Several examples of printed blood results were loosely filed in the notes, alongside handwritten entries in the notes relating to the same blood results.

Housekeeping Point: Blood results should be filed in a systematic manner.

Nutrition and Hydration

Adherence to protected meal times was generally good. A menu choice was available and included specialised diets; meals served were appetising. Staff could access the main kitchen up to midnight if meals were missed; tea and toast were available 24/7 on the ward. At meal times, a RN supervised and coordinated the service of meals in each bay.

Patients had a choice to remain in bed and eat their meal, or sit at the bed side. Fresh water was available at each patient's bed side, in covered jugs and rigid plastic glasses. Nutritional supplements were prescribed and administered appropriately. Effective mechanisms were in place to identify patients that required assistance with meals. Patients were prepared for meal times, food was placed in front of the patient and assistance given in the appropriate manner where needed.

A review of fluid balance charts demonstrated inconsistent documentation; not all charts were reconciled and signed. This issue had been highlighted in the trust care quality assurance audit (8 October 2015) for action. Food charts, when in use were well documented, but when discontinued there was no written indication on the chart for the reason, and the discontinuation date was absent.

Recommendation: Fluid balance and food record charts should be completed and reconciled according to trust policy.

Pain Management

During the inspection, patients appeared comfortable; pain relieving measures were available and in place; and staff responded promptly to patients' requests for pain relief. Pain medication was administered as prescribed in the medicine Kardex; however the pain score on the NEWS chart was not always recorded. Prescribed pain relief was appropriate for the condition; however the effectiveness of pain medication was inconsistently reviewed.

Recommendation: Staff should ensure that pain scores are recorded and the effectiveness of pain medication should be consistently reviewed.

Pressure Ulcers

Staff were knowledgeable about and good practices were observed in regard to pressure ulcer care. This corresponds with the September skin care bundle audit, where 100 per cent compliance was achieved. Patients appeared comfortable and appropriately positioned with pressure relieving equipment used appropriately. Staff stated that pressure relieving equipment was delivered promptly when ordered. A validated classification tool and wound chart was in use and where required, a SSKIN (surface, skin, keep moving, incontinence, nutrition) bundle was in place and evaluated to reflect patients' ongoing care needs.

Staff could access advice on minor skin issues via the trust intranet and with a tissue viability nurse (TVN), using the online trust business area. When required, staff would contact the TVN for detailed advice and guidance. Regular mattress audits were carried out to assess mattress integrity.

Promotion of Continence and Management of Incontinence

Staff were observed providing patients with the appropriate assistance to promote continence and care for incontinence. Patients were given the opportunity to wash hands after toileting. Staff had access to continence/stoma specialist services, and stoma/incontinence aids were available on the ward.

A review of the documentation for a patient requiring self-retaining catheter care evidenced that the catheter insertion was not documented in the medical notes and the date of insertion was not written in the care bundle. These issues were highlighted in a recent IPC independent audit on urinary catheter on going care. Staff should ensure that all elements in the urinary catheter on going care bundle are fully documented.

Housekeeping Point: Staff should ensure that all elements in the urinary catheter ongoing care bundle are fully documented.

The inspection team found that whilst good practice was noted in this domain for pressure ulcer care, the management of pain, nutrition, continence and incontinence and medical patient records, nursing care records were poorly completed and significant improvement was needed.

3.4 Is Care Compassionate?

Person Centred Care

Inspectors noted that although busy, the ward was organised and calm, and noise levels were low. Call bells were within reach and answered promptly. Privacy curtains were pulled when personal care was delivered to patients and staff were discreet when delivering personal care within the screened bed space. Intentional care rounding was carried out to ensure that nursing staff carry out scheduled tasks or observations of patients to meet and anticipate their fundamental care needs.

Inspectors observed an escalation bed in one of the bays. A protocol was in place for the use of escalation beds; however, maintaining patients' privacy and dignity remains an issue.

On the first day of the inspection, a female patient who required specialised monitoring had been placed in a male bay. We noted that staff transferred the patient to a female bay as soon as a suitable bed became available.

There are no sanitary facilities in bays; sanitary facilities are located off the ward corridors.

The ward displayed appropriate signage for best practice in dementia care. The ward sister's office is used to speak privately to relatives, as no quiet room is available.

Patients had access to the ward telephone, but this was at the nurses' station where conversations could be overheard.

Recommendation: The trust should ensure that arrangements in place promote the privacy and dignity of patients, including the use of escalation beds, same sex bays and designate separate sanitary areas for male or female.

Housekeeping Point: Staff should facilitate areas within the ward for patients to have quiet and confidential conversation.



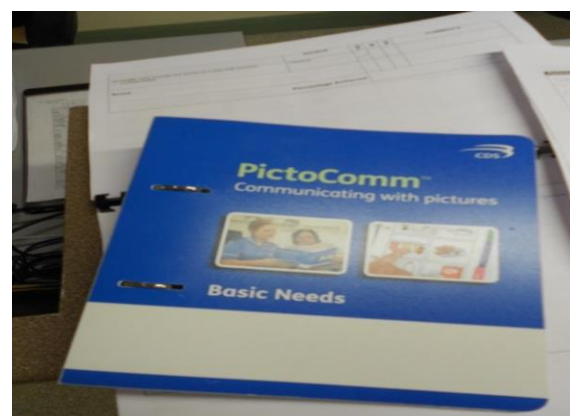
Picture 3: Open Ward System

Advocacy services are available and a chaplain was observed visiting patients during the inspection. Patient information was updated on the Open Ward System (Picture 3) behind the nurses' station and anonymity was respected. Symbols were used to advise staff of specific issues such as risk of falls, dementia or an infection.

Communication

There was good signage to direct visitors to the ward and within the ward. Where required, there was discreet signage relating to fasting, infection prevention and control, and communication aids.

Staff were observed treating patients and visitors courteously. Patients were encouraged in a sensitive manner, and were discreetly given an easily understood explanation of the care they were to receive. Communication aids were available (Picture 4), and there was access to appropriate information and leaflets, some in various formats and different languages.



Picture 4: Communication Aids

The ward had participated in the 10,000 Voices project. This gives patients, as well as their families and carers the opportunity to share their overall experience of the care they had received. The project then gathers and feeds back the views. The ward sister had received feedback from the patient stories relating to the ward; these described mainly positive experiences.

End of Life Care

At the time of inspection, there were no patients on the ward who required end of life care. Staff were knowledgeable when questioned about the systems in place, and the support and guidance available. A few single rooms were available to ensure that patients who required privacy away from the open ward environment could be cared for.

Housekeeping Point: Staff should ensure that a side room is available for patients at end of life to optimise privacy and dignity.

The ward used the University of Edinburgh Supportive and Palliative Care Indication Tool (SPICT) and the Gold Standards Framework. Staff could easily access this guidance on end of life care. The palliative care team was available out of hours and staff had access to an on-call oncology consultant and Macmillan Cancer Services. Information and support systems were available for patients and carers and visitors could stay at the bedside with their family member.

One patient had been assessed as requiring a do not attempt to resuscitate (DNAR) order. The order had been appropriately completed and signed by a doctor. The decision maker had been clearly identified in relation to advance directives, consent or cardio-pulmonary resuscitation.

Patient and Relative Questionnaires

The views and experiences of people who use services were obtained as part of the inspection. The findings combine both the patient and relative perception of staff communication, and the care they received, including pain management; food and nutrition; infection control; and safety.

In Ward B2 a total of 11 questionnaires were completed.

- nine patient questionnaires
- two relatives/carers questionnaires

Patients were very satisfied with the standard of care and treatment they received; they stated that staff introduced themselves, were polite, and addressed them by their correct or preferred name. They told us that staff were courteous and compassionate and patients were treated with respect and dignity. Most patients knew who to speak to if they had any concerns.

Some patients felt there were not enough staff to care for them, but most felt involved in decisions about their care.

In general, call bells were answered promptly, and patients received assistance when required, although, they did comment that delays occurred due to staff pressures. They told us that staff did check on their level of pain, and comfort. The findings indicated that the ward was clean, choice of food was good, and fluids were readily available. Patients considered that staff hand hygiene was good.

Overall, patients stated they were informed about how long they could expect to be in hospital. Patients were very satisfied that they were safe; had received a good standard of care; and would be happy for a member of their family or a friend to be cared for in this ward.

Two relatives completed questionnaires. Both indicated they were happy and confident that their relatives were receiving good care. They knew who to speak to regarding their relatives' care, and felt their relatives were treated with respect and dignity. In relation to the question: Do staff have enough time to care and treat my relative? One relative stated that they doubted it, as staff were under pressure.

Patient Comments

“More staff as doctors and nursing, staff are run off their feet.”

“Has had a very good experience.”

“Everything is grand. Patient has been on this ward for one week. Is very happy with her care. No complaints.”

“Spotless. Domestics are very thorough.”

“Has had some pain”. Patient stated: “Staff check regularly if I need pain relief.”

“If they don't come straight away they are with another patient.”

Relatives Comments

“Felt care received was excellent.”

Observation of Practice

Observation of communication and interactions between staff and patients and staff and visitors, was included in the inspections. This was carried out using the QUIS.

Inspectors and peer reviewers undertook a number of periods of observation in each hospital ward. Each session lasted for approximately 20 minutes. Observation is a useful and practical method that can help to build up a picture of the care experiences of older people.

The observation tool uses a simple coding system to record interactions between staff, patients and visitors. Details of this coding have been included in Appendix 1.

Nineteen observations were carried out over four observation sessions. Staff interaction was excellent. Staff introduced themselves and took an interest in the patient, providing support and care and treating the patient as an individual. Active conversations took place between staff and patients at meal times and when care was being delivered. Family and ward staff were observed engaging in respectful discussion about patients' progress.

Housekeeping point: The trust should include patient, relative and carer comments as part of the overall strategy to improve the patient experience.

The inspection team found that staff demonstrated a caring, sensitive and insightful response to the needs of patients and some examples of good practice were noted.

3.5 Conclusions for Ward B2 Medical/Endocrine

We found evidence of strong leadership, effective governance and an open and transparent culture. Staffing levels and staff training were good; staff performance was monitored against a range of clinical indicators. There was good multidisciplinary teamwork and safeguarding of vulnerable patients.

The ward was clean, bright and welcoming; adaptations to the ward assisted patients with a disability or dementia. We observed caring, sensitive and insightful staff who responded promptly to patients' requests for assistance.

Fire exits were blocked by equipment due to limited storage facilities and the number of hand wash sinks did not comply with local or regional guidance. We observed mixed gender bays and the use of escalation beds which presented a particular challenge to staff in maintaining the privacy and dignity of the patient.

IPC practices were good however improvement is needed in completion of IPC documentation. Patient safety performance indicators/bundles are evaluated however the trust has not introduced the Sepsis Six bundle to wards.

We noted variations in the completion of some nursing documentation. Medical patient records were generally legible, dated, and had clear evidence of direct senior review.

Protected meal times were supervised, coordinated and patients assisted when required. Good practices were observed in pressure ulcer care.

Overall the findings of the inspection of ward B2 were good. We have made 14 recommendations and 10 housekeeping points for further improvements within the ward.

3.6 Recommendations and Housekeeping Points

Recommendations

1. The trust should review storage facilities in the ward to reduce the risk of trips and falls and ensure that fire exits are not blocked.
2. The hand wash sink and taps in the clinical room should be replaced and hot tap signage displayed where required.
3. Medical staff should complete all documentation relating to all care bundles and ANTT practices.
4. Staff should receive update training on NEWS and adhere to guidelines when completing documentation.
5. The Sepsis Six bundle should be implemented for use within the ward.
6. The trust should review the supply of piped oxygen points in the ward.
7. Staff should adhere to trust policy in the administration of medicines and ensure that the reason, for any omission of medication is documented correctly.
8. The trust medicines management policy should be updated to clearly guide staff on patient self-administration of medicine.
9. A list of critical medicines where timeliness of administration is crucial should be available for staff.
10. All staff should correctly document the prescription and administration of oxygen therapy.
11. The recording in nursing care records should be improved to accurately reflect patients' needs, their involvement in their care, and be in line with NIPEC best practice guidelines.
12. Fluid balance and food record charts should be completed and reconciled according to trust policy.
13. Staff should ensure that pain scores are recorded and the effectiveness of pain medication should be consistently reviewed.

14. The trust should ensure that arrangements in place promote the privacy and dignity of patients, including the use of escalation beds, same sex bays and designate separate sanitary areas for male or female.

Housekeeping Points

1. Staff should display agreed and actual staffing levels for each shift.
2. Badges to denote designation of staff should be supplied and worn.
3. Current results of ward audits and patient experience data should be displayed on the ward.
4. All identified environmental hazards within the ward should be risk assessed, analysed and control measures implemented.
5. Staff should ensure cleaning schedules are completed and all dispensers have sufficient content.
6. Staff should complete all elements of the fall safe bundle.
7. Blood results should be filed in a systematic manner.
8. Staff should ensure that all elements in the urinary catheter ongoing care bundle are fully documented.
9. Staff should ensure that a side room is available for patients at end of life to optimise privacy and dignity.
10. The trust should include patient, relative and carer comments as part of the overall strategy to improve the patient experience.



Inspection Findings: Ward C6 Surgical Ward

4.0 Inspection Findings: Ward C6 Surgical Ward

C6 is a 26 bed male colorectal surgical ward. The ward consists of three, six bedded bays, one five bedded bay and three single rooms, one with ensuite facility.

4.1 Is the Area Well Led?

Governance

Strong leadership by the ward sister, who is easily identified by a distinct uniform and a photograph on the ward entrance notice board, was observed. Throughout the inspection the ward sister was visible, coordinating ward activities and, although supernumerary to agreed staffing levels, could support ward staff, if patient acuity or occupancy increased. The ward sister reported that she has sufficient time to undertake both the ward managerial duties and provide clinical leadership.

The ward received good support from a range of allied health professions such as: physiotherapy, speech and language therapy, dietetics and social work. Patients are referred to these disciplines electronically.

Staff had access to a range of policies and an effective system was in place to ensure that all ward staff were familiar with new policies or procedures.

An open and transparent culture was displayed in relation to the investigation of complaints and incidents; information relating to these was discussed at safety briefings. We were informed by staff that they had been updated with learning arising from incidents and complaints. A record of verbal complaints was not available; these should be held locally to allow any trends or patterns to be identified.

Housekeeping Point: Verbal complaints should be recorded and reviewed to identify trends and patterns in the ward.

The ward sister attends a variety of meetings. On a daily basis, the ward sister gathers data on admissions and discharges to bring to the trust's morning safety meeting. Ward performance is reviewed at monthly governance meetings, which review performance against key indicators, care bundles and audits. Complaints and incidents are also discussed and trends identified however no formal reports were available for staff to access. Information from the governance meetings is disseminated to ward staff at team and at safety brief meetings.

Information is disseminated to staff robustly by safety briefings, handovers, ward meetings, multi-professional meetings and link nurse meetings. Staff told us they had good access to patient related information and electronic care records, whenever required.

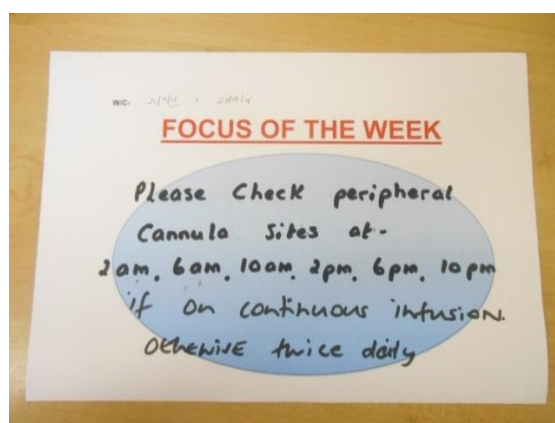
Not all trained nursing staff within the ward had access to email; however, we were informed that this is soon to be addressed.

Housekeeping Point: All nursing staff should have email access.

To facilitate a focus on measuring outcomes of care, the ward had introduced a number of key performance indicators which are subject to continuous review at governance meetings. These indicators, which include compliance with NEWS, falls safe bundle, SSKIN bundle and record keeping, were clearly displayed on a dashboard which is accessible to all staff. The ward receives a formal report against these indicators, and poor performance prompts an action plan and rapid re-audit.

Staff were knowledgeable about how the ward performs against these key indicators. Audits of hand hygiene and environmental cleanliness are routinely carried out and displayed for public viewing on the ward entrance notice board.

When audits, incidents and complaints identify aspects of care practices that require improvement, as part of an action plan, these are identified to all staff as the Focus of the week (Picture 5).



Picture 5: Focus of the week poster

Patient experience data is captured on 'Tell Us What You Think' leaflets; the information gathered is reviewed by the ward sister and actions taken as appropriate. The information is then forwarded to the service user feedback department of the trust for analysis. Trust board information in relation to patient experience is posted on the trust's internet as part of monthly performance reports.

Staff were routinely updated in relation to performance against trust targets in healthcare associated infections, although knowledge in relation to trust and ward cardiac arrest rates was limited. Nursing staff do not currently attend surgical morbidity and mortality meetings; attendance would help to improve shared learning from adverse clinical events. All staff reported that they felt supported and valued by their directorate's management team and felt empowered to raise any concerns when appropriate.

Housekeeping Point: Ward nursing staff should attend morbidity and mortality meetings.

Staffing and Supervision

A review of staffing records indicated deficits in the number of permanent registered nurses available to work particular shifts. The ward did not display information on agreed and actual staffing levels for each shift.

Housekeeping Point: The ward should display agreed and actual staffing levels for each shift.

Patients informed us that whilst their care needs were being met by ward staff, nursing staff appeared rushed. Ward nursing levels had been reported as a concern. We noted that sickness absence rates were high at 17.16 per cent and there were 3.6 WTE staff vacancies. We were informed that staff retention is good and that vacant posts are as a result of natural attrition. The ward sister reported that senior management has been proactive in the recruitment of staff and anticipates that these posts will soon be filled. Three staff awaiting nurse registration had been recently employed within the ward. Staff sickness is being actively managed in line with trust policy and supported with advice from the trust's human resources and occupational health departments.

Use of temporary bank and agency staff was increased to ensure that the needs of patients could be met. Throughout September 2015, combined bank and agency hours totalled 630.25 hours for band 2 staff, and 438 hours for registered nursing staff. Having the appropriate skill mix on the ward with a heavy use of agency staff is a reported challenge. We saw that when the ward used temporary staff, there was evidence of induction.

Recommendation: Nurse staffing variances should be reviewed to ensure that patient care and safety is not compromised due to staffing levels.

We were informed that medical staff levels were sufficient to maintain patient care needs; this is inclusive of out of hours and weekend cover. A system was in place to ensure that ward inliers/outliers are reviewed promptly by medical staff.

There were annual appraisals and regular supervision sessions for nursing staff who talked positively about these processes. The appraisal provided opportunities for discussion of development needs. From 1 April 2015, 41 per cent of staff appraisals had been completed and 76 per cent of staff had two sessions of supervision. Both staff appraisal and supervision sessions are on track to be completed by the end of the financial year.

Staff Training

Currently the ward had 16 sign off mentors and preceptors. On most occasions the ward would accept up to five student nurses; however this has been reduced to two. This is to facilitate the induction and preceptorship of the three staff currently awaiting nurse registration.

New members of staff told us that they had been supported since joining the ward and were currently progressing through their ward induction programme with their nominated preceptor. All staff had completed a trust wide corporate induction programme, which consists of two days of mandatory training.

There was a range of mandatory training available, which was delivered both electronically and via face to face sessions. Staff confirmed to us that mandatory training included sessions related to patient safety, such as: manual handling, life support, infection prevention and control, as well as customer care training.

Compliance with mandatory training is monitored by the ward sister. The majority of staff have either received or are booked to attend mandatory training. At the time of the inspection, 84 per cent of trained nursing staff and 50 per cent of untrained nursing staff were up to date with mandatory training. We were informed that staff would complete any outstanding mandatory training sessions. Some staff reported that trust wide mandatory training had been cancelled during the winter months to manage ward pressures.

Aggression and violence in the hospital workplace is relatively uncommon; however, it is more frequent in emergency departments. Management of actual or potential aggression (MAPA) training was provided to equip staff to manage challenging and aggressive behaviours. Staff told us that they felt safe within the ward and, when required, security staff respond in a timely manner.

Staff had access to role specific training to ensure they were able to meet the particular needs of their patients. For example, some ward staff had received training in stoma care, palliative care, wound care and dementia care practices.

Nursing staff were required to complete competency assessments in various aspects of their roles. For example, intravenous drug administration, cannulation and taking blood specimens.

All staff were encouraged to participate in safety improvement initiatives. A number of staff were nominated as champions of infection prevention and control; wound care; stoma care; palliative care; and dementia care.

Patient Flow

During the inspection, we observed that ward rounds were unscheduled ad hoc processes.

We noted that while the ward sister was in attendance at the trust safety meeting, three consultant led ward rounds were being undertaken simultaneously. There were no trained nursing staff available to participate in these ward rounds. Staff reported that this was a common occurrence.

It is essential that nursing staff participate in ward rounds as they play a crucial role in ensuring patients receive and understand all the relevant information about their care. The ward round is a key organisational process, providing a link between patients' admission to hospital and their discharge or transfer elsewhere. Absence or poor communication between disciplines can result in inertia in the patient flow of the ward.

During the inspection, we were informed by patients that communication between medical and nursing staff could be improved to ensure that there is a consistent knowledge of patients' care. Staff informed us that communication of clinical concerns between medical staff was carried out appropriately; either in person or by telephone conversation.

One patient commented that:

"I have experienced the care of Antrim Area Hospital on two occasions and find the nursing and ward staff are very helpful. I feel that sometimes the communications between the nursing and the consultant to be sometimes unclear and the right hand does not seem to always know what the left hand is doing. If a member of each ward could travel around the patients with the doctor I feel this would help communications."

Recommendation: Medical staff should review the scheduling of ward rounds to ensure nursing staff participation.

We were informed that discharges from the ward are routinely held up by the completion of patient discharge letters. To improve efficiency of flow, staff utilise the discharge lounge where patients wait to be collected by their families; for transport; or for their medication to be dispensed. Following discharge from hospital, the Northern Trust provides a short term reablement service which aims to assist people to regain the necessary skills and confidence to live as independently as possible, within their own home and community.

Medical staff informed us of some ongoing quality improvement initiatives. Ward round, patient safety and discharge checklists had been developed in the surgical wards by a number of FY1 surgical staff. These checklists were reported to be working very well. Surgical staff were positive about moving to a surgeon of the week model for their take in rota.

A suggestion to improve flow, made by a surgical registrar at a focus group, was to add two more computers in the surgical doctors' room.

The only computer there is used by multiple staff members (at least six middle grade staff) which results in delays. Both patient care as well as continuing professional development opportunities would be greatly enhanced by providing additional workstations.

Housekeeping Point: The trust should provide additional computer workstations within the surgical doctors' room.

Safeguarding

Appropriate systems and processes reflecting legislation and local requirements were in place to safeguard patients from abuse. Staff were aware of the trust safeguarding lead and communication arrangements.

If a safeguarding risk is identified, the ward sister will make a referral through to the hospital social work team, who are responsible for gathering all evidential information. The social work team subsequently makes a referral to the designated officer, who will decide if it will be managed under vulnerable adult procedures.

Staff are aware that additional safeguards may be required for children, including contribution to the Understanding the Needs of Children in Northern Ireland (UNOCINI) assessments.

The inspection team found that the ward was well led and some examples of good practice were noted. Staffing levels were a concern; the trust has been actively working to address current staffing deficits.

4.2 Is Care Safe?

Environmental Safety

The ward environment was in a good state of repair and free from trip and fall hazards. Lighting was sufficient within the ward and allowed nursing staff to maintain good visual contact with high risk patients. Emergency equipment on the resuscitation trolley was easily accessible and well maintained. Fire safety and life support training was part of a ward staff mandatory training programme. However, we observed that emergency exits were not clearly identified. There was sufficient moving and handling equipment to enable patients to be cared for safely.

Housekeeping Point: Emergency exit doors should be clearly identified.

Limited storage areas within the ward present a challenge for ward staff. There has been some reconfiguration of equipment in the treatment room clean utility room to improve clinical space; however some refurbishment work is required. Minor refurbishment to provide a work bench and high density storage units had been requested in 2014.

Recommendation: The trust should ensure that refurbishment works are progressed within the treatment room to improve space for the preparations of clinical procedures.

The ward had various adaptations to meet the needs of patients with physical disabilities and also adaptations to meet the needs of patients with dementia, such as large clocks and clear pictorial signage (Picture 6).



Picture 6: Clear pictorial signage

We were informed that a documented risk assessment of identified ward hazards had not been undertaken. The ward sister reported that she will be attending training on the assessment and management of clinical risk. Following this training session, a programme of ward risk assessments will commence.

Recommendation: The Ward Sister should ensure that all identified hazards within the ward are assessed, analysed and control measures implemented.

Infection Prevention and Control

We observed that most staff, except for a number of medical staff, complied with being bare below the elbows in the clinical environment, to enable thorough hand washing.

Housekeeping Point: Medical staff should robustly adhere to the trust's hand hygiene and uniform policies.

Clinical hand washing sinks were available throughout the ward, although the number within patient bays was not in accordance with national guidance. This has been raised at previous RQIA infection prevention and control inspections. Signage was displayed at hand wash sinks which provided instruction on the correct methods for removing possible contaminants. We saw regular use of these facilities by staff, in addition to hand decontamination rub in accordance with trust policy.

We noted there was easy access to personal protective equipment such as gloves and aprons and they were used appropriately by staff.

Staff were compliant with ANTT practices, and can demonstrate when ANTT procedures are applied. We observed documentation omissions in relation to an invasive device.

Housekeeping Point: Invasive device documentation should be fully completed.

The ward had a range of equipment which was seen to be visibly clean and well maintained. A MRSA care bundle and clostridium difficile care pathway were available to guide care through the clinical experience. To reduce the incidence and consequences of surgical site infection, ward staff, during the preoperative phase, screen patients for MRSA using local guidelines. If patients are found to be positive, they are decolonised prior to surgery according to the recommended protocol.

In July 2015, a patient was identified within the ward with a bacteraemia caused by MRSA. A post infection review of this case was carried out in line with trust policy.

We observed that, there was no documented evidence that blood cultures were obtained for a patient who was experiencing pyrexia.

Recommendation: Medical staff should ensure that blood cultures are obtained when clinically indicated and on completion, the procedure should be clearly documented.

Patient Safety

All patients reviewed that were receiving treatment wore an accurately printed identity band; staff were aware of the actions to take if identification details were incorrect. We observed all inpatients had 24/7 access to key diagnostics.

NICE Guidance on the management of the Acutely ill Patient was available for staff to reference. NEWS, were completed within set timescales and there was an appropriate clinical response to NEWS triggers. As part of an established audit programme of key performance indicators, compliance with each element of the early warning score was assessed. Overall compliance with NEWS was achieved throughout September 2015.

A Sepsis Six bundle was not in place for the early recognition and management of sepsis; however, when a patient had been identified for sepsis management the appropriate measures were in place, or implemented in line with the care bundle.

Recommendation: The Sepsis Six bundle should be implemented for use within the ward.

A fall safe bundle is in place. The bundle is based on a collective set of elements that when carried out reliably and continuously, can help reduce inpatient falls.

One of the elements includes the performing of a urine test on admission of the patient. Only 30 per cent compliance was achieved in September 2015 in relation to key performance indicator.

Housekeeping Point: Staff should comply with all elements of the falls safe bundle.

Falls walking stick and pressure sore safety-cross posters were displayed within the clinical room. They provide, at a glance, the number of patients that have had a fall or developed a pressure sore within the ward since the beginning of the month. This real time data helps raise awareness within the ward team and promotes good practice to improve patient safety.

Patients admitted to the ward for surgical procedures were required to have an assessment of their risk of developing a venous thromboembolism (blood clot in the vein). We observed that in the patients' notes, VTE assessments were completed and prophylaxis VTE treatment commenced.

In the medical notes, consent forms were completed fully and appropriately and evidence was available that patients were involved in decision making, in line with the DoH guidance on consent. In one set of notes, we found that hospital theatre staff did not reliably complete the WHO surgical safety checklist, which outlines procedures to safely manage each stage of a patient's surgery.

Additional Trust Recommendation: The trust should ensure that theatre staff complete all procedures within the WHO surgical safety checklist, and the checklist is fully documented.

Patient safety/medical device alerts are reported to all staff at safety brief meetings. The notification letters are posted on the wall of the sister's office and all staff have to sign and date that they have read the alert and learning points.

Medicines Management

Medicines were stored safely and securely in designated cupboards. Daily checks of the temperature of fridges were undertaken where medicines required storage under a temperature control. All intravenous infusions were stored in their original boxes or in appropriately labelled containers, with potassium-containing solutions kept separately.

The drug preparation area was well lit, uncluttered and positioned appropriately to prevent unnecessary interruptions. When staff were administering medicines, on most occasions they undertook their duties to the expected standards of practice.

However, we noted that when intravenous medication was being administered, it was not in line with the trust's medicines administration and management policy.

We observed intravenous medication being prepared and second checked by two RNs; the medicine Kardex was then signed by two RNs, but administered at the bedside by one RN. The policy states that IV administrations must be witnessed by two nurses.

Recommendation: All staff should adhere to trust policy in the administration of medicines.

We also noted that the trust medicines administration and management policy does not provide clear guidance for staff in the administration of controlled drugs and patient self-administration of medicines.

Recommendation: The trust's medicines management policy should be updated to clearly guide staff in the administration of controlled drugs and patient self-administration of medicines.

We observed that, prescribed pain relief was appropriate for patients' conditions and the effectiveness of pain medication was routinely reviewed. Ward records confirm that stock checks of controlled drugs are carried out twice daily and recorded.

The ward has a dedicated full time pharmacist with additional pharmacists providing support in medicines reconciliation at admission and discharge. Staff had access to pharmaceutical advice at all times. Full time pharmacy technicians undertook regular stock reconciliations for medications on the ward and ensured that appropriate medicines were available for patients. There was evidence of IMM being implemented on the ward, with pharmacy involvement in the completion of medicines reconciliation on admission and discharge.

We noted that on the majority of medicine charts, during patients' admissions, the pharmacist signatory review box was unsigned. A list of critical medicines where timeliness of administration is crucial was not available for staff to view. Staff were unaware of a critical medicines list, however, were aware of the importance of administration of certain medications.

Housekeeping Point: A list of critical medicines where timeliness of administration is crucial should be available for staff guidance.

There is evidence of medication incidents being reported, investigated, learning identified and shared at governance meetings.

On discussion with patients, there was variation in their involvement in decisions about their medications. One patient was unaware that they had been prescribed new medications.

Housekeeping Point: All patients should be involved in decisions about their medication.

The inspection team found some examples of good practice however improvement was needed in some areas.

4.3 Is Care Effective?

Nursing Care Records

A number of nursing care records were reviewed. We noted variations in the recording and completion of the core sections of nursing process to ensure the quality of patient care. We found that the nursing assessments and risk assessments were not always fully or comprehensively completed. In some cases a risk assessment was not completed for a clearly identified need.

Pre-printed care plans were in use within the ward, however, these were not always individualised to meet the needs of the patient. When care plans were in place, they did not always reflect the nursing assessment. Within one record we identified that a number of specific care plans were missing.

Nursing care records did not always adhere to NMC and NIPEC standards of documentation. We also observed that information within the records in relation to discharge planning was scarce.

Record keeping is routinely assessed as a KPI within the ward. Our findings reflect those assessed by the trust in September 2015. Poor compliance was achieved in admission, risk assessment, care and discharge planning.

The ward had been piloting a patient centred care plan record. This document ensures that the patient is involved in agreeing their own care plan. We found good evidence that the patient was involved in their care planning. We also found that referrals to members of the MDT were clearly evident within the documentation.

Recommendation: Nursing care records should be improved to accurately reflect patients' needs, their involvement in their care, and be in line with NIPEC best practice guidelines.

Medical Care Records

Three medical notes were reviewed. Generally entries were legible, dated and clear, with evidence of direct senior review from middle grade and consultant staff. The time that entries were made in the medical records was not always documented. Several examples of printed blood results were loosely filed in the medical notes alongside handwritten entries related to the same blood results. We were told that urgent or unexpected results are telephoned directly to the ward.

Housekeeping Point: Blood results should be filed securely

Nutrition and Hydration

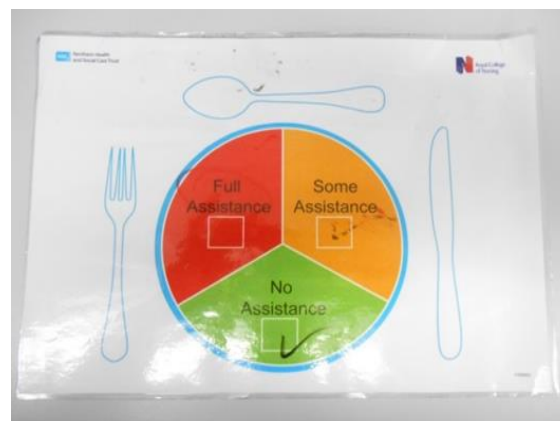
Protected mealtimes (Picture 7) were adhered to. This allowed patients to eat their meals in a calm and relaxing environment, without unnecessary interruption. Nursing staff monitored and assisted patients in meeting their nutritional needs.



Picture 7: Protected mealtime poster

There was a good menu choice, including specialised diets. There was a good variety of meals which were warm, nutritious, appetising and of a good portion size. Patients were provided with jugs of fresh water, which were within easy reach. Throughout the inspection, we observed staff proactively encouraging patients with consumption of food and fluids.

Effective mechanisms were in place to identify patients that require assistance at mealtimes (Picture 8). We observed that patients were appropriately positioned or prepared prior to their meals being served. Timely assistance was given to those patients that required assistance with their meals. During this inspection, although no issues were identified with the serving of meals, we noted that there was limited input from trained nursing staff into the coordinating of mealtimes.



Picture 8: Patient mealtime assistance poster

Housekeeping Point: A senior nurse should take the lead role in supervising and coordinating meal service.

Patients who were assessed to be nutritionally at risk were referred to a dietician. Dietary supplements were given to people when prescribed. We observed that fluid balance charts used to monitor patients' hydration status were routinely reconciled.

Where a meal is interrupted or missed, a replacement meal can be accessed from the hospital kitchen which is open to 11.00pm. Snacks such as tea, toast and biscuits are provided on the ward when requested.

Pain Management

Patients appeared comfortable and adequate pain relieving measures were available. Patients who spoke with us said that staff respond promptly to requests for pain relief. Prescribed pain relief had been administered and recorded appropriately. Ward staff could contact the specialist pain team for advice and support for pain that was difficult to manage.

Pain assessment was generally carried out as routine practice within the NEWS assessment; however, for one patient, we observed a number of omissions in pain assessment. We also noted that some staff were unfamiliar with use of pain assessment scales for those patients who cannot verbalise.

Recommendation: Staff should consistently record pain assessments and use appropriate pain assessment scales for patients who cannot verbalise their pain.

Pressure Ulcers

Staff were knowledgeable with regard to pressure ulcer care. Patients appeared comfortable and appropriately positioned, with pressure relieving equipment used appropriately. A validated pressure ulcer classification tool and a SSKIN bundle were in place and evaluated to reflect patients' ongoing care needs. We observed that the frequency of the repositioning section of the SSKIN care bundle was not always completed for patients.

Housekeeping Point: The frequency of the repositioning section of the SSKIN care bundle should be completed for all patients.

When required, staff can contact tissue viability nurses for detailed advice and support. Monthly mattress audits were carried out to assess mattress integrity. Excellent compliance with pressure ulcer management was achieved on the key performance dashboard for September 2015.

Promotion of Continence and Management of Incontinence

Staff were observed providing patients with the appropriate assistance to promote continence and care for incontinence. Patients have the opportunity for hand hygiene after toileting. Staff have access to continence/stoma specialist services during inpatient episodes and on discharge. Stoma/continence aids (commode, bedpans etc.) are available on the ward if required. For patients with urinary catheters, the clinical indications for catheterisation were documented within the patient records.

The inspection team found that good practice was noted in the domains of pressure ulcer care, the management of pain, nutrition, continence and incontinence and medical patient records.

However, within patient nursing records, we noted variations in the recording and completion of the core sections of nursing process to ensure the quality of patient care.

4.4 Is Care Compassionate?

Person Centred Care

The ward was clean, bright and welcoming, and although staff were busy, the atmosphere was generally calm. Ward noise did not disturb patient's sleep or increase stress.

We observed caring, sensitive, and insightful staff who anticipated the care needs of patients and on all occasions staff endeavoured to maintain the dignity and privacy of patients. A call bell system was in place and each non-ambulatory patient had a call bell within easy reach. Call bells and requests for assistance were responded to promptly. An adapted form of intentional care rounding was in place to ensure that nursing staff carry out scheduled tasks and observations to meet and anticipate the fundamental care needs of patients.

Privacy curtains were used effectively when patients were receiving personal care and during interviews with medical and allied health professionals. Disposable privacy curtains were used in the ward. These were of adequate length and appeared fresh and clean. The ward did not have access to a patient quiet room that could be used by patients to phone or speak confidentially with staff or relatives. The ward sister's office was mostly used.

We were informed that escalation beds are used within the ward when there is an intensified demand on hospital services (Picture 9). Escalation beds can present a particular challenge for ward staff in terms of adequate clinical space between beds and maintaining the dignity and privacy of patients without appropriate bed screening.



Picture 9: Escalation Bed

Patients in these escalation beds do not have access to a nurse call system, or piped oxygen or suction. We were informed that patients are risk assessed prior to being placed in these beds.

Although the ward is designed to provide single sex accommodation, on the second morning of the inspection we observed a female patient being cared for in a male patient bay. We were informed that this had been due to an increased demand on hospital beds, and the patient would only be placed in the male bay for a short period of time. During this period, we observed that nursing staff took actions to ensure that the dignity and privacy of this patient was maintained.

Recommendation: The trust should ensure that arrangements are in place promote the privacy and dignity of patients, including the use of escalation beds and same sex bays.

Communication

There was good signage to direct visitors to the ward and within the ward. Where required, there was discreet signage relating to fasting, infection prevention and control, communication aids and nutritional assistance.

Ward staff were easily identified from their name badges. Staff treated patients and visitors courteously; patients were engaged and encouraged in a sensitive manner; and easily understood explanations were given prior to carrying out care.

Trust information was available in various formats and different languages. Staff can request interpreting services for face to face interpreting, telephone interpreting and the translation of documents. A wide range of patient literature was available on the ward covering disease and procedure specific information, health advice and general information.

A simple practical tool called About Me is used within the ward to improve communication with patients with a cognitive impairment.

The tool is used to tell staff about the patient's needs, preferences, likes, dislikes and interests. This helps staff tailor care specifically to the person's needs.

On most occasions, the privacy of information was maintained within the ward. Most staff endeavoured to speak with discretion when discussing patient information. However, during ward rounds in multi-bedded areas, this presented a particular challenge for staff. A consultant was clearly overheard from outside the patient bay discussing confidential patient information.

In a patient questionnaire, one patient commented that:

“Curtains hide vision, but you can hear other patient's problems on the ward.”

Housekeeping Point: Staff should facilitate areas within the ward for patients to have quiet and confidential conversation.

End of Life

Staff were knowledgeable in relation to the management of patients at the end of their life.

Some staff had received additional palliative care training.

For comprehensive guidance, staff can refer to an end of life symptom management file located on the ward and can also contact the palliative care team for advice and support. Family and carers have access to complimentary car parking and a dedicated relative room for overnight stay.

We were informed that limitations in the number of available side rooms on the ward may result in patients at the end of life being cared for within a patient bay.

Housekeeping Point: Staff should ensure that a side room is available for patients at end of life to optimise privacy and dignity.

One patient had been assessed as requiring a DNAR order. The order had been completed but not signed by a doctor.

Recommendation: Medical staff should ensure that DNAR documentation is reviewed and signed by a senior decision maker.

Patient and Relative Questionnaires

The views and experiences of people who use services were obtained by questionnaires. The findings presented combine the patient and relatives' perception, of staff communication, the care they received, including pain management; food and nutrition, infection control and safety.

During the inspection a total of 13 questionnaires were carried out in Ward C6:

- nine patient questionnaires
- four relatives/carers questionnaires

Overall, patients were satisfied with the standard of care and treatment they received. They told us that staff were courteous, introduced themselves and addressed them by their preferred name. On most occasions staff listened to their concerns and involved them in decisions about their care. One patient commented that they were not always involved in decisions about their care, and attributed this to a break down in communications.

The questionnaire showed that just over half the patients surveyed thought that there was sufficient staff to care for them, but did feel that staff responded to call bells and requests for personal assistance in a timely manner. All patients were happy that they were treated with respect and dignity.

Patients told us that staff checked on their level of pain and if they were comfortable in the bed or chair. The ward was clean, the choice of food was good and fluids were readily available. There was good staff hand hygiene.

All patients felt safe and most were satisfied with the information they were given regarding the period of time they would be in hospital. Overall the patients' questionnaires indicated they would be very satisfied/satisfied for a relative or friend to be cared for in Ward C6.

In general relatives felt welcomed, but felt they did not receive up to date information about their relatives care or who to speak to. Most thought their relatives were treated with respect and dignity, although one person did not. This relative highlighted that they felt the patient was not treated with dignity and respect and did not feel confident they were receiving good care and treatment.

Most felt confident that their relative was receiving good care. Two did not feel involved in the planning of their relatives care. Overall, relatives thought that staff only sometimes had enough time to care for patients.

Patient Comments

"More help for nurses to take the pressure off them."

"Has had a very positive experience."

"Cannot complain."

"Unable to walk but is given appropriate help when using the commode."

"Nurses are excellent but rushed off their feet."

"You can see the pressure they're under."

Relatives Comments

"More staff needed, seem overworked."

"Could do with more updates."

"Not always involved in decisions about care as there is sometimes a breakdown in communications."

Observation of Practice

Observation of communication and interactions between staff and patients and staff and visitors was included in the inspections. This was carried out using the QUIS.

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

Observation is a useful and practical method to help build up a picture of the care experiences of people.

The observation tool uses a simple coding system to record interactions between staff, patients and visitors. Details of this coding have been included in Appendix 1.

Thirty-one observations were carried out over four observation sessions.

The majority of the observations were positive. Most staff actively engaged with patients; there was encouragement and comfort provided during care tasks; staff treated patients respectfully; and explanations of care were tailored to the individual.

We observed some basic observations in relation to some staff failing to engage in conversations beyond good morning and yes/no replies. We observed limited engagement while staff were carrying out medicine or clinical observation rounds.

A negative observation related to a conversation between a doctor and a patient during a ward round. The doctor's discussion was of an intimate nature but could be clearly heard by all other patients in the bay.

Recommendation: The trust should include patient, relative and carer comments as part of the overall strategy to improve the patient experience and ensure appropriate staff interactions with patients at all times.

The inspection team found that staff that were caring, sensitive, and insightful and anticipated the care needs of patients as and when required; some examples of good practice were noted.

4.5 Conclusions for Ward C6 Surgical Ward

We saw many examples of positive leadership at ward level. Complaints, incidents, audits and service performance information were discussed and actions agreed. There were systems to protect patients from the risk of abuse.

Levels of sickness absence were high and patients advised that while their care needs were being met staff appeared rushed. We were advised that a normative staffing exercise was taking place to assess nursing levels. The trust had undertaken a number of activities to fill vacancies.

Staff received necessary training to enable them to carry out their roles effectively. We saw that all medicines were stored safely and securely.

We observed variations in the recording and completion of some nursing documentation. We found that the arrangements for ward rounds were not enabling nurse participation on a regular basis.

The ward environment was clean and in a good state of repair. There was a good meal menu choice and the protective meal service allowed patients to eat their meals in calm and relaxing environment. Patients appeared comfortable. Adequate pain relieving measures were available and staff responded promptly to requests.

We observed that staff were clearly committed to the care of their patients. Care was delivered in a compassionate, respectful and kind manner. Patients and relatives we spoke with were mainly positive about the care they received.

Overall the findings of the inspection of ward C6 were good. We have made 14 recommendations and 16 housekeeping points.

4.6 Recommendations and Housekeeping Points

Recommendations

1. Nurse staffing variances should be reviewed to ensure that patient care and safety is not compromised due to staffing levels.
2. Medical staff should review the scheduling of ward rounds to ensure nursing staff participation.
3. The trust should ensure that refurbishment works are progressed within the treatment room to improve space for the preparations of clinical procedures.
4. The Ward Sister should ensure that all identified hazards within the ward are assessed, analysed and control measures implemented.
5. Medical staff should ensure that blood cultures are obtained when clinically indicated and on completion, the procedure should be clearly documented.
6. The Sepsis Six bundle should be implemented for use within the ward.
7. The trust should ensure that theatre staff completes all procedures within the WHO surgical safety checklist, and the checklist is fully documented.
8. All staff should adhere to trust policy in the administration of medicines.

9. The trust's medicines management policy should be updated to clearly guide staff in the administration of controlled drugs and patient self-administration of medicines.
10. Nursing care records should be improved to accurately reflect patients' needs, their involvement in their care, and be in line with NIPEC best practice guidelines.
11. Staff should consistently record pain assessments and use appropriate pain assessment scales for patients who cannot verbalise their pain.
12. The trust should ensure that arrangements are in place promote the privacy and dignity of patients, including the use of escalation beds and same sex bays.
13. Medical staff should ensure that DNAR documentation is reviewed and signed by a senior decision maker.
14. The trust should include patient, relative and carer comments as part of the overall strategy to improve the patient experience and ensure appropriate staff interactions with patients at all times.

Housekeeping Points

1. Verbal complaints should be recorded and reviewed to identify trends and patterns in the ward.
2. All nursing staff should have email access.
3. Ward nursing staff should attend morbidity and mortality meetings.
4. The ward should display agreed and actual staffing levels for each shift.
5. The trust should provide additional computer workstations within the surgical doctors' room.
6. Emergency exit doors should be clearly identified.
7. Medical staff should robustly adhere to the trust's hand hygiene and uniform policies.
8. Invasive device documentation should be fully completed.
9. Staff should comply with all elements of the falls safe bundle.
10. A list of critical medicines where timeliness of administration is crucial should be available for staff guidance.

- 11.** All patients should be involved in decisions about their medication.
- 12.** Blood results should be filed securely.
- 13.** A senior nurse should take the lead role in supervising and coordinating meal service.
- 14.** The frequency of the repositioning section of the SSKIN care bundle should be completed for all patients.
- 15.** Staff should facilitate areas within the ward for patients to have quiet and confidential conversation.
- 16.** Staff should ensure that a side room is available for patients at end of life to optimise privacy and dignity.



Inspection Findings: Emergency Department (ED)

5.0 Inspection Team Findings: Emergency Department

The ED has a five bedded resuscitation area, one bed is designated for paediatrics; triage areas, including ambulance triage; 13 major treatment rooms including isolation, gynaecology and bariatric facilities; six minor treatment rooms, six paediatric treatment rooms with designated waiting area; mental health assessment area; ultrasound/procedure room; and an integrated radiology department. The adjoining observation unit has 10 centrally monitored short stay (24 hours) observation rooms and an emergency department decision area (EDDA) with eight spaces.

5.1 Is the Area Well Led?

Governance

In the main ED, on the first day of the inspection, the band 7 sister, manager, had a rostered managerial day. A band 6 RN, designated in charge, was working on the floor with eight RNs and two healthcare assistants. The senior nurse on duty was not immediately visible to support ward activities. During the course of the inspection, we did not observe direct ED line management support for the band 7 sister. The band 6 nurse in charge was not easily identifiable by uniform or badge. We were advised that the trust intends to change the uniform of senior staff, to make them easily recognisable.

Housekeeping Point: All staff should wear name badges.

Staff have access to a range of policies and procedures to accommodate learning and when required, to affect change. Mechanisms are in place for staff to learn from ward complaints. Verbal complaints are not recorded centrally to identify trends and patterns. The sister told us that generally complaints related to waiting times and communication. We were informed that issues relating to crowding and long trolley waits have been identified on the ED risk register.

Housekeeping Point: Verbal complaints should be recorded and analysed to identity patterns and trends.

The trust has systems and process in place for the management of SAls, incidents and near misses and staff spoken with were aware of reporting mechanisms. Staff were aware of the process to report SAls, incidents and near misses; however, they were not aware of any formal analysis of trends. Some staff told us that they were not always updated with the outcome of incidents and investigations. In reference to a learning letter from the PHA relating to timely triage for children, nursing staff with responsibility and working in children's triage were aware that changes to the children's triage protocol had been made, but were unaware of the incident that prompted this change.

Recommendation: The trust should ensure the regular dissemination of formal analysis reports on SAls, incidents, near misses to staff for learning.

Recommendation: PHA learning letters should be communicated to all relevant staff.

ED specific morbidity and mortality, meetings are consultant led. The last meeting was held in July 2015. The band 7 sister attends this meeting, which is open to all ED staff. There is currently no dissemination of information for learning to staff who have not attended. Staff were not aware of trust cardiac arrest rates and actions for learning within the department.

Recommendation: Communication with staff should be improved to ensure learning from morbidity and mortality meetings and from analysis of cardiac arrest rates.

The ED holds monthly governance meetings which are attended by senior nurses, consultants and the lead nurse. Minutes of these meetings are recorded however were not available when requested by the inspection team. A weekly joint ED nursing and medical performance meeting also occurs. If issues arise relating to infection prevention and control, the infection prevention and control team is available for advice. Staff were aware of the trust's healthcare associated infection targets and performance against these.

Department of Health Targets for Emergency Department

The ED is monitoring a range of quality indicators in line with DoH targets. At the time of the inspection, trust performance statistics and reports indicated that patient 60 minute, four hour and 12 hour performance targets to be seen by a decision making clinician, treated, discharged or admitted are not being achieved.

The DoH target is for 95 per cent of patients to be treated, discharged or admitted within 4 hours. In August 2015 the trust achieved 61 per cent. The target of 95 per cent for patients to be seen by a decision making clinician within 60 minutes is only analysed weekly. On the week of 2 October 2015, 49 per cent was achieved.

The 12 hour performance target has improved in recent months; however this is still well below the DoH target that no patient should wait 12 hours. For the period April to August 2015, in the ED, 168 twelve hour breaches occurred; a 45 per cent reduction in the same period in 2014 (305 breaches).

Patient's time to triage within 15 minutes of arrival at ED is a new DoH indicator, introduced for 2015-16. Figures indicated the trust has a 75 per cent to 89 per cent achievement rate.

Monthly figures show that the ED is achieving the College of Emergency Medicine standard of less than five per cent of patients leaving before treatment is complete. There are fewer than five per cent of unscheduled re-attenders to the department.

Recommendation: The trust should undertake further work to improve quality indicators in line with DoH targets.

Some nursing staff advised that under times of pressure, targets could be seen as a priority over patient clinical need. A disclosure to the inspection team relating to this issue was passed on to the Director of Nursing. Due to the timing of the disclosure on the final day of the inspection, this issue could not be fully investigated by the inspectors. However, the trust agreed to carry out an immediate review of this issue.

An ED doctor in training told us they felt real pressure to see patients less thoroughly because of the sheer volume of patients.

Recommendation: The trust position that clinical priorities always come before targets should be clearly communicated to staff.

Staffing and Supervision

We were informed that band 7 sisters do not have sufficient time to undertake managerial duties and provide effective clinical leadership.

The sisters are counted as part of staffing numbers and can have a designated patient caseload. We were told that one managerial day per week is insufficient to complete office work.

There are two band 7 sisters for the main ED and one for the observation unit. A large proportion of nurse in charge shifts, including night duty, are designated to band 6 staff.

Recommendation: The trust should review the role and number of the band 7 nurses in ED to ensure effective clinical leadership.

We were informed that nursing normative staffing levels are under review. At the time of inspection it was planned to complete this exercise by the beginning of 2016. The ED has three separate nursing staff rotas: ED main, minors, and observation unit. There are plans to develop one rota for the entire ED.

Housekeeping Point: One central nurse staffing rota should be developed. Agreed and actual nurse staffing levels should be displayed.

During observation and following discussions with staff the inspection team considered that staffing levels, especially under times of pressure, were not sufficient to meet ED needs. For example, there were only one to two nurses in resuscitation, rather than one per patient.

On the busy afternoon of the first day of the inspection there was only one nurse allocated to ambulance triage. The nurse was triaging and monitoring patients, with no additional support.

Staffing levels are supplemented by the use of bank and agency nurses; however, shifts are not always filled. This is reflective of issues across the region in recruitment and retention of nursing. Due to the pressures on the ED service and increased patient numbers, there are occasions when different areas within ED have to be staffed with nurses working later than anticipated or reopened to facilitate patient placement and care. For example, paediatric triage which normally operates between 10.00am and 10.00pm was open until 3am on day one of the inspection.

At the start of one overnight shift, the EDDA was not in use or staffed, as all patients had been transferred to wards. However, the area had to be reopened due to an increase in patient numbers. Staff are often moved from the ED majors, to other areas within the department. We were told by staff that they are worried about maintaining patient safety, especially when the ED is overcrowded.

There is no information on the agreed and actual nursing staffing levels displayed for each shift.

Staff retention has become an issue over the last six months, with staff leaving the department. At the time of inspection there are currently five RN WTE vacancies and 7.4 per cent overall sick leave in the main ED. The trust plans to advertise specifically for ED nurses to fill the vacant posts, however this process can take up to three months to complete. Completion of the normative staffing review may affect the requirement for further staff.

Recommendation: The trust should review nurse staffing levels across all areas within the ED and the recruitment of new staff should be expedited.

Middle grade medical staff cover is available, 24 hours a day, seven days a week, except for two hours on a Saturday and Sunday between 6.00am and 8.00am Medical staff told us that there are good working relationships between staff in ED and other areas within the hospital. An ED registrar who attended the focus group told us that staff feel supported by their seniors.

The band 6s and enhanced nurse practitioners (ENPs) support the ward sister through carrying out clinical duties, mentoring and supporting junior staff. However, information supplied during the inspection identified that yearly mentorship training, supervision and appraisal is not up to date.

Recommendation: Staff supervision and appraisal should be up to date.

We were informed by the majority of nurses that they enjoyed working within ED.

However due to pressures such as crowding, staff shortage, patient acuity, and patient placement, they did not always feel equipped to carry out their role, or feel they had the skills to nurse patients with specialist conditions e.g. cardiology.

Staff raised concerns to us about increases in workload, unrealistically high expectations, burn out, staffing levels, staff turnover, and low morale. We were advised that these issues have also been raised with management.

Nursing staff told us that they can raise concerns to their direct line manager for action. However, they are not aware of any resultant action taken by senior management staff as a result of the concern. One staff disclosure to inspectors was raised with the Director of Nursing for action.

Core medicine trainees (CMT) told inspectors there are times that they can feel unsupported while working in the ED. However, ED consultants were praised for their attempts in supporting all staff including CMT trainees.

Recommendation: Senior trust ED staff should take action to alleviate staff concerns outlined in the report and ensure any issues raised by staff are immediately addressed by senior management.

Nursing staff informed us that they do not always feel safe and the provision of an adequate security service is of concern. There is only one member of security staff available for the entire site between 3.00pm and 6.00am. Staff also told us that security staff can have a hands off approach to situations. Nursing staff call the Police Service for Northern Ireland (PSNI) for assistance, if required.

Each patient room has a staff alarm and staff can carry personal alarms. These personal alarms have not been in use for a number of weeks due to a malfunction. We were told that this is being addressed.

Recommendation: To provide a safe working environment the trust needs to review the provision of security staff on the hospital site and have malfunctioning staff personal security alarms repaired immediately.

We were told that there are no designated AHPs or social work staff aligned to ED, but services can be accessed by phone. Only physiotherapy and social work services are available at weekends. Social work is available on call 24 hours a day; however they are not always on site. Staff told us that timely access to these services would assist with patient recovery, patient flow and, on occasions, prevent admissions.

In spring 2015, a physiotherapist was aligned to the minors area as part of a pilot scheme. This proved to be successful, but has now finished. The PHA, as part of commissioning services, plans to invest in the development of AHP services within EDs across Northern Ireland.

This will allow for the establishment within the ED of AHP cover, 9.00am to 5.00pm, seven days a week and allow for the re-establishment of physiotherapy input into minors on the back of the successful pilot.

Recommendation: Timely access to AHPs should be developed as part of the PHA commissioning services.

Staff Training

There is a comprehensive induction pack for new staff who also attend corporate induction consisting of two days of mandatory training. At the time of the inspection there were three nurses who needed to complete their corporate induction programme. Their departmental induction was complete.

A range of trust based training and external specialist practice courses are available to assist staff to fulfil their role, for example, specialist practice, conferences, and dementia care. The training matrix provided during the inspection indicates that staff attendance at mandatory training requires significant improvement.

We were told that all staff working in triage had received training commensurate with the role. Nursing staff told us they had previously taken blood samples and inserted IV access lines for medical staff. Due to their work pressures this has ceased as they have to put the nursing care of their patients first. Medical staff reiterated this.

MAPA training is available for staff; however, staff we spoke to had not attended. This was supported by the review of the training matrix which indicated that at the time of inspection only one member of staff had attended. Training in the areas of domestic violence and safeguarding is available. Information provided identifies that uptake of training needs improvement.

Recommendation: All staff should attend mandatory training and staff should have the opportunity to attend in house training commensurate with their role.

Patient Flow

An internal ED specific escalation plan interlinks with an overall trust escalation plan. This is a good initiative, however, it was noted that the current criteria place the ED into escalation on a frequent basis. When an alert system is frequently escalated, it can create complacency with the system.

Recommendation: Visible and effective leadership is needed during the initiation of the ED escalation plan. The criteria for the ED escalation plan should be reviewed and updated as required.

We did not observe proactive walk rounds by senior nursing and medical staff or regular patient reviews, led by the designated lead consultant for that shift.

We were told by nursing staff that medical staff will only come onto the floor when the IT system shows patient numbers and pressures in ED are escalating. Patients in the ED are then individually discussed by the team and decisions made by the consultant. RQIA recommends that ED consultants have a more active presence on the floor and that proactive walk rounds should be introduced by ED staff.

There is some disparity between staff disciplines in relation to whether a joint nursing and medical round occurs across the department. We received conflicting information. The ward sister told us these did not now happen, whereas medical staff told us they did. We were told that medical staff review patients as part of the daily 8am handover. Nursing staff advised that medical staff are very approachable and constantly talk to nursing staff on the floor. However, there are occasions when nursing staff have to seek out medical staff. We observed good one to one medical and nursing staff engagement.

Recommendation: Daily reviews and routine senior medical and nursing walk rounds should be carried out.

Senior staff advised us that the ED was particularly busy prior to and over the period of inspection. We observed and recognised this increase in the number of admissions and the pressures all staff were under to review and institute effective care for patients during this time.

There have been certain initiatives designed to improve ED waiting times and streamline services in several patient admission routes and areas that feed into the ED. Following ambulance triage, patients can be transferred to either the EDDA to wait for an available inpatient bed, or be admitted to the 24 hour short stay, observation unit.

Older patients can be admitted directly to an elderly assessment unit (EAU) if triaged as care of the elderly, and beds are available. An admission unit and discharge lounge are also available for patients admitted from the General Practitioner (GP).

The Northern Ireland Ambulance Service (NIAS) provides an on-site member of staff as a trust liaison officer, which has been beneficial in assisting with pending admissions and discharges.

A joint initiative involving ED and the radiology department, to improve the agility of critical scan reporting with an aspiration to move to real-time scan reporting in certain cases is progressing. Day procedures are increasingly being carried out, such as blood transfusions and abdominal or chest paracentesis in the recently opened GP Hub, situated in the former ED premises.

During the inspection, the short- stay ward was functioning as a medical inpatient ward. Patients were not flowing through the service, with discharge not facilitated within 24 hours.

Activity in the main hospital site, lack of discharges, pressures on ward services and inpatient beds all impacted on the movement of patients through the ED.

We observed that ambulance triage was, on many occasions during the inspection, overcrowded with patients.

In short stay observation rooms, responsibility for patient care can be transferred from the ED physician to the care of medical, surgical or specialist doctors. Nursing staff told us of difficulties accessing a speciality review, with some patients being seen late at night.

Medical staff also expressed concern as to the responsibility for patients admitted under general medicine. Concerns described included the relative lack of attendance by medical staff to ED outside 9.00am and 5.00pm and the level of seniority of medical staff reviewing patients. Although this may result in sub optimal or delayed management of complex patients; we were not informed of any specific patient safety concerns in relation to this.

However, in one patient case, a more timely senior review out of hours from a registrar, or discussion with the on- call medical consultant would have identified the need for this patient to receive the correct fluid and electrolyte replacement, without unnecessary delay.

Recommendation: Improvement is required in the interface between ED, and medical, surgical and specialist services to ensure timely patient assessment and review.

Medical staff discussed the increasing burden of both acute and chronic illness seen in ED and advised that they have raised the issue of patient flow with the trust senior management team. A number of ambulatory and integrated care pathways are in place including head injury and chest pain. Inspectors considered that pathways could be further developed, for example, treatment of deep vein thrombosis and chronic respiratory conditions.

Recommendation: Ambulatory and integrated care pathways should be further developed.

An effective integrated IT system called symphony, is in place. Administration staff are present 24 hours a day and keep this system updated to accurately record patient flow in the ED. This system is used in conjunction with live information from the NIAS (9.00am to 9.00pm) to identify patients attending the ED, and to assist with flow and department management.

Patient ED attendance record and discharge summaries are scanned onto the IT system and are immediately available for staff in case of re-attendance. ED consultants review and monitor the quality of this data.

Communication

We were informed that communication and dissemination of information to staff is accomplished through various formats such as safety briefings, handovers, ward meetings, and email access for all staff. The newly appointed lead nurse is establishing a range of staff meetings; the last staff meeting before the inspection was held in September 2015. There is no standard agenda to ensure continuity of information shared with staff. As previously outlined, some learning and information has not filtered through to staff. Channels to ensure effective communication should be improved.

Housekeeping Point: An agenda should be available for all staff meetings and the minutes of meetings disseminated to staff.

All medical and nursing staff have access to electronic care records (ECR) to access up to date patient GP information.

Audits of practice are carried out within the main ED involving environmental cleanliness, hand hygiene and mattresses. In the observation unit, further audits are carried out on falls and NEWS, used to detect a deteriorating patient.

We were informed that staff receive feedback in relation to audit results and subsequent action plans. Nursing quality performance indicators in use should be reviewed and further introduced where appropriate. Audit and performance results are not displayed throughout the ED for patients and staff to view.

Recommendation: Senior ED staff should review and further introduced where appropriate nursing quality performance indicators into ED.

Housekeeping Point: Audit and performance results should be displayed throughout the ED for patients and staff to easily view.

The ED, as part of the PHA's 10,000 voices patient experience initiative, receives a breakdown of issues that are identified within the department for action. Trust board information regarding patient experience is posted on the trust internet site as part of monthly performance reports.

Safeguarding

Arrangements reflecting legislative and local requirements were in place to safeguard adults and children from abuse. Staff are aware of the trust safeguarding lead and communication arrangements. An on-call social work service is available 24 hours a day.

In a case of suspected child abuse, staff are aware that a consultant paediatrician is called and child protection procedures commence immediately. Staff are aware that additional safeguards are required for children, including contribution to a UNOCINI assessment.

Staff can liaise with the Sexual Assault and Referral Centre (SARC), and contact the PSNI as appropriate. The social services IT system can be accessed as it provides information on patients who have already been identified and registered as at risk.

The inspection team found that significant work is needed to ensure that the ED is well led. We found deficits and gaps in the organization and management of the unit which need urgent attention. These concerns were raised with senior trust staff at the time of the inspection.

5.2 Is Care Safe?

Environmental Safety

The new ED was opened in June 2013 and the environment has been maintained in good order. Spacious single room facilities, throughout the ED, promote good infection control practices, however there are space limitations in the ambulance triage area.

The environment was light, bright and free from hazards. Patient equipment was stored in designated areas, not accessible to the public. All single rooms had privacy blinds and a door promoting minimum noise level. Nursing staff could maintain visual contact with high risk vulnerable patients by placing them close to the nurses' station; doors can remain open when appropriate.

Ambulance triage comprises two small curtained trolley spaces and a small triage reception desk, with an ambulance liaison point. This area works well, however, at times of peak pressure can become very congested, with space insufficient to facilitate patient numbers.

Inspectors observed at one period, three ambulance crews with patients waiting to be handed over to nursing staff, two patients in the cubicles waiting to be assessed and ten patients waiting on chairs in the corridor. The crowding of this area can compromise patients' safety, dignity and staff ability to give the right care to a large number of patients in such confined space, or to respond in a timely manner to an emergency situation.

Recommendation: Staff should ensure patients are always treated with respect and dignity during times of crowding in a manner that maintains privacy and confidentiality.

Observation of patients by staff in ambulance triage and in the resuscitation area can be challenging when staffing levels are inadequate and there is patient crowding.

In the main ED, contact details for the resuscitation team were not clearly displayed and one nurse told us they were unsure of how to contact them in an emergency.

Recommendation: All staff should be aware of how to contact the resuscitation team and contact details should be clearly displayed.

Infection Prevention and Control

The ED environment was clean and in a good state of repair. Environmental cleanliness audits are carried out and trust compliance rates were achieved. Clinical hand wash sinks, alcohol rub and glove and apron dispensers were clean and easily accessible and located near to the point of care. Spacious single room facilities, each with a clinical hand wash sink, promote good infection control practices. Contact precaution notices were displayed appropriately for those patients nursed under isolation.

We observed that most staff carried out hand hygiene at the appropriate times, in line with WHO, five moments of care guidelines. However, on occasions some staff, for example after contact with a patient and surroundings, after body fluid exposure and removal of gloves did not carry out appropriate hand hygiene measures. Generally the principles of ANTT were adhered to during clinical procedures. However, on occasions some staff did not carry out best practice. For example, a doctor was observed taking blood from a patient in a busy corridor, the skin was not cleansed, a paper mache bowl was used rather than a cleanable ANTT tray to hold equipment, and the paper mache bowl was placed on the floor. The doctor did not wash or alcohol gel their hands when the procedure was completed. On another occasion the phlebotomist did not clean the skin and leave to dry for the appropriate time.

Recommendation: All staff disciplines should carry out hand hygiene in accordance to the WHO 5 Moments of care, and adhere to aseptic non-touch technique (ANTT) procedures.

We were advised that hand hygiene audits and patient equipment cleaning audits are carried out; however evidence of these was not available at the time of inspection. The department does have infection prevention and control link nurses.

Housekeeping Point: Hand hygiene and patient equipment audit results should be readily available.

Patient Safety

All patients we observed wore an accurately printed identity band, staff were aware of the actions to take when identification details are incorrect.

Guidance on the management of the acutely ill patient was available. Patient NEWS was in most instances totalled and completed within set timescales.

However, in two sets of nursing care records, staff did not refer an escalation in the scoring or the action to take in accordance with the NEWS algorithm, on detection of a deteriorating patient.

Recommendation: Staff should ensure that national early warning scores are totalled and completed within the set timescales, and escalation in scoring and action taken recorded at all times.

A Sepsis Six bundle is in place for the recognition and timely management of sepsis. A bundle is a set of interventions that, when used together, significantly improve patient outcomes. It was advised that the Sepsis Six bundle has not been routinely audited since first introduced in 2013-14.

Copies of the bundle flow chart printed/photocopied in the ED were of poor quality with difficult to read text and an oversaturation of colour.

Not all patients with sepsis symptoms were commenced on the Sepsis six pathway.

Recommendation: Staff should ensure that the Sepsis Six bundle is fully completed and legible copies available.

The observations unit had implemented a falls safe care bundle and the numbers of falls figures were available. Throughout October 2015, three falls were recorded. A falls referral pathway is in place for patient follow up following discharge into the community.

Housekeeping Point: Staff should continue to implement the falls safe care bundle to reduce the risk of falls.

VTE risk assessments were completed for each patient reviewed and VTE prophylaxis was administered where required.

On admission, an assessment tool is in place to identify patients at risk of developing a pressure ulcer. However, there is no way of monitoring the incidence of preventable pressure ulcers in the observation ward for example safety cross. Staff have received theoretical training on haemovigilance. However, completion of competency assessments requires improvement.

Housekeeping Point: All staff should complete haemovigilance competency assessments.

Staff told us that speedier action could be taken by ED senior management when a safety concern is raised, such as staffing or patient flow. Staff also told us that they are left to deal with situations and are then questioned at a later stage as to why a situation had occurred. Staff we spoke to were supportive of band 7 staff.

Patient safety/medical alerts are communicated via safety briefings; a folder of action plans is available for staff to view. The sister completes a proforma for actions taken in relation to medical device alerts, which is forwarded to the medical devices manager.

All patient areas have appropriate equipment, which is maintained and replaced to meet the needs of the patient. However, when ED becomes crowded, the supply of equipment, number of oxygen points and availability of patient trolleys in triage can become an issue. It was identified by inspectors that a patient in the EDDA was not connected to a cardiac monitor, as their condition would dictate. Therefore there is no way of knowing if a patient is developing a potentially dangerous arrhythmia or sustains a cardiac arrest.

Recommendation: Staff should ensure that patients are connected to a cardiac monitor as their condition dictates and ensure that additional essential patient equipment is available during times of crowding.

Consideration is given to patient placement, safety and vulnerability. However, within the short stay observation unit, rooms designated for use by patients presenting with mental health problems or having taken an overdose are often used to admit medical or surgical patients.

Recommendation: The short stay ward should function as designed. When this cannot be facilitated there should be systems in place to ensure services are available for vulnerable and longer-term inpatient beds.

Patients brought in by ambulance are generally seen and assessed promptly by ED staff. However, at times of crowding within ambulance triage, patients can be placed in corridors. This can delay handover by ambulance staff and has the potential to compromise patient safety during this period. Throughout the afternoons and evenings of the inspection, when patient numbers in ambulance triage increased, patients had no access to call bells and staff were unable to observe patients at all times .

On the afternoon of the first day, we observed that the one nurse working in this area was struggling to cope with the influx of patients and the handover from ambulance staff was delayed. A recommendation regarding handover times was made in the section of the report relating to the handover theme.

At times of crowding, we observed that the number of patients occupying ambulance triage was beyond the capacity for which it was designed and resourced to manage at any one time.

The patient status board is updated and in conjunction with the NIAS information system, gives a real time view of the status of patients in the ED and pending admissions.

The consultant and nurse in charge do not routinely carry out hourly safety rounds and four hourly patient reviews. Previously this would have happened two to three times a day, however, this has now stopped.

The safe and effective flow of patients from ED to the ward can be affected by activity within the main hospital, for example delayed discharge from other wards. Patient flow can also be improved, as already discussed within the report, by timely patient review and access to AHPs.

A self-harm patient pathway, initiated during triage, is in place, with good interface between mental health services and the wider community.

A RAID service is operated by the mental health team, 24 hours, and seven days a week. Staff told us that this provides an invaluable service and supports them in the assessment and management of patients presenting with mental health illness and self-harm.

Older people are not automatically fully formally assessed for all common frailty syndromes and a recognised assessment tool to identify high risk older patients is not in use.

Recommendation: The assessment of older patients for all common frailty syndromes, during clinical review, should be fully documented using a recognised assessment tool.

Medical staff advised that they feel supported in ED to carry out quality improvement work and trainees have made suggestions for improvements to the triage system such as increasing the number of health care assistants in ED to assist with observations in the ambulance triage area.

This was not evident during the inspection. However, given the findings in relation to ambulance triage, would be considered beneficial. We have been informed that this proposal is being taken forward.

The College of Emergency Medicine Clinical Standards for the ED are being implemented. The trust is one of three within Northern Ireland which receives funding from the College of Emergency Medicine to carry out audits against ED Clinical Standards. Three audits are completed yearly which cover all clinical standards. To date, audits have been carried out on: fractured neck of femur, feverish children, pain, the fitting child, cognitive impairment in older people, severe sepsis and septic shock in adults and mental health.

In 2015-16 planned audits are paediatric early warning scores (PEWS) and children, procedural sedation in adults and VTE risk assessment in lower limbs. Once completed, staff advised that there is no re-audit programme in place. A national seizure audit is also underway. Not all staff within ED were aware of the College standards and their implementation.

Recommendation: The learning from the audits of ED clinical standards should be actioned and cascaded to staff.

We reviewed statistics for treatment of thrombolysis in acute stroke for the period February to August 2015. The target of 13 per cent was achieved in all months with the exception of May and August 2015 when 9.2 per cent and nine per cent were achieved. This was described by the trust as a normal fluctuation in rates. This was not attributed to a lack of service, but rather, to patients' medical contraindications to treatment, not being able to establish the time of onset of symptoms, or patients attending ED outside the timeframe that lysis treatment is effective.

Medical staff told us that the use of a continuous rolling audit (the first in Northern Ireland in this area) has improved the provision and quality of stroke services within the hospital. All stroke lysis is supervised by the acute stroke team in-hours, with support from the on-call medical registrar out of hours.

We were told that the stroke unit is in the process of applying to become a hyperacute stroke unit for the rapid assessment of stroke patients. Staff informed us that they have the clinical and nursing expertise to deliver this service. Current challenges faced in stroke medicine include: the need for greater availability of AHPs on the ward, and more dedicated acute stroke beds.

Good working relationships have been developed with the radiology department, which has improved access to emergency CT scanning by providing an in-house radiographer.

Medicines Management

Medicines, including IV infusions were not always stored safely and securely. In the resuscitation area, fridges and some drugs cupboards were unlocked. In the observation ward the drugs fridge was unlocked. In resuscitation, lidocaine one per cent was stored with propofol and acetone liquid was stored in the same drawer as internal medicine. In the minors/majors area IV fluids with potassium were stored in the same cupboard as glucose five per cent. IV Volplex was stored inappropriately in the drawer with mannitol 10 per cent and 20 per cent. On one occasion expired volplex was observed (July 2015). Issues were identified to the nurse in charge and immediately actioned. Oral syringes used to administer medication were mixed inappropriately with syringes for injectable use.

CDs were stored safely and securely; staff advised that CDs were administered with a second signatory and two RNs at the bedside. The drug preparation area was well lit and uncluttered. The inspector observed IV medication prepared by one RN and checked by a second. The medicine Kardex was signed by the two RNs, but administered at the bedside by only one RN. IV medications were frequently reconstituted. Oral medication was administered directly to the patient and not left unattended.

We noted that the trust medicines administration and management policy does not provide clear guidance for staff in the administration of controlled drugs and patient self-administration of medicines.

In ED patients do not self-administer medication.

Recommendation: The medicines management policy should be updated to clearly guide staff in the administration of controlled drugs and patient self-administration of medicines.

In the observation ward, documentation evidenced that the delay or reason for omission of some medication was not clearly and accurately recorded in the Kardex. Codes used did not always correspond to those on the front of the medicine Kardex. The reason for consecutive medication omissions was recorded on occasions as medication not being available.

A system should be in place to ensure medications are ordered immediately when identified as not available.

Overall, we observed that medication administration was in line with good practice guidance; however, medical staff signatures on some Kardex were not always legible. The importance of prescribing medication with a legible signature and the administration of same should be reinforced with medical and nursing staff.

Recommendation: All staff need an immediate update on their role and responsibility in the safe storage, security, administration and documentation of medication. Staff practice should be monitored to ensure adherence to best practice.

The ED pharmacist is assigned to the observation unit until 8.00pm; thereafter an on call service is available. This pharmacist also provides advice and assistance to the main ED, with only occasional pharmacy technician cover. On the day of inspection the two ED pharmacists were not on duty. One band 6 pharmacist covered main ED, children's, the EDDA and admissions ward. We were advised that this is an exceptional circumstance. The main focus of the pharmacist's role appears to be on patient discharge medication, rather than medicine reconciliation on admission. During the inspection, it was unclear if IMM was in operation as the pharmacist was covering a number of locations. Kardex reviewed identified that the pharmacy section for medicines reconciliation on admission and during inpatient stay was not always signed. Pharmacy staffing within the ED requires review, to ensure a fully implemented IMM service.

Recommendation: The trust should review ED pharmacist cover to improve and facilitate effective integrated medicines management.

Patients told us that they were not always involved in decisions about their medications. On discussion with patients, not all were aware of why they were started on new medication. However, there was evidence that patients' concordance with prescribed medicines is assessed on admission. Patient weights were not recorded.

Housekeeping Point: All patients should be involved in decisions about their medications.

Housekeeping Point: Patients weight should be recorded on the medicine kardex.

A list of critical medicines where timeliness of administration is crucial was not available. Staff we spoke to were unaware of a critical medicines list; however they were aware of the importance of the administration of certain medications. On observation, critical medicines were available in the ED.

Housekeeping Point: All staff should be familiar with critical medications. A list of critical medications should be displayed.

Staff were aware of how to access anti Parkinson's medication from the Stroke ward. A patient safety alert poster on novel oral anticoagulants was in place.

There is evidence of medication incidents being reported, investigated, learning identified and shared through governance review.

Good practice by NIAS staff was observed regarding the transportation of patient medications from home to hospital. When taking a patient to hospital from their own home, the NIAS crew place the patient's own medication, if accessible, into a green medication bag. The bag is given to ED staff on the patients' arrival to the hospital.

This initiative ensures that patients and hospital staff have access to all prescribed medication with no delay and assists with medicines reconciliation.

The inspection team found that significant work is needed to ensure improvement in all sections within this domain. We found deficits and gaps which need urgent attention and these concerns were raised with senior trust staff at the time of the inspection.

5.3 Is Care Effective?

Nursing Care Records

The ED Nursing Documentation booklet used in majors only has been reviewed by the trust and includes documentation of clinical observations, investigations, cannulation, social history, skin assessment, infection prevention and control, falls, mobility, moving and handling. However, booklets reviewed during the inspection were not fully completed.

Patient flimsies commenced in triage and used in minors and majors, did not always have the pain score completed. In the main ED, NEWS charts reviewed were not always completed.

In the observation ward, nursing admission assessment booklets, risk assessments, and a range of observation charts to include NEWS charts, SSKIN charts, peripheral cannula charts were reviewed. These were not always completed correctly. A comprehensive nursing assessment and relevant risk assessments were not always fully completed or regularly reviewed. In some cases a risk assessment was not in place for a patient's identified need. Completed risk assessments did not always have a care plan devised to provide instruction. Core care plans in use were not individualised to meet the needs of the patient, or reviewed.

Nursing care records were not always up to date and did not always reflect the nursing assessment, or the care required for the patient, identified through observation and examination. Not all care records demonstrated that nurses 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 NIPEC guidelines. Patient details, such as their healthcare number were not always recorded on documentation.

There was good documentation of MDT involvement with patients; however, not all records contained details of patient and family involvement in planning aspects of patient care, or discharge planning.

Staff advised that keeping documentation up to date in real time is not always possible due to the mix of acutely ill patients, and a very busy department.

Nurse record keeping is not a quality indicator audited within the ED. The findings here support the need for this indicator to be introduced.

Recommendation: The recording in nursing care records should be improved to accurately reflect patients' needs, their involvement in their care, and be in line with NIPEC best practice guidelines.

Medical Care Records

The medical records were generally excellent, with clear handwriting, a logical noting of history, examination, differential diagnosis and management plan. Notes were tidy and arranged logically in the ED as loose sheets in a folder. Almost all relevant information had been clearly documented and laboratory results printed out. Some areas of notable and good practice included: NIAS staff underlining an oral anticoagulant, circling key words, and findings in the narrative of the patient's journey; medical staff writing a list of patients' drugs, highlighting those of significance, or those that likely contributed to presentation such as nephrotoxic, and cardiac medications.

Nutrition and Hydration

Patients admitted to the short stay ward or who are within the ED, and waiting for an inpatient bed are provided with meals, as appropriate.

Nursing staff are responsible for ensuring that individual patient nutrition and hydration needs are met throughout their stay within ED.

The observation unit orders meals for observation unit patients; the remainder of the meals are served in the main ED. Meals are ordered 24 hours in advance, using a handheld electronic device. Special diets can be ordered for the observation unit, via the electronic system. Special diets for main ED can be ordered directly from the catering department and will be delivered by a porter. Snack boxes/bags (Picture 11) are available for patients who require food out of the normal service hours and are suitable for both normal and for gluten-free diets.



Picture 11: Snack bags

A light lunch of soup or salad was available. The hospital offers a choice of four to five evening meals; this has been limited in the observation unit to only two of the most popular choices, on the understanding that patients will stay only for a 24 hour period. However, we noted that many of the patients within the observation rooms were inpatients for more than 24 hours. This restricts patient choice and results in a further restriction of meal choice for patients within main ED.

There was no senior member of nursing staff available to supervise or co-ordinate the meal service during all mealtimes.

Service appeared disorganised and staff were unaware of patient requirements. Evening meal service was observed to be late, at 6:20pm in main ED.

Housekeeping point: A senior nurse should supervise and co-ordinate meal service.

Effective mechanisms were not in place to identify patients that require assistance at mealtimes. Information was passed on verbally from nurse to healthcare assistant and catering staff. A nurse told us that this practice could lead to a patient being over looked at times of pressure.

Housekeeping Point: A robust system should be implemented to ensure patient dietary requirements are correctly identified and to ensure no patient is overlooked during meal service.

A choice of milk or water was provided along with lunch and evening meal service. However, fresh water was not available or within easy reach at the patient's bedside in main ED. There was no system to encourage patients to drink. Patients were given water on request from a water dispenser in the corridor. On two occasions, inspectors relayed patients' requests for fluids to staff; this was immediately actioned.

Housekeeping Point: Patients should be regularly provided with fluids and routinely encouraged and if necessary assisted to drink.

We observed that patients were not appropriately positioned or prepared prior to their meals being served by catering staff. Patients and catering staff had to ask nursing staff to assist, for example, in lowering bedrails to allow access to meals after the meal had been served. In the main ED, due to a shortage of bedside tables, patients had to eat from trays positioned on top of a low bedside clinical procedure unit. In the observation unit, staff were observed assisting patients at breakfast time; however, beds were raised and staff stood and faced patients. As good practice, staff should lower the bed and be seated beside the patient.

Housekeeping Point: All patients should be prepared for meals prior to meal service. Staff should be seated beside patients when giving assistance.

Recommendation: The trust should improve the system in place for the ordering, delivery and service of patient meals.

Food and fluid charts were not completed consistently. A review of food and fluid balance charts revealed inconsistent documentation; not all charts were reconciled and signed.

Recommendation: Staff should ensure that fluid balance and food record charts are completed and reconciled in accordance with trust policy. A robust audit of the documentation should be undertaken.

Adapted cutlery or crockery was not available for patients with limited manual dexterity. Milk and water were served in polystyrene cups or clear flimsy plastic glasses. These can be difficult to handle, and have the potential to collapse on pressure, causing the content to spill.

Housekeeping Point: Adapted cutlery and crockery should be available for patients.

Pain Management

Patients appeared comfortable; pain relieving measures were available, and in place. Staff responded promptly to patients' requests for pain relief. Pain medication was administered as prescribed, with the effectiveness of analgesia reviewed. Variation in the recording of the pain score on the NEWS was noted in documentation.

Housekeeping Point: Pain scores should be completed at all times on the NEWS.

On retrospective review of documentation, we noted that not all patients are assessed for pain within 15 minutes of first contact with ED. Although a standard question in triage documentation, patients are not routinely asked if they are in pain. Staff told us that only patients presenting with a condition that indicates possible pain are asked. This pain assessment is subjective and dependant on triage nurses' experience and interpretation of the patient's condition. Not all staff were aware of the Abbey pain score for patients who are unable to communicate.

Recommendation: Staff should ensure that all patients attending triage are assessed for pain. Staff should use appropriate pain assessment scales for patients who cannot verbalise their pain.

Pressure Ulcers

Patients appeared comfortable; pressure-relieving equipment was available. A SSKIN care bundle was in place. Gaps were noted in the completion of documentation and there were a number of occasions when the bundle had not been initiated.

A Braden risk assessment tool, for predicting pressure ulcer risk, was not always completed for patients who had been in the department more than six hours. On two occasions, inspectors asked staff to assess patients within the main ED and to provide pressure relieving equipment as appropriate. Staff carried this out immediately. Pressure ulcer figures are not measured as a quality indicator within ED.

Recommendation: Staff should ensure that the Braden risk assessment tool is completed for patients who have been in the ED for more than six hours. Staff should be made aware of their role and responsibilities in prevention of pressure ulcers and completion of documentation.

Staff can access advice on wound care via the trust intranet and tissue TVN service. When required, staff will contact the TVN for detailed advice and guidance. Staff were unaware that pressure ulcers can be photographed by the TVN. Regular mattress audits are carried out to assess mattress integrity.

Mechanisms were in place for the reporting, investigation and follow up of pressure ulcers.

Promotion of Continence and Management of Incontinence

Staff were observed providing patients with appropriate assistance to promote continence and care for incontinence. However, documentation identified gaps in the completion of the SSKIN care bundle in use, where promotion of continence is a key component.

For patients with self-retaining catheters in situ, the clinical indicators for catheterisation and all relevant information were documented within the patient records. A stool chart was not always in place appropriate to the patient's condition.

Staff have access to continence/stoma specialist services and stoma/incontinence aids were available.

The inspection team found that significant work is needed to ensure improvement in most sections within this domain. We found deficits and gaps which need urgent attention these concerns were raised with senior trust staff at the time of the inspection.

5.4 Is Care Compassionate?

Person Centred Care

On day one of the inspection, the senior nurse on duty was not immediately visible to support ward activities. Within the ever-changing nature of an ED, we considered that the lack of an identifiable senior nurse contributed to a disorganised atmosphere.

We observed staff, of all grades, displaying compassion and empathy, and frequent checks were made by nursing staff to ensure patients' comfort. In the observation ward we noted that these checks were not always recorded in the intentional care rounding documentation. These checks are to ensure that nursing staff carry out scheduled tasks or observations to meet and anticipate their fundamental care need of patients. We observed that a patient with confusion was attended to more frequently. The need for up to date and accurate recording of nursing documentation is discussed in the section on nursing records.

Some patient monitoring equipment alarms went unnoticed by nursing staff, as they were attending to other patients. We informed staff and this was addressed immediately. All patient bed spaces had a working call bell system; however, these were not within reach of the patients in the main ED, leaving patients unable to summon assistance, if required.

We noted that call bells in the observation unit were appropriately placed. There were prompt responses to call bells and requests for assistance; staff should silence bells when they attend the patient.

Recommendation: Staff should ensure that call bells should be positioned within patient reach, and monitoring equipment alarms responded to in a timely manner.

Overall, throughout the ED, patients' privacy was maintained, room doors were closed and blinds pulled (Picture 10). However, in the ambulance triage, privacy curtains were not always used or fully closed.



Picture 10: Typical patient examination room

Patients could be viewed and conversations overheard by other patients waiting in close proximity. When curtains were fully in place, staff did not always ask permission before entering the patient space. Patients on trolleys in the corridor of the ambulance triage were asked questions about their condition and had procedures such as venepuncture undertaken in view of other patients.

Computers with patient details and scans were left unattended in corridors and could be easily read by non-staff members.

Staff should ensure that personal details of patients cannot be viewed. On several occasions, health care records were observed open and unattended at the nurse's station.

Staff told us that maintaining a constant supply of bed linen, in particular pillows, during peak times can be a challenge. There were no issues identified at the time of inspection.

Housekeeping Point: The supply of bed linen and pillows should be sufficient to any increase in demand.

Communication

There was good signage which clearly indicated the many areas within this large department, for example, triage, minors, majors, paediatrics. A rolling information board is in place for the public. This explains the type of conditions treated in each of these departments, and the length of time a patient might expect to wait.

There are various public information leaflet racks throughout the ED. The reception area has good toilet facilities and a shop with coffee bar. The ED should ensure that the comprehensive trust A-Z for carers book is available on all leaflet racks for public access.

Housekeeping Point: The trust 'A-Z for carers' book should be available on all leaflet racks for public access.

We found staff to be courteous to patients and relatives, introducing themselves at triage, and again in minors or majors. Staff provided patients with information and explained the care or procedures they were to receive in a clear, easily understood manner. The lack of a name badge system made it difficult for patients to identify staff.

Access to aids and services for patients with language barriers were available. We observed staff speaking loudly to patients with hearing difficulties, instead of moving closer to the patient so that conversations could not be overheard. This is particularly relevant in ambulance triage where staff need to speak to patients privately during times of crowding.

End of Life

Staff can access guidance on end of life care information. However, work is required in implementing best practice guidelines from the College of Emergency Medicine for End of Life Care. An on call palliative care team is available 24 hours a day.

Information supplied identifies that staff attendance at training on dealing with distressed and grieving relatives could be improved. There was no evidence that staff were aware of or had availed of palliative care training.

Recommendation: Guidance from the College of Emergency Medicine for End of Life Care should be implemented into ED as best practice guidelines.

At the time of inspection, there was one patient in the ED requiring palliative care. Clinical review and admission for further treatment and care, was carried out in a timely manner. Staff told us that patients requiring palliative or end of life care would be admitted immediately.

The ED has a large number of single rooms, some with ensuite facilities. Family members can, if required, remain with their relative while they are in the ED. A relative's room is available and car parking permits can be issued.

Information and support systems were available for patients and carers before and after a patient dies. A new purple bag containing support information has been introduced. A private room is available within the ED for relatives to view deceased patients in privacy.

A DNAR order reviewed had been appropriately completed and signed by the doctor. A record was made of discussion with the patient and relatives.

Patient and Relative Questionnaires

The views and experiences of people who use services were obtained by questionnaires. The findings combine the patient and relative perceptions of staff communication, the care they received, including pain management, food and nutrition; infection control; and safety.

During the inspection, a total of 18 questionnaires were carried out in ED

- five patient questionnaires
- 13 relatives/carers questionnaires

Most patients were satisfied with the standard of care and treatment they received. They told us that staff were courteous, introduced themselves and addressed them by their preferred name. Patients knew who to speak to if they had concerns, and most felt involved in the decisions about their care.

The questionnaires showed that two of the five patients thought there were not enough staff to care for them. Most patients were independent; one patient did not have a buzzer to summon help and had to approach staff for assistance; another patient stated they received assistance for personal care when needed.

Most patients were treated with respect; one patient was concerned that their conversations could be overheard; another patient had an issue with comfort and appropriate positioning. All patients thought their dignity was protected during care and treatment. Patients were happy with their pain management.

The department was clean, the choice of food was good, but fluids were not readily available. There was good staff hand hygiene, but one patient stated they were not given the opportunity to clean their hands.

All patients felt safe most of the time and most were satisfied with the information they were given regarding the period of time they would be in hospital. Overall, the patients' questionnaire indicated they would be very satisfied/satisfied for a relative or friend to be cared for in the ED.

In general, relatives felt welcomed, but some felt they did not receive up to date information about the patient's care or who to speak to. All thought their relative was treated with respect and dignity. Most felt confident that their relative was receiving good care and treatment. Two did not feel involved in the planning of their relatives care. Overall, relatives thought that staff had enough time to care.

Patient Comments

"Haven't had a jug or glass supplied – thirsty."

Comments made by patients to lay assessors:

At 3pm was waiting in the observation area, waiting for a bed on the ward, patient was very appreciative and commentary about the nursing staff. She said they were extremely busy but still very attentive. She has been waiting several hours but understands the reason for the delay.

Pain control is not sufficient at present but this has been explained to patient. The patient stated they were waiting for a further explanation before stronger painkillers could be given.

One patient was concerned, that conversations about her condition would be overheard.

I don't have a buzzer. Have to approach, a member of staff for information or help. Staff appear very busy.

Relatives Comments

One patient didn't think that there was a staff shortage. "Staff have time to talk and explain what is happening."

"Appears to be a shortage of staff."

Finds, that they are just left waiting for a long time.

"We have to ask sometimes. Realise they are very busy."

"Not always sure who is in charge."

"I was surprised that the medics weren't aware of the patient's history via previous visits to Antrim Area Hospital, having to give history of all his ailments, surely this is held on computer."

"As a parent I have been very pleased that everything was done calmly and without drama, very satisfied with their treatment."

Observation of Practice

Observation of communication and interactions between staff and patients and staff and visitors were included in the inspections. This was carried out using the QUIS.

Inspectors and peer reviewers undertook a number of periods of observation throughout the ED. Each session lasted for approximately 20 minutes. Observation is a useful and practical method to help build up a picture of the care experiences of people. The observation tool uses a simple coding system to record interactions between staff, patients and visitors. Details of this coding are included in Appendix 1.

Twenty-eight observations were carried out over four observation sessions.

We observed that staff were friendly and engaging. There was good verbal and non-verbal communication; staff engaged in conversations with patients and gave clear explanations as care was delivered. Basic interactions related to overheard conversations and conversations between staff that did not include patients. There was little engagement between staff and patients during the delivery of the meal service.

The only negative observation was in relation to a patient in ambulance triage. The area was very busy; a patient was admitted to a cubicle; the curtain was not fully pulled; and the handover from ambulance staff to the triage nurse could be observed and heard by other patients in close proximity.

Recommendation: The trust should include patient, relative and carer comments as part of the overall strategy to improve the patient experience and ensure appropriate staff interactions with patients at all times.

The inspection team found that staff were friendly and engaging and gave clear explanations as care was delivered. However we found instances where privacy, dignity and confidentiality could be improved.

5.5 Conclusions for the Emergency Department

We were advised by senior staff that the ED was particularly busy prior to and during the period of inspection. We observed and recognised the impact of these increased attendances for staff during this busy period.

The environment was clean, bright and free from hazards. Staff observed were compassionate, showing empathy to patients, and positive interactions were noted. Staff were courteous to patients and relatives, providing clear, easily understood information.

The inspection identified areas for improvement in the systems and processes which impact on the delivery of care in the ED.

We observed that when the department was busy the processes to promote flow of patients throughout the ED did not work effectively. We did not observe proactive leadership during times of escalation with limited use of walkrounds to assess the situation across the department.

During times of crowding inadequate staffing levels affected observation of patients, with essential patient equipment not always available. Staff advised that requests for additional resources were not always responded to in a timely manner.

Attendance at mandatory training was not up to date. Communication with staff was not always effective. We were advised that the trust is actively working to review nurse staffing levels and address current deficits.

The safe storage, security, administration and documentation of medication required improvement. Nursing assessments, risk assessments, care plans and charts were not always fully completed; up to date; or reviewed regularly.

The system in place for ordering, delivery and service of patients' meals was not effective.

In general patients and relatives told us they were satisfied with the care they or their relative had received. Some issues were identified in relation to communication, staff shortages and waiting times

Overall the findings of the inspection identified that the ED requires improvement. We have made 37 recommendations and 19 housekeeping points for this clinical area.

5.6 Recommendations and Housekeeping Points

Recommendations

1. The trust should ensure the regular dissemination of formal analysis reports on SAs, incidents, near misses to staff for learning.
2. PHA learning letters should be communicated to all relevant staff.
3. Communication with staff should be improved to ensure learning from morbidity and mortality meetings and from analysis of cardiac arrest rates.
4. The trust should undertake further work to improve quality indicators in line with DoH targets.
5. The trust position that clinical priorities always come before targets should be clearly communicated to staff.

6. The trust should review the role and number of the band 7 nurses in ED to ensure effective clinical leadership.
7. The trust should review nurse staffing levels across all areas within the ED and the recruitment of new staff should be expedited.
8. Staff supervision and appraisal should be up to date.
9. Senior trust ED staff should take action to alleviate staff concerns outlined in the report and ensure any issues raised by staff are immediately addressed by senior management.
10. To provide a safe working environment the trust needs to review the provision of security staff on the hospital site and have malfunctioning staff personal security alarms repaired immediately.
11. Timely access to AHPs should be developed as part of the PHA commissioning services.
12. All staff should attend mandatory training and staff should have the opportunity to attend in house training commensurate with their role.
13. Visible and effective leadership is needed during the initiation of the ED escalation plan. The criteria for the ED escalation plan should be reviewed and updated as required.
14. Daily reviews and routine senior medical and nursing walk rounds should be carried out.
15. Improvement is required in the interface between ED, and medical, surgical and specialist services to ensure timely patient assessment and review.
16. Ambulatory and integrated care pathways should be further developed.
17. Senior ED staff should review and further introduced where appropriate nursing quality performance indicators into ED.
18. Staff should ensure patients are always treated with respect and dignity during times of crowding in a manner that maintains privacy and confidentiality.
19. All staff should be aware of how to contact the resuscitation team and contact details should be clearly displayed.
20. All staff disciplines should carry out hand hygiene in accordance to the WHO 5 Moments of care, and adhere to ANTT procedures.

- 21.** Staff should ensure that national early warning scores are totalled and completed within the set timescales, and escalation in scoring and action taken recorded at all times.
- 22.** Staff should ensure that the Sepsis Six bundle is fully completed and legible copies available.
- 23.** Staff should ensure that patients are connected to cardiac monitors as their condition dictates and ensure that additional essential patient equipment is available during times of crowding.
- 24.** The short stay ward should function as designed. When this cannot be facilitated there should be systems in place to ensure services are available for vulnerable and longer-term inpatient beds.
- 25.** The assessment of older patients for all common frailty syndromes, during clinical review, should be fully documented using a recognised assessment tool.
- 26.** The learning from the audits of ED clinical standards should be actioned and cascaded to staff.
- 27.** The medicines management policy should be updated to clearly guide staff in the administration of controlled drugs and patient self-administration of medicines.
- 28.** All staff needs an immediate update on their role and responsibility in the safe storage, security, administration and documentation of medication. Staff practice should be monitored to ensure adherence to best practice.
- 29.** The trust should review ED pharmacist cover to improve and facilitate effective integrated medicines management.
- 30.** The recording in nursing care records should be improved to accurately reflect patients' needs, their involvement in their care, and be in line with NIPEC best practice guidelines.
- 31.** The trust should improve the system in place for the ordering, delivery and service of patient meals.
- 32.** Staff should ensure that fluid balance and food record charts are completed and reconciled in accordance with trust policy. A robust audit of the documentation should be undertaken.
- 33.** Staff should ensure that all patients attending triage are assessed for pain. Staff should use appropriate pain assessment scales for patients who cannot verbalise their pain.

34. Staff should ensure that the Braden risk assessment tool is completed for patients who have been in the ED for more than six hours. Staff should be made aware of their role and responsibilities in prevention of pressure ulcers and completion of documentation.
35. Staff should ensure that call bells should be positioned within patient reach, and monitoring equipment alarms responded to in a timely manner.
36. Guidance from the College of Emergency Medicine for End of Life Care should be implemented into ED as best practice guidelines.
37. The trust should include patient, relative and carer comments as part of the overall strategy to improve the patient experience and ensure appropriate staff interactions with patients at all times.

Housekeeping Points

1. All staff should wear name badges.
2. Verbal complaints should be recorded and analysed to identify patterns and trends.
3. One central nurse staffing rota should be developed. Agreed and actual nurse staffing levels should be displayed.
4. An agenda should be available for all staff meetings and the minutes of meetings disseminated to staff.
5. Audit and performance results should be displayed throughout the ED for patients and staff to easily view.
6. Hand hygiene and patient equipment audit results should be readily available.
7. Staff should continue to implement the falls safe care bundle to reduce the risk of falls.
8. All staff should complete Haemovigilance competency assessments.
9. All patients should be involved in decisions about their medications.
10. Patients' weight should be recorded on the medicine kardex.
11. All staff should be familiar with critical medications. A list of critical medications should be displayed.
12. A senior nurse should supervise and co-ordinate meal service.

- 13.**Patients should be regularly provided with fluids and routinely encouraged and if necessary assisted to drink.
- 14.**All patients should be prepared for meals prior to meal service. Staff should be seated beside patients when giving assistance.
- 15.**A robust system should be implemented to ensure patient dietary requirements are correctly identified and to ensure no patient is overlooked during meal service.
- 16.**Adapted cutlery and crockery should be available for patients.
- 17.**Pain scores should be completed at all times on the NEWS.
- 18.**The supply of bed linen and pillows should be sufficient to any increase in demand.
- 19.**The trust 'A-Z for carers' book should be available on all leaflet racks for public access.



Focus Groups

6.0 Findings from Focus Groups

On the second day of the inspection five focus groups were held with the following groups of staff:

- 11 nursing staff with a mix of band 5,6 and 7 nurses, healthcare assistants and a student nurse from cardiology, respiratory, general medicine, stroke, and admission wards
- 12 allied health professionals, including occupational therapists, speech and language therapists, physiotherapists, pharmacists, podiatrist, social worker, dietician, radiology staff from computerised tomography (CT) and magnetic resource imaging (MRI)
- eight senior managers, from a range of services
- six support staff from, porters, rapid response cleaning team, domestic services, catering and ward clerk

We found that all staff who took part in these groups to be open, transparent and willing to discuss both strengths and challenges within their areas of work.

6.1 Senior Manager Focus Group

Senior managers told us that care is prioritised over finance. They informed us that work on systemising improvements has helped them improve against targets.

They stated that, despite normal tensions, the medicine and surgery directorates are a collegiate group. We were told of the positive relationship between managers and clinicians. However, they said that ED consultants can be difficult to engage with at times.

Currently there are four ICT initiatives across the trust with the overall aim of seeing more patients and improving their care.

Senior managers also spoke about their difficulties in achieving all their planned work; too much of this is undertaken outside of their normal working hours. Senior posts remain vacant, acting or temporary, as planned restructuring which has been ongoing for a year has not yet been implemented in full. The unstable position does affect morale.

We were told of the difficulties in the recruitment of nurses for medical wards; the trust now has an open advert for nurses.

All members of the group informed us of the difficulties created by the introduction of a human resource (HR), payroll, travel and subsistence ICT system (HRPTS). The system has created difficulties with recruitment, and has increased senior manager administration time. Many of the HR tasks have transferred to assistant directors.

We were informed that new posts have to be created on the HRPTS, structure; go to finance; then to an organisational manager; then back to finance. There is a difficulty in putting these into HRPTS and managers are struggling with the operation of the system.

Managers received basic training, but are still having difficulty in operating HRPTS and the 10 day email support response. This has been highlighted by staff to the trust's HR department. The system is not user friendly and time spent struggling with this system is frustrating and has impacted on time to undertake quality improvement initiatives. Senior managers stated that on a personal level, training is computer based it is taken home and done on your own time.

We were informed that the HRPTS user forum has a team support role planned, but this has not been taken forward. Senior managers were unsure if this is a regional post or local to the trust.

The rebasing of budgets encouraged managers to make savings last year but this resulted in a cut in budget spend for year two.

Managers expressed fears about winter pressure. Bed pressures lead to concerns about infection control procedures and the reduction in bed space between patients. They have worked on systemising improvements. They are the best performing elective trust; however there is a 98 per cent occupancy rate in the hospital which creates pressure on beds.

There are monthly chief executive briefings, with working groups to take forward the RAMP strategy, but staff feel hindered in delivering it. Despite this, managers consider that the trust has a clear vision and strategy; senior managers are aware of the trust's core values.

When asked about discharge we were informed that the medical director had just presented a paper on readmissions to the trust board, which has provided reassurance that these have not increased as a result of early discharge. However, during the nursing focus group, concerns were expressed that patients were being discharged too soon and subsequently readmitted.

Senior managers, in contrast to other groups, commented that they were unsure of the need for doctors to attend the morning safety briefing where the discharge of patients is discussed.

As a group they would all be happy for family and friends to be cared for in hospital.

6.2 Nursing Focus Group

We were informed by nurses of some of the quality improvement initiatives currently being taken forward. Recent work to reduce patient falls has made a difference in the care of the elderly unit. Work is ongoing using care plans to improve communication with relatives at visiting times, and the hello my name is initiative has been introduced.

In providing up to date information on the care of the patient they hope to improve the patient's experience and help to reduce the number of phone calls, which take nursing staff away from patient care.

Some staff would like to introduce their own improvements on the ward, but have been unable to, due to time and staffing constraints. There is a forum for band 7s to meet, to share learning and provide peer support. The band 6 forum has not met recently.

The hospital morning safety briefing is very beneficial to identify high-risk patients etc. Although the focus is on discharges, there is a need to ensure that discharge is safe. As previously mentioned, staff told us that they are concerned about the focus on discharge; patients may be discharged too soon, and some are subsequently readmitted.

The group advised that nurse led discharges can take place but the patients are often so sick that this is not possible. Previously there was quite a number of nurses who could discharge patients, however they have since moved on. The group told us that nurses are being pushed to discharge patients, but this is largely a medical responsibility; they stated that medical staff should be attending the hospital morning safety briefing.

Nurses informed us about the difficulties in ensuring a nurse was free to accompany consultants on ward rounds, although the consultants are quite good at feeding back information to the lead nurse. Sometimes (on days when there are clinics) ward rounds only occur in the afternoon, which has an impact on discharges. Doctors are often absent from the ward to see outliers.

All staff were aware of the trust's vision and strategy, but stated there are insufficient resources to deliver it. Individual wards have their own vision and strategy and this is shared with staff on a daily basis. Generally lead nurses are visible; they felt there was good support from the lead nurse. Some staff told us that they do not have a lead nurse in post; however there is always someone who you can ask for advice if you have a problem.

The group informed us their biggest challenge was the recruitment of staff and safe staffing levels on the ward. All were aware of the normative staffing levels assessment, with an obvious up lift in staffing numbers in the wards that have had this assessment, but there are vacancies, particularly in the acute medical admissions unit.

It is a daily challenge to recruit, fill posts and up-skill new staff. Recruitment is a lengthy process. Skill mix is difficult when there are new starts and also student nurses; it puts a lot of pressure on the more senior nurses on the ward.

In the respiratory ward (A3) there are eight escalation beds staffed on an ad hoc basis. These beds can be brought into service overnight and the challenge then is to get appropriate staffing cover for the day. Ward staff understand the pressure and the need for escalation beds, but the difficulty is the uncertainty of when these beds will be opened for patient use. This was raised at the safety meeting. There is an expectation that the ward will discharge eight patients to restore the balance and close the beds. This is dependent on ward rounds.

Long-term sickness and maternity leave is not covered. The plan for a list of core staff to rotate and cover maternity leave has not yet been implemented. The escalation process to follow when additional bank and agency staff are required has improved, as the ward sister can now approve additional staff.

Staff stated that clinical care is their priority; however, they feel the trust is focused around targets. Staff stated they are questioned around long length of stays. They feel the drive to meet targets is strongly linked to finance.

Training could be improved; mandatory training is ever increasing; and the system improved to allow staff to complete this. There are difficulties with new staff getting the time to attend corporate induction training. Staff proposed that mandatory/induction training should be held before new staff start. This would make it easier for staff to be released to attend.

Last year's winter pressures (2014-15) resulted in the cancellation of much training which was rescheduled for the summer months. It is hoped this will not be a recurring problem. Supervision and appraisal are not as regular as they should be. Sisters do have some administrative support on one day a week. A student nurse told us that managers/mentors do not always have time to explain things and sign worksheets.

All staff would be happy for their family and friends to be cared for on the ward/area they were working, or in the hospital. They stated that they support the core values within the limits and pressures that they face every day. They are compassionate and willing to do extra shifts and often go over and above their expected duties.

We spoke with some staff who told us they enjoyed working within ED. However, during times of increased capacity and patient numbers, they did not always feel equipped to carry out their role. Staff raised concerns about increased workload, unrealistic high expectations, burn out, staffing levels, staff turnover, and low morale. Nursing staff advised that targets could be a priority over patient clinical need, they advised that the observation ward was functioning as an inpatient ward and not as intended as a 24 hour admission area.

We were told that staff had raised concerns and were supportive of their direct line manager with regard to action taken in response. However, they were not always informed by senior management staff of these actions. Nursing staff informed us that they do not always feel safe. Access to training and regular supervision was not always possible.

6.3 Support Staff Focus Group

This group of staff told us that they have good job satisfaction and are happy and proud to work in Antrim Area Hospital.

We were informed of an initiative undertaken by the rapid response team to ensure that bedrooms were ready to clean when they arrived on the ward. This created problems for patients in the ED waiting for beds, but they were able to work with the wards to resolve this issue.

Catering staff stated that the menu choices are now sent to them via computer tablets, so the timing of patient meals has improved. Snack bags for ED patients are now available out of hours; these are tailored to specific dietary requirements.

Some staff told us that they do not have access to computers. Corporate issues are brought up at staff meetings where they can share best practice. It is difficult for porters to have staff meetings as staff cannot be released from their duties.

We were informed that if their staffing numbers are down this has to be covered by existing staff, as they do not have a bank system. Ward clerks stated that they often have to cover two wards which is difficult and the number of phone calls to the ward is a major issue. It takes so much time away from the patients to respond to multiple enquiries. They would welcome some sort of policy or time periods put in place for family phone calls, unless the patient is very sick.

The staff felt that there is a push for discharges and they see a lot of pressure put onto the nursing staff to facilitate discharges, or to get ED cleared and patients into beds. There are (bounce back) readmissions that come in via ED. They go to the ward, are discharged and then they appear back in ED. As a ward clerk you see many repeat admissions.

Training is good and managers are supportive of additional training. Staff told us there was good support from line managers, who will help out on the ground if needed.

Porters informed us of their difficulties in identifying patients that need to be moved or taken for tests. Nurses are allocated their own bay of patients and do not know who is in the other bays.

Domestics informed us of their issues with access to supplies and to the correct colour coded equipment.

In some wards mops are delivered to the ward daily from the laundry, in other wards they waste time searching for equipment. They question why the same system is not used in all wards.

All of the group would recommend the hospital to anyone. They feel that all staff regard the patient as their number one priority.

6.4 Allied Health Professionals Focus Group

The group informed us of some quality improvement initiatives currently being taken forward. The speech and language therapists (SLTs) have developed prioritisation criteria for referrals. Pharmacy staff have just completed a project in relation to follow up phone calls after discharge, resulting in a reduction of readmission rates; they would like to take this forward.

Radiology staff told us that MRIs have a high did not attend (DNA) rate and would like to introduce a system to allow patients to ring and confirm their appointments. Podiatry staff informed us that although their service is mainly community based; they now have a presence in the hospital, which they believe has improved their service. The diabetic pathway for podiatry has been rolled out across all sites, and now, with cover five days a week they can meet all the NICE guidelines requirements.

The pharmacy department has introduced 12 hour shifts in some areas. There is a Saturday and Sunday service in wards, but not in the ED. The development of the right med system has improved their service. Funding was provided by the HSC Board to review medicine prescribed on an admissions ward; this has in turn released doctors' time. The live automated microbiology and pharmacy system has freed up time to allow for microbiology ward rounds.

The SLT swallowing assessment clinic had previously been taken by a medical consultant. This is now run with a radiologist, which has resulted in a cost saving and has reduced cancellations. A mobile assessment service is about to commence.

Occupational therapists (OT) now have a fully functional seven day a week service working to promote discharge. This has reduced capacity during the week but has improved discharges over the weekends.

The group told us about what could be introduced to improve patient care. There is a need for a bank staff list for all AHP disciplines. This could be difficult to arrange, but would be desirable for the future. There is a need for a rapid response community service to ensure that when patients are discharged they are picked up within an appropriate time period.

AHP staff informed us that they were aware of the trust's strategy and vision, but feel that finance and budgets dictate everything. There are capacity and demand issues for all AHPs.

The complexity of the patients they are seeing is also increasing. This could take a lot of time, but their input is still recorded as only one contact. SLT staff stated that they have had no extra staff for their work in the respiratory ward. When this opened they were informed that no additional staff were required. They now take 30 per cent of all referrals, and while they have no delays currently, they predict there will be once winter pressures start.

They told us they feel pressurised as a result of the amount of paperwork and record keeping and that there has to be an easier system.

The term end of acute has been introduced by the trust instead of the usual expected date of discharge (EDD), which makes it difficult for AHPs to prioritise their workload. Social workers told us that this also impacts on their work with complex cases for discharge and after significant work some patients are still not fit for discharge.

The group informed us that they have just moved to the HRPTS system and described issues similar to those described by the senior manager group. The time that this is taking away from senior management is significant and these tasks had previously been processed by administrative staff. The system is not very user friendly. You cannot speak to people in organisational management to check on progress. Problems cannot be sorted out over the phone.

Replacement posts are slightly easier but it is still taking months to get vacancies filled. When posts are vacant and a risk is identified, then incident forms are completed and submitted to the trust.

There is no bank of AHP staff. Staff tend to come in from leave to cover gaps as there is no additional capacity to allow for sick or annual leave. Staff stated they rarely take a two week holiday as this puts additional pressure on others. Unexpected leave creates major problems and it is difficult to replace some posts. In general, sick leave is covered by the teams and maternity leave is covered at a 0.69 WTE.

MRI was traditionally not an inpatient service; there is now pressure to extend MRI to inpatients. Some outpatient appointments have therefore had to be cancelled. It is difficult to get locum cover, they are often waiting for staff to return from sick leave, but this is often extended at short notice. There is external assistance from the independent healthcare sector to help the trust see all necessary patients.

The group informed us that from October 2015 to January 2016 they were told to not plan any training due to winter pressures. They can arrange courses, but they may well be cancelled at short notice. Appraisals have also been suspended over the winter months to allow staff to return to clinical duties. The teams do provide each other with support and advice, but formal supervision and appraisal is not happening. Social workers stated that supervision is important, but it is often cancelled and rescheduled due to pressures.

OT staff stated that holding staff meetings is difficult. When they did try to have a staff meeting, ward staff complained and they were accused of holding up discharge. This was not the case. They have worries that they have not been able to do everything for the patient. They do what keeps the patient safe but they don't have time for rehabilitation. The group worried about capacity and demand. Staff are crisis and risk managing; they are not using all of their skills. This is starting to take its toll on the staff and is impacting on morale.

The trust has been working with the unscheduled care task group. One of the areas examined was the availability of 24/7 diagnostics, pharmacy, and AHPs such as, OT and physiotherapists being available in the ED. They are trying to avoid unnecessary admissions via ED, however, it is difficult, as the packages required are not always easy to secure in the community.

It was noted that SLT is not part of this initiative. However, the demand for this service is steadily increasing. For SLT, one therapist picks up six wards per day, and they continue to take on additional work for which there is no funding.

Social workers have seven day cover, managed via a bank of staff who volunteer to cover weekends on a rota basis. The bank is wider than the trust acute service, as it includes staff from the community.

All staff would be happy for their family and friends to be cared for on the ward/area they were working or in the hospital.

6.5 Medical Staff Interviews/Focus Group

Doctors in Training

The inspection team met with six trainee doctors working in emergency medicine, general surgery and acute medicine. They ranged in seniority from foundation year one to specialist registrar. All rated their experience of working in Antrim highly, with favourable comparisons made with other similar rotations. Training opportunities in medicine, surgery, emergency medicine and in foundation year rotations were rated highly. The group told us that there is a good range of experience in acute presentations as well as in managing longer term conditions, and trainees feel valued members of their clinical teams.

We were informed that the demands of service provision can conflict with training.

There is only one training grade registrar for general surgery in Antrim; the rest of the middle grade rota is comprised of locum appointment to training (LAT) doctors.

This creates an increased leadership burden for the surgical registrar, particularly in the areas of clinical teaching, workload and supervision of junior staff. Surgical trainees felt that cover from 1.00pm to 8.00pm on weekends was “a bit of a struggle”.

They suggested that there should be two FY1 doctors present, one for the long day, the other 9.00am to 5.00pm and that this could be a great help to ward nursing staff by performing electrocardiograms (ECGs), siting cannulas, and taking blood. The trainees were willing to provide this additional coverage at weekends to help each other out.

Medical registrars informed us that, at times they can miss training sessions, such as procedures for cardiac catheterisation laboratory sessions and endoscopy due to the nature of their rotas after working nights. This was, however, admitted to be a general problem throughout Northern Ireland. More significantly, no medical registrar is free from other rostered commitments when supervising and managing the acute medical take from 9.00am to 5.00pm. The core trainee grades stated that they can feel guilty contacting registrars as they know this interrupts their attendance, at for example, outpatient clinics. A suggestion was made for a dedicated middle grade to cover the acute take from 9.00am to 5.00pm.

Whilst working in the ED, medical core trainees said they can feel you're on your own after a patient has been referred to medical specialists as ED junior medical staff are often busy with other emergency patients. ED consultants were praised for frequently supporting all staff, including medical trainees.

Surgery had no concerns to report in this area other than some patients can be bounced between various specialties. This is particularly the case with surgical specialties; such as urology and gynaecology, where ownership can default to general surgery. This was felt to be inappropriate in a number of cases. An ED trainee felt a real pressure to see patients less thoroughly in order to deal with the sheer volume of patients in a sub-optimally resourced ED in order to meet the four hour targets.

Induction training was described as adequate with most areas covered well. We were told of a concern about cover for ear, nose and throat surgical patients. The trainee was expected to perform nasendoscopies alone and to report on findings to an off-site, on call consultant, as there is no middle grade Ear, Nose and Throat (ENT) cover. The trainee felt they were asked to work beyond their competency, and the consultant did not attend the ward when contacted.

All trainees had met with their education and clinical supervisors, were able to complete workplace-based assessments and had discussed a personal development plan. All trainees were able to access annual and study leave in line with their contractual requirements. Some lunchtime training sessions were not bleep-free, and trainees were often interrupted. They understand the difficulties faced by the foundation year supervisor in getting a person to corral the bleeps for this time.

We were told about some ongoing quality improvement initiatives, including a ward round, patient safety and discharge checklist in the surgical wards. This had been developed from the ground up by a number of FY1 surgical staff and was reported to be working very well.

The foundation trainees meet weekly with their programme supervisor and an assistant director at a feedback forum. This provides an additional route for junior staff to raise concerns, ask questions, and identify improvements. Surgical staff were looking forward to the positive impact of soon moving to a surgeon of the week model. There is support in the ED for quality improvement work and trainees were able to make suggestions for improvements to the triage system.

All staff would be happy for their family members and relatives to be treated at the hospital. There were no specific patient safety concerns raised. One participant felt some patients were sent to the medical ward too quickly from the resuscitation area in ED. This did not result in harm on any occasion, but this is an ongoing problem due to the pressure in the ED. One focus group participant gave an example of the timely, effective and compassionate care their relative had received, and their subsequent good outcome, promoted by use of the stroke thrombolysis pathway.

Interviews with Consultant Staff

Consultant Staff were not part of the focus groups; however, we had the opportunity to speak with a number of consultants during the inspection.

Foundation Supervisor

A foundation supervisor told us that some trainees had been proactive in pursuing quality improvement initiatives alongside their clinical ward work. Checklists had been developed for the surgical ward. The supervisor told us that there is a need to provide access to training in quality improvement.

Foundation teaching, while delivered to a comprehensive curriculum can be compromised by the challenges of ensuring bleep-free teaching, with attendance suffering as a result.

Allocation of foundation trainees has been complicated by several factors including a lack of updated job specifications on the foundation programme application system (FPAS) for those having to repeat their foundation year. Additionally, final numbers from the deanery are often unknown/unreleased until one week before changeover in August.

A weekly feedback forum permits foundation trainees to drop in and raise concerns confidentially with the foundation programme supervisor and an assistant director.

Medicine

One consultant in acute medicine told us that he has seen improvements following trust reorganisation in 2011.

The increase in the number of junior staff in the hospital has been positively received and told us there is good communication with all disciplines and at a senior level.

The ward manager often makes him aware of issues from the morning safety brief. He found expediting discharges in many cases challenging. Families of frail, comorbid patients may require extensive contact with family members and this requires additional time, and discharge may be unnecessarily delayed.

Emergency Department

An ED physician discussed the increasing burden of both acute and chronic illness seen in the department. We were told that there is a daily 8.00am handover. Admissions from the previous day are vetted, with opportunities for teaching and discussion. This is consultant-led and involves both nursing and medical staff. The inspection team verified this positive culture by observation and direct questioning of nursing, medical and support staff.

We were told of the recurring patient flow problems for the ED, which often manifest as crowding in the ambulance triage area. One of the ED consultants provided a list of practical ways to help address these issues. Escalation procedures were perceived by the consultant to be a communication exercise to senior levels rather than resulting in tangible actions. Due to the lack of ED staff, when all areas are under pressure, the reallocation of existing staff is not effective.

Concern was expressed as to the consultant responsibility for patients admitted under the medical take. The ED consultants, who were often present out of hours, were concerned about relative lack of attendance of medical consultants outside 9.00am to 5.00pm. The admissions core trainee, or registrar who may also be a core trainee acting up in the role of a middle grade, have to make difficult decisions. The ED consultant considered that there was a lack of communication between the on-call medical consultant and junior staff on the ground out of hours. They suggested that there need to be an expansion in the number of acute medicine consultants.

Alternatives to ED admission are being developed. This includes a recently formed GP hub. This has proven effective, as it permits medical patients to be referred directly from primary care for assessment. The inspection team visited the GP hub and talked with the medical staff grade and final year medical student present there. We were told that, although sufficient investment has been made to develop this area, there has been no extra staff assigned.

We were told that ambulatory care pathways were underdeveloped. For example, ED does not have the physical room or time to follow up certain conditions such as Deep Vein Thrombosis (DVTs) or Pulmonary Embolism, or adults with a first uncomplicated generalised seizure. It is often easier and safer to admit.

It was suggested that these pathways should be prioritised for development alongside the acute medical team.

6.6 Points for Consideration from Focus Groups

1. The planned restructure of senior posts to provide a more stable organisational leadership.
2. The difficulties created by the introduction of HRPTS in relation to increased administration time and recruitment.
3. The number of acute beds and the bed profile at Antrim Area Hospital should be reviewed in relation to the workload pressures which are being experienced at the hospital.
4. Sufficient staff trained to facilitate nurse led discharge where appropriate.
5. The timings of ward rounds to ensure nursing attendance.
6. The development of contingency plans to ensure the appropriate staffing levels when escalation beds are used.
7. A list of core staff to rotate and cover maternity leave is in place.
8. All staff to be facilitated to attend staff meetings.
9. A bank system be explored and introduced for support and AHP staff.
10. Review access to supplies and equipment for domestic services staff.
11. Explore the introduction of a rapid response community service, to ensure that when patients are discharged they are picked up by community staff within a quick time period.
12. Review the capacity and demand issues for all AHP staff, including arrangements to ensure appropriate supervision and appraisal.
13. Explore with AHP staff their difficulties in using the term end of acute in place of EDD, to ensure that AHPs can prioritise their workload.

14. A core trainee grade doctor should be dedicated solely to weekend discharges in medicine, without the requirement to round with the fourth consultant should be considered.
15. A dedicated middle grade doctor who does not have other rostered commitments should cover the medical take from 9.00am to 5.00pm should be considered.
16. A weekday consultant-led afternoon ward round at 4.00pm to review patients admitted in the preceding eight hours should be considered.
17. Explore the possibility of having two FY1 grades on at the weekend in surgery.
18. The workload of the FY1 doctor covering the geriatric ward at weekends should be monitored and reviewed.
19. A dedicated middle grade registrar support should be considered to supervise the work of the admissions FY2 core medical trainee.
20. Medical consultants should be proactively encourage senior review and discussion out of hours of complex or acutely unwell patients.
21. The trust should consider review of current arrangements for ENT coverage, and training to ensure that trainees are not asked to work beyond their competence in this area. A more formalised process for escalating clinical questions along with expected actions from the on-call ENT consultant is required.



Theme: Handover Arrangements

7.0 Theme: Handover Arrangements

Effective handover is recognised as an essential component of safe practice in hospitals. We were present at several formal handover meetings. These included:

- 7.30am ED briefing
- 8.00am handover of medical patients admitted on the take
- 8.30am hospital safety briefing
- nursing handovers in the wards inspected

7.1 8.00am Handover

The 8.00am handover was attended by four medical consultants, along with trainees from the night shift, an incoming core trainee and nursing staff from patient flow/bed management and the hospital at night team. The meeting was hosted in the old ED site in an open but otherwise secluded area. There was adequate seating, a table and a computer and screen on which to view clinical results. A handwritten template list of patients was photocopied for all in attendance; the handover was led by medical registrar.

The medical registrar was a CT2 core medical trainee who was acting up into the role of registrar. For the purposes of the handover, patients had been divided into one of four specialty streams: care of the elderly, respiratory, acute and general medicine, and gastroenterology. The main diagnoses, management plans and issues were briefly presented.

There were 37 patients admitted in the previous 24 hours; almost all had complex acute medical and/or chronic disease issues. During handover, a number of manual amendments were made to the take list. These included adding in the names of three patients: two admitted within the previous hour, and another whose name had been overlooked. Ward locations for two other patients were also altered. Communication was almost exclusively one-way from registrar to the rest of the assembled team. There was no evidence of teaching or discussion of any of the patients with the consultant staff. No radiology scans or blood results were reviewed at this meeting. Whilst unwell patients were identified, there was no obvious tally of these or summing up at the end. No foundation year FY1 house doctors were present. The process was concise and the meeting concluded at 8:20am.

7.2 Hospital Safety Briefing

The 8.30am safety briefing was attended by a large group of nursing staff, allied health professional leads, radiographers, service and governance managers, along with representatives from estates and domestic services. Each ward was reviewed. Notably, there were no doctors present.

The meeting was held in a moderate sized room in the old ED and space was cramped. Each ward described any safety issues, the current bed state, staffing issues and how many planned or potential discharges there were for that day. If a patient's discharge was delayed because they were waiting for a certain radiological scan, this could be actioned directly for follow-up. A large spreadsheet showing information for each ward had been completed. Additionally, predictions could be made as to the expected number of admissions such as, cardiology, elderly care and surgical admissions, based on previous longitudinal data from ED attendances.

7.3 Medical Ward B2

All oncoming nursing staff attended handover safety briefings in the morning and at night. These briefings identified vulnerable patients, risk of falls, equipment issues, IPC concerns, staff training that needed to be completed and the number of patients on IV antibiotics or requiring assistance with feeding. We observed that staff sign that they had received this information. Nursing handovers were well led, informative, focussed and structured. Information was comprehensive and displayed electronically.

There was an effective handover system for medical staff; clinical concerns were communicated to medical colleagues in an appropriate manner. Core trainee grades reported that handover was well organised with each ward completing handover sheets for the weekend teams.

We were informed of a suggestion that medical consultants on take should do an afternoon ward round at around 4.00pm or 5.00pm to assist decision making. It was also suggested that one of the core medical trainees working at the weekend be dedicated purely to the discharge process. This system had previously been successful; however, following the introduction of a fourth consultant into the weekend rota, the trainee had been assigned to them and was now unable to expedite discharges and complete documentation. This change in working pattern was felt to be counterproductive in facilitating appropriate and timely discharge to free up bed spaces.

7.4 Surgical Ward C6

Arrangements were in place for nursing staff to handover the care of patients between shifts. Nursing handovers were well led, informative, focussed and structured. Staff carried printed handover sheets, which contained relevant information about specific patients' needs. Ward healthcare assistants received a Royal College of Nursing award in 2014 for their role in developing a healthcare assistant handover. In addition, safety briefings were used to handover pertinent information regarding patient care. Safety briefings identified patients at risk from falls, pressure ulcers, and deterioration. Other information included issues of ward staffing, infection prevention and control, DNAR orders and patient safeguarding.

Medical staff handovers were informal, which carries a risk with regard to the effective continuity of information. Continuity of information is paramount to protect patient safety; a more formal structured approach to medical handover should be undertaken.

7.5 Emergency Department

All oncoming nursing staff attend daily safety briefings at 7.30am, and 8.00pm. Safety briefings last 15 minutes and identify safety issues including: staffing, number of patients in ED, vulnerable patients, equipment issues, infection and targets. Staff communication methods include; safety alerts, memos and new policies. The same safety briefing can be repeated for up to a week or even longer, if required, to ensure all staff receives information.

Nursing staff then disperse and receive either individual nursing handovers on designated patients, or in the observation unit, handover which includes all patients. Nursing handovers were well led, informative, focused and structured. Handover information is either written, or takes the form of pre-printed and populated handover sheets.

The nurse in charge attends the trust wide 8.30am safety meeting, at which all trust wide issues relating to patient flow, admissions, discharges, infection prevention and control, safety and trust activity are discussed.

We received conflicting information in relation to whether a joint nursing and medical round or handover occurs across the department. A ward sister told us this did not now happen, whereas medical staff told us it did. We were told that medical staff review patients as part of the daily 8am handover. Nursing staff advised that medical staff are very approachable and constantly talk to nursing staff on the floor. However, there are occasions where nursing staff have to seek out medical staff. We observed one to one medical and nursing staff engagement. We did not observe proactive walk rounds, or handover between senior nursing and medical staff.

This area has been discussed in patient flow in the body of the ED section of the report, and a recommendation made.

7.6 Northern Ireland Ambulance Service

Patients brought in by ambulance are generally seen and assessed promptly by ED staff. However, at times of crowding within ambulance triage, patients can be placed in corridors. Figures supplied identify that NIAS achievement against a target of patient handover within 15 minutes can be as low as 52 per cent. Staff told us that nursing staffing levels have the potential to compromise patient safety during this period.

7.7 Staff Interviews

In order to assess the impact of the 8.30 am safety briefing, staff on several medical and surgical wards were approached. They were asked how the safety briefing information changed the order of priority in which patients are reviewed on ward rounds, or with regards to the discharge process. We found that generally there was no formal mechanism for linking the information on current bed state to actions on the part of post-take or business as usual ward rounds in prioritising patients for discharge.

Whilst some consultant staff and ward managers would liaise at the start of ward rounds to identify those patients who were close to, or ready for discharge, this was not universal practice. Junior staff shared that they did not see any change in ward round structure or activity as a result of the 8.30am safety briefing. For example, a system to prioritise patients to be seen first on the ward round who were unwell or requiring a clinical decision to be made, and then a mechanism to review those who were potentially ready for discharge, or required completion of a discharge letter or medication script early in the day. There also did not seem to be a system where investigations are appropriately expedited to facilitate discharge for these patients.

Pharmacy staff told us that they were not aware of patients who were ready for discharge, or if they were, this was often unfiltered and they were not given enough information to be able to prioritise. This was of particular significance for those individuals who were being discharged back to nursing homes. Many nursing homes will not take patients back if they arrive after 6.00pm.

One pharmacy staff member told us that it can be a regular occurrence for some patients to stay an extra night in hospital. There was a lack of communication between wards and the pharmacy department regarding discharges so many complex scripts were not prioritised and filled, in time for transport to be arranged before the 6.00pm deadline. In view of the severe bed pressures mentioned at the morning safety briefing and evident during the three days of the inspection, this is an area that could be straightforwardly addressed. Some areas had proactive nursing staff, particularly where there was a nurse practitioner present, who communicated regularly with the pharmacy team to expedite discharges.

On some occasions the foundation trainee doctor is able to begin the discharge letter the day before an expected discharge.

Pharmacists are present in many wards and also ED. Some pharmacists can complete scripts and only require the discharge doctor to check and sign the documentation. Where there is no pharmacist or prescribing pharmacist, junior medical staff complete scripts to varying degrees of accuracy. A proportion of these are returned to the ward for correction, before medicines can be dispensed. Pharmacy staff informed us of further potential delays in waiting for juniors who were at lunch or lunchtime teaching sessions to return to amend scripts.

All of this had an effect in shifting the time for discharge to later in the day and reducing the number of available beds during working hours.

Whilst handover was praised, there was no specific mechanism by which bed pressures or potential discharges could influence the structure of the subsequent ward rounds. An ad hoc mechanism exists in some wards, dependent on the particular ward sister, to brief medical staff on outcomes from the 8.30am safety briefing. Junior staff commented that when discharges have built up over the weekends, there were “tons of e-mails from management”, but no explicit solutions proposed to expedite discharge.

There is no effective link between the 8.30am safety huddle and the medical on-take team, with no evidence of any change in ward round process. This reduces the potential effectiveness of this meeting to really drive improvements in patient flow and safety. Notification of potential and actual discharges is inconsistently performed across wards, with evidence of patients having to stay an extra night in hospital.

7.8 Recommendations for the Trust from the Handover Theme

1. It is recommended that links between the 8.30am safety huddle and medical teams are strengthened to ensure more robust communication about bed pressures and potential discharges.
2. It is recommended that the time of the medical handover meeting is reviewed to facilitate more two-way communication and provide time to discuss cases, draw out important teaching points, and review important scans.
3. It is recommended that ward staff communication with the ward pharmacy team is improved to provide them with the information required to prioritise and facilitate discharge.
4. It is recommended that ambulatory care pathways are developed in conjunction with the multidisciplinary team to improve patient care and ease pressure on medical admissions.
5. It is recommended that systems be put in place to enable and facilitate a more effective medical handover in surgery.
6. It is recommended that immediate steps are taken to improve the handover times between NIAS and triage staff.

8.0 Next Steps

On the 23 October 2015 the RQIA inspection team provided detailed verbal feedback to each area inspected. This was followed by feedback to the Chief Executive Dr Tony Stevens, directors and senior managers on the key findings from the inspection.

This inspection report has been shared with the Northern Trust for factual accuracy. Following publication of the report the trust has been asked to submit a QIP to address the recommendations. This will be made available on the RQIA website in due course. RQIA will review progress on the QIP at the next unannounced inspection.

The final report will be shared with the Northern Trust, DoH, HSC Board and PHA. The report will be published onto RQIA's website for public viewing.
www.rqia.org.uk

For recommendations that may take a longer period of time to address the trust will be asked to provide a further update on these recommendations. The timing of this request will be dependent of the timescales set out in the QIP.

Appendix 1 QUIS Coding Categories

The coding categories for observation on general acute wards are:

<p>Positive social (PS) – care over and beyond the basic physical care task demonstrating patient centred empathy, support, explanation, socialisation etc.</p>	<p>Basic Care: (BC) – basic physical care e.g. bathing or use of 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.</p>
<p>Examples include:</p> <ul style="list-style-type: none"> • 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 where 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. 	<p>Examples include:</p> <p>Brief verbal explanations and encouragement, but only that the necessary to carry out the task.</p> <p>No general conversation.</p>

<ul style="list-style-type: none"> • 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. 	
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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: <ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> • 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).



Quality Improvement Plan

Quality Improvement Plan

Quality Improvement Plan: Ward B2 Medical

Reference number	Trust Recommendations	Designated department	Action required	Date for completion/ timescale
1.	The Trust should review storage facilities in the ward to reduce the risk of trips and falls and ensure that fire exits are not blocked.	B2	Declutter has been completed. The geographical layout of the ward cannot facilitate any additional storage space. General Risk Assessment Northern Trust (GRANT) has been completed. COSHH Assessment valid and up-to-date.	Completed
2.	The hand wash sink and taps in the clinical room should be replaced and hot tap signage displayed where required.	B2	Hot tap signage has been erected where required. Minor Capital Works to replace sink raised to Estates Department. Date of installation to be confirmed by Estates when equipment available.	31-10-16
3.	Medical staff should complete all documentation relating to all care bundles and ANTT practices.	B2	Dr Kate Scott, Medical staff Foundation Programme Director, has confirmed these points are covered on the junior doctor induction programme.	Complete

Reference number	Trust Recommendations	Designated department	Action required	Date for completion/ timescale
			Also covered with medical staff at training sessions.	
4.	Staff should receive update training on NEWS and adhere to guidelines when completing documentation.	B2	<p>All staff are retaking NCEPOD NEWS training and providing Ward Sister with certificate on completion.</p> <p>Daily NEWS audits completed and recorded on Alamac dashboard. Compliance currently graded at 90%.</p>	31-8-16
5.	The Sepsis Six bundle should be implemented for use within the ward.	B2	The Trust has in place a Neutropenic Sepsis Guideline, Bacterial Sepsis in Pregnancy and Puerperium Policy and Antibiotic therapy in Adults Policy which was approved November 2015. This policy provides guidance on Antimicrobial Therapy for Sepsis Syndromes. The Trust will continue to work closely with the Safety Forum in the development of a regional protocol.	Ongoing
6.	The Trust should review the supply of piped oxygen points in the ward.	B2	<p>This has been reviewed and the number of oxygen points is confirmed as appropriate for the specialty.</p> <p>Ward staff will review the placement of the small number of patients who require piped oxygen and place appropriately on the ward at an oxygen point.</p>	Completed

Reference number	Trust Recommendations	Designated department	Action required	Date for completion/ timescale
7.	Staff should adhere to Trust policy in the administration of medicines and ensure that the reason, for any omission of medication is documented correctly.	B2	<p>All staff are aware of the NHSCT Medicines Administration and Management Policy.</p> <p>Compliance with the policy is audited daily.</p> <p>Critical Medicines Poster is now displayed and data collated on a daily basis via the Alamac dashboard.</p> <p>Ward Sister and Assistant Clinical Services Managers to carry out random audits on ward.</p>	30-10-16
8.	The Trust Medicines Management Policy should be updated to clearly guide staff on patient self-administration of medicine.	B2	NHSCT Medicines Administration and Management Policy is currently being updated and will be integrated into a Trust-wide Medicine Code which includes guidance on patient self-administration of medicine.	31-8-16
9.	A list of critical medicines where timelines of administration is crucial should be available for staff.	B2	A list of critical medicines has been issued to all Ward Sisters for display and recording of delayed or omitted critical medicines.	1-6-16

Reference number	Trust Recommendations	Designated department	Action required	Date for completion/ timescale
10.	All staff should correctly document the prescription and administration of oxygen therapy.	B2	<p>NHSCT Policy on Prescribing and Administration of Oxygen in Adults has been reinforced to all staff and is audited through the Critical Medicines omission.</p> <p>Regular audits to be carried out by Ward Sister and Assistant Clinical Services Manager and results shared with all staff.</p> <p>Oxygen is a prescription only medicine (POM) therefore record of prescription and administration should be made as with any POM.</p>	<p>30-10-16</p> <p>Ongoing</p>
11.	The recording in nursing care records should be improved to accurately reflect patients' needs, their involvement in their care, and be in line with NIPEC best practice guidelines.	B2	All staff have reviewed the NIPEC Best Practice Guideline.	30-10-16
12.	Fluid balance and food record charts should be completed and reconciled according to Trust policy.	B2	<p>All staff have completed Fluid Balance training for adult and child.</p> <p>All staff have completed e-learning training.</p> <p>Further enhanced training provided by Dietitian.</p>	Completed

Reference number	Trust Recommendations	Designated department	Action required	Date for completion/ timescale
			Food Charts are commenced as per MUST score. MUST compliance is audited daily and recorded on Alamac dashboard.	
13.	Staff should ensure that pain scores are recorded and the effectiveness of pain medication should be consistently reviewed.	B2	<p>All staff to review the information available at ward level on the Abbey Pain Tool and understand fully how to implement.</p> <p>Ward currently using the pain score on the NEWS chart.</p>	31-10-16
14.	The Trust should ensure that arrangements in place promote the privacy and dignity of patients, including the use of escalation beds, same sex bays and designate separate sanitary areas for male or female.	B2	<p>All staff are aware of the NHSCT Policy on same sex bays, which provides guidance on the placement of patients in same sex bays. Risk assessments are completed as required.</p> <p>Staff are reminded of policy at Ward Safety Briefings.</p> <p>Compliance audited on daily basis.</p> <p>Signage to male and female toilets has been erected at ward level.</p>	Complete

Quality Improvement Plan: Ward C6 Surgical

Reference number	Trust Recommendations	Designated department	Action required	Date for completion/ timescale
1.	Nurse staffing variances should be reviewed to ensure that patient care and safety is not compromised due to staffing levels.	C6	Staffing variance reviewed daily and escalated at daily Safety meetings. Staff redeployed from other wards / departments when possible. Bank / agency requested when required.	Completed 19-7-16
2.	Medical staff should review the scheduling of ward rounds to ensure nursing staff participation.	C6	Discussed at Surgical Governance meetings. Consultants facilitate timely ward rounds according to other clinical priorities. Nursing staff in each bay where possible accompany Consultants on ward rounds	Completed 19-6-16
3.	The Trust should ensure that refurbishment works are progressed within the treatment room to improve space for the preparations of clinical procedures.	C6	Requisition sent to Estates and Pharmacy in May 2016 – currently being costed. Plan to be in place by November 2016. Funding has been received for High Density Storage (HDS) within Ward C6 for the storage of drugs.	30-11-16 31-3-17
4.	The Ward Sister should ensure that all identified hazards within the ward are assessed, analysed and control measures implemented.	C6	General Risk Assessment Northern Trust (GRANT) completed and kept on ward from 30-5-16. This has identified hazards within the ward and is regularly reviewed.	Completed 30-5-16

Reference number	Trust Recommendations	Designated department	Action required	Date for completion/ timescale
5.	Medical staff should ensure that blood cultures are obtained when clinically indicated and on completion, the procedure should be clearly documented.	C6	Addressed at Induction by Infection Control Team and reinforced on ward. Medical staff information folder contains information on blood cultures available on ward. Raised with medical staff at Surgical Governance meetings.	Completed 19-7-16
6.	The Sepsis Six bundle should be implemented for use within the ward.	C6	The Trust has in place a Neutropenic Sepsis Guideline, Bacterial Sepsis in Pregnancy and Puerperium Policy and Antibiotic therapy in Adults Policy which was approved November 2015. This policy provides guidance on Antimicrobial Therapy for Sepsis Syndromes. The Trust will continue to work closely with the Safety Forum in the development of a regional protocol.	Ongoing
7.	The Trust should ensure that theatre staff completes all procedures within the WHO surgical safety checklist, and the checklist is fully documented.	C6	WHO checklist is fully implemented in Theatres within NHSCT.	Completed 19-7-16
8.	All staff should adhere to Trust policy in the administration of medicines.	C6	The importance of adherence to the Medicines Administration and Management Policy, in relation to administration of IV drugs, has been reinforced to staff.	Completed 19-7-16

Reference number	Trust Recommendations	Designated department	Action required	Date for completion/ timescale
9.	The Trust's medicines management policy should be updated to clearly guide staff in the administration of controlled drugs and patient self-administration of medicines.	C6	NHSCT Medicines Administration and Management Policy is currently being updated and will be integrated into a Trust-wide Medicine Code which includes guidance on patient self-administration of medicine.	31-8-2016
10.	Nursing care records should be improved to accurately reflect patients' needs, their involvement in their care, and be in line with NIPEC best practice guidelines	C6	New patient care plans in line with NIPEC best practice guidelines have been introduced. These care plans are reviewed daily and audited 2-weekly.	Completed 30/5/16
11.	Staff should consistently record pain assessments and use appropriate pain assessment scales for patients who cannot verbalise their pain.	C6	Recording pain using Turner Stokes Analogue Scale which is on the NEWS Chart. Abbey Pain Score is used for patients with dementia.	Completed 19-7-16
12.	The Trust should ensure that arrangements are in place promote the privacy and dignity of patients, including the use of escalation beds and same sex bays.	C6	The Trust Privacy and Dignity Policy is in place which provides guidance to staff if the placement of patients in a mixed sex bay becomes necessary.	Completed 19-7-16
13.	Medical staff should ensure that DNAR documentation is reviewed and signed by a senior decision maker.	C6	The Trust has had a DNACPR Policy in place since 2012 which outlines the responsibilities of health professionals. The policy is being reviewed in line with current guidance.	31-10-16

Reference number	Trust Recommendations	Designated department	Action required	Date for completion/ timescale
14.	The Trust should include patient, relative and carer comments as part of the overall strategy to improve the patient experience and ensure appropriate staff interactions with patients at all times.	C6	Patient-centered nursing care plans are in place. Patient notes are written at the patient's bedside and patients are involved in care. Feedback through 10,000 Voices methodology is managed widely. Feedback / complaints / compliments are shared at team / Governance meetings.	Completed 19-7-16

Quality Improvement Plan: Emergency Department

Reference number	Trust Recommendations	Designated department	Action required	Date for completion/ timescale
1.	The Trust should ensure the regular dissemination of formal analysis reports on SAs, incidents, near misses to staff for learning.	Emergency Department	<p>Quality and Safety Board is now active to report on governance issues.</p> <p>Audit results and learning etc. are shared by email and discussed at Safety Briefing twice daily.</p> <p>Monthly Governance meeting of the Senior Nursing, Consultant and Management team.</p> <p>Minutes of Governance meeting are available via Lead Nurse or Consultant secretary.</p>	Complete and ongoing
2.	PHA learning letters should be communicated to all relevant staff.	Emergency Department	<p><u>Nursing</u> Learning Alerts are shared via Emergency Department email distribution list. This includes all staff of all grades. They are also raised twice daily in Safety Briefing and a hard copy available in the Ward Sister's Office.</p> <p><u>Medical</u> Learning Alerts are shared via Consultants to the medical team and discussed at medical handover and training sessions. Learning Alerts are part of the set agenda for the monthly Governance meetings and actions required identified.</p>	Complete and ongoing

Reference number	Trust Recommendations	Designated department	Action required	Date for completion/ timescale
			All actions from Learning Alerts are shared with Corporate Governance.	
3.	Communication with staff should be improved to ensure learning from morbidity and mortality meetings and from analysis of cardiac arrest rates.	Emergency Department	Introduction of a new Cardiac Arrest Audit to incorporate trauma patients end of April 2016. Cardiac Arrest Audits (excluding out of hospital arrests) to be reviewed and analysed by Assistant Clinical Service Lead quarterly in conjunction with the Resuscitation Officer.	Complete
			A Trust-wide review of Morbidity and Mortality meetings has taken place. ED has a schedule of meetings in place and will use the updated review process.	30-9-16
4.	The Trust should undertake further work to improve quality indicators in line with DHSSPS targets.	Emergency Department	Implementation of the Care Quality Assurance Audit in conjunction with Corporate Nursing. Learning identified and disseminated via an action plan.	31-8-16
5.	The Trust position that clinical priorities always come before targets should be clearly communicated to staff.	Emergency Department	Clinical priority over targets reinforced at staff induction, triage training, clinical supervision and staff meetings. Trust Vision and Corporate Objectives actively promoted. Feedback from 10,000 Voices workshop held for staff to reinforce the importance of the patient experience.	Completed and ongoing

Reference number	Trust Recommendations	Designated department	Action required	Date for completion/ timescale
6.	The Trust should review the role and number of the band 7 nurses in ED to ensure effective clinical leadership.	Emergency Department	<p>Role clarification exercise completed in September 2015. Roles and responsibilities framework complete – actions cards in safety briefing. ED Standard Operating Procedure completed to incorporate role of Nurse-in-charge.</p> <p>All Nurses-in-charge are easily identifiable by name badge and regionally recognised uniform.</p>	Complete
7.	The Trust should review nurse staffing levels across all areas within the ED and the recruitment of new staff should be expedited.	Emergency Department and Corporate Nursing	<p>All permanent vacancies have been raised and filled. Ongoing recruitment and retention strategies in place.</p> <p>Pending outcome of regional ED normative staffing review.</p>	Complete
8.	Staff supervision and appraisal should be up to date.	Emergency Department	<p>A programme of appraisals agreed for 2016/2017 has been outlined with all members of the Band 6 and Band 7 team who have been assigned teams of responsibility.</p> <p>Promotion of opportunities for clinical supervision agreed.</p> <p>Supervision session log available in Ward Sister's office.</p>	Ongoing

Reference number	Trust Recommendations	Designated department	Action required	Date for completion/ timescale
9.	Senior Trust ED staff should take action to alleviate staff concerns outlined in the report and ensure any issues raised by staff are immediately addressed by senior management.	Emergency Department	<p>Regular staff meetings with Assistant Clinical Services Manager and concerns raised actioned or escalated.</p> <p>Executive Team visible in clinical area and openly welcome and encourage dialogue with all staff.</p> <p>Daily operational issues also raised and addressed through morning Safety Briefing meeting and twice daily escalation meetings.</p>	Complete
10.	To provide a safe working environment the Trust needs to review the provision of security staff on the hospital site and have malfunctioning staff personal security alarms repaired immediately.	<p>Emergency Department</p> <p>Site Support Team</p>	<p>The Trust takes the security of staff and patients seriously. The Trust has a Multi-disciplinary Trust-wide Security Advisory Committee which meets quarterly and is chaired by an Assistant Director.</p> <p>Membership includes representation from Senior Managers, Clinicians, Operational Managers, Trade Unions (including RCN), ED Consultants and PSNI.</p> <p>This committee reviews security statistics, incidents and corrective actions that have been taken. It provide regular reports to the Trust Corporate Governance Steering Group.</p>	Complete

Reference number	Trust Recommendations	Designated department	Action required	Date for completion/ timescale
			<p>The Site Managers within Antrim Hospital work closely with the PSNI in relation to incidents within the ED and to offer advice when requested.</p> <p>The PSNI assist with Security Protocols within the Trust.</p> <p>The Trust has a contract with a security firm to supply trained security guards who have all relevant registration, clearance and training to manage incidents within the ED and the hospital. The Security Guard is based in ED, and a handover is done to Trust staff each morning where incidents can be reviewed and any corrective action taken.</p> <p>Routine security presence has increased out-of-hours in the ED. Security activity also tracked and reviewed by Support Services Manager on an ongoing basis.</p> <p>Staff are encouraged to report incidents as soon as possible so that CCTV footage can be retrieved and saved in case further action is required.</p>	

Reference number	Trust Recommendations	Designated department	Action required	Date for completion/ timescale
			<p>Staff are also encouraged to pursue perpetrators through the courts and managers have worked with the Trust Health and Safety Advisor and Trade Unions to support staff through this process.</p> <p>The Trust has reviewed the staff alarm system within the ED. The alarms are now fully functional and staff carry and respond to personal alarms. This is monitored by Ward Sisters.</p> <p>ED Focus Groups will continue to be held in order to manage issues as they arise.</p>	
11.	Timely access to AHPs should be developed as part of the PHA commissioning services.		<p>Early Intervention Team commenced in March 2016 to incorporate Physiotherapy, Occupational Therapy and Social Work. The Community Discharge Co-ordinator is also active in this team. There is a Musculoskeletal Physiotherapist in the minors stream of the ED.</p> <p>ED Pharmacist present in the department 7 days a week who provide cover 8.00am – 8.00pm. In addition, Pharmacy Technician provides support.</p>	Complete

Reference number	Trust Recommendations	Designated department	Action required	Date for completion/ timescale
12.	All staff should attend mandatory training and staff should have the opportunity to attend in house training commensurate with their role.	Emergency Department	In-house programme is in place. Mandatory training continues to be prioritised in accordance with the needs of the department. In addition, there is an identified core mandatory programme for staff in the ED.	October 2016
13.	Visible and effective leadership is needed during the initiation of the ED escalation plan. The criteria for the ED escalation plan should be reviewed and updated as required.	Emergency Department	Daily activity on site is reviewed 3 times per day during escalation when demand exceeds capacity as per Escalation Plan. Senior management liaise with Nurse-in-charge and Tracker throughout this time. Directorate Managers undertake regular walkarounds and review of the department interacting with the Tracker, Nurse-in-charge, Consultant and Patient Flow.	Complete and ongoing
14.	Daily reviews and routine senior medical and nursing walk rounds should be carried out.	Emergency Department	With reference to the Standard Operating Procedure, the Consultant and Nurse-in-charge review areas of highest demand and clinical need at the start of the morning shift, 5.00pm (when evening Consultant arrives) and at 10.00pm before the evening Consultant is on call. On-call consultant is accessible overnight until 8.00am. Due to the dynamic nature of ED on-going communication with Consultant by Nurse-in-charge continues outside of these times. All standby calls and category one patients are escalate to the Senior Doctor immediately by the Nurse-in-charge.	Complete Complete

Reference number	Trust Recommendations	Designated department	Action required	Date for completion/ timescale
15.	Improvement is required in the interface between ED, and medical, surgical and specialist services to ensure timely patient assessment and review.	Emergency Department	Referral processes to Direct Assessment Unit for medical presentations in place. Other specialty pathways include stroke team and gynae team.	Complete
			Current processes under development are Direct Assessment Unit pathways for cardiac, surgery and gynaecology. Also, on establishment of paediatric ambulatory a referral pathway from ED is to be completed.	September 2016
16.	Ambulatory and integrated care pathways should be further developed.	Medicine and Emergency Medicine Directorate	The development of ED Ambulatory Pathways are being explored in the Reform and Modernisation Programme to include resources required in terms of space and staffing. Ambulatory is progressing well in several other specialisms for example, acute medicine in the Direct Assessment Unit.	Ongoing
17.	Senior ED staff should review and further introduced where appropriate nursing quality performance indicators into ED.	Emergency Department	Care Quality Assurance Audit with Corporate Nursing completed regularly.	31-8-16
			Band 7 staff for each designated area to complete the care and compassion audit (Fundamentals of nursing care 15 steps) monthly with action plans developed.	31-7-16

Reference number	Trust Recommendations	Designated department	Action required	Date for completion/ timescale
18.	Staff should ensure patients are always treated with respect and dignity during times of crowding in a manner that maintains privacy and confidentially.	Emergency Department	Escalation process agreed to address periods of congestion within the department. Patients with a “decision to admit” prioritised by Patient Flow and Senior Management to de-escalate ED where possible. Privacy and confidentiality raised through staff meetings and clinical supervision when necessary.	Complete
			Provision of training around customer designed and implemented in conjunction with Administration Manager and Organisation & Development.	31-12-16
19.	All staff should be aware of how to contact the resuscitation team and contact details should be clearly displayed.	Emergency Department	Contact details for cardiac arrest clearly visible in all clinical areas. Cardiac arrest number saved as number 1 on all phones in the ED.	Complete
20.	All staff disciplines should carry out hand hygiene in accordance to the WHO 5 Moments of care, and adhere to aseptic non-touch technique (ANTT) procedures.	Emergency Department and IPC Team	Weekly audits completed by nursing team on hand hygiene and PPE. Senior nursing team provide high level challenge and support. Infection Control Team visible within the ED for periods of supervision and audit. Learning shared by Ward Sister.	Complete

Reference number	Trust Recommendations	Designated department	Action required	Date for completion/ timescale
21.	Staff should ensure that national early warning scores are totalled and completed within the set timescales, and escalation in scoring and action taken recorded at all times.	Emergency Department	Monthly NEWS audit using regional tool. Learning identified and disseminated via safety huddles. Identified issues managed through clinical supervision or raised in staff meeting.	Complete
22.	Staff should ensure that the Sepsis Six bundle is fully completed and legible copies available.	Emergency Department	Legible copies of Sepsis Six Bundle available within ED. Due for review in August 2016 due to change in regional guidelines. Sepsis Six incorporated into multidisciplinary summer training programme. The Trust has in place a Neutropenic Sepsis Guideline, Bacterial Sepsis in Pregnancy and Puerperium Policy and Antibiotic therapy in Adults Policy which was approved November 2015. This policy provides guidance on Antimicrobial Therapy for Sepsis Syndromes. The Trust will continue to work closely with the Safety Forum in the development of a regional protocol.	Ongoing
23.	Staff should ensure that patients are connected to cardiac monitors as their condition dictates and ensure that additional essential patient equipment is available during times of crowding.	Emergency Department	Cardiac monitors are available in each room and clinical area. Equipment list reviewed with Ward Sister to include equipment required during times of crowding.	Complete

Reference number	Trust Recommendations	Designated department	Action required	Date for completion/ timescale
24.	The short stay ward should function as designed. When this cannot be facilitated there should be systems in place to ensure services are available for vulnerable and longer-term inpatient beds.	Emergency Department	Operational policy for Short Stay Ward available. Additional resourcing sought when demand increased in ward area to assist with longer-term inpatients. Patients in this area are under continuous review by Patient Pathway and the Ward Sister. Patients with a length of stay greater than 5 days are escalated to the Assistant Clinical Services Manager.	Complete
25.	The assessment of older patients for all common frailty syndromes, during clinical review, should be fully documented using a recognised assessment tool.	Emergency Department	Development of an assessment for frailty syndrome to include current assessments on polypharmacy, falls and continence. Direct referral to Direct Assessment Unit for Comprehensive Geriatric Assessment where appropriate.	Complete
26.	The learning from the audits of ED clinical standards should be actioned and cascaded to staff.	Emergency Department	Audit results detailed in audit folders held in the Ward Sister's office. Audit results shared via safety huddles.	Complete and ongoing
27.	The medicines management policy should be updated to clearly guide staff in the administration of controlled drugs and patient self-administration of medicines.	Pharmacy	NHSCT Medicines Administration and Management Policy is currently being updated and will be integrated into a Trust-wide Medicine Code which includes guidance on patient self-administration of medicine.	31-8-2016

Reference number	Trust Recommendations	Designated department	Action required	Date for completion/ timescale
28.	All staff need an immediate update on their role and responsibility in the safe storage, security, administration and documentation of medication. Staff practice should be monitored to ensure adherence to best practice.	Emergency Department	Compliance is observed on each observational audit and immediate feedback provided to staff.	Complete
29.	The trust should review ED pharmacist cover to improve and facilitate effective integrated medicines management.	Emergency Department and Pharmacy	ED Pharmacist present in the department 7 days a week who provide cover 8.00am – 8.00pm. In addition, Pharmacy Technician provides support.	Complete
30.	The recording in nursing care records should be improved to accurately reflect patients' needs, their involvement in their care, and be in line with NIPEC best practice guidelines.	Emergency Department	Nursing documentation reviewed and social risk matrix incorporated to reflect patient's needs and permit early assessment for discharge planning. Representative has been nominated to attend the NIPEC Regional ED Documentation Working Group, as commissioned by the CNO through the Recording Care Group.	Complete
31.	The trust should improve the system in place for the ordering, delivery and service of patient meals.	Emergency Department	Meal service reviewed and system for provision of meals implemented. This is a nurse led process incorporated into the Care Quality Assurance audit. The Catering Service in ED has been reviewed in conjunction with nursing staff and a revised daily standardised service has been put in place as follows:	Complete

Reference number	Trust Recommendations	Designated department	Action required	Date for completion/ timescale
			<p>Breakfast Tea / coffee / toast / porridge / cereal.</p> <p>Lunch Soup of the day / bread selection / pancake / individual dessert. Tea / coffee / milk.</p> <p>Afternoon Beverage Service Tea / coffee / biscuits.</p> <p>Dinner Irish Stew / individual dessert. Tea / coffee / milk.</p> <p><u>Supper Service</u> Tea / coffee / biscuits.</p> <p>A Named Nurse is responsible for supervising and co-ordinating the meal service and is identified on the whiteboard in Majors. The Named Nurse is also identified on each cubicle door.</p> <p>In the Observation Ward, patient orders are completed on the electronic menu ordering tablet which contains the 2 week menu cycle. Also included on the tablet is an" extras" list should a patient not wish to choose from the daily menu selection.</p>	

Reference number	Trust Recommendations	Designated department	Action required	Date for completion/ timescale
32.	Staff should ensure that fluid balance and food record charts are completed and reconciled in accordance with trust policy. A robust audit of the documentation should be undertaken.	Emergency Department	<p>Fluid Balance Charts completed in accordance with Trust policy.</p> <p>Audit of Fluid Balance Charts led by Ward Sisters.</p> <p>Food Charts are linked to MUST scores which are commenced within 48 hours if the patient is transferred to a ward. However, within the ED Food Charts are completed when indicated by clinical assessment.</p>	Complete and ongoing
33.	Staff should ensure that all patients attending triage are assessed for pain. Staff should use appropriate pain assessment scales for patients who cannot verbalise their pain.	Emergency Department	<p>Pain assessment integral part of triage and included in triage training.</p> <p>Audit of pain assessment is incorporated into the triage quality audit as lead by the triage trainer.</p> <p>Abbey Pain Score introduced for assessment of pain in proforma for management of neck of femurs for patients with dementia, in accordance with NICE and SIGN.</p>	Complete

Reference number	Trust Recommendations	Designated department	Action required	Date for completion/ timescale
34.	Staff should ensure that the Braden risk assessment tool is completed for patients who have been in the ED for more than six hours. Staff should be made aware of their role and responsibilities in prevention of pressure ulcers and completion of documentation.	Emergency Department	Braden Risk Assessment flagged in nursing assessment for patients in the ED over 6 hours. Work is currently ongoing with the Tissue Viability Team to ensure a reliable process is in place. Raised awareness via staff meetings.	Complete
35.	Staff should ensure that call bells should be positioned within patient reach, and monitoring equipment alarms responded to in a timely manner.	Emergency Department	Incorporated into the Care Quality Assurance Audit. Compliance is monitored by the Nurse-in-charge. All staff has been reminded of importance. Feedback provided to staff at daily briefing. Compliance will be recorded on Alamac dashboard as part of ED reporting.	Complete
36.	Guidance from the College of Emergency Medicine for End of Life Care should be implemented into ED as best practice guidelines.	Emergency Department	End of Life Care guidance reviewed and actions identified. Engagement with Organ Donation Services and Palliative Care in development of in-house training.	October 2016
37.	The Trust should include patient, relative and carer comments as part of the overall strategy to improve the patient experience and ensure appropriate staff interactions with patients at all times.	Emergency Department	All complaints and compliments are shared with staff through shared drive, email and Quality and Safety Board. Issues identified addressed with individual staff through clinical supervision.	Complete

Quality Improvement Plan: Handover Theme

Reference number	Trust Recommendations	Designated department	Action required	Date for completion/ timescale
1.	It is recommended that links between the 8.30am safety huddle and medical teams are strengthened to ensure more robust communication about bed pressures and potential discharges.	Surgical Wards	Bed pressures escalated daily to on-call Consultant team and all Consultants asked to review patients and identify those suitable for discharge.	Completed 19-7-16
2.	It is recommended that the time of the medical handover meeting is reviewed to facilitate more two-way communication and provide time to discuss cases, draw out important teaching points, and review important scans.	Surgical Wards	Medical handover takes place at 8.00am in the Surgical Seminar room. Ill patients are prioritised and seen first on the post take ward rounds.	Completed 19-7-16
3.	It is recommended that ward staff communication with the ward pharmacy team is improved to provide them with the information required to prioritise and facilitate discharge.	Surgical Wards	Pharmacist attends staff meetings and Governance meetings with Medical staff and multidisciplinary team. Daily discussion with pharmacists on ward re potential discharges.	Completed 19-7-16
		B2 / C6 / ED	B2 – Pharmacy issuing a memo to ward staff advising them to update pharmacy staff of any changes to discharges as soon as possible to facilitate quick turnaround of discharges. B2 - Staff put discharges on whiteboard in pharmacy office when patient is a potential or confirmed discharge. ED – Pharmacist present in the ED 7 days a week / 8.00am – 8.00pm.	Completed

Reference number	Trust Recommendations	Designated department	Action required	Date for completion/ timescale
4.	It is recommended that ambulatory care pathways are developed in conjunction with the multidisciplinary team to improve patient care and ease pressure on medical admissions.	Surgical Wards	Plan in place to develop pathways for Surgical emergencies and commence surgical assessment in the Direct Assessment Unit. Within Direct Assessment Unit Ambulatory Service will be developed in September 2016.	30-9-16
5.	It is recommended that systems be put in place to enable and facilitate a more effective medical handover in surgery.	Surgical Wards	See answers 1 and 2 above.	Completed 19-7-16
6.	It is recommended that immediate steps are taken to improve the handover times between NIAS and triage staff.	ED	Antrim ED frequently achieves the highest regional percentage in relation to NIAS turnaround times. However, there is always room for improvement and staff are frequently reminded of NIAS turnaround times and the need to free-up ambulance trolleys. ED Escalation Policy facilitates additional resources on the arrival of several ambulances at the same time.	Ongoing



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