The Regulation and Quality Improvement Authority

Acute Hospital Inspection:
Altnagelvin Area Hospital 5 – 8 July 2016

Ward 3
Ward 8
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 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 5 July to 8 July 2016, at Altnagelvin Area Hospital. The following areas were inspected:

- Ward 3 Medical
- Ward 8 Surgical
- Emergency Department (ED)

In these areas the four domains examined were:

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

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

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

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

Ward 3

Is the Area Well Led?

Throughout the inspection we observed a ward sister who demonstrated good clinical leadership. The sister was very visible coordinating ward activities and supporting patients and staff.

In anticipation of this RQIA inspection, it was pleasing that ward staff had carried out some dry run exercises using the inspection tool. Staff had used the information generated from these exercises for learning and improvement. This was evidenced by the robust nature of the information provided to inspectors.

Staff informed us that they were kept up to date with learning from incidents and complaints. Communication and dissemination of information to staff is through various formats such as team meetings, safety briefs, handovers, communication book and displayed notices. The introduction of an electronic nursing handover had increased efficiency and accuracy of information. There was good multidisciplinary team meeting (MDT) ward input and support, with an effective weekly MDT meeting

The ward had introduced a number of quality indicators which are subject to continuous assessment. Actions plans to address areas of non-compliance were available. Ward staff have participated in a number of national audits with the British Thoracic Society. A number of initiatives have been employed to capture patient experience and satisfaction.

We were informed that there is a minimum of 1.33 whole time equivalent (WTE) registered nursing staff per patient occupied bed. Currently there is a nursing staff deficit of 3.64 WTE. It was reported by the ward sister that this deficit is due to increase over the months of July and August 2016, with staff some leaving and others going on maternity leave. The ward sister reported that when this happens the delivery of safe and effective care will not be sustainable, if staff are not found to fill this deficit.

Retention and recruitment of staff within the ward was a reported challenge. Three senior staff have taken up roles within the community respiratory team and although this has been a very positive initiative for the community team staff reported that it had resulted in disruption of the balance of skill mix within the ward. We were informed that senior managers have been proactive in attempting to recruit staff; however a national shortage of band 5 registered nurses (RNs) has made this difficult.

While most staff reported that morale was good, others reported that morale is being affected by the challenges of increasing work intensity. Some staff reported that although they were supported and valued by the ward sister there was a lack of acknowledgement or engagement from the trust executive team.

All staff had access to mandatory and role specific training to meet the needs of their role. Staff supervision and appraisal sessions were up to date and in line with trust policy.

During the inspection, we observed that ward rounds were scheduled early to facilitate transfer or discharge. We observed that nursing staff were not always in attendance as some ward rounds were not held when scheduled.

Appropriate systems and processes reflecting legislation and local requirements were in place to safeguard patients from abuse.

Is Care Safe?

Although the fixtures and fittings of the ward are showing signs of age related wear, it was maintained to reasonable standard. Large items of equipment which may present a trip hazard were stored along its central corridor due to the wards limited storage capacity. Emergency equipment on the resuscitation trolley was easily accessible however checks of the emergency equipment were inconsistent. Fire safety and life support training was part of a ward staff mandatory training programme.

We observed that there were limited adaptations in place to meet the needs of patients with dementia. Known hazards in the ward environment had been risk assessed and preventive actions have been implemented.

We observed good compliance with hand hygiene. There was easy access to personal protective equipment such as gloves and aprons however it was not always used effectively. Greater attention to detail was required in the cleaning of equipment and equipment cleaning schedules should be introduced as a mechanism for cleaning assurance.

National early warning scores (NEWS) were well completed. A sepsis bundle should be introduced for the early recognition and management of sepsis. Records highlighted that there had been an increased level of patient falls. Further work is required to further analyse falls incident reports to identify any contributing factors. Venous thromboembolism (VTE) assessments were well completed and prophylaxis VTE treatment commenced.

All medicines were stored in locked cupboards and trolleys. A pharmacist is involved in the medicines management process from admission to discharge. Patients told us they that were involved in the decisions about their medicines which included changes in dosing or commencement of new medicines during their stay. The documentation reviewed indicated that medicine kardexes were well maintained.

Is Care Effective?

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

The nursing documentation reviewed did not always adhere to Nursing and Midwifery Council (NMC) standards of documentation and was not always written legibly. The ward had been involved in the piloting of new documentation for nursing care called PACE, facilitated by Northern Ireland Practice and Education Council for Nursing and Midwifery (NIPEC). This initiative aims to improve care planning by taking a more person/family centred approach. Medical notes well organised and entries completed to a high legible standard. It was reported that some sets of medical notes were large and unwieldy.

A protective meal service was in place; we however observed some unnecessary disruption of patients during mealtimes. There was a good menu choice that included specialised diets. On the first day of the inspection, we observed a meal service that was poorly coordinated. Mechanisms were in place to identify patients that require assistance at mealtimes and in place to identify/report patients' intake at mealtimes. However, we observed that fluid balance and food charts were not always reconciled and for some patients staff failed to provide timely assistance with or prepare patients prior to meals.

During the inspection we observed that patients appeared comfortable, pain relieving comfort measures were available and staff responded promptly to patients' requests for pain relief. Staff were knowledgeable with regard to pressure ulcer care. Staff could avail of adequate support and resources for patients with pressure ulcers. Appropriate assistance to promote continence and care for patients with incontinence was observed.

Is Care Compassionate?

The ward was bright and welcoming although observed to be very busy. Throughout the inspection we observed caring and committed staff. Call bells and requests for assistance were responded to promptly.

Patients' personal hygiene needs had been attended to as appropriate, patients appeared comfortable and suitability clothed. Staff endeavoured to maintain the dignity and privacy of patients at all times however staff reported this can be challenging when the escalation bed is used.

We considered that the number of toilets and wash rooms within the ward are limited in number for the needs of a busy 30 bedded ward. We were informed that at times patients can be delayed in using these facilities due to availability.

There was good signage to direct visitors to the ward, and within the ward. The majority of staff were easily identified by clearly labelled name badges. Trust information was available in various formats and different languages with interpreting services available on request.

It was evident from speaking with staff that they were passionate about the delivery of quality care for patients at the end of their life. A number of staff had received additional palliative care and bereavement training.
The palliative care team was available to provide support and guidance for those patients at the end of their life. The limited number of side rooms on the ward has resulted in some patients at the end stages of their life being cared for in multi-bedded bays.

Patients and relatives we spoke with were positive about the care they received. They told us that they were satisfied that they were safe; had received a good standard of care; and would be happy for a member of their family or a friend to be cared for in this ward.

Ward 8

Is the Area Well Led?

Throughout the inspection, we observed evidence of good leadership. Staff told us there was good dissemination of information to staff. The ward sister was easily identifiable however we observed that some staff did not wear name badges. Staff told us morale was good and they were supportive of the ward sister.

Staff reported easy access to policies and procedures and were aware of the process for reporting serious adverse incidents (SAIs), incidents and near misses. We observed that regular audits of compliance with key performance indicators were carried out. Action plans were compiled following poor compliance results and repeat audits evidenced improvement.

We were told that normative staffing rates had been agreed and the ward was at its full complement of staff; we were told that retention of staff was good. The ward sister, although not supervisory told us she had sufficient time to both undertake managerial duties and provide clinical leadership. We observed that supervision and appraisal were up to date however documentation reviewed evidenced that attendance at mandatory training and dissemination of information from governance meetings need to be improved. We were told that the nurse practitioner/practice educator role has proved to be a good initiative.

Staff reported that the number of daily ward rounds presents a challenge. We were told that medical staffing levels were good however issues such as timely review of inliers by medical staff, completion of discharge letters and pharmacy could delay discharge. Medical staff reported that there was no set medical handover meeting or handover sheet used to record information. Staff advised that timely access to occupational therapy could be an issue for medical inliers on the ward. We were told that a pilot of a ward based pharmacist had proved beneficial but had been stopped due to lack of funding.

We observed that the mid - morning safety briefing provided a forum to highlight staffing, vacant beds, incidents, learning and safety issues. On review the staff meeting standard agenda does not fully cover all ward governance issues and the template for the ward safety briefing could be improved. We were told that safety briefings are not routinely carried out for night staff. Staff reported that patient experience data was not captured, recorded or routinely analysed and acted on.

Is Care Safe?

We observed that the ward environment was in good repair, clean and clutter free. Adaptations had been made to meet the needs of patients with a disability but not dementia patients. We were told that there is to be a dementia champion for the ward; purple folders to identify patients with dementia, were in use.

We observed that staff were not always visible on the ward, spending a lot of time in the clinical room. Staff advised that they had been waiting for a month for essential equipment to stock the paediatric emergency trolley which was being stored in the treatment room and not the ward. We observed that patient equipment was clean and in good repair; detailed cleaning schedules were available.

Environmental and hand hygiene audits reviewed demonstrated compliance with trust target levels and staff adhered to aseptic non touch technique (ANTT) best practice. We observed that not all medical staff washed hands prior to and after donning personal protective equipment (PPE) and some staff were not compliant with the trust dress code policy. Documentation reviewed evidenced that medical staff did not always fully complete invasive devices and blood culture documentation. NEWS were completed appropriately.

We were advised that a sepsis bundle to ensure the recognition and timely management of sepsis was not in place. A falls safe bundle was in place and the ward monitored falls and trends. The type and occurrence of pressure ulcers were monitored. On review of documentation, we found that consent forms and surgical safety checklists were in place and completed.

Staff told us they can raise concerns with the ward sister and that senior management are visible and approachable on the ward. Safeguarding information/support/leaflets were not readily available on the ward for staff, patients, family/carers to access.

We observed that further work is required in the storage of medicines as the clinical room was often left unlocked and unattended. We were told there was no integrated medicines management service on the ward. We observed controlled drugs stored and administered safely however two nurses did not routinely prepare IV medicines.

Is Care Effective?

We reviewed five nursing records which did not always demonstrate on-going assessment and evaluation of the daily care; a care plan was not always in place and relevant risk assessments had not always been undertaken or fully completed.

Medical records were very well organised. We noted in records that for both medical and allied health professionals' documentation of the time of entry needed improvement.

We observed that the system for delivery and service of patients' meals requires immediate review and improvement, to ensure patients nutrition and hydration needs are met. We did not observe staff supervising and encouraging patients to eat and drink during meal times. We observed that protected meal times were not adhered to, fluid balance and food charts were not always completed.

We observed that pain medication was administered as prescribed however some patients identified there could be a delay at busy times. Staff were knowledgeable and good practices were observed in regard to pressure ulcer care. A validated classification tool and wound chart were in use and where required a repositioning chart was used to reflect patients' ongoing care needs.

Staff were observed providing patients with the appropriate assistance to promote continence and care for incontinence.

Is Care Compassionate?

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. Although checks were made by nursing staff to ensure patients' comfort, these checks were not recorded in any intentional care rounding or similar documentation that we reviewed.

We observed that patients' confidentiality and conversations were not always maintained. At times during ward rounds we heard details of patients' medical condition being discussed in the corridor outside ward bays. We observed call bells within reach and generally answered promptly. However, some patients reported a delay in response when the ward was busy. We observed that the exit doors of the ward did not open automatically on leaving and required a member of staff to activate the system.

At the time of inspection, the development of an integrated care pathway/care plan for the dying was not completed, used and embedded in practice within the trust.

Staff however, were knowledgeable when questioned about the systems that were in place.

Overall, patients reported being satisfied with the standard of care they received, were informed and involved in decisions about their care, although some patients stated they did not know who to speak to if they had concerns. Patients were satisfied that they were safe; had received a good standard of care; and would be happy for a member of their family or a friend to be cared for in this ward.

Relatives said they were welcomed, knew who to speak to and that their relative was treated with dignity and respect. Most staff kept them informed and staff had time to care. They reported that the standard of care was good.

Emergency Department

Is the Area Well Led?

The inspection identified areas for improvement in the systems and processes which impact on the delivery of care in the ED. There was a band 8A department manager with responsibility for the operational management and coordination of services. The band 8A was supported by band 6 deputy sisters. band 7 enhanced nurse practitioners (ENPs) worked independently.

There was an open and transparent culture for the investigation of complaints, staff had access to policies and procedures and were aware of the process for reporting SAIs, incidents and near misses. The substance misuse nurse was a valuable asset and there was a clear link between the ED and community addiction services.

We found staff morale was low. Most staff reported that they did not feel supported and valued by executive management and there was a delay in response to raised concerns. A stress audit had been carried out but staff had not received any feedback.

Staffing levels for nursing and healthcare assistants (HCAs) had been agreed and additional nursing posts advertised however staffing levels were low, bank and agency staff could not always be secured to cover shifts. The delay in recruitment was impacting on staff who raised concerns over issues including; staffing levels; staff retention; staff induction; having the relevant clinical skills; workload; mandatory training; patient privacy and dignity. Staff told us they were feeling tired, ‘burnt out’ and stressed.

At busy times nurse staffing levels were concerning, with areas within the department not staffed adequately to ensure appropriate patient care. The recruitment of paediatric nurses for the ED was a reported challenge. We were told and observed during the inspection staff working outside their competencies. During day three and four, we found the day shift designated leader was a senior band 5 RN.

Discussions with staff and a review of the duty rota demonstrated that the department would not have sufficient RN cover during August 2016. This issue was raised at the trust feedback as a matter of urgency.

Nurse staff training was not up to date. The establishment of a practice educator post in ED will support newly appointed staff and the ED sisters in ensuring mandatory and additional training needs are being met.

Limited nursing quality performance indicators, to monitor and improve patient care, had been implemented within the main ED however there was little evidence of action plans to address sub optimal performance. Department of Health (DoH) quality indicator targets were on many occasions not being achieved. The internal ED escalation plan and the trust Policy for Patient Flow and Escalation were in draft (January 2016).

The department closely monitored its performance against ministerial targets. Four hour and 12 hour trust performance targets were not being achieved.

Medical records were well organised and clearly laid out. Sepsis management was good although in some cases the documented proforma had not been completed. Medical staff told us the demands of their rota can stop them from fully availing of potential training opportunities.

There was evidence of good leadership within ED; however an improvement is essential to ensure the clinical area is managed and organised in a way that patients and staff feel safe, secure and supported.

Is Care Safe?

A large flow diagram under the main reception desk explained the patient's journey through the department. The environment was light and bright; older areas showed signs of wear related to age.

Not all the patient cubicles were equipped with piped oxygen and suction or monitoring equipment, some did not have individual wall lighting, and none had clocks. Insufficient storage contributed to equipment, linen and stores being stored in corridors. The majors floor area is small and can quickly become congested. The clinical preparation area, situated in the centre of majors, was shared with medical staff and not sufficient to meet the requirements of this busy department.

Nursing staff expressed concerns regarding their ability to care for patients who present with self-harm when staffing levels were low and spread across the department. Medical and nursing staff expressed concerns that staff shortages contributed to underuse of the resus area. At nursing handovers, healthcare assistants did not attend and safety briefs were not conducted for all nursing staff.

Patient equipment was clean and in good repair however venepuncture trolleys were accessible to patients and visitors.

It was challenging for staff to comply with good infection prevention and control (IPC) practices in majors' cubicles two to four, due to their size. There was some inappropriate wearing of disposable gloves by nursing and medical staff.

Patient early warning scores, to detect deterioration in a patient's condition, were not always totalled, completed within the set timescales and the escalation algorithm followed. The paediatric observation sheet in use did not have an escalation or algorithm guidance. Hourly safety rounds and four hourly patient reviews were not carried out by the nurse in charge and consultant.

A Sepsis Six bundle for the recognition and timely management of sepsis was in place. A detailed policy and trust risk assessment for VTE patients requiring immobilisation in plaster of Paris were available to guide staff however there was no system in place to monitor falls.

The storage of routine medicines required some improvement. Controlled drugs were stored and administered safely. There was no dedicated area for the preparation of medicines including controlled drugs. An integrated medicines management service was not being provided. RNs did not administer IV medicines. Discussion with staff indicated that they had an awareness of critical medicines. A list of critical medicines was displayed.

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

Is Care Effective?

Nursing staff in ED documented nursing actions and observations on a section in the 'flimsy'. Not all flimsies demonstrated that nurses had adequately carried out assessment, planning, evaluation and monitoring of the patient's needs. Continuation sheets were more a diary of events rather than a plan of care. Nursing records did not always adhere to NIPEC best practice guidelines.

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

Patients appeared comfortable, pain relieving measures were available and in place, with good response from staff to patients' requests for pain relief.
A retrospective review of documentation evidenced that a pain score was not always printed onto the blue flimsy after the patient had come through triage.

The Braden scale to assess risk for the development of pressure ulcers and the Abbreviated Mental Test (AMT 4) were not being completed on the flimsies for patients over 65 years. Staff provided patients with assistance to promote continence and care for incontinence. Specialist nurse advice was available.

Medical records were well completed.

Is Care Compassionate?

There was good signage to indicate the areas with the department. A rolling information board was in place for the public in majors reception. Staff had access to aids and services for patients with language barriers. Facilities and information was 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. Although checks were made by nursing staff to ensure patients' comfort, these checks were not recorded in any intentional care rounding documentation.

Staff attempted to ensure patient privacy and dignity were maintained however there were occasions when curtains were not fully closed during a medical examination and screens were not completely opened after patient care.

At times, call bells were not appropriately positioned and within easy reach. There appeared to be an issue with the system as lights were on with no sound being heard. This was raised with the ED manager for further investigation.

Overall, patients were satisfied with the standard of care they received, they reported that they were informed and involved in decisions about their care, although some patients stated they did not know who to speak to if they had concerns. Patients reported that staff responded to requests for help in a timely manner and assistance with personal care was given when required. Most patients reported that 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. Relatives said they were welcomed but were less satisfied about the up to date information they received about their family member. Some reported that staff did not have enough time to care but were confident that their relative was receiving good care.

Focus Groups

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

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

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

Discharge

The inspection identified ongoing initiatives to improve both the process and quality of discharge. These included the use of Patient Centre for discharge letters, direct dispensing from the ward and the opening of the clinical decision unit in ED.

We were told challenges around discharge include: timely access to allied health professionals, completion of discharge letters and access to care packages and nursing home placements.

Summary

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

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

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

Following publication of the report, the Western Trust should complete a quality improvement plan within four weeks, to set out how the recommendations of the inspection will be addressed. RQIA will review progress at subsequent inspections. The final report and quality improvement plan (QIP) will be available on the RQIA website.

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

1.0 Introduction

The aim of the Acute Hospital Inspection Programme is to:

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

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

1.1 Inspection Framework

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

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

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

The inspection process is supported by:

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

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

- the use of lay assessors (service users and members of the public 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 refer to 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 Altnagelvin Area Hospital and where appropriate, across the trust.

2.0 Background information on the Western Health and Social Care Trust and Altnagelvin Area Hospital

Altnagelvin Hospital

Altnagelvin Area Hospital is an acute hospital which offers a range of services, including a 24-hour Accident and Emergency Department and is one of Northern Ireland's five designated cancer units. It has 472 inpatient beds and 36 day case beds.

The main hospital building consists of a tower block with a number of adjoining new extensions accommodating the outpatients department, day case unit, medical imaging, theatres, surgical wards, maternity ward, oncology unit and physiotherapy department. There are also separate buildings such as the Renal Unit, Spruce House, Anderson House, Breast Screening Unit and the laboratories and pharmacy building. These are all signposted throughout the site.

Corporate Information

The Western Trust's vision is ‘to provide high quality patient and client-focused HSC services through well trained staff with high morale’ is supported by six core values underpinning the organisational culture and have been developed to help the trust achieve its purpose:

- **High quality and safety**: the trust is committed to excellence and accountability in its services to individuals, families and communities.

- **Enabling our staff**: the trust strives for a safe working environment which promotes growth and development, teamwork, pride, creativity and trust.

- **Integrity**: the trust believes integrity is the foundation for individual and corporate actions. It adheres to the values of honesty, openness and respect for all.

- **Equality**: the trust promotes equality and fairness for patients, clients and staff.

- **Partnerships**: the trust is committed to working in partnership with service users, policy makers, commissioners and other service providers.

- **Employing our resources efficiently and effectively**: the trust is committed to ensuring the best possible use of all public funds.

As a public body, the Western Trust has a responsibility to ensure that it puts all its resources (funding, staff and equipment) to the best possible use for the benefit of the community it serves.

The trust has in place internal performance management and accountability arrangements to monitor how well it is doing this and provide assurance to its trust Board, the DoH, the Health and Social Care Board (HSC Board) and the public that it is fulfilling this obligation.

The trust's internal arrangements cover all aspects of performance such as meeting targets and quality standards and how resources are being managed. These all come under the scrutiny of trust Board and its sub-committees. The trust's directors are responsible for different areas of performance and they provide detailed reports for trust Board on a monthly basis. These arrangements are designed to ensure that underperformance in any area is quickly detected and investigated and that appropriate action is taken to ensure improvement.

Externally, on an annual basis the DoH sets out a wide range of performance targets for each HSC trust in Northern Ireland which are detailed in 'Priorities for Action'. These cover the following areas:

- service delivery and the experience of our service users
- financial performance
- governance performance
- service levels agreed with Commissioners
- performance targets achieved
- performance associated with staffing

The Trust's performance in all these areas is monitored by the DoH and the HSC Board.

Targets and standards are also set by other groups and organisations which are aimed at promoting best practice and high standards within HSC.

Inspection Findings
Ward 3
Medical Ward

3.0 Inspection Team Findings: Ward 3 Medical

Ward 3

Ward 3, respiratory ward is situated on the third floor of Altnagelvin Area Hospital main tower block. The ward has 30 beds consisting of both multi-bedded bays and side rooms. The ward provides care for patients presenting with acute and chronic respiratory medical conditions.

3.1 Is the Area Well Led?

Governance

In anticipation of this RQIA inspection ward staff had carried out some dry run exercises using the inspection tool. Staff had used the information generated from these exercises for learning and improvement. This was demonstrated to the inspection team by the robust nature of the information provided to inspectors.

The ward is managed by a senior nurse who works closely with the lead respiratory physician. This ward sister is responsible for the allocation of resources that facilitates the ward function. We observed a ward sister that displayed good clinical leadership qualities. Throughout the inspection the sister was very visible, coordinating ward activities and supporting both patients' and staff needs. The ward sister was easily identified by wearing a distinct uniform.

Normative staffing levels are designed to allow the ward sister to be supervisory; however limitations in actual ward staffing levels have meant that the sister has had to take a more active role in direct patient care. The ward sister reported that at times it can be difficult to balance the ward managerial duties with providing effective clinical leadership. The ward sister reported that she often has to carryout managerial duties outside her allocated working hours.

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

While most staff reported that morale was good, others reported that morale is being affected by the challenges of increasing work intensity. Some staff reported that although they were supported and valued by the ward management team this was not the case with the trust executive team, highlighting a lack of acknowledgement or engagement.

Recommendation: The trust executive team should improve engagement with staff.

We were told that there was good ward support from a range of AHPs and other specialities including physiotherapy, speech and language therapy, social work, respiratory specialist nurses, pharmacy and dietetics. A MDT meeting occurs on a weekly basis. The team's role is to review all ward patients to ensure that all available treatment options are considered for each patient. It was reported by staff that occupational therapy cover on the ward can be limited which on occasions had delayed the discharges/transfers of some patients.

Recommendation: Occupational therapy ward level support should be improved.

Medical staff commended the well organised MDT meetings and the good working relationships amongst medical and nursing staff and a high interest in supporting audit and quality improvement work. Consultants are very supportive and carry bleeps.

Staff can access a range of policies and documents via the Western Trust intranet site however it was reported that staff can find it difficult to navigate through the system to find ward relevant policy documents. Systems were in place to ensure that all ward staff were familiar with new policies or procedures.

Housekeeping Point: The trust should ensure that policies are easy to locate on the trust intranet site.

The ward sister attends monthly accountability meetings. Ward performance is reviewed at these meetings against key indicators and action plans developed to address areas of poor compliance.

Staff informed us that they were kept up to date with learning from incidents and complaints at ward team meetings and safety briefs; however no formal trend reports were available for staff to access. Staff were aware of their responsibility to complete an incident report on the datix software system. Records of informal local complaints are recorded in a ward log book and recorded within the patient's notes.

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

Communication and dissemination of information to staff is through various formats such as team meetings, safety briefs, handovers, communication book and displayed notices. We observed a morning handover for oncoming and departing nursing staff. The handover had clear leadership from the deputy sister who kept the handover focused and structured. Patient information was comprehensive and delivered effectively. The ward had introduced an electronic nursing handover which we were told has increased both the efficiency and accuracy of information.

Nursing staff team meetings occur monthly. Minutes of the meetings showed a clear structured agenda. Ward safety briefs are undertaken weekly. The inspection team considered that daily safety briefs should be introduced where the exchange of information is rapid and structured to optimise provision of only the essential information.

Recommendation: Daily safety briefs should be introduced.

Staff reported that they had good access to patient related information and electronic care records (ECR). Not all staff within the ward had access to email which would further assist in the dissemination of ward information.

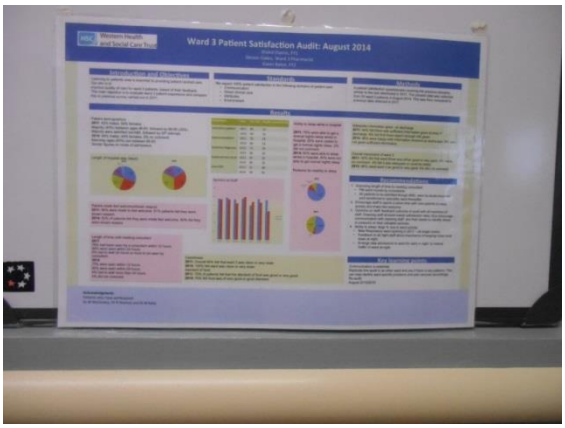
Housekeeping Point: All ward staff should have email access

The ward was subject to continuous assessment using trust wide quality indicators, they include:

- environmental audit
- NEWS
- Malnutrition Universal Screening Tool (MUST)
- patient ID
- falls assessment
- C Difficile
- peripheral line (insertion and ongoing care)
- skin care bundle
- nursing supervision
- record keeping
- omitted dose

Ongoing monthly performance against these quality indicators was displayed for ward staff and routinely discussed within team meetings and accountability meetings. Actions plans to address areas of non-compliance with these quality indicators were available for inspection. We were told that ward staff have participated in a number of national audits in conjunction with the British Thoracic Society.

We were told of a number of initiatives that have been employed to capture patient experience and satisfaction. The ward is involved with the 10,000 voices initiative and had also carried out a ward patient satisfaction audit in 2014, which is due to be repeated within the next six months (Picture 1). A ward staff satisfaction survey was also being undertaken during the inspection. The information gathered is reviewed by the ward sister and actions taken as appropriate.



Picture1: Patient satisfaction audit poster

The ward sister is routinely updated in relation to performance against trust targets for healthcare associated infections and in relation to trust cardiac arrest data. Ward nursing staff attend morbidity and mortality meetings; attendance improves shared learning from adverse clinical events.

Staffing and Supervision

We were informed that there is a minimum of 1.38 WTE registered nursing staff per patient occupied bed. Currently there is a nursing staff deficit of unfilled posts of 3.64 WTE.

Over the last year, three senior staff have taken up roles within the new integrated community respiratory team. The aim of the team is to provide a seamless service to manage patients with respiratory conditions more effectively in primary care and community settings and reduce the likelihood of hospital admission. This has been a very positive initiative for the community team although some ward staff reported that losing experienced staff to the respiratory team has disrupted the balance of skill mix within the ward.

Ward management staff reported that they have been proactive in attempting to recruit staff however a national shortage of RNs has made this very difficult. All staff commented that staffing levels are routinely reviewed and that managers are proactive in booking bank and agency staff where the need is required, although availability of staff at times of booking presents an issue.

It was reported that the current staffing deficit is due to get worse over the course of July and August 2016 with some staff going on maternity leave and two staff members leaving. The ward sister reported to inspectors that as a result, the delivery of safe and effective care will not be sustainable, with the ward sister proposing to close beds if staff are not found to fill this deficit.

Managerial staff are proposing to carry out a further acuity and dependency study in the next few weeks to reassess ward workforce needs. Resources have also been allocated from the tracheostomy team to support ward staff levels.

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

We observed that staff appraisal and supervision sessions have been kept up to date in line with trust policy.

Staff Training

Currently the ward has five sign-off mentors. All nursing students progress through a learning and objectives programme with their allocated mentor. New ward nursing staff members progress through a band 5 induction programme which is used to facilitate staff development.

We saw evidence that all staff had completed a trust wide corporate induction programme. There is 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: moving and handling, life support, fire safety and infection prevention and control. Compliance with mandatory training is monitored by the ward sister.

Staff had access to role specific training to ensure they were able to meet the particular needs of their patients. For example, some staff had completed the respiratory competence programme (RCATS). The programme is designed to develop the knowledge, and skills of staff to equip them to effectively assess and care for patients with a range of respiratory conditions. Staff also receive training when new equipment is introduced within the ward e.g. syringe drivers, pumps, humidifiers, non-invasive ventilation machines etc.

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

All staff were encouraged to participate in safety improvement initiatives. A number of staff have been nominated as champions of infection prevention and control; tissue viability, palliative care, haemovigilance, diabetes and control of substances hazardous to health (COSSH).

Patient Flow

During the inspection, we observed that ward rounds were scheduled and timed early to facilitate transfer or discharge. We observed that nursing staff were not always in attendance on all ward rounds throughout the morning. We were also informed that although ward rounds are scheduled, not all medical staff keep to this schedule. It is essential that nursing staff participate on all ward rounds as they play a crucial role in ensuring patients receive and understand all the relevant information about their care.

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

Medical staff reported that medical admissions to the ward are busy and there are multiple paths of entry to the ward, most often via the Acute Medical Unit (AMU). The medical admissions proforma was commended for its ease of use.

During the inspection we observed five patients whose discharge had been delayed. These patients were either awaiting nursing home placement or arrangement of a care package.

Following discharge from hospital, the Western 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 has introduced an interactive whiteboard system. The benefits of this system include: real time view of the live bed state, electronic bed requests and a faster way to update patients' status and track patients in real time.

Safeguarding

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

If a safeguarding risk is identified, support can be sought through the hospital social work team or the Adult Protection Gateway Team. Safeguarding leaflets were available on the ward and via the trust intranet for staff, patients, and family/carers.

3.2 Is Care Safe?

Environmental Safety

Although the fixtures and fittings of the ward are showing signs of age related wear, it was maintained to a reasonable standard. Large items of equipment which may present a trip hazard were stored along its central corridor due to the ward's limited storage capacity.

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

Emergency equipment on the resuscitation trolley was easily accessible; however we observed that checks of the emergency equipment were sometimes inconsistent. The top surface of the trolley was damaged. A new surface has been procured however we were informed that there have been long delays involving estates services in relation to changing the trolley surface.

Housekeeping Point: The trust should ensure that maintenance requests are addressed in a timely fashion.

Housekeeping Point: Equipment on the resuscitation trolley should be routinely checked as per trust guidance.

Fire safety and life support training were part of a ward staff mandatory training programme. During the inspection a notes trolley had been abandoned in front of the back entrance fire escape.

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

There was sufficient moving and handling equipment and adaptions throughout the ward to meet the needs of patients with physical disabilities e.g. corridor handrails. There were however no adaptions to meet the needs of patients with dementia, such as large clocks and clear pictorial signage. We were informed that a staff member had been nominated to coordinate an initiative to improve the ward environment for patients with dementia.

Recommendation: Appropriate adaptations should be put in place to meet the needs of patients with dementia.

Known hazards in the ward environment had been risk assessed and preventive actions implemented.

Infection Prevention and Control

Signage was displayed at hand wash sinks which provided instruction on the correct methods for removing possible contaminants. We saw regular use of these facilities by staff, in addition to hand decontamination rub.

We noted that there was easy access to personal protective equipment such as gloves and aprons however it was not always used effectively. One example included a staff member in contact with foul/ infected laundry, wearing gloves but no apron.

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

Staff were able to demonstrate to us when ANTT procedures should be applied and observed practices were in line with best practice.

We observed that a number of items of equipment required further cleaning and maintenance. The underside of a raised toilet seat was stained; a patient's disposable hoist sling was stained, some bed pans were excoriated and needed replaced and a bathroom soap dispenser was broken. Equipment cleaning schedules were not in place.

Recommendation: Staff should ensure that all equipment is clean and well maintained and equipment cleaning schedules introduced.

A prepared bottle of disinfectant solution (actichlor plus) was observed unattended on a worktop in the dirty utility room. The bottle was not documented with the date and time of preparation.

Meticillin-resistant staphylococcus aureus (MRSA) and clostridium difficile care pathways were available to guide care. We observed that an MRSA pathway was not being used for a patient identified with MRSA colonisation.

Housekeeping Point: Staff should ensure that the MRSA care pathway is used to guide the treatment of patients colonised or infected with MRSA.

We observed that areas of a patients' bay were cluttered with equipment. This made it difficult for cleaning staff to effectively clean this area. The cleaning schedule of this bay was also inconsistently recorded.

Housekeeping Point: Staff should ensure that ward areas are consistently cleaned as per guidance and all areas are decluttered to allow effective cleaning.

Patient Safety

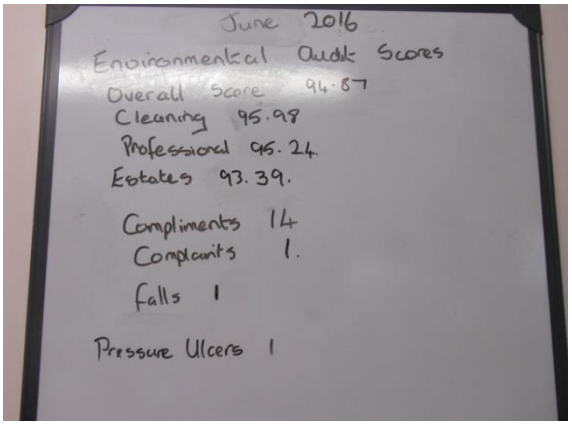
All patients receiving treatment wore an accurately printed identity band; staff were aware of the actions to take if identification details were incorrect. Vulnerable at risk patients were identified at the nursing handover. We were informed that patient safety/medical device alerts are reported to 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. With one exception, 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 quality indicators. A 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.

Staff complete a falls risk assessment for all patients within six hours of admission. Since the beginning of January 2016, there have been 28 patient falls recorded within the ward. The ward sister reported that there were no obvious factors to explain the level of falls within the ward. Work is however required to further analyse falls incident reports to identify any contributing factors. A ward falls prevention group should be considered to act upon both clinical and environmental risk factors.

Recommendation: Further analysis of falls incidents should be undertaken to identify trends or patterns.



The ward notice board displays the number of patients that have had a fall or developed a pressure sore within the ward since the beginning of the month (Picture 2). This real time data helps raise awareness within the ward team and promotes good practice to improve patient safety.

Picture 2: Ward notice board

Patients admitted to the ward 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.

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

Medicines Management

Storage of medicines was observed to be satisfactory. All medicines were stored in locked cupboards and trolleys. The refrigerator temperature was monitored and recorded daily; however, the consistent nature of the readings indicated that the thermometer was not being reset.

Housekeeping point: The refrigerator thermometer should be reset daily following the recording of the temperature.

Controlled drugs were stored and administered safely. Reconciliation checks were completed at shift changes.

IV infusions were observed to be stored safely. Potassium containing infusions had been clearly segregated from other infusions and were stored above the controlled drugs cabinet.

The preparation area was well lit, uncluttered and positioned appropriately to prevent unnecessary interruptions.

The documentation reviewed indicated that kardexes were well maintained. When oxygen was prescribed, it had been recorded on the kardex. There was good recording of blood glucose levels and the administration of insulin.

There was evidence that appropriate action was taken when blood glucose levels were outside the usual range. The allergy status had been recorded on all kardexes examined. The patient's weight was recorded on one out of three kardexes examined.

The ward has a full time pharmacist assigned to it who is involved in the medicines management process from admission to discharge and staff advised that they had access to pharmaceutical advice if required. The pharmacist reconciles medicines on admission and rationalised their use during inpatient stay. The patient's concordance with prescribed medicines was assessed on admission. A clinical check was completed by the pharmacist at discharge. The use of Patient's Own Drugs made the discharge process more efficient.

Patients told us they that were involved in the decisions about their medicines which included changes in dosing or commencement of new medicines during their stay. During the administration of medicines, a nurse explained each medicine prior to administration and no medicines were left unattended on the bedside locker/table.

Discussion with staff indicated that they had an awareness of critical medicines.

3.3 Is Care Effective?

Nursing Care Records

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

The nursing documentation reviewed did not always adhere to NMC standards of documentation. Documentation was not always written legibly, with clear signatures, dated, timed and signed. Documentation did not always include the patient name, date of birth, healthcare number, ward and date.

Within one patient's records there was no documented evidence of MDT discharge planning and little evidence of family involvement in planning aspects of care.

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

The ward had been involved in the piloting of a new initiative called PACE, facilitated by NIPEC. This initiative is aimed to improve care planning by taking a more person/family centred approach.

Medical Care Records

Medical notes well organised and entries completed to a high legible standard although the time of entry was noted on less than 50 per cent occasions. Some sets of notes were large and unwieldy. Documentation and review of patients requiring analgesia, and those who were receiving end of life care was well completed with appropriate clinical review and early involvement of the palliative care team.

Medical admissions are busy and there are multiple paths of entry to the ward, most often via the AMU. The medical admissions proforma was commended for its ease of use.

Nutrition and Hydration

A protected mealtime protocol was in place within the ward however on a number of occasions we observed that some medical staff disturbed patients during mealtimes.

Housekeeping Point: Staff should ensure that there is no unnecessary disruption during mealtimes.

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. Patients were provided with jugs of fresh water, which were within easy reach. Patient snacks were however not available 24/7.

Housekeeping Point: Patient snacks should be available 24/7.

On the first day of the inspection, we observed a meal service that was poorly coordinated. For some patients who required assistance, their meal was left on their bedside table by staff. Some meals were allowed to go cold as these patients did not receive timely assistance. We also observed that staff failed to prepare some patients prior to meals. We were pleased that these issues had been addressed by the second day of the inspection.

Recommendation: Senior nursing staff should coordinate and supervise meal services ensuring that all patients are prepared for and receive timely assistance with meals.

We were told that mechanisms were in place to identify patients that require assistance at mealtimes and 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.

Pain Management

During the inspection we observed that patients appeared comfortable, pain relieving comfort measures were available and staff responded promptly to patients' requests for pain relief.

Pain assessment is carried out as part of routine practice within patient NEWS charts. Pain medication is administered as prescribed in the medicine kardex.

We observed that prescribed pain medication was appropriate to patients' conditions and the effectiveness of the analgesia was reviewed. A pain team and palliative care team are available within the hospital for advice and support.

Pressure Ulcers

Staff were knowledgeable in regard to pressure ulcer care. Patients appeared comfortable and appropriately positioned, with pressure relieving equipment in use. Pressure relieving equipment is ordered and is delivered promptly when required.

A validated pressure ulcer classification tool and wound charts are used to guide management. Patient repositioning charts were in place and evaluated to reflect the patient's ongoing care needs.

Nutritional supplements are offered to adults at risk of, or who have pressure ulcers, or who have a nutritional deficiency. When required, staff can contact the tissue viability nurses for detailed advice and support. Staff were aware of the policy for the photographing of pressure ulcers. Staff were also aware of the need to completed an incident form and carry out an RCA for specific grade hospital acquired pressure ulcers. Mattress audits are undertaken on a regular basis.

Promotion of Continence and Management of Incontinence

Staff were observed providing patients with the appropriate assistance to promote continence and care for incontinence. We observed that some patients were not given the opportunity for hand hygiene after toileting.

Housekeeping Point: All patients should be given 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.

For a patient that had a urinary catheter inserted; there was no documented planned date of removal within the patient records.

Housekeeping Point: Staff should ensure for patients with a urinary catheter, the planned date of removal is recorded.

3.4 Is Care Compassionate?

Person Centred Care

The ward was bright and welcoming although observed to be very busy. Throughout the inspection we observed caring and committed staff. 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 and patients appeared comfortable and suitability clothed. Staff endeavoured to maintain the dignity and privacy of patients at all times. Privacy curtains were used effectively when patients were receiving personal care and during interviews with medical and allied health professionals. Disposable privacy curtains were used in the ward. These were of adequate length and appeared fresh and clean. Staff alerted patients prior to entering private areas. Same sex accommodation in patient bays was adhered to throughout the inspection.

There are adequate supplies of laundry to meet the needs of the ward. The number of toilets and wash rooms within the ward are limited in number and insufficient to meet the needs of a busy 30 bedded ward. We were informed that at times, patients can be delayed in using these facilities due to availability. The ward had access to a patient quiet room that could be used for quiet private conversation with staff or relatives.

The ward exit doors did not open automatically on leaving and required a member of staff to activate the system.

Housekeeping Point: The ward exit doors should have a button which visitors can use to automatically open the doors and exit the ward.

Although not used during the inspection, we were informed that an escalation bed is occasionally used in the ward during times of bed pressures. To facilitate this, an extra bed is placed into a single patient side room. This single room which now holds two patient beds is severely restricted in core clinical space. Staff report that it can very difficult to maintain the dignity and privacy of the patients in this room with both beds placed in close proximity and without appropriate fixed curtained screens. Staff also reported that it can be very difficult to manoeuvre equipment within this room which may have significant implications in the event of an emergency. We observed that a risk assessment with control measures had not been completed for the use of these beds.

Recommendation: A risk assessment should be carried out for the use of escalation beds.

Communication

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 observed appropriately placed posters to guide staff in the appropriate IPC precautions to be employed for patients identified with alert organisms. Most staff were easily identified by clearly labelled 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.

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. Staff endeavoured to speak with discretion when discussing patient information.

End of Life

During the inspection, there were a number of patients within the ward at the end stages of life. When we spoke with staff it was evident that they were passionate about the delivery of quality care for patients at the end of their life. A number of staff had received additional palliative care and bereavement training. During the inspection we observed a continuous presence on the ward from members of the palliative care team who were supporting and guiding care practices.

For evidence based guidance, staff can refer to NICE Guideline NG31 - Care of dying adults in the last days of life.

Family and carers have access to complimentary car parking and can remain with their relative while they are on the ward. Information and bereavement support systems were available for patients and carers and are signposted on the trust website. Chaplaincy services are available on request.

We were informed that as a result of the limited number of side rooms on the ward, some patients at the end of their life may have to be cared for in multi-bedded bays. During the inspection, ward staff had been pressured by the bed manager to move a patient at the very end stages of life into a patient bay to make way for another patient. It was pleasing that ward staff resisted this pressure which ensured that the patient and their relatives have the added advantage of privacy during this difficult time.

During the inspection, do not attempt resuscitate orders were correctly completed with evidence of discussions with patients and their relatives.

Patient and Relative Questionnaires

The RQIA inspection included obtaining the views and experiences of people who use services. Questionnaires were used to allow patients and relatives to share their views and experiences with the inspection team. The findings are presented from a composite perspective combining the patient and relative perceptions. During the inspection a total of 13 questionnaires were carried out in Ward 3:

- 10 Patient Questionnaires
- three Relatives/Carers Questionnaires

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

Call bells were answered quickly and staff assisted with personal care when required. Patients were satisfied that staff checked with them regarding pain relief, and that they received it in a timely fashion. Most patients were comfortably positioned. Some patients reported that there was not enough staff to care for them.

Patient thought the ward and sanitary areas were clean, the choice of food was good and fluids were readily available.

Patients reported that staff hand hygiene was good, and that they were offered the opportunity to wash their hands before meals.

Overall, patients were satisfied that they were safe; had received a good standard of care; and would be happy for a member of their family or a friend to be cared for in this ward.

Patients Comments

"They are very, very courteous."

"I have no concerns. I am content."

"Sometimes is a bit hectic, but you have to put up with things."

"They are running off their feet."

"The curtain is always pulled when the doctor comes in to the room."

"Two or three food choices every day. I am happy, there is plenty."

"Water is changed twice a day."

"Very, very clean."

"They explain everything to you."

"There is a great feeling here."

"Excellent! Could not be better. I have been in here a few times."

"Very happy, could not ask for better."

"You could have a bit more time for washing and showering. It is not too bad. I have no qualms about coming here. I have been well looked after."

"We are very, very lucky to have a hospital like this. Everyone is professional".

"No. I am quite satisfied. I do not think there is much to improve unless get them more staff."

Relatives Questionnaires

Overall, questions answered by relatives were positive. Relatives told us they were welcomed, informed and they knew who to speak to in relation to their relative. Relatives were treated with dignity and respect. Most told us that staff kept them informed, staff had time to care and the standard of care was good. One relative did not always feel involved in their relatives care or that the staff had enough time to care.

There was only one comment: *"My dad is waiting four days on a scan! This is not good enough!"*

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.

Twenty four observations were carried out over four observation sessions. There was some positive engagement and interaction between staff and patients during meal times. Staff engaged in conversations when delivering personal care and medical ward rounds. Explanations of the procedures they were carrying out, providing support and care and treating the patient as an individual.

Basic and neutral observations occurred during the meal service, staff were not available to assist patients who required help in a timely manner. Staff removed trays but did not confirm with the patient they were finished. A nurse was observed wearing gloves and an apron when assisting a patient to eat. Improved practice was observed on day two, the meal service was staggered, patients were assisted or monitored and were given more time to eat their meal.

3.5 Conclusions for Ward 3

The environment was light and bright and welcoming and although the ward is showing signs of age related wear, it was maintained to reasonable standard. We observed staff who were committed to the care of their patients. While most staff reported that morale was good others reported that morale is being seriously affected by the challenges of increasing work intensity.

We found that the leadership and governance arrangements within the ward were good. The ward sister was very visible throughout the inspection, coordinating ward activities and supporting patients and staff needs. Complaints, incidents, audits and service performance information were discussed and actions agreed. There were mechanisms to listen to patients and staff are using audits and questionnaires to improve the quality of care provided.

With an increase in nursing staff deficits over the summer months it is reported that the delivery of safe and effective care will not be sustainable; with a proposal to close beds during this period. The trust had undertaken a number of activities to fill vacancies.

Nursing staff were not always in attendance as some ward medical rounds were did not follow schedule.

Known hazards in the ward environment had been risk assessed and preventive actions have been implemented. Some infection prevention and control practices require improvement. Checks of the emergency equipment were inconsistent and equipment cleaning schedules were poorly completed. Further work is required to identify any contributing factors related to an increased incidence of falls within the ward.

NEWS and VTE assessments; were well completed. A sepsis bundle should be introduced for the early recognition and management of sepsis.

A ward based pharmacist is in place who is involved in the medicines management process from admission to discharge. Medicine kardexes were well maintained and the storage and administration of medicines were in line with best practice. Patients told us they that were involved in decisions about their medicines.

We found that the nursing assessments and risk assessments had not always been completed. The nursing documentation reviewed did not always adhere to NMC standards of documentation. Medical notes well organised and entries completed to a high legible standard. It was reported that some sets of medical notes were large and unwieldy.

We observed that patients appeared comfortable, pain relieving comfort measures were available and staff responded promptly to patients' requests for pain relief. Staff were knowledgeable in regard to pressure ulcer care and appropriate assistance to promote continence and care for patients with incontinence was observed.

A protective meal service was in place however it was not always adhered to. During the first day of the inspection we observed a meal service that was poorly coordinated. We observed that some staff failed to provide timely assistance with meals or prepare patients prior to meals. Fluid balance and food charts were not always reconciled.

Patients' personal hygiene needs had been attended to as appropriate, patients appeared comfortable and suitability clothed. Staff endeavoured to maintain the dignity and privacy of patients at all times. The number of toilets and wash rooms within the ward was limited.

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

They told us that they were satisfied that they were safe; had received a good standard of care; and would be happy for a member of their family or a friend to be cared for in this ward.

We have made 16 recommendations and 14 housekeeping points.

3.6 Recommendations and Housekeeping Points

Recommendations

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

2. The trust executive team should improve engagement with staff.

3. Occupational therapy ward level support should be improved.

4. Daily safety briefs should be introduced.

5. The trust should ensure that patient care and safety is not compromised due to staffing levels. The recruitment of new staff should be expedited.

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

7. Equipment on the resuscitation trolley should be routinely checked as per trust guidance.

8. All staff should comply with the trust PPE policy.

9. Appropriate adaptations should be put in place to meet the needs of patients with dementia.

10. Staff should ensure that all equipment is clean and well maintained and equipment cleaning schedules introduced.

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

12. Further analysis of falls incidents should be undertaken to identify trends or patterns.

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

14. Senior nursing staff should coordinate and supervise meal services ensuring that all patients are prepared for and receive timely assistance with meals.

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

16. A risk assessment should be carried out for the use of escalation beds.

Housekeeping Points

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

2. The trust should ensure that policies are easy to locate on the trust intranet site.

3. All ward staff should have email access.

4. Staff should ensure that items of equipment that present a trip hazard are removed.

5. The trust should ensure that maintenance requests are addressed in a timely fashion.

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

7. Staff should ensure that the MRSA care pathway is used to guide the treatment of patients colonised or infected with MRSA.

8. Staff should ensure that ward areas are consistently cleaned as per guidance and all areas are decluttered to allow effective cleaning.

9. The refrigerator thermometer should be reset daily following the recording of the temperature.

10. Staff should ensure that there is no unnecessary disruption during mealtimes.

11. Patient snacks should be available 24/7.

12. All patients should be given the opportunity for hand hygiene after toileting.

13. Staff should ensure for patients with a urinary catheter, the planned date of removal is recorded.

14. The ward exit doors should have a button which visitors can use to automatically open the doors and exit the ward.

Inspection Findings
Ward 8
Surgical Ward

4.0 Inspection Findings: Ward 8 Surgical

Ward 8 is an 18 bed specialist head and neck surgical ward. The ward has four, four bedded bays and two single rooms with an ensuite. Situated within the ward, the additional enhanced care unit has four patient trolleys and is used for patients attending the ward for a day procedure. During times of full ward patient occupancy this unit can be used, short term, to place patients waiting for a bed in the main ward.

4.1 Is the Area Well Led?

Governance

Throughout the inspection, we observed evidence of good leadership, effective governance and the dissemination of information to staff.

The ward sister was easily identifiable by uniform and name badge to support ward activities. The deputy ward sister and staff nurses wear the same uniform so the deputy ward sister was not easily identifiable. We observed that some staff wore pictorial badges, which hung from their uniform pocket, rather than name badges.

Housekeeping Point: Name badges to denote the designation of staff should be supplied and worn.

Staff had access to a range of policies and procedures. We observed daily safety briefings, handovers, and minutes reviewed demonstrated that regular staff meetings take place. On discussion, staff demonstrated knowledge of the complaints procedure and the reporting of incidents and SAIs. Verbal complaints are recorded and discussed with the senior nurse and investigated by sister.

Datix software allows for analysis of all reported incidents to identify themes or patterns. At the onset of the inspection, sister was not aware of any trends or of a formal report of the review of SAIs, Incidents and Near Misses for trends or patterns. However, we were provided with 'Incidents by Adverse event' April 2016 to July 2016 figures during the inspection. We observed that incidents and learning were discussed at safety briefings.

The ward sister was not aware of any issues occurring on the ward that warranted being placed on the trust's risk register.

Morbidity and mortality are discussed at oral/maxillofacial and orthopaedic governance meetings which sister attends. Sister does not currently attend, but had asked during the inspection to attend the next Ears Nose and Throat (ENT) meeting. There was no evidence of dissemination of information from these meetings to staff.

Recommendation: The 'Incidents by Adverse event' figures and learning from morbidity and mortality meetings should be regularly disseminated to staff.

Ward healthcare associated infection rates were displayed on a notice board. There was documented evidence of ward cardiac arrest rates being reviewed.

Audits of practice and documentation were carried out routinely. These included audits of compliance with key performance indicators, such as falls, skin (pressure ulcers), record keeping, environmental cleanliness, hand hygiene, and care bundles (Picture 4).

Picture 4: Key Performance Indicator

Action plans were compiled following poor compliance results, and we noted that repeat audits demonstrated improvement.

Staffing and Supervision

Normative staffing rates had been agreed for Ward 8. We were told that staffing levels were continually reviewed with senior nurses; bank and agency staff were used when required. The ward was at its full complement of staff, with one RN outstanding to facilitate one RN rotation to another ward. Beds had not been closed due to staff shortage; however we were advised that at weekends bed numbers could be reduced to 12. We were told that retention of staff was good; there were two RNs and a ward clerk on sick leave.

The ward sister was not supervisory, was counted in the ward numbers and tried to undertake managerial duties in the afternoon. We were told that with the full staff establishment in place, the ward sister has sufficient time to undertake managerial duties and provide clinical leadership. Mentor and preceptor nurses supported junior staff and nursing students to fulfil their roles and responsibilities.

We observed a positive organisational culture during the inspection. Staff reported they did not work outside their competency levels, were able to raise concerns and appropriate support was provided by line management. Documentation reviewed demonstrated that supervision and appraisal were up to date. We were told that with the exception of occupational therapy, AHP and support staff levels did not compromise patient care. When required, the weekend on call physiotherapist could be booked on a Friday.

We were told that medical staffing levels did not compromise patient care and there was a system in place to ensure that ward inliers/outliers are reviewed promptly by medical staff. We were told that they enjoyed working on the ward. We were told that there was an open and supportive culture, with one commenting that they were able to raise concerns or to admit if something had gone wrong.

We observed a mid -morning safety briefing which provided a forum to highlight staffing and safety issues, as well as providing an update on the current position as to the number of vacant beds and expected discharge numbers.

Staff Training

A range of link nurses was available. We were told that mandatory training attendance had improved however training such as data protection, hyponatraemia, safeguarding and cardiopulmonary resuscitation (CPR) specifically for healthcare assistants required improvement. Some staff had received role specific training. One RN was in the process of being inducted to the ward. There was a comprehensive trust induction pack. We were told that the nurse practitioner/practice educator role has proved invaluable in improving and developing staff training and providing clinical support at ward level.

Recommendation: Staff should be facilitated to attend mandatory training.

Staff told us they worked well with each other and any issues affecting individual performance or teamwork would be discussed and generally resolved at ward level. Staff told us that morale was good and they were supportive of the ward sister.

Patient Flow

We observed that the ward sister or nurse in charge took part in daily early morning consultant ward rounds. Twice a week, the nurse educator does the ward round. The ward rounds facilitated communication, early transfer and discharge however we were told that issues such as timely review of outliers by medical staff, completion of discharge letters and pharmacy could delay discharge. We were advised that timely access to occupational therapy can be an issue for medical inliers on the ward. We were told that the number of ward rounds could be challenging; at times there could be six to eight consultant ward rounds and ward rounds held post-surgery. We were told that a three-month pharmacy pilot of a ward based pharmacist had proved beneficial but had been stopped due to lack of funding.

Recommendation: Systems and processes that impact on patient flow and discharge should be reviewed and improved.

We were told that a pre-operative assessment clinic has been created in light of cancellations of procedures for up to 25 per cent of patients who had been admitted due to medical comorbidities or abnormal blood tests. Audit has demonstrated that pre-operative assessment has significantly cut down cancelled procedures along with a telephone call to patients pre-admission. Consent is taken appropriately by trained staff.

Staff were aware of the trust's reablement service to help people whose health has deteriorated.

Communication

Inspectors saw examples of effective communication and dissemination of information to staff. These included safety briefings, nursing handovers, electronic board, staff notice board, ward meetings, ward rounds and multi-professional meetings. Nursing handovers were conducted at the start of each shift with a mid-morning safety briefing to inform staff of any relevant issues needing addressed. We were told that safety briefings are not routinely carried out for night staff.

On review of documentation the staff meeting standard agenda is not detailed enough to fully cover all ward governance issues, for example complaints, incidents and audit feedback. The inspection team considered that the template for the ward safety briefing could be improved.

We were told by medical staff that there was no set medical handover meeting or handover sheet used to record information.

Recommendation: The system used for medical handover should be reviewed to ensure effective communication of information.

Housekeeping point: The staff meeting standard agenda and safety briefing template should be reviewed and improved. Regular safety briefings should be held for night duty staff.

We were told that staff have access to a personal email account. The ward displayed audit results in relation to performance indicators. Staff reported that apart from participating in the 10,000 voices campaign in 2015, patient experience data was not captured, recorded and routinely analysed and acted on.

Recommendation: The ward should capture record and routinely analyse and act on patient experience data.

Safeguarding

A policy and information folder was available containing information on safeguarding patients from abuse, including additional safeguards required for under 18s on the ward.

Staff were aware of trust safeguarding communication arrangements and would follow the trust's safeguarding pathway. We were told that it was more common in the ward to hold discharge planning meetings for patients with complex needs rather than safeguarding issues.

Staff were aware that in a case of suspected child abuse, the Consultant Paediatrician would be called immediately and child protection procedures commenced. Additional safeguards would be required for children including contribution to Understanding the Needs of Children in Northern Ireland (UNOCINI) assessment.

4.2 Is Care Safe?

Environmental Safety

We observed that overall the ward environment was in good repair, free from trip hazards and equipment and supplies were stored in areas only accessible to staff. We observed that staff were not always visible on the ward, spending a lot of time in the clinical room to write up notes, gather equipment and prepare medication. On one occasion during morning handover a healthcare assistant was left in charge of the ward (giving out breakfast and feeding a patient) while the only nurse on the ward took a patient to theatre. A member of the inspection team intervened and asked nursing staff in the handover to come onto the ward. The ward sister discussed this incident with staff at the mid-morning safety brief.

Recommendation: Staff should be visible on the ward to maintain a level of visual contact with higher risk patients.

We noted that there were both adult and paediatric emergency trolleys. The paediatric trolley was located in the treatment room and was in the process of being restocked. We were told that the ward had been waiting for over a month for some essential equipment for this trolley. When fully stocked it was to be moved back into the ward. We observed missing daily checks and a sharps box not secured appropriately to the trolley. The contact details for the resuscitation team were not fully visible.

Recommendation: Emergency trolleys should be fully stocked and located in an accessible area. Sharps boxes should be stored securely on the trolley and contact details for the emergency team displayed in a fully visible manner.

We observed and were advised that the ward had not been assessed and adapted to meet the needs of dementia patients with provision of, for example, large clocks. The ward sister reported that a dementia champion for the ward will be identified. Purple folders were already in use to identify patients with dementia. Adaptations had been made to the environment to meet the needs of patients with a disability.

Recommendation: The ward should be assessed to ensure that appropriate adaptations are put in place to meet the needs of patients with dementia.

Infection Prevention and Control

We observed that the ward was clean and clutter free. Environmental audits demonstrated compliance with trust target levels. Patient equipment was clean and in good repair and detailed cleaning schedules were available. A range of PPE was available and worn appropriately by nursing staff.

We observed good hand hygiene practice; hand hygiene audits were carried out in line with trust policy. However, we observed that not all medical staff washed hands prior to and after donning PPE. A few staff were not always compliant with the trust dress code policy; wearing stoned earrings, attending the ward with theatre hat and scrubs with no theatre overcoat, or wearing tie and wrist watch.

Overall, we observed that staff adhered to ANTT best practice; however on one occasion staff did not use a tray to carry IV drug infusion equipment to a patient.

Recommendation: Medical staff should comply with the trust hand hygiene and PPE policies.

A review of nine invasive device charts demonstrated that five were not correctly completed with batch number, gauge, site of insertion, name and number of attempts. Documentation in medical notes for a patient who had a blood culture carried out demonstrated that the site had not been recorded.

Recommendation: Medical staff should complete all documentation relating to invasive devices and blood cultures.

Patient Safety

On review of charts, we found that patients' NEWS were completed within the set timescales, and there was an appropriate response to NEWS triggers.

We were told that a sepsis bundle to ensure the recognition and timely management of sepsis was not in place. Key investigations to aid clinical diagnosis were available for inpatients, 24 hours a day.

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

A falls safe bundle was in place and the ward monitored falls and trends. Patients who require supervision were placed in view of the nurses' station. We were told that monthly audits were discussed at ward meetings and as part of the ward safety briefing.

On review of documentation, we found that consent forms and surgical safety checklists were in place and completed. Only one VTE risk assessment had not been completed for a patient on admission; VTE prophylaxis was administered where required.

The type and occurrence of pressure ulcers were monitored. Staff were compliant with blood transfusion competency assessments and were aware of their responsibility to complete blood transfusion record sheets. Patient safety/medical alerts were cascaded to staff by email, highlighted at safety briefings, and posted in a folder.

Staff told us they can raise concerns with the ward sister and that senior management are visible and approachable on the ward.

We observed that safeguarding information/support/leaflets were not readily available on the ward for staff, patients and family/carers to access.

Housekeeping Point: Safeguarding information/support/leaflets should be easily accessible.

Medicines Management

We observed that the majority of medicines were stored in locked cupboards; however, the clinical room was often left unlocked and unattended (Picture 5). The medicines that were not in locked cupboards within this room were therefore not stored securely. The clinical room was observed to be cluttered and untidy. There was insulin in the refrigerator which had been labelled and used for one patient who had since been discharged and another insulin pen which was used but unlabelled. There was a box of medicines labelled for a patient which contained several strips of different medicines.

Picture 5: Clinical room open and unlocked

Recommendation: Medicines should be stored safely and securely in line with trust policy.

Controlled drugs were stored and administered safely.

We observed that 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 least twice per day at shift changes; however, the records of these checks were not complete indicating that the process may not be robust.

Recommendation: Robust procedures should be in place for reconciling supplies of controlled drugs.

We observed that the preparation area for IV infusions was subject to unnecessary interruptions. The administration of an IV medicine to one patient was observed. The medicine was prepared by one nurse who then asked a second nurse to check her work prior to administration. Two nurses were at the patient's bedside for the administration.

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

Documentation indicated that kardexes were generally well maintained. The allergy status had been recorded on all kardexes examined. The patient's weight had been recorded on two out of three kardexes.

We were advised that an integrated medicines management service was not being provided. The ward did not have a pharmacist assigned to it although staff told us 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 systems were in place for the provision of appropriate support with medicines prior to discharge.

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 dosing 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 a stock of medicines was held and could be obtained within the hospital. A list of critical medicines was displayed in the nurses' station.

Staff were aware of the procedures in place for reporting incidents and near misses.

4.3 Is Care Effective?

Nursing Care Records

Five care records were examined. Records did not always demonstrate on-going assessment and evaluation of the daily care and were more of a narrative of events. A care plan was not always in place for patients' identified need. Relevant risk assessments were not always undertaken or fully completed; for example infection prevention and control, bedrails, MUST. The inspection team considered that documented evidence that the patient had been involved in agreeing their own care plan could be improved.

Nurse record keeping did not always adhere to NMC and NIPEC guidelines. We observed that documentation was not always signed in full, and errors were not always crossed out and signed legibly with the staff designation. A patient healthcare number was not always written on documentation and an ID label was not always used.

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

Medical Care Records

Medical notes reviewed were very well organised and kept in folders along with nursing notes. However, the time of entry from both medical as well as allied health professional staff was missing on 50 per cent occasions and less than 40 per cent of consultant ward rounds had a time documented. The inspection team noted that there was a different consultant doing a ward round every day for six consecutive days in ENT and four consecutive days for general surgical patients. Pathology diagnoses and results were, on two occasions entered into the medical notes but there was no documented evidence of discussion with patients or their relatives. Analgesia prescribing and review and involvement of the palliative care team early in the patient journey were of a particularly high standard.

Recommendation: Documentation should include time of entry and evidence of discussion of diagnosis with patients or their relatives.

Nutrition and Hydration

We observed that protected meal times were not adhered to, despite signage. We observed medicine rounds and medical staff reviewing patients during meal times. A menu choice was available and included specialised dietary requirements as appropriate.

Housekeeping point: Staff should adhere to protected meal times.

A senior member of nursing staff did not always supervise and co-ordinate the service of meals. We observed that ward staff did not assume this role when the ward sister was not present.

Although we considered that there were sufficient staff allocated to support and supervise those who needed assistance, this was not evident. We observed that nursing staff did not always participate in the serving of patient meals and mechanisms to identify patients that required assistance at mealtimes were not effective. There was confusion over patient dietary needs as the handover sheets and electronic board were not used effectively. We observed that staff did not routinely prepare the patient who required assistance at mealtimes including positioning in chair/bed, removing obstacles from the bedside tables, hand hygiene and food was not always appropriately placed in front of patients and assistance given.

Recommendation: Nursing staff should coordinate and supervise meal services ensuring that all patients are prepared for and receive timely assistance with meals.

We did not observe staff supervising and encouraging patients to eat and drink during meal times. Tableware was not always appropriate, for example paper drinking cups for patients with manual dexterity issues. We observed patients doubling up drinking cups for support.

There was no effective mechanism in place to identify/report patients' intake at mealtimes. Catering staff collected trays; nursing staff did not participate in this process. We observed nursing staff asking catering staff in retrospect what the patient had eaten or drunk to complete food and fluid balance charts. Fluid balance charts were not always completed, in place or reconciled and food charts were not always completed.

Recommendation: The mechanism for monitoring patients' intake should be reviewed and improved. Nursing staff should ensure that fluid balance and food record charts are completed and reconciled.

We were told that during the week following the inspection, the ward would have meal volunteers' between 11.30am and 12.30pm, to assist patients at meal times.

Pain Management

During the inspection, patients reported that they were comfortable; pain relieving measures were available and in place; and staff generally responded promptly to patients' requests for pain relief. Pain medication was administered as prescribed in the medicine Kardex; there was appropriate recording of the pain score on the NEWS chart.

Some patients identified that at busy times there could be a delay in receiving pain relief.

Pressure Ulcers

Staff were knowledgeable and good practices were observed with regard to pressure ulcer care. Patients reported and we observed the appropriate use of pressure relieving equipment. Staff stated that pressure relieving equipment was delivered promptly when ordered. A validated classification tool and wound chart was in use and where required, repositioning chart was used to reflect patients' ongoing care needs. A pressure ulcer safety cross was displayed at the nurses' station.

Staff reported that they could access advice on pressure ulcer care via the trust intranet or contact with a tissue viability nurse (TVN) for additional detailed advice and guidance. The TVN had recently provided update training for staff. We observed quarterly mattress audits. Staff confirmed that daily mattress checks were carried out and any faults or problems were reported and dealt with promptly.

Promotion of Continence and Management of Incontinence

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

A review of the documentation for a patient requiring self-retaining catheter care evidenced that the documentation was fully completed. Staff told us that stool charts are only for patients with diarrhoea on admission. However, the ward sister advised that a stool chart can be used for any patient experiencing abnormal bowel symptoms.

Housekeeping point: Staff should be aware that stool charts should be used for all patients experiencing abnormal bowel symptoms.

4.4 Is Care Compassionate?

Person Centred Care

We noted that although busy, the ward was organised and calm and noise levels were low. We observed that privacy curtains were pulled when personal care was being delivered to patients and staff were discreet when delivering personal care within the screened bed space. Call bells were within reach and generally answered promptly. However, some patients reported a delay in response when the ward was busy.

Regular intentional care rounding or similar was not in place to ensure that nursing staff carried out scheduled tasks or observations of patients to meet and anticipate their fundamental care needs.

Recommendation: Care rounds should be introduced.

The ward exit doors did not open automatically on leaving and required a member of staff to activate the system. The ward exit doors should have a button which visitors can use to automatically open the doors and exit the ward. A camera was located at the nurses' station for staff to view those entering or exiting the ward.

Housekeeping Point: The ward exit doors should have a button which visitors can use to automatically open the doors and exit the ward.

There were adequate supplies of laundry to meet the needs of the ward. Toileting was not carried out at the bedside during meal service. A quiet room to facilitate private conversation and relaxation was not available. Staff told us that treatment rooms and offices would be used for private conversations. We observed and were advised that one of the ward offices designated for medical staff was not used.

Housekeeping Point: The ward should review and were possible reconfigure areas within the ward for patients to use to facilitate quiet and confidential conversation.

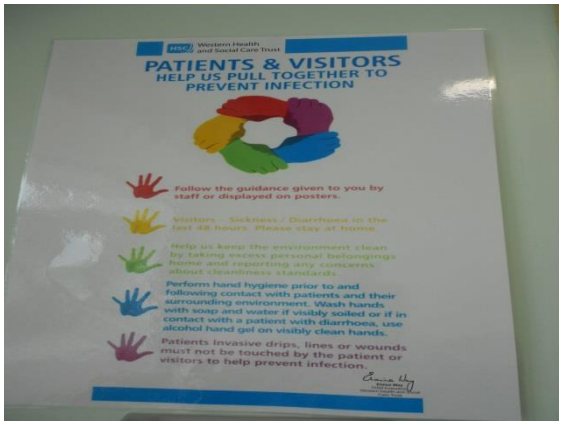
Patients had access to the ward telephone which could be moved to the treatment rooms or offices for private conversations.

Advocacy services are available and staff could access a chaplain on request.

Communication

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

Staff were observed treating patients and visitors courteously. Patients were encouraged in a sensitive manner, and staff were generally discreet, giving an easily understood explanation of the care they were to receive. Patients' confidentiality and conversations at times were not maintained. At times during ward rounds we heard details of patients' medical condition being discussed in the corridor outside ward bays. Communication aids were available and there was access to appropriate information, leaflets, interpreter services and a communication writing board (Picture 6).



Picture 6: Patient and Visitor Infection Control Poster

Housekeeping: Staff should speak discreetly and maintain patients' confidentiality at all times.

End of Life Care

At the time of inspection, the development of an integrated care pathway/care plan for the dying had not been completed.

Staff were knowledgeable when questioned about the systems that were in place. However, end of life guidance reviewed did not include information on care of the patient after death and cultural practices. Two side rooms with ensuite facilities were available when necessary, to ensure privacy and dignity for the end of life patient.

The palliative care team was available out of hours and staff had access to an on-call oncology consultant and Macmillan Cancer Services. Information and support systems were available for patients and carers and visitors could stay at the bedside with their family member.

Patient and Relative Questionnaires

The RQIA inspection process included obtaining the views and experiences of people who use services. Questionnaires were used to allow patients and relatives to share their views and experiences with the inspection team. The findings are presented from a composite perspective, combining the patient and relative perceptions. During the inspection a total of 14 questionnaires were carried out in Ward 8

- nine Patient Questionnaires
- five Relatives/Carers Questionnaires

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

Most patients knew who to speak to if they had any concerns, although two patients told us this way not always the case. On most occasions patients reported that they were involved in decisions about their care. Some patients said there could be better communication. Patients were generally satisfied that staff checked and administered pain relief when required; however some identified that at busy times there could be a delay. Call bells were generally answered quickly. Patients reported that sometimes there was not enough staff to care for them.

One patient was unhappy about his experience in the ward; he stated that surgery had been delayed due to his notes being incorrectly filed and he had spent a long time on a trolley in considerable pain.

Patients told us that the ward and sanitary areas were clean, the choice of food was good and fluids were readily available.

Patients reported that staff carried out hand hygiene and that they were offered the opportunity to wash their hands before meals.

Overall, patients were satisfied that they were safe; had received a good standard of care; and would be happy for a member of their family or a friend to be cared for in this ward.

Patients Comments

Comments from a patient waiting for a day procedure and on a trolley for several hours: *"very uncomfortable".*

Patient who suffers pain*: "sometimes it takes quite a while for pain control to be given".*

"It is not a restaurant but food is ok."

"Buzzer is not within reach."

"Sometimes staff are too busy to respond immediately but they always come back."

"Very busy, sometimes they appear rushed."

"Appear calm, but very busy."

"Staff always being available to help when required."

Patient has been on this ward for two weeks. *She is: "very satisfied with her care and treatment". She says: "they are great, no complaints"*.

"Staff are very kind and carrying. No complaints."

“Very happy with the care. Staff are excellent. Staff all seem familiar with his condition and he is happy that they are working together to give him proper care.”

"From the moment that I came on the ward I took cared for and was reassured by all the staff who dealt with me."

"The ward appears to be very well-led and this aura of calm and efficiency filters down to all the staff."

Commented that there *“appears to be a very good relationship between all grades of staff*”.

“Ward 8 is an excellent ward! Other wards could learn from them.”

Came to ward via ED department on Saturday for surgery to remove appendix. Says that this *“experience has been a positive one, cannot think of anything that needs to be improved“.*

Relatives Comments

Overall, answered questions provided by relatives were positive. Relatives reported that they were welcomed onto the ward and they knew who to speak to in relation to their relative. They told us that their relatives were treated with dignity and respect. Most staff kept them informed and staff had time to care. They reported that the standard of care was good. One relative did not always feel involved in their relatives care or that the staff had enough time to care.

“He has been sick and they have been in and out checking he is alright.”

“Couldn't say nothing bad. Everything is 100 per cent. In twice a day, for last three days, as visited father. Anything we ask for, the staff get it. They are very helpful.”

“Staff are very good. Very busy, but have time to chat to us. Especially what I can't be here all the time, so it’s reassuring to know. “

“Staff were very polite, informative and helpful during my son's visits, despite that the ward was very busy.”

“Not enough beds on ward.”

Observation of Practice

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

Inspectors and peer reviewers undertook a number of periods of observation 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.

Twenty five observations were carried out over four observation sessions.

We observed that there was good verbal and non-verbal communication; staff engaged in conversations with patients and gave clear explanations as care was delivered. Staff could were observed checking on patients need for pain relief and giving assistance. Information and reassurance was given to patients by medical staff during ward rounds.

Basic observations related to some conversations between staff that did not include patients. Neutral and negative observation related to conversations between patients in bed in bays and medical staff, the conversations could be clearly heard in the corridor.

4.5 Conclusions for Ward 8 Surgical

Throughout the inspection, we observed evidence of good leadership. Staff told us morale was good and they were supportive of the ward sister. Staff told us they can raise concerns with the ward sister and that senior management are visible and approachable on the ward.

We were told that normative staffing rates had been agreed and the ward had its full complement of staff and we were told that retention of staff was good. We were told that the nurse practitioner/practice educator role has proved to be a good initiative.

Staff reported that the number of daily ward rounds was challenging. We were told that medical staffing levels were good however issues such as timely review of inliers by medical staff, completion of discharge letters and pharmacy could delay discharge. Staff advised that timely access to occupational therapy could be an issue for medical inliers on the ward. We observed that nursing staff were not always visible on the ward, spending a lot of time in the clinical room.

We observed that regular audits of compliance with key performance indicators were carried out. However, we observed that not all medical staff were compliant with the handwashing and dress code policy. They did not always complete documentation fully for invasive devices and blood cultures.

We were advised that a sepsis bundle to ensure the recognition and timely management of sepsis was not in place.

A falls safe bundle was in place and the ward monitored falls and trends. The type and occurrence of pressure ulcers were monitored.

We observed that further work is required in the storage of medicines as the clinical room was often left unlocked and unattended. We were told there was no integrated medicines management service on the ward.

We reviewed five nursing records, which did not always demonstrate on-going assessment and evaluation of the daily care. Medical records were well organised; improvement could be made in the documentation of time of entry and discussion of diagnosis with patients or their relatives.

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

Staff were knowledgeable with regard to pressure ulcer and end of life care. We observed that pain medication was administered as prescribed however some patients told us there could be a delay at busy times.

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.

We observed that patients' confidentiality and conversations were not always maintained. At times during ward rounds we heard details of patients' medical condition discussed in the corridor outside ward bays.

Overall, patients reported to be satisfied with the standard of care they received. Relatives said that they were welcomed and reported that the standard of care was good.

The findings of the inspection of ward 8 were good. We have made **20** recommendations and **eight** housekeeping points.

4.6 Recommendations and Housekeeping Points

Recommendations

1. The 'Incidents by Adverse event' figures and learning from morbidity and mortality meetings should be regularly disseminated to staff.

2. Staff should be facilitated to attend mandatory training.

3. Systems and processes that impact on patient flow and discharge should be reviewed and improved.

4. The system used for medical handover should be reviewed to ensure effective communication of information.

5. The ward should capture record and routinely analyse and act on patient experience data.

6. Staff should be visible on the ward to maintain a level of visual contact with higher risk patients.

7. Emergency trolleys should be fully stocked and located in an accessible area. Sharps boxes should be stored securely on the trolley and contact details for the emergency team displayed in a fully visible manner.

8. The ward should be assessed to ensure that appropriate adaptations are put in place to meet the needs of patients with dementia.

9. Medical staff should comply with the trust hand hygiene and PPE policies.

10. Medical staff should complete all documentation relating to invasive devices and blood cultures.

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

12. Medicines should be stored safely and securely in line with trust policy.

13. Robust procedures should be in place for reconciling supplies of controlled drugs.

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

15. An integrated medicines management service should be provided.

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

17. Documentation should include time of entry and evidence of discussion of diagnosis with patients or their relatives.

18. Nursing staff should coordinate and supervise meal services ensuring that all patients are prepared for and receive timely assistance with meals.

19. The mechanism for monitoring patients' intake should be reviewed and improved. Nursing staff should ensure that fluid balance and food record charts are completed and reconciled.

20. Care rounds should be introduced.

Housekeeping Points

1. Name badges to denote the designation of staff should be supplied and worn.

2. The staff meeting standard agenda and safety briefing template should be reviewed and improved. Regular safety briefings should be held for night duty staff.

3. Safeguarding information/support/leaflets should be easily accessible.

4. Staff should adhere to protected meal times.

5. Staff should be aware that stool charts should be used for all patients experiencing abnormal bowel symptoms.

6. The ward exit doors should have a button which visitors can use to automatically open the doors and exit the ward.

7. The ward should review and were possible reconfigure areas within the ward for patients to use to facilitate quiet and confidential conversation.

8. Staff should speak discreetly and maintain patients' confidentiality at all times.

Inspection Findings
Emergency Department

5.0 Inspection Team Findings: Emergency Department

The Altnagelvin Hospital ED provides a 24-hour, seven day a week comprehensive emergency service. The department is divided into five distinct areas; triage, paediatric/minors, majors floor and majors wing, resus and a plaster room.

One room is dedicated to triage; there are five minor cubicles and two paediatric rooms (Picture 7). The majors floor has six cubicles, one sitting cubicle and a procedure room, the majors wing has five cubicles and one room with an ensuite. There are two adult and one paediatric beds in resus.

Picture 7: Paediatric area in minors

5.1 Is the Area Well Led?

Governance

A band 8A department manager is responsible for the operational management and coordination of services provided within the ED. The band 8A is also responsible for the allocation of resources that facilitate unit function and management. On day one of the inspection, the band 8A was supported by a band 6 deputy sister who coordinated floor activities. Throughout the inspection, the department sisters were visible and easily identified by wearing a distinctly coloured uniform and name badge. We were informed that the designated shift leader is a band 6 deputy sister however this role at times is filled by a band 5 RN. This was observed on day three and four of the inspection. We observed there was a deficit of band 7 posts in ED. Inspectors were informed that band 7 RN posts were being advertised. This role is integral to facilitate the allocation of resources and facilitate unit management.

Recommendation: The trust should expedite the appointment of band 7 nurses in ED.

On day one, we observed the band 6 deputy sister was working on the floor with seven band 5 RNs, one band 7 ENP and three HCAs. The ENP and one HCA covered the minors/paediatric area.

Staff have access to a range of policies and procedures via the trust intranet site and a selection of hard copies was stored behind the main reception in majors. We were informed of an open and transparent culture in relation to the investigation of formal complaints. Mechanisms were in place for staff to learn from department complaints.

Staff were aware of the process for the reporting of SAIs, incidents and near misses. The Datix software system used by the trust allows for routine formal analysis of incident trends which was subsequently cascaded to staff.
We examined documentation which demonstrated that staff were completing incident forms when staffing levels and congestion in the ED were a cause for concern. Complaints and safety incidents including incidents and SAIs were reviewed at senior clinical staff meetings. This information was disseminated to all staff.

Six to eight weekly Morbidity and Mortality meetings are held. The band 8A and nurse in charge attend along with the consultants, staff grades, registrars and junior medical staff.

Nursing team meetings were held; however we were told that it can be difficult for staff to attend due to low staffing levels. We reviewed the Annual Health and Safety Generic Risk Assessment form where issues specific to ED such as staffing levels, business of the department and volume of patients have been included.

Recommendation: The trust should strive to ensure that the risks identified in the Annual Health and Safety Generic Risk Assessment form in relation to ED are actioned accordingly.

A limited number of quality performance indicators have been introduced within the ED. These were subject to continuous review at accountability and safe and effective patient care meetings. These indicators included compliance with hand hygiene, peripheral line insertion, environmental cleanliness and nursing supervision. The ED receives a formal report against these indicators using a monthly patient care performance dashboard.

We saw minimal evidence of action plans and increased audit activity to address sub optimal performance. We observed a validation audit on peripheral lines carried out in September 2015 where compliance was 48 per cent. There were no follow up audits carried out and recorded. We also observed self -audit hand hygiene scores of 100 per cent and a subsequent validation audit of 73 per cent, with no action pan or follow up audit. Up to date audits were also not on display.

Recommendation: Where audits do not achieve trust compliance levels, action plans should be in place to ensure improved practice and compliance.

Department of Health Targets for Emergency Department

EDs 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 department closely monitored its performance against ministerial targets. Four hour and 12 hour trust performance targets were not being achieved. We were informed that an ED 12 Hour Breach Review Group will have corporate responsibility for ensuring that both Altnagelvin Hospital and South West Acute Area Hospital are able to ensure that at least 95 per cent of patients conclude their emergency department stay within four hours of arrival and that no patient breaches 12 hours.

Patients' time to triage within 15 minutes of arrival at ED is a new DoH indicator introduced for 2015-16. Statistics indicate that the target of 95 per cent of patients to be seen within 60 minute from triage to the start of treatment by a medical professional was not being achieved.

Monthly figures demonstrated that the ED was not achieving the College of Emergency Medicine standard of less than five percent of patients leaving the ED before treatment was complete. Statistics demonstrated this target had improved in the previous months. There were however fewer than five percent of unscheduled re-attenders to the department.

Information forwarded by the trust demonstrated that between November 2014 to February 2015 and November 2015 to February 2016 there was an increase of 4512 attendances which included an increase of 14 per cent in over 14 year old patients and 15 per cent in under 14 year old patients.

There were 1954 (15 per cent) more attendances during the three month period November 2015 to end of January 2016. The biggest increase (44 per cent) was in Category 2 (Very Urgent) attendances while Category 3 (Urgent) increased by 11 per cent.

Staffing and Supervision

We were told that staffing levels had been agreed at a total of 66.14 WTE for the department. We were told funding had been granted to employ further staff including five WTE band 7s and an additional 1.8 WTE band 6 RNs.

As stated previously, these posts have been advertised. A Practice Educator was due to start employment in mid-August 2016. At the time of inspection there were ten band 5 RN vacancies and four other RNs were leaving to take up more senior posts elsewhere. This was having a major impact on staffing levels within ED.

Documentation supplied by the trust provided evidence that the proposed increase in nursing staff by 6.8 WTE is part of the regional assessment of Normative Nursing and it had been expected that funding would be made available for this in 2016-17. The trust has been advised however that there would be no recurrent allocation for Normative Nursing in 2016-17. It was therefore proposed that non-recurrent bridging funding should be made available to the trust to enable it to proceed with the recruitment of additional nursing posts in 2016-17 until the recurring funding is made available.

A review of the off duty rota demonstrated that the ED deputy sisters were all band 6 RNs; only the ENPs were band 7. Deputy sisters provide floor based leadership for the day to day coordination of activities. We were informed that the deputy sisters, in the absence of a band 7, did not have sufficient time to undertake managerial duties, such as staff appraisal and supervision, as well as provide effective clinical leadership. Staff were staying on after their shift was complete to undertake office based duties.

We were told that a band 5 RN can be designated nurse in charge for both day and night shifts. Discussions with staff and a review of duty rotas identified that staffing within the ED was inadequate to meet recognised staffing requirements. We were told and observed during the inspection of staff working outside their competencies. Band 2 HCAs were performing electrocardiograms (ECGs) and patient observations without having received formal training. Observations recorded were not always countersigned by a RN.

Recommendation: The trust should ensure staff are not working outside their competency level.

During the inspection, the inspection team considered that the level of nursing staff in the resuscitation area was a concern. Information reported to the inspection team by staff and also supported by examination of the staff duty rota demonstrated that staff were not allocated to specifically work in resus. When patients were required to go to resus, staff from majors and triage were transferred into resus to maintain adequate cover. This left a deficit of RN cover in majors. Inspectors observed an unsupervised band 2 HCA given a designated area in majors to look after for a short period of time. This was during a resuscitation call when nursing staff were covering the resus area.

A review of the nurse rota demonstrated that on day one of the inspection, 1:1 RN cover could not be facilitated in resus and on most days there was insufficient RN cover for minors. Medical and nursing staff confirmed that there was underuse of the resus area and patients were kept in majors due to staff shortages.

We were informed that this area was not fully equipped to resus standard and that HCAs have been requested to assist in resus but have not had basic life support (BLS) training.

Doctors also expressed their concerns about the underuse of resus.

Recommendation: Nurse staffing in the resuscitation area should be reviewed to enable a one nurse to one patient ratio.

Further discussions with staff and a review of the duty rota for the month of August 2016 demonstrated that the department would not have sufficient RN cover. This issue was raised at the trust feedback as a matter of urgency.

Staffing levels were supplemented with the use of bank and agency nurses, however, at times, 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 overcrowded.

Staff retention has become an issue over the last year, with staff leaving the department, some to more senior posts. We were told that a band 5 RN who had been successful at interview for a band 7 position in ED, might not be able to take up post as they could not be released from their band 5 post. The lack of sufficient paediatric RN cover was also highlighted to trust representatives. The recruitment of paediatric nurses for the ED was also a challenge that was reported to the review team.

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

We were informed by the majority of nurses that they enjoyed working within ED. However, when having to deal with issues such as crowding, late off duty rotas and staff shortages, they did not always feel valued or supported by senior management. Staff raised concerns to us about increases in workload, unrealistically high expectations, staffing levels and lack of induction and training. We found staff morale to be low.

Recommendation: The trust should put in place systems to support staff working in ED to help them feel valued and empowered to raise concerns.

Nursing staff told us that they could raise concerns to their direct line manager for action. However, they were not aware of action taken by senior management staff. A stress audit had been carried out involving staff working in ED. Staff commented that the audit did not allow for free text comments and they had not received any feedback.

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

Housekeeping point: The trust should ensure ED staff receive feedback from the stress audit, an acknowledgement of issues raised and an action plan to address the issues raised.

Medical staff in the ED enjoyed working there but junior medical and staff grade staff described the rota as "tough". There is consultant cover in ED rostered from 9.00am to 8.00pm and middle grade cover to 3.00am. Between 3.00am and 8.00am there are two senior house officers (SHO)-grade doctors in training providing care. Training and staff development for both nursing and medical staff is given a high priority although both medical staff as well as the emergency nurse practitioners feel that the demands of their rota stop them from fully availing of potential training opportunities.

Crowding is a particular problem on Mondays mentioned by several staff. The issues were felt to be decreased flow from medical admissions to discharge or placement with resulting backlog in the ED whilst patients were waiting for beds. Beds often started to only become available in the evenings.

Nursing staff informed us that they did not always feel safe. There were no designated security staff, some porters had security duties but this is on a hands off basis. There was a direct line to the Police Service for Northern Ireland (PSNI) for assistance, but there could be a delay in response.

Recommendation: To provide a safe working environment, the trust needs to review the provision of security staff for the ED.

Support services, while not all on site at weekends, were accessible seven days a week. Within ED, there was one occupational therapist, one physiotherapist, one alcohol liaison nurse and a pharmacist, Monday to Friday, 9.00am to 5.00pm. The allocated social worker was on duty 9.00am to 5.00pm Monday to Friday. We were told that access outside these hours was available but there is often a delay while waiting for return calls.

The Public Health Agency (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

We were provided with evidence of an induction programme for newly qualified band 5 staff nurses and experienced nurses new to ED. We were told by staff, both new to the unit and newly qualified, that their induction to ED had either not always taken place or if started had not always been completed.

We were given the draft mandatory training matrix – Western Trust Nursing and Midwifery Workforce January 2016, which identifies trust mandatory training. However there was limited supporting evidence to substantiate staff attendance at both mandatory and additional training courses. The band 8A confirmed that mandatory training attendance statistics were low. Examples of mandatory training include safeguarding children, vulnerable adults, IPC, blood competency assessments, hyponatraemia, immediate life support and advanced life support training. We were told by HCAs that they were rarely offered training and had not received BLS training.

Additional training such as triage, stroke lysis pathway, sepsis, deep venous thrombosis, patient group directives (PGD), minor injuries management, trauma care was available. Uptake of mandatory and additional training needs to be improved.

Recommendation: All staff should be facilitated to attend mandatory and in house training commensurate with their role.

As reported in a previous section, the trust had recently appointed a band 7 practice educator for the ED. Their role is to ensure that all staff are provided with sufficient training to carry out their role. An essential component of the educator role is to carry out a training needs analysis and set up a training database or matrix.

Recommendation: An up to date, comprehensive and easily understood matrix which identifies staff attendance at courses should be in place.

Deputy sisters and ENPs support the department manager 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.

Patient Flow

Patients triaged as a minor were either seen and treated by an ENP with the assistance of a HCA or sent to majors for assessment and treatment. Lack of staff had resulted in the department not being able to provide a minors stream.

On the afternoon of the first and second days of the inspection we observed a surge in activity within the ED. The crowding peaked in the late afternoon and evening until beds became available to transfer patients from ED. We were told by nursing and medical staff that it was a common occurrence between 5.00pm and 8.00pm to have to wait for an available bed on a ward. We observed ambulatory patients who were waiting for assessment and treatment sitting on chairs outside cubicles; however there were never any patients inappropriately waiting on trolleys outside a cubicle.

We were informed that increased numbers of patients attending the ED and a lack of bed capacity in the downstream system were central causes contributing to exit block within the ED. This issue demonstrated the trust's difficulty in managing the demands placed upon the ED as observed during the inspection.

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

Handover of specific patient information for oncoming and departing nursing staff was observed. The handover was brief and not fully informative, HCAs were not in attendance. We were told that staff had requested short handovers to reduce time away from patients; however further work is needed to ensure relevant information is forwarded to staff, including HCAs.

Housekeeping point: Departing nursing staff should ensure the handover is relevant and conveys all necessary information to oncoming staff. HCAs should be included in the handover.

An internal ED escalation plan and the trust Policy for Patient Flow and Escalation were in draft (January 2016). We were told that the ED escalation plan and the Policy for Patient Flow and Escalation were not aligned and a Consultant and middle grade were reviewing this issue.

Recommendation: The trust should agree and sign off the ED Escalation Plan. The differences between the Major Incident Plan and the Escalation Plan should be investigated and a resolution agreed.

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

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 had opened up close to the ED, known as the Clinical Decision Unit (CDU). There are 14 care spaces consisting of 10 beds and four chairs and it is open 24/7.

The Northern Ireland Ambulance Service (NIAS) did not provide an on-site member of staff as a hospital ambulance liaison officer (HALO). The ED participated in a pilot where a HALO was appointed temporarily to the ED. Staff found this beneficial in assisting with pending admissions and discharges; however there was no funding for a permanent position.

We were told that a substance misuse nurse located in minors was a valuable asset. We were also told that recruitment for an additional staff member had been successful and there would now be seven day a week cover in ED.

There was a clear link between the ED and community addiction services and where appropriate, a patient could be referred for home detoxification.

A reablement model is available in the Western Trust's home care services. It is occupational therapy led and delivers a focused short term therapeutic intervention, to maximise and sustain independence and reduce the demand for long term care and support. The older persons' assessment and liaison service enables patients to be assessed by an RN and physiotherapist for rehabilitation provision.

The ED has an effective IT system (Symphony) for tracking patients. This provides a comprehensive view of patient flow through the ED. It is used for both tracking patient activity and monitoring the status of each individual patient within the department. However, we were told at the time of inspection, that there were no trackers employed to update this system. Nursing staff had been given this responsibility which was resulting in increased nursing time away from the patient.

Housekeeping point: The trust should consider the use of patient trackers within the ED.

We were told that the trust was planning to integrate Symphony with an electronic toolset named 'FLOW', which was in use throughout the wards in Altnagelvin. Each department/ ward could interface with this system to improve the flow of patients through the hospital. Some of the benefits would include; real time view of the live bed state, electronic bed requests and user update with interactive whiteboards which offer a faster way to update patients' status and track patients in real time.

Communication

Clear communication is essential in healthcare settings. Through review of documentation and observation, inspectors noted that there was a variety of method for communication and dissemination of information to staff. Examples included safety briefings, handovers, ward meetings, link nurse meetings, poster displays and via email to senior nursing staff. To improve communication with band 5 RNs and to assist staff with eLearning and dissemination of information, personal email accounts should be available.

Recommendation: The trust should ensure all nursing staff have a personal email account.

All clinical staff had access to the ECR to access up to date patient General Practitioner (GP) information. Up to date results of audits and patient experience data were not displayed for patients and staff to view.

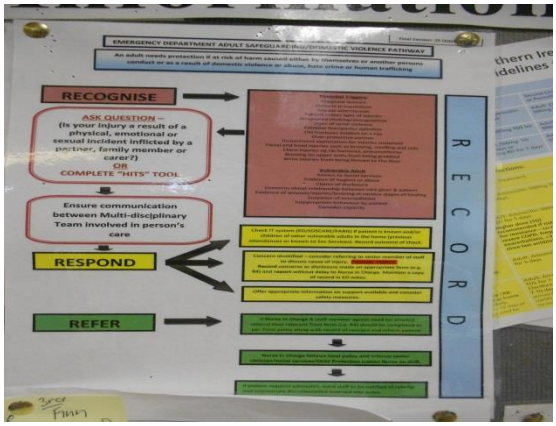
Housekeeping point: ED staff should ensure up to date audits and patient experience data are visibly displayed.

We saw clear evidence in relation to 24 hour community psychiatric nurse (CPN) contact and we were told that the card before you leave (CBYL) proforma had to be completed before the patient left ED.

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; however not all staff were knowledgeable about the vulnerable adult (VA1) referral form, the process of completion and the Mental Health (NI) Order 1986. They stated they were only aware of what 'form three' (detaining a patient) was for.

The Adult Safeguarding/Domestic Violence Pathway algorithm (Picture 8) directs staff to complete the HITS tool; however none of the staff questioned by the inspection team were aware of this tool and how to access it. The department manager informed us that the pathway was out of date. Staff told us that they did not have enough knowledge on how to care for those individuals with mental health problems and worried they sometimes "make the situation worse".



Picture 8: The Adult Safeguarding/Domestic Violence Pathway

In a case of suspected child abuse, staff were aware that the ward based consultant paediatrician would be called immediately and child protection procedures commenced. Staff were aware that additional safeguards are required for children, including completion of a UNOCINI assessment. There is a dedicated child protection clerical officer who, on admission, checks all under 18s for any child protection history.

Documentation reviewed demonstrated that staff are offered Safeguarding/ Protection of Vulnerable Adults minimum level 2 and level 3 training. A review of the documentation evidenced that adult safeguard training was not up to date. Staff expressed concerns over their lack of knowledge of mental health issues and were worried that poor staffing levels would contribute to the reduced supervision of patients, notably self-harmers.

We were told that 25 per cent of admissions to ED were under 18s. A review of the trust draft training matrix identified that only level 1 Safeguarding Children training was offered to ED staff. The Chaperoning Policy (2010) and Admission, Care and Discharge of Under 18 Years Where There Are Concerns (2012) were past their review date.

Recommendation: The trust should show consistency in the safeguarding training offered to nursing staff in the ED.

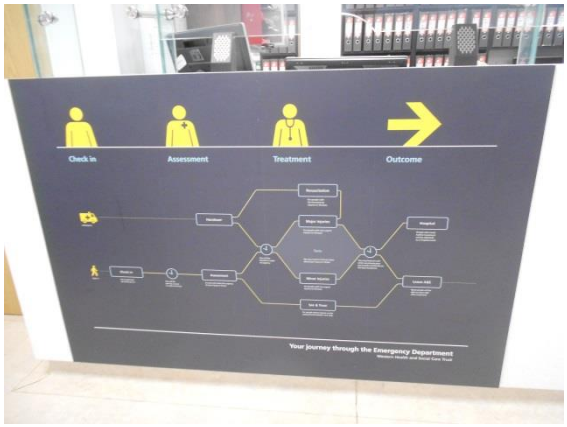
Recommendation: All policies that have passed their review date should be updated.

5.2 Is Care Safe?

Environmental Safety

The environment was light and bright. Certain areas within the ED, the majors' floor area and resuscitation area date back to 1985 and were showing signs of wear related to age. Recent refurbishment work included a new majors' wing and minors' cubicles, receptions, public toilets and waiting areas. Minors had a two bed paediatric area with separate waiting and play area. The alcohol liaison nurse was based in an office in minors. Parents commented to the inspectors on the inappropriateness of its location beside the paediatric area.

Recommendation: A risk assessment should be carried out to review the close proximity of the alcohol liaison office and the paediatric area.



There was good signage information in the reception areas explaining the function of majors and minors; a flow diagram under the main reception desk explained the patient's journey through the department (Picture 9). There was no display screen in reception to advise patients of expected waiting times.

Picture 9: Photo ED Journey

Not all the patient cubicles were equipped with piped oxygen and suction or monitoring equipment; cubicles seven to nine did not have individual wall lighting, and none had clocks. Staff reported that only those patients who did not require an ECG were put in these cubicles and that portable oxygen and suction were available. We were told that an assessment of the environment had not been carried out.

Directional signage was good although it was difficult to find the toilet in majors and find directions from majors to minors.

The inspection team considered that there was insufficient storage space, resulting in patient equipment, domestic trolleys and supplies of clean linen being stored in corridors. The ED has only one dirty utility room located in the majors' wing area. The room was small and not sufficient to meet the needs of this busy department. Although it had a key pad lock the door was held open by a bin, therefore chemicals were not held in line with Control of Substances Hazardous to Health (COSHH) control guidance. Linen was stored in the corridor between majors and minors; the trolley was over flowing and uncovered, incontinence pads had been removed from the packaging and were exposed on a lower shelf.

The majors' floor area is small and can quickly become congested and difficult to move around with the presence of staff, ambulatory patients, ambulance triage trolleys and relatives. Staff told us that patients assessed as high risk were placed in close proximity to the nurses' station to enable staff to maintain a level of visual contact. Staff did express concerns to the inspectors regarding their ability to care for patients who present with self-harm, when staff levels are low and staff are spread across the disjointed layout of the department. The clinical preparation area was situated in the centre of majors; this space was shared with medical staff and not sufficient to meet the requirements of this busy department. The area was also accessible to the public.

During the inspection we observed systems in place to manage the patients arriving via ambulance and through triage. Patients were then allocated to designated assessment and treatment spaces. The ED has open access 24/7. Staff expressed concerns about the open access at night.

Recommendation: A risk assessment should be carried out to review the open access of the department at night.

Housekeeping Point: Chemicals should be held in line with COSHH guidance.

Infection Prevention and Control

The ED environment was clean, but some areas of flooring in the old part of majors required repairs.

Clinical hand washing sinks were clean, accessible and located near to the point of care. All but one of the sinks were in good repair; the area around the clinical hand wash sink in majors was damaged. Alcohol gel dispensers were available and located appropriately throughout the department.

We observed good hand hygiene practice by staff; audits were carried out regularly but results were not displayed. PPE for staff was available throughout the department and on most occasions was worn appropriately.

Staff should ensure gloves are donned immediately before a procedure and removed immediately after. Medical staff were observed wearing gloves when completing paper work and answering phones. Nursing staff were observed wearing gloves when gathering equipment for a procedure and not wearing an apron when cleaning a bed. This was brought to the attention of staff.

Housekeeping point: Up to date results of hand hygiene and environmental cleanliness audits should be displayed.

On 12 February 2016, infection prevention and control nurses (IPCNs) visited ED and carried out baseline audits on ANTT wound care (95 per cent), hand hygiene (60 per cent) and high impact intervention; peripheral cannulation (zero per cent). Following the audit, educational support was offered to ED in the form of one half day per week for four weeks. Further audits were carried out and although some improvement was noted the IPCNs did recommend additional support from the IPC team focusing mainly on ANTT practices for both nursing and medical staff.

Recommendation: Further IPC educational support and training should be provided to staff in ED.

We observed mixed compliance with ANTT procedures. In minors, although most of the staff used a specialist trolley for carrying out procedures, we observed staff using papier mache bowls rather than cleanable trays. Cubicles two to four in majors are small, and we observed that it was difficult for staff to comply with good IPC practice. On occasions, staff used the waste bins as a work surface. This had been identified in a February to March 2016 IPC audit. IPC trolleys with appropriate PPE were placed outside the cubicles as required, however their placement restricted access to this work area.

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.

We observed that patient equipment was clean and in good repair. Cleaning schedules for both nursing and domestic staff were in place. Resuscitation trolleys were accessible but daily checks were not carried out consistently. The work surfaces on the top of the resuscitation trolleys were cluttered and the catches on the emergency drugs box in majors was broken.

Housekeeping point: Staff should ensure checks are carried out daily, the equipment in the resuscitation trolley is in good repair and that the work surface is free from clutter.

Trolleys containing equipment for venepuncture were stored at the waiting area in the majors wing beside the water dispenser (Picture 10). Monitoring equipment and vital signs trolleys were stored by the reception desk. All were accessible to patients and visitors.

Picture 10: Accessible venepuncture equipment and patient monitoring equipment in waiting area of majors wing

The majority of staff were compliant with the trust dress code policy; there were some exceptions in relation to staff wearing stoned earrings and long unsecured hair.

The department has an infection control link nurse who regularly attends meetings and who then cascades the latest information back to staff in the department.

Patient Safety

Staff reported variation in the application of the criteria of patient identity armbands. We reviewed the guidance on the use of armbands in ED and noted that patients receiving medication, with the exception of conscious sedation, were not included. The guidance did not have version control, a date of development and review and was not in the format of a trust policy. Identification errors could have serious consequences for patient safety.

On one occasion we observed a patient transferred from majors to resus who required medication but did not have an armband. This was addressed appropriately; staff were aware of the actions to take when identification details were incorrect.

Recommendation: Clear, consistent and robust criteria for the issuing of identification wristbands within the ED should be introduced.

Guidance on the management of the acutely ill patient was available.
We observed that patient NEWS were not always totalled, completed within set timescales and the escalation algorithm followed, 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.

There was no paediatric early warning scores (PEWS) record sheet available. Staff were instead using an observation sheet which did not have an escalation or algorithm guidance in place. We were told and evidence forwarded by the trust, confirmed that in 2014-15 and 2015-16 23 per cent of attendances at the ED were under 18s.

Recommendation: A PEWS or similar record sheet with a recognised algorithm to guide staff on escalation and actions specific to paediatrics, should be available in the ED.

A Sepsis Six bundle for the recognition and timely management of sepsis was in place in some wards in the hospital. We were advised that the Sepsis Six bundle was not routinely audited in ED, although there had been a one off audit conducted a few years ago. It is anticipated that the introduction of a sepsis trolley will improve practice.

Housekeeping: The Sepsis Six bundle should be robustly audited in the ED.

Staff complete an incident report form (IR1) form for reportable falls occurring in the ED. These are forwarded on to risk management. The incidence of falls is available through Datix, however there was no system in place in ED to monitor falls and figures. A falls safe bundle was not in place.

Housekeeping: Staff should implement the falls safe bundle in the ED.

Review of a consent form, demonstrated full and appropriate completion and patient involvement in the decision making. In ED, a detailed policy and trust risk assessment for VTE patients requiring immobilisation in plaster of Paris were available to guide staff. There is an informative risk assessment pack for patients going home with a plaster of Paris in situ. Inspectors reviewed the notes of a patient who was being admitted and requiring a short leg plaster and a VTE risk assessment had been completed. The medical admission booklet also contains a VTE risk assessment.

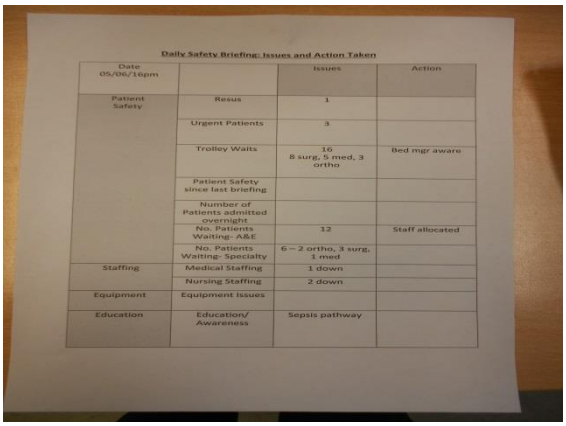
There was no system in place to monitor preventable pressure ulcers.
A review of ED flimsies demonstrated that none of the patients had been risk assessed for skin integrity and the surface, skin, keep moving, incontinence, nutrition (SSKIN) care bundle, which is in use in the wards, was not in place. The flimsy has a small box to document a Braden score. The Braden Scale for Predicting Pressure Sore Risk is a tool for predicting the development of pressure ulcers. Clinicians typically use the tool to assess six risk areas for developing pressure ulcers: sensory perception, skin moisture, activity, mobility, nutrition and friction/shear. The ED flimsy for four patients over 65 was reviewed and a Braden score had not been inserted. Risk assessments had not been completed and repositioning charts had not been put in place for those patients at risk of pressure ulcer damage.

Patient safety/medical alerts were communicated to staff via a notice posted in the staff room and written in the daily diary. There was no system in place to confirm staff acknowledgement.

Housekeeping Point: The communicating of patient safety/medical device alerts to staff should be formalised, with a system to insure confirmation by staff.

In the majors' floor, not all cubicles had piped oxygen and suction. As a result of the busyness of the ED combined with staff shortages, we observed that the quality of care that patients received in the ED reduced. We observed an increase in patient anxiety as dignity, privacy and timeliness of basic nursing care became compromised. The underuse of the resus area resulting in patients being kept in majors due to staff shortages has been discussed in a previous section of the report.

Safety briefs were not conducted for all nursing staff at handover; however the departing nurse in charge provided a safety brief for the oncoming nurse in charge. A safety brief template was completed and left at reception for staff to read (Picture 11). The safety brief contained minimum detail and there was no mechanism in place to ensure staff had read the brief. Safety Briefings are a simple, easy-to-use tool that staff can use to share information about potential safety problems and concerns on a daily basis. It can help increase staff awareness of patient safety issues, create an environment in which staff share information without fear of reprisal, and integrate the reporting of medication safety issues into daily work.



Daily Safety Briefing: Issues and Action Taken

Date 05/06/16pm		Issues	Action
Patient Safety	Resus	1	
	Urgent Patients	3	
	Trolley Waits	10 8 surg, 5 med, 3 ortho	Bed mgr aware
	Patient Safety since last briefing		
	Number of Patients admitted overnight		
	No. Patients Waiting- A&E	12	Staff allocated
	No. Patients Waiting- Specialty	6 – 2 ortho, 3 surg, 1 med	
Staffing	Medical Staffing	1 down	
	Nursing Staffing	2 down	
Equipment	Equipment Issues		
Education	Education/ Awareness	Sepsis pathway	

Picture 11: Example of a completed safety brief

Recommendation: Mechanisms should be put in place to ensure the safety briefings convey important information and patient safety problems. All staff should be present during the safety briefings.

We observed that patients brought in by ambulance were generally seen and assessed promptly by ED staff. In reception, the patient status board was updated and gave a real time view of the patients in the ED and pending admissions.

We did not observe any proactive walk rounds by senior nursing and medical staff. We were told that medical staff meet at 9.00am and 4.00pm to discuss patient issues. Hourly safety rounds and four hourly patient reviews were not carried out by the nurse in charge or consultant. We were told and observed that the nurse in charge constantly reviews patients and the consultant of the day attends the 11.00am bed meeting when the department was busy to try and expedite patient flow.

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.

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

Self-harm patient protocols were in place and discussions with staff demonstrated good interface between the mental health services and the wider community. Staff were aware of the Self Harm Registry and the CBYL scheme. The department based alcohol liaison nurse targets at risk drinkers and provides an outreach service to the wards.

Out of hours, there was no provision by the mental health team for older people who presented with self-harm to be assessed for ongoing risk of further self-harm.

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

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

Medicines Management

Medicines were stored in locked cupboards accessible by use of keys or fobs; however the medicines cupboards were in several locations throughout the department. In one medicine cupboard, there was a large quantity of mixed tablet strips in the bottom drawer which could lead to errors in the administration of medicines. In the medicine refrigerator, there were several used insulin pens. The RN advised that they were for single patient use. Although they had been marked with the date of opening, the patient's name was not recorded. This could lead to one pen being used for more than one patient. The medicines fridge in majors was unlocked; this was raised with staff to address.

Recommendation: Medicines should be stored safely and securely.

There was no dedicated area for the preparation of medicines including controlled drugs. Medicines were prepared in a central area with limited bench space and where staff were often interrupted.

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.

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

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

An integrated medicines management service was not being provided. The department did have a pharmacist who had recently been appointed and staff advised that they had access to pharmaceutical advice if required. There was no pharmacist on duty at the time of this inspection.

Improvement is required in the reconciliation of medicines on attendance at ED. There was limited recorded evidence of what medicines patients were prescribed at attendance to the ED and no evidence that staff had checked whether these medicines had been taken prior to attendance at ED. One patient that we spoke to at 12.00pm told us that they had not taken their regularly prescribed medicines the night before or on the morning of the inspection. There was no recorded evidence that staff were aware of this.

The medication for one patient that required a time critical medicine was well managed. There was a flowchart displayed in the ED showing how patients' own drugs should be managed.

As the role of the recently appointed pharmacist becomes embedded, some of these issues may be resolved.

Recommendation: A robust medicines management process should be in place on attendance at the ED.

We were told that the registered nurses in the department did not administer IV medicines. The inspection team thought that this should be reviewed. One patient we spoke to was prescribed two antibiotics which were to be administered at 12.00pm. At 12.30pm, these had not been administered. When this was discussed with the RN, they were unaware that these medicines were due for administration. They advised that they would contact the department/ward that the patient was being admitted to so that they could come to administer the antibiotic. This process leads to unnecessary delays in the administration of medicines and could potentially lead to missed doses, which could compromise the health and well-being of the patient. We were told by nursing staff who had been trained to administer IV medication that they were frustrated by the rule in ED where they were not allowed to carry out this procedure.

Recommendation: The administration of IV medicines by registered nurses should be reviewed.

Recommendation: IV medication should be administered according to the prescribed timescales.

Staff also had access to “over labelled” medicines which could be issued by registered nurses on the ward at discharge. This facilitated a timely discharge process.

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’ concordance with prescribed medicines had been assessed on admission or at discharge.

Discussion with staff indicated that they had an awareness of critical medicines. A list of critical medicines was displayed.

Staff were aware of the procedures in place for reporting incidents and near misses.

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 on a section of the ‘flimsy’. For those patients in ED for over six hours, comprehensive nursing assessments and relevant risk assessments in relation to a patient’s identified need were not in place. There was minimal planning of care observed; continuation sheets were more a diary of events rather than a plan of care.

The flimsy had a section to record a Braden Score and abbreviated mental test (AMT 4), both used for over 65s. Documentation reviewed demonstrated these sections were not being completed. We also noted IPC risk assessments were not being completed.

Housekeeping point: Medical staff should complete the abbreviated mental health assessment sections on the ED flimsy.

Not all flimsies demonstrated that nurses had adequately carried out assessment, planning and evaluation and monitoring of a 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.

Nursing care records did not always adhere to NMC and NIPEC standards of documentation. Documentation was not always legible, or signed.

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

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

Medical Care Records

Medical records in the ED were well organised and clearly laid out. Sepsis management was good although in some cases the documented proforma had not been completed.

Nutrition and Hydration

On observation there were no visible information posters and in discussion there was poor staff awareness in relation to protected meal times. Breakfast was limited to a drink and a pancake; cereal or toast was not available.
We were told by staff in the department and during focus groups that patients had to be in ED for four hours before they could be offered a meal.
The department manager told us that all patients in ED at meal times would be offered a meal, although did not see that the provision of nutrition and hydration as a role for an ED.

Meals had to be pre ordered up to an hour and a half before service for lunch and tea time. Staff informed us that it was difficult to increase or change the order. This was a particular issue with regard to ordering special diets. Salt and pepper were not available. Hand hygiene wipes were not provided. There was no provision for meals after 5.00pm; tea and toast was the default meal/snack and no special dietary foods were kept in the kitchen. We were later advised at a focus group that snack boxes were available; however staff in ED were not aware of this facility.

The meal service was observed on several occasions; it was not supervised or co-ordinated by a senior member of nursing staff. The meal service was HCA led. Information on who was to be offered a meal or who required assistance or special diet was passed to HCAs by word of mouth by RNs. Patients were not prepared for mealtimes (positioning in chair/bed). We were told that due to staff shortages, nursing staff did not have the time to assist patients when required. The HCAs would assist patients.

We observed that drinks were only served with a meal. Patients were not encouraged to drink at other times. There was a water dispenser in majors and the staff room but patients relied on relatives to fetch water for them.

The ED does not have a kitchen facility (Picture 12). Meals were delivered in a heated trolley and used crockery is then returned to the main kitchen for cleaning. Cutlery was made from disposable flimsy plastic and drinking cups were of ridged paper. There was no provision for patients with reduced dexterity.

Picture 12: Catering storage area in ED

Recommendation: The trust should review the current provision of patients meals in ED to ensure an effective process is in place that meets the individual nutritional needs of the patient while in the department.

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

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

Pain Management

We observed nurses trying very hard to settle patients who reported being in pain and staff responded promptly to patients' requests for pain relief. Pain relieving measures were available and in place. Pain medication was administered as prescribed, with the effectiveness of analgesia reviewed.

We observed that a pain score was not always printed onto the blue flimsy after the patient had come through triage. On further investigation, for those patients that had no pain, this section of the flimsy was being left blank rather than recording 'zero'. The paediatric flimsy did not have a dedicated section for the recording of pain.

All beds were repositionable and pillows and blankets were obtained on request.

Housekeeping: Pain scores should always be recorded onto ED patient flimsies.

Staff advised that palliative staff were available to cover oncology patients but were not necessarily part of a pain team.

At times we observed medics asking for medication when in the process of discharging a patient. Subsequently, RNs were not aware that medication had been given and medication kardexes had not been completed.

Documentation reviewed demonstrated that PGDs allowed nurses to administer paracetamol, ibrupofen, and paediatric analgesia; however not all nurses had PGD training. Training for PGDs is facilitated by pharmacists.

Housekeeping Point: All registered nursing staff should complete PGD training.

Pressure Ulcers

Patients appeared comfortable; pressure-relieving equipment was available. A validated classification tool was available in the trust to guide management on pressure ulcers; this was not in use in ED.

As mentioned in a previous section, a Braden risk assessment tool, for predicting pressure ulcer risk, was not always completed for patients who had been in the department for more than six hours. A SSKIN care bundle or similar was not in place to reflect the patient's ongoing care needs (surface, skin, keep moving, incontinence, nutrition)i.e. for patients in ED for over six hours.

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

Recommendation: A SSKIN care bundle or similar should be introduced for use within the ED.

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. A terminal clean schedule was available demonstrating that trolley mattresses were cleaned and checked after each use as well as on a daily basis. We were told that one trolley is picked each day for a deep clean.

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

Promotion of Continence and Management of Incontinence

Staff were observed providing patients with appropriate assistance to promote continence and care for incontinence. We observed staff unobtrusively assist a patient with personal care following an episode of incontinence.

A urinary catheter care pathway was in place and documented accordingly for a patient with an indwelling urinary catheter. Hand wipes and sanitisers were available for individual patients.

However, we observed that one patient with cognitive impairment was wandering about looking for a toilet as the signage was not prominent.

Housekeeping point: Signage for the patient toilet should be more visible.

Staff had access to continence/stoma specialist services and stoma/incontinence aids were available. On discharge to the community, patients are given a 'take home' pack which is a starter pack with products.

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 however that these checks were not recorded in any intentional care rounding documentation. These checks are designed to ensure that nursing staff carry out necessary 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: The structured process of Intentional Care Rounding or similar should be introduced within the department.

We observed that some call bells were not appropriately positioned and within easy reach. It was difficult to assess staff response to call bells as there appeared to be an issue with the system. Lights were on but no sound was heard. This was raised with the ED manager for further investigation.

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

Staff attempted to ensure that patient privacy and dignity were maintained throughout the ED. There were however occasions when curtains were not fully closed at all times during a medical examination and screens were not completely opened after patient care. There was an adequate supply of bed linen. A family room was available.

Communication

There were well placed informative signs at the entrance to ED to inform patients how their journey through ED would progress.

There were various public information leaflet racks throughout the ED; the reception area had toilet facilities and a vending machine.

In reception, we observed a free standing computer, “Saviance”, for patients who could self-register and self-triage. This provides patients with an easy-to-use self-streaming system for checking in and to report their condition using a touch screen kiosk. The kiosk provides an opportunity to enhance the current triage system that is in operation within the ED, minimise delays and signpost patient to the appropriate care stream.

At the time of inspection, the “Saviance” system was not in place and staff were waiting to receive bespoke training (Picture 13). In the majors area, a TV screen provided staff and patients with up to date live ED waiting times.

Picture 13: Information poster for patients on Saviance

Nursing staff were easily identifiable but other members of the ED team did not wear easily identifiable name badges. Staff were courteous to patients and relatives; introducing themselves and providing patients with information and an explanation of the care or procedures they were to receive in a clear, easily understood manner.

Access to aids and services for patients with language barriers were available. There was a portable induction loop to assist those patients with hearing difficulties. The use of a purple folder to identify individuals with cognitive impairment is a positive measure which respects and protects the dignity of the individual.

End of Life

Staff were aware and able to access the trust Care of the Dying Patient for Personalised Care Planning guidance. This is to assist health professionals to deliver personalised care to the dying. We observed a strong support network in place for staff that have to deal with death and bereavement.

Suitable side rooms were available for patients receiving end of life care.

The palliative care team was available to 5.00pm; during the out of hours period, staff contacted the hospice or Macmillan.

Information and support systems were available for patients and carers before and after a patient dies. Specialist additional arrangements are in place in relation to the death of a young child.

Patient and Relative Questionnaires

The RQIA inspection methodology includes obtaining the views and experiences of people who use services. Questionnaires were used to allow patients and relatives to share their views and experiences with the inspection team. Composite findings are presented combining both patient and relative perceptions. During the inspection, a total of 12 questionnaires were administered 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; they reported that 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 reported 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.

In general, patients were treated with respect and dignity. Most patients reported that 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 reported that they were 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 said they were welcomed and generally 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 reported that staff did not have enough time to care but however in general were confident they were receiving good care.

Patients Comments

"Staff are very friendly."

"The staff keep me updated, am very happy."

For 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."

"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."

"No juice or water available."

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."

"Forty 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."

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.

Normative staffing had been agreed and additional nursing appointments had been advertised, however staffing levels were low, with limited support from bank and agency staff.

At busy times nurse staffing levels were concerning. We were told and observed documentation demonstrating that the department would not have sufficient RN cover during August 2016. This issue was raised at the trust feedback as a matter of urgency. We were told and observed nursing staff working outside their competencies. Medical and nursing staff expressed concerns that staff shortages contributed to underuse of the resus area.

Nurse staff training was not up to date. The establishment of a permanent practice educator is a positive initiative. There was limited implementation of nursing quality performance indicators and DoH quality indicator targets were on many occasions not achieved.

Medical records in the ED were well organised and clearly laid out. We were told medical staff felt that the demands of their rota stopped them from fully availing of potential training opportunities.

The environment was light and bright; older areas showed signs of wear related to age; there were limited storage facilities. Patient equipment was clean and in good repair, however venepuncture trolleys were accessible to the public.

The majors' floor area can quickly become congested and this led to difficulties for staff in complying with good IPC practices. There was no dedicated area for the preparation of medicines, including controlled drugs. An integrated medicines management service was not being provided. Registered nurses did not administer IV medicines.

The nurse in charge and consultant did not jointly conduct regular patient reviews. Healthcare assistants did not attend nursing handovers and safety briefs did not include all nursing staff.

Pain relieving measures were available and in place, with good response from staff to patients' requests for pain relief. An improvement is needed in documenting patient early warning scores and documenting the pain score on the ED flimsy. A Sepsis Six bundle was in place however there was no system in place to monitor falls. Staff provided patients with assistance to promote continence and care for incontinence. Specialist nurse advice was available.

An improvement is required in nursing documentation and completion of risk assessments. Nursing records did not always adhere to NIPEC best practice guidelines. The system for delivery and service of patients' meals requires review and improvement.

There was good signage to indicate the different areas with the department. Staff had access to aids and services for patients with language barriers. Facilities and information were available for bereaved families.

Staff were compassionate, courteous to patients and relatives and provided clear, easily understood information. Checks made by nursing staff to ensure patients' comfort, were not formally recorded.

There were occasions when patient privacy and dignity were compromised. At times, call bells were not appropriately positioned and within easy reach.

Overall, patients were satisfied with the standard of care they received; although some patients stated they did not know who to speak to if they had concerns. Patients reported that staff responded to requests for help and pain relief in a timely manner. The majority of patients said they were never given a choice of food at meal times. Relatives said they were welcomed, were confident that their relative was receiving good care but were less satisfied about the up to date information they received on their family member.

We have made **36** recommendations and **19** housekeeping points.

5.6 Recommendations and Housekeeping Points

Recommendations

1. The trust should expedite the appointment of band 7 nurses in ED.

2. The trust should strive to ensure that the risks identified in the Annual Health and Safety Generic Risk Assessment form in relation to ED are actioned accordingly.

3. Where audits do not achieve trust compliance levels, action plans should be in place to ensure improved practice and compliance.

4. The trust should ensure staff are not working outside their competency level.

5. Nurse staffing in the resuscitation area should be reviewed to enable a one nurse to one patient ratio.

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

7. The trust should put in place systems to support staff working in ED to help them feel valued and empowered to raise concerns.

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

9. To provide a safe working environment, the trust needs to review the provision of security staff for the ED.

10. All staff should be facilitated to attend mandatory and in house training commensurate with their role.

11. An up to date, comprehensive and easily understood matrix which identifies staff attendance at courses should be in place.

12. Staff supervision and appraisal should be up to date.

13. The trust should review the impediments to patient flow from the ED to better cope with the demands placed upon the service.

14. The trust should agree and sign off the ED Escalation Plan. The differences between the Major Incident Plan and the Escalation Plan should be investigated and a resolution agreed.

15. The trust should ensure all nursing staff have a personal email account.

16. The trust should show consistency in the safeguarding training offered to nursing staff in the ED.

17. All policies that have passed their review date should be updated.

18. A risk assessment should be carried out to review the close proximity of the alcohol liaison office and the paediatric area.

19. A risk assessment should be carried out to review the open access of the department at night.

20. Further IPC educational support and training should be provided to staff in ED.

21. 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.

22. Clear, consistent and robust criteria for the issuing of identification wristbands within the ED should be introduced.

23. 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.

24. A PEWS or similar record sheet with a recognised algorithm to guide staff on escalation and actions specific to paediatrics, should be available in the ED.

25. Mechanisms should be put in place to ensure the safety briefings convey important information and patient safety problems. All staff should be present during the safety briefings.

26. Formal daily reviews and routine senior medical and nursing walk rounds should be carried out.

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

28. Medicines should be stored safely and securely.

29. A robust medicines management process should be in place on attendance at the ED.

30. The administration of IV medicines by registered nurses should be reviewed.

31. IV medication should be administered according to the prescribed timescales.

32. Nursing care records should be improved to accurately reflect completed risk assessments, care plans, patients' needs, their involvement in their care and be in line with NIPEC best practice guidelines.

33. The trust should review the current provision of patients meals in ED to ensure an effective process is in place that meets the individual nutritional needs of the patient while in the department.

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

35. A SSKIN care bundle or similar should be introduced for use within the ED.

36. The structured process of Intentional Care Rounding or similar should be introduced within the department.

Housekeeping points

1. The trust should ensure ED staff receive feedback from the stress audit, an acknowledgement of issues raised and an action plan to address the issues raised.

2. Departing nursing staff should ensure the handover is relevant and conveys all necessary information to oncoming staff. HCAs should be included in the handover.

3. The trust should consider the use of patient trackers within the ED.

4. ED staff should ensure up to date audits and patient experience data are visibly displayed.

5. Chemicals should be held in line with COSHH guidance.

6. Up to date results of hand hygiene and environmental cleanliness audits should be displayed.

7. Staff should ensure checks are carried out daily, the equipment in the resuscitation trolley is in good repair and that the work surface is free from clutter.

8. The Sepsis Six bundle should be robustly audited in the ED.

9. Staff should implement the falls safe bundle in the ED.

10. The communicating of patient safety/medical device alerts to staff should be formalised, with a system to insure confirmation by staff.

11. Potassium containing infusions should be clearly labelled and segregated from other infusions.

12. Medical staff should complete the abbreviated mental health assessment sections on the ED flimsy.

13. Nurse record keeping should be introduced as a quality indicator.

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

15. Adapted cutlery and crockery should be available for patients with reduced dexterity.

16. Pain scores should always be recorded onto ED patient flimsies.

17. All registered nursing staff should complete PGD training.

18. Signage for the patient toilet should be more visible.

19. Staff should ensure that call bells are positioned within patient reach.

Focus Groups

6.0 Findings from Focus Groups

On day two and three of the inspection five focus groups were held with the following groups of staff:

- a mix of band 5 and 6 nurses, healthcare assistants and nursing students
- Allied Health professionals including Occupational Therapists, Physiotherapists, Pharmacists, Social Workers, Dieticians and Orthoptists
- Senior Managers including Clinical Directors, Senior Doctors ,Heads of Service and Lead Nurses
- Support Staff including ,porters, domestic services, catering, switchboard and secretarial staff
- Medical Staff including; FY1,FY2 ,GP trainee and specialist registrar

We found all staff who took part in these groups to be open and transparent and willing to discuss both positive and negative issues within their area of work.

6.1 Senior Manager Focus Group

The senior management group outlined some of their challenges. We were told about the current difficulties with staffing in the respiratory team and the drop in respiratory consultant numbers which will result in the reduction in the number of clinics. There are difficulties in the recruitment of consultants; the trust has tried to encourage international recruitment of staff. Physiotherapy and nurse led clinics have helped to fill some gaps. More medical staff grades are needed. Managers stated that it is difficult attracting senior medical staff. We were informed that multi-disciplinary meetings do not happen on all wards.

Nurse staffing in Ward 3 has been depleted due to the development of a respiratory community team. This has been an excellent initiative however it has resulted in the loss of senior nurses from Ward 3 to take up post in the community. The remaining team is very committed which helps but staffing resources are a challenge. In the nursing team there are issues with getting shifts covered; patient acuity has increased and there are many palliative patients and patients with high dependency. There has been good work in developing ‘acute care at home’ services to prevent patient admission; however again this has depleted staff in some areas.

Lack of bed capacity has put pressure on less experienced junior staff and relationships with bed management can at times be strained. Part of the trust’s pressure management plan includes the opening of a CDU. This 14 bed unit was designed to provide sufficient beds to cover the increased demand during the winter period.

However, there has been an unprecedented increase in numbers of patients attending ED and a nine per cent increase in admission rates which have placed additional pressure on beds. This is now seen as a sustained increase and the trust is concerned about coping with this increase in demand for beds. Senior managers stated that they would struggle to find an area in the trust to increase bed capacity, and it is difficult to speak to the right people in the HSC Board to drive issues forward.

We were informed that there is an elderly population in the trust. More adaption and capacity is needed in the community to cope with older patients' needs. There is also a need for more home support for orthopaedic, mental health and alcohol related brain injury as it is not currently available. Respiratory delayed discharge is also an issue. There are no facilities for young people with alcohol related brain injury requiring a long stay in hospital due to their mental state. The rehabilitation consultant for Spruce House is leaving and we were informed that there are no new places for rehabilitation.

Pharmacists told us about their changing role and the lack of staff to ensure that comprehensive medicines reconciliation for inpatients is carried out. Currently they can only focus on medication management at admission and discharge. They have asked for additional funding for higher risk areas. There is no dispensing service or on call on Sunday and there are issues with attracting staff to the trust.

For 14 to 16 year olds with asthma clarification is needed to decide if these patients are admitted as paediatric or respiratory patients. The HSC Board is working with Paediatric Consultants to resolve the matter of under 16 admissions.

Managers expressed their concern regarding learning letters from the PHA. The trust is not always fully engaged in the process or resulting recommendations and this can cause issues with their implementation.

The temporary opening of an elective procedure unit (EPU) for surgery had been very successful; in the six months since it opened it has shortened length of stay and improved the patient journey. However, this has not been permanently funded. Managers stated that if there was a reconfiguration of surgical beds they could reopen the EPU. For orthopaedics, the addition of a staff grade with care to the elderly skills would help to improve patient care.

Staff from Ward 3 stated that they did a trial run of using the RQIA core indicator inspection tool three weeks ago and found it of great benefit.

We were told that the restructuring for senior managers, happening at the moment is confusing. Senior managers stated that they were aware of the vision and strategy for the own work area but had difficulty expressing what the overall vision and strategy was for the trust. They stated that the hospital has limited room for the development of new services so in many instances they are unable to take new ideas to another level.

The continued use of agency and locum staff has had an impact; managers stated that it is difficult to develop a vision due to the transient workforce. Senior managers stated that they were confident that targets or finances had never been prioritised over clinical need.

Clearer communication is needed from the trust senior executive team to ensure that all staff are aware of the vision and strategy to improve patient care.

They are working to develop a process to identify trends to assist learning. The process to identify trends and provide feedback from Datix should be expedited.

The group told us that mandatory training is up to date and there is regular supervision, appraisal and induction. Revalidation training for nurses has been introduced however releasing staff can be difficult due to shortages.

Senior managers reported that they were supported by their line managers. However, the group as a whole informed us of the difficulties created by the introduction of Human Resources, Pay and Travel Portal (HRTPS) ICT system. Ward managers feel that they are also spending more time on this administrative duty which has created additional pressure as they have only one administrative day per week. An increase in nursing support officers for ward sisters would be very beneficial. Currently human resources remain in the trust; senior managers expressed their concern regarding the future move to shared services.

The group stated that they worry about the sheer volume of workload; they stated that they are constantly firefighting. Staff sickness and morale and slow recruitment are concerning and they would welcome additional support for staff at this time.

The group informed us about improvements that had been put in place which included the implementation of a community respiratory team with a pharmacist as part of the team. The Productive ward initiative introduced by the respiratory ward and a new protocol for teaching in relation to chest drains were other examples. Improvement talks have been carried out by visiting specialists. Key Performance Indictor monitoring has been implemented, and monthly safe and effective care meetings are held. Pharmacist prescribers run outpatient clinics for older people and cancer services and there is outreach prescribing pharmacist in diabetes. The development of EPU has shown good results.

We were told that senior managers would like to introduce the following improvements: a consultant pharmacist for long term conditions; stabilisation of the workforce and improvements in staff morale; a pastoral service is needed as morale is low. There should be a greater emphasis on leadership and investment for younger staff to maintain pride and focus.

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

6.2 Nursing Focus Group

The nursing group spoke about their current challenges. We were told that there were shortages in nurse staffing levels in most areas and many staff are off on sick or maternity leave. The workload is constantly heavy; staff stated they feel under pressure and morale is low. Deficits in staffing cannot always be covered by bank and agency staff. Patient acuity has increased and many patients are highly dependent meaning nurses are unable to provide the one to one care required. Nurses stated that staff retention is poor and there are delays in recruitment from time of appointment to actual start on ward. HRPTS system has not helped and nurses described it difficult and slow. Staff stated that the transfer list has been cancelled and they have to be interviewed for posts.

There is a huge demand on services and staff described the current situation as similar to winter pressures. The lack of seven day working by AHP's, mental health and critical care outreach can cause delays in discharge. Staff stated that there are up to 30 patients waiting for discharge. There is a lack of beds and there are safety concerns involving patients waiting on trolleys in ward 32 or in the GP unit on beds. We were told that on one ward today there were three extra patients on trolleys overnight which has caused an extra pressure for staff.

We were informed that there are days that staff go without breaks, and handovers can run past end of shift or are cut back.

Nurses were not aware of the trust's vision and strategy for improving patient care. They stated that patient care is very good and they have high standards, but there is no long term plan and they deal with each issue that arises one day at a time. Ward sisters have no say; bed managers can overrule decisions even when managers say it is unsafe.

All stated that at times targets or finances can be prioritised over clinical need.

Inappropriate admissions can be an issue; patients are sent from ED to a surgical ward without a review and then discharged from the ward two hours later. ED staff stated that surgical review is slow; patients are made to wait then when the time is approaching that of breaching targets, sending patients out of ED becomes a priority. Staff stated that at times patients are sent up to the ward by staff without full knowledge of what the patient has had in terms of medications.

Mandatory training is ongoing however staff cannot always attend due to work pressures. Management has been notified. New staff are placed on the waiting list for induction training however classes are not available until September 2016.

Staff stated that there are not enough available classes and more induction training is needed. All agreed that they had regular supervision and appraisal and were supported by their line managers.

The nurses talked about their concerns or worries about their ability to deliver care. They stated that additional escalation beds, providing one to one care, doctors' awareness about the level of nursing care needed and assessment for high dependency unit ward as no weekend or out of hours service by critical care outreach are important issues.

Staff stated that placing patients with alcohol withdrawal, or who are aggressive with other patients in their wards can make them feel very vulnerable. Management of Actual or Potential Aggression (MAPA) training is available but it is only the four day course which staff stated doesn't fully equip them to deal with these patients. Porters who also have security duties can't be hands on, so they have to call the police to provide restraint. They stated that there have been occasions where staff have been assaulted. There is limited security and night duty can be frightening. Porters check on the wards but are unable to do anything.

The Incident process is lengthy and staff expressed a reluctant to start the process; they stated that one ward manager was told not to raise an unsafe issue as an incident. She was told that she should have dealt with it internally.

The student of nursing who was an observer on the inspection talked to other students about their lack of hospital experience or the type of placements they had experienced. They stated that they would benefit from more time in hospitals.

We asked nurses about recent improvements and initiatives. We were told about the use of purple folders for those patients who have been diagnosed with Dementia. The folders contain personal information gathered from the patient's family, describing the patient's life story. Staff stated that this was a brilliant idea and has helped them understand better the needs of those patients with challenging behaviour. Staff stated this should be rolled out in all wards. They were also however aware of the limitations of this initiative in that it is only for those patients who have been formally diagnosed and not for delirium patients. One to one nursing for delirium patients is not always facilitated and there are patients who are free to wander around who could fall.

The introduction of the morning huddle for all staff has improved communication in relation to safety issues. Two staff from the renal unit are going to England to train on "Shared Care" for patients to support dialysis. A Memory ward has been introduced for Dementia patients. However, the productive ward system has stopped even though staff found that it was beneficial. There is an ongoing pilot called PACE on some wards to try and improve recording keeping.

Nurses would like to see improvements in nurse staffing levels for wards and seven day working for all AHPs including pharmacy and social workers. Clinical support officers would be helpful and a house keeper for all wards would be invaluable.

A psychiatry service for renal patients would assist young people as they can become institutionalised and reluctant to have transplants. There is also a lack of psychiatry for both adults and children in dermatology. There is a crisis team, however they are only for high risk patients and again there is no cover at weekends.

As a group they would all be happy for family and friends to be cared for in hospital. Staff talked positively about relatives who had been cared for in the hospital

Emergency Department Nursing Focus Group

As nurses from ED were unable to attend the main focus group a small focus group was held with three staff asking the same questions. Staff raised similar challenges around staffing, increased workload and the fact that skills mix is an issue with new staff. Staff stated that trolley waits are spread throughout the department which creates difficulty in ensuring 15 minute observations are carried out.

Staff told us that at times, cover for breaks can leave the area short and they are then concerned about the ability to deliver safe and person centred care. Covering the resuscitation area can be difficult due to staff shortages and at times patients requiring this level of care are placed in majors. Ensuring patients receive appropriate assistance with their meals is a big challenge.

Increased documentation is at times difficult to complete due to time restraints and staff shortages; staff suggested use of a single booklet containing all charts and documentation.

Staff stated that accessing portering or security staff during the night is an issue. Requests for portering or security at night have to be made on a computerised system; this can cause delays for assistance. Staff do have a direct line to the PSNI.

Staff stated that their questions and concerns are listened to but there is no action taken. Staff meetings are not well attended and occur only every three or four months. However, the sister has a very open door policy and is approachable. Staff stated that most of the time the team feels valued and the band 6 always thanks staff at the end of shifts.

All staff believed they try to improve patient care. Staff suggested a twilight shift to improve patient flow as there are particular issues with patient placement at the beginning of the night shift.

Handover, needs to be improved; staff only receive a verbal handover for their area; only the sister and second in charge receive a handover involving all patients; healthcare assistants are not part of the handover. Staff told that as the checking of controlled drugs at each shift is given to the first nurse on duty resulting in staff holding back as they don't want to be first in.

The practice educator is a good asset to the team they have left but are coming back to a permanent post in ED. There are new starts which need extra time to be trained and inducted. They stated that they need 10 staff on main floor to facilitate training and induction. We were told that training in some areas needs to improve. Nursing staff receive training to carry out triage. Doctors can at times suggest lowering triage status and if this happens the nursing staff get the notes countersigned by the doctor. Mandatory training is not up to date and staff were not aware of any major incident plan or what it might entail. Appraisal uptake is poor; there is no formal supervision and can't always get competencies signed off. However, they do feel supported by their managers.

We were told there is a medical Registrar and a surgical Registrar on call; however there is no cardiac cover.

The staff told us that targets are a priority to ensure that there are no time breaches. Bed managers are useful but they can come under pressure from assistant directors when targets are going to be breached. Bed managers do come down in the morning but not in the evening and do most of their organising by phone. It depends on the bed manager whether or not the bed management plan for the hospital is sent to ED. Staff told us that trolley waits in corridors do not happen; on occasions the resus area can be used to facilitate bed waits. We did not observe any trolleys waiting in the corridor during the inspection. Ward 41 has a trolley bay of four beds in the direct GP admission unit.

Staff stated they were concerned about the way the duty rota is issued. Staff are only given their duties a week before, leaving little time to arrange child minding arrangements. There is no band 7 so the band 6 does the duty rota; however no dedicated time is given so they often do this at home or on days off.

Staff stated that they worry about not being to care for patients properly and also ensuring they get a meal; they stated they are stressed, morale is low and some are actively looking for jobs. They stated that healthcare assistants are undertaking duties that they are not qualified for such as ECG's, observations and signing the NEWS chart. They are also covering for nurses when on their breaks in majors and there is only one healthcare assistant on night duty.

We were told about recent improvements such as access to physiotherapy and occupational therapy services.

CPN services which include card before you leave are available and staff are quick to come when requested and that there is good follow up. A new transfer form (HANDI) has helped the transfer process.

Staff told us that the following improvements would help. The allocation of one nurse to do controlled drug checks; improving food for patients at night; better security at night as the ED has open access and return of the patient tracker post.

They stated that they hoped that the wait for medication from pharmacy would improve with the appointment of a pharmacist. Taking handovers from NIAS can be an issue if very busy. They also stated that all doctors should wear their Vocera system, so they can be contacted quickly in an emergency.

Nurses stated that training band 3 healthcare assistants to undertake IV cannulation, bloods, observations and ECG's would free up time for nurses to assist doctors.

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

The group told us that we do have complaints but they are outweighed by thanks. Patients would know what to expect if electronic waiting times were displayed.

6.3 Support Staff Focus Group

The group was asked about their current challenges. They told us that there are staff shortages, staff are working beyond their job description and there is no cover for extended leave or unexpected sick leave. The group told us that in the past there was a relief team trained to cover medical secretaries, but not now as they have become part of the team. There is no seasonal staff now just agency. There is a ward clerk who floats and covers leave but only in primary care medicine, not other directorates. They have a funded established staff quota but no contingency built in for shortages.

Porters have to provide security. They have had some MAPA training, but no other training is provided. They can't put their hands on an aggressive patient but providing security is part of their contract. Catering staff have been asked to cover cleaning in kitchens.

Clerical staff stated they are worried about the increasing amount of paperwork. There is a backlog of test results; they have to leave the ward to search for files as there is not enough clerical support for the amount of paperwork produced. Medical records are an issue as staff stated that due to a delay in filing results, thousands of loose notes are present throughout the hospital. This has been raised as a risk.

Staff were asked about the trust vision and strategy for improving patient care and how it was communicated to them. They stated that not everyone has access to a computer; however some information was communicated at monthly meetings. None were really aware of the trust vision and strategy. Porters and ward clerks stated that don't have meetings the ward clerks have limited knowledge of who their line manager is. They stated that carer's leave is at a manager's discretion and some staff at the group had never heard of it.

The group was asked if targets or finances are ever prioritised over clinical need. They all stated yes, very much so, all is according to the budget. All orders are queried and have to go through scrutiny and they are questioned for even ordering marker pens. Approximately one order in four would be referred back. This stops staff from performing their duties to the best of their ability.

Porters stated that their new uniform is inadequate "almost see through". They have no separate uniform or proper personal protective equipment for handling clinical waste and household waste. The steel toe cap boots supplied are too heavy; porters are the only staff that have to clock in and out and for breaks.

The group told us that mandatory training is up to date. The British Institute of Cleaning Science training for cleaning staff is ongoing; however no ICT training, European Computer Driving Licence**,** is available now. Jobs within the hospital such as band 3 require qualifications but there is no way to increase skills. No basic life support training is provided for porters although resuscitation training is starting next week. Most of the group stated that there was little money for training. All had induction when they started. When asked about appraisals, a ward clerk stated that they have had one appraisal in 13 years; however domestic staff are up to date with appraisal. A band 5 manager stated that it is difficult to fit in for 50 staff, porters' appraisal started this year.

The group was divided regarding support from their line manager. Porters didn't feel fully supported and medical secretary support issues take too long to happen or change. Staff are dedicated and feel guilty if they take a day off. Personal staff achievements are not acknowledged by the trust.

The improvements staff would like to see are. One booklet for admission on the ward to be used until the patient leaves the ward as some charts are huge. Admission sheets get lost amongst the papers in a huge chart. A steering group was formed to discuss the introduction of a new chart, however, this has financial implications so it has not happened. Improved staffing and inconsistency in banding; some band 2 ward clerks who asked for an upgrade to band 3 received this but it was not for all ward clerks so there is a discrepancy between posts. Steps taken to improve recruit retain consultants to the hospital and more specialist services.

Generally they would be happy for their family and friends to be cared for in the hospital.

6.4 Allied Health Professionals Focus Group

The group of AHPs told us that the speed of bed turnover is getting greater, there are not enough beds and at times it seems that the bed is more important than the patient. There are not enough AHP staff to deal with this turnover. The group told us that they had escalated staff shortages to their managers. They have no cover for sick leave or maternity leave and recruitment is slow. There are 10 radiologists short within the trust so radiology reporting is sent out to an agency. Pharmacy is struggling to recruit pharmacy technicians and currently they are only offered temporary contracts so people won't leave permanent jobs for this. Pharmacy hopes to roll out seven day working before October 2016.

Patient acuity is increasing with higher demands and more complex needs. Patient discharge is being delayed but there are no beds in nursing homes and there is a long wait for patients to be assessed for care packages.

Staff in the community need to work with staff in the hospital and at times there is conflict if the patient doesn't fit within the "boxes". Referrals can be sent at short notice, with the patient about to leave, even though they have been in hospital for several days. There is no intermediary coordinator for discharge. Other trusts have this and but there is no community hub in the Western Trust. Social workers stated that there was a need for a team between hospital and community to assess patients. The Older Persons Assessment and Liaison (OPAL) team sees only over 75's.

The group stated that there was a clear trust vision and strategy for improving patient care but it is not communicated to staff. Strategy and vision are good, but to achieve it they need to engage with frontline staff. There is a gap between management and frontline staff and improved communication is needed. One member of staff stated that the improvement team are doing a great job. However, most of the group were unaware of what the service improvement team do; they stated that more engagement with staff is needed. Seven day working has halted as consultation has not happened and staff haven't been brought together to discuss this.

The entire group stated that at times targets or finances could be prioritised over clinical need, but stated there were supported by their managers.

Mandatory training has been cancelled due to lack of staff to deliver it. Some staff stated that if they want to do additional training but can only do this if it has been highlighted at appraisal, so if a new course becomes available they cannot go on it.

Staff stated that they worry about having to deal with complex discharges on Fridays.

If no care packages are available in the community, patients have to go to a nursing home to wait.

The patient needs to agree, but is given three nursing homes to choose from so there is limited choice and it is not always personal choice. Physiotherapists worry about junior staff covering at the weekends

Staff spoke about the introduction of eNISAT 4 which comes into use on 18 July 2016 across the region but this is not linked to liquid logic and will be available on share point. There is no joined up system between community and hospital.

We asked about improvements that could be made to the pharmacy system and we were told that they would need more specialist roles; time to train up technicians; a pharmacist on each ward and increased working with patients. All staff would like patient centred care not service led care and more collective engagement. Social work staff stated that an intermediate team between the hospital and community to assess patient need would be useful. Staff stated that a dedicated stroke unit would be very beneficial.

All would be happy for their family and friends to be cared for in the hospital they stated that all staff work hard with the resources available.

6.5 Medical Staff Interviews Focus Group

Medical Trainee Focus Group

We met with a group of junior doctors ranging in seniority from foundation year one to specialist registrar. All stated that their experience of working in Altnagelvin Hospital was positive, with favourable comparisons made with other similar rotations. We were told that training opportunities for foundation year trainees was good. The group told us that they get a good range of experience dealing with acute presentations as well as managing longer term conditions and trainees feel valued members of their clinical teams. Induction was generally good. However, one FY1 stated the ward didn't know he was arriving.

We were informed about the increasing demands of the service and all areas were very busy. In neonatal there is only one registrar out of hours which can make cover difficult however they have doubled up on staff and then reimbursed for their time.

We were told about the shortage of FY2s; there should be 19 across the site but only 15 at present. Numbers are to be increased in August 2016. There can be gaps in the rota as two doctors are on long term sick leave and as it is proving difficult to fill their shifts locum rates of cover are offered. Rotas are forwarded too late by human resources to ensure all shifts can be filled.

We were told that generally there enough FY1s to cover the wards; FY1s spoke positively about the opportunity to shadow a FY2 for a week on the admissions rota for ED. They stated that this has proved to be a valuable learning experience; this is the only trust which offers this training opportunity.

All stated there was good support from senior doctors and consultants were very approachable.

The group spoke about the difficulties involved with discharge. For example ward 40 has no pharmacist so a discharge letter needs to be sent the day before to ensure timely discharge.

We were told that they can be asked to do a discharge and write a script for someone they haven't seen out of hours. Finding suitable placements can block beds as there is a lack of care packages in the community. All stated that there could be an improvement in multidisciplinary working. Some areas do not have multidisciplinary team meetings so it can be difficult to connect with AHPs and social workers.

We were told that handover generally happens two to three times a day. It is easier to attend ward rounds in medical wards. In surgery this can be more difficult. They stated the medical notes are too big and it can be difficult to find information due to large volumes and repetition of information. Some wards have specific admission notes which make finding details much easier.

We were informed about some improvements in post-natal care such as the daily huddle and monthly junior medical forum to look at what has gone well or what needs improvement.

Generally, the group would be happy for their family and friends to be cared for in the hospital.

Theme: Discharge

7.0 Theme: Discharge

7.1 Approaches to Discharge

Approaches to improve the quality and speed of discharge processes:

- Pharmacy involvement in the medicines management process from admission to discharge.

- Ward rounds were scheduled early to facilitate transfer or discharge.

- The ED participated in carrying out a pilot in conjunction with the ambulance service. A liaison officer was appointed temporarily to the ED. Staff found this beneficial in assisting with pending admissions and discharges however there was no funding for a permanent position.

7.2 Challenges to Discharge

General challenges to discharge mentioned to or observed by the team:

- The lack of 7 day working by AHP's, mental health and critical care outreach can cause delays in discharge.

- There is no intermediary coordinator for discharge.

- It was reported by staff that occupational therapy cover on the ward can be limited which on occasions had delayed the discharges/ transfers of some patients.

- Timely review of inliers by medical staff, completion of discharge letters.

7.3 Ward 3

We were informed that ward pharmacists, and the facility to directly dispense from the ward speeds up discharge. A particular point that staff commented on was the involvement of consultants in typing up discharge letters in addition to junior medical staff. The main delays in discharge were in waiting for care packages and nursing home placements. Board rounds were beneficial in proactively identifying patients for discharge.

7.4 Ward 8

Staff told us that discharges are completed quickly using Patient Centre with good access to computers. Some delays in waiting for processing of pharmacy scripts were mentioned although medical staff were completing scripts, where appropriate, the day before to expedite discharge.

7.5 Emergency Department

A clinical decisions unit had recently opened close to the ED. This catered for patients who were most likely to be turned around quickly. It is staffed by a small but enthusiastic team who reported that it was achieving its aims and worked well with both ED and AMU. It provides 12 beds to expedite diagnostic and clinical decisions and would have a typical throughput of 16 patients every 24 hours. The review team was told that less than 15 per cent of patients will require admission from this unit. A consultant and FY2 doctor provide the regular medical presence and out of hours cover is provided by the medical team. Pharmacy, occupational therapy and physiotherapy support was described as excellent but there can be delays in processing discharge documentation with just one FY2 doctor present.

GPs can directly admit to the AMU Trolley Bay 9.00am to 5.00pm daily but after that GP referrals attend ED, before onward referral to the medical team. Direct GP referrals to the medical registrar on call can help to avoid admission but often there is little or no handover between the Trolley Bay, the medical team and ED when a GP makes contact out of hours requesting admission. This issue was to arise from the busyness and complexity of the admissions process and medical trainees commented that they sometimes did not feel in control of decision making when phoned by a GP out of hours. For example, patients were told they had been ‘accepted under medics’ whenever a decision was given to refer to ED, to exclude a surgical cause of the patient’s symptoms.

A new initiative to have an occupational therapist based in the ED was working well. Staff are able to turn several patients around quickly who would otherwise have required admission whilst waiting for aids or assessment. Audit of the work so far has demonstrated a reduction in number of admissions for those patients requiring early occupational therapy input.

Staff in the Trolley Bay located in AMU described the initiatives they have put in place. GPs have direct access by phone to this area where they are assessed by senior medical staff. The average throughput is 15 to 20 patients per day, half of whom are able to be discharged. This area provides rapid assessment and treatment of patients who would have otherwise required direct ward admission or attendance at ED.

There is proactive allied health support and an OPAL which can expedite assessment and transfer to intermediate care and rehabilitation beds.

7.6 Recommendations for the Trust from the Discharge

Additional to the recommendations and housekeeping points concerning discharge in the body of the report the following should be implemented:

1. Review of AHP services to assess its impact on timeliness of assessment of ward patients.

8.0 Next Steps

On the 22 April 2015 the RQIA inspection team provided detailed verbal feedback to each area inspected. This was followed by feedback to the Chief Executive Miss Elaine Way, directors and senior managers on the key findings from the inspection.

This inspection report has been shared with the Western 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 Western 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 3 Medical

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.	**Ward 3 Manager**	One more band 6 sister recruited. All 3 band 6's will be in post by Jan 2017 to facilitate band 7 protected time. Job plan will reflect protected time.	Feb 2017
2.	The trust executive team should improve engagement with staff.	**Director**	The Director will provide physical presence in a structured and organised way to engage with front line staff.	Ongoing
3.	Occupational therapy ward level support should be improved.	**Head of OT**	We now have 1 WTE occupational therapist for ward 3. This is a 100% increase in OT services.	Completed Oct 2016
4.	Daily safety briefs should be introduced.	**Ward 3 Manager**	Daily safety briefs have been introduced since Aug 16 and records kept on the Trust template.	Completed Aug 2016
5.	The trust should ensure that patient care and safety is not compromised due to staffing levels. The recruitment of new staff should be expedited.	**Service Manager Cardiology and**	5 new S/N's have been introduced to the ward since Sep/Oct 2016 Vacancy rate at Jan 2017 is 1.0 WTE S/N. The Trust remains committed to	Completed Oct 2016

Reference number	Trust Recommendations	Designated department	Action required	Date for completion/ timescale
		Respiratory	the band 5 stabilisation programme. Staff in post are reviewed monthly.	
6.	Medical staff should review the scheduling of ward rounds to ensure nursing staff participation.	**Ward 3 Manager** **Clinical Lead**	Scheduling of ward rounds has been reviewed by medical and nursing staff to ensure no more than one formal ward round is ongoing at a time. However, due to patient demand some impromtue rounds may occur outside formal rounds and will continue to be supported.	Completed Aug 2016
7.	Equipment on the resuscitation trolley should be routinely checked as per trust guidance.	**Ward 3 Manager**	The daily checklist has been completed every day following the review. This has been highlighted and fed back to staff through ward meetings and safety briefs.	Completed Aug 2016 & ongoing
8.	All staff should comply with the trust PPE policy.	**Ward 3 Manager**	All staff have been informed again of the PPE policy. Onging IP&C audits indicate good performance.	Completed Aug 2016
9.	Appropriate adaptations should be put in place to meet the needs of patients with dementia.	**Ward 3 Manager** **Service Manager Cardiology and Respiratory**	All appropriate adaptions have been put inplace with the exceptions of clocks in rooms which is ongoing. All appropriate signage has been put up on the ward. The Trusts award winning purple tool kit	March 2017 Completed Sep 2016 Completed

Reference number	Trust Recommendations	Designated department	Action required	Date for completion/ timescale
			for care of dementia patients in acute services is now in place and dementia champion is now trained.	Oct 2016
10.	Staff should ensure that all equipment is clean and well maintained and equipment cleaning schedules introduced.	**Ward 3 Manager**	Equipment cleaning schedules have been introduced for equipment.	Completed Aug 2016
11.	The Sepsis Six bundle should be implemented for use within the ward.	**Trust**	Work on the Sepsis six bundle is onging with a Trust prevalence study completed in Sep 2016. A Trust implementation and spread plan is currently being developed.	March 2017 Ongoing
12.	Further analysis of falls incidents should be undertaken to identify trends or patterns.	**Risk Management**	Ward 3 staff are currently recording a monthly report on falls activity with the development work on trends on going. The Falls Safety Cross is being reviewed and refreshed to allow trends to be identified and improvement work to commence. There is regional work ongoing to improve the Falls data collection with Datix. A pilot on two wards will take place Jan/Feb 2017 with an implemental plan to be developed.	On going

Reference number	Trust Recommendations	Designated department	Action required	Date for completion/ timescale
13.	The recording in nursing care records should be improved to accurately reflect patients' needs, their involvement in their care, and be in line with NMC best practice guidelines.	**Ward 3 Manager**	The PACE methodology for recording care is a work in progress. PACE is underpinned by patient involvement and the PACE approach and standard of recording by nursing is under review. With the introduction of PACE improvements are ongoing. All staff are being trained and records are audited 3 monthly in line with the NMC guidelines.	March 2017
14.	Senior nursing staff should coordinate and supervise meal services ensuring that all patients are prepared for and receive timely assistance with meals.	**Ward 3 Manager**	This has been implemented. All patients requiring red trays at handover in the morning then supervised by the nurse in charge at all meal times.	Completed Aug 2016
15.	Staff should ensure that fluid balance and food record charts are completed and reconciled in accordance with trust policy.	**Nursing**	Fluid Balance: Newly appointed Band 5 staffs induction has included the correct way to complete fluid balance charts. The Trust has applied to GAIN for funding to undertake improvement work in fluid balance recording and plans to commence work Feb/Mar 2017. Food charts Patient food charts are completed after every meal by each specific team.	March 2017

Reference number	Trust Recommendations	Designated department	Action required	Date for completion/ timescale
16.	A risk assessment should be carried out for the use of escalation beds.	**Assistant Director EC&M**	The use of escalation beds has been discontinued.	Aug 2016

Quality Improvement Plan: Ward 8 Surgical

Reference number	Trust Recommendations	Designated department	Action required	Date for completion/ timescale
1.	The 'Incidents by Adverse event' figures and learning from morbidity and mortality meetings should be regularly disseminated to staff.	Ward 8	Monthly M&M Mtgs in place where incidents are discussed and Ward manager feeds back to ward staff.	Completed – Dec 16
2.	Staff should be facilitated to attend mandatory training.	Ward 8	Training database in place and action plans to ensure all staff attend Mandatory training.	End of March 17 and Ongoing
3.	Systems and processes that impact on patient flow and discharge should be reviewed and improved.	Medicine/ Ward 8	Ongoing pressure with Medical Outliers for completion of discharge letters, however an additional Consultant Physician has been employed specifically to attend to medical outlying patients which has improved the situation.	Ongoing
4.	The system used for medical handover should be reviewed to ensure effective communication of information.	Ward 8	A medical handover sheet that is in place in other wards is being considered in Ward 8. Further discussion required with Consultants/Junior Medical staff.	Ongoing
5.	The ward should capture record and routinely analyse and act on patient experience data.	Ward 8	Patient satisfaction surveys are now completed quarterly. Information is analysed and action plans put in place. Ward has also introduced a suggestion box.	Ongoing

Reference number	Trust Recommendations	Designated department	Action required	Date for completion/ timescale
6.	Staff should be visible on the ward to maintain a level of visual contact with higher risk patients.	Ward 8	An RN is on the floor at all times plus patient evaluations are now written up in the room at the patient's bedside.	Dec 16 - Ongoing
7.	Emergency trolleys should be fully stocked and located in an accessible area. Sharps boxes should be stored securely on the trolley and contact details for the emergency team displayed in a fully visible manner.	Ward 8	Recommendations implemented and are monitored by Nurse in Charge daily and Ward Sister monthly for compliance.	Completed – July 16
8.	The ward should be assessed to ensure that appropriate adaptations are put in place to meet the needs of patients with dementia.	Ward 8	Adaptations implemented as per recommendation. Ward now has a nominated Deminata Champion.	Completed – Oct 16
9.	Medical staff should comply with the trust hand hygiene and PPE policies.	Ward 8	Hand Hygiene audits now routinely include medical staff. PPE instruction for medical staff is now provided by the Practice Educator.	Completed – Oct 16
10.	Medical staff should complete all documentation relating to invasive devices and blood cultures.	Ward 8	Medical staff have been instructed how to complete the documentation and a rolling programme is in place for new staff. This is audited monthly to ensure compliance.	Dec 16 and Ongoing
11.	The Sepsis Six bundle should be implemented for use within the ward.	Ward 8	As per recommendations – Practice Educator trained and to cascade training to staff in New Year which is currently being rolled out.	March 17 - Ongoing

Reference number	Trust Recommendations	Designated department	Action required	Date for completion/ timescale
12.	Medicines should be stored safely and securely in line with trust policy.	Ward 8	Recommendation implemented and is monitored by Nurse in Charge daily and Ward Sister monthly for compliance.	Completed – July 16
13.	Robust procedures should be in place for reconciling supplies of controlled drugs.	Ward 8	Recommendation implemented and is monitored by Nurse in Charge daily and Ward Sister monthly for compliance. In addition, Pharmacy also audit quarterly for compliance.	Completed – July 16
14.	Nurses should adhere to NMC Standards in the administration of medicines.		Recommendation implemented and ongoing updates and audits by Practice Educator for compliance.	Completed – July 16
15.	An integrated medicines management service should be provided.	Ward 8	Funding issue but raised within Directorate as a priority.	Ongoing
16.	Nursing care records should be improved to accurately reflect patients' needs, their involvement in their care, and be in line with best practice guidelines.	Ward 8	The RNs have been involved in learning sets with the Practice Educator to reflect on how best to individualise the patient's care record, they are following PACE guidelines and this is monitored by RNs and Ward Sister is doing monthly audits.	Dec 16 - Ongoing
17.	Documentation should include time of entry and evidence of discussion of diagnosis with patients or their relatives.	Ward 8	This has been highlighted to Medical and AHP staff. RN currently carrying out audits to ensure compliance.	Ongoing

Reference number	Trust Recommendations	Designated department	Action required	Date for completion/ timescale
18.	Nursing staff should coordinate and supervise meal services ensuring that all patients are prepared for and receive timely assistance with meals.	Ward 8	Protected meal times in place when possible and a RN is assigned to coordinate patient preparedness and assistance with meals.	Completed – July 16
19.	The mechanism for monitoring patients' intake should be reviewed and improved. Nursing staff should ensure that fluid balance and food record charts are completed and reconciled.	Ward 8	Each RN team leader is responsible for the accurate fluid balance and food record for the patients within their team. If HCAs are delegated duties, then they should report any issues to the RN.	Completed - July 16 and Ongoing
20.	Care rounds should be introduced.	Ward 8	Intentional Care rounds have been introduced. Daily checks that staff call bell is working ensures patients confidence that they can get staff in time of need.	Completed – Dec 16

Quality Improvement Plan: Emergency Department

Reference number	Trust Recommendations	Designated department	Action required	Date for completion/ timescale
1.	The trust should expedite the appointment of band 7 nurses in ED.	**Assistant Director**	5 Band 7 staff appointed	Oct 2016
2.	The trust should strive to ensure that the risks identified in the Annual Health and Safety Generic Risk Assessment form in relation to ED are actioned accordingly.	**Assistant Director**	An annual Health and Safety generic risk assessment will be completed in January with an action plan developed and action by end of March	Commenced Jan to be completed March 2017
3.	Where audits do not achieve trust compliance levels, action plans should be in place to ensure improved practice and compliance.	**Designated Ward Sisters**	Designated Band 6's and 7's responsible for completion of audits. There is a plan to ensure audit results are shared publicly on the departments notice board and work is on-gong with estates to facilitate notice boards being erected A safety brief approach is being developed in ED which will be the mechanism to ensure scores, both good and poor are shared with ED staff and improvement plans agreed. Exception reporting and improvement plans are discussed at the monthly ward	Nov 2016 & ongoing End Feb 2017 Feb2017 Commenced &on- going

Reference number	Trust Recommendations	Designated department	Action required	Date for completion/ timescale
			sisters meeting within Emergency Care and Medication Consistent poor scores are further raised formally at the Safe and Effective care meeting with the Assistant Director	
4.	The trust should ensure staff are not working outside their competency level.	**ED Manager** **Assistant Director- Workforce planning**	All staff were reminded at Staff Meeting on 30 November not to work outside their skill set. Review of the current Band 2 workforce roles and responsibilities to ensure they are working in roles they are fully supported to do and are not outside the remit of band has commenced A review of the Band 2&3 workforce to future proof the role within the ED and appropriate training and education support has commenced ED Departmental Manager to work with Assistant Director of Workforce planning on Phase 2 of Normative Staffing.	Completed Nov 2016 Dec 2016 – Mar 2017 Commenced & ongoing Jan 2017 Commenced and ongoing to complete June 2017

Reference number	Trust Recommendations	Designated department	Action required	Date for completion/ timescale
5.	Nurse staffing in the resuscitation area should be reviewed to enable a one nurse to one patient ratio.	**Department Manager** **Head Estates Projects**	Work has commenced and is ongoing to ensure the E roster and day to day working practice is scheduled to allow one to one nursing support for patients in the resuscitation area. Further work is currently ongoing to implement phase 2 of the normative staffing which will enhance this work In conjunction with estates, a review of the geographical placement of the resuscitation area has commenced to determine any reasonable adaptions and or expansions that may be made against the backdrop of the wider ED extension plans.	Commenced and is ongoing Commenced and ongoing
6.	The trust should review nurse staffing levels across all areas within the ED and the recruitment of new staff should be expedited.	**Assistant Director**	Engagement regarding the regional workforce planning model for ED departments i.e. Phase 2 of Normative Staffing has commenced Director of Nursing and AHPs of the PHA has visited and is in further discussions regarding phase 2 normative staffing	Commenced & ongoing

Reference number	Trust Recommendations	Designated department	Action required	Date for completion/ timescale
			Recruitment of new staff has been successful with the recruitment of 5 band 7 staff and additional 1.80 band 6 staff. A further 2.86 WTE band 5 staff are currently in the recruitment process Practice Educator was appointed and took up post in September 2016 Lead nurse post was appointed to in July 2016 General manager for ED was appointed in September 2016	
7.	The trust should put in place systems to support staff working in ED to help them feel valued and empowered to raise concerns.	**Assistant Director & Department Manager**	Monthly Meetings with the band 7 & 6 nursing staff have been established to include input from the Director of Acute services and Assistant Director of Medicine and Emergency Care as requested. Facilitated workshops for staff with members of the Trust Management and Development departments have been held during September and October for all grades of staff to determine the staff concerns and plan a way forward	Completed Oct 2016 Completed Nov 2016

Reference number	Trust Recommendations	Designated department	Action required	Date for completion/ timescale
			Within unscheduled care, a ward sisters group has been established with the purpose of reviewing patient flow matters and care practices against defined protocols to support patient flow and care of patients with unscheduled care Monthly staff meetings established with protected time or time owing to facilitate attendance	Established in Nov 2016 & ongoing Jan 2017 & ongoing
8.	Senior trust staff should communicate with ED staff regarding concerns relating to crowding, staffing levels and other issues raised by ED staff.	**Assistant Director**	Interim appointment of Service Manager for Unscheduled Care to be based in ED for 3 months initially Daily update from Service Manager for Unscheduled Care to Assistant Director and Lead Nurse for Unscheduled Care regarding ED daily concerns. Alternate week meeting with Senior Management Team and ED Staff regarding progress of Agreed Action Plan for ED General Manager and Lead Nurse attend ED senior clinician meetings.	Completed Jan 2017 Completed Jan 2017 Completed Jan 2017 Completed Nov 2016

Reference number	Trust Recommendations	Designated department	Action required	Date for completion/ timescale
9.	To provide a safe working environment, the trust needs to review the provision of security staff for the ED.	**ED Manager & Head of Support Services**	A review of security arrangements within the ED department is now ongoing with the Head of Support Services to determine the best approach to security within ED and in light of the Trusts security policy In conjunction with the Trust Risk Management department, a risk assessment of ED, staff and service users will be undertaken and action plan agreed to address any security issues raised A review of security related incidents with ED will be completed and trends identified and action plans completed as appropriate	Jan – March 2017 Jan – March 2017 March 2017
10.	All staff should be facilitated to attend mandatory and in house training commensurate with their role.	**Practice Educator**	A practice educator was appointed in September 2016 and has developed a training needs analysis which reflects the needs of the ED nursing workforce in order to meet the service requirements The staffing roster is developed to support staff attend training as appropriate	January 2017 Jan 2017 & ongoing

Reference number	Trust Recommendations	Designated department	Action required	Date for completion/ timescale
			Short weekly in-house education sessions that reflect current needs of ED staff is being established	February 2017
11.	An up to date, comprehensive and easily understood matrix which identifies staff attendance at courses should be in place.	**Practice Educator**	Practice Educator is responsible for the development of a system (paper or electronical) that will house the attendance at training, will have in-built renewal warnings and this will be reviewed on a monthly basis	February 2017
12.	Staff supervision and appraisal should be up to date.	**Department Manager & Practice Educator** **Department Manager & ED sisters**	**Supervision** In conjunction with corporate nursing, a review of staff who have attended training on clinical supervision has been completed These staff have been met and their ongoing supervision training requirements agreed Supervision sessions have been commenced, led by corporate nursing, with a plan for the ED staff to implement the on-going supervision plan **Appraisal** A plan to implement appraisal for all nursing staff is being developed at present with completion and roll out for March 2017	Commenced and ongoing Commenced and ongoing March 2017

Reference number	Trust Recommendations	Designated department	Action required	Date for completion/ timescale
			Staff will be identified to attend appraisal training	
13.	The trust should review the impediments to patient flow from the ED to better cope with the demands placed upon the service.	**Assistant Director Unscheduled Care**	An Unscheduled Care Strategic Working Group is established with the purpose of reviewing patients who remain longer than 12 hours and key learning identified and shared Internal audit have completed a review of the systems in place within ED The report is due in February 2017 after which an action plan will be developed The daily 'gold report' will be re-engaged with and decisions to support patient flow. A staff information session has been held to ensure staff understand this report and act appropriately. The report will form part of the patient flow meetings Work and training on active engagement from wards with the patient FLOW system as a means of correlating bed capacity has been completed Job plans for the Patient Flow Team have been developed to aid the team work efficiently ,effectively and	Ongoing Feb 2017 February 2017 Completed Nov 2016 Completed

Reference number	Trust Recommendations	Designated department	Action required	Date for completion/ timescale
			collaboratively with ED and maximise patient flow	January 2017
			A review of performance of the CDU has been held and the barriers to maximising the pathway have been identified and work is ongoing to improve	October 2016 and ongoing
			In Collaboration with Primary Care and Older Persons Services, the complex discharge delayed list is formally reviewed twice weekly with a daily update provide at the patient flow meetings. The discharge co-ordinator is present on a daily basis at patient flow meetings	Commenced and ongoing
			A Full Capacity Protocol has been developed and approved by the Trust Corporate Management Team with criteria for activation which will in turn minimise congestion	January 2017
			A review of Senior Manager on-call arrangements to ensure on site presence during evening congestion is to take place.	March 2017

Reference number	Trust Recommendations	Designated department	Action required	Date for completion/ timescale
14.	The trust should agree and sign off the ED Escalation Plan. The differences between the Major Incident Plan and the Escalation Plan should be investigated and a resolution agreed.	**Assistant Director**	The current ED escalation plan is being actively reviewed, reworked and will require approval from the SMT. Major Incident Plan and Escalation Plan are now clearly defined and training programme has been agreed for Major Alert.	April 2017 Jan 2017 – Mar 2017
15.	The trust should ensure all nursing staff have a personal email account.	**Assistant Director & Head of IT**	The Information Technology Department are to provide individual e-mail addresses for all Bands 5, 6, 7 staff.	Feb 2017
16.	The trust should show consistency in the safeguarding training offered to nursing staff in the ED.	**Practice Educator**	As part of the overall training needs analysis safe guarding training will be included and training offered as agreed and set out in the regional adult safeguarding report. A local Adult/Paediatric Safeguarding study day is to take place in February 2017 to create and raise initial awareness of the protocol and polices.	Feb 2017
17.	All policies that have passed their review date should be updated.	**Assistant Director & Practice Educator**	ED Policies requiring updating are being identified and a plan is being developed to review and update in according with Trust guidance on writing policies.	June 2017

Reference number	Trust Recommendations	Designated department	Action required	Date for completion/ timescale
18.	A risk assessment should be carried out to review the close proximity of the alcohol liaison office and the paediatric area.	**Assistant Director & Alcohol Liaison Nurse**	A review of clients that are seen in the Alcohol Liaison Office has been completed and the findings will be shared at the Acute Governance Meeting to agree the way forward.	Feb 2017
19.	A risk assessment should be carried out to review the open access of the department at night.	**Assistant Director & Head of Support Services**	As per the response to Q9 this will all be included as part of the review of security to be taken forward with the Head of Support Services and Assistant Director/Department Manager of ED. Engagement with the Trust Risk Management Department regarding all actions above.	Jan – March 2017
20.	Further IPC educational support and training should be provided to staff in ED.	**Practice Educator**	Practice Educator has requested IP&C for a half day of internal improvement work in ED – to be linked with weekly education days in ED.	Jan- Mar 2017
21.	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.	**Practice Educator**	Staff were reminded of their personal requirement to work within the Trust IP&C guidance in respect of ANTT and the correct use of PPE. Hand hygiene audits are on-going within the department and results shared as per system outline in question 3.	January 2017

Reference number	Trust Recommendations	Designated department	Action required	Date for completion/ timescale
22.	Clear, consistent and robust criteria for the issuing of identification wristbands within the ED should be introduced.	**Department Manager**	The Trust Patient Identification policy was revised in October 2016 with a section outlining the responsibility of ED staff and the use of patient ID bands.	Feb 2017
23.	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.	**Practice Educator**	Staff training session in use of the EWS has been held during September and October by the Practice Educator supported by the Resuscitation Team. All staff to be encouraged to complete online NEWS Training and gain certification in competence. Sister will complete NEWS audits and issues of concern raised through the appropriate processes. Development of robust action plans for under-performance and sharing of action plans with all staff.	Completed October 2016 Feb 2017
24.	A PEWS or similar record sheet with a recognised algorithm to guide staff on escalation and actions specific to paediatrics, should be available in the ED.	**Practice Educator**	An implementation plan to roll out PEWS has been established. This plan includes the correct completion of a PEWS chart and how to allocate the correct escalation plan for children.	Dec 2017 and ongoing

Reference number	Trust Recommendations	Designated department	Action required	Date for completion/ timescale
			An audit schedule will be developed following implementation of PEWS.	
25.	Mechanisms should be put in place to ensure the safety briefings convey important information and patient safety problems. All staff should be present during the safety briefings.	**Department Manager & Ward Sisters**	Safety briefings will be introduced formally from Feb 2017 with agreed criteria what will be included on the brief.	Feb 2017
26.	Formal daily reviews and routine senior medical and nursing walk rounds should be carried out.		Discussions are ongoing about the introduction of formal rounding of patients by nursing and medical staff with agreed protocols on the frequency and purpose of the rounding to be established by senior ED staff. This will be linked to the escalation plans as and when appropriate. Twice daily formal handovers in place at 9:00am and 4:00pm for medical staff. Shift handovers are well established and with the introduction of the formal rounding, more frequent systematic short discussions will occur between the nurse in charge, senior medical staff and the patient flow staff.	Feb 2017 Feb 2017

Reference number	Trust Recommendations	Designated department	Action required	Date for completion/ timescale
27.	A recognised assessment tool for all common frailty syndromes should be introduced.	**ED Medical Lead OPALS currently offer input 9am-5pm, 6 days per week**	This requires input from the medical staff. Currently being explored through Frail Elderly group.	May 2017
28.	Medicines should be stored safely and securely.	**Department Manager and ward Sisters**	Staffs have been reminded of their role and responsibilities towards the safe management of medication in line with Trust and NMC policies. A quality improvement approach to safe management of medications is being developed.	September 2017
29.	A robust medicines management process should be in place on attendance at the ED.	**Ward Sisters**	Pharmacist to develop a protocol for robust medicine reconciliations for those patients requiring admission from ED.	Jan –Mar 2017
30.	The administration of IV medicines by registered nurses should be reviewed.		A review of the staff trained and who administer IV medication is being completed and collected and agreement on how many are needed to meet the demand will be set. As part of the training needs analysis, administration of IV medications will be reviewed and the demand will be	March – June 2017

Reference number	Trust Recommendations	Designated department	Action required	Date for completion/ timescale
			addressed with aim at least 2 staff on shift who can complete this activity. Training on anaphylaxis training will be included. Development of nursing rotas should reflect the ability for nursing staff to have capacity to administer IV Antibiotics.	
31.	IV medication should be administered according to the prescribed timescales.	**ED Medical Lead & Department manager**	Staff were reminded on the need to ensure IV medications are administered according to the patients prescription and trust policies.	August to Sept 2016
32.	Nursing care records should be improved to accurately reflect completed risk assessments, care plans, patients' needs, their involvement in their care and be in line with NIPEC best practice guidelines.	**Practice Educator**	The Trust is actively engaged on the regional working group under the auspices of NIPEC's recording care work to develop and implement an ED nursing record for patients in the department over 4 hours. Criteria for completion of this document are still being developed with a plan to test in late Feb/March and then the record will be finalised. Use of the PACE framework is being considered for EDs and this will be a regional decision.	Feb - March 2017 for the pilot

Reference number	Trust Recommendations	Designated department	Action required	Date for completion/ timescale
33.	The trust should review the current provision of patients meals in ED to ensure an effective process is in place that meets the individual nutritional needs of the patient while in the department.	**Ward Sisters Support Services 10, 000 Voices Lead**	A systematic review of the provision of nutrition and hydration for patients whilst in ED, including clear identification of roles, responsibilities and service delivery has been undertaken. Patient attending the ED have been surveyed on their experience on the provision of food and drink with a report completed in early Jan 2017 and which will be shared with ED staff. The report is positive and shows an improvement with the provision of meals by the Trust and availability of snacks and how to obtain. Some areas have been identified for improvement and a plan is being put in place.	Mar 2017 Jan 2017
34.	Staff should ensure that the Braden risk assessment tool is completed and documented for patients who have been in the ED for more than six hours. Staff should be made aware of their role in prevention of pressure ulcers.	**Practice Educator**	Braiden scores and completion of same are all part of the regional work and are included in the ED nursing assessment booklet which is due to be piloted in Feb 2017.	February 2017
35.	A SSKIN care bundle or similar should be introduced for use within the ED.	**Practice Educator**	Work will be required to upskill staff in the elements of the SKINN bundle and this will be taken forward in conjunction with tissue viability.	February/ March 2017

Reference number	Trust Recommendations	Designated department	Action required	Date for completion/ timescale
36.	The structured process of Intentional Care Rounding or similar should be introduced within the department.	**ED Medical lead & Department Manager**	Please see answer to No. 26 above.	

The **Regulation** and
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