The Regulation and Quality Improvement Authority

Acute Hospital Inspection:
Ulster Hospital 9 – 12 February 2016

Ward 13 Medical
Ward 11 Surgical
Emergency Department

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Assurance, Challenge and Improvement in Health and Social Care

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 four days, from 9 February to 12 February 2016, at the Ulster Hospital. The following areas were inspected:

- Ward 13 Medical
- Ward 11 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 framework 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 the Ulster Hospital focused on discharge 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.

The overall findings of the RQIA inspection found that improvements including nurse staffing levels, staff attendance at training and completion of documentation was required in all areas. These matters were brought to the attention of those with responsibility for oversight of the services.

This report makes a number of recommendations in areas 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 South Eastern Health and Social Care Trust (South Eastern Trust), as a vehicle to promote and facilitate further improvements in service delivery.

Senior staff from the trust advised that all areas were particularly busy prior to and during the period of inspection.

We recognise that this increase in the activity placed additional pressure on staff in ensuring the provision of effective care for patients. However, it is vitally important that safe and effective care continues to be delivered at these times of pressure.

Ward 13 Medical

Is the Area Well Led?

Ward 13 is a general medical respiratory ward. Throughout the inspection, we identified a number of areas for improvement in the systems and processes which impact on the delivery of care in the ward. Improvement is required to support and ensure effective leadership is displayed and the clinical area is managed and organised.

Staff told us communication of information to them was not always effective. Overall staff reported that morale was low. Nursing staff informed us they were supported by the band 7 sister; however told us there was a lack of support from directorate senior management. We found issues including lack of nursing supervision, delayed patient discharge, poor patient flow, undesignated 'corridor' beds, inadequate staffing levels, and the lack of senior clinical decision makers. This lack of senior clinical decision makers affected the running of the ward. We were informed that the number of junior medical staff is insufficient, particularly at weekends and at nights.

Staffing levels and clerical support for the ward sister, to enable her to meet the managerial requirements of the ward need to improve. Staff supervision, appraisal and training records indicate that staff attendance at mandatory training and additional role specific training requires improvement. We were told that by nursing staff on the ward the availability of allied health professionals (AHPs) physiotherapy, occupational health, speech therapy, social work and on occasions medical review was not timely. Staff knowledge of safeguarding of children requires improvement.

We observed the use of an undesignated or 'corridor' bed. This is a bed placed in the ward corridor. The bed has a portable privacy screen, bedside table and chair. There is no nurse call bell, light, suction point or piped gases available (cylinder supply only). The patient condition is risk assessed prior to placement in this bed. We were advised by staff that this bed is permanently in use.

Staff have access to a range of policies and procedures. We were advised that specialist nurses who attend the ward are invaluable in providing advice and guidance on the care delivered to patients. Patient experience data is captured in the form of an inpatient user satisfaction survey.

Is Care Safe?

Staff maintained visual contact with patients who required supervision. All single rooms have a clinical hand wash sink, promoting good infection control practices and minimum noise level.

A falls safe bundle is in place and documentation for Venous Thromboembolism (VTE) risk assessments was complete. Theoretical training and assessment on Haemoviligence has been carried out. Staff reported that they can raise concerns with their direct line manager.

The environment was cluttered, with potential trip and fall hazards from equipment. The emergency exists were blocked by a 'corridor bed' and the stairwell was blocked by abandoned storage cages. We observed that due to the busy nature of the ward, patient monitoring equipment alarms were not always audible.

The ward environment has not had an assessment for dementia patients. Ward risk assessments were out of date for example Control of Substances Hazardous to Health (COSHH) assessments were dated December 2014. Patient equipment and horizontal surfaces were dusty and required cleaning; gaps were noted in cleaning schedules.

We observed that overall staff carried out hand hygiene in line with best practice. However, not all staff complied with trust policies in relation to uniform, use of gloves and aseptic non-touch technique. Visual infusion phlebitis (VIP) charts to record the management of peripheral venous cannula and National Early Warning Scores (NEWS) observation charts were not always in place. A Sepsis Six care bundle is in place for the recognition and timely management of sepsis. There is no information available on the ward for patients or visitors on who to contact for advice on safeguarding issue.

Immediate action is required to improve medicines management within the ward. All staff require an immediate update on their role and responsibility in the safe storage, security, administration, prescribing and documentation of medication.

Is Care Effective?

Patients reported they were comfortable, pain and pressure relieving measures were available and in place. Staff responded promptly to patients' requests for pain relief. However, we were informed by nursing staff that the availability of junior medical staff to prescribe medication during the night can be an issue, as they cover many clinical areas. Staff provided patients with assistance to promote continence and care for incontinence. Specialist nurse advice was available.

Six of the six nursing care records we assessed were not up to date and did not always reflect the nursing assessment or the care required for the patient. There was no evidence to demonstrate assessment, planning, evaluation and monitoring of the patient's needs.

Nurse record keeping did not always adhere to Northern Ireland Practice and Education Council (NIPEC) guidelines. Patient details such as healthcare numbers were not always recorded on documentation. Medical records were at times difficult to read and inconsistently organised.

The system in place from delivery to service of patients' meals does not ensure nutrition and hydration needs are met. A senior nurse did not take the lead role in supervising and co-ordinating meal service.

Effective mechanisms were not in place to identify and ensure patients receive the appropriate assistance during meal times.

Gaps were noted in the completion of the intentional care rounding and surface, keep moving, incontinence, nutrition (SKIN) care bundle in place for patients deemed 'at risk' of pressure damage.

Is Care Compassionate?

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

Overall, patients' privacy and dignity was maintained when staff were delivering care. Patient call bells were accessible and on the majority of occasions answered promptly. Staff were knowledgeable regarding facilities and information for end of life care.

However, the use of a 'corridor bed' and lack of available services and facilities raises issues of privacy, dignity, assistance, noise and continual interruption for patients.

The ward was on many occasions throughout the inspection disorganised, with no apparent routine. This was exacerbated by space constraints, the busy ward activity and large footfall through the ward. There is no enforced patient rest period. The ward is old therefore space in bed bays and between beds is insufficient. There is no quiet room on the ward for private conversation with patients and relatives.

We observed that staff did not always communicate with patients in a way that ensured patient privacy. We heard staff calling to patients from across the ward and outside bays. There is no information leaflet rack to display leaflets.

Patients and relatives reported they were happy with the care they or their relative had received, however they told us communication, privacy and the use of 'corridor' beds can be a problem.

There was good signage to direct visitors. Staff had access to aids and services for patients with language barriers. Patient healthcare records confidentiality was maintained.

Ward 11 Surgical

Is the Area Well Led?

Throughout the inspection, we observed a ward sister who demonstrated good clinical leadership. Normative staffing levels have allowed the ward sister to be supervisory; however, limitations in ward staffing levels have meant that the sister has had to take a more active role in direct patient care. This has made it difficult for the ward sister to balance ward managerial duties with providing effective clinical leadership.

Staff informed us that they were kept up to date with learning from incidents and complaints. They also reported that they felt supported and valued by the ward sister and the directorate's management team and empowered to raise any concerns when appropriate. Staff reported that although morale is good many staff have been upset by the decision to close the ward. There was good support on the ward from a range of allied health professionals although it was reported that the new social work referral system was delaying patient review.

Ward rounds were scheduled to facilitate early transfer or discharge. We observed that nursing staff were in attendance on all ward rounds which is essential in ensuring patients receive and understand all the relevant information about their care.

There were a number of methods used to disseminate information to staff such as handovers, displayed notices, email etc.

Information provided indicated that staff meetings were infrequent and safety briefs lacked a clear structure. Ward performance is monitored using a range of audits against key performance indicators (KPI). We observed charts highlighting ongoing improvements in compliance with KPIs.

A number of staff reported that current staffing levels are a concern. Information provided indicated that the ward is funded for 27.92 WTE nursing staff. Currently 18.39 WTE nursing staff are in post, a deficit of 9.53 WTE. Retention and recruitment of staff had been an issue since the decision was made to close the ward. We were informed that senior managers had been proactive in attempting to recruit staff. Records indicated that improvement is required in the management of staff appraisals, supervision and attendance at mandatory training. We were informed that it has been difficult to free staff up to attend sessions because of staffing pressures.

There were systems in place to protect patients from the risk of abuse and to maintain their safety, in line with current best practice guidelines. Results of the Patient and Client Experience Standards survey indicated that patients were satisfied with the care they had received on the ward.

Is Care Safe?

The fixtures and fittings of the ward were old, however maintained to a reasonable standard. Due to limited ward storage capacity, large items of equipment which may present a trip hazard were stored along its central corridor. We observed that the corridor bed was placed in very close proximity to the emergency exit doors which compromises this evacuation route. Fire safety and life support training were part of the ward staff mandatory training programme. Emergency equipment on the resuscitation trolley was easily accessible; however checks of the emergency equipment were inconsistent.

We observed that limited adaptations were in place to meet the needs of patients with a physical disability and those patients with dementia.

Piped oxygen and suction is not available at all bedsides. Known hazards in the ward environment had been risk assessed and preventive actions have been implemented. Adherence to infection prevention and control practices required improvement. Not all staff complied with the trust policy in the use of personal protective equipment. Notable gaps were observed in equipment cleaning schedules.

NEWS were completed within set timescales and there was an appropriate clinical response to triggers. The Sepsis Six bundle should be introduced for the early recognition and management of sepsis.

Medicine cupboards and trolleys were disorganised and medicines were not stored in an easily retrievable fashion. A number of medicines were removed from stock by inspectors as they had passed the date of expiry. The dedicated medicine preparation area is located in the middle of the ward leading to unnecessary interruptions. An integrated medicines management service was not being provided. Medicine kardexes were not always fully completed. Patients told us they that they were involved in the decisions about their medicines for example changes in medication doses.

Is Care Effective?

The nursing care records of three patients were reviewed during the inspection. We found that the nursing assessments and risk assessments were not always completed. Where care plans were in place, they did not always reflect the issues identified within the nursing assessment. Nursing care records did not always adhere to Nursing and Midwifery Council (NMC) standards of documentation.

Medical records were well organised and easy to use.

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. We observed that the serving and coordination of meals was carried out by healthcare assistants; with minimal input from Registered nurses (RNs). We observed that fluid balance and food charts were not always reconciled. Meals were also not always served at standard mealtimes; the lunch meal was served to patients at 11.40am.

Patients reported to inspectors that they were comfortable and adequate pain relieving comfort measures were available. Patients reported that staff responded promptly to requests for pain relief.

Staff were knowledgeable in regard to pressure ulcer care and could avail of adequate support and resources for patients with pressure ulcers. We observed that a patient at risk of pressure damage did not receive nutritional supplements as prescribed. 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 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. We observed prompt responses to call bells. Not all ward staff were easily identified as they did not have name badges.

Staff endeavoured to maintain the dignity and privacy of patients; however ward facilities made this challenging. We observed that there was no changing room available for day surgery patients, patients changed into a hospital gowns in ward toilets. Theatre gowns did not always adequately cover the patient which compromised dignity and privacy. We observed that same sex accommodation in patient bays was not being achieved. There were limited washing, toileting facilities in the ward and there were no changing facilities available for day surgery patients. A corridor bed was observed within the ward which is used when there are bed pressures within the trust. Although not in use during the inspection we were informed that it is frequently used. Staff reported that it presents a significant challenge to maintaining the privacy and dignity of patients. Patients who are placed in this bed are in full view of passing corridor traffic from the adjoining ward.

An adapted form of intentional care rounding was in place (SKIN Bundle) which is aimed to ensure that nursing staff carry out scheduled tasks or observations for patients, to meet and anticipate their fundamental care needs. We observed that for some patients the bundle interventions were not always documented as completed. Compliance with the SKIN bundle is assessed as an element of the ward KPI audit programme.

There was no quiet room available for private conversation with patients and relatives; however during ward rounds we observed that staff endeavoured to speak with discretion. Staff had access to aids and services for patients with language barriers.

Staff were knowledgeable in relation to the management of patients at the end of their life and some staff had received additional palliative care training.

Patients and relatives we spoke with were mainly positive about the care they received.

Emergency Department

Is the Area Well Led?

The ED at the Ulster Hospital is a busy type 1 Emergency Department. Throughout the inspection, we observed that staff worked diligently to manage the flow of patients through the department.

At busy times nurse staffing levels were concerning, with areas within the department not staffed adequately to ensure appropriate patient care. During day two, we found that the night shift designated leader was a senior band 5 RN.

The trust has been active in the recruitment of nursing staff for the ED. Although a positive step, it has presented challenges in managing nursing staff skill mix within the department. Funding for additional staff has been agreed.

Staff raised concerns over issues including crowding; staffing levels; having the relevant clinical skills; workload; and patient privacy and dignity. It is of note, that despite the crowding and number of additional patients, the atmosphere within the ED was one of calm.

We did not observe any walk rounds by senior nursing and medical staff, particularly during times of escalation. Throughout the inspection, staff reported that morale was low. The majority of staff we spoke reported that they were not supported and valued by the directorate senior management and there was a delay in response to raised concerns.

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

Nurse staff training was not up to date. We were advised that this was a result of nursing vacancies. The trust has recently appointed a clinical educator for the ED. Additional training sessions have been facilitated. The clinical educator will support newly appointed staff and the ED sisters in ensuring mandatory and role specific additional training needs are being met.

Nursing quality performance indicators, to monitor and improve patient care, were not being implemented within the main ED. The Department of Health (DoH) four and 12 hour targets were on many occasions not being achieved.

ED medical cover is good, with medical staff feeling supported. The ED is participating in the Public Health Agency's (PHA) 10,000 voices patient experience initiative.

Is Care Safe?

The environment was clean and bright. During times of increased patient numbers, insufficient staffing levels affected observation of patients throughout the department, especially in ambulance triage and resuscitation. Crowding and limited space in the ambulance triage area, resuscitation area and majors is an issue. We observed that the majors area when crowded presents a challenge for staff if they have to manoeuvre resuscitation equipment in the event of an emergency.

We observed that not all staff adhered to best practice infection prevention and control guidelines for hand hygiene, aseptic non-touch technique (ANTT) and the use of personal protective equipment.

Patient early warning scores, to detect deterioration in a patient's condition, were not always totalled, completed within the set timescales and escalation actions taken were not always recorded. Where risk is identified the falls safe care bundle should be implemented.

We were told that during times of increased patient numbers, additional essential patient equipment was not available. Designated rooms to care for vulnerable patients, for example those presenting with mental ill health or self-harm, could not be guaranteed. We observed patient flow through the ED was delayed on many occasions. Routine safety rounds and patient reviews were not carried out.

Recommendations from audits of ED clinical standards were actioned and learning was cascaded to staff.

We observed the administration of medicines in line with NMC guidance. An integrated medicines management service should be provided to assist with the discharge process.

Safeguarding information and support was available for staff, patients and family/carers.

Is Care Effective?

Nursing and medical documentation was reviewed throughout the ED. In the 25 nursing records reviewed, nursing assessment, risk assessments, care plans and charts were not fully completed, up to date, reviewed regularly or in line with NMC best practice guidelines.

A review of the Observation Ward's Admission Assessment Booklet demonstrated it had not been completed for any patient.

There was good evidence of appropriate multi-disciplinary team (MDT) referrals. Documentation reviewed did not evidence that patients and relatives were routinely involved in planning patient care.

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

A retrospective review of documentation demonstrated that patients attending triage were assessed for pain; however there was variation in the recording of pain scores. A Braden risk assessment tool, for predicting pressure ulcer risk, was not completed for patients at risk.

Medical records were well completed. At the time of inspection patients reported to be 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.

A new SKIN care bundle had been developed for use in ED. However there was little evidence in the documentation we reviewed of its use. Documentation in relation to urinary catheter care and food charts needs to be improved.

Is Care Compassionate?

The first impressions of the emergency department were positive. The department was bright and welcoming and there was good signage to direct visitors to the many areas of this large department. A rolling information board was in place for the public. Staff had access to aids and services for patients with language barriers. Facilities and information were available for bereaved families.

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

At busy times, patients' privacy and dignity could not be guaranteed. Staff reported they found it extremely difficult to meet patients' care needs and be discreet when communicating.

Patients waiting on trolleys around the central work stations reported that they found it difficult to summons assistance for personal care needs. Patients did not have access to a nurse call bell in the central area. Nurse call bells were not always positioned within patients' reach.

Patients and relatives were happy with the care that they or their relative had received; however they reported concern about waiting times, communication, staff shortages, and patient placement. There were positive comments from patients and relatives regarding the ED.

Focus Groups

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

- nursing staff
- allied health professionals
- 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; however had reservations about patients waiting on trolleys for long periods. We were informed that the trust strives to build a culture which encourages staff to be able to raise issues.

Staff told us they are concerned about staffing levels and fulfilling the demands of their service. However, they also identified areas were service improvement work has been carried out in for example radiology.

Discharge

The inspection identified several trust and ward based initiatives ongoing to improve both the process and quality of discharge. These included a discharge lounge operating Monday to Friday 9.00am to 5.00pm, realignment of staff and services at weekends and peak periods and an observation and ambulatory ward in the ED to prevent unnecessary admissions or provide rapid patient turnaround.

Challenges identified around discharge include: junior doctor staffing levels to complete timely and accurate discharge documentation, patients waiting for specialist multidisciplinary assessment and social care needs and a new social work referral system which had unintentionally contributed to delay assessments.

Conclusion

The RQIA inspection under the new programme for acute hospitals took place in three clinical areas of the Ulster Hospital.

The inspection team found that improvements including nurse staffing levels, staff attendance at training and completion of documentation was required in all areas.

The focus groups highlighted some trust wide and regional issues, whilst the discharge theme identified both ward-based initiatives to improve the process and quality of discharge and constraints to effective discharge.

Following the inspection, the South Eastern Trust received feedback on the findings to facilitate early action against identified areas for improvement.

Following publication of the report the South Eastern Trust should complete a quality improvement plan within four weeks, to set out how the recommendations from 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 South Eastern Trust for their assistance during this inspection.

1.0 Introduction

The aim of the Acute Hospital Inspection Programme is to:

- provide public assurance that services are safe and effective, 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?

This 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 [1]Inspection 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

[1] http://www.nursingtimes.net/nursing-practice/specialisms/wound-care/what-is-the-sskin-care-bundle/5076722.article

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

The inspection framework draws from a range of sources, including 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 Ulster Hospital and where appropriate, across the trust.

2.0 Background Information on the South Eastern Health and Social Care Trust and Ulster Hospital

Ulster Hospital

The Ulster Hospital is the major acute hospital for the South Eastern Trust delivering a full range of acute services. This includes a type 1 Emergency Department which is open 24/7, a comprehensive range of diagnostic services, the full range of outpatient, inpatient and daycase medical and surgical services, cancer care, coronary care, obstetrics and paediatric services. The regional Plastic and Maxillo-Facial services are mainly delivered from the Ulster site.

The South Eastern Trust Annual Quality Report for 2014-15 centres on five key themes. These are:

- effective health and social care
- delivering best practice in safe health and social care settings
- protecting people from avoidable harm
- ensuring people have positive experiences of service
- resilient staff

The South Eastern Trust Corporate Plan for 2016-17 center's on the themes:

- safety, quality and experience
- access
- health and well-being
- efficiency and service reform
- our staff
- stakeholder engagement

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 trust winter planning strategy is managed and implemented under trust governance arrangements with oversight from an Unscheduled Care Board. Over the last year, the trust has been in constant communication with the Health and Social Care Board (HSC Board) regarding the shortfall of acute bed capacity at the Ulster Hospital and the impact of winter pressures. These discussions are constantly informing strategy and operational implementation. The trust is identifying and implementing areas for reform and improvement within Unscheduled Care Services, particularly in times of pressure (not just winter periods).

Listed below are the winter planning areas of focus:

1. open beds in Lagan Valley Hospital
2. additional Consultant PAs across medicine
3. additional Junior Doctor Cover
4. Accidents and Emergency (A&E) OOH Consultant cover until January 2016
5. pharmacy support
6. phlebotomy Services to ED and Cardiology
7. Frail Elderly Assessment Unit Pilot in Downe Hospital
8. additional theatre lists - emergency cholesectomy service

Primary Care and Community

1. Discharge Hub Weekend Cover to provide 7 day service
2. Domiciliary Care
3. additional support for Domnall IS beds
4. additional Nursing Home beds

With a second tranche of winter planning funding available, the trust again focused on the implementation of practical solutions for pressures within the remainder of the winter period (until 31 March 2016). The areas below were:

1. Physiotherapy - discharge to assess service
2. Physiotherapy - expand seven day service to surgical wards and ICU
3. Deep cleaning at Ulster Hospital, Lagan Valley Hospital and Downe Hospital
4. clinical staff - Locums times three and Junior Medical
5. Mental Health Home treatment Practitioner and ED support
6. Echo - additional resource at weekends
7. additional ward workforce - Surgical (including clerical, nursing support)
8. additional nursing workforce - Medical (including clerical and nursing support)
9. vocera communicator for ED (revenue only)
10. additional IS domiciliary care capacity
11. Expeditor for South Eastern Trust patients in Belfast Health and Social Care Trust (Belfast Trust) for three months
12. three additional temporary Hospital Social Work staff for three months
13. additional interim block purchase beds
14. discharge dispensing service provided on a Sunday using staff volunteers

Safety, Quality and Experience

The South Eastern Trust has placed improving safety, quality and the patient/client experience (SQE) as the priority corporate objective for 2011-15.

What this means:

- Assuring Safety: avoiding and preventing harm to patients and clients from the care, treatment and support that is intended to help them.

- Improving Quality: involves monitoring and use of deliberate and defined improvement processes focused on efficiency, effectiveness, performance, accountability and outcomes, which improve the health and social care of the individuals and communities we serve.

- Testing the Experience of the Patient/Client: recognising that patients and clients have a right to experience respectful and professional care, in a considerate and supportive environment, where their privacy is protected and dignity maintained. We recognise that staff working closely with patients/clients, are well placed to identify priority local objectives/metrics which provide the most rigorous indication of performance against SQE.

- South Eastern Trust SQE approach provides clear fundamental standards, driven by the interests of patients, and devised by clinicians; delivering a “bottom up” as opposed to a “top down” system to assuring safety, quality and positive experience.

Information on areas of service delivery and improvement are detailed in the trust Annual Quality Report.

In 2014-15 work included:

- research and audit
- social care indicators – protecting children at risk, adult safeguarding
- cardiac arrest rates – reducing hospital cardiac arrests
- reducing Healthcare Associated Infections (HCAI)
- Medication Safety – omitted medicines, medicines reconciliation
- adverse incidents – resulting in reduction of harm
- complaints and compliments – lessons learnt
- Patient Client experience standards – patient and client satisfaction
- ED – four and 12 hour standard
- staff achievements, improving attendance at work
- looking after staff
- staff support and development – staff training, continued professional development

Inspection Findings:
Ward 13 Medical Ward

3.0 Inspection Team Findings: Ward 13 Medical Ward

Ward 13 is a 20 bed general medical respiratory ward. The ward consists of two six bedded bays, one four bedded bay and four side rooms, two with sanitary facilities. During times of extreme pressure within the trust the ward will open a corridor bed, increasing its bed occupancy to 21. We were advised that when the trust's full escalation plan in initiated, two undesignated corridor beds can be opened.

3.1 Is the Area Well Led?

Governance

On day one of the inspection, the band 6 nurse in charge had a rostered ward management day; however we were advised that due to staff shortages was working on the floor as part of the ward staffing numbers, managing both staffing and ward operational issues. On day two of the inspection, the band 7 sister was on duty, rostered as a management day. We were informed that management days are deemed supernumerary.

We observed a busy ward with admissions and discharges and high dependency patients. We noted that the ward sister was not always easily identifiable or visible on the ward to support ward activities.

The band 6 nurse takes charge of the ward in the absence of the band 7 sister. The nurse in charge wears a red 'nurse in charge' badge to indicate their position; however this was not always worn. A blue uniform indicates the designation of band 7 sister but the band 6 nurse in charge is not easily identifiable by uniform. We were informed that the trust plans to change staff uniform, making the nurse in charge more identifiable.

Recommendation: A senior nurse presence should be evident on each shift. The senior nurse should be visible and identifiable.

Housekeeping Point: The 'nurse in charge' badge should be worn at all times.

Staff have access, via the trust intranet HUB, to a range of policies and procedures. We observed that some policies and procedures required review or further development and these included deprivation of liberties and falls reduction. The trust was aware and had a plan to carry this out. Minutes of the of the medical directorate ward manager meetings demonstrated that complaints are discussed. Common themes highlighted from past directorate complaints include; communication and miscommunication, attitude of staff and visibility of medical and senior staff at ward level. The ward sister responds to complaints.

Minutes identified that ward sisters required feedback from senior staff on the effectiveness of their responses to complaints. This was being addressed by senior staff.

We were advised that due to insufficient staffing levels the last ward staff meeting was held in November 2014; a ward communication book is in place. Unless immediate action is required by staff in response to a complaint, there is no mechanism in place for ward staff to learn from ward complaints. We were informed that issues identified on the risk register included; use of non-designated beds, nursing vacancies and trache patients.

Recommendation: Regular ward staff meeting should be scheduled. Staff meetings should have a standard agenda.

Staff were aware of the process for reporting Serious Adverse Incidents (SAIs), incidents and near misses. Staff informed us that they were not aware of a formal analysis of trends. On discussion, staff told us that they were not always updated on the outcome of incidents and investigations, *'it's just another piece of paper'*. There was no evidence of dissemination of this information.

Recommendation: The trust should ensure that formal analysis of SAIs, incident, near misses and complaints is conducted and shared with staff.

The trust has morbidity and mortality meetings to review deaths as part of professional learning. The ward sister does not attend or receive feedback from these meetings for learning. Locally, the ward sister, consultant and members of the multidisciplinary team, including occupational therapist and social worker when available, meet weekly to develop patients' care plans and to review patient care and morbidity and mortality at ward level.

Information on ward cardiac arrest rates and performance in HCAIs is not displayed and staff were not aware of this.

Recommendation: Communication with staff should be improved to ensure learning in relation to complaints, SAIs, incidents, investigations, morbidity and mortality, cardiac arrest rates and HCAIs.

Staffing and Supervision

We were informed that the band 7 sister does not currently have sufficient time to both undertake managerial duties and provide effective clinical leadership.

The ward housekeeper who assists the ward sister with administrative duties is on maternity leave. There is no system in place to replace this role. This should be reviewed and assistance provided. The senior nurse completes the on-line human resources, payroll, travel and subsistence computer system (HRPTS) as part of her administrative duties.

On review of the ward work roster, the ward sister's duty includes a number of managerial sessions and at other times the role should be to provide clinical leadership for ward staff. We were informed and the roster showed that the ward sister has been regularly rostered and counted in the ward staff complement since August 2015.

We were informed by staff that the ward manager was not always present on the ward to provide clinical leadership. We understand the need for ward managerial time in order for the ward sister to fulfil their role; however at all other times a supervisory element and presence at ward level is essential to support all ward staff and provide clinical leadership; we observed that at times this was not evident.

Recommendation: Ward sisters should provide visible and robust clinical leadership for ward staff.

There is one band 7 sister and one band 6 sister for the ward. We were told that staff retention is an issue. Between January 2015 and January 2016, 10 staff have left the ward; seven staff were subsequently replaced and of these seven, three are now leaving. Staff advised us that they are leaving the ward for reasons such as shift patterns, acuity of patients and car parking cost. Exit interviews are not carried out. We were informed that the nursing normative staffing review was completed in March 2015. There are currently five RN WTE posts in the recruitment process. The ward sister is aware of one post being filled. The ward has two RN WTE on sick leave and nine per cent overall sick leave.

We were informed by senior management that the trust has been proactive in attempting to recruit staff regionally and nationally. However, a national shortage of band 5 nurse has made this very challenging and consideration is being given to the recruitment of foreign nurses to fill the shortfall.

We were told that staffing levels are reviewed and supplemented, with a high reliance on the use of bank and agency nurses; however shifts are not always filled. We were advised of occasions when band 5 nursing shifts are filled by healthcare assistants. We were told that student nurses can indirectly be rostered to cover vacant shifts. Beds are not closed due to staff shortages.

Housekeeping Point: Student nurses should not be rostered to cover vacant shifts.

Discussion and observation identified that due to retention and recruitment problems, sickness, and high ward activity, staffing within the ward during the inspection was insufficient to meet the ward needs.

The band 6 nurse supports the ward sister by carrying out clinical duties. Experienced ward nursing staff take on the role of mentors and preceptors; however, due to experienced staff leaving, there are only three mentors, two of which are undertaking mentorship training. Information supplied during the inspection identifies that staff supervision and appraisal are not up to date.

Recommendation: All staff supervision and appraisal should be up to date.

Currently there are no link nurses for diabetes and manual handling; however we were advised that they are being appointed.

Overall, staff advised us that morale was low. Staff identified patient care as being at the centre of their work. However, they expressed frustration about their current working environment, at times each other, and also the lack of support provided through the trust senior management structure. Nursing staff reported that the band 7, only experienced and understood the pressures they were under when working on the floor. We found that staff identified issues including: lack of nursing supervision, delayed patient discharge, patient flow, undesignated 'corridor' beds, staffing, and the lack of senior clinical decision makers. This lack of senior clinical decision makers affected the running of the ward. These are issues we identified during the inspection. Staff told us they were not working outside their ability.

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

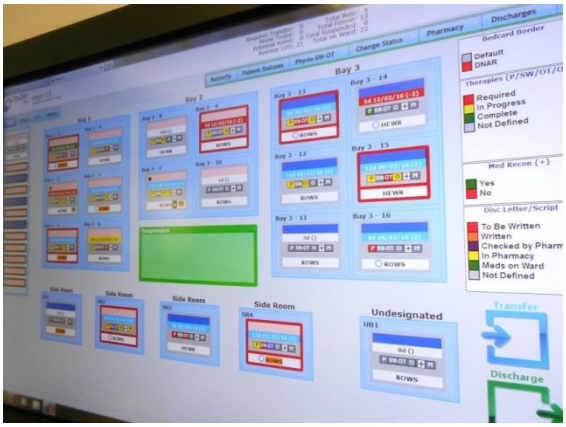
Nursing staff informed us that they feel safe as each bed bay and room has a call bell. However, ward doors cannot be locked at night. Staff told us that security staff are quite quick to respond to incidents but they operate a 'hands off' approach to situations. Some staff have attended management of actual or potential aggression (MAPA) training.

Nursing staff told us that the number of junior medical staff is insufficient to cover all medical and outlier wards. They told us junior medical staff do not always get to participate on ward rounds and are '*up to their eyes all the time'*. We were told that there is limited Foundation Year 1 (FY1) House Officer Coverage at weekends and at nights. The limited FY1 coverage leads to delays in the timely completion of discharge letters.

Recommendation: Nursing and junior medical staffing levels should be reviewed and improved.

We were told that there is a lack of AHP staff across the site.

We were told there are no AHPs assigned to the ward and referrals are made via the ward electronic board (Picture 1) or by phone Monday to Friday, 9.00am to 5.00pm. On call services are available. We were told physiotherapy services are available at weekends and patients with respiratory conditions are prioritised. Occupational therapists provide a targeted seven day week service. The ward has recently obtained a ward based pharmacist.



Picture 1: Electronic board

We were told that by nursing staff on the ward the availability of AHPs physiotherapy, occupational health, speech therapy, social work and on occasions medical review was not timely. We were advised by nursing staff that AHP staff prioritise discharge planning rather than patient rehabilitation. Nursing staff told us that timely and earlier intervention from these services would assist with patient recovery.

A designated social worker visits the ward Monday to Friday. We were informed that the timing of this visit does not always facilitate the implementation of decisions made during ward rounds. A social worker is available on call 24 hours a day, seven days a week.

Recommendation: Access to physiotherapy, occupational health, speech therapy and social work should be improved to ensure timely intervention.

We were advised that specialist respiratory, oncology and palliative nurses who attend the ward are invaluable, providing advice and guidance in the care delivered to patients.

Staff Training

Staff have received induction training to meet the needs of their role. Nursing staff complete a one day trust corporate induction and two day nursing and midwifery induction. Band 2 staff new starts receive a one day trust corporate induction and a one week induction. Staff receive a six months ward based induction for the first two weeks of which they are supernumerary. At present, there are two new staff on the preceptorship programme.

A range of mandatory and additional trust based training and external specialist practice courses is available for staff e.g. infection prevention and control, moving and handling, safeguarding adult and children, tracheostomy care and chest drain management. We were told that staff training figures were not up to date to indicate staff attendance at mandatory training. We were advised that attendance could be improved. Staff can attend additional role specific training.

Recommendation: All staff mandatory training should be up to date. Training records should be up to date.

Patient Flow

All oncoming nursing staff attend a handover at 7.30am or 8.00pm. We observed the nursing handover to be well led, informative, focused and structured. Handover information was in the form of a verbal report, with staff hand writing on standard handover sheets. Following this, the ward sister completes a safety briefing proforma.

We were told that the ward sister, or if unavailable, a designated ward nurse should participate in medical ward rounds. We were advised that this does not always occur due to the busy ward and lack of nursing staff. We were informed that senior medical staff will update the nurse in charge of changes in patient care, via the electronic ward board. We were advised by nursing staff that communication between junior medical staff and nursing could be improved in relation to the plan of care for patients. The ward sister updates all staff on the outcome of ward rounds.

There are two ward based medical consultants, who rotate as consultant of the week. There are two daily medical ward rounds, however we were advised by nursing staff that timely access to a senior decision maker can sometimes be an issue as consultants may not get to the ward until the afternoon due to clinics. Staff reported that medical staff will review patients in the morning, however senior staff may be in clinic and unable to review patients until the afternoon, affecting patient treatment and possible discharge. Both doctors in training and nursing staff mentioned the usefulness of the shorter board rounds that also occur each day.

We were advised that patient discharge from the ward is affected by issues including ; the lack of senior decision makers, time waiting for prescriptions to be dispensed by pharmacy, availability of junior medical staff for timely completion of discharge letters, availability of AHPs and timely care packages. Patients waiting for prescriptions could use the discharge lounge; however they require a discharge prescription letter before accessing. We were informed that on occasions, junior medical staff work over their hours to complete patient discharge letters but are often writing letters for patients they have had no medical contact with.

The trust has implemented a number of initiatives to expedite patient discharge:

- discharge lounge in Ward 25 – opened Monday to Friday, 9.00am to 5.00pm – requires a discharge prescription to be in pharmacy before accessing
- weekends – extra occupational therapy/physiotherapy staff on duty to expedite discharge

- pharmacy – plan to extend their opening hours on Saturday from 8.30am - 4.30pm to increase the capacity to supply discharge prescriptions. Additional resources are required to allow a Sunday service to be provided.

During the inspection we observed the use of an undesignated or 'corridor' bed (Picture 2). This is a bed placed in the ward corridor, backed onto an emergency exit and looking sideways into two single rooms. The bed has a portable privacy screen, bedside table and chair. There is no nurse call bell, light, suction point or piped gases available (cylinder supply only). We were advised that patients are risk assessed and deemed suitable for placement in this bed by the emergency department medical staff and patient flow co-ordinator. We were advised that this is permanently in use. On discussion with the band 7, we identified that ward staff can disagree with the risk assessment and decision to place some patients in this bed.

Picture 2: Undesignated 'corridor bed'

We were advised that there are occasions that, when the trust initiates its full escalation plan two 'corridor beds' are in use, placed at either end of the ward. Privacy and dignity issues related to the use of these beds will be discussed within the compassionate section of this report.

Recommendation: Systems and processes that affect patient flow, bed capacity and discharge throughout the ward should be reviewed and improved.

Recommendation: Work towards phasing out the use of corridor beds.

Housekeeping Point: Communication should be improved between medical and nursing staff.

Staff were unaware of the trust reablement service to help people who have experienced deterioration in their health and/or have increased support needs to relearn the skills required to keep them safe and independent at home.

Housekeeping Point: Staff should be familiar with reablement.

Communication

We were informed that communication and dissemination of information to staff is through various formats such as handovers, communication book, notices and email access for all staff. As previously mentioned, the last ward staff meeting was in November 2014.

There is no standard agenda to ensure continuity of information shared with staff. Staff advised that they have no time to access their emails.

We observed that a daily safety briefing is in place. However, this is just a proforma where the number of patients with a specific condition is recorded, for example, the number of confused patients or patients with infection. The current system is not used to communicate information to staff or identify safety issues such as; staffing levels, incidents and equipment. The use of a safety briefing is a positive way of communicating information to staff and can be repeated for day and night staff to ensure all staff receive necessary information.

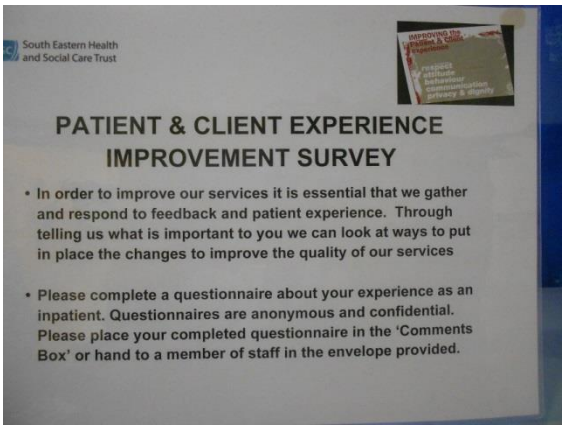
As previously outlined, some information including learning from a number of sources has not filtered through to staff. Channels to ensure effective communication and dissemination of information should be further developed and improved.

Recommendation: The use and format of safety briefings should be reviewed and improved.

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

We reviewed documentation on audits of practice carried out against a range of performance indicators which includes; environmental cleanliness, hand hygiene and preventing pressure ulcers. However, results are not displayed at the ward entrance for patients, visitors and staff to view. Action plans were not developed and further audits were not carried out in cases where the need for improvement was required. For example an environmental cleanliness audit on 20 January 2016 achieved 82 per cent compliance and this had not been re-audited. In November and December 2015, compliance with the SKIN bundle was 40 per cent and in January 2015 50 per cent; frequency of audit was not increased to improve practice.

Patient experience data is captured in the form of an inpatient user satisfaction survey (Picture 3). Questionnaires are issued to patients on discharge from the ward, with a freepost return envelope to encourage response. The last ward survey report was compiled in October 2015, covering the period May to September 2015. The response rate was 14 per cent. Overall respondents were positive about their experience on the ward. We observed information displayed on ward user satisfaction surveys was not up to date.



Picture 3: Patient survey

Housekeeping Point: Following audit action plans should be developed where improvement is required.

Housekeeping Point: Audit information should be displayed and up to date.

Safeguarding

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

We were informed that neither the ward sister nor other ward staff have been involved in Best Interest Case Conferences.

We were informed that the ward has the potential to admit children. In a case of suspected child abuse, staff questioned were not aware that the consultant paediatrician is called immediately and child protection procedures commenced. Staff questioned were not aware that additional safeguards are required for children, including contribution to Understanding the Needs of Children in Northern Ireland (UNOCINI) assessment.

Recommendation: All staff should receive training on safeguarding of children.

3.2 Is Care Safe?

Environmental Safety

We observed that the environment was cluttered, with potential trip and fall hazards from equipment stored in corridors and around the nurses' station. The emergency exits were blocked by a 'corridor bed' and the stairwell was blocked by abandoned storage cages. Overall, ward supplies were locked in stores, not accessible to the public.

With the exception of the ‘corridor bed’, individual lighting at the bedside was available and sufficient for nurses attending to patient care needs. Nursing staff maintained visual contact with patients who required supervision by placing them in the bed bay bedside the nurses’ station.

Recommendation: A space utilisation review and productive ward project should be carried out. Emergency exits should be easily accessible at all times.

We observed that due to the busy nature of the ward, patient monitoring equipment alarms were not always audible. Ward staffing levels affect staff hearing and responding appropriately to alarms.

We observed gaps in the ward resuscitation trolley daily records, and the trolley required cleaning. The sharps box on the trolley had contents in situ and needed to be changed. Contact details for the resuscitation team were available.

Recommendation: The resuscitation trolley should be cleaned and checked daily. Staff should ensure the sharps box on the trolley is renewed after use.

The ward environment has not had an assessment for dementia patients. Wall clocks were not available in all areas.

Recommendation: The ward should have a full dementia assessment carried out. Wall clocks should be erected.

We observed out of date ward risk assessments in the Health and Safety folder for example COSHH assessments from December 2014. The ward sister acknowledged that these required updating.

Housekeeping Point: Ward risk assessments should be reviewed and updated.

Infection Prevention and Control

The ward environment was old, worn and in need of refurbishment. Clinical hand wash sinks, alcohol rub and glove and apron dispensers were easily accessible, located near to the point of care. We noted clutter around the nurses’ station and greater attention to detail is required when cleaning horizontal surfaces which we observed to be dusty. Environmental cleanliness audits are carried out; the last audit carried out on 21 January 2016 scored 82 per cent.

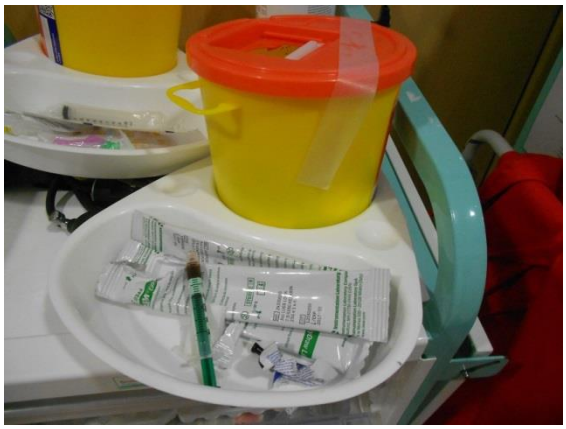
We spot checked three pieces of patient equipment, two were dusty and required cleaning. Gaps were observed in patient equipment cleaning schedules. Regular ward equipment cleaning audits are not carried out by senior ward staff.

Recommendation: Ward clutter should be removed and environmental and equipment cleaning should be improved. Patient equipment cleaning schedules should be fully completed and regular patient equipment cleaning audits carried out.

Single room facilities, each with a clinical hand wash sink, promote good infection control practices. Contact precaution notices were not displayed appropriately.

Housekeeping Point: Contact precaution posters should be on display.

We observed that overall staff carried out hand hygiene at the appropriate times, in line with the World Health Organisation (WHO), five moments of care. However, staff should ensure hands are washed prior to and after removing gloves, when in the patient environment and between patients or after using equipment. A number of staff did not comply with the trust uniform policy and wore non-stud earrings. Staff did not always adhere to ANTT and did not dispose of waste after taking blood (Picture 4).



Picture 4: Syringe and waste not disposed of after procedure

We observed continual incorrect use of gloves and aprons. Staff did not always remove gloves between tasks.

Recommendation: All staff disciplines should carry out hand hygiene in accordance to the WHO five moments of care. All staff disciplines should adhere to trust policies for uniform, use of gloves, ANTT procedures and best practice in infection prevention and control.

On review of bedside charts we observed that in two out of three patients a visual infusion phlebitis (VIP) chart was not in place for the management of a peripheral venous cannula, in line with best practice guidance. Hand hygiene audits are carried out. The ward achieved 91 per cent compliance between September and December 2015. We were advised that the ward will complete an incident form and participate in a root cause analysis for infection if required. The ward infection prevention and control link nurse is due to leave and this should position should be filled as soon as possible.

Housekeeping Point: The ward infection prevention and control link nurse position should be filled as soon as possible.

One patient admitted from ED with sepsis had a sepsis bundle completed along with a record of the time when blood cultures were obtained; however there was no record of the site were the sample was taken.

Housekeeping Point: Documentation for the management of peripheral venous cannula and sepsis should be completed.

Patient Safety

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

Guidance on the management of the acutely ill patient was not available, however an algorithm to follow for the deteriorating patient is available at the back of the NEWS observation chart. On review of bedside charts we identified that NEWS were not always completed within set timescales, or the total score calculated. Nursing records identified that in cases when action was required, staff did not always record the scoring and the action to take in accordance with the NEWS algorithm. The ward audited the completion of NEWS charts in November and December 2015 and the ward achieved 90 per cent compliance.

Recommendation: Guidance on the management of the Acutely Ill Patient should be developed. National early warning scores should be completed within the set timescales, totalled and appropriately documented where actions are required.

A Sepsis Six care bundle is not in place on the ward for the recognition and timely management of sepsis. A care bundle is a set of interventions, that when used together, significantly improve patient outcomes.

Recommendation: A Sepsis Six care bundle should be implemented.

A falls safe bundle is in place. The ward monitors the rate of falls using ward incident data. A SKIN care bundle is in place. Audit scores for January 2016, showed a score of 100 per cent for the falls bundle, but a score of 50 percent for the SKIN bundle, related to completion of documentation.

Housekeeping Point: Compliance for the SKIN care bundle requires improvement.

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

Staff have received theoretical training and assessment on Haemoviligence. Staff questioned were aware of their responsibility to complete the blood transfusion record sheet.

Staff reported that they can raise concerns with their direct line manager, however they told us senior managers listen but *'expect you to get on with it'.* Staff are unaware of how concerns raised are actioned. Patient safety/medical alerts are printed and kept in a folder for staff to view.

We were advised by staff that there was insufficient patient equipment to meet the needs of the patient for example IV pumps and fans. Staff told us of the lack of services available at the 'corridor' bed, previously outlined in this report.

Recommendation: Additional patient equipment should be provided for the ward.

There is no information available on the ward for patients or visitors on who to contact for advice on safeguarding issue. However, staff advised and we observed consideration given to placement, safety and vulnerability of patients.

Medicines Management

Storage of medicine requires improvement. We observed that medicines cupboards in the middle of the ward were disorganised and medicines were not stored in an easily retrievable fashion. Injectable, oral and inhaled medicines were not segregated and some loose vials were noted. The medicine trolley was not attached to the wall and was disorganised due to the volume of medicines contained within it. Staff advised that a second trolley had been requested but was not permitted and the wall attachment was reported for repair several months ago.

Picture 5: Out of date medication

We observed during the medicine rounds the medicine trolley was left open and unattended while the nurse administered medicines to each patient. Loose strips of medicines were observed throughout the medicine trolley.
We observed six medicines which had passed the expiry date or the expiry date could not be determined as the date of opening had not been recorded (Picture 5).

Recommendation: A system should be introduced to ensure the timely removal of expired medicines. The date of opening should be recorded on medicines with a limited shelf life once opened; staff should be familiar with the in use expiry date.

We observed the medicines refrigerator located in the staff room and access was limited due to the position of furniture within the room.

Recommendation: Medicines should be stored safely and securely.

Housekeeping Point: The location of the medicines refrigerator should be reviewed to ensure that all medicines are readily accessible.

We observed controlled drugs were stored and administered safely. Reconciliation checks were completed at least twice per day at shift changes. Controlled drugs were prepared by two nurses in the office and both nurses were involved in the administration at the patient's bedside. The controlled drugs registers were fully completed.

All IV infusions were stored appropriately. Potassium-containing solutions were kept separately from other solutions. There was no dedicated preparation area for IV infusions; the area used was located in the middle of the ward and was prone to unnecessary interruptions. The preparation of an IV medicine for two patients was observed. Two nurses were involved in the preparation and administration of the IV infusions. On discussion with staff it was found that although two nurses were routinely involved in the preparation of IV infusions, during busy periods, a second nurse did not always witness the administration.

A review of the medicine round indicated that with the exception of one patient, the medicines were administered directly to the patient and were not left unattended. One patient was receiving nebulised medicines. We observed that this patient's oral medicines were left at the bedside for the patient to administer.

Recommendation: Nurses should ensure they adhere to NMC Standards in the administration of medicines.

It was observed that the kardex was signed during the preparation of the medicine prior to administration to the patient.

Despite the use of tabards to alert staff and visitors that a medicine round was taking place, nurses were still subject to a variety of distractions.

We reviewed patient medicine kardexes. Kardexes were not always fully completed; start dates for medicines, the delay or reason for omission for some medicines, and the patient weight were not clearly and accurately recorded. Oxygen had been prescribed on the kardex for those patients receiving oxygen therapy.

Recommendation: Medicines kardexes should be fully and accurately maintained.

Patients told us that they self-administered some of their medicines; however, this was not always recorded on the kardex. A trust policy or guidance was not available.

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

The ward had a clinical pharmacist assigned to it; this service should include medicines reconciliation on admission and discharge. Staff advised that they had access to pharmaceutical advice if required. There was evidence that the pharmacist had reviewed patients' medicines during their inpatient stay; however, there was no evidence of medicines being reconciled on admission. At the time of discharge, medicine reconciliation did not always happen. Resources are required to fund technical support to allow an IMM service including the use of patients own drugs and one stop dispensing to be introduced. Staff advised that by sending the kardex and prescription to the pharmacy, this often delayed the administration of medicines especially if it coincided with for example lunchtime.

Recommendation: An integrated medicines management service should be provided.

Patients told us they that were involved in the decisions about their medicines which included changes in dose or commencement of new medicines during their stay.

Discussion with staff indicated that they were aware of critical medicines.

Staff had access to a list of critical medicines on-line and there was a system in place to show where the stock of medicines was held and could be obtained within the hospital. A list of critical medicines was also displayed in the nurses' station and on the medicine trolley.

Staff were aware of the procedures in place for reporting incidents and near misses but it was unclear of the process for feedback and learning following the incident.

3.3 Is Care Effective?

Nursing Care Records

We found that comprehensive nursing assessments and relevant risk assessments were not always in place, completed and reviewed. A care plan was not always developed to provide instruction for care needs identified on assessment.

Six of the six nursing care records we assessed were not up to date and did not always reflect the nursing assessment or the care required for the patient. There was no evidence to demonstrate 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.

Nursing record keeping did not always adhere to NIPEC guidelines. Patient details such as healthcare number, ward and date were not always recorded on documentation. There was evidence of appropriate MDT referral, including discharge planning. There was minimal documented evidence of involvement of patients and families in planning aspects of patient care or discharge planning.

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

Recommendation: Nursing record keeping should be improved to accurately reflect patients' needs and be in line with NIPEC best practice guidelines. Nursing record audits should be undertaken.

Housekeeping Point: Nursing records should evidence involvement with the patient and families in planning of patient care.

Medical Care Records

We found that clinical notes were not consistently organised with in one instance incorrectly filed loose pages. It was difficult to find the current admission entries within the medical records. Several pages in most charts were missing the patient's name and time of the entry was recorded for most, but not all entries. Overall legibility was fair but there were multiple examples of difficult to read handwriting and many instances of deletions, score-outs and amendments that were neither signed nor dated. Transfer of patients between wards and clinical teams was not always accompanied by a clear change in the responsible consultant being identified in the medical notes.

Examples of good practice included a ward-round stamp (allied to an ongoing Quality Improvement initiative) that provided a ward round and patient safety checklist. Whilst there was evidence of discussions occurring between clinical staff and patients and their relatives about diagnosis and management plans, the content of these discussions was not always documented.

Recommendation: The quality and organisation of medical notes should be improved. The content of discussions with patients and families should be recorded.

Nutrition and Hydration

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

Over the two-day inspection we observed two lunch and one breakfast meal services. Although we noted improvements in meal service over the two days, considerable work and effort is required by staff to ensure patients are prepared and supported during mealtimes, to maintain and improve their food and fluid intake.

We observed that there was no senior member of nursing staff to supervise or co-ordinate the meal service during mealtimes. All staff should participate and oversee meal service as part of their role. Service was disorganised and at times staff were unaware of patient requirements. We observed that patients were not appropriately positioned or prepared prior to their meals being served.

Protected meal times are not adhered to. We observed staff reviewing patients and taking blood during meal service. Of particular note was the dispensing of medication during meal service. Patients who were commenced on nebuliser therapy were interrupted and taken off this while meals were delivered. The nebuliser therapy was not turned off. Therefore, when the mask was reapplied to the patient they did not receive the full nebuliser therapy treatment.

Housekeeping Point: A senior nurse should take the lead role in supervising and co-ordinating meal service. All staff should participate and oversee meal service as part of their role.

Housekeeping Point: All patients should be prepared for meals prior to meal service and protected mealtimes should be adhered to.

Pre–ordered meals are served from a meal trolley. We were told that special diets or missed meals can be ordered directly from the catering department. On observation, meals looked appetising. Snacks are available from nursing staff at ward level, 24 hours a day as required.

A dinner plate symbol is present on the ward electronic board to identify the level of assistance a patient requires at mealtimes. This mechanism while in place is ineffective. We observed food placed in front of patients; however appropriate assistance was not always given. Staff were not always allocated to provide assistance. We observed staff carrying out tasks who were not evident in bays, checking on patients during meal service. Patients who refused to eat were not encouraged with their meal and we observed uneaten meals removed from the patient bedsides. Drinks were available at the bedside; however, there was no encouragement for patients to drink. Nutritional supplements were not always administered as prescribed. We observed staff inappropriately standing over patients while assisting with meals and referring to the use of patient ‘bibs’ and on one occasion ‘feeders’.

Housekeeping Point: A robust system should be implemented to ensure all staff are made aware of the patients dietary requirements.

Housekeeping Point: Patients should be routinely encouraged and where necessary assisted to eat and drink.

Adapted cutlery or crockery is available for patients with limited manual dexterity. We observed fluids served in difficult to handle, clear flimsy plastic glasses, with the potential to collapse on pressure causing the content to spill. We observed the use of polystyrene bowls.

Housekeeping Point: Clear flimsy plastic glasses and polystyrene bowls should not be used for patients, especially those with limited manual dexterity.

The mechanism in place to identify and report a patient's intake at mealtimes is ineffective. Nursing staff collect food trays; however we observed that food and fluid charts were not completed consistently and were not kept up to date. Patients who were nil by mouth/fasting were not kept fasting for long periods and had appropriate assessment.

Housekeeping Point: Food and fluid charts should be consistently completed.

The ward audits completion of the Malnutrition Universal Screening Tool (MUST). This is a five-step screening tool to identify adults who are malnourished, at risk of malnutrition (undernutrition), or obese. The ward achieved 100 per cent compliance in the trust audit of completion of this tool in November and December 2015.

Recommendation: The system in place for delivery and service of patients meals should be immediately reviewed and improved.

Pain Management

Patients reported they were comfortable and pain relieving measures were available and in place. Staff responded promptly to patients' requests for pain relief. On one occasion, a patient commented on the timely availability of medical staff to prescribe pain relief overnight. However, we were informed by nursing staff that this can be an issue, as junior medical staff cover many clinical areas at night times. Records indicated that pain medication was administered as prescribed. Documentation indicated that a pain score was not always recorded on the NEWS chart or completed at the correct frequency. A trust pain team is available for advice and support, however not all staff were aware of this. Staff liaise with the palliative team for advice on pain relief for palliative patients.

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

Housekeeping Point: All staff should be aware of how to contact the trust pain relief team.

Pressure Ulcers

Patients reported they were comfortable, pressure-relieving equipment was available.

As previously stated a SKIN care bundle is in place for patients deemed 'at risk' of pressure damage however again gaps were noted in the completion of documentation. Nutritional supplements were offered to 'at risk' adults.

Staff can access advice on wound care via the trust intranet and tissue viability nurse (TVN) service. Pressure ulcers can be photographed, with patient consent, by the TVN. Regular mattress audits are carried out to assess mattress integrity. The last mattress audit was carried out in November 2015 and following this 10 new mattresses were purchased for the ward.

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

Housekeeping Point: SKIN bundle documentation should be fully completed.

Promotion of Continence and Management of Incontinence

Staff were observed providing patients with the appropriate assistance to promote continence and care for incontinence. However, documentation identified gaps in the completion of the SKIN care bundle where promotion of continence is a key component. We observed that not all patients were given the opportunity for hand hygiene after toileting.

For a patient with a self-retaining catheter in situ, the clinical indicators for catheterisation and all relevant information were not fully documented within the patient records. Stool charts were appropriately completed. Staff have access to continence/stoma specialist services and stoma/incontinence aids were available.

Housekeeping Point: Ensure all patients are offered hand hygiene after toileting.

Housekeeping Point: All relevant information for the insertion of a urinary catheter should be documented.

3.4 Is Care Compassionate?

Person Centred Care

We observed that the ward was on many occasions throughout the inspection disorganised, with no apparent routine. This was further exacerbated by space constraints, the busy ward activity and large footfall through the ward. On one occasion, 17 staff of various disciplines were counted around the nurses station, some with no clear reason other than social conversation.

Recommendation: Ward systems and processes should be reviewed to promote effective work systems and reduce the ward footfall.

With the exception of the undesignated ‘corridor bed’, all patient bed spaces had a working call bell system within easy reach. However, due to the noise levels within the ward, these were at times difficult to hear.

Overall, staff responded promptly to call bells and requests for assistance. However, patients commented that it could take a while for staff to return as they are busy, *'sometimes staff are too busy with other patients to respond quickly'.* Patients moved freely around the ward as their condition dictated.

The ward is old with space in bed bays and between beds is insufficient. Patients in undesignated 'corridor beds' have no dedicated private space. High noise levels and broken window blinds, to block out light, can make it difficult for patients to rest. We observed that there is no enforced patient rest period.

Overall, patients privacy and dignity were maintained when delivering care; room doors were closed, blinds or privacy curtains pulled and blankets used to cover patients. Staff alerted and sought consent from patients prior to entering private areas, for example the bathroom.

The use of an undesignated 'corridor bed' and lack of services and facilities as already discussed in this report raise issues of privacy, dignity, excessive noise and continual interruption for patients. We observed that the portable privacy screen in use for this bed does not fully screen the patient; the bed's corridor position beside two side rooms and at an emergency exit results in continual interruption from people moving through the ward. On occasions when nursing staff were carrying out procedures and interventions in the limited corridor space, for example cannulation, other staff pushed past.

Patients' personal and oral hygiene needs were appropriately attended to; patients reported to be comfortable and were suitability clothed. We observed that patients' personal items were available and easily accessible. Bedside tables were uncluttered. Overall, there was no toileting carried out at the bedside during meal service. This did occur on one occasion in a bay when then patient was immobile and restricted to bed. Staff did not hold off meal service in the bay until this was completed.

Recommendation: All staff should promote and ensure patient privacy and dignity at all times.

We observed staff displaying compassion and empathy to patients. Intentional care rounding was carried out as part of the SKIN care bundle. These checks are to ensure that nursing staff carry out scheduled tasks or observations to meet and anticipate patients' fundamental care needs. Extra staff can be requested if additional care interventions are required, for example one: one nursing. However, we were advised that this may not always be possible to achieve.

The provision of sanitary facilities is inadequate. We observed one designated male and female toilet, one communal shower and one communal toilet within the ward. As the majority of these facilities are at the rear of the main ward, they are not easily accessible for those with mobility problems.

The communal toilet opens directly onto the nurses station, raising issues of privacy and dignity for those patients who require staff to enter and provide assistance.

Recommendation: The provision of adequate sanitary facilities should be essential for new builds within the trust.

There is no quiet room on the ward available for private conversation with patients and relatives. A room used in the past has now been re-designated as offices. We were advised and then observed that staff have to use the sisters office, staff room or take the patient and relatives off the ward, sometimes into the stairwell for private conversations.

Recommendation: A quiet room should be available for patient private conversation and relaxation. This should include provision for relatives of patients receiving 'end of life' care.

Hospital chaplaincy is accessible. All staff were not familiar with advocacy services available through social services and were not aware of advocacy information on the trust intranet.

Housekeeping Point: All staff should be updated on available advocacy services and how to access them.

Patient personal details on computer could not be easily viewed by non-staff members and information on the ward electronic board was kept to a minimum. We observed health care records stored untidily in trolleys at the nurses station. There was no ward clerk employed on the ward.

Housekeeping Point: Patient records should be stored tidily.

Communication

There was good signage to direct visitors within the ward. Information leaflets were available for example infection prevention and control, and clinical conditions. These were not displayed on a rack for the public to easily identify. There was no ward information leaflet.

We observed staff to be courteous to patients and relatives; however not all staff introduced themselves at the start of a first contact with the patient.

Having discreet conversation with patients can be challenging due to space constraints, the lack of a ward quiet room and the use of a 'corridor bed'. We heard staff calling to patients from across the ward and outside bays. Staff should endeavour to ensure conversations are not overheard by reducing the volume of their voice, moving closer to the patient and not calling to patients from across the ward and outside bays. The use of name badges made it easy for patients to identify staff; these should be worn at all times by nursing staff.

Recommendation: All staff should introduce themselves and communicate with patients in a volume that ensures patient privacy.

Housekeeping Point: All staff should wear name badges.

Staff provided patients with information and explained the care or procedures they were to receive in a clear, easily understood manner. However, we observed and spoke to one relative who was experiencing difficulty in getting information about a patient. The patient had been in hospital for one month and the relative reported that as time passed they were less and less involved in discussions about the patient. The relative had tried to make appointments to speak to medical staff, but was repeated '*put off*' by staff and now feels ignored.

Information relating to patient care was sometimes not treated as confidential. For example we observed on the wall behind a bed, information on a patients' personal assistance needs. The ward electronic board details this information which is available for staff.

Access to communication aids and interpreting services was available for patients with language barriers. Trust information leaflets were available for complaints, comments and suggestions but were not easily accessible. Information leaflets were not available in Braille. There is no bedside or portable ward telephone for patients to use.

Recommendation: Information and leaflets as outlined throughout this report should be easily accessible and in different format for patients and visitors.

Housekeeping Point: A portable ward telephone should be purchased

End of Life Care

Staff can access Guidance for the Management of Symptoms in Adults in the Last Days of Life via the trust intranet. However, there is currently no integrated care pathway in use at ward level. We were informed that staff provide 'comfort care' to patients, however there is no guidance to direct staff and ensure standardised practice. The DoH has recently endorsed NICE Guideline NG31 - Care of dying adults in the last days of life.

Recommendation: Implement actions outlined in the DoH Circular related to the NICE Guideline NG31 - Care of dying adults in the last days of life.

Housekeeping Point: Standardised guidance should be developed for the delivery of 'comfort care'.

24 hour palliative care advice is available from the palliative care team, and Marie Curie.

At the time of inspection, there were patients on the ward requiring palliative care intervention. We observed that nursing staff liaised with the family and the medical staff to ensure clinical review and care interventions were carried out in a timely manner.

The ward has four side rooms, two with sanitary facilities. Family members can, if required, remain with their relative while they are in the ward. Car parking permits can be issued.

Information and bereavement support systems were available for patients and carers before and after a patient dies. Information leaflets were available for relatives to access.

On discussion, families told us that they were very appreciative of being able to stay with their relatives, especially during the night. However, they were unable to find somewhere private to rest during the night; chairs outside the ward were uncomfortable. A do not attempt resuscitate (DNAR) order reviewed had not been appropriately completed as there was no endorsement by a senior decision making clinician and Part 7 was not completed. Additionally, while there was reference in the notes to a next of kin as the responsible person and decision maker, there was no name documented to identify this person definitively.

Recommendation: DNAR documentation should be fully completed.

Patient and Relative Questionnaires

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

In Ward 13 a total of 12 questionnaires were completed:

- eight patient questionnaires
- four relatives/carers questionnaires

Patients stated they were satisfied with the standard of care they received. In general staff introduced themselves; they were polite and addressed the patient by their correct or preferred name. Patients told us they were involved in the decisions about their care, but some patients did not know who to speak to if they had concerns. Half of the patients questioned did not think staff had enough time to care.

Patients told us staff were courteous and compassionate. Patients told us they received assistance when required and were treated with respect and dignity. They told us they did not have enough privacy when discussing their condition. One patient would have liked more assistance in the form of a mobility aid to help with walking.

Overall call bells were responded to in a timely manner and if not answered it was because staff were busy with other patients. One patient in a corridor bed commented that they had *“no buzzer or light”*.

On most occasions patients stated they received pain relief in a timely manner; one patient stated this was not always the case and staff do not always explain why it cannot be given.

Patients told us that overall the ward was clean, but one patient commented that the cleanliness of the shared toilet needed improved. Overall, the choice of food was good; one patient told us this was not always the case; food was sometimes cold. They told us fluids were readily available and staff hand hygiene was good.

Patients told us they felt safe and had received a good standard of care during their stay. They told us they would be happy for a member of their family or a friend to be cared for in this ward.

All relatives told us staff treated patients with respect and dignity, and in general patients were receiving good care and treatment. Overall, relatives they were welcomed on the ward, knew who to speak to about their relative and received up to date information and advice about their relatives care.

Overall relatives did not think staff had enough time to care or treat their relative.

One relative commented that they did not always feel welcomed by staff, she did not know who to speak to and did not receive up to date information on their relatives care.

In the ward user satisfaction survey report complied in October 2015 there were seven responses, a response rate of 14 percent. Overall patients were very satisfied with their ward experience. Privacy was identified as a concern and one patient who had a negative experience cited communication, task centred approach and staff attendance time as issues.

Patients Comments

“Staff treat me as an individual.”

“I have been involved up to the point where medical decisions are made I have been able to ask questions and staff have taken time to answer and explain.”

"Sometimes they don't explain enough. But I always ask."

“Staff are busy but copying. Don't appear to be over stretched.”

“Appeared to be short staffed- always 'pushed'. I don't like to bother them because they are so busy.”

“Staff will always explain if they can't come right away.”

“Staff has checked on a number of occasions that I was ok in the corridor.”

“Beds seem close together and there isn't a lot of privacy.”

"This ward has limitations - I am not happy to discuss all my conditions within hearing of others. But staff recognise this and have attempted to be as discreet as possible.”

“The corridor bed is not private- but I understand the reasons it is here.”

Relating to corridor bed: “*…it is better than being stuck in A&E, still getting treatment.”*

Question on pain relief: "*Sometimes the staff have been too busy." “I've had to wait a bit.”*

“Food looks well prepared but very bland.” “Sometimes it's cold.”

“Jugs of water are regularly replenished.”

“The shower was clean but there was nowhere to hang clothes. The floor was soaked afterwards, as were my shoes and pyjamas. The floor was also a slip hazard.”

“Sometimes the unisex toilet isn't as clean as it should be.”

‘’*I am getting good care on this ward.”*

General Comments

“Medical and nursing care is good. Being on Ward 13 has been a positive experience so far". The ward is small, short of space, busy and a bit dated. Privacy is an issue but I recognised the restrictions of the ward.”

“Very happy with the care and this ward. Everything is done to the best of their ability.”

“*Happy with care given by nurses and medical staff*”. This patient was very accepting of the fact that he was in the "corridor bed."

“*Repetition- so many people are asking the same questions.” "Do they not read any notes*?”

“Thought should be given to having more nurses and require more available beds, never reached a ward.” “Just A&E and a corridor, over the four days I had to stay."

"*More staff, staff are under a lot of pressure. Overall no complaints*."

Relatives Comment

"*Staff on the ward do the best they can, however well-intentioned we appreciate they are under extreme pressure. No major issues although it is clear the ward is under resourced*."

"*Staff haven't enough time*."

"*A few more nurses on the ward, they sometimes seem stretched*."

"*The nurses don't have the time to fully answer all their questions."*

Recommendation: The trust should continue to 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.

Observation of Practice

Observation of communication and interactions between staff and patients or 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 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.

Twenty seven observations were carried out over four observation sessions. Observers considered that staff interactions could be improved. There was some evidence of positive interaction of staff engaging with patients, where staff introduced themselves and gave explanations of the procedures they were carrying out. However, the majority of interactions were basic, neutral, with some negative. Basis interactions observed were between staff and patients around the meal service and when delivering personal care during which conversation was minimal.

Examples of neutral/negative interactions were in relation to a doctor looking into a screened bed space while a patient was on a commode. Lunch time and medicine rounds were carried out at the same time and the drugs trolley was left unattended. Nursing staff did not prepare patients for meals. Meals were set down in front of patients receiving nebuliser therapy who had to stop the therapy to eat. Two patients who required assistance at meal times were not offered help.

Patients who required assistance were not encouraged to eat or drink. Patients were referred to in inappropriate terms *'leave bed space…she's a feeder'.* Medication for a patient with poor eyesight was left on their table and staff advised them to leave it for a few minutes then take.

On a number of occasions staff failed to wear the correct Personal Protective Equipment (PPE) or carry out the appropriate hand hygiene.

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

3.5 Conclusions for Ward 13 Medical

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

We were advised that specialist nurses who attend the ward are invaluable, providing advice and guidance in the care delivered to patients. Patient experience data is captured in the form of an inpatient user satisfaction survey.

However, the inspection identified areas for improvement in the systems and processes which impact on the delivery of care in the ward.

Communication of information to staff to improve practice was not always effective. Staff reported that morale was low. Nursing staff informed us they were supported by the band 7 sister; however told us there was a lack of support from directorate senior management.

Staff supervision, appraisal and training records indicate that staff attendance at mandatory training and additional role specific training requires improvement. Availability of AHPs and on occasions medical review was not timely.

We observed the use of an undesignated or 'corridor' bed. This is a bed placed in the ward corridor. The bed has a portable privacy screen, bedside table and chair. There is no nurse call bell, light, suction point or piped gases available (cylinder supply only).

On observation the ward environment was old, worn and in need of refurbishment. Patient equipment and horizontal surfaces were dust and required cleaning; gaps were noted in cleaning schedules.

The ward was on many occasions throughout the inspection disorganised, with no routine. This was further added to by space constraints, the busy ward activity and large footfall through the ward.

We observed that overall staff carried out hand hygiene in line with best practice. However, not all staff complied with trust policies in relation to uniform, use of gloves and aseptic non-touch technique.

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. Medical records were at times difficult to read and inconsistently organised.

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

Overall patients' privacy and dignity were maintained when staff were delivering care. However, the use of a 'corridor bed' and lack of services and facilities raises issues of privacy, dignity, assistance, excessive noise and continual interruption for patients.

Overall patients and relatives were happy with the care they or their relative had received. However communication, privacy and the use of 'corridor' beds can be a problem.

The findings of the inspection identified that Ward 13 requires improvement. We have made **41** recommendations and **29** housekeeping points for this clinical area.

3.6 Recommendations and Housekeeping Points

Recommendations

1. A senior nurse presence should be evident on each shift. The senior nurse should be visible and identifiable.

2. Regular ward staff meeting should be scheduled. Staff meetings should have a standard agenda.

3. The trust should ensure that formal analysis of SAIs, incident, near misses and complaints is conducted and shared with staff.

4. Communication with staff should be improved to ensure learning in relation to complaints, SAIs, incidents, investigations, morbidity and mortality, cardiac arrest rates and HCAIs.

5. Ward sisters should provide visible and robust clinical leadership for ward staff.

6. All staff supervision and appraisal should be up to date.

7. Senior trust staff should take action to alleviate staff concerns outlined in the report and ensure any issues raised are immediately addressed.

8. Nursing and junior medical staffing levels should be reviewed and improved.

9. Access to physiotherapy, occupational health, speech therapy and social work should be improved to ensure timely intervention.

10. All staff mandatory training should be up to date. Training records should be up to date.

11. Systems and processes that affect patient flow, bed capacity and discharge throughout the ward should be reviewed and improved.

12. Work towards phasing out the use of corridor beds.

13. The use and format of safety briefings should be reviewed and improved.

14. All staff should receive training on safeguarding of children.

15. A space utilisation review and productive ward project should be carried out. Emergency exits should be easily accessible at all times.

16. The resuscitation trolley should be cleaned and checked daily. Staff should ensure the sharps box on the trolley is renewed after use.

17. The ward should have a full dementia assessment carried out. Wall clocks should be erected.

18. Ward clutter should be removed and environmental and equipment cleaning should be improved. Patient equipment cleaning schedules should be fully completed and regular patient equipment cleaning audits carried out.

19. All staff disciplines should carry out hand hygiene in accordance to the WHO 5 Moments of care. All staff disciplines should adhere to trust policies for uniform, use of gloves, ANTT procedures and best practice in infection prevention and control.

20. Guidance on the management of the Acutely Ill Patient should be developed. National early warning scores should be completed within the set timescales, totalled and appropriately documented where actions are required.

21. A Sepsis Six care bundle should be implemented.

22. Additional patient equipment should be provided for the ward.

23. A system should be introduced to ensure the timely removal of expired medicines. The date of opening should be recorded on medicines with a limited shelf life once opened; staff should be familiar with the in use expiry date.

24. Medicines should be stored safely and securely.

25. Nurses should ensure they adhere to NMC Standards in the administration of medicines.

26. Medicines kardexes should be fully and accurately maintained.

27. The trust medicines management policy should be updated to clearly guide staff on the self-administration of medicine.

28. An integrated medicines management service should be provided.

29. Nursing record keeping should be improved to accurately reflect patients' needs and be in line with NIPEC best practice guidelines. Nursing record audits should be undertaken.

30. The quality and organisation of medical notes should be improved. The content of discussions with patients and families should be recorded.

31. The system in place for delivery and service of patients meals should be immediately reviewed and improved.

32. Ward systems and processes should be reviewed to promote effective work systems and reduce the ward footfall.

33. All staff should promote and ensure patient privacy and dignity at all times.

34. The provision of adequate sanitary facilities should be essential for new builds within the trust.

35. A quiet room should be available for patient private conversation and relaxation. This should include provision for relatives of patients receiving 'end of life' care.

36. All staff should introduce themselves and communicate with patients in a volume that ensures patient privacy.

37. Information and leaflets as outlined throughout this report should be easily accessible and in different format for patients and visitors.

38. Implement actions outlined in the DoH Circular related to the NICE Guideline NG31 - Care of dying adults in the last days of life.

39. DNAR documentation should be fully completed.

40. The trust should continue to 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.

41. Staff should ensure patients are always treated with respect and dignity and in a manner that maintains privacy and confidentiality.

Housekeeping Points

1. The 'nurse in charge' badge should be worn at all times.

2. Student nurses should not be rostered to cover vacant shifts.

3. Communication should be improved between medical and nursing staff.

4. Staff should be familiar with reablement.

5. Following audit action plans should be developed where improvement is required.

6. Audit information should be displayed and up to date.

7. Ward risk assessments should be reviewed and updated.

8. Contact precaution posters should be on display.

9. The ward infection prevention and control link nurse position should be filled as soon as possible.

10. Documentation for the management of peripheral venous cannula and sepsis should be completed.

11. Compliance for the SKIN care bundle requires improvement.

12. The location of the medicines refrigerator should be reviewed to ensure that all medicines are readily accessible.

13. Nursing records should evidence involvement with the patient and families in planning of patient care.

14. A senior nurse should take the lead role in supervising and co-ordinating meal service. All staff should participate and oversee meal service as part of their role.

15. All patients should be prepared for meals prior to meal service and protected mealtimes should be adhered to.

16. A robust system should be implemented to ensure all staff are made aware of the patients dietary requirements.

17. Patients should be routinely encouraged and where necessary assisted to eat and drink.

18. Clear flimsy plastic glasses and polystyrene bowls should not be used for patients, especially those with limited manual dexterity.

19. Food and fluid charts should be consistently completed.

20. Pain scores should be completed at all times and recorded on the NEWS chart.

21. All staff should be aware of how to contact the trust pain relief team.

22. SKIN bundle documentation should be fully completed.

23. Ensure all patients are offered hand hygiene after toileting.

24. All relevant information for the insertion of a urinary catheter should be documented.

25. All staff should be updated on available advocacy services and how to access them.

26. Housekeeping Point: Patient records should be stored tidily.

27. All staff should wear name badges.

28. A portable ward telephone should be purchased

29. Standardised guidance should be developed for the delivery of ‘comfort care’.

Inspection Findings:
Ward 11 Surgical Ward

4.0 Inspection Findings: Ward 11 Surgical Ward

Ward 11 is a 20 bed surgical ward with specialities that include plastic surgery and maxillofacial surgery. The ward consists of two, six bedded bays, one four bedded bay and four single rooms, two with ensuite facilities.

4.1 Is the Area Well Led?

Governance

Throughout the inspection we observed a ward sister that demonstrated good clinical leadership. The ward sister was easily identified by wearing a distinct uniform and red badge that highlighted 'Nurse in Charge'. We were informed that regionally, the colour of the band 7 sisters uniform is soon to change.

The ward sister is responsible for the allocation of resources that facilitates ward function. Normative staffing levels have allowed the ward sister to be primarily supervisory however limitations in ward staffing levels had meant that the sister has had to take a more active role in direct patient care activities. The ward sister reported that it had become more difficult to balance the ward managerial duties with providing effective clinical leadership on the ward. We observed that the ward sister was very visible throughout the inspection, coordinating ward activities and supporting patients and staff needs.

Recommendation: The ward sister should have protected time to undertake the managerial duties of the post.

Staff reported that they were supported and valued by the directorate's management team and empowered to raise any concerns when appropriate. There was good support on the ward from a range of allied health professionals such as: physiotherapy, occupational therapy, speech and language therapy and dietetics.

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. On a monthly basis, the ward sister attends the surgical specialties sisters meeting. Ward performance is reviewed at these meetings against key indicators. Minutes of the meetings provided evidence of discussion of complaints, incidents and progress with identified actions.

Staff were aware of their responsibility to complete an IR1 form in the event of a safety incident. We were informed by staff that they had been updated with learning arising from incidents and complaints; however no formal trend reports were available for staff to access.

Housekeeping: Incident and complaint trend reports should be available for staff to review.

A record of informal local complaints was available on the shared sisters' folder for the surgical directorate. An agenda which included recording of informal local complaints was outlined at surgical a specialties sisters meeting. These complaints are reviewed by the surgical directorate clinical co-ordinator to assess for trends or patterns.

Communication and dissemination of information to staff is through various formats such as handovers, a communication book, displayed notices and email. We observed a morning handover that had clear leadership from the ward sister who kept the handover focused and structured. Patient information was comprehensive and delivered effectively by staff. The ward continues to employ a written handover system with staff reporting that this process is more practical due to the high turnover of patients within the ward. On review of one staff member's completed handover sheet, there was evidence of a loss of patient data from the information that was delivered at the morning handover. A pre-prepared electronic handover sheet that is passed to the next shift in conjunction with a verbal handover will assist in eliminating the loss of data.

Housekeeping Point: The current system of a written handover should be reviewed.

The ward sister reported that nursing staff team meetings were infrequent as they were difficult to facilitate, due to the staffing pressures on the ward. We were informed that most information is disseminated to staff at safety briefings. We observed that safety briefs which were attached to the shift handover lacked a clear structured criterion that is used to heighten staff awareness of salient patient safety issues.

Recommendation: Staff team meetings should occur more frequently and safety briefs should follow a clear structured criterion used to heighten staff awareness of salient patient safety issues.

We observed an effective system in use for medical handovers. Staff reported that they had good access to patient related information and electronic care records. All trained nursing staff within the ward had access to e-mail.

The ward had introduced a number of KPIs which are subject to continuous review. These indicators, which include compliance with NEWS, falls, food and nutrition, VTE, pressure ulcers, omitted medications and record keeping, were clearly displayed in the staff room. The ward receives a formal report of performance against these indicators which is discussed at ward sisters; meetings and at nursing governance meetings. Audits of hand hygiene and environmental cleanliness are routinely carried out and displayed for public viewing. We were unable to evidence actions plans to address areas of non-compliance with KPIs.

Housekeeping point: Action plans should be completed for areas of non-compliance with KPIs.

The trust monitors compliance with the Patient and Client Experience Standards: respect, attitude, behaviour, communication, and privacy & dignity through a range of methodologies including surveys, patient stories and observations of practice. Results of this survey undertaken in the ward highlighted that patients were 'most satisfied' with the Patient and Client Experience Standards. A number of other initiatives have been employed to capture patient experience and satisfaction data within the ward. Initiatives include:

- 'Have your Say' Comments leaflets
- 10,000 voices
- Head and Neck Specialist Service patient satisfaction survey 2015
- Complex Skin Service 2015 – user satisfaction survey

The information gathered is reviewed by the ward sister and actions taken as appropriate.

The ward sister is routinely updated in relation to performance against trust targets in relation to healthcare associated infections at ward sisters' meetings. Information on trust and ward cardiac arrest rates was included within the trust KPI report. Ward nursing staff do not currently attend surgical morbidity and mortality meetings; attendance would help to improve shared learning from adverse clinical events.

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

Staffing and Supervision

We were informed that the ward is being closed as a surgical ward and then reopened as a medical ward. This reconfiguration was planned to take place in November 2015, however it had been delayed as the trust had found it difficult to recruit band 5 RNs to adequately staff the ward. Staff reported that it has been very unsettling since the decision was made to close the ward. Ward staff are waiting to be redeployed to other surgical wards throughout the hospital.

A review of staffing records indicated deficits in the number of permanent registered nurses available to work particular shifts. A number of staff reported that current staffing levels are a concern.

We were informed that the ward is funded for 27.92 WTE nursing staff. Currently 18.39 nursing staff are in post, a deficit of 9.53 WTE. Staff retention and recruitment was good up until the decision was made to close the ward. Retention of staff has since been an issue, with three RNs taking up post in other areas. These posts had not been filled. Sickness absence is 0.8 per cent.

Staff commented that staffing levels are routinely reviewed and that managers are proactive in booking bank and agency shifts where required, although availability at times of booking is an issue. There is a heavy reliance on bank and agency shifts to staff the ward although beds are not closed due to staff shortages. The ward sister reported that senior managers have been proactive in attempting to recruit staff from other areas of the United Kingdom, however a national shortage of band 5 RNs has made this difficult

Recommendation: The trust should ensure that any identified nurse staffing variances are reviewed to ensure that patient care and safety is not compromised due to staffing levels. The recruitment of new staff should be expedited.

We were informed that limited time for the ward sister to carryout managerial duties has significantly impacted on facilitating staff appraisal and supervision sessions. Only 37 per cent of all ward staff had an annual appraisal and 48 per cent of staff had supervision sessions.

Recommendation: Staff supervision and appraisal should be in line with trust policy.

Staff Training

Currently the ward has six mentor/preceptors, three of which are sign-off mentors. All nursing students progress through a learning and objectives programme with their allocated mentor. New nursing staff members progress through a career development induction programme with their nominated preceptor.

All staff had completed a trust wide corporate induction programme. There was a range of mandatory training available which was delivered both electronically and via face to face sessions. Staff confirmed 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. It was reported to inspectors that attendance by ward staff at mandatory training needs to be improved. We were informed that poor attendances are as a result of staffing pressures.

Recommendation: Staff mandatory training should be kept up to date.

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 responds 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 staff on the ward had received training in the management of a patient with a tracheostomy, paediatric fluid balance training, and epidural high dependency course. 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 for infection prevention and control; tissue viability, palliative care and haemovigilance.

Patient Flow

During the inspection, we observed that ward rounds were scheduled early to facilitate early transfer or discharge. We observed that nursing staff were in attendance on all ward rounds throughout the morning. 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. All medical and nursing staff had access to ECR for up to date patient information.

We were informed that a new system for referring patients to a social worker had recently been implemented. Previously there had been one social worker allocated to the ward for which all case referrals could be directed. The new system however employs a case assignment service which means that there may be a number of different social workers reviewing cases on the ward. Ward staff reported that this new service had weakened communications with social work staff and caused delays in patients being reviewed on the ward.

Recommendation: The trust should review the social worker referral system to ensure that there are no delays in patient review.

There were 10 medical outliers in the ward on day one of the inspection and seven on day two of the inspection. Two dedicated consultants from Ward 13 carry out a round of the medical outliers in the ward before lunchtime.

To improve efficiency of flow, staff utilise the discharge lounge, where patients wait to be collected by their families or for their medication to be dispensed. To assist with patient flow the trust has developed a list of medicines that are provided as over labelled stock to allow nursing staff to supply these at ward level against a discharge prescription. This initiative assists in reducing pressure on the trust dispensary and improves the availability of beds on the ward.

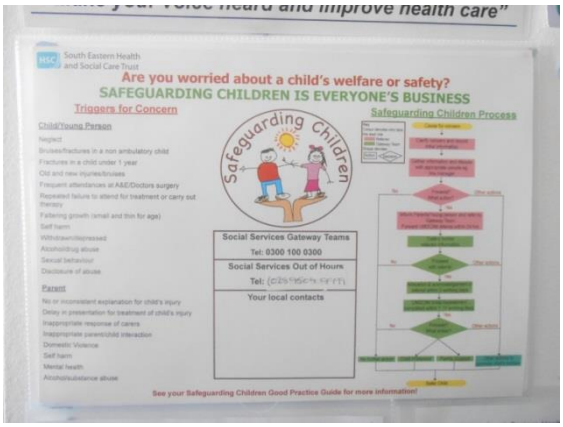
During the inspection we observed one delayed discharge of a medical patient. Ward staff were awaiting assessment of this patient by staff from an allocated nursing home.

Following discharge from hospital, the South Eastern Trust provides a short term reablement service, which aims to assist people to regain skills and confidence to live as independently as possible within their own home and community.

The ward is preparing to introduce an interactive whiteboard system. We were informed that the touch-screen system will give real-time information and allow the recording of patient admissions, discharges and transfers. Staff will are also able to input discrete symbols on the system to identify specific patient needs e.g. assistance requirement with meals or infection status.

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.



Picture 6: Safeguarding children poster

If a safeguarding risk is identified, the ward sister will make a referral through to the hospital social work team, which is responsible for gathering all evidential information. Safeguarding leaflets were available on the ward and via the trust intranet for staff, patients, and family/carers. A safeguarding children process poster was displayed within the ward sister's office (Picture 6).

4.2 Is Care Safe?

Environmental Safety

The fixtures and fittings of the ward were old however overall maintained to a reasonable standard. Due to limited storage capacity within the ward, large items of equipment which may present a trip hazard were stored along its central corridor.

Housekeeping Point: Staff should ensure that items of equipment that present a trip hazard should be removed.

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; however we observed that checks of the emergency equipment were inconsistent. The trolley and relevant emergency equipment were very dusty (Picture 7) and the sharps box on the trolley had contents in situ.

Picture 7: Dusty emergency slide sheet bag

Fire safety and life support training were part of the ward staff mandatory training programme. We observed that the corridor bed was placed in very close proximity to the emergency exit doors which potentially compromises this evacuation route. A notes trolley had also been abandoned in front of a fire escape.

Housekeeping Point: The resuscitation trolley should be cleaned and checked daily. Staff should ensure the sharps box on the trolley is renewed after use.

Housekeeping Point: Staff should ensure that emergency exit doors are free from obstruction.

There was sufficient moving and handling equipment however there were limited adaptations available throughout the ward to meet the needs of patients with physical disabilities e.g. corridor handrails. There were also no adaptions to meet the needs of patients with dementia, such as large clocks and clear pictorial signage.

Recommendation: The trust should ensure that appropriate adaptations are put in place to meet the needs of patients with a physical disability and those patients with dementia.

Known hazards in the ward environment had been risk assessed and preventive actions recorded and implemented. Piped oxygen and suction is not available at all bedsides throughout the ward; however a risk assessment had been completed to reduce the risk of harm to the patient. Control measures included having additional portable suction units and oxygen cylinders available.

We observed that ward staff complete a quarterly health and safety inspection proforma. The proforma assesses compliance with maintaining up to date health and safety risk assessments, incident reporting, working fire alarms and unobstructed exits.

It also reviews the maintenance of equipment and prompts staff to assess against trip and slip hazards and the storage of substances hazardous to health.

Infection Prevention and Control

We observed that all ward staff complied with being bare below the elbows to enable thorough hand washing. Hand washing sinks were available throughout the ward although they did not all meet recommended national specifications. The number of hand wash sinks in patient bays was also 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 contaminants. We saw regular use of these facilities by staff, in addition to hand decontamination rub in accordance with trust policy. We observed only one staff member that did not follow a seven step technique when decontaminating their hands with alcohol rub.

We noted there was easy access to personal protective equipment such as gloves and aprons however they were not always used appropriately. We observed two RNs looking through equipment cupboards with aprons and gloves donned.

Recommendation: All staff should comply with the trust hand hygiene and PPE policy.

Staff can demonstrate when ANTT procedures are applied and observed practices were in line with best practice. One RN was however unaware of the recommended drying time following the cleaning of a venous access device hub, before it is used. We also observed a documentation omission following the removal of an invasive device.

Recommendation: Staff should ensure that they aware of the key principles of ANTT and invasive device documentation should be fully completed.

We observed some items of patient equipment that required further cleaning. The holder of a tympanic thermometer contained ear wax debris; a clinical observation trolley had sticky tape attached to its monitor and the protective coating of the basket of the trolley was torn and could not effectively be decontaminated. The lower frame of the computer on wheels was also very dusty. We observed an equipment cleaning schedule in place, however it was poorly completed.

Recommendation: Staff should ensure that equipment is clean and equipment cleaning schedules should up to date and audited by a senior member of nursing staff.

Meticillin-resistant staphylococcus aureus (MRSA) and clostridium difficile care pathways were available to guide care.

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.
An infection prevention and control improvement tool has recently been implemented within the ward. The tool is a set of recurring themes that had been identified as part of regional hygiene and environmental cleanliness audits. The ward is assessed against recurring themes on a quarterly basis.

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. Vulnerable at risk patients were identified at the nursing handover. We were informed that patient safety/medical device alerts are reported to all staff at safety brief meetings. The notification letters were displayed in the staff room.

A guidance algorithm to follow for the deteriorating patient was available at the back of the NEWS observation chart. NEWS, were completed within set timescales and there was an appropriate clinical response to NEWS triggers. Accurately completed NEWS charts are part of the established audit programme of key performance indicators. A Sepsis Six bundle was not in place for the early recognition and management of sepsis.

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

We were informed that access to key diagnostics at times can be difficult. Clinical staff highlighted that it can be difficult to access computerised tomography (CT) and ultrasound scans ‘out of hours’, which may lead to delays in surgical decision making.

Recommendation: The trust should review patient access to key diagnostics out of hours.

A fall safe bundle was in place. The bundle is based on a collective set of elements that when carried out reliably and continuously, can help reduce inpatient falls. Falls walking stick and pressure sore safety cross posters were displayed within the ward. 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 of these incidences 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 VTE assessments were well completed and prophylaxis VTE treatment commenced.

We observed that one VTE patient assessment was not signed and dated when completed. VTE compliance is assessed as part of the established audit programme.

Staff have received theoretical training and assessment in relation to Haemoviligence. Staff members questioned were aware of their responsibility to complete blood transfusion record sheets.

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

Medicines Management

The majority of medicines were stored in locked cupboards; however, a small number of cupboards were unlocked at the time of the inspection. The cupboards were disorganised and medicines were not stored in an easily retrievable fashion. Injectable local anaesthetics had not been segregated from other injectable medicines. The medicine trolleys were disorganised and loose strips of medicines were observed throughout the trolley and in a plastic cup on each trolley (Picture 8). Following discussion these plastic cups were removed by the ward sister who advised that they had been transferred from other wards within the hospital. Five medicines were removed from stock by inspectors as they had passed the date of expiry and for one medicine, the date of expiry could not be determined.

Picture 8: Loose strips of medicine

Recommendation: It is recommended that medicines are stored safely and securely.

Housekeeping Point: Staff should be reminded of the trust policy in relation to transfer of medicines between wards.

Housekeeping Point: A system should be introduced to ensure the timely removal of expired medicines.

Housekeeping Point: The date of opening should be recorded on medicines with a limited shelf life once opened; staff should be familiar with the in use expiry date.

Controlled drugs were stored and administered safely. Reconciliation checks were completed at least twice per day at shift changes. Controlled drugs were prepared by two registered nurses in the office and both nurses were involved in the administration at the patient's bedside. The controlled drugs registers were fully completed.

IV infusions were observed to be stored in their outer boxes and epidural infusions were stored in a separate cupboard. Potassium containing infusions had been segregated from other infusions and red storage labels were in place to distinguish them from the other infusions.

There was no dedicated preparation area for IV infusions; the area used is located in the middle of the ward and is prone to unnecessary interruptions. The administration of an IV medicine to one patient was observed. The medicine was prepared and administered by one registered nurse. The patient's identity wrist band was on the table in front of the patient. A new wrist band was put on prior to the administration of the medicine.

Medicines were administered directly to the patient and were not left unattended. It was observed that the kardex was signed during the preparation of the medicine prior to administration to the patient.

Recommendation: Registered nurses should adhere to NMC Standards in the administration of medicines.

Documentation indicated that kardexes were not always fully completed; start dates for medicines, the delay or reason for omission for some medicines, and the patient weight were not clearly and accurately recorded. There was evidence that the kardex was not promptly rewritten when it was complete.

Recommendation: Medicine kardexes should be fully and accurately completed.

Patients reported that they self-administered some of their medicines; however, this was not always recorded on the kardex. A trust policy or guidance was not available.

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

An integrated medicines management service was not being provided. The ward did not have a pharmacist assigned to it, although staff advised that they had access to pharmaceutical advice if required. There was no evidence of pharmacist involvement in reconciliation of medicines on admission or during inpatient stay.

There was no evidence that patients' concordance with prescribed medicines was assessed on admission. Staff advised that medicines were reconciled by a pharmacist in the dispensary on discharge if required.
Staff also had access to "over labelled" medicines which could be issued by registered nurses on the ward at discharge. There was a policy in place for this practice and a running stock balance of each medicine was recorded. Staff advised that systems were in place for the provision of appropriate support with medicines prior to discharge.

On the day of the inspection, we were informed by ward staff that one patient's discharge did not occur as planned, due to a delay in the supply of medicines at the time of discharge. This patient was planned to be discharged in the morning and had a care package organised which included a lunch time call on the same day. We were informed that this package had to be postponed.

Recommendation: An integrated medicines management service should be provided.

Patients told us they that were involved in the decisions about the medicines which included changes in dose or commencement of new medicines during their stay.

Discussion with staff indicated that they had an awareness of critical medicines. Staff had access to a list of critical medicines on-line and there was a system in place to show where stock of medicines were held and could be obtained within the hospital. A list of critical medicines was displayed in the nurses' station.

4.3 Is Care Effective?

Nursing Care Records

The nursing care records of three patients were reviewed during the inspection. We found that the nursing assessments and risk assessments were not always completed.

We observed that care plans were not always in place to meet patient needs. When care plans were in place, they did not always reflect the issues identified within the nursing assessment. Care plans were not routinely reviewed or evaluated.

The nursing care records did not always adhere to NMC standards of documentation. Some signatures were illegible and timings of written input at times omitted.

There was evidence of appropriate MDT referral, including discharge planning however; there was minimal documented evidence of patient and family involvement in planning aspects of patient care or discharge planning.

Recommendation: Nursing care records should be improved to accurately reflect patients' needs, their involvement in their care, and be in line with NMC standards of documentation.

Medical Care Records

Medical records were well organised and easy to use.

Whilst there was limited information regarding what information was given to patients and relatives about diagnosis and management, these were elective plastic surgery admissions.

Nutrition and Hydration

Protected mealtimes were adhered to; this allowed patients to eat their meals in a calm and relaxing environment, without unnecessary interruption.

There was a good menu choice, including specialised diets. There was a good variety of meals served, which were warm, nutritious, appetising and of a good portion size.

We observed that the serving and coordination of meals was carried out by healthcare assistants; with minimal input from RNs.

Patients were provided with jugs of fresh water, which were within easy reach. We observed staff encouraging patients with food and fluids throughout the inspection.

Mechanisms were in place to identify patients that require assistance at mealtimes. We observed that patients were appropriately positioned or prepared prior to their meals being served. Assistance was given to those patients that required assistance with their meals without delay.

Mechanisms were in place to identify/report patients' intake at mealtimes. However we observed that fluid balance and food charts were not always reconciled.

Recommendation: Staff should ensure that fluid balance and food record charts are completed and reconciled in accordance with trust policy.

Where a meal is interrupted or missed a replacement meal can be accessed from the hospital kitchen. Snacks such as tea, toast and biscuits are provided on the ward when requested. Patients who were nil by mouth/fasting were not kept fasting for long periods and had appropriate assessment.

On the first day of the inspection we observed that the lunch meal was served at 11.40am. We were informed that this is routine practice to ensure that meals are served at an appropriate temperature as the ward receives its meal trolleys early from the hospital kitchens.

We were informed that this issue had been reported to the hospital catering managers. A patient commented in relation to this issue when questioned as part of the ward patient experience survey.

"Quality and variety of meals is very good. Only issue is timing of evening meal, in my opinion delivered too early."

Recommendation: The system in place for delivery of patients' meals should be reviewed. Staff should ensure that patients receive meals at standard mealtimes.

Pain Management

Patients reported to be comfortable and adequate pain relieving comfort measures were available. Patients who spoke with us said that most staff respond promptly to requests for pain relief. One patient however reported that she had been sore throughout the night; when pain relief was requested the patient was told by an RN that she was not due any further pain relieving medicines. The medicines kardex evidenced that the patient had been prescribed other pain relieving medication that should have been administered following this request.

Ward staff could contact the specialist pain team for advice and support for pain that was difficult to manage. We observed that pain assessments were poorly completed within the NEWS assessment charts.

Housekeeping point: Staff should ensure pain assessments on patients NEWS charts are consistently completed.

We observed in one medicine kardex that a pain relieving medication had been prescribed to be given intravenously, however it had been administered in an oral format on a number of occasions.

Recommendation: Staff should ensure that pain relieving medication is administered promptly prescribed.

Pressure Ulcers

Staff were knowledgeable with regard to pressure ulcer care. Patients reported to be comfortable and were appropriately positioned, with pressure relieving equipment in use. A validated pressure ulcer classification tool and a SKIN bundle were in place. As previously discussed, we observed that the SKIN care bundle was not always completed.

A patient who was at risk of pressure damage had been prescribed nutritional supplements drinks on admission.

The medicine kardex evidenced that the supplement drinks had been given to the patient less frequently than prescribed. The kardex did not evidence that the patient refused the drinks.

Recommendation: Supplement drinks should be administered to patients as prescribed and any refusal should be clearly documented within the medicine kardex.

When required, staff can contact tissue viability nurses for detailed advice and support. Staff were aware of the policy for the photographing of pressure ulcers. Staff were aware of the need to complete an incident form and carry out a root cause analysis for specific grade hospital acquired pressure ulcers.

Mattress audits are undertaken three times a year in the trust, March, July and November. Mattresses are assessed using a mattress assessment standard which inspects against permeability, damage and bottoming out. When questioned, not all staff were aware of the need to open the mattress cover and check the foam mattress between patient uses.

Housekeeping point: Staff should be aware of the mattress checking process between patient uses.

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.) were available on the ward if required. Stool charts were in place and appropriate for patient conditions.

4.4 Is Care Compassionate?

Person Centred Care

The ward was bright and welcoming, and although staff were busy, the atmosphere was calm. We observed caring, sensitive and insightful staff who anticipated the care needs 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.

Patients' personal hygiene needs had been attended to as appropriate, patients reported to be comfortable and were suitability clothed. An adapted form of intentional care rounding was in place (SKIN Bundle) which is aimed to ensure that nursing staff carry out scheduled tasks or observations for patients, to meet and anticipate their fundamental care needs.
We observed that for some patients, SKIN bundle interventions were not always documented as completed. Compliance with the SKIN bundle is assessed as an element of the ward KPI audit programme.

Housekeeping Point: Interventions outlined within the SKIN care bundle should be implemented and the bundle documentation fully completed.

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 clean. Staff alerted patients prior to entering private areas.

Although staff endeavoured to maintain the dignity of patients, ward facilities made this difficult. We observed that patients who were admitted for day surgery had to change into a theatre gown in a toilet area as no changing rooms were available on the ward. One patient who had just changed into a theatre gown was observed walking up the ward corridor to the day room with a nurse; the gown did not adequately provide sufficient coverage to maintain the patient's dignity.

We observed that same sex accommodation in patient bays was not always being achieved. We observed female patients in male designated bays. We were informed that this had been due to an increased demand for hospital beds. It was a reported as being difficult for nursing staff to maintain the dignity and privacy of patients cared for in a mixed sex bay. The trust should take every opportunity to eliminate this practice as achieving single sex accommodation plays a pivotal role in upholding patients' privacy.

Ward washing and toilet areas were extremely limited. There was only one male toilet and two female toilets on the ward. Toilets were not easily accessible for those patients with mobility problems. We observed that a number of patients used a commode at the bedside due to availability of the toilet. We were informed that a new hospital ward block is being constructed which will address the limitations of current toilet and washing facilities.

Auditory noise was kept to a minimum although one patient commented that their sleep was disturbed at night-time due to the noise of the closure of waste bins. We were informed that soft closure waste bin are being ordered for the ward.

The ward sister's office was mostly used for quiet private conversation with patients or relatives.

Picture 9: Corridor bed

During the inspection we observed a 'corridor' bed (Picture 9). Documentation provided for inspectors highlighted that this bed should only be used as a last resort, in the event of extreme bed pressures. Although we didn't observe this bed in use during the inspection, staff informed us that this bed is used frequently.

These ‘corridor’ beds do not have access to a nurse call bell, or piped oxygen or suction. We were informed that consideration is given to choosing the most appropriate patient to be cared for in a corridor bed through risk assessment e.g. patients with minimal to moderate risk factor co-morbidity. This corridor bed however presented a significant challenge for ward staff in maintaining the dignity and privacy of patients without appropriate fixed curtained screens. Patients who are placed in this bed are in full view of passing corridor traffic from the adjoining ward. A risk assessment with control measures had been completed for the placement of patients in corridor beds.

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

Communication

Picture 10: Poorly positioned infection prevention and control precaution poster

There was good signage to direct visitors to the ward. Where required, there was discreet signage relating to fasting, communication aids and nutritional assistance. We did observe that a poster to guide staff in the appropriate infection prevention and control precautions to be employed for a patient identified with an alert organism, was not clearly displayed (Picture 10).

Housekeeping Point: Staff should ensure that all signage is clearly displayed.

Not all ward staff were easily identified as they did not wear name badges.

Housekeeping Point: All staff should wear name badges.

We observed that staff treated patients and visitors courteously. On most occasions staff engaged well with patients and provided easily understood explanations prior to carrying out care. On some isolated occasions, when nursing staff were carrying out medicine rounds, we observed that engagement with patients could be improved.

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 range of patient literature was available on the ward covering disease and procedure specific information, health advice and general information.

The privacy of information was maintained within the ward. Most staff endeavoured to speak with discretion when discussing patient information.

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. Staff can access Guidance for the Management of Symptoms in Adults in the Last Days of Life via the trust intranet. The DoH has recently endorsed NICE Guideline NG31 - Care of dying adults in the last days of life.

24 hour palliative care advice is available from the palliative care team, and Marie Curie out of hours service. Ward staff have received training in palliative oral hygiene and one ward RN had been nominated as a palliative link nurse.

At the time of inspection, there were no patients on the ward requiring palliative care intervention. The ward has four side rooms, two with ensuite facilities. Family members can remain with their relative while they are on the ward. Car parking permits can be issued by the ward sister. Information and bereavement support systems were available for patients and carers. Chaplaincy services are available on request.

During the inspection, no patients had been assessed as requiring a DNAR order.

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 perceptions of staff communication, and the care they received, including pain management; food and nutrition; infection control; and safety.

During the inspection a total of 10 questionnaires were carried out in Ward 11:

- seven Patient Questionnaires
- three Relatives/Carers Questionnaires

Overall, the feedback received from patients was good. They were satisfied with the standard of care they received. Staff introduced themselves; they were polite and addressed the patient by the correct or preferred name. Staff were courteous and compassionate and patients and told us they received assistance when required and that they were treated with respect and dignity. Only half of the patients questioned required a call bell and they were responded to in a timely manner.

Half of the patients questioned reported that there was enough staff to care for them, two patients told us that there was not always enough staff and one patient said there were never enough staff.

Similarly while some patients were involved in decisions about their care and knew who to speak to if they had concerns, some patients did not. Patients reported that staff did check on patient pain management and analgesia was given in a timely manner.

Patients commented that the ward was clean and in general the choice of food was soft diet. Fluids were readily available; none of the patients questioned required assistance at meal times. Patients reported that they observed good staff hand hygiene practices.

In general, patients were satisfied with the information they had received regarding the period of time they would be on the ward. Patients reported that they felt safe and had received a good standard of care during their stay and would be happy for a member of their family or a friend to be cared for in this ward.

Relatives told us that they felt welcomed and most of the time knew who to speak to about their relatives care although one relative said they never knew who to speak to. Relatives reported that they felt that their relatives were treated with dignity and respect and staff kept them informed. Relatives advised us that they felt staff had time to care and the standard of care was good.

Patients Comments

"The consultant does discuss things with me. As far as others are concerned it depends on who you go."

"If they have time, they are very busy."

"I go to nurses or sister, doctors are around every day too - it's magic."

"Things are difficult at shift handovers. There are not enough nurses."

"In day time probably enough, at night time not enough".

"I think there are times when they are really pushed and I don't like asking them."

"For me state of these old wards is well kept."
"The building is 'tired'. There are maintenance issues such as toilet flushing and the coat hangers."

"I would always have a good word to say about the ward. Everybody is pleasant which I think is lovely."

"They do listen to anything I say and take it on board. They are good. They are a special lot of nurses here."

Relatives Comments

“I always feel as if I am disturbing them. I understand they are very busy and I don't want to take them away from their duties.”

“”They've always made me feel welcome. They are all very busy.”

“They've always been very good and very helpful.”

Observation of Practice

Observation of communication and interactions between staff and patients or 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 throughout the 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.

Twenty four observations were carried out over four observation sessions. Overall, staff interaction was good. Staff introduced themselves, engaged in conversations and gave explanations of the procedures they were carrying out, providing support and care and treating the patient as an individual. Basic interactions related to minimal conversation or engagement with the patient.

Neutral and Negative observations were in relation to a nurse giving medications with no interaction with the patients and staff using inappropriate terms when referring to a patient for example “bed 5” rather than use the patients name.

On three occasions staff failed to preform hand hygiene after patient contact and some staff failed to carry out all seven steps when preforming hand hygiene.

4.5 Conclusions for Ward 11

We saw examples of positive leadership at ward level. Normative staffing levels have allowed the ward sister to be primarily supervisory; however limitations in ward staffing levels have meant that the sister has had to take a more active role in patient care activities. There was a large deficit of RNs within the ward. The trust had undertaken a number of activities to fill vacancies.

Morale was good, however it has been unsettling for many staff since the decision was made to close the ward. Complaints, incidents, audits and service performance information were discussed and actions agreed. There were systems in place to protect patients from the risk of abuse.

There were a number of mechanisms utilised to disseminate information to staff; however some mechanisms require improvement. Staff received necessary training to enable them to carry out their roles effectively.

The fixtures and fittings of the ward were old; it was however maintained to a reasonable standard; storage capacity was limited. Known hazards in the ward environment had been risk assessed and preventive actions have been implemented. We did observe that emergency exits were compromised due to patient equipment. Checks of the emergency equipment were inconsistent and equipment cleaning schedules were poorly completed. Adherence to good infection prevention and control practices required improvement. Not all staff complied with the trust policy in the use of personal protective equipment.

NEWS, were completed within set timescales and there was an appropriate clinical response to triggers. The Sepsis Six bundle should be introduced for the early recognition and management of sepsis. Overall, medicines management requires improvement.

We observed that same sex accommodation in patient bays was not being achieved. There were limited washing and toileting facilities within the ward. These limitations presented challenges for ward staff in maintaining the dignity and privacy of patients. The corridor bed also added to these challenges.

We observed variations in the recording and completion of some nursing documentation. There was a good meal menu choice and the protective meal service allowed patients to eat their meals in a calm and relaxing environment. Not all patients were receiving nutritional supplements as prescribed. Patients reported to be comfortable and adequate pain relieving comfort measures were available. Staff responded promptly to requests for pain relief.

We observed that overall, staff were committed to the care of their patients. Patients and relatives we spoke with were overall positive about the care they received.

Overall the findings of the inspection of ward 11 were good. We have made **23** recommendations and **15** housekeeping points.

4.6 Recommendations and Housekeeping Points

Recommendations

1. The ward sister should have protected time to undertake the managerial duties of the post.

2. Staff team meetings should occur more frequent and safety briefs should follow a clear structured criterion used to heighten staff awareness of salient patient safety issues.

3. The trust should ensure that any identified nurse staffing variances are reviewed to ensure that patient care and safety is not compromised due to staffing levels. The recruitment of new staff should be expedited.

4. Staff supervision and appraisal should be in line with trust policy.

5. Staff mandatory training should be kept up to date.

6. The trust should review the social worker referral system to ensure that there are no delays in patient review.

7. The trust should ensure that appropriate adaptations are put in place to meet the needs of patients with a physical disability and those patients with dementia.

8. All staff should comply with the trust hand hygiene and PPE policy.

9. Staff should ensure that they aware of the key principles of ANTT and invasive device documentation should be fully completed.

10. Staff should ensure that equipment is clean and equipment cleaning schedules should up to date and audited by a senior member of nursing staff.

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

12. The trust should review patient access to key diagnostics out of hours.

13. It is recommended that medicines are stored safely and securely.

14. Registered nurses should adhere to NMC Standards in the administration of medicines.

15. Medicine kardexes should be fully and accurately completed.

16. The trust medicines management policy should updated to clearly guide staff on patients' self-administration of medicine.

17. An integrated medicines management service should be provided.

18. Nursing care records should be improved to accurately reflect patients' needs, their involvement in their care, and be in line with NMC standards of documentation.

19. Staff should ensure that fluid balance and food record charts are completed and reconciled in accordance with trust policy.

20. The system in place for delivery of patients' meals should be reviewed. Staff should ensure that patients receive meals at standard mealtimes.

21. Staff should ensure that pain relieving medication is administered promptly as prescribed.

22. Supplement drinks should be administered to patients as prescribed and any refusal should be clearly documented within the medicine kardex.

23. The trust should ensure that arrangements in place promote the privacy and dignity of patients, especially the use of escalation beds and same sex bays.

Housekeeping Points

1. Incident and complaint trend reports should be available for staff to review.

2. The current system of a written handover should be reviewed.

3. Action plans should be completed for areas of non-compliance with KPIs.

4. Ward nursing staff should attend morbidity and mortality meetings.

5. Staff should ensure that items of equipment that present a trip hazard should be removed.

6. The resuscitation trolley should be cleaned and checked daily. Staff should ensure the sharps box on the trolley is renewed after use.

7. Staff should ensure that emergency exit doors are free from obstruction.

8. Staff should be reminded of the trust policy in relation to transfer of medicines between wards.

9. A system should be introduced to ensure the timely removal of expired medicines.

10. The date of opening should be recorded on medicines with a limited shelf life once opened; staff should be familiar with the in use expiry date.

11. Staff should ensure pain assessments on patients NEWS charts are consistently completed.

12. Staff should be aware of the mattress checking process between patient uses.

13. Interventions outlined within the SKIN care bundle should be implemented and the bundle documentation fully completed.

14. Staff should ensure that all signage is clearly displayed.

15. All staff should wear name badges.

Inspection Findings:
Emergency Department

5.0 Inspection Team Findings: Emergency Department

Emergency Department

The Ulster Hospital ED is a busy type 1 Emergency Department. It is divided into five distinct areas; Minors, known as Rapid Assessment Treatment Unit (RATU) and including triage, Majors, Resus, Observation ward and Ambulatory care. There is also an Urgent Care area which is run by the emergency nurse practitioners (ENPs).

There are four cubicles in Urgent Care, two rooms in triage and seven cubicles, a consultant's room and investigation room in RATU. The High Dependency Unit (HDU) is a bay with four bed spaces which can take two additional beds; there is one paediatric and one adult resus cubicle. Majors consists of nine cubicles, one secure room and one procedure room. The Observation Ward has 11 bed spaces, no piped oxygen or call bells and the Ambulatory Ward is configured for a mix of trolley and beds (n=10). Call bells and piped oxygen are available.

5.1 Is the Area Well Led?

Governance

We were informed that there are two band 7 managers who alternate clinical and office based duties, and who are responsible for the allocation of resources that facilitate unit function and management. On day one of the inspection, we observed two band 7 RNs, one with clinical duties and the other with managerial office based duties. They were supported by one band 6 sister who coordinated floor activities and was identifiable by wearing a red 'Nurse in Charge' badge.

We were informed that the designated shift leader is either a band 6 or band 7 sister/charge nurse. We were told that when staffing levels are good, a band 6 manages RATU, Observation ward and Ambulatory ward while another band 6 manages Majors, HDU and triage. On day two, we found the night shift designated leader was a senior band 5 RN.

The band 6 RN, designated in charge, was working on the floor with 13 RNs, two preregistration nurses and two healthcare assistants. Throughout the inspection, staff told us morale was low. The majority of staff reported that they were not supported and valued by the directorate senior management team. We were told by the majority of staff that they did not feel empowered to raise any concerns when appropriate.

Recommendation: The trust should put in place systems to support staff working in ED.

Staff have access to a range of policies and procedures. An annual report of trust complaints and compliments was available on the trust website for public viewing. A record of verbal complaints concerning the ED was however not available. Verbal complaints should be held locally to allow any trends or patterns to be identified. Staff were not aware that trends for verbal complaints are examined by the trust.

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

We were informed that crowding in the ED had been included on the directorate trust risk register. We observed and discussed with the band 7 other risks that should be assessed and if necessary placed on a risk register such as, lack of available buzzers and piped oxygen in the observation ward. We were told that patients are risk assessed prior to admission and are moved out in the event of deterioration.

Recommendation: Identified risks such as lack of available buzzers and piped oxygen should be assessed and where necessary placed on the trust risk register.

Staff told us they were aware of the process for reporting of SAIs, incidents and near misses; however, they were unaware of any formal analysis of trends. We examined minutes of staff meetings where incidents and complaints formed part of the agenda. We also examined a significant audit report (July 2015) which recommended the implementation of a revised falls safe bundle in the Ambulatory ward for all patients awaiting admission. This however had not yet been actioned.

Recommendation: The trust should ensure that formal analysis of SAIs, incident, near misses and complaints is conducted and shared with staff.

We were told that the band 7s do not attend ED specific morbidity and mortality meetings as part of professional learning. However, we were told the MDT has discussed its intention to set up a group which will include nursing staff. The band 7s receive quarterly reports from the resuscitation team of the trust cardiac arrest rates for dissemination to staff.

Housekeeping point: The trust should facilitate the establishment of nurse attendance at ED mortality and morbidity meetings.

Monthly nursing team meetings are held; however we were told that as a result of increased staffing pressures during November and December 2015, meetings were cancelled. Minutes of staff meetings demonstrated poor attendance levels. Minutes reviewed provided evidence of ED representation at other meetings such as a Major Incident Planning Workshop, ED Governance Meetings, the Bereavement Forum and Senior Nurse Meetings.

In the observation and ambulatory wards in the ED we observed three of the five key performance indicators, subject to continuous review at senior nurse meetings. These indicators include compliance with NEWS charts, SSKIN bundle and the VTE risk assessment.

Only hand hygiene compliance is audited in the main ED. We were informed that none of the areas in ED carry out audits of falls, MUST and invasive device care bundles. The ED receives formal reports on a monthly "balance score card"; these demonstrated repeated poor hand hygiene compliance. We were not provided with evidence of action plans developed or escalation audits carried out.

Recommendation: Senior ED staff should introduce where appropriate further nursing quality performance indicators into ED. Action plans should be developed to improve practice.

Department of Health Targets for Emergency Department

Emergency departments throughout Northern Ireland are monitored in line with two overarching Ministerial targets to ensure patients are seen and treated as quickly as possible:

1. The four hour target aims to ensure that as many as possible of emergency care patients are seen, treated and either admitted or discharged within four hours of their arrival in the department. The national target is 95 per cent.

2. The 12 hour target aims to ensure that no emergency care patients wait longer than 12 hours to be seen, treated and either admitted or discharged.

The Ulster Hospital has failed to achieve these targets.

Patient's time to triage within 15 minutes of arrival at ED is a new DoH indicator introduced for 2015-16. The hospital target of 85 per cent is not always achieved.

Data forwarded from the trust to RQIA indicated that the trust had a 55-62 per cent achievement rate throughout January 2016 for patients being seen within 60 minutes of arrival in ED. This is an improvement on monthly figures for October 2014 to October 2015.[2]

Monthly figures demonstrated that the ED was achieving the College of Emergency Medicine standard of less than five percent of patients leaving the ED before treatment was complete. There were also fewer than five percent of unscheduled re-attenders to the department.

[2] South Eastern Health and Social Care Trust Performance Management Framework, Corporate Scorecard October 2015

We observed the ED has an information technology (IT) system for tracking patients-the electronic Emergency Medicine System (eEMS).

Every staff member has access to this system and two trackers are employed to keep information up to date. During the inspection, one tracker was on sick leave and one had just returned from sick leave and was working only part time hours. We were informed that senior ED staff have asked for more funding for this position as nursing staff continually had to update the system in the absence of a tracker.

Staffing and Supervision

We were informed that the trust has recently been active in the recruitment of nursing staff for the ED. Funding has been granted to employ further staff including band 7 RNs. Nine RNs and two band three healthcare assistants have been employed since November 2015. Although a positive step, we were informed that it has presented challenges in managing nursing staff skill mix within the department. We were informed that the two band 7 RNs alternate weekly between managerial and clinical duties. Their shifts cover Monday to Friday, so there is not always band 7 RN cover, in the evenings, at weekends or nights. We were told that band 6 sisters have been allocated one administration day a month but this had ceased due to low staffing levels. The band 6 is needed for clinical duties in ED. A large proportion of nurse in charge shifts, including night duty, are designated to band 6 staff. On day two of the inspection, a band 5 RN had been designated nurse in charge for the previous night shift as due to unplanned sickness there were no band 6 RNs available.

Discussion and review of duty rotas identified that staffing within the ED was inadequate to meet recognised staffing requirements. For example, there were only one to two nurses in resuscitation, rather than one per patient. On the busy afternoon of the second day of the inspection, there were two RNs allocated to HDU and Resuscitation to deal with seven patients in total. We were advised that the he band 7 had been unsuccessful, in obtaining bank staff.

We were advised that staffing levels were supplemented with the use of bank and agency nurses, however, as previously stated, shifts were not always filled. Due to the pressures on the ED service and increased patient numbers, there were occasions when in different areas within ED nursing staff had to stay later than anticipated. We were told by staff that they are worried about maintaining patient safety, especially when the ED is crowded. We were informed that review of normative staffing levels by NIPEC is an ongoing project. We were advised that staff retention has become an issue over the last year, with staff leaving the department, due to personal circumstances, some to more senior posts, with one retirement. There were nine WTE RN vacancies and of the eight staff on sick leave, three were due to return on the week following the inspection. Completion of the normative staffing review may affect the requirement for further staff.

Recommendation: The trust should review the role, number and skill mix of nurses in ED.

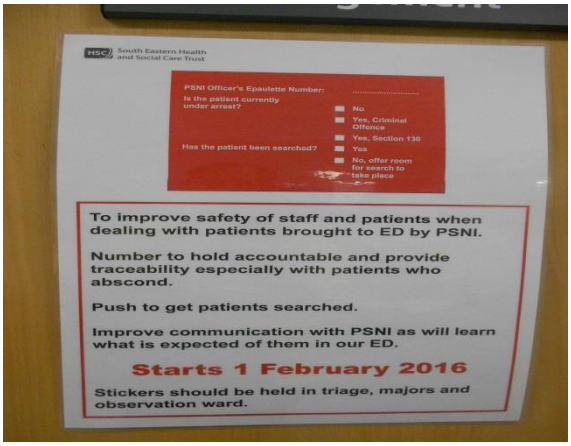
We were informed by the majority of nurses that they enjoyed working within ED. However, they told us that when having to deal with issues including crowding, staff shortages, increased patient acuity, and patient placement, they were not always valued or supported by senior staff. Staff raised concerns 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 but staff told the inspection team that they were not aware of action taken to address these issues.

Recommendation: Senior trust staff should communicate with ED staff regarding concerns relating to crowding, staffing levels, patient acuity and other issues raised by ED staff.

In the ED all doctors in training were positive about their clinical experiences with opportunity to manage a wide range of emergency presentations. They told us there is close supervision by the several consultants present and a middle grade presence (ST3 or above) 24/7. There is weekly protected teaching in the department on Wednesdays which was highly valued in addition to monthly regional teaching which they had few difficulties in attending. Simulation exercises and teaching were highly commended by the doctors interviewed. Doctors in training and Staff Grade doctors working in the department told us they had no patient safety concerns with regards treatment delivered by the ED. However, they mentioned, crowding, slow patient flow, long ambulance waits and difficulty in finding beds in the hospital as having a significant and detrimental impact on quality and effectiveness of care. Doctors in training reported that medical staffing in the ED was good but identified a lack of nursing staff, especially when there were large numbers of 'medical' patients outlying in the various areas in ED such as short stay observation ward and ambulatory unit.

Nursing staff informed us that they do not always feel safe. There can be a delay in response from security staff when they are short staffed and in these cases nursing staff call the Police Service for Northern Ireland (PSNI) for assistance, if required.

We were told of a new initiative had commenced on 1 February 2016 to improve staff safety when dealing with patients brought in by the PSNI. This will provide traceability for patients who abscond, improve communication with the PSNI and alert staff if the patient needs searched (Picture 11). Stickers were available to post in the patient's notes to inform staff of the patient's status.



Picture 11: PSNI prisoner alert information

Staff did not carry personal alarms.

We observed and staff told us that the isolation of staff in the observation ward had been acknowledged by as a risk by senior management. We were told that senior staff had agreed that the VOCERA real time voice communication system would be installed. This however was not in place at the time of the inspection.

Recommendation: To provide a safe working environment, the trust needs to review the provision of security staff on the hospital site and ensure VOCERA is installed.

We identified and were told that Practitioner Assistants (PAs) are an asset to the ED. PAs support staff by carrying out venepuncture, cannulation and ECGs and it is planned to recruit more staff to this role. Support services, while not all on site at weekends, are accessible seven days a week. Within ED, there are two occupational therapists and two physiotherapists Monday to Friday, with partial cover on Saturdays and Sundays. A social worker is on duty 8.00am to 8.00pm Monday to Friday and 8.00am to 5.00pm at the weekend. Two pharmacists and a pharmacy technician work Monday to Friday 9.00am to 5.00pm. Staff told us that timely access to these services assists with patient recovery, patient flow and, on occasions, prevent admissions.

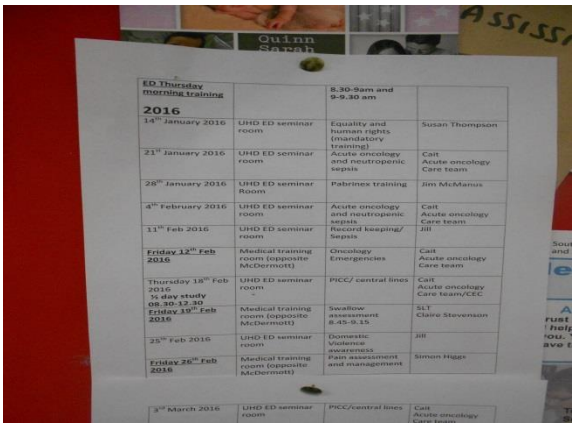
The PHA, as part of commissioning services, plans to invest in the development of AHP services within EDs across Northern Ireland. This will allow for the establishment within the ED of AHP cover, 9.00am to 5.00pm, seven days a week.

Staff Training

There is a two week ED induction programme for newly qualified band 5 staff nurses and experienced nurses new to ED. We were informed that new starts are supernumerary for two weeks. Newly appointed staff, when questioned, were unaware of their supernumerary status.

Newly qualified staff stated that two weeks induction was inadequate to prepare them to work in an ED. While they had been provided with mentors and preceptors, staffing pressures had resulted in their mentors and preceptors not working on the same shift.

Staff were unable to provide the inspection team with a staff training matrix for ED; the band 7 confirmed that mandatory training statistics were not up to date as a result of nursing vacancies. The trust has recently appointed a clinical educator for the trust EDs and a component of this role is to set up a training database and organise mandatory training. Since this appointment, a mandatory training and additional in house training programme has been established for staff which runs every Thursday 8.30am to 9.30am (Picture 12). Friday morning sessions are consultant led with a multi- disciplinary approach running simulation exercises, mock scenarios and resuscitation exercises. We were told that all staff working in triage had received training commensurate with their role.



Picture 12: ED training schedule

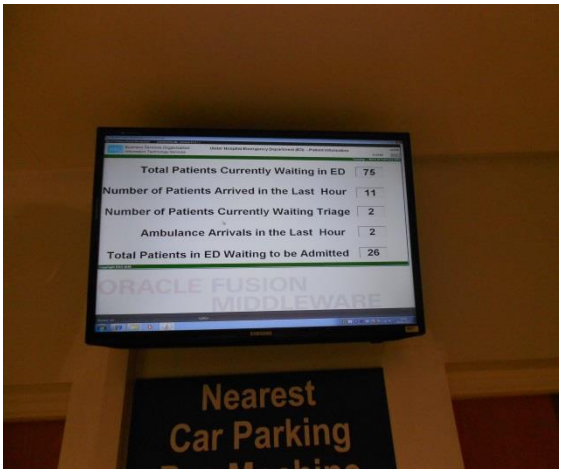
The band 6 RNs and ENPs support the ward sister through carrying out clinical duties and mentoring and supporting junior staff. However, information supplied during the inspection identified that yearly mentorship training; supervision and appraisal were not up to date.

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

Additional training such as MAPA, butterfly scheme, ASIST, STORM, venepuncture, NIPPV, nursing spinal injuries and intravenous antibiotic training was available. However information provided identified that uptake of mandatory and additional training needs to be improved.

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

Patient Flow



During the first morning of the inspection, staff were dealing with the aftermath of a very busy night. There were 26 patients, not allocated a bed space, waiting for admission. Staff worked diligently to transfer the patients and manage patient flow effectively (Picture 13). It is of note, that despite the crowding and number of additional patients, the overall atmosphere within the ED was one of calm.

Picture 13: Patient Information in main waiting area

On the afternoons of the first and second days of the inspection we observed a surge in activity within the ED which resulted in the entire ED being crowded. The crowding peaked in the evening, however issues of crowding were observed for the remainder of the inspection.

In the ambulance corridor, RATU and majors, we observed that the number of patients exceeded the number of designated assessment spaces. RATU and majors became quickly congested with patients placed on chairs and trolleys in very close proximity to one another, in and around the central work stations. We observed that ambulance triage was, on many occasions during the inspection, crowded; Northern Ireland Ambulance Services (NIAS) staff were chaperoning patients who were waiting to be triaged and admitted.

Nursing staff told us they found it challenging to meet and prioritise the care needs of patients. During this period we observed that staff were actively working to remove any obstacles to patient flow however limited bed capacity throughout the hospital was seriously impacting on flow.

As a result of crowding we observed patient dignity, privacy and timeliness of nursing care compromised. Specific issues will be discussed in further detail throughout the report.

At the time of inspection, the trust Unscheduled Care Escalation Plan was still a working document. When questioned about the escalation plan, some staff were unaware of it and some stated they acted by experience. The escalation plan held in ED for staff to reference was out of date.

Recommendation: The trust should agree and sign off the Unscheduled Care Escalation Plan and ensure all staff in ED are aware of the contents and actions to take.

We did not observe any walk rounds by senior nursing and medical staff. We were told by nursing staff that the nurse in charge carries out a two hourly board round in each area and discusses NEWS.

We were also told that an ED consultant joins the 4.00pm board round and medical staff have an MDT meeting every afternoon. Regular joint rounds with senior nursing staff and ED consultants did not take place. Nursing staff advised that medical staff were very approachable and constantly talked to nursing staff on the floor. We observed good one to one medical and nursing staff engagement.

Housekeeping point: There should be more frequent joint reviews of patients by both senior medical and nursing staff.

Senior staff advised us that the ED was particularly busy prior to and over the period of inspection, however this was becoming a more normal event. We recognised this increase in the number patients and the resultant increased pressure all staff were under to institute effective care for patients during this time.

We were informed that there have been a number of initiatives to try to improve ED waiting times by trying to streamline several patient admission routes and areas that feed into the ED. A new area has opened up in ED, known as Urgent Care.

This is run by ENPs who can triage and treat patients without having to go through the main ED. Ambulatory care is an area which provides medical care on an outpatient basis, including diagnosis, observation, treatment and rehabilitation. The area can also be used from time to time for ED patients waiting for an in-patient bed. There are eight trolley spaces and two recliner chair spaces in the unit. During the inspection, there were 11 patients on a combination of trolleys and beds. There are no shower facilities in this area.

The observation ward is designed to provide rapid and highly competent clinical assessment and targets patients with low to moderate risk symptom who could be discharged within 48 hours. There are 11 bed spaces but no piped oxygen, call bells or shower facilities. No patient can be admitted to the ward unless agreed by an ED consultant. During the inspection there were 12 patients in the observation ward.

We observed that both wards, mentioned above, were functioning as a medical inpatient ward. Patients were not flowing through the hospital and discharge was not facilitated within 24 or 48 hours. We were advised that activity in the main hospital site, lack of discharges, pressures on ward services and lack of inpatient beds impacted on the movement of patients through the ED.

Recommendation: The trust should review patient flow from the ED to cope with the demands placed upon the service.

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

Safety briefings for nursing staff are held at 7.30 am, 12.30 pm and 8.00pm (night duty) in the staff room. The safety brief was led by the nursing shift lead. We observed in the morning that the brief was well directed informative and succinct. Staff were given a quick update of department patient status, nurse allocation, staff sick leave, infective patients, incidents, unexpected deaths and any patients who have absconded. Actions taken were discussed. Staff used a document entitled the 'ABC Emergency Department Handover Safety Brief. The briefing also allowed staff to be informed of any infection control, equipment and medication issues, training courses, memos or alerts. The shift leader then raised any issues which had been highlighted on a white board (communication board). The brief was signed by both the handover and receiving nurse.

A more detailed handover of specific patient information for oncoming and departing nursing staff was exchanged in each area. We observed a handover carried out this took account of patient privacy and dignity.

Communication

We were informed and were provided with evidence that showed that communication and dissemination of information to staff is through various formats such as safety briefings, handovers, ward meetings, staff room communication board and email access for all staff. In August 2015, the trust launched the Every Day Matters newsletter. This bulletin is produced quarterly to improve communication, celebrate successes and recognise staff commitment to the emergency department. It reports on items such as: workforce, service developments, improvements, infection prevention and control issues, 10,000 voices, NMC revalidation etc. A bi-monthly Medical Directorate Learning Lessons Bulletin aims to support staff by communicating and strengthening the lessons learned, from SAIs and complaints but also to share and showcase good practice and provide examples of exemplary care by directorate staff.

Clear communication is essential in healthcare settings. We observed the HOTBOARD initiative which allows staff to update service users about services provided in the ED. The boards also provide information about the nurse in charge, visiting in ED, compliments, triage and the ENP service. Information is updated six weekly. The department was in the process of establishing an ED 'Facebook' page. This will be across the three ED sites and will be a closed group, accessible to ED staff only.

All medical and nursing staff had access to ECR to access up to date patient GP information.

The ED, as part of the PHA's 10,000 voices patient experience initiative, received a breakdown of issues that had been identified within the department.

The role of volunteers in ED has been discussed as a means of improving communication. Trust board information regarding the patient experience was posted on the trust internet site.

While it is commendable that the trust has provided and facilitated different forms of communication and dissemination of information for staff, there remains a disparity in what is provided and staff understanding of the information. We were told by numerous staff that they were unsure of what was happening in ED and what was being planned for the future.

Housekeeping point: The trust should facilitate more face to face engagement between senior management and ED staff to promote better dialogue and a forum where issues raised can be discussed.

Safeguarding

Arrangements were in place to safeguard adults and children from abuse that reflect legislation and local requirements. 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 the consultant paediatrician is called immediately and child protection procedures should commence. Staff are aware that additional safeguards are required for children, including completion of a UNOCINI assessment.

5.2 Is Care Safe?

Environmental Safety

The environment was light and bright. Equipment stores were inaccessible to patients and key pads were in use. However we observed patient equipment and bed trolleys stored in corridors and accessible to the public within ED areas such as RATU, ambulance triage corridor and majors (Picture 14). We observed the resuscitation trolleys in RATU, majors and paediatrics were dusty, daily checks were inconsistently recorded and sharps boxes were used and not changed. We observed that the majors area when crowded presents a challenge for staff if they have to manoeuvre resuscitation equipment in the event of an emergency. We observed that nursing staff could maintain visual contact with patients who required supervision by placing them close to the nurse's station.

Picture 14: Trolleys in corridor

Housekeeping Point: Staff should ensure daily checks are carried out on resuscitation trolleys.

The ambulance triage area consists of a single corridor. The corridor has no natural light, and at times of peak pressure can become very congested, with space insufficient to cope with patient numbers. At peak times we observed patients and NIAS staff extending into the corridor leading to the triage corridor.

We observed in this area, at one period, six ambulance crews with patients waiting to be handed over to nursing staff. This can compromise patients' safety, dignity and staff's ability to provide the right care for a large number of patients in such confined space. It also compromises their ability to respond in a timely manner to an emergency situation.

We observed that the RN working in ambulance triage also carried out duties in majors and was constantly working between two areas. Patient observation in ambulance triage and in the resuscitation area is difficult when staffing levels are inadequate and there is patient crowding.

Contact details for the resuscitation team were clearly displayed, toilet facilities were disability friendly and there were clocks in cubicles and various points in ED.

Infection Prevention and Control

The ED environment was clean but damage was noted to floors, walls and doors. Repairs to and painting of walls was in progress during the inspection. The vinyl cover on some chairs was badly torn exposing the foam underneath. Environmental cleanliness audits were carried out and trust compliance rates were achieved. Clinical hand wash sinks, alcohol rub and glove and apron dispensers were clean and easily accessible, located near to the point of care. We observed some dusty or stained equipment and some observation trolleys were old with damaged paintwork. We observed on one occasion a patient admitted with gastro enteritis who did not have an infection prevention and control alert sign in place.

We observed that not all staff carried out hand hygiene at the appropriate times, in line with WHO five moments of care standards, for example after contact with a patient and surroundings, after body fluid exposure and removal of gloves. Staff did not always wear PPE correctly or adhere to ANTT procedures and invasive devices and blood cultures were not managed or documented in line with best practice guidelines. As mentioned previously, the recent poor compliance with hand hygiene standards had not been escalated or an action plan put in place to raise compliance levels.

Recommendation: All staff disciplines should carry out hand hygiene in accordance with the WHO 5 Moments of care, adhere to aseptic non-touch technique and wear PPE appropriately.

Patient equipment cleaning schedules were inconsistently completed and not validated by senior staff.

Housekeeping Point: All patient equipment should be identified on cleaning schedules and cleaning schedules should be audited to ensure compliance.

Patient Safety

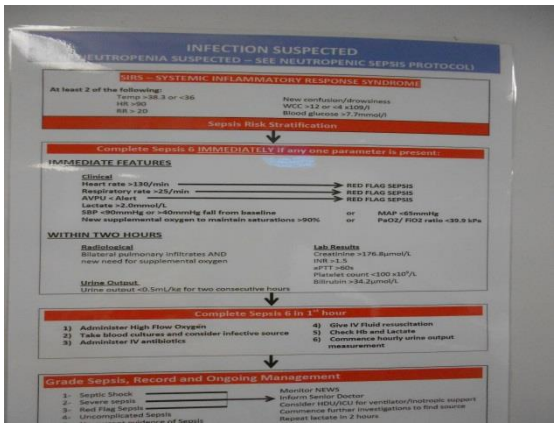
All patients we observed wore an accurately printed identity band and staff were aware of the actions to take when identification details were incorrect.

Guidance on the management of the acutely ill patient was available. Patient NEWS were not always totalled or completed within set timescales, although we observed improved practice when the ED was not so busy.

In one set of nursing records, staff did not record an escalation of the NEWS score or the appropriate triggered response in accordance with the NEWS algorithm.

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

A Sepsis Six bundle for the recognition and timely management of sepsis was in place in some wards in the hospital. A sepsis checklist proforma was available in ED and a copy was posted on the wall of Resus. On review of notes, two patients with indicators of likely sepsis (increased temperature, tachycardia) had not been commenced on a sepsis pathway and one had been started on a renal colic/stone pathway. A number of other Sepsis 6 components such as lactate measurement and blood cultures had also not been completed. Sepsis should be audited regularly and uploaded to the Trust's qlicview. However we were advised by staff that the Sepsis Six bundle was not routinely audited in ED (Picture 15).



Picture 15: Neutropenic Sepsis Protocol

Housekeeping Point: Effective use of the Sepsis Six bundle should be robustly audited in the ED.

There was no system in place in the ED to monitor falls. We were advised that following an audit in July 2015, the falls safe prevention bundle was to be introduced in the ambulatory care ward for all patients awaiting admission. A review of records and discussion with staff indicated that this action had still not been implemented.

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

The SSKIN bundle was available for use within the observation ward of ED however review of notes demonstrated that none of the patients had been risk assessed for the bundle nor was a bundle in place. This was disappointing as the trust KPIs April 2015 to December 2015, illustrated a dip in compliance during July to September (59 per cent) and an improvement in November (90 per cent) with 100 per cent compliance in December 2015.

Housekeeping Point: The observation ward SKIN bundle should be used by staff and robustly audited.

On the evening of day one, we were informed by a consultant in RATU that two patients were unable to have cardiac monitoring in RATU as the monitor was broken. One patient was elderly and was waiting in an arm chair in RATU; the other patient was sitting in the waiting room as there was no space available in RATU or HDU. The monitor was subsequently repaired and in use the following day. We observed an ultrasound machine which was unable to print out results. Staff told us that speedier action could be taken by senior management when safety concerns such as staffing levels and patient flow are raised. We were told by staff that when they question an action they are told to just get on with it.

Patient safety/medical alerts were communicated via safety briefings; a folder of action plans was 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.

We observed that consideration was given to patient placement, safety and vulnerability. However, within the short stay observation unit, as previously stated; there were no call bells, piped oxygen or showering facilities.

Patients brought in by ambulance were seen and assessed promptly by ED staff. However, at times of crowding within the ambulance receiving area, we observed patients accompanied by NIAS staff, waiting on chairs in the corridor leading to the ambulance triage corridor. This could delay handover by ambulance staff and had the potential to compromise patient safety.

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

As stated previously, the consultant and nurse in charge did not routinely carry out hourly safety rounds and four hourly patient reviews. Patient flow could be affected by lack of an effective patient review process.

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

A recognised assessment tool to identify high risk older patients is not in use.

Recommendation: A recognised assessment tool for all common frailty syndromes should be introduced.

Medicines Management

Storage of medicines was observed. All medicines were stored in locked cupboards accessible by keypads. The same key code was used for each medicine cupboard and we were told by staff that the code had not been changed for at least a year.

We observed that the cupboards were organised and medicines were stored in an easily retrievable fashion; however, injectable local anaesthetics had not been segregated from other injectable medicines.

Recommendation: Injectable local anaesthetics should be stored safely and securely.

Housekeeping: Key codes should be changed at timely intervals to prevent unauthorised access to medicines.

Controlled drugs were stored and administered safely. Controlled drugs were prepared by two registered nurses and both nurses were involved in the administration at the patient's bedside. Reconciliation checks were completed at shift changes. This occurred up to three times per day.

IV infusions were observed to be stored in their outer boxes. Potassium containing infusions had been segregated from other infusions; however, we observed they were stored close to other infusions and were not clearly highlighted.

A dedicated preparation area was available to limit interruptions; however, this was not always used to prepare IV medicines. It was found that one IV medicine was prepared in the main workstation in the department. This area was extremely busy and noisy. The administration of an IV medicine to two patients was observed. On both occasions, the medicine was prepared and administered by one rather than two nurse.

The administration of IV paracetamol to one patient was reviewed in the majors' area. The patient had arrived by ambulance, and the documentation indicated that IV paracetamol had been administered by NIAS staff. There was no evidence however of the time of the administration as the documentation provided by NIAS could not be located. IV paracetamol was subsequently administered by one nurse. The record of administration again did not show what time this second dose of paracetamol was given. It could not therefore be determined if the appropriate dosage interval for the administration of this medicine had been adhered to. Furthermore, it could not be determined when the next dose of paracetamol could be administered.

Recommendation: Nurses should adhere to NMC Standards in the administration of IV medicines.

Housekeeping Point: Potassium containing infusions should be clearly labelled and segregated from other infusions.

Kardexes reviewed in the ambulatory ward were not always fully completed. Start dates for medicines, the delay or reason for omission for some medicines, one patient's drug allergy status and the patient weight were not clearly and accurately recorded. Oxygen was being administered to two patients; this had not been prescribed on the kardex.

Recommendation: Kardexes should be fully and accurately completed.
One patient was responsible for the self-administration of their medicines; however, this was not fully recorded on the kardex. A trust policy or guidance was not available.

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

An integrated medicines management service was not being provided. The department did have a pharmacist assigned to it and staff advised that they had access to pharmaceutical advice if required. We observed there was limited pharmacist involvement in the reconciliation of medicines on admission or during inpatient stay in ED.

Staff advised that medicines were reconciled by a pharmacist in the dispensary on discharge if required, but this was usually only when anticoagulants were prescribed and during pharmacy opening hours. To assist with patient flow the trust have developed a list of medicines that are provided as over labelled stock to allow nursing staff to supply these at ward level against a discharge prescription. The pharmacist advised that following approval of funding, there was now a portable dispensary which would be used to dispense prescriptions.

Patients told us they that were involved in decisions about their medicines which included changes in dosing or commencement of new medicines during their stay. However, there was no evidence that patients' compliance with prescribed medicines had been assessed on admission or at discharge. It was established that there are occasions when patients are discharged without their medicines to expedite discharge.

We were told the medicines had either been sent by taxi, the family/representative had collected the medicines the following day or the patient was issued with a letter to take to their general practitioner.

Recommendation: An integrated medicines management service should be provided.

Discussion with staff indicated that they were aware of critical medicines. Staff had access to a list of critical medicines on-line and there was a system in place to show where the stock of medicines was held and could be obtained. A list of critical medicines was displayed.

Staff were aware of the procedures in place for reporting incidents and near misses but they were unclear of the process for feedback and sharing of learning following the incident.

5.3 Is Care Effective?

Nursing Care Records

Nursing documentation in all areas of the ED was reviewed. Nursing staff in ED documented nursing actions and observations in the admission booklet, or 'flimsy'. In the 25 nursing records reviewed, comprehensive nursing assessments and relevant risk assessments in relation to a patient's identified need were not in place. This impacted on nursing care plans which were more a diary of events rather than a plan of care. There was a specific admission booklet for the observation ward, however in all notes reviewed; the booklet had not been completed.

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 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 adhere to NMC best practice guidelines.

There was good written evidence of MDT involvement with patients, however, not all records demonstrated involvement with the patient and families in planning aspects of patient care, or discharge planning.

We were told by staff that keeping documentation up to date in real time was not always possible due to the a mix of acutely ill patients, and a very busy department.

Recommendation: Nursing care records should be improved to accurately reflect in detailed care plans, patients' needs and their involvement in their care.

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

Housekeeping Point: Nurse record keeping should be introduced as a quality indicator.

Medical Care Records

Several sets of medical notes throughout the various sections of the ED were reviewed. Entries were legible, dated and clear with evidence of direct senior review from middle grade and consultant staff where appropriate. Clear assessment and management plans were documented and relevant laboratory and imaging investigations with subsequent actions were recorded where appropriate.

With regards to sepsis management there was a sepsis management proforma available in the ED and a clear sepsis information sheet displayed on the wall of the resuscitation area. In two of three charts examined in the RATU, where a patient had a sepsis syndrome (symptoms including pyrexia, tachycardia) the sepsis proforma was neither referenced nor completed. In both cases there was no documentation of whether blood cultures had been considered or taken. Lactate levels had not been measured and there was a two-hour delay in administration of antibiotics over-night for a patient who subsequently developed a pyrexia >39C.

The trust delivers stroke thrombolysis via a dedicated acute stroke team both in hours and out of hours. Median door to needle time was 50 minutes with a lysis rate of nine per cent for stroke lysis calls. All lysis cases are reviewed at a monthly neuroradiology meeting and there is a bypass protocol agreed with NIAS for patients who would otherwise attend the Downe or Lagan Valley Hospitals. The service collects and audits all relevant data related to stroke thrombolysis and there are links to ongoing quality improvement initiatives in the South Eastern Trust.

Nutrition and Hydration

Patients within the ED, waiting for an inpatient bed were provided with meals as appropriate. Nursing staff were responsible for ensuring that individual patient nutrition and hydration needs were being met. Nursing staff oversaw the distribution of meals by catering staff, however there was no identifiable senior nurse in charge.

Housekeeping Point: A senior nurse should supervise and coordinate meal service.

We observed that a limited choice of meals was available at midday and in the evening; staff could request meals for patients with special dietary needs, for example gluten free or soft diets.

Meals provided were limited to two choices, however we observed that when catering staff served they did not offer the patient any choice. The meals looked appetising and a choice of tea, coffee or juice was served as part of the meal. The main kitchen closed at 6.00pm; an out of hour's trolley was provided with facilities to make tea and coffee and was stocked with custard, rice pots and a bowl of fruit. Staff stated they could make toast if requested.

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

Meals were served in four areas of ED; the ambulatory ward, observation ward, RATU and majors. Overall, staff did not prepare the patients before serving meals; patients were not positioned, nor did they did they receive supplies to clean their hands. On two occasions inspectors observed catering staff help position patients. Tables were available in the ambulatory and observation wards but not RATU or majors. One patient in majors who was sitting on a chair was served a meal using the bed as a table; another patient had a meal placed on his lap but he had fallen asleep. Both incidents were reported to the sister for action. In RATU, seated patients used their knees or the work surface at the nurses' station, to balance or position their trays.

Recommendation: Nursing staff should ensure all patients are prepared appropriately for meals prior to meal service.

The ED has a supply of trays with legs which allow patients to eat with comfort; however the supply was limited.

We observed these trays were only used at breakfast time; for the main and evening meals patients had to balance the trays on their knees. This inconsistency was raised with staff and on day three the trays with legs were in use for all meal service.

Housekeeping Point: An adequate supply of appropriate trays should be available for use throughout ED.

Disposable cups, plates and crockery were used at breakfast time; the midday and evening meals came from the main kitchen pre plated on a tray; the plates were ceramic and the cutlery was stainless steel. There was a small supply of drinking cups with spouts, but no adapted cutlery for patients with dexterity problems.

We were told that at times there were not enough staff on duty to assist patients who required help with eating or drinking. Nutritional supplements were available for patients.

Housekeeping Point: Patients should be routinely encouraged and if necessary assisted to drink, with the provision of regular fluids.

Pain Management

Patients reported to be comfortable; pain relieving measures were available and in place. We observed that some elderly patients would have benefited from additional pillows for support. Staff responded promptly to patients' requests for pain relief. Records indicated that pain medication was administered as prescribed, with the effectiveness of analgesia reviewed. There was variation in the recording of the pain score on the NEWS.

We noted that all patients are assessed for pain within 15 minutes of first contact with ED. Numerous staff told us that the pain team was extremely helpful and would attend ED on request. It is of note that the trust and staff in ED have taken on board criticism following the 10,000 voices project. A pain management week was planned for February 2016 and a reminder of pain management was posted on the white board in order to encourage staff to re-assess pain during the patient's stay in ED. As an aide memoire, a sticker was available to post in the patient's notes.

Pressure Ulcers

Patients reported to be comfortable; pressure-relieving equipment was available.

We were told that a new SKIN care bundle had been developed for ED staff; however it was poorly used. A Braden pressure ulcer risk assessment tool, was not always completed for patients at risk. A new SKIN care bundle had been developed for use in the ED observation ward; however in the documents we reviewed there was little evidence of its use.

Pressure ulcer figures are not used as a quality indicator within ED.

Recommendation: Staff should ensure that the Braden pressure ulcer risk assessment tool is completed for patients who are at risk. Staff should be made aware of their role in prevention of pressure ulcers.

Staff can access advice on wound care via the trust intranet and 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. Weekly bed mattress checks are carried out by the housekeeper but there are no checks on trolley mattresses to assess mattress integrity.

Housekeeping Point: Mattress audits should be carried out regularly.

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 the appropriate assistance to promote continence and care for incontinence. However one patient advised inspectors that he had not been offered hand hygiene after toileting.

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

Housekeeping Point: Staff should ensure that the clinical indicators for catheterisation and relevant information are documented.

Housekeeping Point: Fluid balance; food and stool charts should be completed and reconciled in accordance with trust policy. A robust audit of documentation should be undertaken.

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

5.4 Is Care Compassionate?

Person Centred Care

We observed staff, of all grades, displaying compassion and empathy, and frequent checks were made by nursing staff to ensure patients' comfort. We noted that these checks were not always recorded in an intentional care rounding or similar documentation and all related risk assessment documentation was not completed. These checks are designed to ensure that nursing staff carry out scheduled tasks and observations for patients in order to meet and anticipate their fundamental care needs.

The need for up to date and accurate recording of nursing documentation is discussed in the section on nursing records.

Recommendation: Care rounding documentation should be completed for all patients.

There was a slight increase in noise levels when patient numbers increased, and on occasions when patient equipment alarms were not attended to in a timely manner by staff. We informed staff and this was addressed immediately. In the main ED, all patient bed spaces had a working call bell system; however, these were not always positioned within reach of patients. We observed call bell and verbal requests for assistance were answered promptly; however at times staff did not silence call bells when they attended the patient. We noted that there were no call bells in the observation ward. We were told the lack of call bells was on the trust risk register.

Housekeeping Point: Staff should ensure that call bells are positioned within patient reach.

Housekeeping: Staff should attend to monitoring equipment alarms in a timely manner.

On a number of occasions we observed that patients waiting on trolleys and chairs, who required assistance, relied on calling out directly or having a relative summon help. We observed that a patient who had been placed on a trolley along the central work station in RATU was unable to attract assistance when they required personal care.

We observed that care rounding activities, where nurses carry out regular checks with individual patients at set intervals and then carry out scheduled or required tasks, were limited during times of congestion and crowding.

Overall, staff attempted to ensure patient privacy and dignity was maintained throughout the ED; room doors were closed and blinds pulled.

However, the dignity and privacy of those patients placed on trolleys alongside the central work station was at times compromised. Patients on trolleys or wheelchairs were asked questions about their condition and had procedures such as venepuncture undertaken in view of other patients. In the ambulance triage corridor, portable privacy screens were not always used.

In RATU and majors, patients could be viewed and telephone and investigative results and conversations overheard by other patients waiting in close proximity. When curtains were fully in place, staff asked permission before entering the patient space.

Computers containing patient details and scans were displayed in a way that promotes patient confidentiality. However, staff need to ensure that patients, wearing only night attire, do not have any body parts exposed.

Housekeeping Point: Staff should ensure patients wearing nightwear have their dignity maintained at all times.

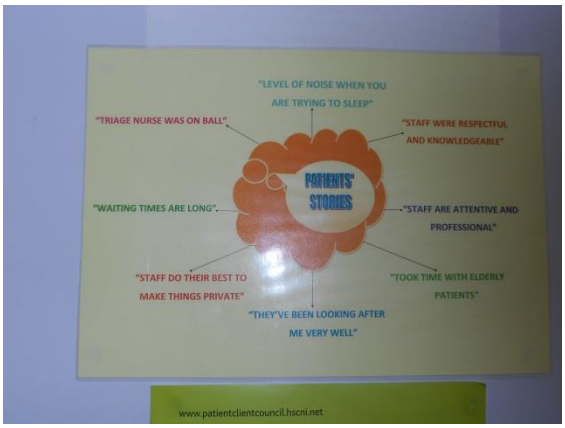
Staff told us that maintaining a constant supply of bed linen, in particular pillows, during peak times can be a challenge. This was observed and identified at the time of inspection.

Housekeeping Point: The supply of bed linen and pillows should be reviewed and increased to meet demand when required.

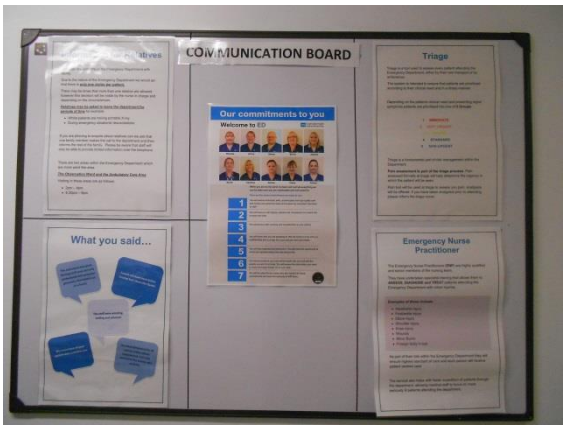
Communication

We found staff to be courteous to patients and relatives, introducing themselves at triage, and again in the RATU or majors. Staff provided patients with information and explained the care or procedures they were to receive in a clear, easily understood manner.

There was good signage which clearly indicated the many areas within this large department, such as, triage, RATU, urgent care, majors, paediatrics. A rolling information board was in place for the public. This explained the type of conditions treated in each of these departments and the length of time a patient might expect to wait. There were various public information leaflet racks throughout the ED; the reception area had toilet facilities and a vending machine. A large whiteboard displayed information for patients and relatives in relation to triage, ENPs, staff commitment and evidence that patients were listened to (Pictures 16 and 17).



Picture 16: Patients' stories



Picture 17: Communication Board

Access to aids and services for patients with language barriers were available. We observed staff speaking discretely, however conversations could at times be overheard.

End of Life

Staff can access guidance on end of life care. The palliative care team was available 24 hours a day, on call. Information supplied identified 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.

Family members could, if required, remain with their relative while they were in the ED. Information and support systems were available for patients and carers before and after a patient dies.

A last office box containing support information had been introduced. A private room was available within the ED for relatives to view deceased patients in privacy.

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.

During the inspection a total of 12 questionnaires were completed in ED:

- seven Patient Questionnaires
- five Relatives/Carers Questionnaires

Overall, the feedback received from patients was good. They were satisfied with the standard of care they received. Staff introduced themselves, were polite and addressed the patient by the correct or preferred name. In general staff were courteous and compassionate; patients told us they were involved in decisions about their care, although some patients stated they did not know who to speak to if they had concerns.

Patients told us that there were enough staff to care for them, and that staff responded to requests for help in a timely manner. Those patients who required assistance with personal care were satisfied they received help when required. One patient would have liked more help to ensure they were appropriately positioned in the bed or chair. Mobility aids were available when required.

Overall, patients reported that they were treated with respect and dignity. Most patients said staff checked on their pain relief and that they received it in a timely manner.

The majority of patients said they were never given a choice of food at meal times; one patient was not happy with portion size, temperature of the food or access to water or juice. Another patient said they could not access water or juice. Patients thought the department was clean.

The majority of patients were satisfied that staff washed or cleaned their hands. There was one patient who said staff never cleaned their hands and two patients said they were never given the opportunity to wash or clean their hands before meals or after using the toilet.

Patients told us they felt safe and informed during their stay in ED; they were satisfied with the care they had received and would be happy for a member of their family or a friend to be cared for in the department.

Relatives

Relatives said they felt welcomed and knew who to speak to, to obtain information about their relatives care; although one relative said they never knew who to speak to. They were less satisfied about the up to date information they received on their relatives' care. Three relatives told us that staff did not have enough time to care but in general were confident they were receiving good care.

Patient Comments

"Staff are very friendly."

"The staff keep me updated, I am very happy."

Question- do staff involve you in discussions about your care*: "Doctor turned his back to speak to nurses."*

"I was really happy with the response to my concerns."

"I was told if I need someone to talk to about a concern that would be a nurse on ward."

When questioned about enough staff one replied *"Really happy" another "Not sure"*.

"Staff very helpful with my personal care."

"Staff respond in a very timely manner."

"Very helpful with my personal care."

"They checked up to ask if I was comfortable."

"Happy with my privacy."

"I was not given a choice about my food."

"Have not been given water/juice."

"Would like a cup of tea."

"No juice or water available."

General Comment

"I cannot say a bad word about this ward, the doctors, nurses were kind, help, very pleasant and are doing everything there, kind and to help you no matter what it is".

Relatives Comments

"Depends on staff A&E department is very busy and staff to."

"I am almost always confident that my relative will receive good care."

When questioned had they been fully involved in the planning of their relatives care?

"Yes - within the knowledge of her present condition."

"They do extremely well in the crowded and demanding situation of A&E."

"They do their best."

"40 people in A&E."

"More staff to cope with volume of patients."

"Would like transferred to the ward quicker - not enough staff."

"More beds available in wards to free up A&E. Mum ready last night to go to ward but there is no beds and she is one of dozens of patients."

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. There were some very good positive interactions were observed between medical and nursing staff and patient and relatives.

Good two way conversations, staff introduced themselves and gave explanations of the procedures they were carrying out and plan of care.

The basic observations were in relation to minimal conversation between staff and patients for example, little interaction between staff and patients on trolleys when being wheeled from waiting areas to majors, patients asked "alright" and no further conversation. Patients not positioned for meals.

Neutral observations were in relation to a patient was wheeled from resuscitation to HDU bay there was no conversation between staff or the patient and relative. Nurse erected an IV but there was no conversation with the patient. There were no negative observations.

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.

5.5 Conclusions for the Emergency Department

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

Although the trust had been active in the recruitment of nursing staff for the ED, during times of increased patient numbers, inadequate staffing levels. Staff told us morale quite low with a perceived lack of support from directorate senior management.

Communication of information with staff to improve practice was not always effective. Staff supervision, appraisal and training records indicated that staff attendance at mandatory training and additional role specific training requires improvement. The establishment of a clinical educator post in ED is a positive step.

Nursing quality performance indicators, to monitor and improve patient care, were not implemented within the main ED. DoH quality indicator targets were on many occasions not achieved.

ED medical cover was good, with medical staff feeling supported. The ED is participating in the PHAs 10,000 voices patient experience initiative.

The environment was clean and bright. We observed staff that were compassionate, showing empathy to patients and positive interactions were noted. The ED when crowded presented a challenge for staff; in the manoeuvring of resuscitation equipment in the event of an emergency; to be discreet when communicating with patients; to meet patients' care needs. Designated rooms to care for vulnerable patients, for example those presenting with mental ill health or self-harm could not be guaranteed.

Patients waiting on trolleys around the central work stations reported that they found it difficult to request assistance for personal care needs. An improvement is required in the availability and access to nurse call bells.

Routine safety rounds and patient reviews were carried out two hourly by nursing staff. Patient flow through the ED was delayed on many occasions.

An integrated medicines management service should be provided to assist with the discharge process.

Medical records were well completed. Nursing records were completed in line with NMC best practice guidelines. Nursing assessments, risk assessments, care plans and documentation such as the Observation Ward's Admission Assessment Booklet, SKIN care bundle, urinary catheter and food charts required improvement.

In general, patients appeared comfortable. There was a variation in the recording of pain scores at triage however effective pain relieving measures were in place with quick staff response.to requests for pain relief. Staff provided patients with assistance to promote continence and care for incontinence.

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

Overall patients and relatives were happy with the care they or their relative had received, however they identified issues concerning waiting times, communication, staff shortages, and patient placement.

The findings of the inspection identified that the ED requires improvement. We have made **25** recommendations and **21** housekeeping points for this clinical area.

5.6 Recommendations and Housekeeping Points

Recommendations

1. The trust should put in place systems to support staff working in ED.

2. Identified risks should be assessed and where necessary placed on the trust risk register.

3. The trust should ensure that formal analysis of SAIs, incident, near misses and complaints is conducted and shared.

4. Senior ED staff should introduce where appropriate further nursing quality performance indicators into ED. Action plans should be developed to improve practice.

5. The trust should review the role, number and skill mix of nurses in ED to ensure effective clinical leadership.

6. Senior trust staff should communicate with ED staff regarding concerns relating to crowding, staffing levels, patient acuity and other issues raised by ED staff.

7. To provide a safe working environment the trust needs to review the provision of security staff on the hospital site and ensure VOCERA is installed.

8. Staff supervision and appraisal should be up to date.

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

10. The trust should agree and sign off the Unscheduled Care Escalation Plan and ensure all staff in ED are aware of the contents and actions to take.

11. The trust should review patient flow from the ED to cope with the demands placed upon the service.

12. All staff disciplines should carry out hand hygiene in accordance with the WHO 5 Moments of care, adhere to aseptic non-touch technique and wear PPE appropriately.

13. Staff should ensure that the patient early warning scores are totalled and completed within the set timescales; escalation in scoring and action taken should be recorded at all times.

14. A recognised assessment tool for all common frailty syndromes should be introduced.

15. Injectable local anaesthetics should be stored safely and securely.

16. Nurses should adhere to NMC Standards in the administration of IV medicines.

17. Kardexes should be fully and accurately completed.

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

19. An integrated medicines management service should be provided.

20. Nursing care records should be improved to accurately reflect in detailed care plans, patients' needs and their involvement in their care.

21. The trust should improve the system in place for the delivery and service of patient meals.

22. Nursing staff should ensure all patients are prepared appropriately for meals prior to meal service.

23. Staff should ensure that the Braden pressure ulcer risk assessment tool is completed for patients who are at risk. Staff should be made aware of their role in prevention of pressure ulcers.

24. Care rounding documentation should be completed for all patients.

25. 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 analysed to identity patterns and trends.

2. The trust should facilitate the establishment of nurse attendance at ED mortality and morbidity meetings mortality and morbidity meetings.

3. There should be more frequent joint reviews of patients by both senior medical and nursing staff.

4. The trust should facilitate more face to face engagement between senior management and ED staff to promote better dialogue and a forum where issues raised can be discussed.

5. Staff should ensure daily checks are carried out on the resuscitation trolleys.

6. All patient equipment should be identified on cleaning schedules and cleaning schedules should be audited to ensure compliance.

7. Effective use of the Sepsis Six bundle should be robustly audited in the ED.

8. The observation ward SKIN bundle should be implemented by staff and robustly audited.

9. Key codes should be changed at timely intervals to prevent unauthorised access to medicines.

10. Potassium containing infusions should be clearly labelled and labelled and segregated from other infusions.

11. Nurse record keeping should be introduced as a quality indicator.

12. A senior nurse should supervise and coordinate meal service.

13. An adequate supply of trays should be available for use throughout ED.

14. Patients should be routinely encouraged and if necessary assisted to drink, with the provision of regular fluids.

15. Mattress audits should be carried out regularly.

16. Staff should ensure that the clinical indicators for catheterisation and relevant documentation are documented.

17. Fluid balance; food and stool charts should completed and reconciled in accordance with trust policy. A robust audit of documentation should be undertaken.

18. Staff should ensure that call bells are positioned within patient reach.

19. Staff should attend to monitoring equipment alarms in a timely manner.

20. Staff should ensure patients wearing nightwear have their dignity maintained at all times.

21. The supply of bed linen and pillows should be reviewed and increased to meet demand when required.

Focus Groups

6.0 Findings from Focus Groups

On the second and third day of the inspection 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 the areas of 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 CT and magnetic resonance 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. Information provided to us by staff is outlined below.

6.1 Senior Manager Focus Group

Senior managers told us about some of their current challenges which are outlined in the following paragraphs.

The shortfall in beds was the main challenge highlighted by the group. We were told the trust is currently working with the HSC Board and reviewing bed capacity. The trust estimates that they have a 50 bed shortfall throughout the year, rising to 100 beds during winter pressures. The trust has winter plans in place; however we were advised these cannot cover this shortfall in beds.

Staff reported that the demand for services and the acuity of patients has risen and is a challenge; it is difficult to keep up with demand. We were advised that there has been a 40 per cent increase in patients attending ED over past four years in comparison to the United Kingdom average of 30 per cent over the past 10 years. The demography of the hospital indicates a raising elderly population.

We were advised that nurse staffing is also an issue. Even when money is available there is still a shortage of nurses. We were told of the difficulties in the recruitment of nurses. The trust has 70 nurses waiting to be interviewed. The opening of the new ED in the Royal Victoria Hospital had an impact on ED staffing and some staff have left for more senior posts.

Bank and agency staff are used but there are difficulties getting all shifts covered, and currently 90 per cent of shifts are filled. A safe care patient dependency tool is used to identify levels of staff required. Normative staffing ranges have been agreed for medical and surgical ward funded beds, not for escalation beds or trolleys in ED. The trust has received some extra funds to increase the number of band 6 sisters on medical wards.

We were advised that there is a rolling advertisement and media campaign to address nursing vacancies. The trust has also attended staff recruitment fairs. It is a challenge to keep staff morale up due to the heavy workload.

We were told that the trust has requested an increase in junior doctors from NIMDTA. The trust has fewer registrars than other trusts and relies on locums; however these can be difficult to secure. The group stated that at times it is a struggle to get medical outliers seen and to provide sufficient staff cover to ensure safety at weekends.

At the Ulster Hospital, car parking is a big issue. We were told it is expensive and there are currently 650 staff on a waiting list for a space. The trust believes that this has had an impact on the staff recruitment.

The group informed us that the vision and strategy for the hospital is communicated by a “Bottom up” approach for improvement. Nursing professional days with guest speakers and lunch and learn sessions are carried out. We were informed that the trust strives to build a culture to enable staff to raise issues. Senior clinicians meet monthly to discuss how they are enacting the strategy. Communication is also achieved by way of a quarterly governance newsletter and notice boards. It is a challenge to keep these up to date and to provide staff with time to access information. The development of a Facebook page is underway to help address these issues.

Senior managers stated that they receive good support from their line management to allow them to carry out their roles and responsibilities. They stated that they worry about staffing levels, but don’t worry about money as it’s the staff who matter and how they can be helped.

A cardio hub operates Monday to Friday with consultant cover. A proposal to change how cardio is managed “Transforming care” is currently with the Health and Social Care Board. Pharmacy and imaging services are moving to seven day working. There is improved discharge at weekends. The trust is liaising with the Belfast Trust in relation to any learning arising from the introduction of their new Clinical Decision Unit and ambulatory assessment management. There is a third neurologist in post.

The trust is currently undertaking a pilot in Downe Hospital for the frail elderly group. A visiting professor will share advice and pathway planning. As some of the Dundonald district falls within the Belfast Trust area the hospital currently has 21 patients with complex delayed discharges waiting for a placement in Belfast. Surgery has introduced fracture clinics and day of procedure admissions along with day theatres to try and free up beds.

We were informed of the difficulties created by the introduction of a human resource, HRPTS ICT system. The system has increased senior manager administration time. Many of the HR tasks have transferred to assistant directors. New staff posts are difficult to input into HRTPS and managers are struggling with the operation of the system.

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

6.2 Nursing Focus Group

The group informed us of their current challenges. They stated that they are worried about their jobs. They stated that they have not been consulted about the new build. It has not been made clear if wards will be amalgamated and this is causing anxiety about job losses or change of ward.

The constant lack of beds in the wards and difficulties with patient flow are regular problems. Corridor beds on wards have no curtains and no oxygen point and every ward has one to two corridor beds. In ED some areas function as medical wards which ED nurses cover and crowding with patient trolley waits is a problem while ambulance crews wait in the corridor to handover patients.

We were advised that every ward has staffing issues and vacancies. Shifts are unable to be filled by bank and agency, demand for staff outstrips supply and staff can only do overtime in extreme circumstances. The trust states that they are actively recruiting staff but it seems to take a long time. Staff stated that there is a constant level of pressure and staffing is always an issue and they worry about the care being delivered. They advised us that vacant shifts should go to agency sooner. There is little cover for maternity or long term sick. Frequently there are three staff working at night when there should be four. The directorate office has to authorise extra staff; normative staffing has been carried out in some wards but vacancies have yet to be filled.

There have been 15 new nurses employed in ED though some of these are pre-registration. They do not always spend the first two weeks with a mentor. They have no study time and study at home. There is a quick induction sheet, but some areas do not have written proof of induction. There are issues with clinical skills of junior staff. Staff stated that the new housekeepers in ED have been a great help.

Staff stated that not all mandatory training is up to date. Only some wards get allocated hours for e-learning. Appraisals are once per year and not all are up to date; informal supervision is provided but not documented. The ward sister is often not visible on the ward; they are counted in staffing numbers but are not able to carry out care as are they are constantly called away to do managerial work. Staff stated that some patients can be aggressive and they would like MAPA training provided for all staff. Currently they are given two and a half hours training on challenging behaviours but only after an assault.

The group stated that there are issues with social work input into some wards, making patient discharge at times slow. We were told that when a care package for a patient expires, a doctor is needed to re-start this. The medical wards now have a dedicated social worker, which means that they are able to keep services in place or re-start a care package when needed.

The nurses present at the focus group stated they were unaware of the strategy and vision for trust or of current initiatives to improve patient care. Some staff stated they attended staff meetings. In ED there had been frequent meetings but now they are too busy. They do have a safety brief every day at 7.30 am. Safety issues are covered but there is no information about incidents, other department information or safety letters etc. In some wards information is emailed to staff.

Staff told us they feel supported by line managers who they would see someone every day and senior staff are always available. However, staff stated that the constant pressure due to staffing levels and patient acuity is affecting job satisfaction and morale. At present it is more a case of putting up with it. When busy, specialist nurses can be deployed to wards; however outpatient staff are never redeployed even when they are not busy.

Staff stated that they worry about staffing levels in their wards and ED. A nursing student at the group stated that because of this placement, lack of induction and too much responsibility she was questioning why she has chosen this career. There is no support on the ward and nurses have insufficient time to be mentors.

Car parking is a major issue and can put nurses off working in the hospital. There is a long waiting list and cost for their parking is £80 per month.

ED staff advised that there is a lack of observation machines and some need to be replaced. Some staff stated that it is hard to get uniforms.

When asked if they would be happy for their family and friends to be care for in the areas they worked in, they eventually said yes but with reservations regarding trolley waits in ED.

6.3 Support Staff Focus Group

The group stated because the wards are so busy and have corridor beds, they can have difficulty doing their work. They told us that meet and greet volunteers are unhappy with the standard of cleanliness at the main hospital front entrance and wards are cluttered. They advised that in some wards it would be difficult to evacuate patients if there was a fire. Some staff stated that it is difficult to keep up a professional appearance as there is a lack of uniforms and some have different tops, different colours and are in a bad state of repair.

The group stated that the lack and quality of equipment can hamper their work. A lack of waste bins means that bags are left on the floor and the quality of cleaning cloths is poor. Cheap disposable drinking cups are used and doubled up to prevent squashing and spills. A ward clerk said there was a lack of computers.

We were told that staffing levels, especially for domestic staff are an issue as they have been unable to fill vacant posts. There is a lot of sickness, bank staff are used and staff morale is low. Some staff can do overtime but, heavy work and long shifts impact on home life. However, some cannot do overtime leaving them short staffed.

The group was not aware of the trust vision and strategy for improving patient care.

Staff team briefings happen but not as often as needed. One member said it had been years. Some staff have no access to intranet or e-mail and only see information that is distributed by leaflet or on notice boards.

Clerical staff stated they are aiming for chartless, paperless records. This practice started on ward 17 and has now filtered down to other wards. This helps to reduce workload as charts are only needed for discharges. However, it is difficult to get all medical consultants to agree this way of working. They think that further improvement could be made if they had “med speech” on computer instead of tapes.

Induction is satisfactory and basic training is organised by the audit and training department. Mandatory training is undertaken annually. Most said appraisal was up to date, except for clerical staff. The group told us there was good support from line managers and supervisors; they listen to staff and are willing to discuss any issues.

The group stated that because of the new hospital a lot of things are on hold. They are not provided with updates on progress of the new building and have only seen the plans which are on the screen at reception. There are not sufficient lockers and some staff do not have changing or shower facilities. Facilities are not repaired or clean; the staff dining room carpets are threadbare.

Overall, the group would be happy for their family and friends to be cared for in the hospital. The nurses are great, there is good community spirit and good teamwork.

ED is understaffed, nurses are under pressure and they wouldn’t want their relatives or friends in ED when busy. Overall the group stated they were happy in their jobs and like where they work.

6.4 Allied Health Professionals Focus Group

We were told that all wards do not have pharmacists. Pharmacy is understaffed and busier, with high sickness levels. Staff provide an on call service which is extra to allocated hours. They have been told there is no funding for more staff. Pharmacy is closed at 4.30pm to 5.00pm daily. Staff have to volunteer to stay later, which is not satisfactory and time owed comes out of services. There is no funding for pharmacy technicians.

Radiology staff stated that there are difficulties with the regional recruitment of band 5 staff. A wide staff skill set is needed as skills are not interchangeable and they need more staff. Dietetics and speech and language therapy (SALT) staff are stretched as they deliver both a hospital and community service. Occupational therapy (OT) has a high turnover of staff. Recruitment processes take months and there is no backfill as staff are not adequately trained. There is no staff bank for AHP staff. Staff tend to come in from leave to cover the gaps; there is no additional capacity to allow for sick or annual leave. There are capacity and demand issues for all AHPs. The complexity of the patients they are seeing is also increasing and this can take a lot of time, but their input is still recorded as only one contact. They stated that staff goodwill is quickly disappearing.

The group was aware of the vision and strategy to improve patient care. They stated that the Chief Executive is proactive and keen to listen. They have teaching sessions and succession planning. In ED the focus is on seeing people quickly and to empty beds. They stated there are difficulties with accessing appropriate discharge. Rehabilitation for under 65's in the Belfast Trust can't be accessed and there are difficulties with over 65's. In the South Eastern Trust access is good. The Belfast Trust won't accept patients with alcohol dependency or cognitive impairment without seeing them. The South Eastern Trust is reviewing the possibility of starting an alcohol care team.

Pharmacy staff stated that there is a communication huddle every morning to discuss quality as well as safety issues. Radiology staff have tried to introduce handover in ED however this has been unsuccessful as the mind-set is that the patients have gone. OT and SALT staff state they have a verbal handover and there is good communication. SALT staff stated that there are so few of them it is hard for them all to get together.

Dietetic staff stated that there is no triage of referrals; they are targeting wards to try and reduce the number of inappropriate referrals. Dietitians and SALT services have been given money to meet waiting list targets. This has not been thought through and is reactive rather than proactive.

Training and induction are good but at times it can be difficult to achieve completion and sign off due to pressures of work and staffing shortages. There are freeze weeks for mandatory training. Lunchtime training is regularly organised but is not always practical as staff get no break if they attend. Supervision was recently launched and some areas have good coaching and mentoring in place.

Some staff stated they have good support from line managers but some thought that management don't understand day to day issues. Busy wards, many challenges and worry about things going wrong reduces confidence and staff morale. The group told us that when the trust receives extra money it goes to doctors. IR1 forms generate work but they are not always sure of the outcome of filling forms in.

Staff told us of some improvements in radiography such as reduction in barium enemas due to new technology in CT scanning. Imaging services are changing with more developments and great improvements. In pharmacy the introduction of IPads will save time and ED will have a technician and have applied for mobile dispensing.

The improvement they would most like to see is seven day AHP cover in ED. The trust has been working with the unscheduled care task group and in ED, areas looked at were the availability of 24/7 diagnostics, pharmacy, and the availability of AHPs such as OT and physiotherapists. It also looked at the possibility of having a pharmacist on every ward, the introduction of more technicians, pharmacy issues to be included in nurse induction and nurses to have training in anticoagulants. SALT needs money for training new staff.

The group stated that they would be happy for their family and friends to be cared for in some wards. They were worried about the number of medical outliers currently 51 not including those in the ED Ambulatory and Observations wards. There are insufficient junior doctors during the week, which is exacerbated at weekends. Junior doctors are writing prescriptions for patients they haven't seen and during escalation, patients are being sent home without medications. There have been mix ups with prescriptions resulting in patients receiving the wrong medications because junior doctors do not have the time to see all patients. Pharmacists told us that they have corrected some of these.

6.5 Medical Staff Interviews/Focus Group

Focus Groups and Opportunistic Interviews with Doctors in Training

Doctors in training including all grades from Foundation Year 1 to Specialty Registrar level from Medicine, Surgical and Anaesthetic specialties and Emergency Medicine were interviewed. Staff Grade and Associate Specialists doctors were also included.

There were no reports of bullying or undermining and all trainees (in ED and across the specialties) felt able and were clear on how to raise concerns should the need arise. Senior staff were reported to be always very supportive across the specialties.

Consultants in the focus group described the collegial atmosphere, good working relationships between medical and surgical specialties and the positive engagement with management.

Trainees had concerns about the busyness and crowding in ED, the effect of corridor beds and the many patients, particularly in medicine who were outliers throughout the hospital. Handover was described as good with robust arrangements for specialty-specific handovers as well as a well-functioning hospital at night system. Some trainees had become involved with Quality Improvement initiatives and found these rewarding. All were able to meet with their educational and clinical supervisors and complete required work-placed based assessments.

Foundation year 1 doctors described positive training and workplace experiences overall. In some wards, FY1 doctors rarely get to attend registrar or consultant-led ward rounds. There are many delays in the completion of discharge letters due to FY1 doctors being busy and rota gaps/sickness. This is compounded when there are multiple outliers throughout the various wards, as the FY1 doctor usually does not know the patient, contributing to further delays in the writing of discharge scripts. An extra FY1 doctor at weekends was reported to be essential by all grades of medical staff. The FY1 often has to cope with not only basic ward tasks (worsened when phlebotomy coverage reduces) but also multiple unwell individuals at the same time. Whilst the SHO and registrar grades were very supportive, the FY1 doctors felt that they too were under a great deal of pressure to see patients on the medical take. If there were two or more unwell medical patients on the wards in the hospital out of hours, the medical admissions process, and patient flow from ED, essentially stops.

Foundation and Core trainee staff feel stretched when they have to review a list of outlying patients on multiple wards. On reviewing patient charts of some medical outliers, the inspection team found incomplete management plans and inconsistent quality and timing of reviews between SHO-grade doctors.

Doctors in training were particularly complimentary of the electronic system (EDAMS) to record and communicate medical admissions and junior doctor workstreams.

6.6 Points for Consideration from Focus Groups

1. There needs to be a review of the information provided by the trust that they are 50 beds short throughout the year rising to 100 beds in winter pressures.

2. The trust should ensure that there are sufficient staff to ensure appropriate service delivery in all groups of staff.

3. The trust needs to further engage with NIMDTA to ensure sufficient junior doctors are in place, to provide sufficient cover to ensure safety at weekends and also to identify the reasons for the smaller number of registrars compared to other trusts.

4. The trust needs to explore the difficulties in securing locum medical staff.

5. The issues surrounding car parking need to be reviewed to determine if there any steps can be taken to resolve this issue.

6. The trust should review the difficulties created by the introduction of HRPTS in relation to increased administration time and recruitment.

7. The trust needs to improve communication with staff regarding the new hospital build, to alleviate fears and anxieties.

8. The trust should ensure that all staff in all areas have up to date and documented mandatory training, appraisal and supervision.

9. The trust needs to review social work input into some wards.

10. Work is needed to ensure all staff are aware of the trust strategy and vision and current initiatives to improve patient care.

11. Staff meetings should occur for all staff.

12. The trust should provide additional support for staff who feel under constant pressure, due to staffing levels and patient acuity, which is affecting their job satisfaction and morale.

13. The trust needs to ensure nursing students are given appropriate induction and responsibility during placements. Mentors should be given sufficient time to undertake their role.

14. Ensure sufficient observation machines in ED.

15. The trust should ensure that all areas are clean and uncluttered.

16. Staff should ensure the quality of equipment, facilities and uniforms. The lack of computers for clerical staff should be addressed.

17. Further work is needed to encourage medical consultants to work towards chartless, paperless records.

18. Work is required with the Belfast Trust to improve access to rehabilitation services and the acceptance of patients with alcohol dependency and cognitive impairment.

19. Radiology staff, should introduce a handover process in ED.

20. Inappropriate referrals to the dietetic services should be investigated.

21. Staff should be informed of outcomes of IR1 incidents.

22. It is recommended that a bank system be explored and introduced for AHP staff.

23. The trust should review the capacity and demand issues for all AHP staff.

24. The trust should review the need for an extra FY1 doctor at weekends.

Theme: Discharge

7.0 Theme: Discharge

7.1 Approaches to Discharge

Several ward-based initiatives were ongoing to improve both the process and quality of discharge.

- A discharge lounge operating Monday to Fridays 9.00am to 5.00pm aided in freeing up physical bed spaces and provided a convenient location for patients to wait for their discharge medications.

- Timing of medical and surgical ward rounds prioritised patients who were awaiting discharge decisions to be made.

- Afternoon board rounds to review current and expected discharges.

- Use of IT – nursing and medical staff have access to electronic care records and systems to ensure timely completion of discharge documentation. An interactive white-board system is soon to be introduced to improve referrals to the multidisciplinary team, monitoring of patient flow and real-time update of the state of beds on the wards.

- Realignment of staff and services at weekends and peak periods, such as Pharmacy opening earlier and closing later on Saturdays.

- Nurse dispensing of simple analgesia to speed the discharge process on Ward 13.

- In the Emergency Department there is both an observation ward and an ambulatory ward. These aimed to prevent admission or provide rapid turnaround.

- Increasing presence of Pharmacists and Allied Health Professionals in the Emergency Department and medical wards with expansion to include 7-day working.

7.2 Challenges to Discharge

Ward 13

The main constraints to effective discharge centred on the role of the most junior medical staff being able to complete discharge documentation in a timely and accurate manner.

Specific challenges included:

- Staffing levels of junior doctors and clerical staff. Junior doctors do not get to attend ward rounds as a norm; there is limited coverage by Foundation Year 1 house officer doctors at weekends and often FY1 doctors are completing discharge letters for complex patients they know little about.

- A mismatch between the morning ward round and the availability of senior staff in the afternoons due to clinics.

- Requirement for a discharge prescription to be completed and into pharmacy before a patient can physically go to the discharge lounge.

- Pharmacy still has no specific cover on Sundays.

Focus groups and discussions with medical staff also highlighted the increasing co-morbidity and complexity of patients who required specialist multidisciplinary assessment and social care needs, despite being 'medically fit for discharge'. Many patients were waiting for assessment for increased packages of care, or placement in residential or nursing homes following their acute episode.

Patients admitted to the Ulster, but who were not resident in the South Eastern Trust faced particular delays in accessing placement and social care services. We were told of specific barriers in transfer of information across medical and social care teams from one trust to another. This was believed to have a significant impact on increasing the length of stay of such individuals.

Ward 11

In general, discharge of surgical patients from Ward 11 was working well. Medical patients who were outlying usually had a greater length of stay after their medical issues were addressed and a new social work referral system had unintentionally contributed to delay assessments. Previously, one social worker was assigned to the ward. A new system, employing case assignments, distributed referrals amongst several social workers who were aligned with the ward, but staff told us that this had not improved patient flow but had simply delayed previous timely assessments.

Emergency Department

Despite the presence of the observation ward and ambulatory clinic the majority of patients observed during the inspection were medical patients. Indeed, both wards were functioning as additional inpatient medical wards with >70 per cent of patients present being under the care of medical consultants rather than ED consultants. Both nursing and medical staff did not feel at present that these ward areas could be used as intended to facilitate discharge/assessment and a quick turnaround of 24-48 hours.

7.3 Recommendations for the Trust from the Discharge Theme

Additional to the recommendations and housekeeping points concerning discharge in the body of the report the following should be implemented:

1. Electronic patient discharge letters should be populated with a clinical narrative and pre-existing diagnoses early during admission.

2. Review of the social work referral system to assess its impact on timeliness of assessment of ward patients.

8.0 Next Steps

On the 12 February 2015 the RQIA inspection team provided detailed verbal feedback to each area inspected. This was followed by feedback to the Chief Executive Mr Hugh McCaughey, directors and senior managers on the key findings from the inspection.

This inspection report has been shared with the South Eastern 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 South Eastern 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:

Positive social (PS) – care over and beyond the basic physical care task demonstrating patient centred empathy, support, explanation, socialisation etc.	**Basic Care: (BC) –** basic physical care e.g. bathing or use if toilet etc. with task carried out adequately but without the elements of social psychological support as above. It is the conversation necessary to get the task done.
Examples include: • Staff actively engage with people e.g. what sort of night did you have, how do you feel this morning etc (even if the person is unable to respond verbally). • Checking with people to see how they are and if they need anything. • Encouragement and comfort during care tasks (moving and handling, walking, bathing etc) that is more than necessary to carry out a task. • Offering choice and actively seeking engagement and participation with patients. • Explanations and offering information are tailored to the individual, the language used easy to understand, and non-verbal used were appropriate. • Smiling, laughing together, personal touch and empathy. • Offering more food/ asking if finished, going the extra mile. • Taking an interest in the older patient as a person, rather than just another admission; • Staff treat people with respect addressing older patients and visitors respectfully, providing timely assistance and giving an explanation if unable to do something right away.	**Examples include:** Brief verbal explanations and encouragement, but only that the necessary to carry out the task. No general conversation.

• Staff respect older people's privacy and dignity by speaking quietly with older people about private matters and by not talking about an individual's care in front of others. • Staff use of curtains or screens appropriately and check before entering a screened area and personal care is carried out with discretion.	

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

Events

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

Quality Improvement Plan

Quality Improvement Plan

Quality Improvement Plan: Ward 13 Medical

Reference number	Trust Recommendations	Designated department	Action required	Date for completion/ timescale
1.	A senior nurse presence should be evident on each shift. The senior nurse should be visible and identifiable.	Nursing	The regional uniform has been reviewed and the Ward Sister will wear red or dark blue tunic. Nurse in Charge badges are provided and expected to be worn	Rec met. Monitoring arrangements in place.
2.	Regular ward staff meeting should be scheduled. Staff meetings should have a standard agenda.	Nursing	Ward meetings take place on alternate weeks. Agenda is based on safety, quality, experience and AOB. In addition there are weekly MDT meeting which are minuted and filed	Rec met. Monitoring arrangements in place.
3.	The trust should ensure that formal analysis of SAIs, incident, near misses and complaints is conducted and shared with staff.	Nursing-led	There is a monthly "lessons learnt" bulletin which is shared with staff on the communication board.	Rec met. Monitoring arrangements in place.
4.	Communication with staff should be improved to ensure learning in relation to complaints, SAIs, incidents, investigations, morbidity and mortality, cardiac arrest rates and HCAIs.	Nursing-led	There is a monthly "lessons learnt" bulletin which is shared with staff on the communication board. M&M meetings currently being reviewed regionally and policy will be implemented within the Trust. There is a weekly multidisciplinary meeting where M&M at ward level is discussed. Minutes of the meeting are available for staff to view in the “minutes of meeting folder”	Rec met. Monitoring arrangements in place.

Reference number	Trust Recommendations	Designated department	Action required	Date for completion/ timescale
			Staff are aware that HCAI rates are available on infection control intranet page http://iconnect/NursingPrimaryCareOlder/InfectionControl/Pages/Links-and-Publications.aspx. All staff have been made aware of this link. Cardiac arrests are discussed at weekly MDT meetings and minuted for staff awareness. Staff debrief following a cardiac arrest. All SE Trust staff can access crash calls for wards/departments on the dashboard which is found on the iconnect page on the intranet.	
5.	Ward sisters should provide visible and robust clinical leadership for ward staff.	Nursing	Since the inspection in February there has been recruitment of another full time band 6 deputy sister. There are now 2 in total who provide good leadership. In the absence of the deputy sister, a senior nurse takes charge. The red “nurse in charge” badge is worn to identify the nurse in charge.	Rec met. Monitoring arrangements in place.
6.	All staff supervision and appraisal should be up to date.	Nursing-led	Staff appraisal and supervision are currently up to date. Further appraisals and supervision are planned for February next year of staff starting within last 6 months	Rec met. Monitoring arrangements in place.
7.	Senior trust staff should take action to alleviate staff concerns outlined in the report and ensure any issues raised are immediately addressed.	Nursing-led	Support always available from ward sister and deputy ward sisters as well as from mentor when requested. ward sister has informed senior management. clinical manager has an open door policy	Rec met. Monitoring arrangements in place.

Reference number	Trust Recommendations	Designated department	Action required	Date for completion/ timescale
8.	Nursing and junior medical staffing levels should be reviewed and improved.	Nursing Medical	Nursing and junior medical staffing for the ward (review and improvement) is managed through Trust level workforce management arrangements. Normative staffing is being implemented. This is a regional problem- recruitment is continuous. since inspection there are 2 band 6's. Winter planning arrangements include provision of additional junior medical staffing.	In progress. Aligned to Trust-level workforce arrangements.
9.	Access to physiotherapy, occupational health, speech therapy and social work should be improved to ensure timely intervention.	AHP Leadership	Daily AHP meeting with ward sister/deputy sister at 10 am to establish a plan for all patients on the ward.	Rec met. Monitoring arrangements in place.
10.	All staff mandatory training should be up to date. Training records should be up to date.	Nursing-led	All mandatory e-learning up to date. Staff are all aware that it is their own responsibility to book mandatory face to face training via HRPTS	Rec met. Monitoring arrangements in place.
11.	Systems and processes that affect patient flow, bed capacity and discharge throughout the ward should be reviewed and improved.	Nursing-led	Daily AHP meeting with ward sister/deputy sister at 10 am to establish a plan for all patients on the ward. Weekly MDT meetings take place and EDD's established and reviewed daily. Currently ward 13 is involved in "champion ward" which will review current patient flow systems	Rec met. Monitoring arrangements in place.

Reference number	Trust Recommendations	Designated department	Action required	Date for completion/ timescale
12.	Work towards phasing out the use of corridor beds.	Nursing	Corridor bed returned to bed store when not in use. To plan towards phasing out use.	Work in progress.
13.	The use and format of safety briefings should be reviewed and improved.	Nursing	Safety briefings discussed following handover and any high risk patients are highlighted. Documented on back of safety briefings daily	Rec met. Monitoring arrangements in place.
14.	All staff should receive training on safeguarding of children.	Nursing-led	Currently working to ensure all staff attend training on this. Monitoring arrangements in place will assure of completion and maintenance of position.	Steps to meet rec taken. Monitoring arrangements in place.
15.	A space utilisation review and productive ward project should be carried out. Emergency exits should be easily accessible at all times.	Nursing-led	Aspects of the productive ward implemented- “the well organised ward”. Both stores reviewed and organised with frequently used equipment close at hand. Everything labelled for ease of access. Corridors less cluttered so that emergency exits are accessible.	Rec met. Monitoring arrangements in place.
16.	The resuscitation trolley should be cleaned and checked daily. Staff should ensure the sharps box on the trolley is renewed after use.	Nursing	Trolley checked daily and expiry dates checked. Trolley cleaned daily and trigger tape in place	Rec met. Monitoring arrangements in place.

Reference number	Trust Recommendations	Designated department	Action required	Date for completion/ timescale
17.	The ward should have a full dementia assessment carried out. Wall clocks should be erected.	Nursing	Wall clocks now within bays so that patients can see them. Clocks ordered for outside bay 2, ward managers office and each sideward.	Steps to meet rec taken. Monitoring arrangements in place.
18.	Ward clutter should be removed and environmental and equipment cleaning should be improved. Patient equipment cleaning schedules should be fully completed and regular patient equipment cleaning audits carried out.	Nursing	Ward decluttered daily, corridor bed removed when not in use, COWS kept in back corridor and used in this location. Fold down tables erected to prevent accumulation of staff in one space. Cleaning schedules kept in sluice and completed daily. New above bed cleaning schedule above each bedspace for decontamination of the patient bed area	Rec met. Monitoring arrangements in place.
19.	All staff disciplines should carry out hand hygiene in accordance to the WHO 5 Moments of care. All staff disciplines should adhere to trust policies for uniform, use of gloves, ANTT procedures and best practice in infection prevention and control.	Nursing-led	Signage of WHO 5 moments of care outside bay 1, in the sluice area and outside bay 3 for staff reference. Staff are aware of uniform policy and their obligation to comply with this. All staff aware of policies for use of gloves, ANTT procedures and best practice in infection control	Rec met. Monitoring arrangements in place.
20.	Guidance on the management of the Acutely Ill Patient should be developed. National early warning scores should be completed within the set timescales, totalled and appropriately documented where actions are required.	Nursing	NEWS chart currently being adapted and developed and ward 13 to be used as a pilot ward in implementation of this. KPI “champion” identified who will lead on the roll out of this. Staff aware of the importance of the completion of NEWS documentation. As part of a CCOT SQE project, all registered staff will be trained in ALERT by march 2017, and all unregistered staff will be trained in AWARE	Steps to meet rec taken. Monitoring arrangements in place.

Reference number	Trust Recommendations	Designated department	Action required	Date for completion/ timescale
21.	A Sepsis Six care bundle should be implemented.	Nursing-led	This will be implemented in line with the roll out of the new NEWS charts	Steps to meet rec taken. Monitoring arrangements in place.
22.	Additional patient equipment should be provided for the ward.	Nursing	Equipment ordered when required.	Rec met. Monitoring arrangements in place.
23.	A system should be introduced to ensure the timely removal of expired medicines. The date of opening should be recorded on medicines with a limited shelf life once opened; staff should be familiar with the in use expiry date.	Nursing Pharmacists	Weekly check of non-stock cupboard. Expired medicines disposed of in burns bin. Staff aware that all medicine expiry dates should be checked prior to administration of medicines	Rec met. Monitoring arrangements in place.
24.	Medicines should be stored safely and securely.	Nursing Pharmacists	All medicines stored in locked cupboards or drug trolley which is has a security chain attached to the wall. A second drug trolley has been ordered to ensure that there is no “overcrowding” of medicines	Rec met. Monitoring arrangements in place.
25.	Nurses should ensure they adhere to NMC Standards in the administration of medicines.	Nursing	All nurses aware of the NMC standards in administration of medicines and of the trust medicines management policy	Rec met. Monitoring arrangements in place.

Reference number	Trust Recommendations	Designated department	Action required	Date for completion/ timescale
26.	Medicines kardexes should be fully and accurately maintained.	Nursing Medical Pharmacists	All medical and nursing staff made aware to ensure every aspect of prescribing and administration is complete on the kardex.	Rec met. Monitoring arrangements in place.
27.	The trust medicines management policy should be updated to clearly guide staff on the self-administration of medicine.	Pharmacy	To run self-administration we need pharmacy staff including technical support on all wards to allow assessment and use of patients own prior to self-medication Links to point below – resource dependent Diabetes team developing policy for insulin self admin	Requires resource
28.	An integrated medicines management service should be provided.	Pharmacy	Currently no pharmacist to complete medicines reconciliation Additional Pharmacy resources required to allow a service to be provided to all wards. Have bid on a number of occasions to HSCB but not successful. Has been raised with Director of Hospital Services,	Requires resource
29.	Nursing record keeping should be improved to accurately reflect patients' needs and be in line with NIPEC best practice guidelines. Nursing record audits should be undertaken.	Nursing	Audits are completed monthly by KPI champions in controlled drugs, food and nutrition, falls, NEWS, omitted medicines, SKIN bundle and VTE risk assessment.	Rec met. Monitoring arrangements in place.

Reference number	Trust Recommendations	Designated department	Action required	Date for completion/ timescale
30.	The quality and organisation of medical notes should be improved. The content of discussions with patients and families should be recorded.	Nursing Medical	When the patient is seen by their consultant a plan of care is communicated to the patient and agreement is always documented in the notes. Families and carers are updated on all aspects of patient care at visiting time and queries regarding care are answered. Any issues they have are addressed by the appropriate member of the multi-disciplinary team and documented in the notes.	Rec met. Monitoring arrangements in place.
31.	The system in place for delivery and service of patients meals should be immediately reviewed and improved.	Nursing	All staff aware that when meals are being served that this takes priority. Patients requiring assistance with feeding are highlighted at handover and on e-whiteboard. Nurse in charge ensures that all patients have been prepared for mealtimes when they are repositioned at 11am	Rec met. Monitoring arrangements in place.
32.	Ward systems and processes should be reviewed to promote effective work systems and reduce the ward footfall.	Nursing	Ward Management quality improvement approach will incorporate review and adjustments. The ward is engaged in Productive Ward quality improvement focus. A stores re-organisation has taken place. Ward extremely busy environment with a range of disciplines delivering care.	In progress.

Reference number	Trust Recommendations	Designated department	Action required	Date for completion/ timescale
33.	All staff should promote and ensure patient privacy and dignity at all times.	Nursing-led All staff	Privacy and dignity is promoted at all times. Screens are provided when the corridor bed is in used. Staff are aware to keep voices at a minimum within the bays and side wards to ensure confidentiality and privacy as able	Rec met. Monitoring arrangements in place.
34.	The provision of adequate sanitary facilities should be essential for new builds within the trust.	New Build Leadership Team	New build facilities will meet requirements.	Rec met with move to new build. Monitoring arrangements in place.
35.	A quiet room should be available for patient private conversation and relaxation. This should include provision for relatives of patients receiving 'end of life' care.	Nursing	This will be addressed in the new build. Relatives are currently given use of the ward manager's office with the door closed if requested. Tea and coffee are offered by staff at all times	Rec met with move to new build. Monitoring arrangements in place.
36.	All staff should introduce themselves and communicate with patients in a volume that ensures patient privacy.	Nursing-led All staff	All staff try to implement "my name is" when dealing with patients. name badges are worn with designation by all nursing staff at all times. Trustwide #hellomynameis / introduction Profiling Day held 31.10.2016 with manned stands per hospital site and range of communications to promote and refresh message	Rec met. Monitoring arrangements in place.

Reference number	Trust Recommendations	Designated department	Action required	Date for completion/ timescale
37.	Information and leaflets as outlined throughout this report should be easily accessible and in different format for patients and visitors.	Nursing	Leaflets are readily available in the leaflet rack outside to ward manager's office. This includes infection control leaflets and a variety of information about respiratory conditions. Information provision guide introduced to support checking of information present and access to information required.	Rec met with move to new build. Monitoring arrangements in place.
38.	Implement actions outlined in the DoH Circular related to the NICE Guideline NG31 - Care of dying adults in the last days of life.	Nursing Medical	The ward works to NG31 guidance. Ward 13 staff recognise palliative patient requiring and of life care, agree a plan with the patient (if able) and their relatives, provide good oral hygiene and hydration when required, ensure pain, breathlessness, nausea, vomiting, anxiety, delirium, agitation and noisy secretions are managed through anticipatory prescribing by our medical staff. Good emotional support and empathy is provided at all times by both ward staff and the palliative care team who review our palliative patients daily and ensure that the correct medicines are prescribed to keep these patients comfortable in their final days and hours if life. All of this is documented within the medical notes and handed over on every shift. Staff have been reminded of compliant practice.	Complete

Reference number	Trust Recommendations	Designated department	Action required	Date for completion/ timescale
39.	DNAR documentation should be fully completed.	Medical Nursing	Medical staff made aware of this at MDT meetings	Rec met. Monitoring arrangements in place.
40.	The trust should continue to 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.	Nursing Safe and Effective Care	Appropriate monitoring arrangements in place with added introductions set to enhance model. Local areas working to action plans populated by findings of continuous user feedback monitoring. A high-level QI project commences Jan 2017.	Rec met. Monitoring and QI arrangements in place.
41.	Staff should ensure patients are always treated with respect and dignity and in a manner that maintains privacy and confidentiality.	Nursing-led All staff	Staff are aware that all patients must be treated with respect and dignity and ensure privacy and confidentiality at all times. Monitoring / QI arrangements as per item 40.	Rec met. Monitoring and QI arrangements in place.

Quality Improvement Plan: Ward 11 Surgical

Reference Number	Trust Recommendations	Designated Department	Action Required	Date for completion / timescale
1.	The ward sister should have protected time to undertake the managerial duties of the post	Nursing	Arrangements in place to meet requirement. Arrangements in place to meet requirement. 6 of the wards in surgery now have 2 deputy ward sisters in post to facilitate the ward sister to be 100% supervisory. The exception is ward 8, which will be closing when the wards transfer to the new generic ward block. Recruitment is on-going for the band 5 staff nurses to fully staff wards to funded level.	Completed
2.	Staff team meetings should occur more frequent and safety briefs should follow a clear structured criterion used to heighten staff awareness of salient patient safety issues	Nursing	Ward closed as a Plastics ward in May 2016 Surgical Ward sisters plan to hold team meeting approximately every 6 – 8 weeks If unable to hold staff team meeting – printed team communication information is supplied, which follows the ward sister team meeting agenda template Ward sisters reviewing safety brief template	Completed with supporting arrangements in place.

Reference Number	Trust Recommendations	Designated Department	Action Required	Date for completion / timescale
3.	The trust should ensure that any identified nurse staffing variances are reviewed to ensure that patient care and safety is not compromised due to staffing levels. The recruitment of new staff should be expedited	Nursing	Recruitment has been expedited since February 2016 Monthly review at ward sisters 1-1 meeting with Clinical Manager	On track for completion at February 2016
4.	Staff supervision and appraisal should be in line with trust policy	Nursing	Increased focus due to NMC Revalidation requirement Additional pressure due to training requirement for staff transferring into the new ward block	Aiming to complete within March 2017 timescale.
5.	Staff mandatory training should be kept up to date	Nursing	Additional pressure due to training requirement for staff transferring into the new ward block	Aiming to complete within March 2017 timescale.
6.	The trust should review the social worker referral system to ensure that there are no delays in patient review		Ward 11 currently a medical ward - social worker process will have changed	
7.	The trust should ensure that appropriate adaptations are put in place to meet the needs of patients with a physical disability and those patients with dementia	Nursing	In the interim prior to transfer to new ward block – simple signage will be reviewed on the surgical wards for dementia patients	Aiming to complete within December 2016 timescale.

Reference Number	Trust Recommendations	Designated Department	Action Required	Date for completion / timescale
		Nursing	Will be achieved on transfer to the new ward block.(medical ward)	On track for completion at March 2017
8.	All staff should comply with the trust hand hygiene and PPE policy	All staff	Reminder communications issued. Monitoring arrangements in place.	Complete - October 2016
9.	Staff should ensure that they are aware of the key principles of ANTT and invasive device documentation should be fully completed	Nursing	Reminder communications issued. Monitoring arrangements in place.	Complete - October 2016
10.	Staff should ensure that equipment is clean and equipment cleaning schedules should be up to date and audited by a senior member of nursing staff	Nursing	Cleaning schedule is in place. Weekly / monthly review by ward sister	Complete - October 2016
11.	The Sepsis Six bundle should be implemented for use within the ward	Nursing	Training on – going, implementation on surgical wards planned January 2017	Commenced November 2016. To implement on surgical wards – January 2017.
12.	The trust should review patient access to key diagnostics out of hours	Leadership	Additional out of hours weekend USS service introduced	Complete - September 2016

Reference Number	Trust Recommendations	Designated Department	Action Required	Date for completion / timescale
13.	It is recommended that medicines are stored safely and securely	Nursing	Staff reminded re: compliant practice. Monitoring arrangements in place.	Complete - September 2016
14.	Registered nurses should adhere to NMC standards in the administration of medicines	Nursing	Staff reminded re: compliant practice. Monitoring arrangements in place.	Complete - September 2016
15.	Medicine kardexes should be fully and accurately completed	Nursing	KPI monthly monitoring Spot checks performed by ward sister / deputy sister Results discussed at KPI review meeting with the Clinical Manager / Clinical Coordinators and ward sisters	Complete - September 2016
16.	The trust medicines managements policy should be updated to clearly guide staff on patients' self-administration of medicine	Pharmacy	To run self-administration we need pharmacy staff including technical support on all wards to allow assessment and use of patients own prior to self-medication Links to point below – resource dependent Diabetes team developing policy for insulin self admin	Requires resource
17.	An integrated medicines management service should be provided	Pharmacy	Currently no pharmacist to complete medicines reconciliation Additional Pharmacy resources required to allow a service to be provided to all wards. Have bid on a number of occasions to HSCB but not successful. Has been raised with Director of Hospital Services	Requires resource

Reference Number	Trust Recommendations	Designated Department	Action Required	Date for completion / timescale
18.	Nursing care records should be improved to accurately reflect patients' needs, their involvement in their care, and be in line with NMC standards of documentation	Nursing	Record keeping KPI audits are being rolled out within the Trust Regional Pace framework pilot is also taking place with consideration of roll out. t	Aiming to complete at March 2017
19.	Staff should ensure that fluid balance and food record charts are completed and reconciled in accordance with trust policy	Medical Nursing	Charts reviewed on daily medical and nursing ward round The Trust has provided update training on Fluid balance management for registered staff and	Complete - November 2016 Continuing monitoring in place.
20.	The system in place for delivery of patients' meals should be reviewed. Staff should ensure that patients receive meals at standard mealtimes	Nursing Catering	Difficult due to delivery to all the wards Catering will be involved regarding delivery time from hub kitchen to each ward on the new generic wards	On track for completion at March 2017.
21.	Staff should ensure that pain relieving medication is administered promptly as described	Nursing	Staff reminded re: compliant practice. Monitoring arrangements in place.	Complete - September 2016
22.	Supplement drinks should be administered to patients as prescribed and any refusal should be clearly documented within the medicine kardex	Nursing	Staff reminded re: compliant practice. Monitoring arrangements in place.	Complete - September 2016

Reference Number	Trust Recommendations	Designated Department	Action Required	Date for completion / timescale
23.	The trust should ensure that arrangements are in place to promote the privacy and dignity of patients, especially the use of escalation beds and same sex bays	Nursing All staff	Appropriate monitoring arrangements in place with added introductions set to enhance model. Local areas working to action plans populated by findings of continuous user feedback monitoring. A high-level QI project commences Jan 2017. Not wholly achievable until transfer to new generic ward block – surgical wards	Patient Experience Standards are upheld and monitored. Difficulties exist re: escalarion and mixed gender at present. On track for completeion at March 2017

Quality Improvement Plan: Emergency Department

Reference number	Trust Recommendations	Designated department	Action required	Date for completion/ timescale
1.	The trust should put in place systems to support staff working in ED.	Leadership	Resilience training available to trust staff. ED specific resilience training for senior nurses and ED B5s Staff supported through team meetings with Assistant Director twice yearly. Monthly senior nurse meetings Monthly senior MDT meetings 'Health and well- being' work stream currently being set up in department to identify ways to support staff working in ED. The workforce model is currently under review – awaiting approval for funding for Normative Phase 2. In anticipation of this new model the Trust has appointed a Lead Nurse Band 8A to ensure day to day operational leadership and additional Band 7s to ensure support for staff.	Rolling programme Complete Jan / Feb 2017
2.	Identified risks should be assessed and where necessary placed on the trust risk register.	Nursing	Risk assessments completed and recorded in directorate register.	Complete

Reference number	Trust Recommendations	Designated department	Action required	Date for completion/ timescale
3.	The trust should ensure that formal analysis of SAIs, incident, near misses and complaints is conducted and shared.	Nursing Leadership	Learning points collated and circulated on email to all staff monthly. Those with higher risk are shared immediately. These learning points are also shared at safety briefs and recorded in communication files Fortnightly meetings with governance team, senior nurses and medical staff established to review current IR1s and IR2s and ensure that learning is identified. The Quarterly Directorate Learning Lessons bulletin is made available to staff. This ensures that wider learning of issues across the whole Directorate. Analysis of trends for Oct 2015/Dec 2015 compared with Jan 2016-March 2016. Completed and shared with staff at team meetings, notice boards and safety briefs.	Complete
4.	Senior ED staff should introduce where appropriate further nursing quality performance indicators into ED. Action plans should be developed to improve practice.	Nursing	The following KPI are already reported VTE, NEWS, Skin bundle and omitted medications. The only exception is MUST. KPI Audit reports are shared with staff monthly and displayed on notice boards, shared at team meetings, safety briefs and via staff individual e mail. Action plans to address areas of lower compliance shared and discussed at team meetings New service specific KPI for pain and documentation developed and audited monthly.	Complete. Rec met. Monitoring and QI arrangements in place.

Reference number	Trust Recommendations	Designated department	Action required	Date for completion/ timescale
5.	The trust should review the role, number and skill mix of nurses in ED to ensure effective clinical leadership.	Nursing	Awaiting approval for staff funding for normative staffing phase 2. A number of posts have been appointed [without funding] including: • 3 WTE Band 7. • A lead nurse [band 8a] has also been seconded to provide day to day clinical leadership. • 16 WTE band 2. Rolling monthly band 5 advert in local press / NHS recruit.	Complete December 2016 Ongoing
6.	Senior trust staff should communicate with ED staff regarding concerns relating to crowding, staffing levels, patient acuity and other issues raised by ED staff.	Leadership	Assistant Director meets with respective group of band 5, 6 and 7 staff twice yearly. MDT senior Departmental meeting monthly Senior nurse meeting 6 weekly Lead nurse now in post to provide clinical leadership to staff Appointment of additional band 7 staff to provide leadership to junior staff.	Complete
7.	To provide a safe working environment the trust needs to review the provision of security staff on the hospital site and ensure VOCERA is installed.	Leadership	Trust will explore implementation of Vocera Continue to maintain good communications with security team.	Aiming to complete at Feb/ March 2017 Complete

Reference number	Trust Recommendations	Designated department	Action required	Date for completion/ timescale
8.	Staff supervision and appraisal should be up to date.	Nursing	Appraisal training completed for Band 6/7. Appraisal training calendar developed to ensure that staff and appraisers are aware when appraisals due. Reviewed monthly by Lead Nurse/band 7 Band 6/7 staff have under taken supervision training. Supervision recorded on training database which will be transferred to health roster. Supervision sessions for senior team 3 times/year with safeguarding nurse.	Complete
9.	All staff should attend mandatory training and staff should have the opportunity to attend in house training commensurate with their role.	Nursing All staff	Training data base available. Data collated by clinical educator including mandatory training. In house training provided on Thursday and Friday as minimum. Training by other providers recorded on training calendar e.g. IPC, TV, alcohol liaison etc. Shared training calendar accessible to all senior staff band 6 and 7 to record ongoing training sessions	Complete
10.	The trust should agree and sign off the Unscheduled Care Escalation Plan and ensure all staff in ED are aware of the contents and actions to take.	Leadership	Currently under review by Unscheduled Care Board. A new departmental escalation plan developed and will be piloted December 2016	In progress

Reference number	Trust Recommendations	Designated department	Action required	Date for completion/ timescale
11.	The trust should review patient flow from the ED to cope with the demands placed upon the service.	Nursing	Unscheduled care escalation plan in place. New departmental escalation plan developed and piloted December 2016 Resilience plan in place in preparation for Winter 2016/2017	Ongoing
12.	All staff disciplines should carry out hand hygiene in accordance with the WHO 5 Moments of care, adhere to aseptic non-touch technique and wear PPE appropriately.	Nursing-led All staff	Weekly hand hygiene audits carried out and results displayed on notice boards, shared at team meetings, safety briefs. Action plans to address areas of lower compliance shared and discussed at team meetings Infection control work stream established. Development of action plans to address poor compliance/performance. Regular Teaching sessions with infection control, regarding hand washing carried out and recorded on training calendar / database Senior walk arounds planned 6 weekly involving Senior Infection Prevention Control Nurse, Lead Nurse and Senior ED Consultant. First walk round completed 12th October 2016. November Focus of the Month featured Infection control – including hand hygiene, additional training, ANTT training	Complete

Reference number	Trust Recommendations	Designated department	Action required	Date for completion/ timescale
13.	Staff should ensure that the patient early warning scores are totalled and completed within the set timescales; escalation in scoring and action taken should be recorded at all times.	Nursing	NEWS audited monthly as per KPI Audit reports are shared with staff monthly and displayed on notice boards, shared at team meetings, safety briefs and via staff individual e mail. Action plans to address areas of lower compliance shared and discussed at team meetings Learning from KPI addressed with staff through Learning Points Focus of fortnight (November 2016) featured NEWS with a specific focus on training, completion of NEWS charts Ongoing training regarding new NEWS charts - recorded on the training calendar and database	Complete and continuing
14.	A recognised assessment tool for all common frailty syndromes should be introduced.	Nursing Medical	ED attend Trust Frailty work stream	In progress. No barriers.
15.	Injectable local anaesthetics should be stored safely and securely.	Nursing	All local anaesthetics are stored in key cupboards appropriately	Complete
16.	Nurses should adhere to NMC Standards in the administration of IV medicines.	Nursing	Staff adhere to administration of medications including that of IV medicines	Complete

Reference number	Trust Recommendations	Designated department	Action required	Date for completion/ timescale
17.	Kardexes should be fully and accurately completed.	Nursing Medical	KPI audit for omitted medicines completed monthly in Observation ward Nursing/ medical staff to ensure that medicine kardexs are fully completed. Inaccuracies or omitted areas on kardex to be completed by medical staff	Complete
18.	The trust medicines management policy should be updated to clearly guide staff on patient self-administration of medicine.	Nursing, Pharmacy and Safe and Effective Care	There is no trust policy regarding self- administration of medicines. Section 9.14 refers to self-administration and recommends a local policy should be developed if this practice is to be used.	Aiming to develop a local policy by Feb 2017
19.	An integrated medicines management service should be provided.	Pharmacy	The department has 7 day cover with pharmacy. Mobile dispensing unit used in department. Medicines reconciliation on admission and discharge.	Nov 2016
20.	Nursing care records should be improved to accurately reflect in detailed care plans, patients' needs and their involvement in their care.	Nursing	Regional documentation has now been phased into the Observation Ward and Ambulatory Unit. This documentation will be audited monthly. The Lead Nurse / Band 7 participate in the regional work regarding ED documentation /NIPEC project. New care planning tool to be trailed Feb 2017 (PACE framework). A new documentation tool has been introduced which records care provided hourly. The tool will be audited after 3 month pilot period.	Complete Aiming to complete at Feb 2017 Aiming to complete at March 2017

Reference number	Trust Recommendations	Designated department	Action required	Date for completion/ timescale
21.	The trust should improve the system in place for the delivery and service of patient meals.	Nursing	All patients are given a choice of meals Bed tables are used in Observation Ward and Ambulatory Unit. Lap trays are used with patients on trolleys in Main ED. Currently trialling a table top tray. Hand wipes now available and are placed on all patients trays by PE staff. SQE project regarding nutrition (MUST) currently being developed	Complete - Oct 2016 Feb/ March 2017
22.	Nursing staff should ensure all patients are prepared appropriately for meals prior to meal service.	Nursing	Band 6/ Senior band 5 to oversee meal service in each area. The roles and responsibility of the meal co-ordinator to be developed.	Ongoing Jan 2017
23.	Staff should ensure that the Braden pressure ulcer risk assessment tool is completed for patients who are at risk. Staff should be made aware of their role in prevention of pressure ulcers.		Regional documentation used in Observation ward and Ambulatory area includes Braden risk assessment Monthly KPI audit completed and reports are shared with staff and displayed on notice boards, shared at team meetings, safety briefs . Action plans to address areas of lower compliance shared and discussed at team meetings Specific ED skin bundle developed and used in ED for all other patients.	Complete

Reference number	Trust Recommendations	Designated department	Action required	Date for completion/ timescale
24.	Care rounding documentation should be completed for all patients.	Nursing	New documentation currently being phased into ED will ensure that nursing care is clearly documented hourly as a minimum	Dec 2016
25.	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.		Feedback from service users currently via compliment forms, thank you letters/ cards and face book, social media. Planned work to obtain feedback from service users and careers including contact via telephone a few days post discharge Trustwide ED drinks / food user satisfaction programme initiated (first phase of data collection completed. High-level QI programme commences Jan 2017.	Complete Jan 2017

Quality Improvement Plan: Discharge

Reference number	Trust Recommendations	Designated department	Action required	Date for completion/ timescale
1.	Electronic patient discharge letters should be populated with a clinical narrative and pre-existing diagnoses early during admission.	Medical Staff	Electronic patient discharge letters are completed pre discharge. It is junior medical staff who usually complete. They are usually done day prior to discharge Due to rotas etc if it was begun early they may not necessarily be there to complete Plastics is the only ward in the Surgical Specialities which uses an electronic discharge letter. As the ward has a fairly fast throughput of patients these would usually be completed day before or on the day of discharge. General Surgery are awaiting final changes to be made to their electronic discharge letter template, regarding histopathology results. It is hoped that the NIECR will support reliable use of electronic patient discharge letters.	**In place and with further improvement work continuing.**
2.	Review of the social work referral system to assess its impact on timeliness of assessment of ward patients.	Hospital Social Work	There has been Ward aligned Social Work service for approximately 7 months. Feedback form has been recently forwarded to all Ward managers to get some feedback in relation to the impact of Ward alignment. Returns to date all provide a 4 or 5 rating, indicating a very good or excellent service. Qualitative comments are extremely positive highlighting the efficiency and effectiveness of Ward alignment which facilitates timely intervention and discharge planning and good multidisciplinary working.	**Completed and continuing focus.**

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