The Regulation and Quality Improvement Authority

Unannounced Hospital Inspection Report
5 – 7 December 2016

Daisy Hill Hospital

www.rqia.org.uk

Assurance, Challenge and Improvement in Health and Social Care

Contents

Membership of the Inspection Team

Hall Graham	Acting Director of Reviews Regulation and Quality Improvement Authority
Sheelagh O'Connor	Senior Inspector, Healthcare Team Regulation and Quality Improvement Authority
Lyn Gawley	Inspector, Healthcare Team Regulation and Quality Improvement Authority
Margaret Keating	Inspector, Healthcare Team Regulation and Quality Improvement Authority
Thomas Hughes	Inspector, Healthcare Team Regulation and Quality Improvement Authority
David Philpot	Project Manager Regulation and Quality Improvement Authority
Paulina Spychalska	Inspection Coordinator Regulation and Quality Improvement Authority
Dr Lyndsey Thompson	Clinical Leadership Fellow Regulation and Quality Improvement Authority
Olive Macleod	Chief Executive Regulation and Quality Improvement Authority
Theresa Nixon	Director for Mental Health, Learning Disability and Social Work Regulation and Quality Improvement Authority
Dr Lourda Geoghegan	Medical Director
Lorna Bingham	Registered Nurse, Deputy Associate Director of Nursing/Manager GP out of Hours Belfast Health and Social Care Trust
Jenny Braiden	Registered Nurse, Deputy Ward Manager, Emergency Department, Belfast Health and Social Care Trust
Jenny McMahon	Registered Nurse, Clinical Coordinator Surgical Directorate Belfast Health and Social Care Trust
Dr Sara Lawson	Paediatrician, Adept Fellow Belfast Health and Social Care Trust
Dr Neil McLoughlin	Anaesthetic, Speciality Registrar South Eastern Health and Social Care Trust
Helen Daly	Inspector, Pharmacy Team Regulation and Quality Improvement Authority
Judith Taylor	Inspector, Pharmacy Team Regulation and Quality Improvement Authority
Alan Craig	Lay Assessor
Neill Wallace	Lay Assessor

1.0 What We Look for

We assess if services are delivering, safe effective and compassionate care and if they are well led.

2.0 How We Inspect

To prioritise the areas we visit, we consider a range of factors including risk, quality and the context of the services.

These may include, for example, wards/departments:

- where previous inspections or our intelligence monitoring has flagged a concern or risk
- about which we have received a complaint, there has been a safeguarding alert or we have heard a disclosure from a whistle blower
- we have not inspected for a long period or have not previously inspected at all
- we have been made aware of areas of good practice
- a request has been made by the Department of Health, Health and Social Care Board or Public Health Agency
- which have been subject to media attention

We review a range of intelligence relevant to the service including: ward performance reports, healthcare associated infections rates, quality indicators, improvement plans and ward and trust wide governance documents.

Each hospital is assessed using an inspection framework. The approaches used include; observation of practice; focus groups with staff; discussion with patients and relatives and review of documentation. Records examined during the inspection include: nursing records, medical records, end of bed charts, staffing levels and rotas, performance reports and training records.

Acute Hospital Inspections will be led by Regulation and Quality Improvement Authority's (RQIA's) Medical Director, and carried out by Healthcare Team inspectors and other specialist RQIA inspectors. A senior Northern Ireland Medical and Dental Agency post-graduate trainee may be involved in our Acute Hospital Inspection Programme, thus providing medical representation and input to the team. RQIA is working in partnership with universities in Northern Ireland to provide opportunities for year three nursing students to participate, as observers.

Each inspection is supported by the use of peer reviewers (staff who are engaged in the day to day delivery of health and social care) and the use of lay assessors (service users and members of the public and who bring their own experience, fresh insight and a public focus to our inspections).

Guidance documentation related to the Acute Hospital Inspection Programme can be accessed on RQIA's website.
https://www.rqia.org.uk/guidance/guidance-for-service-providers/hospitals/

3.0 Profile of Service

Daisy Hill Hospital is one of two acute hospitals that make up the Southern Health and Social Care Trust. The hospital has a 24 hour Emergency Department (ED), a maternity department, special care baby unit and provides a range of inpatient beds including - medicine, stroke, rehabilitation, surgery, gynaecology, ear, nose and throat and paediatrics. The hospital has a coronary care unit, a surgical high dependency unit, a day procedure unit, endoscopy unit, elective admissions and day clinical unit and a radiology department. A 28 station, adult sub-regional haemodialysis unit is based within the hospital. The hospital offers a wide range of diagnostic and therapy services, with mental health and general practitioner (GP) out of hours services also provided from the hospital site.

Responsible person:	**Position:**
Mr Francis Rice	Interim Chief Executive Officer

4.0 Inspection Summary

An unannounced inspection was undertaken at Daisy Hill Hospital over three days from Monday 5 December to Wednesday 7 December, 2016. The following areas were inspected:

- Female Medical Ward
- Emergency Department

Female Medical Ward

The leadership and governance systems within the ward promote the delivery of safe, effective and compassionate care. We observed that senior ward nursing and medical staff were visible, approachable, suitably experienced and were leading effectively. Nursing staff told us that morale was good and they feel respected and valued.

Throughout the inspection, we observed that staff responded compassionately to patients' care needs. Patients were spoken to and given information in a way that they understood. We observed that staff ensured patients' privacy and dignity were maintained at all times.

Ward nursing normative staffing levels were achieved. Staffing levels and skill mix are planned, implemented and reviewed. Some staff however reported that with reduced staff numbers at night, they can sometimes find it challenging to be responsive to patient needs. Staff have received the appropriate training to carry out their role and are supported to further develop their professional skills and experience.

Junior doctors highlighted many areas of good practice on the ward including high quality, regular teaching and supervision, an emphasis on quality improvement and good team-working at all levels. They did however highlight concerns over staffing levels, especially at evenings, nights and weekends and reported not always feeling involved in decision - making about patient care.

Systems to manage and share information needed to deliver care were in place; however the frequency of team meetings and safety briefs should be increased. Staff work collaboratively with other members of the multidisciplinary team (MDT) to understand and meet the range and complexity of patients' care needs. We were informed that reduced allied health professional (AHP) services at weekends can sometimes cause delays in patient assessment, intervention and subsequent discharge.

We were told that openness, transparency and candour are encouraged on the ward and lessons are shared and acted upon.

Staff were engaged in activities to monitor and improve quality performance. Systems were in place to protect patients from the risk of abuse.

The ward was observed to be clean and although showing some signs of age-related wear, it was maintained to a good standard. Adaptations were in place to meet the needs of patients with dementia and those with a physical disability. The sharing of a resuscitation trolley with the adjacent coronary care ward was identified and reported as a risk to patient safety.

We observed that medicines were secured safely and there was evidence of some integrated medicines management. Patients confirmed that they were informed and involved in the decisions made regarding their medicines. A system to monitor antimicrobial prescribing was in place. Further improvement is required in relation to the segregation of medicines, as we observed medicine blister packs being stored loosely out of their packaging.

Staff reported that they can access the information they need to assess, plan and deliver care to patients in a timely way. Patients had a comprehensive nursing and medical assessment of their needs, however some nursing risk assessments were not always re-evaluated. We observed that for some patients, venous thromboembolism (VTE) risk assessments were not completed and clinical observations were not always undertaken at the prescribed frequency. A sepsis bundle to ensure the recognition and timely management of sepsis was not in place.

The meal service was good, however could be enhanced by designating a staff member to coordinate the service and prevent any unnecessary disruption to patients during mealtimes. There was a good menu choice that included meals for specialised diets. The recording of patients' food and fluid intake was not always up to date.

Staff were knowledgeable with regard to pressure ulcer and continence care.

Feedback from patients and relatives was mostly positive about staff treatment of patients, reporting that staff listened and responded to their care needs in a timely manner and that their privacy and dignity were maintained. Some patients told us that sometimes, especially at night, there were not enough staff to deliver care and that they did not always know who to speak to about their concerns.

Some Patient and Relative Comments

'It is spotless. They never stop cleaning.'

'The staff seem rushed at times especially at night. I do not feel they have enough staff to cope at night.'

Emergency Department

The department was well led; both the lead ED consultant and nurse-in-charge were visible and took an active role in co-ordinating the department. The department was well staffed and there were good governance systems in place to support staff to carry out their role in a safe, effective and compassionate manner. We observed patients and relatives being treated courteously and with sensitivity. Staff introduced themselves and included patients in general conversation, even when the department was particularly busy. Staff clearly explained - prescribed clinical procedures and next steps in patient care.

Staff told us they were well supported by their line manager and senior management. There was evidence of good staff retention; nursing staffing levels exceeded funded levels and additional band 6 and band 7 positions were in the process of being filled. We were advised that the ED consultant was due to retire and that recruitment was actively progressing (with interviews scheduled) - to secure a replacement consultant.

There was evidence of good multi-disciplinary team working, for example we were advised and saw evidence of weekly team meetings, improvement groups and patient surveys. Staff were kept informed through various formats such as regular handovers, safety briefings, staff meetings, emails and speciality link nurses. We observed and were told by staff of the good working and supportive relationship with other health professionals providing service to the ED, in particular radiography and portering staff. An area for further improvement would be the introduction of regular joint nursing and medical walk arounds.

Junior doctors reported were well supervised and felt supported in their clinical decision-making. They stated that they had good working relationships and good communication with other specialities. They reported they attended the twice weekly ED consultant-led review clinic and the daily x-ray review clinic.

Staff training was up-to-date; however appraisals and supervision for nursing staff need to be prioritised, especially when expected newly-appointed nursing staff commence in post.

The department is well equipped and in good decorative order. We observed however that at times of peak patient flow the area can become congested. There was a lack of rooms or private areas to carry out patient observations.

We observed good compliance with general infection prevention and control practices within the department, however staff require an update on the correct use of personal protective equipment (PPE) and aseptic non touch technique (ANTT) practices.

We observed good staff awareness of ensuring patients were hydrated and in receipt of appropriate meals. The delivery of the food service could be improved with the provision of water dispensers and patient kitchen facilities. Staff were delivering these services to patients from their own staff room.

Nursing care records were completed for patients in the department for six hours or more, however some risk assessments were either not competed or not re-evaluated.

We observed that patient admission care records (flimisies) were not categorised in order of time or triage category, with no separation between categories. Some of the investigation results and management plans were not documented and/or clearly legible.

Staff introduced themselves when delivering care and protected patient privacy by ensuring curtains were drawn. Patient call bells were available but not placed within patient reach. Staff frequently asked patients if they required pain relief. Pressure relieving equipment was ordered promptly and was available.

Junior doctors reported they felt well supported and were supervised in their clinical decision making. Although there was a heavy reliance on locum doctors within the department, this was not seen as an issue as many of the locum doctors were working in the department for some time (or a long time) and therefore were providing continuity of service (or care).

We were told that the medical handover arrangement was informal and could potentially cause confusion over designated responsibility for individual patients. Entries on patients' notes were not always fully compliant with General Medical Council (GMC) guidance. There was a sepsis documentation sticker present in patient notes to summarise investigations and management, but in the case notes we reviewed this was not completed.

We observed that medicines were stored safely in a dedicated room within the department. A new system to store and maintain the stock control of medicines had been introduced; some areas for improvement were identified regarding the storage and segregation of medicines.

Feedback from patients and relatives was mostly positive, reporting that staff were attentive and that privacy and dignity was maintained. We were told that the department can be busy, crowded and there is sometimes not enough staff to deliver care. Patients did not always know who to speak to about their concerns.

Some Patient and Relative Comments

'More information about what is going on would be helpful.'

'So far everything has been fine.'

'Perfect! I have been in other hospitals and this is very clean.'

'They are very busy. I was not happy about the delay we were kept four hours after triage.'

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

4.1 Inspection Outcome

Following the inspection, detailed feedback was provided to ward sisters and staff within the ward and department inspected. This highlighted areas of good/best practice observed and also issues for improvement that could be addressed immediately. High level feedback which included areas of good practice and those for improvement was also provided to trust senior staff.

As this was an initial inspection of these clinical areas (Female Medical Ward and Emergency Department), there were no previous areas for improvement to be reviewed. Escalation procedures (as available on the RQIA website) were not required during this inspection.

www.rqia.org.uk/who-we-are/corporate-documents-(1)/rqia-policies-and-procedures/other-rqia-policies-and-procedures/rqia-escalation-policy-and-procedure/

Inspection Findings
Executive Management Team

5.0 Inspection Findings: Executive Management Team

On the second day of this inspection RQIA's Executive Management Team (EMT) met with the trust's EMT to discuss overarching trust governance and management issues. Areas of good practice were acknowledged and clarification was sought on areas identified during the inspection.

During discussion, the trust advised that the hospital is very busy, with around 50,000 attendees to the ED per year. There is a mixed patient population including the elderly, children and patients attending from the Republic of Ireland. There has been a 10 % increase in adults and 7 % increase in paediatric attendees to ED. We were told that the hospital estate was built in the 1970s and buildings are small and cramped.

RQIA sought clarification on the use of medical locums and progress on the recruitment of a senior medical consultant in ED; as the current post holder is to retire in January 2017. The trust advised and RQIA recognise the regional and national challenges relating to recruitment of medical staff to the ED. The trust advised that in past recruitment drives there have been no applicants for the post of senior medical consultant, however some interest has been received and the trust is hopeful that this post will be filled in the near future. All locums working within the ED are long term staff; this is preferable to short term locums where it may be difficult to maintain continuity of service and training standards at senior level.

Discussion arose in relation to the care of elderly patients, especially those with dementia and the level of nursing staff input to care for these patients. Mental health patients who attend ED have access to a 24 hr referral service. An ambulatory ward is available at Craigavon Area Hospital however this is not yet established on site in Daisy Hill Hospital. Once in place, the use of this ward is expected to result in fewer patients coming into the ED for admission in the future. On discussion of delayed discharges, the trust advised that a variety of care pathways are available; however there are some constraints with the capacity and provision of private domiciliary care packages in community settings. A range of actions are in place and being taken forward to address this.

The trust EMT advised that there are regular onsite visits from members of the EMT, with formal and informal walk rounds. The trust told us that in order to engage medical staff further, senior clinicians are reviewing the terms of reference for medical committee meetings. This is to give medical staff more opportunities to be innovative and try new models of care. We were told by the trust EMT that results of renal patient clinical outcomes are the second best in the United Kingdom.

The trust identified that senior staff were very committed and supportive, however as senior staff retire or leave this may not always be sustainable.

We were advised that all trust staff and teams work and think collectively to deliver patient care. We were told that staff were positive about the inspection and appreciated the fact that they had been directly observed caring for patients.

RQIA considered that all staff are working very hard, with no down time. ED is under pressure due to an increased numbers of patients attending. However, nursing staff levels are good and staff told us they feel supported and valued. The senior team is visible in the ED and Female Medical Ward, and there is a strong sense of effective MDT working.

Inspection Findings
Female Medical Ward

6.0 Inspection Findings: Female Medical Ward

The female medical ward is situated on the 5th floor of Daisy Hill Hospital (Picture 1). The ward has 34 beds consisting of both multi-bedded bays and side rooms. The ward provides care for female patients presenting with a wide range of medical conditions.

Picture 1: Entrance to the female medical ward

6.1 Is Care Safe?

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

Areas of Good Practice

- The ward was observed to be clean and uncluttered and although showing some signs of age-related wear, it was maintained to a good standard.

- There were adaptions to meet the needs of patients with dementia, such as large clocks and clear pictorial signage (Picture 2). Fire safety and life support training were part of a ward staff mandatory training programme. There was sufficient moving and handling equipment, and adaptions throughout the ward to meet the needs of patients with physical disabilities.

Picture 2: Dementia friendly clock

- A range of consumables was available to enable hygiene practices to be carried out effectively. Clinical hand washing sinks were clean, located near to the point of care and were observed to be only used for hand hygiene purposes. We saw regular use of these facilities by staff, in addition to hand decontamination with alcohol rub. Staff were able to demonstrate when ANTT procedures should be applied, and invasive devices were managed in line with best practice. Patients identified with an infection prevention and control (IPC) risk had been isolated to minimise the risk.

- Staff told us that openness, transparency and candour in reporting safety incidents is encouraged. Staff were engaged in activities to monitor and improve quality and safety. Safety incidents are investigated with all relevant staff.

- There was a system in place to monitor falls and preventable pressure sores. Appropriate information relating to these systems was displayed on the ward notice board. This real time data helps to raise awareness within the ward team and promotes good practice in improving patient safety.

- Systems were in place to protect patients from the risk of abuse and to maintain their safety in line with current best practice guidelines.

- Medicines were stored securely in the medicine trolleys and pharmacy room. Staff were familiar with critical medicines and their timely administration. Injectable medicines were prepared and administered by two registered nurses. This safe practice was readily facilitated by the availability of a designated medicines preparation area. There was evidence of some integrated medicines management on the ward and most of the kardexes were well maintained. A system to monitor antimicrobial prescribing was in place. Patients confirmed that they were informed and involved in the decisions regarding their medicines.

Areas for Improvement

- The ward shares a resuscitation trolley with the adjacent coronary care ward. Some staff reported that the sharing of the trolley between two large wards presents a risk to patient safety. This practice should be reviewed taking into specific consideration the acuity of the patients within these wards. We observed that some emergency medicines on the resuscitation trolley had passed their use-by date.

- We observed that not all staff adhered to standard IPC precautions for example not being bare below the elbow when in a clinical environment and not using appropriate PPE when there was a risk of body fluid contamination.

- We observed that while National Early Warning Scoring System (NEWS) charts, to facilitate early detection of deterioration, were in place for patients' vital signs these were not always undertaken at the prescribed frequency. We observed variation relating to nursing staff documentation of triggered responses to patient NEWS scores, with some staff recording triggered responses on the back of the NEWS chart and others recording the response within the nursing notes.

- A sepsis screening tool for the timely initiation of treatment of patients with sepsis was not in place. We were informed that plans are in place to introduce the Sepsis Six care bundle within the ward. This should be expedited.

- Patients admitted to the ward are required to have an assessment of their risk of developing a venous thromboembolism (blood clot in the vein). VTE risk assessments were not always completed, notably for one patient had multiple risk factors for VTE. When blood cultures were taken, the time, date and site of these cultures was rarely documented.

- There were some areas for improvement in medicines management, particularly in relation to storage. Medicines were not always segregated correctly, blister strips were stored loosely and the opening dates of medicines with a limited shelf life were not always recorded.

Recommended Actions

1. **Staff compliance with standard IPC precautions should be improved and assured.**

2. **Access to resuscitation equipment should be reviewed to ensure equipment is readily available and easily accessible to all patients in line with best practice guidelines. All equipment should be in date, with an effective monitoring system in place.**

3. **The Sepsis Six bundle should be introduced and its implementation assured.**

4. **The storage of medicines should be reviewed and monitored to ensure that all medicines are stored safely, securely and in accordance with the manufacturer's instructions.**

5. **The ward should improve and monitor the completion of documentation related to VTE risk assessment, blood cultures, NEWS observation charts and standardised recording of NEWS triggered responses.**

6.2 Is Care Effective?

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

Areas of Good Practice

- Staff reported that they can access information required to assess, plan and deliver care to patients in a timely way. We observed that patients had a comprehensive nursing and medical assessment of their needs, which included consideration of clinical needs, mental health, physical health and wellbeing. Care and treatment delivered was regularly recorded and updated within patient notes. The ward had introduced a new initiative called PACE in full. This initiative is aimed at improving documentation, through taking a more person/ family centred approach to care planning.

- There was a good menu choice, including provision for specialised diets. Meals were served warm, looked appetising and were of a good portion size. Patients were provided with jugs of fresh water, which were within easy reach. A number of mechanisms were in place to identify patients that require assistance at meal times e.g. discrete symbols on an electronic white board. Patient nutritional supplements were prescribed and administered appropriately.

- Patients reported that when they experienced physical pain, discomfort or emotional distress, staff responded in a compassionate, timely and appropriate way. Pain relieving comfort measures were available. The pain team and palliative care team were available within the hospital for advice and support. We observed that pain medication was administered as prescribed in medicine kardexes.

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

A validated pressure ulcer classification tool and wound charts are used to guide management.

- Staff were observed providing patients with the appropriate assistance to promote continence and care for incontinence. Staff have access to continence/stoma specialist services. Stoma/continence aids for example commodes and bedpans were available on the ward if required. Stool charts were in place and used appropriately for patient conditions.

Areas for Improvement

- We observed that nursing risk assessments were not always revaluated following initial assessment.

- The pain assessment section on NEWS charts was not routinely completed. We observed that patients identified as high risk of developing a pressure sore were not always commenced on a pressure sore prevention pathway.

- Within medical notes, improvements could be made in the areas of documentation of GMC number and details of amendments/deletions.

- A protective meal service was in place; however we observed some unnecessary disruption to patients during mealtimes for tasks such as venepuncture. The meal service could be enhanced by designating a staff member to coordinate the service and prevent any unnecessary disruption to patients during mealtimes. We observed that not all staff participated in the collection of food trays after meal service, to accurately identify intake at mealtimes. This was reflected in poorly completed fluid and food charts.

Recommended Actions

6. **A staff member should be designated to supervise and coordinate meal service. All staff should ensure that there is no unnecessary disruption of patients during mealtimes.**

7. **The ward should improve and monitor the completion of medical notes and documentation related to nursing risk assessments, pathways, fluid balance and food charts.**

6.3 Is Care Compassionate?

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

Areas of Good Practice

- Throughout the inspection we observed caring and committed staff. Patients were treated with kindness and respect while they received care and treatment. Staff ensured that patients' privacy and dignity were maintained. Staff engaged well with patients and provided easily understood explanations prior to carrying out care.

- The ward was bright and welcoming. Same sex accommodation was maintained throughout the inspection. There are adequate supplies of laundry to meet the needs of the ward. There was good signage to direct visitors to the ward. Where required, there was discreet signage relating to fasting, communication aids, nutritional assistance and IPC precautions.

- Trust information was available in various formats and different languages. Staff can request interpreting services for face-to-face or telephone interpreting, and for the translation of documents.

- On discussion with staff it was evident that they were passionate about the delivery of quality care for patients at the end of life. A number of staff had received additional palliative care and bereavement training. During the inspection, members of the Macmillan care team, who were supporting and guiding care practices, were a continuous presence on the ward. We observed that when a decision to apply an in full 'do not attempt resuscitation' order was made, the form was comprehensively completed with evidence of patient and family involvement in decision making.

- Family and carers have access to complimentary car parking and can remain with their relative while they are on the ward. Bereavement and patient support services were available on request (Picture 3).

Picture 3: Displayed patient support services poster

Areas for Improvement

- Comfort or intentional care rounds were not always documented as completed for patients.

- A quiet room was not available for private conversation. We were informed that an area at the entrance to the ward is being refurbished to facilitate a quiet room.

- We observed that the number of sanitary areas is inadequate for the number of ward patients. The ward contains only two shower rooms. Staff reported that toilets are small, making it challenging to assist patients with toileting needs. Staff reported that raised toilet seats were not in use, but would be beneficial to those patients with limited mobility.

Recommended Actions

8. **As part of any ward refurbishment or new build planning, the number and size of sanitary facilities should be improved.**

9. **Patient comfort rounds should be recorded and assured in line with trust guidance.**

6.4 Is the Area Well Led?

The clinical area is managed in and organised in a way that patients and staff feel safe, secure and supported.

Areas of Good Practice

- The leadership and governance systems within the ward promote the delivery of safe, effective and compassionate care.

We observed that senior ward nursing and medical staff were visible, approachable, experienced and were leading effectively. Nursing staff told us that morale was good and that they were supported and valued by the ward sisters.

- A review of records indicated that ward nursing normative staffing levels were achieved. The funded nursing establishment is 43.86 whole time equivalent and there were no current staff vacancies. We were informed that staff retention is good. Sickness absence rates were 6.5% of the total establishment. Staff sickness is being actively managed in line with trust policy and supported with advice from the trust's human resources and occupational health departments.

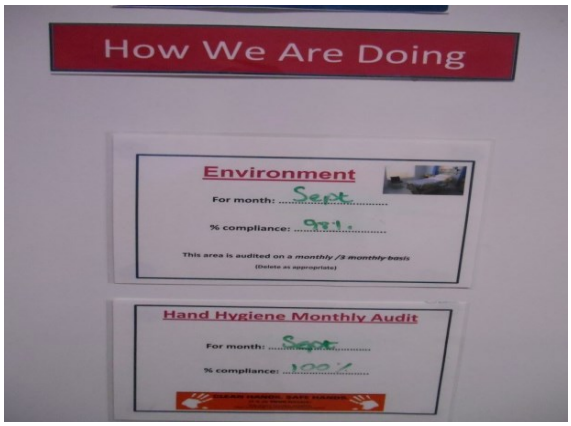
- Staff told us they are supported in their role through meaningful and timely supervision and appraisal; staff talked positively about these processes.

- Junior doctors highlighted many areas of good practice on the female medical ward including high quality, regular teaching, high level of supervision, an emphasis on quality improvement and good team-working at all levels.

- Staff had good access to a range of policies on the trust intranet site and systems were in place to ensure that all ward staff were familiar with new policies or procedures. Staff have received mandatory and role-specific training to enable them to carry out their roles effectively. Staff were aware of the process to report incidents including serious adverse incidents and near misses and were kept up-to-date with learning from incidents and complaints.

- Ward staff work collaboratively to understand and meet the range and complexity of patients' needs. It was reported that there was good MDT ward input and support, with effective MDT meetings. The ward had 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. Where there were patients outlying, there is a system in place to ensure that these patients are appropriately reviewed.

- There was evidence of assurance of systems for quality and safety on the ward. Staff were knowledgeable about how the ward performs against quality indicators. The ward displayed up-to-date safety and performance information for both patients and staff (Picture 4).



Picture 4: Displayed ward performance information

- Known hazards in the ward environment had been risk assessed and preventive actions implemented. There was evidence that identified risks included on the directorate risk register are prioritised and mitigated in relation to issues identified on the ward (Clinical management of medical outliers).

- We observed the morning nursing staff handover. The handover was focused and structured by the deputy sister. Patient information was comprehensive and delivered verbally using electronic handover sheets. We were told that there is also an effective system in use for medical handovers.

- The views of patients that use the ward are seen as vital to learning and improvement. We were informed of a number of initiatives that have been employed to capture patient experience and satisfaction.

Areas for Improvement

- The band 6 deputy sisters were not easily recognisable from other nursing staff, by their uniform. We were informed that this issue will be addressed following the introduction of a new regional uniform.

- We were informed that AHP services are mostly available during the core working week (Monday to Friday). At weekends this can cause delays in patient assessment, intervention and subsequent discharge.

- Some junior doctors on the ward had concerns over staffing levels, especially at evenings, nights and weekends and are having to frequently stay late to complete daily tasks. They stated that a proportion of their time is being spent performing tasks that could be performed by other staff, such as venepuncture and insertion of cannulae. Junior doctors on the ward also reported that they did not feel involved in decisions about patient care and felt under pressure to prioritise discharges, occasionally over patient care.

- We observed that a large number of patients being cared for within the ward were 'confused', as a result of an underlying condition. Some staff reported that with reduced staff numbers at night it can be challenging for staff to be responsive to patient needs when much of their time is spent managing patients with unpredictable behaviours as a result of their confusion.

- We observed a number of mechanisms to disseminate information to ward staff. Ward staff meetings are however an infrequent occurrence. Scheduled ward meetings should be introduced as they are an effective means for communicating information and gathering input from ward staff.

- A safety brief occurs once daily, each morning at 07.30. The inspection team considered that the frequency of the safety brief should be increased to at least twice daily to ensure that night duty staff have good awareness of key daily safety issues.

- Some health care support workers do not attend the morning nursing handover as they remain on the floor to ensure that patient care needs are met. We were informed that following handover they are not always provided with a comprehensive handover of patient information.

- We were informed that medical ward rounds occur in the morning however their time is unscheduled. We observed that trained nursing staff were not always available to participate on these rounds, as many occur simultaneously. It is essential that nursing staff participate in ward rounds as they play a crucial role in delivering holistic patient care and ensuring patients receive and understand relevant information about their care.

Recommended Actions

10. **AHPs as required should be available at weekends to ensure timely assessment, intervention and discharge of patients.**

11. **Nurse staffing levels on the ward during the night should be reviewed.**

12. **All ward nursing staff should receive a comprehensive handover of patient information. Nursing staff meetings and safety briefs should be increased in frequency.**

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

14. **The role of junior medical staff on the ward should be reviewed to ensure greater input into patient care and decision-making.**

6.5 Quality of Interaction Schedule /Questionnaires/Observations

During inspections the views and experiences of patients and service users are central to helping the inspection team build up a picture of the care experienced in the areas inspected.

We use questionnaires to allow patients and relatives to share their views and experiences. The inspection team also observed the communication and interactions between staff and patients and staff and visitors. This is carried out using the Quality of Interaction Schedule (QUIS)[1].

Findings are presented from a composite perspective, combining the patient and relative perceptions.

Questionnaires

We were told by patients that their privacy and dignity was maintained. Staff were courteous, however did not always use the patient's preferred name. Generally staff listened and responded to their care needs in a timely manner; however this can be affected by the busy nature of the ward. Patients identified that sometimes, especially at night, there were not enough staff to deliver care.

Patients told us they did not always know who to speak to about their concerns, however were generally satisfied with the information they received regarding there expected length of stay. They are satisfied with the environment and the meal service available.

Patient Comments

'It is spotless. They never stop cleaning.'

'Perfect! I have been in other hospitals and this is very clean.'

'It is not clear to me who is in charge.'

'Staff and especially doctors do not have time to speak to me.'

Relatives told us staff were courteous to them, their relative was treated with dignity and respect and they were satisfied with the care they received. However, it was identified that relatives did not always know who to speak to about concerns and that there were not always enough staff to deliver care.

[1] https://www.rqia.org.uk/guidance/guidance-for-service-providers/hospitals/

Relative Comments

'The staff are under pressure and seem to rush all day. Too much time is spent on paper work.'

'More staff are needed to help with pressures.'

Observation

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

We observed positive interactions between staff and patients. Staff engaged in conversation when delivering care, providing support, encouragement during the delivery of care and treating the patient as an individual. Patient's privacy and dignity was generally maintained.

However, we observed that when the ward was busy staff could become task orientated for example when dispensing medication.

Inspection Findings
Emergency Department

7.0 Inspection Findings: Emergency Department

The ED in Daisy Hill Hospital is separated into four distinct areas. Resuscitation can accommodate three patients in cubicles. The minors area has four cubicles and the majors area has six cubicles and a single room. The recently refurbished paediatric area has a waiting room and an investigation room. A negative pressure isolation room is adjacent to the paediatric area.

7.1 Is Care Safe?

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

Areas of Good Practice

- The area is bright and in good decorative order. The patient seated area at reception was clean and there was good access to sanitary facilities. Patient cubicles were light bright, spacious and well equipped (Picture 5).

Picture 5: Cubicle in Minors

- A range of hand hygiene consumables was available. Alcohol gel, PPE dispensers and clinical hand wash sinks located throughout the department were all clean, in good repair and used regularly and appropriately by staff.

- Nursing assessments were completed as required for patients who are in the department for more than six hours.

- A new system to store and maintain the stock control of medicines was introduced in July 2016; staff advised that this had a positive impact on medicines management and reduced the work load for nurses (for example not having to look for keys (Picture 6)). There was a system in place to monitor antimicrobial prescribing.

Picture 6: Omnicell medicine storage system

- NEWS charts were well documented and we evidenced appropriate clinical responses to NEWS triggers.

Areas for Improvement

- We observed that at times of congestion, the lack of space within the ED challenged staff's ability to deliver care. We were told that Monday is always a busy day in the department with the added pressure of a Monday review clinic. We observed additional pressure on staff trying to access private areas within the department to carry out patient observations and investigations, for example performing electrocardiogram's or venepuncture.

- Cleaning schedules were in place for nursing and domestic staff, however there were some instances where surfaces and patient equipment required further cleaning.

- Daily checks are carried out on the resuscitation and airways trolleys however we observed out-of-date items in both trolleys.

- Phlebotomy trolleys and wipeable trays were not always used when nursing staff were carrying out an ANTT procedure.

- We observed staff did not always perform hand hygiene in line with the five moments of care and did not always adhere to best practice when wearing aprons or gloves.

- Some areas for improvement in medicines management related to storage.

Medicines were not always segregated correctly, blister strips were stored loosely and medicines with a limited shelf life once opened were not dated.

- We did not observe regular joint consultant and nurse in charge, patient reviews and safety rounds.

- The current practice of storing flimsies on top of a procedure trolley in minors and on the desk top in majors needs to be reviewed as there is potential for error. We observed that flimisies were not categorised in order of time or triage category, with no separation between categories. Some of the investigation results and management plans were not documented and/or clearly legible.

- Medical records were of satisfactory standard, but the need to date, time, print, sign and include GMC number at each entry made should be emphasised. Documentation in relation to the taking of blood cultures was fully completed. In reference to sepsis management the time, date and site when blood cultures were obtained was not documented. There was a sepsis documentation sticker present to summarise investigations and management, but this was not completed in the records we reviewed.

Recommended Actions

1. **A review of the use of facilities and the scheduling of clinics should be undertaken in response to the congestion in the department at times of increased patient attendance.**

2. **Effective monitoring systems should be in place to ensure daily equipment checks, cleaning schedules and clinical practices are carried out and assured compliance checked.**

3. **Staff compliance with standard IPC precautions should be improved and assured**

4. **The storage of medicines should be reviewed to ensure that all medicines are stored safely, securely and in accordance with manufacturers' instructions.**

5. **The department should improve and monitor the completion of documentation related to medical records and in particular the management of sepsis.**

6. **Joint medical and nurse in charge safety rounds should be introduced.**

7. **A robust system should be implemented and monitored to ensure the appropriate storing and categorising of flimsies.**

7.2 Is Care Effective?

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

Areas of Good Practice

- Invasive device documentation and patient end of bed charts were well completed. Patients reported that they were comfortable and we observed staff frequently asked patients if they required pain relief.

- Junior doctors told us that they are well supervised and feel supported in their clinical decision making, with consultants described as approachable and supportive at all times. They describe very good relationships with other specialties, leading to effective and efficient communication and patient management. Junior doctors are supported by 'safety nets' such as a twice weekly ED consultant-led review clinic, and daily X-ray review.

- Junior doctors described a high proportion of locum doctors on junior, middle-grade and consultant rotas. They felt this wasn't a large issue as many of the locum doctors were working in the department for some time (or a long time) and therefore were providing continuity of service (or care).

- We observed patients' nutritional and fluid needs were met, meals were available and patients were encouraged to drink fluids regularly. Snacks were available during the evening and night.

- Patients appeared comfortable and appropriately positioned, with pressure relieving equipment in use. It was reported that pressure relieving equipment is ordered and is delivered promptly when required.

- Staff were observed providing patients with the appropriate assistance to promote continence and care for incontinence. Documentation for those patients with a self-retaining catheter was completed in detail. Staff had access to specialist services and equipment.

Areas for Improvement

- We found that nursing risk assessments had not always been completed and re-evaluated and there was no evidence of comfort rounds.

- A review of patients' notes demonstrated the prescription and administration of pain relief needs to be more timely.

- Medical staff described inadequate handover arrangements. We were told there is currently one handover per day and this is on an informal basis in a non-private setting. This may lead to confusion over responsibility for patient care.

- We were told that medical cover at night has recently been improved, with two first-tier junior doctors present in the department overnight. However, the current medical staff told us this could be improved by changing the seniority of those present overnight, to one first-tier and one middle-tier doctor, which would improve decision making.

- While a nurse in each area of the ED had responsibility for ensuring that their patients received a meal, there was no designated person responsible for the overall supervision or co-ordination of the meals service. We observed that suitable tables were not available for patients being served meals; we were told five were on order.

- The department does not have access to a patient kitchen or water dispensers; staff make tea and toast and fill flasks and water jugs in their staff room for patient use.

Recommended Actions

8. **The structured process of Intentional Care Rounding or similar should be introduced.**

9. **Medication should be prescribed and administrated in a timely manner.**

10. **Medical handovers should be formalised.**

11. **The department should review the level of medical seniority present overnight.**

12. **The system and equipment in place for meal service and the promotion of patients' nutritional and hydration needs should be improved. A staff member should be designated to supervise and coordinate meal service and all equipment required should be readily available.**

7.3 Is Care Compassionate?

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

Areas of Good Practice

- Patients privacy was maintained at all times, cubicle curtains were pulled and staff checked before entering or opening curtains. There was an adequate supply of linen for the needs of the department.

- We observed staff treat patients and relatives courteously and with sensitivity; they introduced themselves, and included patients in general conversation. Staff explained any clinical procedures and next steps in care.

- There was good signage and identification of areas and access to information leaflets (Picture 7).

Picture 7: Signage in ED

- Family and carers have access to complimentary car parking and can remain with their relative while they are in ED. Information and bereavement support systems were available for patients and carers and these are signposted on the trust website. Chaplaincy services are available on request and a family room is located in the department.

Areas for Improvement

- Call bells were available, however were not placed within the patients reach.

- There was only one toilet for patients to access when in the clinical area of the department. The emergency pull cord was missing.

- We observed not all staff wore identification badges.

- We were told that there was no formal ED policy for end of life care and not all staff were knowledgeable on the trust's Care of the Dying Patient: Guidance for Personalised Care.

Recommended Actions

13. **As part of any ward refurbishment or new build planning, the number and size of sanitary facilities should be improved.**

14. **Patient call bells should be accessible, within easy reach of the patient at all times.**

15. **Staff should ensure identification badges are worn at all times.**

16. **The department should ensure staff are aware of the trust policies for end of life care.**

7.4 Is the Area Well Led?

The clinical area is managed in and organised in a way that patients and staff feel safe, secure and supported.

Areas of Good Practice

- The trust has taken the positive step of reviewing nursing staff levels to ensure they meet the department's needs (in the context of having not received additional funding). There is good staff retention, interviews for two band 6 nursing posts in progress and funding has been secured for a band 7 practice nurse facilitator.

- Staff had good access to a range of policies on the trust intranet site and have received mandatory and role specific training to enable them to carry out their roles effectively. Staff were aware of the process to report incidents and were kept up-to-date with learning from incidents and complaints.

- We observed effective nursing handovers, regular review of staffing numbers and rotation of staff to ensure best placement and professional development of staff. There was strong evidence of effective communication and dissemination of information to staff at all levels. Following the report of the 10,000 voices initiative, a patient satisfaction survey had been introduced in the department.

- We evidenced proactive medical and nursing staff. Examples include that following a review of safety incident trends, the department developed its own mental health risk assessment to address the management of patients who abscond from the department. Following implementation of the policy, recent data have demonstrated a reduction in the number of absconders. In response to health visiting not always receiving ED referrals, ED attendances of children under four years are now scanned immediately to one address. We were told this has resulted in 100 per cent compliance for the health visitor receiving the referral. The department developed and updated a fracture neck of femur pathway and a new deep venous thrombosis pathway is being implemented.

- Junior medical staff, supervised by the consultant, conducted audits on; foot and ankle injuries, computerised tomography use, head injury and eye injuries. Following audits in the ED where poor documentation by medical staff was highlighted, medical staff carried out a further audit to assess quality of documentation in the ED notes. This confirmed improved documentation and included action plans to ensure staff would sustain good practice.

- Systems are in place to protect patients from the risk of abuse and to maintain their safety in line with current best practice guidelines.

Areas for Improvement

- It was difficult at times for patients and carers to know who was in charge, as clinical sisters were not identifiable by uniform and did not wear a nurse in charge badge.

- At times of increased patient numbers, the ward manager also performs a clinical role and does not remain supernumerary. Current administrative support is insufficient for the department, contributing to additional clerical duties for nursing staff.

- Although the trust has been proactive in recruiting nurses, there is a recognised increased workload for experienced nurses to assist with preceptorship, induction and competency training of newly appointed staff.

- Issues such as the increased number of attendances to the department, waits for available beds and/or external medical staff and senior decision-makers to examine patients could delay patient movement through the ED.

- Up to date key performance indicators audit results were not displayed.

- The internal Unscheduled Care ED escalation policy, to identify and manage increasing pressures within the department, is currently under review and is a working draft.

- Staff training was up-to-date, but work is required to ensure appraisals and supervision for nursing staff are prioritised when expected new nursing staff are in post.

Recommended Actions

17. **The department managers should have protected time to carry out their managerial role. The nurse in charge should be identifiable.**

18. **The department should consider the recruitment of a housekeeper and or administration staff to support the department manager in carrying out their role.**

19. **Up to date key performance indicators audit information should be displayed.**

20. **The internal unscheduled care escalation policy should be finalised and implemented.**

21. **Staff appraisals and supervision should be brought up to date.**

7.5 Quality of Interaction Schedule/Questionnaires/Observations

During inspections the views and experiences of patients and service users are central to helping the inspection team build up a picture of the care experienced in the areas inspected.

We use questionnaires to allow patients and relatives to share their views and experiences. The inspection team also observes the communication and interactions between staff and patients and staff and visitors. This is carried out using the QUIS.

Findings are presented from a composite perspective combining the patient and relative perceptions.

Questionnaires

We were told by patients that their privacy and dignity were maintained. Staff were courteous, listened to them and generally responded to patients' care needs in a timely manner. Patients identified that sometimes there was not enough staff to deliver care.

Patients told us they did not always know who to speak to about their concerns, however were generally satisfied with the information they received during the period of time they were in the ED.

Patient Comments

'More staff. The staff are excellent. Good people and hard working.'

'The NHS is underfunded. They are understaffed and staff are underpaid. The staff are wonderful.'

Family members/carers told us their relative was treated with dignity and respect and they were generally satisfied with the care they received. However, it was identified that the ED can be busy and crowded, and physical space is very limited.

Relative Comments

'They are very busy.'

'There are a lot of crossed wires here today. … There is just no communication… Nobody seems to know what is going on.'

Observations

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

We observed positive interactions between staff and patients. Staff engaged in conversation when delivering care, providing explanation, support and treating the patient as an individual. Patient's privacy and dignity were maintained.

However, we observed that when the department was particularly busy staff had only basic interaction with patients for example when monitoring the patient's vital signs such as blood pressure.

Inspection Findings
Focus Groups

8.0 Inspection Findings: Focus Groups

During the inspection a series of focus groups and/or interviews were held with the following groups of staff who were aligned to the clinical areas inspected:

- Nurses and healthcare assistants
- Allied Health Professionals
- Support Staff
- Junior and Senior Medical Staff
- Senior Managers
- Executive Management Team

We found all staff to be open, transparent and willing to discuss good practice and areas for improvement within their area of work. This confirmed findings outlined in the report for the female medical ward and the ED.

Issues identified in relation to each specific area inspected are detailed in previous sections of the report.

All groups of staff told us they were supported to carry out their role. Executive, senior management and senior clinical teams were accessible and visible in the different areas for advice and guidance. We were told that all areas were very busy and could be challenging to work in, especially as a result of increased hospital attendances, workload and acuity of patients, resulting in increased demands on current resources, particularly out of hours. In the ED there is a recognised increased workload for experienced nurses to assist with preceptorship, induction and competency training of newly appointed staff.

We were told that the recruitment process to select new staff can be slow; however plans are in place to increase pharmacy and dietician provision. Recruitment of medical staff to ED continues to be difficult, with long term experienced locums in place. Improvements have been made to the medical ward and ED rota. It is difficult to get GPs to staff the GP out of hours service. Staff told us that a number of support services staff are on agency/bank contract. The senior management team reported that the trust plans to recruit, to these positions this should be communicated to staff.

We were told that access to training and teaching was good, with a supervision and appraisal process in place. Staff identified however that it can at times be hard to secure release for time to undertake training and to complete appraisals.

Quality improvement was evident, with staff discussing new developments in the provision of pharmacy services, acute care at home, access to investigations/new technology, regional frameworks in use and shared learning throughout the trust.

Learning from Peer Reviewers

9.0 Learning from Peer Reviewers

The inspection was carried out by a team of healthcare inspectors supported by peer reviewers drawn from a range of professionals, including clinicians, nurses, social workers, pharmacists and allied health professionals, currently working within Health and Social Care in Northern Ireland.

The peer reviewer's role is vital to provide an independent assessment of the performance of the areas inspected against identified standards/guidance, as part of the multidisciplinary inspection team. Peer reviewers participate fully in all discussions and their contribution is invaluable to assist the healthcare team's assessment of the areas subject to inspection. Their findings are used to complement the inspector's judgement and are incorporated into the inspection report.

We were told by peer reviewers during this inspection that they enjoyed the experience and would be willing to participate in future inspections. They considered that that it was a positive development to see the inspection team highlight good practice as well as picking up on areas of concern or where improvement could be made.

We received suggestions about the need to improve the layout of the medical documentation used for inspection and also clarification on how to use the relatives' questionnaires.

All comments are used by the healthcare team to reflect on lessons learnt after each inspection and to improve the inspection process.

Provider Compliance Improvement Plan

10.0 Provider Compliance Improvement Plan

A provider compliance improvement plan should be completed detailing the actions taken and planned to achieve the recommended actions outlined below. This improvement plan should be returned to Healthcare.Team@rqia.org.uk for assessment by the inspector. The Chief Executive Officer should note that failure to comply with the findings of this inspection may lead to escalation action. The Chief Executive Officer should ensure that all recommended actions are taken within the specified timescales.

The inspection identified areas for improvement which were discussed with trust representatives as part of the inspection process.

Female Medical Ward

Reference number	Recommended Actions	Responsible Person	Action/ Required	Date for completion/ timescale
1.	Staff compliance with standard IPC precautions should be improved and assured.	HOS/Lead Nurse	Link with ICP regarding survey with all professions regarding the standard re Infection control precautions	On going
2.	Access to resuscitation equipment should be reviewed to ensure equipment is readily available and easily accessible to all patients in line with best practice guidelines. All equipment should be in date, with an effective monitoring system in place.	HOS/Lead Nurse	Discuss with resus officer	Update 18th January 2017 Discussed with Resus Officer and the decision is that with the ongoing monitoring of cardiac arrests there is no indication that harm has occurred due to the travel of the trolley across the two wards.

Reference number	Recommended Actions	Responsible Person	Action/ Required	Date for completion/ timescale
				The resuscitation process initiates chest compressions as a first line response which allows for the timely arrival of the cardiac team This was based on risk assessment by Resuscitation officer, reviewing the number of cardiac arrest calls over a 12 month period in both wards and across DHH site.
3.	The Sepsis Six bundle should be introduced and its implementation assured.	HOS/Lead Nurse	Will be part of the roll out of Sepsis Six bundle within the Trust.	Ongoing
4.	The storage of medicines should be reviewed and monitored to ensure that all medicines are stored safely, securely and in accordance with the manufacturer's instructions.	HOS/Lead Nurse	Monthly inspections of ward environment have commenced. Medicine Storage is part of inspection and feedback provided and action plan developed.	Ongoing
5.	The ward should improve and monitor the completion of documentation related to VTE risk assessment, blood cultures, NEWS observation charts and standardised recording of NEWS triggered responses.	HOS/Lead Nurse	Part of monthly audits. Monitor compliance and develop action plans as required.	Ongoing

Reference number	Recommended Actions	Responsible Person	Action/ Required	Date for completion/ timescale
6.	A staff member should be designated to supervise and coordinate meal service. All staff should ensure that there is no unnecessary disruption of patients during mealtimes.	HOS/Lead Nurse	Nominated staff member identified as part of the Nursing Roster. This will be monitored as part of ongoing monthly audits.	January 2017 Ongoing
7.	The ward should improve and monitor the completion of medical notes and documentation related to nursing risk assessments, pathways, fluid balance and food charts.	HOS/Lead Nurse	NQI audit rolled out and action plan developed.	Ongoing
8.	As part of any ward refurbishment or new build planning, the number and size of sanitary facilities should be improved.	HOS/Lead Nurse	Review of estates has taken place on the 5th Floor and design planned. Funding to be secured.	March 2018
9.	Patient comfort rounds should be recorded and assured in line with trust guidance.	HOS	Review of Intentional rounding chart. Monitored as part of rolling monthly audit.	Ongoing
10.	AHPs as required should be available at weekends to ensure timely assessment, intervention and discharge of patients.	Head of AHP'S	This is currently being reviewed by AHP and Human Resources regarding 7 day working.	Ongoing

Reference number	Recommended Actions	Responsible Person	Action/ Required	Date for completion/ timescale
11.	Nurse staffing levels on the ward during the night should be reviewed.	HOS	Review of Nursing staff on duty at night has taken Place. Now ward divided into two teams with two staff and HCA per Team Therefore an extra Staff nurse band 5 allocated to Night Duty.	Completed April 2017
12.	All ward nursing staff should receive a comprehensive handover of patient information. Nursing staff meetings and safety briefs should be increased in frequency.	HOS	Review of nursing handover completed. All staff involved in handovers Patient safety briefings being carried out in am and pm. Compliance re safety Briefings monitored.	Completed April 2017
13.	Medical staff should review the scheduling of ward rounds to ensure nursing staff participation.	HOS Clinical Medical Lead	Review of timing of ward rounds by medical team. Nurse must be present on Ward Round. To monitor compliance with this through monthly audits.	On going
14.	The role of junior medical staff on the ward should be reviewed to ensure greater input into patient care and decision-making.	HOS Clinical Medical Lead	Weekly meeting with FY1 Trust is reviewing the role of FY1's across specialities.	On going

Emergency Department

Reference number	Recommended Actions	Responsible Person	Action/ Required	Date for completion/ timescale
1.	A review of the use of facilities and the scheduling of clinics should be undertaken in response to the congestion in the department at times of increased patient attendance.	Head of Service	Currently no additional capacity. This will be reviewed when works completed in base wards which will allow cardiac investigations to move and rooms will be given to ED for treatment area and sanitary facilities.	December 17
2.	Effective monitoring systems should be in place to ensure daily equipment checks, cleaning schedules and clinical practices are carried out and assured compliance checked.	Charge Nurse	Cleaning schedules in place Daily checks in place Audit tool developed Charge Nurse to carry out ad hoc audits to provide assurance of compliance.	In Place
3.	Staff compliance with standard IPC precautions should be improved and assured.	Charge Nurse	Attendance at IPC training (94% of staff attended to date) Independent Environmental Audit - overall 93.7% nursing section 97.5%.	May 17
4.	The storage of medicines should be reviewed to ensure that all medicines are stored safely, securely and in accordance with manufacturers' instructions.	Charge Nurse	Omnicell cabinets now in place Weekly stock checks in place.	January 17

Reference number	Recommended Actions	Responsible Person	Action/ Required	Date for completion/ timescale
5.	The department should improve and monitor the completion of documentation related to medical records and in particular the management of sepsis.	Clinical Director	Sepsis audit – completed monthly and learning shared at M & M patient safety briefs. Ad hoc audit of medical notes to be completed.	Ongoing June 17
6.	Joint medical and nurse in charge safety rounds should be introduced.	HOS Charge Nurse Clinical Director	Walkarounds in ED with nursing/medical team three times a day and as required depending on pressures in ED.	January 2017
7.	A robust system should be implemented and monitored to ensure the appropriate storing and categorising of flimsies.	Admin	In place – new shelves erected	February 2017
8.	The structured process of Intentional Care Rounding or similar should be introduced.	Charge nurse	In place The new documentation that has been implemented which allows the nurse assess the patients basic nursing needs e.g pressure area care, nutrition, mobility. The outcome of the assessments would determine the ongoing nursing care that the patient receives. The care the patient receives is documented.	January 2016

Reference number	Recommended Actions	Responsible Person	Action/ Required	Date for completion/ timescale
9.	Medication should be prescribed and administrated in a timely manner.	Charge nurse	Reinforced with staff Audit to be competed to provide assurance of same.	Ongoing December 2017 July 2018
10.	Medical handovers should be formalised.	Clinical Director	Formal medical handovers in place at 0800, 16:00 and 22:00 hours. When the department is busy there are walkarounds where each patients plan of care is discussed.	January 2017
11.	The department should review the level of medical seniority present overnight.	Clinical Director	Ongoing review of medical staffing. Currently Consultant on to 2200hrs and on call overnight. Middle grade on to 0200hrs to support the doctors on overnight.	ongoing
12.	The system and equipment in place for meal service and the promotion of patients' nutritional and hydration needs should be improved. A staff member should be designated to supervise and coordinate meal service and all equipment required should be readily available.	Charge Nurse	Nursing staff prepare patients for their meals, assist patients with eating and drinking, and document same in notes/FBC. A member of staff is designated to oversee the distribution of meals. New table trollies have been purchased to ensure there is adequate tables for patients.	December 2016

Reference number	Recommended Actions	Responsible Person	Action/ Required	Date for completion/ timescale
13.	As part of any ward refurbishment or new build planning, the number and size of sanitary facilities should be improved.	Estates HOS	The sanitary facilities will be reviewed in due course. Currently no capacity to create additional facilities until work is completed on base wards and room's will then be vacated beside the ED which will be converted to treatment rooms and sanitary facilities.	December 2016
14.	Patient call bells should be accessible, within easy reach of the patient at all times.	Charge Nurse	All cubicles have a call bell which are in working order and are left within reach for the patient. Clinical sisters check this on their walkarounds and staff are encouraged to do same.	December 2016
15.	Staff should ensure identification badges are worn at all times.	Charge nurse	In place All staff have name badges and "Hello my name is" is embedded in the ED. Sister in charge checks with member of staff if they are not wearing their name badge.	December 2016
16.	The department should ensure staff are aware of the trust policies for end of life care.	Charge Nurse	New guidance has been issued to all staff and this has been shared at staff meeting.	April 2017

Reference number	Recommended Actions	Responsible Person	Action/ Required	Date for completion/ timescale
17.	The department managers should have protected time to carry out their managerial role. The nurse in charge should be identifiable.	HOS/Lead Nurse	In place The Department Charge nurse has supervisory status and has protected time to undertake their management role. They are not counted in the numbers on the floor which ensures they have protected time.	January 2017
18.	The department should consider the recruitment of a housekeeper and or administration staff to support the department manager in carrying out their role.	HOS	Currently rotated through HCA's JD for house keeper role finalised Funding to be identified Ward sister/Charge Nurse has a ward support x1 day each week to assist with Administration.	August 2017
19.	Up to date key performance indicators audit information should be displayed.	Charge Nurse HOS	In place- same displayed in ED	January 2017
20.	The internal unscheduled care escalation policy should be finalised and implemented.	HOS/ED consultant	Currently being updated	ED consultant HOS
21.	Staff appraisals and supervision should be brought up to date.	Charge Nurse	Weekly supervision session Appraisals - ongoing	Ongoing

Appendix 1: Abbreviations

AHP	Allied Health Professional
ANTT	aseptic non touch technique
ED	Emergency Department
EMT	Executive Management Team
GMC	General Medical Council
GP	General Practitioner
IPC	infection prevention and control
MDT	Multidisciplinary Team
NEWS	National Early Warning Scoring System
PPE	personal protective equipment
QUIS	Quality of Interaction Schedule
RQIA	Regulation and Quality Improvement Authority
VTE	venous thromboembolism

The **Regulation** and
Quality Improvement
Authority

The Regulation and Quality Improvement Authority

9th Floor

Riverside Tower
5 Lanyon Place
BELFAST

BT1 3BT

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