The Regulation and Quality Improvement Authority

RQIA Acute Hospital Inspection Programme – Phase 1 Summary Report

www.rqia.org.uk

Assurance, Challenge and Improvement in Health and Social Care

Contents

1. Ministerial Statement

In 2014, the then Minister for Health, Social Services and Public Safety, Minister Poots asked Regulation and Quality Improvement Authority (RQIA) to carry out a series of inspections in acute hospitals across Northern Ireland. This rolling programme of unannounced inspections, was to examine the quality of services in acute hospitals in Northern Ireland from 2015-16 onwards.

In a statement to the Northern Ireland Assembly on 1 July 2014 the Minister stated that 'inspections will focus on a number of quality indicators about triage, admission, assessment, care, monitoring and discharge of patients. They will focus on a selection of quality indicators that will not be pre-notified to the trusts for each inspection, and no advance warning will be provided to trusts as to which sites or services within a hospital will be visited as part of an unannounced inspection. It is intended that the RQIA inspection reports will be published on a hospital-by-hospital basis as they are completed'.

In a letter dated 14 April 2014, the Chief Medical Officer formally asked RQIA to put in place appropriate arrangements, to deliver a rolling programme of unannounced inspection of the quality of services in acute hospitals in Northern Ireland.

2. Development of the RQIA Hospital Inspection Programme

Following this, RQIA set up a project using a modified Prince 2 methodology with the object of developing, designing and piloting an agreed hospital inspection process and associated procedures, which would conclude with the delivery of a fully tested methodology to deliver the programme of unannounced inspections. Project management support was supplied by a project manager from the RQIA Reviews Directorate.

The overall aims of the Acute Hospital Inspection Programme were identified as:

- providing public assurance
- promoting public trust and confidence in the delivery of acute hospital services

The proposed key deliverables for the project to establish the new programme of unannounced inspection were to:

- develop, pilot and implement a hospital inspection process, and associated procedures, in accordance with legislation, standards and relevant best practice guidance
- identify and agree access to relevant sources of information which could inform the content and delivery of the programme of inspections
- develop a comprehensive training package to ensure that RQIA inspection staff, peer reviewers and lay assessors are suitably trained to carry out the inspections
- develop a database to coordinate the programme of inspections
- establish a forward work plan for the programme of inspections over the period 2015-18
- ensure that relevant stakeholders, including the public, are kept informed about the development of the programme

A project board was established chaired by the RQIA Director of Reviews with representation from:

- RQIA
- RQIA Board
- Department of Health (DoH)
- NI Safety Forum
- Public Health Agency
- Service Users and Carers

A project team was established consisting of the RQIA Healthcare Team and an RQIA project manager.

An initial inspection framework was designed around 14 areas of inspection underpinned by relevant criteria.

Each area of inspection was designed to correlate with one of the RQIA core objectives of:

- Safe care
- Effective care
- Compassionate care

The inspection process was designed to use a number of methodologies:

- use of core indicators
- views of patients and relatives
- review of documentation
- observation of practice
- staff feedback

Each inspection would be led by the RQIA Healthcare Team supported by:

- the use of peer reviewers (staff who are engaged in the day to day delivery of health and social care)
- the use of lay assessors (who are service users and members of the public and who bring their own experience, fresh insight and a public focus to our inspections)
- medical trainee(s) supplied by Northern Ireland Medical and Dental Training Agency
- nursing students supplied by Ulster University and Queen's University Belfast

Inspections would also examine a specific theme from a list agreed by Department of Health. All of these findings would be aggregated to provide an assessment of care and to make recommendations for improvement.

Hospitals were categorised dependent upon the number of beds and specialist areas. The number of inspections and wards/areas to be inspected were to be proportionate to the type of services provided and the size of the hospital.

In Year 1, RQIA planned to inspect wards and departments in the following areas in each HSC acute hospital subject to inspection:

- Emergency Care
- Medical Care (including older people's care)
- Surgical Care

In subsequent years, other areas would be inspected, particularly if areas of concern were identified or where the quality of care may have been compromised. Wards would be inspected on a rolling programme.

Five pilot inspections were carried out in the following hospitals:

- Antrim Area Hospital

- Ulster Hospital
- Craigavon Area Hospital
- Mater Hospital
- Altnagelvin Area Hospital

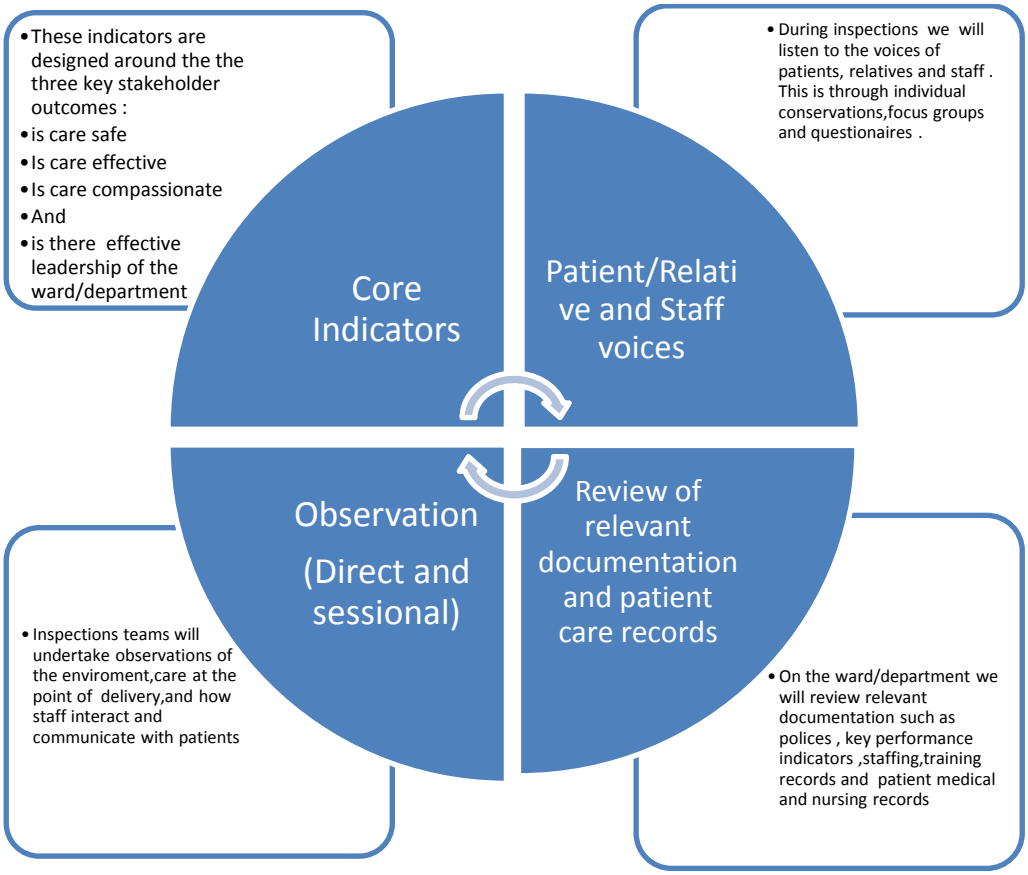
These pilots were designed to test the process and inspection tools. No formal feedback sessions were held, a report including a compliance assessment was not sent to trusts following each inspection and no feedback was sought from the trusts at the end of the pilot process.

The definitive programme planned to visit in order:

- Antrim Area Hospital
- Royal Victoria Hospital
- Ulster Hospital
- Craigavon Area Hospital
- Altnagelvin Area Hospital

Just prior to the first inspection, a well led domain was added to the areas that would be reflected in the inspection report and a number of indicators were added to provide an assessment of how well each clinical area subject to inspection was managed and led.

A decision matrix was added that aggregated the information that the inspection team would use to come to a conclusion as to performance against each of the now four domains.



The inspection report was set out against the four domains and it was planned that areas of good practice would also be identified. Areas that were identified as needing improvement would receive either a:

- **recommendation**: where indicators or standards are found to be partially or minimally compliant, and would require significant change and/or improvement, and would be reviewed at future inspections.

- **housekeeping point**: a deficiency where improvement was considered to be achievable within a matter of days, or at most weeks, through the issue of instructions or changing routines

The initial inspections of Antrim and the RVH ran over three days. This was subsequently extended to four days and the size of the inspection team also increased over the course of the first five inspections.

3. Themes Arising from the First Five Inspections

1. Staffing Levels

Nursing staffing levels were identified as being a problem in almost every area that had been inspected. An exception was in Craigavon Emergency Department (ED) where the trust had taken the decision to exceed its funded establishment although these posts had been designated by the trust as being "at risk" as they were not funded from within the ED budget. In those areas where low staffing levels were most acute, morale among staff was low and this was having a knock on effect on for example, sickness levels, levels of staff training, appraisal and supervision, communication and engagement with the multidisciplinary team. Levels of audit were low and improvement following audit was not being demonstrated. The cumulative effect was leading, in some cases, to less effective care being provided for patients. The development of roles such as nurse educators and nurse development leads was helping to provide some balance to the workload of ward sisters.

Staffing levels were particularly an issue in some areas of the ED where a lack of nursing staff was leading to an inappropriate nurse: patient ratio which had a direct impact on patient safety.

The level of Allied Health Professionals (AHP) support also had a substantial effect on how an area was performing. Timely access to Occupational Therapist, Physiotherapist and social work input had a dramatic effect on patient flow throughout the ward and facilitated discharge. However, trusts were actively working to improve the situation. Some wards now had dedicated AHP provision and access to weekend cover was also being improved.

In the large majority of cases, drugs, including controlled drugs were stored safely and apart from a few cases, being administered in line with trust policy. In those areas that had a dedicated pharmacist, true integrated medicines management was facilitated. In the absence of a dedicated ward pharmacist reconciliation of medicines at both admission and discharge was not taking place.

In some areas, the number of junior medical staff was considered to be too low to perform all necessary functions.

2. Support for Ward/ED Sisters

In those areas where the sister had time and capacity to perform both managerial and clinical roles, the ward could be considered to be well led. Where this was not the case, it contributed was to poor communication in terms of staff meetings, attendance at ward rounds and staff briefings that were poorly organised and inefficient. Staff were also not aware of feedback/learning from incidents/complaints and performance against trust Key Performance Indicators such as cardiac arrest.

In those instances where sisters were provided with clerical backup, performance in the well led domain was much better.

3. Communication

One of the indicators of a well-functioning ward/ED is the level and effectiveness of communication between all members of the multidisciplinary team. In relation to nursing staff, effective and well-structured safety briefings and handovers are an essential part of the provision of safe and effective patient care. In a number of instances these processes were observed to be less than effective.

Regular meetings involving the entire multidisciplinary team, including input from all AHP colleagues, should also take place and again this is an area for improvement.

Suitably timed structured ward rounds with input from both medical and nursing staff are extremely important. Most wards are now trying to time their ward rounds to facilitate discharge but it is surprising that a number do not include nursing staff.

In those areas where senior nursing staff attended mortality and morbidity meetings and also governance meetings, where incidents and complaints were discussed, they were able to feed this information directly back to staff. It was also fed back that more walk-rounds by senior management, making them more visible to staff on the ground, would be seen as beneficial.

4. Nutrition and Mealtimes

In a number of areas the concept of protected mealtimes was not being adhered to. In the instances where a senior nurse was not in charge, mealtimes were haphazard, staff were often not aware of specific patient requirements, calorific intake was not recorded, patients were not encouraged to maintain their fluid intake and fluid charts were not being completed consistently.

5. Environment

In the majority of cases the environment was good, though in most cases a full assessment for dementia patients had not been carried out and resulted in a deficit of appropriate adaptations had not been carried out.

Staff were aware of trust policies in relation to hand hygiene, uniform, Aseptic Non Touch Technique**,** and use of Personal Protective Equipment. However, during each inspection a number of staff were observed who did not fully adhere to these policies. Audits of hand hygiene are carried out regularly.

6. Patient Care

A frequent finding was that nursing care plans were not always up to date and were not always reflective of individual patient care needs. Nursing records did not always comply with Nursing and Midwifery Council and Northern Ireland Practice and Education Council for Nursing and Midwifery guidance. Medical records were mostly well completed and contemporaneous though on a number of occasions test results were sitting loose in the file and could be easily misplaced.

Staff awareness and training in relation to safeguarding was generally good and there was generally good awareness in relation to end of life care. Venous thromboembolism risk assessments were completed and prophylaxis administered where appropriate.

Sepsis 6 and falls safe bundles had been introduced in almost all areas. National early warning scores were being recorded, however scores were not always reconciled meaning that appropriate action was not always taken. A SKIN ('Skin Inception, Keep Moving, Incontinence/Moisture, Nutrition/Hydration') or SSKIN ('Surface, Skin Inception, Keep Moving, Incontinence/Moisture, Nutrition/Hydration') bundle had been introduced in almost all areas and a Braden score recorded where appropriate. Good training had been provided in relation to pressure ulcer care and there was universally good access to a tissue viability service.

7. Patient and Relative Feedback

As a part of each inspection, a number of questionnaires had been administered to both patients and relatives. In all cases patients reported that they were happy with the standard of care they had received, though a number commented on nursing staffing levels and their ability to provide care, especially at busy times. They were content that staff introduced themselves, gave them an easy to understand explanation of their care and were aware of protecting their privacy and dignity. Relatives agreed that the standard of care was good but commented that quite often they did not know and were not told, who they could approach to obtain information regarding their relative.

8. Issues in Relation to Emergency Departments

It is not surprising that EDs functioned very well when patient numbers were low but began to perform less well as numbers increased. Each department should have an escalation plan that should set out clearly the steps to be taken when numbers increase. Not all trusts have a fully operational escalation plan that is known to all staff.

As already stated, nurse staffing levels are an issue in almost all EDs. When patient numbers increase, it is proving impossible to maintain a 1:1 staff patient ratio where required and when numbers in ambulance triage rise, it is not possible for a single member of staff to monitor the number of patients that are waiting.

It also compromises their ability to respond to emergency situations. Lack of suitably qualified staff has also led to situations where staff are being asked to perform above their competency level.

In the majority of EDs, senior consultant staff do not perform regular walk-rounds accompanied by senior nursing staff. This regular patient review is essential in maintaining an overall view of what is happening in the department.

In relation to medicines management, there is virtually no medicines reconciliation on acceptance at an ED. If a patient requires a time critical medication, unless they have brought it with them there is a real risk that they will miss their medication, or have its admission delayed considerably.

In most cases there was minimal planning of care, which for those patients with minor issues was not a problem. However, for those patients with co morbidities, some plan of care should be in place. Re triaging of patients who have been in the ED for a considerable period of time should be prioritised.

However a number of improvement initiatives were reported:

- Development of an elderly assessment unit with direct admission for older patients if beds are available
- A joint radiology/ED initiative aiming to lead to real time scan reporting for certain conditions
- Development of a number of ambulatory and integrated care pathways
- Development of IT systems that accurately record the flow of patients through the ED and will provide real time information.
- A working group within the ED has been set up to review the protocols for the management and treatment of minor injuries. It is planned to extend the scope of practice of Emergency Nurse Practitioners whereby they will start seeing patients with minor injuries
- First point of contact physiotherapy- this is where the physiotherapist becomes the first point of contact and takes responsibility for the care of patients with simple and non-urgent peripheral musculoskeletal injuries
- Improved pathways for children and young people
- Patients who are over 65 years of age and frail and over 75 with chronic medical conditions affecting mobility can access a geriatric liaison team
- An urgent care area has been opened in the ED which is staffed by ENPs who can triage patients meaning they do not have to go through the main ED
- Development of an ATTEND (advanced triage treatment by emergency nurse or doctor) within the ambulance receiving area

4. Evaluation of the First Five Inspections

a) External Evaluation

In December 2015, RQIA was awarded the European Foundation for Quality Management (EFQM) 4* Recognised for Excellence Award. As part our hospital inspection evaluation process we engaged the EFQM lead assessor to carry out an external assessment of our inspection processes.

The assessor accompanied and observed members of the inspection team during the inspection of Altnagelvin Hospital. The report sets out a number of strengths:

- By allowing time to focus on only three identified areas, with a large team and a range of skills and experience, a thorough inspection could be and was carried out.
- Inspectors working in pairs allowed less experienced members to settle into the process and resulted in better quality note taking.
- The use of a range of skilled medical practitioners peer reviewing colleagues, in a structured sample based approach, appeared to be sound and robust.
- Guidance notes were comprehensive and well laid out.
- Note taking was observed to be methodical and detailed.
- Seemed to be adequate time to complete workbooks.
- The process of holding regular meetings throughout the day enables findings and emerging trends to be highlighted and shared with the wider team for further exploration.

A number of areas for further discussion were identified:

- Have a more process based approach to inspections. Measures of key process performance are a powerful metric designed to dig deeper into how an organisation is performing.
- Possible further training for inspectors in assessing management practice.

b) Feedback from Trusts

On 21 October, a half day workshop was held as part of the evaluation process. All trusts were invited as well as representatives from Queens University Belfast and Ulster University as both institutions had supplied student nurses for the inspection programme. In advance of the workshop, trust chief executives had been asked to provide high level feedback regarding the first 5 inspections.

During the workshop participants were asked to comment on a number of areas:

- did the hospital inspection programme meet its overall objectives and if not why not?
- unannounced vs announced inspections
- gathering the views of patients, relatives and staff and the use of focus groups
- report – structure and content
- provision of immediate feedback and preliminary findings
- any perceived gaps in the process

It was felt that generally the programme had met its objectives but that more balance was required. The process had concentrated too much on negative findings and areas of good practice had not been emphasised enough, as publicising these elements may lead to improvements in other trusts. It was also considered that there should be more triangulation of evidence to provide more meaningful recommendations.

Participants considered that the well led domain had been concentrated too much at ward level and had been unfairly critical of ward/ED sisters. Trust senior teams had not been given an opportunity to participate.

It was felt that RQIA should ask for a number of corporate documents in advance of the inspection. There was agreement that certain policies and procedures should be readily available at ward level but it was not proportionate for a busy ward/ED sister to find corporate documentation.

All participants considered that unannounced inspections were overwhelming and stressful. It was also difficult to provide suitable staff to attend focus groups at such short notice. Even having 24 hours' notice would be helpful and another suggestion was to carry out focus groups at a different time outside the dates of the inspection.

Participants valued the fact that inspections gathered the views of both patients and relatives and this should continue to be part of the process. With regard to focus groups, some staff were surprised to see that they were quoted in the report even though all quotes were anonymous. It was felt that focus groups should be limited to the areas of inspection and not opened out to the wider hospital.

There was general agreement that the report was too long and repetitive with too many recommendations and there was some confusion as to the status of "housekeeping points". In the future the report should be more high level and have more analysis of information, rather than leaving the reader to draw their own conclusions. It was also felt that reports could be produced more quickly.

Participants agreed that immediate feedback and preliminary findings were valuable. However, during the first round of inspections the immediate feedback seemed to concentrate on many of the positives but the full report was much more negative in tone.

When asked how the process could improve, participants felt that it was too nursing focused and should be more multidisciplinary in nature. Reports should be easier to read and perhaps a short summary leaflet could be provided for each one. It was also felt that perhaps inspection teams could have more relevant expertise for example ED staff being part of the ED inspection.

In conclusion, participants considered that the hospital inspection programme has provided an opportunity to collate findings from across the entire region and identify opportunities for regional improvement. Finally when asked if they had found the process to be useful, all participants agreed that it was and that they had all made changes as a result of findings.

c) Feedback from Peer Reviewers and Areas Subject to Inspection

All peer reviewers who had participated in the inspection process were given an opportunity to complete a post inspection feedback questionnaire which asked a number of questions about the inspection process and the quality of their involvement.

43 out of 53 questionnaires were returned:

- 96% reported that the inspection had been well conducted
- 98% reported that their views and contributions were valued
- 96% reported that overall the inspection was good or very good

Each ward/ED that was subject to inspection was also provided with an opportunity to feedback on the process from their perspective, as the ones being inspected. Twelve questionnaires were returned:

- 100% were very satisfied or satisfied that the inspection team provided clear information about the inspection process
- 100% were very satisfied or satisfied that the inspection team engaged with and took adequate time to speak with staff
- 100% reported that the inspection was well conducted
- 36% reported that the presence of the inspection team had some negative effect on the service being provided
- 92% rated the inspection as being very good or good

d) Feedback from the Patient and Client Council (PCC)

The Patient and Client Council was asked to identify themes arising from its complaints process that would help to identify any gaps in the RQIA inspection process.

1. Complaints Support Service Annual Report 2016/2017

The PCC Complaints Annual Report 2016/2017 provides summary data on complaints support work and on the areas of treatment and care about which people complain.

Inpatient Services are the second most common area of service complained about after Family Practitioner Services. Treatment and care is the most common cause of complaint. Communication, attitude and waiting time complaints while significant are much less frequent.

2. Themes Emerging – Hospital Inpatient Care

Taken from this data – and the more detailed scrutiny of cases the following key themes emerge from complaints about hospital treatment and care:

a. Admission, Discharge and General Wards

It is more likely that complaints will arise in the admission and discharge phases of hospital treatment and care. Accident and Emergency Departments, Medical Assessment Units and General Medical wards generate a greater number of complaints about staff attitude; communication; diagnosis and the overall quality of treatment and care. The impression given by these complaints is of a service under pressure in these areas as regards staffing levels and that this has an impact on attention to basic care and the capacity to maintain good communication with anxious families.

b. Management of Death in Hospital

The management of the end of life in hospital is a key driver for complaints. This involves the unexpected death of a patient rather than the experience of people for whom a well-defined End of Life and Palliative Care plan has been developed (for example – a frail person who contracts an infection in a nursing home for which they are admitted to hospital but then succumb). These complaints are brought by families and while there are sometimes learning points on protocol and procedure, the most common cause of complaint is poor communication and arguably a need for greater support for the relatives of the dying person to understand what Is happening and why. For many families who contact us, the starting point is the suspicion that the service allowed their family to die.

c. Family Support

Complaints brought to the PCC about hospital inpatient treatment are overwhelmingly made by families on behalf of relatives. These will frequently be driven by a need for greater knowledge of what is going on with their relative and about the care plan overall. The management of pain and the management of personal care (especially toileting) are far more likely to give rise to a complaint than the quality of food, ward cleanliness or policies like visiting hours. Families become noticeably more distressed if their relative is in pain or if their dignity is not preserved.

d. Specialist Wards, Treatment and Care

There is a whole other category of complaint that relates to what appears to be pure clinical issues and these will arise in the more specialist areas of care (e.g. cardiology; orthopaedics; oncology and etc.). These complaints focus very much on diagnosis, treatment and care plans and incidents where the service appears to have made a genuine error (for example, injuries to the bowel during surgery). It is difficult to discern any theme to these complaints as the PCC receives a small number of complaints across a wide range of specialties.

It is, however, important to be aware of a qualitative difference between these complaints and those discussed in the preceding paragraphs.

3. Inspections

Taken together, then, the information the PCC derives from its complaints work suggests that the inspection programme might have regard for:

a. Arrangements in place to ensure effective information-sharing with families (e.g. “Consultant of the Day”; “Named Nurse” etc.)
b. Clarity for patients and families on what they should expect from the ward and its staff (e.g.as in the new EDs where there is now a lot of information on how the department works) and possibly what the ward and staff expect from the patient and family
c. Specific arrangements for the care of families whose relative dies in hospital
d. Specific arrangements for family involvement/support in discharge arrangements and identification by the trust of delayed discharges and action plans to address them
e. Possibly compare complaints data; staff to patient ratio; skills mix of staff between specialist treatment wards and general wards used for assessment and discharge planning

PCC was also asked to comment on the RQIA patient questionnaire and changes were made as a result of their input.

5. Proposed Changes to the Process

As a result of the evaluation carried out, and feedback obtained by RQIA a number of changes have been proposed in relation to the next five hospital inspections:

a. It is proposed that the RQIA chief executive and directors of nursing, medicine and social work meet with their trust counterparts on day 2 of the inspection. The results of these discussions will be added to the well led domain adding a more corporate element which will allow an assessment of leadership from ward level through to the senior team and trust board.
b. Inspection tools have been amended to ensure that a comprehensive assessment of each area is completed.
c. Inspection reports will be shorter and contain fewer recommendations. There will be more analysis of information and comparison with best practice to reach more robust conclusions. Housekeeping points will not be used.
d. While keeping junior medical staff as peer reviewers it is hoped to add a number of consultant medical staff. It is also hoped to add more expertise such as ED staff to the peer reviewer group.
e. Trusts have been asked to provide a number of corporate documents in advance of the inspections. This list will then be regularly updated.
f. Focus groups will be targeted at the areas being inspected.
g. A summary leaflet similar to that used for review reports will be produced following each inspection.

The **Regulation** and
Quality Improvement
Authority

The Regulation and Quality Improvement Authority
9th Floor
Riverside Tower
5 Lanyon Place
BELFAST
BT1 3BT

Tel 028 9051 7500
Fax 028 9051 7501
Email info@rqia.org.uk
Web www.rqia.org.uk
@RQIANews