The Regulation and Quality Improvement Authority

# Acute Hospital Inspection:
# Royal Victoria Hospital, 14 - 16 December 2015

## Ward 7B
## Ward 6C
## Emergency Department

## 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 l not be pre-notified to the trusts. No advance warning is provided to trusts as to which sites, or services within a hospital, will be visited as part of an unannounced inspection.

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## Inspection Summary

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

An unannounced inspection was undertaken over three days, from Monday 14 December to Wednesday 16 December 2015 at the Royal Victoria Hospital (RVH).

The following areas were inspected:

- Ward 7B
- Ward 6C
- 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 the RVH focused on Inpatient Diabetes Management and the Clinical Assessment Unit (CAU).

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

The overall findings of the RQIA inspection in relation to Ward 7B were good. Governance and leadership were strong in the ED, however crowding was an issue. The inspection team found that improvements were needed in Ward 6C, with deficits and gaps identified in service delivery. These matters 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 number of recommendations reflects the detailed nature of the inspection. The report should be used by the Belfast Health and Social Care Trust (Belfast Trust), as a vehicle to promote and facilitate further improvements in service delivery.

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

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

## Ward 7B Acute Medical Unit

### Is the Area Well Led?

Ward 7B is a 26 bed acute medical ward. Throughout the inspection, there was evidence of strong leadership, effective governance and effective dissemination of information to staff. Staff understood their roles and responsibilities and have been empowered to raise concerns. There was an open and transparent culture with regards to incident and complaint management. We observed evidence of strong multi-disciplinary teamwork.

Normative staffing numbers had been agreed for the ward, staffing levels were good, with good retention of staff and minimal sick leave. Staff received the necessary training to enable them to carry out their roles effectively; additional training was facilitated and staff were encouraged to proactively engage in new initiatives.

The ward closely monitored its performance against a range of clinical indicators and presented achievement levels in a monthly balanced scorecard. There were systems in place to protect patients from the risk of abuse and to maintain their safety in line with current best practice guidelines.

### Is Care Safe?

The ward environment was clean, in a good state of repair and adaptations had been made to the ward to meet the needs of patients with dementia or a disability. Storage facilities were good with minimal clutter in patient areas.

Although most staff complied with trust policies in relation to infection prevention and control, documentation in regard to aseptic non touch technique (ANTT) and care bundles needs improvement. The Health and Safety folder containing risk assessments for known hazards on the ward was not up to date.

Staff utilise patient safety performance indicators and bundles which are analysed to assess the effectiveness of care patients receive. There is a ward based sepsis initiative, however, the Sepsis Six bundle should be introduced for the early recognition and management of sepsis.

All medicines were stored safely and securely.

Staff were knowledgeable in relation to prescription and administration of medicines, however, at times there were inconsistencies in related documentation. In the administration of intravenous medicines we observed practices that did not comply with trust policy. The Integrated Medicines Management (IMM) service and the handling of critical medicines where timeliness of administration is crucial need developed.

**Is Care Effective?**

There were inconsistencies in the recording and completion of various core sections of nursing documentation. Nursing risk assessments were not always fully or comprehensively completed and reviewed. There was a mix of pre-printed and written care plans, however, these were not always individualised to meet the needs of the patient. Nursing records did not always adhere to best practice standards of documentation. There was good evidence of patients' and families' involvement in planning care, however there was little evidence of multidisciplinary (MDT) involvement.

Medical records were well organised and easy to use; however the recording of data and discussions with patients and family needs to be improved. Discharge documentation was completed in a timely manner with an up to date list of diagnoses, management plans, investigation results and medications.

Protected meal times were generally well adhered to and a varied menu choice and specialised diets were available. The coordination of meal service was excellent and effective mechanisms were in place to identify patients that required assistance at mealtimes.

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

We found that staff were knowledgeable and good practices were observed in pressure ulcer care.

**Is Care Compassionate?**

The ward was well managed and organised, clean, bright and welcoming and although staff were busy, the atmosphere was calm. Signage to direct visitors to the ward and within the ward was good.

There was generally prompt response to call bells and requests for assistance from patients.

We observed staff that were sensitive, caring and insightful and anticipated the care needs of patients; the dignity and privacy of patients were maintained throughout the inspection. A mechanism was in place to ensure that the fundamental aspects of patient care were being delivered reliably. We observed good knowledge and practice in relation to person centred care, end of life care and communication.

## Ward 6C Surgical Ward

### Is the Area Well Led?

The inspection identified areas for improvement in the systems and processes supporting ward activity and the delivery of care including the fact that communication of information to staff was not always effective.

We found and staff identified issues that impacted on the running of the ward such as delayed patient discharge, lack of a ward pharmacist, inefficient patient flow, small clinical room, staff skill mix, and the availability of decision making clinicians. Medical staff expressed concerns about delays in processes during times of extreme pressure.

Staff training was not up to date and additional training commensurate with staff roles was not well attended. Access to allied health professionals (AHPs) requires improvement.

The emergency assessment and admission unit (EmSU) is not functioning as designed. Escalation processes designed to improve patient flow throughout the ward appeared ineffective. There is not always access to timely patient investigations such as scans. On occasions patient ownership and medical review was not timely. Data in relation to the patient experience is not currently collected; however a patient experience questionnaire will soon be implemented.

Staff have access to a range of policies and procedures. An EmSU improvement team is in place. This team is reviewing the existing EmSU service model, to improve the delivery of care provided to patients within the unit and ensure effective communication of EmSU clinical pathways across the trust.

Overall, staff morale was good and staff appeared happy working on the ward. Nursing staff felt supported and told us that they can raise concerns with their direct line manager and senior manager for action. Joint working and support across the surgical floor was evident with staff assisting during extreme pressures and movement of patients.

### Is Care Safe?

The environment was light, bright and free from hazards. Staff maintained visual contact with high risk vulnerable patients. Patient equipment was generally stored in designated areas, not accessible to the public. Staff felt supported by the ward sister and assistant services manager who take action when a safety concern is raised.

The ward environment has not had a full assessment for dementia patients; however disabled sanitary facilities are available. Ward risk assessments were out of date. Greater attention is required to patient equipment and environmental cleaning.

We observed that the majority of staff carried out hand hygiene and adhered to aseptic non-touch technique best practice. Spacious single room facilities, each with a clinical hand wash sink, promote good infection control practices. Contact precaution notices were displayed appropriately.

Visual infusion phlebitis (VIP) charts to record the management of peripheral venous cannula were not always in place. A falls safe bundle was not in place but is to commence in the near future. Staff training for Haemoviligence is required. A Sepsis Six screening tool is present on the back of the National Early Warning Scores (NEWS) chart; however adherence is not audited. Documentation for World Health Organisation (WHO) Surgical Safety Checklists and Venous Thromboembolism (VTE) risk assessments were in place and completed.

All staff need refresher training on their role and responsibility for the safe storage, security, administration, prescribing and documentation of medication. A ward pharmacist is needed to facilitate effective integrated medicines management.

**Is Care Effective?**

Nursing care records reviewed were not always up to date and did not always reflect the nursing assessment or the care required for the patient. Nurse record keeping did not always adhere to Northern Ireland Practice and Education Council for Nursing and Midwifery (NIPEC) guidelines.

Medical notes reviewed were poorly organised with missing pages and contained several instances of incorrect filing, including clinical note entries and fluid balance charts. Not all notes pages were identified with patient name and hospital/healthcare number; however discharge documentation was good.

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

Patients appeared comfortable, pain and pressure relieving measures were available and in place. Staff responded promptly to patients' requests for pain relief. Pain medication was administered as prescribed, however a pain score should be recorded as part of clinical observation. Staff provided patients with assistance to promote continence and care for incontinence. Specialist nurse advice was available.

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

### Is Care Compassionate?

The senior nurse was present and identifiable to support ward activity. We observed that staff were compassionate, showing empathy to patients and positive interactions were noted. Staff were courteous to patients and relatives, providing clear, easily understood information.

Patients privacy and dignity was maintained when delivering care or moving between areas in a ward. Patient call bells were accessible and answered promptly. Staff were knowledgeable about processes and information for end of life care.

As ward activity increased, the overall impression of the ward was one of disorganisation. Staff did not always communicate with patients in a volume that ensured patient privacy and extra staff were not always available to assist with additional care interventions. Intentional care rounding or a similar system is not in place to ensure personal needs and comfort are achieved. Healthcare records were left unattended and easily accessible to unauthorised personnel.

There is no information leaflet rack or leaflets for the public. The lack of name badges made it difficult for patients to identify staff. A do not attempt resuscitation decision (DNAR) documentation was not appropriately completed. An end of life care pathway is not in place; however this was being developed by the trust.

There was good signage throughout the department. Staff had access to aids and services for patients with language barriers. A family room is available for private conversations.

Overall, patients and relatives were happy with the care they or their relative had received. Issues were identified in relation to communication and access to timely car parking.

## Emergency Department

### Is the Area Well Led?

We found that the overall leadership and governance arrangements within the emergency department were good. Throughout the inspection we observed senior nursing and medical staff directing and supporting department activities. Staff morale was good. Staff reported that that they felt supported and valued by senior management and encouraged to raise concerns as and when appropriate.

The designated shift leader is either a band 6 or band 7 sister/charge nurse. A transparent culture was displayed in relation to the investigation of formal complaints. A number of mechanisms were in place to ensure that information is disseminated to all ED staff.

Senior management has been active in the recruitment of nursing staff for the ED however this presented challenges with nursing staff skill mix.

An advertisement campaign had been successful in recruiting consultants to the department; however the recruitment of middle grade doctors and advanced nurse practitioners (ANPs) continues to be a challenge. Attendance at mandatory and role specific training was good and staff had access to a range of policies and procedures to guide practice. There were systems to protect patients from the risk of abuse in line with current best practice guidelines.

There was a focus on measuring outcomes of care through a range of key performance indicators. The department closely monitored its performance against ministerial targets. Although the ED had failed to achieve the four and 12 hour targets, considerable progress had been made. We were informed that the key to this improvement in performance is redesigned pathways, particularly the establishment of a new ambulance triage model operating within the ambulance receiving area and the opening of the clinical assessment unit.

During the first morning of the inspection we observed effective systems in place to manage the input, throughput and output of patients through the department. Designated assessment and treatment spaces were sufficient to meet occupancy levels, ensuring that patient dignity, privacy and nursing care needs were being met. However, a surge in activity throughout the afternoon and evening resulted in the majors area becoming quickly crowded. We observed that this resulted in the number of patients occupying the majors area was beyond the capacity for which it was designed to manage at any one time. As a result, it became more challenging for staff to implement basic nursing care and maintain the dignity and privacy of patients.

**Is Care Safe?**

The new department was clean, uncluttered and in a good state of repair. Fire safety and life support training was part of the ward staff mandatory training programme. Equipment, including emergency resuscitation equipment was generally well maintained however some checks were inconsistent. Crowding in the majors area would present a challenge for staff in the manoeuvring of resuscitation equipment in the event of an emergency. Hand hygiene and environmental cleanliness audits are carried out and trust compliance rates were achieved. Clinical hand wash sinks, alcohol rub and glove and apron dispensers were clean and easily accessible. Most staff complied with the trust policies in relation to infection prevention and control, although during busy times we observed some lapses with hand hygiene and the use of personal protective equipment. Equipment cleaning schedules were not always completed consistently or audited. Some communal equipment in the resuscitation area needed extra attention to detail in cleaning.

We observed an inconsistent approach to the issuing of patient identity armbands. There is no available protocol to guide staff. The introduction of a falls safe bundle may help reduce variations in falls preventative practices. Patient early warning scores, sepsis care bundle interventions and VTE risk assessments were generally well completed.

When the majors area is crowded consideration is not always given to patient placement. This is discussed further with the report.

A good interface with trust mental health services has been developed. Medicines were stored safely and securely and administered to the expected standards of practice. ED pharmacist cover should be improved to facilitate effective integrated medicines management. There was evidence of compliance with best practice in the handling of critical medicines. We observed that when oxygen was administered patients did not always have oxygen prescribed within their medicine kardex.

**Is Care Effective?**

We observed that patient nursing treatment plans and risk assessments were not always consistently completed in line with department protocol. Medical records were well completed.

Meals looked appetising and appropriate to the patient's needs; however staff did not always prepare patients before serving meals. When the majors area was crowded it was difficult for staff to support and assist patients at mealtimes. There were insufficient meal tables for the number of patients receiving meals.

Prescribed pain medication was appropriate to patients' conditions and the effectiveness of the analgesia was subsequently reviewed. Pain assessment of patients was not always completed at triage. We observed that on most occasions, patients appeared comfortable, pain relieving comfort measures were available and staff responded promptly to patients' requests for pain relief. Staff did not always use specific pain assessment tools for those patients who were unable to verbalise their pain.

Staff were knowledgeable in regard to pressure ulcer care. Staff could avail of adequate support and resources for patients with pressure ulcers. Mostly, assistance to promote continence and care for patients with incontinence was observed, however when the majors area was crowded a number of patients did not receive timely assistance.

**Is Care Compassionate?**

Overall, the first impressions of the new emergency department were positive. The new department was bright and welcoming and there was good signage to direct visitors to the many areas of this large department.

Crowding within the majors area was a specific concern. At busy times, we observed that the number of patients occupying the majors area was beyond the capacity for which it was designed to manage at any one time. This resulted in a number of patients placed on trolleys in close proximity to one another, along the central work station. This made it challenging for staff to provide basic nursing care and maintain the dignity and privacy of patients. Although staff tried to be discrete when communicating with these patients, many sensitive discussions could be overheard.

We observed that patients on trolleys around the central work station, found it difficult to request assistance for personal care needs as they did not have access to a nurse call bell.

The number of patient toilets within the majors area is inadequate. Patients and staff commented that the department can be cold at night, with extra blankets required for patients.

The department had a purpose built room to care for a dying patient while being supported by family or carers. The room is also used following the death of a patient to allow the family or carers to view their relative in an appropriate and dignified setting.

Patients and relative questionnaires highlighted that the department can become very busy with staff working professionally under intense pressure. There were a number of positive comments from patients and relatives regarding the emergency department however there were a number of comments relating to concerns about waiting times, communication, privacy, dignity and patient placement.

## Focus Groups

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

- nursing staff
- allied health professionals
- medical staff
- senior managers
- support staff

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

All staff told us they would be happy for their family to be cared for in the hospital, however ED staff stated they would be influenced by the day, crowding and waiting times. Medical staff were concerned about the role and function of the Acute Medical Unit (AMU) and the management of the EmSU.

We were informed of staffing concerns and the difficulties with the lengthy recruitment process and Human Resources, Pay, Travel and Subsistence (HRPTS). AHP staff told us they are worried about staffing levels and fulfilling the demands of their service.

AHP staff were concerned about reablement services for patients under 65 years. Clerical Staff stated there should be an improvement in the delivery of medical notes to the wards.

**Inpatient Diabetes Management and the Clinical Assessment Unit**

**Inpatient Diabetes Management**

Blood glucose monitoring was carried out at appropriate intervals. All relevant medications were correctly prescribed and administered in a timely manner. Patients who did not require referral to specialist diabetes services were appropriately managed on the ward and documentation was clear and precise.

**Clinical Assessment Unit**

CAU caters for patients who require multi-disciplinary/professional assessment or care, a period of assessment or treatment that may last >4 but <24 hours, and provides services such as IV medicine administration. The early consultant-led assessment and team work was highly praised by all staff members spoken to during the RVH visit.

The culture of proactively managing admissions through the ED improves patient experience, safety and quality of care.

The CAU team, in conjunction with surgical colleagues is seeking to expand the CAU model to provide support for patients with predominantly surgical issues and so support the Emergency Surgical Unit.

**Summary**

The RQIA inspection under the new programme for acute hospitals took place in three clinical areas of the RVH. The overall findings of the RQIA inspection in relation to Ward 7B were generally good. Governance and leadership was strong in the ED however crowding was an issue. The inspection team found that significant improvements were needed in Ward 6C, with deficits and gaps in service delivery which need to be addressed.

The focus groups highlighted some trust wide and regional issues, whilst the CAU model is to be commended as an example of data-driven and outcome-focussed care.

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

Following publication of the report the Belfast 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 Belfast 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 (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 and who bring their own experience, fresh insight and a public focus to our inspections)

- consideration of particular focused themes

**Core Indicators**

Core indicators for inspection are designed around 14 areas. Each area is underpinned by relevant criteria. Each indicator correlates to one aspect 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?**<br><br>Leadership and management of the clinical area |
|---|

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

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

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

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

- **Recommendations**: where performance against indicators or standards is found to be partially or minimally compliant. Significant change and/or improvement will be required and performance will be reviewed at future inspections.

- **Housekeeping points**: improvement is achievable within a matter of days, or at most weeks, through the issuing of instructions or changing routines.

- **Examples of good practice**: impressive practice that not only meets or exceeds our expectations, but could be adopted by similar establishments, to achieve positive outcomes for patients.

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

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

## 2.0 Background information on Belfast Health and Social Care Trust and Royal Victoria Hospital

### Royal Victoria Hospital

RVH is one of four linked hospitals that make up the Belfast Trust.

The hospital treats over 80,000 people as inpatients and 350,000 people as outpatients every year, providing local services to the people of Belfast and a large number of regional specialist services to people from across Northern Ireland. These specialist services include Cardiac Surgery, Critical Care and the Regional Trauma Centre.

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

- effective health and social care
- delivering best practice in health and social care settings
- protecting people from avoidable harm
- ensuring people have positive experiences
- supporting staff – strengthening the workforce

### Trust Structure and Values

The Trust delivers its services through five Service Directorates:

1. Unscheduled & Acute Care incorporating Anaesthetics, Critical Care, Theatres & Sterile Services, Emergency Department, Medical, Cardiology, Neurosciences, Imaging, Medical Physics and Allied Health Professions

2. Surgery and Specialist Services, incorporating General and Specialist Surgical Services, Cancer & Specialist Medicine Services, Pathology & Laboratory Medicine and Pharmacy & Medicine Management Services

3. Adult Social and Primary Care Services incorporating Mental Health, Learning Disability, services for Older People, and Physical/Sensory Disability Services

4. Specialist Hospitals and Women's Health, incorporating Maternity Services, Acute and Community Paediatrics, Trauma and Orthopaedics, Gynaecology, Sexual Health & Reproduction, including GUM Services, Ears Nose & Throat and Dental Services

5. Children's Community Services incorporating Family & Child Care Services, Children's Disability Services, Child Health/Child Care & Social Work Governance

These directorates, working together with the Corporate Directorates of Human Resources, Medical Director's Group, Nursing& User Experience, Planning Performance & Informatics, Communications and Finance& Estates, are led by the Belfast Trust Board and Executive Team.

**The Trust has five Values:**

1. Treating everyone with Respect and Dignity
2. Displaying Openness and Trust
3. Being Leading Edge
4. Maximising Learning and Development

Trust performance is measured across a range of areas using a range of indicators set by the DoH. In 2014-15 the trust quality improvement plans included:

- pressure ulcer prevention
- falls prevention in hospitals
- the WHO surgical checklist
- preventing harm from VTE
- cardiac arrest rates
- monitoring and reducing healthcare associated infections

The trust has delivered improvements in its services during 2013-14 including the following:

- Re-organisation of Maternity Services with the Opening of a Midwifery Unit at the Mater Hospital and the provision of additional consultant input at RJMS.

- Development of Self- care Haemodialysis in Knockbreda WTC, the Linear Accelerator expansion, the growth of live-donor transplant work & introduction of DCD (Donations after Cardiac Death) transplants.

- Opening of Helmsworth Court supported housing for people with dementia, the development of Maples supported housing for people with complex disabilities, the first stage in building the single Acute Mental Health Inpatient facility and the planned completion of resettlement of people with mental health and learning disability in the community.

- First Trust Annual Quality Report 2013, which highlights progress in Quality and Safety Improvement across Hospital, Community and Home settings.

- The development and implementation of the Regional Emergency Social Work Service which provides an out of hours response to all five HSC trusts and all programmes of social care in each Trust.

Further information on these and other examples of excellent service delivery and improvement are detailed in the Trust Annual Report and Annual Quality Report.

In 2015 the trust performance plans included:

- Healthcare Associated Infections (HCAI) - Methicillin-resistant Staphylococcus Aureus (MRSA),C Diff
- Cancer Services (urgent breast cancer 14 days; and 62 days treatment)
- Unscheduled Care – A&E (RVH, MIH sites), four hour/12 hour
- Outpatients - Waiting Times (60 per cent < nine weeks, 18 weeks max waiting time)
- Diagnostic - Waiting Times (< nine weeks, two days for urgent diagnostics)
- Inpatient and Daycase - Waiting Times (65 per cent < 13 weeks, 26 weeks max waiting time)
- AHP Waiting Times < 13 weeks
- Learning Disability Discharge (percentage discharged within seven days)
- Acute Hospital Complex Discharges (<48 hours and > seven days)
- Mental Health Outpatient – Waiting Times (Psychological Therapies)
- Hospital Cancelled Outpatient Appointments

# Inspection Findings:
# Ward 7B Acute Medical Unit

## 3.0 Inspection Team Findings: Ward 7B Acute Medical Unit

Previously, the AMU in the RVH functioned as a 60 bed, two ward unit, 7B and 7C. The AMU was inspected as part of the unscheduled care inspection 31 January to 3 February 2014[2], with a follow up inspection in May 2014[3]. Since then the unit has been reconfigured. The AMU now consists solely of ward 7B, a 26 bed acute medical unit consisting of three, six bedded bays and eight single rooms with an en-suite.

### 3.1 Is the Area Well Led?

**Governance**

Throughout the inspection there was evidence of strong leadership, effective governance and effective dissemination of information to staff. Staff had access to a range of policies and procedures to facilitate learning. Since the previous unscheduled care inspection, we were provided with evidence of an improvement in staff knowledge and evidence of shared learning. This was supported by twice daily safety briefings, handovers, and regular staff meetings. Mechanisms were in place to ensure that staff were aware of the complaints procedure, and of the process for reporting of Serious Adverse Incidents (SAIs) and incidents. The ward manager was not aware of any ward issues that had been placed on the trust risk register.

Quarterly Clinical Governance Meetings are held and attended by Wards 7B and 7C consultants, sisters, pharmacist and lead nurse. Standing agenda items for discussion include pharmacy related themes, audits, safety alerts, morbidity and mortality, medical outliers, complaints, Root Cause Analysis and incidents. Following governance meetings action points are then taken forward.
Bi-monthly ward meetings are held to discuss morbidity and mortality figures.

On day one of the inspection, there was a band 7 Registered Nurse (RN) in charge supported by four RNs and three health care assistants (HCAs). Two nursing students were also on duty. The nurse in charge was easily identifiable by the wearing of a red badge which stated “Nurse in Charge”. On entering the ward, a large whiteboard informs visitors and patients of ward staff and their designation and staff photographs are also displayed. Actual nursing staffing levels were displayed; normative staffing was not.

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2 http://www.rqia.org.uk/cms_resources/RVH%20Inspection%20Report%20for%20Publication%20on%20Website_ISBN.pdf

3 http://www.rqia.org.uk/cms_resources/Follow%20up%20Inspection%20Report%20of%20Unscheduled%20Care%20in%20BHSCT_12-14%20May%202014_ISBN.pdf

**Housekeeping Point: Agreed and actual staffing levels should be displayed.**

The hospital has a CAU which has assisted with the reduction in admissions to the acute medical take. CAU will be discussed in the ED section of the report.

Staff questioned commented positively on the reconfiguration of the ward but felt the unit was not functioning as a typical acute medical ward. The categories of patients admitted were also different from those admitted before.

**Staffing and Supervision**

Normative staffing levels have been agreed for Ward 7B and staffing levels were continually reviewed with bank staff being used when required. Beds had not been closed due to staff shortage. Retention of staff was good; a new band 6 RN has been recruited however the recruitment process was slow.

The ward sister had sufficient time to undertake managerial duties and provide effective clinical leadership. Three days a week, a ward support officer who is shared with Ward 7C, undertakes various clerical duties and maintains the training matrix for both ward managers. The ward manager commented very positively on this appointment. Mentor and preceptor nurses support more junior staff and nursing students to fulfil their roles and responsibilities and two RNs were in the process of mentorship training.

The vast majority of nursing staff have received appraisal and supervision. A positive organisational culture was observed during the inspection with good support from allied health professionals within the ward. MDT meetings to discuss and agree patient care were attended by staff from physiotherapy, occupational therapy, social work and pharmacy. These were held Monday to Friday mornings at 10.15am.

Foundation year one doctors described working in 7B as being a very positive experience, with excellent support from senior medical and nursing staff.

**Staff Training**

There was a comprehensive ward induction pack and a corporate induction which includes mandatory training. The majority of staff had either received or are booked to attend trust mandatory training and had received on-going role-specific training. Additional training had been provided for staff. For example, eight staff attended a two day Management of Actual or Potential Aggression (MAPA) course and an RN attended a four day diabetic course. Other one day courses included respiratory and Care of the Deteriorating Patient. Staff and the ward manager have requested training on dementia, Immediate Life Support (ILS) and the Acute Life-threatening Events—Recognition and Treatment (ALERT).

## Patient Flow

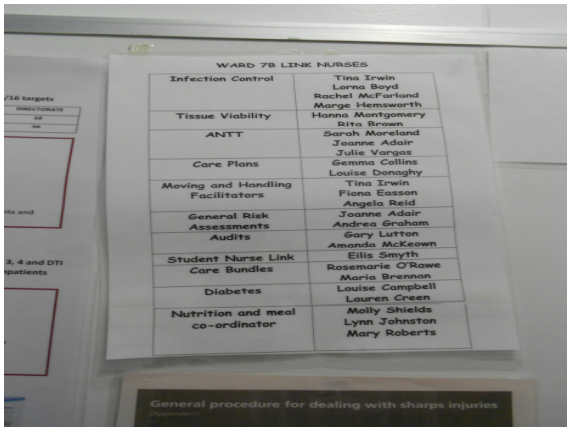
We were told that the ward manager or registered nurse took part in daily consultant ward rounds. There is a 3.00pm catch up meeting with AHPs and a further 3.30pm to 4.00pm meeting with consultants. To facilitate early transfer and discharge at weekends, a meeting is held at 4.00pm on Friday with the on duty week-end senior registrar. Patients at the end of their acute phase of care who needed additional support following discharge were referred to an appropriate social worker for a care package.

A new initiative to enable patients to be discharged home; the Rapid Access Personal Support (RAPS) service has been developed. This provides additional support to the patient before discharge and ensures that prescription collection, discharge letter, take home equipment, property, transport; emergency provisions and home heating are in place. Discharged patients are asked to complete a service user feedback form one week after discharge.

We observed that all oncoming nursing staff attended both morning and night time safety briefings. This identified issues such as ill patients and those with a DNAR, aggressive/confused patients, incidents, alerts, environmental/ equipment issues, infection prevention and control (IPC), concerns, bed state, admission documentation, transfers to Belfast City Hospital (BCH) and meal supervision. Both the night and day nurse in charge signed off that the briefing had taken place. Nursing handovers were well led, informative, focused and structured. Information was documented in in electronic format.

## Communication

We saw examples of effective communication and dissemination of information to staff. These included safety briefings, handovers, ward meetings, ward rounds and multi professional meetings. The ward has numerous link nurses who attend meetings and cascade information to other staff (Picture 1).

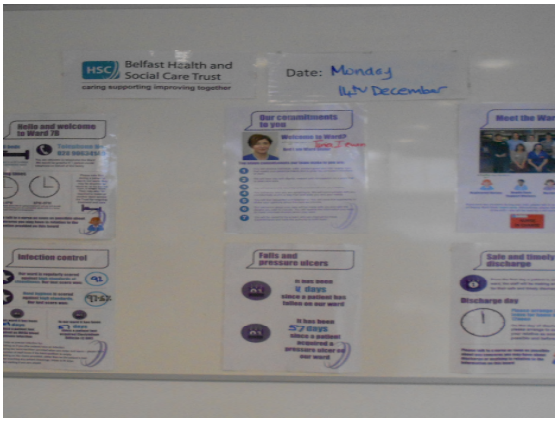


Picture 1: Ward 7B link nurses

Staff have access to a personal email account through which they receive feedback on audit results, e-learning, performance against quality indicators and action plans to address sub optimal performance. At the time of inspection, all medical staff but only one RN had a password for the Electronic Care Record (ECR) system.

**Housekeeping Point: All appropriate staff should have access to ECR.**

Audits of practice and documentation were carried out routinely. These included key performance indicators such as falls, hand hygiene, HCAIs (including MRSA and CDI), IPC care bundles, environmental audit, mattress audit, Skin (pressure ulcers), record keeping (admission and risk assessment, care planning) and compliance with NEWS. The ward information board displayed audit results and information for visitors and patients (Picture 2).




Picture 2: Ward information board

Patient environment/leadership walkabouts were carried out regularly.
To address and improve compliance, a band 6 RN runs an Action Learning Group with staff.

**Safeguarding**

Arrangements were in place to safeguard patients from abuse and staff were aware of the trust safeguarding communication arrangements. In the event of a safeguarding risk being identified, the ward sister would refer the patient to the ward social work team who would subsequently make a referral to the designated officer to decide if the referral should be managed under vulnerable adult procedures. The ward sister was aware of best interest case conferences for a patient who may lack capacity. We were informed that under 18s are not routinely admitted to the ward however staff were aware of actions to follow and Child Protection is included in the trust's mandatory training.

## 3.2 Is Care Safe?

### Environmental Safety

We observed that the ward environment was in good repair and free from trips and hazards. Storage facilities were good and patient equipment was stored appropriately.

Staff maintained a good level of visual contact of the bays and call bells were answered promptly. There had been some adaptation to the ward to meet the needs of dementia patients and patients with a disability, for example, pictorial signs on doors, clocks in bays, hand and grab rails in sanitary areas.

We discussed with staff the ward Health and Safety folder which should contain evidence of known hazards in the ward which were to be regularly risk assessed and followed by preventative action. The folder had not been updated since September 2015.

**Housekeeping Point: Staff should ensure all risk assessments are reviewed and up to date.**

### Infection Prevention and Control

Environmental audits demonstrated compliance with trust target levels; patient equipment was clean and in good repair. A range of personal protective equipment (PPE) was available and worn appropriately. Alcohol rub was available at each bed space; hand washing sinks were clean, accessible and located at the point of care. In the bays there was one sink to six patients which is not in accordance with local and national policy. This issue had been raised at previous RQIA Infection Prevention and Control Inspections.

**Recommendation: The provision of clinical hand wash sinks should be reviewed to comply with local and national guidance.**

Inspectors observed good hand hygiene practice and hand hygiene audits were carried out in line with trust policy. Compliance with the trust dress code policy was generally good. The ward had IPC link nurses who cascaded information to staff and MRSA care pathways were in place where required. We found nursing staff were knowledgeable about ANTT practices and invasive devices. We were told that the ward had ANTT trainers and staff received ANTT competency training and were audited by senior staff. We observed however that medical documentation following cannula insertion was poorly completed.

**Recommendation: Medical staff should complete all documentation in regard to care bundles and ANTT practices.**

**Patient Safety**

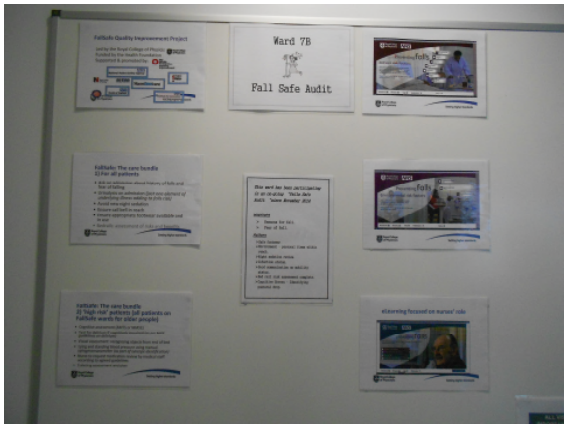
When reviewing the minutes of the November 2015 ward meeting we noted that staff had raised concerns about patients arriving on the ward from ED with no identity armband. To ensure all patients have the correct identity armband and staff act appropriately when identification details are incorrect, this topic is a standing item on the agenda of ward safety briefs and staff meetings.

Patients' Early Warning Scores, NEWS, were completed within set timescales and documented in the notes. Staff were aware of the steps to follow in the NEWS algorithm, the action to take and how to contact the OUTREACH team when required. As part of the ward KPIs, there were routine audits of NEWS scores; the compliance rate for November 2015 was 97 per cent.

A Sepsis six screening tool is present on the back of the NEWS chart. We observed documentation which demonstrated that appropriate measures were in place in line with the care bundle however auditing of the documentation had not been carried out Inpatients had access to key diagnostics 24 hours a day. We were informed that a RN was attending a module on the deteriorating patient and was developing a process with the ward consultant to address sepsis in the ward. The ward had a sepsis box which held information for staff.

**Recommendation: Compliance with the Sepsis Six screening tool should be audited.**

A falls safe bundle was in place and the ward monitors falls and any trends or patterns emerging. This information is clearly displayed. Following a verbal complaint from a family member, a band 6 RN had been proactive in initiating a Falls Project with the aim of reducing falls on the ward and educating staff and patients in relation to falls (Picture 3).




Picture 3: Whiteboard with information on falls

VTE risk assessments were not all fully completed; however, patient notes demonstrated that VTE prophylaxis was administered where required.

**Recommendation: VTE risk assessments should be fully completed.**

There is a ward system in place to monitor preventable pressure ulcers and figures are available at ward level. Staff were compliant with blood transfusion competency assessments and aware of their responsibility to complete blood transfusion record sheets. Patient safety/medical alerts were discussed at clinical governance meetings and cascaded to staff by email and at safety briefings.

**Medicines Management**

All medicines including IV infusions and controlled drugs (CDs) were stored safely and securely, CDs were administered safely with a second signatory present and administered at the bedside by two RNs. The IV drug preparation area was in the treatment room and the clinical room was used to prepare medication for other routes of administration. We observed one member of staff draw up the IV medicines; the second person was not present for this but carried out the check. Both staff went to the bedside for the administration. There was more than one unlabelled syringe in the tray.

**Recommendation: Staff should adhere to trust policy in the administration of medicines.**

The delay or reason for omission for some medication was clearly and accurately recorded in the medicine kardex.

At the time of inspection there was no patient self-administering medication. We were told that the trust did not have a policy or protocol to guide staff for those patients who self-administer. A robust system should be in place to ensure that all self-administered medication is recorded in the kardex.

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

The ward has a new full time pharmacist and staff had access to pharmaceutical advice at all times. We noted issues in the IMM service in the ward such as pharmacy involvement in the completion of medicines reconciliation on admission, during the inpatient stay and at discharge did not always occur. We observed there was no reconciliation of the kardex and discharge prescription as part of the pharmacist clinical check at discharge. We also noted that not all patients' compliance with prescribed medicines was assessed on admission and that systems were not always in place for the provision of appropriate support with medicines taking prior to discharge.

**Recommendation: The Integrated Medicines Management service should be improved within the ward.**

We identified issues in the handling of critical medicines where timelines of administration are crucial.

Some of these medicines had been recorded in the kardex as being not available for several days but arrangements had not been made for the immediate supply of these critical medicines. A list of critical medicines was accessible however not all staff were aware of the specific action to take if these medicines were not available.

**Recommendation: Staff should ensure that immediate arrangements are made for the supply of critical medications and appropriate training provided for staff.**

Documentation demonstrated that oxygen prescription and administration were inconsistently completed.

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

### 3.3 Is Care Effective?

**Nursing Care Records**

We found that some nurses did gather information however this information was not always subsequently reviewed and analysed to collectively identify the care needs of individual patients. Assessments were not always reviewed or used to inform subsequent care interventions. Not all risk assessments had been fully completed. As a result of lack of review, care plans did not always reflect identified risks and methods of mitigating those risks.

Care plans did not always reflect the nursing assessment or the care required for the patient. Some care plans were poorly written with minimal detail and little direction as to the care to be delivered for the patient. Core care plans were not always individualised. Not all care plans contained adequate assessment, planning, evaluation and monitoring of the patient's needs. This is vital in providing a baseline for the care to be delivered and to show if a patient is improving or if there has been deterioration in their condition. Nursing records did not always adhere to Nursing and Midwifery Council (NMC) and NIPEC guidelines with some having illegible signatures, use of initials instead of a signature and some contained unhelpful jargon.

MDT involvement was poorly documented; however records indicated appropriate involvement of the patient and families in planning aspects of patient care or discharge planning.

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

**Medical Care Records**

Medical records were well organised and easy to complete. However, a substantial proportion did not have the patient's name and hospital/H+C number recorded and there was one instance of an incorrect name on one page of a patient's chart. Time and authorship of entries were missing in several instances.

There was little documentation regarding the admission diagnosis and little evidence of management plans being shared with patients or their relatives. Discharge documentation was good and completed in a timely manner with a current list of diagnoses, management plans, investigation results and medications.

**Recommendation: Medical staff should ensure the minimum data requirements (patient name, hospital number, signed, timed and dated entries) are met for patient records.**

**Recommendation: Medical staff should ensure that discussions with patients and families, where relevant, are recorded in the medical notes.**

**Nutrition and Hydration**

Adherence to protected meal times was good. A menu choice was available which included specialised diets and on observation meals served seemed to be appetising. We were impressed with the coordination of meals service in the ward. Staff have worked hard to improve food service, patient comfort and satisfaction at meal times.

A meal supervisor is identified at the morning safety briefing; who is then responsible for coordinating meal service. There was evidence of audits to ensure staff practice at meal times was continuously improving. An aide memoire at each bed helped staff to identify patients who required assistance with meals or needed a special diet.

Patients could either remain in bed and eat their meal, or sit at the bed side. Fresh water was available at each patient's bed side, in covered jugs and rigid plastic glasses. Nutritional supplements were prescribed and administered appropriately.

Patients were prepared for meal times; food was placed in front of the patient and appropriate assistance given where needed. On day two we observed that staff shortages caused some minor delays in staff assisting patients during meal time.

A review of fluid balance charts demonstrated inconsistent documentation; not all charts were reconciled and signed, however food charts when in use, were well documented.

**Recommendation: Fluid balance charts should be completed and reconciled according to regional guidance. There should be robust audit of the documentation.**

**Pain Management**

During the inspection, patients appeared comfortable; pain relieving measures were available and in place and staff responded promptly to patients' requests for pain relief. Pain medication was administered as prescribed in the medicine kardex. Documentation however indicated that the pain score on the NEWS chart was not always recorded.

**Housekeeping Point: Staff should ensure that pain scores are recorded on the NEWS chart**

**Pressure Ulcers**

We found staff to be knowledgeable about and good practices were observed with regard to pressure ulcer care. Patients appeared comfortable, were appropriately positioned with pressure relieving equipment used where necessary. Staff stated that pressure relieving equipment was delivered promptly when ordered. A validated classification tool and wound chart was in use and where required, a SSKIN bundle was in place and evaluated to reflect patients' ongoing care needs.

When required, staff would contact the tissue viability nurse (TVN) for detailed advice and guidance. Regular mattress audits were carried out to assess mattress integrity. Band 2 and band 3 HCAs have received pressure ulcer care training facilitated by the hospital TVN.

**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. Documentation in relation to urinary catheters was good, and stool charts were in place where required. Staff had access to continence/stoma specialist services and stoma/incontinence aids were available on the ward.

## 3.4 Is Care Compassionate?

**Person Centred Care**

We noted that although busy, the ward was organised and calm with minimal auditory clutter. A call bell system was in place and each non ambulatory patient had a call bell within reach. There was, in general, a prompt response to call bells and patient requests for assistance. Privacy curtains were pulled each time personal care was to be delivered and staff were discreet when delivering personal care within the screened bed space.

For bed bound patients staff use the SSKIN bundle to ensure the patient's personal needs and comfort were met. For ambulatory patents, intentional care rounding, to ensure that nursing staff carry out scheduled tasks or observations of patients to meet and anticipate their fundamental care needs, was not carried out.

**Recommendation: Intentional care rounding or a similar system to meet and anticipate patient care should be introduced.**

Bays were designated male or female and a shower room was available in each bay. The "glass house" at the entrance to the ward or the sister's office could be used to facilitate private conversations for and with family members. Patients had access to the ward telephone and some beds had a wall mounted patient entertainment system. Advocacy services were available and a chaplain was observed visiting patients on day one of the inspection.

**Communication**

There was good signage to direct visitors to the ward and within the ward. Where required there was discreet signage relating to fasting, personal assistance required, IPC and communication aids. The ward has devised an aide memoir to assist staff in delivering care. This is a good initiative and not intrusive (Picture 4).


Picture 4: Aide memoire for staff

An easily understood explanation was given prior to carrying out care and staff spoke discreetly to patients.

We observed staff treating patients and visitors courteously and patients were encouraged in a sensitive manner. Communication aids were available and there was access to appropriate information and leaflets, both general and specific to the ward. Information including the trust's complaints policy was available, some in various formats and different languages. At the time of inspection, the ward was waiting for a response to their enquiries about braille leaflets and the loop system.

The ward had participated in the Public Health Agency (PHA) project called '10,000 Voices' and information was displayed on the whiteboard at the entrance to the ward. This gives patients, and their families and carers, the opportunity to share their views and highlight anything that would have improved their experience. The project then gathers and feeds back these views.

A patient satisfaction survey is conducted weekly by the ward support officer. In November 2015, a Patient Satisfaction Survey was carried out using the Patient and Client Standards which are Arrival, Respect, Attitude, Privacy and Dignity, Behaviour and Communication, Areas of Care and Environment. The sample size was 50 patients with a 64 per cent response rate. Overall, the ward achieved 95 per cent compliance with the standards and staff were at the preliminary stage of drafting an action plan to address the issues raised.

**End of Life**

At the time of inspection, there were no patients on the ward who were at the end of life stage. We found staff to be knowledgeable about the systems in place and available support and guidance. We were told that the palliative care team would visit the patient and draw up a care pathway forward staff to follow. Staff could access guidance on end of life care, contact the on call oncology consultant and the palliative care team was available out of hours.

Staff can access information on palliative and end of life care via the trust intranet HUB; however, there is currently no integrated care pathway in use at ward level. As part of its strategic priorities for 2014-17, the trust has set up both a steering and implementation group to implement the recommendations contained in the Living Matters, Dying Matters and End of Life Care Strategy, 2010-15.

Single rooms were available where patients can be cared for in a quiet environment and with dignity and respect. We were impressed by an initiative suggested by a band 2 HCA who had recently attended a bereavement course. A system has been instituted where the family, after their loved one had passed away, receive a card from the ward expressing their thoughts and sympathy. The ward manager and sisters were facilitating this initiative. Information and support systems were available for patients and carers before and after a patient dies. Car parking permits were issued and visitors could stay at the bedside with their family member.

**Patient and Relative Questionnaire**

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

In Ward 7B a total of 11 questionnaires were completed:

- nine patient questionnaires
- two relatives/carers questionnaires

Overall, the feedback received from patients indicated that they were satisfied with the standard of care they received. They informed us that staff introduced themselves; were polite and addressed them by the correct or their preferred name. They told us that staff were courteous and compassionate and they felt they received assistance when required and were treated with respect and dignity. In general, call bells were responded to in a timely manner; if not answered it was because staff were busy with other patients.

Most patients felt there were enough staff to care for them, that they were involved in decisions about their care and knew who to speak to if they had concerns. Although most patients stated that staff did check on their pain management, one patient did say that here could be delays due to "work pressure" or "waiting for doctors to sign scripts".

Patients stated that the ward was clean and the choice of food was good and fluids were readily available. Patients considered that staff hand hygiene was good.

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

**Patients Comments**

*"I am in capable hands here they have a lot to do and they do it." "Staff are very attentive."*

*"If they have to turn you they tell you and are as careful as they can be."*

*"I was ready for my breakfast and I wasn't disappointed."*

*"It is marvellous. I have no complaints at all."*

*I would have no hesitation/highest regard for this hospital."*

**Relatives Comments**

*"Staff are all excellent."*

*"Great staff."*

**Observations 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 seven observations were carried out over four observation sessions. Overall staff interaction was very good. We observed staff introducing themselves and giving explanations of the procedures they were carrying out, providing support and care and treating the patient as an individual.

The basic interactions from the coding system occurred between staff and patients at the meal service and when delivering personal care when conversation was minimal. There were no neutral or negative observations.

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

## 3.5 Conclusions for Ward 7B

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

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

In bays, the number of hand wash sinks did not comply with local or regional guidance. IPC practices were good, however improvement is needed in completion of ANTT documentation. Patient safety performance indicators/bundles are evaluated however the trust has not introduced the Sepsis Six bundle to wards.

We noted variations in the completion of some nursing documentation. Medical patient records required more detailed documentation on family discussions.

Protected meal times were well supervised, coordinated and patients assisted when required. Good practices were observed in pressure ulcer care, end of life, communication and person centred care.

Overall the findings of the inspection of ward 7B were good. We have made 14 recommendations and five housekeeping points to encourage further improvements within the ward.

### 3.6 Recommendations and Housekeeping Points

**Recommendations**

1. The provision of clinical hand wash sinks should be reviewed to comply with local and national guidance.

2. Medical staff should complete all documentation with regard to care bundles and ANTT practices.

3. Compliance with the Sepsis Six screening tool should be audited.

4. VTE risk assessments should be fully completed.

5. Staff should adhere to trust policy in the administration of medicines.

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

7. The Integrated Medicines Management service should be improved within the ward.

8. Staff should ensure that immediate arrangements are made for the supply of critical medications and appropriate training provided for staff.

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

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

11. Medical staff should ensure the minimum data requirements (patient name, hospital number, signed, timed and dated entries) are met for patient records.

12. Medical staff should ensure that discussions with patients and families, where relevant, are recorded in the medical notes.

13. Fluid balance charts should be completed and reconciled according to regional guidance. There should be robust audit of the documentation.

14. Intentional care rounding or a similar system to meet and anticipate patient care should be introduced.

**Housekeeping Points**

**1.** Agreed and actual staffing levels should be displayed.

**2.** All appropriate staff should have access to ECR.

**3.** Staff should ensure all risk assessments are reviewed and up to date.

**4.** Staff should ensure that pain scores are recorded on the NEWS chart.

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

# Inspection Findings:
# Ward 6C Surgical Ward

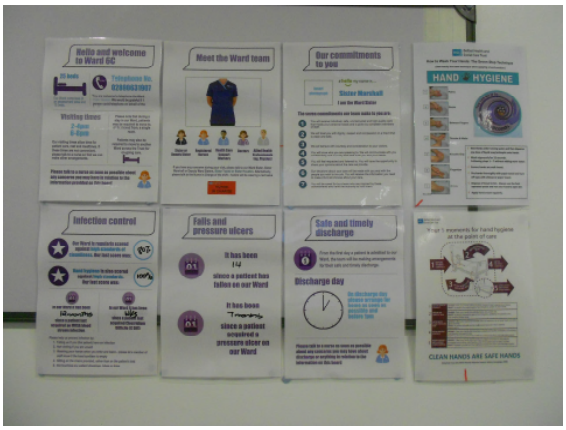
## 4.0 Inspection Team Findings: Ward 6C Surgical Ward

Ward 6C is a general surgical ward consisting of a 10 bedded EmSU and a 15 bedded surgical inpatient ward. The 10 bedded EmSU is split into a six bedded bay and four single rooms. The 15 bedded ward is made up of two six bedded bays and three single rooms.

### 4.1 Is the Area Well Led?

**Governance**

The band 7 ward sister was easily identifiable and visible on the ward. Information posters for patients and visitors are present at the entrance to the ward which identify the name of the ward sister and the designation of staff (Picture 5). We were advised that a staff group picture is to be added to this information.




Picture 5: Posters at ward entrance

The band 6 sister takes charge of the ward in the absence of the band 7 sister. The nurse in charge wore a red 'nurse in charge' badge to indicate their position. All ward sisters wear a blue uniform, however we were advised that there can be a delay in provision of these uniforms.

We observed that the availability of the band 7 sister was impacted on by nursing staff sickness absences and increases in ward activity due to pressures from the ED to admit and discharge patients. The band 7 sister organisational role was observed to be challenging throughout the inspection.

Staff have access, via the trust intranet HUB, to a range of policies and procedures. Mechanisms are in place for staff to learn from ward complaints. Verbal complaints are not recorded centrally to help to identify trends and patterns. The sister told us that generally complaints related to waiting times for investigations and communication problems.

We were informed that a particular issue identified on the ward risk register relates to the endocrine single person service.

**Housekeeping Point: The resolution of local verbal complaints should be recorded centrally.**

Staff were aware of the process to report SAIs, incidents and near misses. The ward sister analyses this information monthly and provides quarterly information on incidents. Staff however were not aware of a trust wide analysis of trends. Some staff told us that they were not always updated on the outcome of SAI, incidents and investigations. Staff meetings are held; however, on review of minutes there was no robust evidence of dissemination of this information.

We were informed that surgical sisters rotate their attendance at directorate morbidity and mortality meetings. Currently information from these meetings is not disseminated to ward staff for learning. Information in relation to ward cardiac arrest rates and performance in healthcare associated infections is displayed for staff.

**Recommendation: Communication with staff should be improved to ensure dissemination of learning in relation to SAIs, incidents, investigations and morbidity and mortality meetings.**

Surgical ward sisters meetings are held every six weeks. An EmSU improvement team, comprising of surgical sisters and surgical and ED medical staff has been set up and meets monthly. This team is reviewing the existing EmSU service model to improve the delivery of care provided to patients within the unit and ensure effective communication of EmSU clinical pathways across the trust. The inspection team view this as a positive initiate.

**Staffing and Supervision**

On review of the Ward 6C work roster, ward sisters are allocated ward management days. However, we were informed that the band 7 sister does not currently have sufficient time to undertake managerial duties and provide effective clinical leadership. On the day of inspection, the sister was counted as part of staffing numbers. We observed a very busy ward, with the band 7 sister managing both staffing and ward operational issues. We were told that there has been no clerical ward support officer to assist the band 7 sister with administration duties, since May 2015, despite requests for a replacement. Only the band 7 sister has permission to access the new on-line human resources, HRPTS computer system to book staff leave, record sick leave etc. This increases the band 7 administrative role.

**Housekeeping Point: There should be sufficient ward clerical cover to support the Band 7. Access to HRPTS should be reviewed and extended.**

There is one band 7 sister and one band 6 sister for the ward. A further band 6 sister was appointed in September 2015, however has yet to take up post due to the prolonged Human Resources (HR) process. Staff retention has become an issue over recent months, with staff leaving the ward to work closer to home or move into community nursing. There are currently 2.8 RN WTE vacancies, 2.8 RN WTE on long term sick and seven per cent overall sick leave, which has however improved from a high of 11 per cent.

We were informed that the nursing normative staffing level review has been completed. As a result, two further band 5 nurses are required for the ward and are currently in the process of recruitment (counted in above vacancy figures). Staffing levels were agreed based on a 1.6 WTE nurse: patient ratio, per assessment bed and 1.46 WTE per inpatient bed. We were advised that this ratio does not take into account the acuity and specialist nature of the ward. There is no information displayed on the agreed and actual nursing staffing levels for each shift.

**Recommendation: Nursing staffing levels should be further reviewed, taking into account the acuity and specialist nature of the ward. The appointment of staff via HRPTS should be expedited.**

**Housekeeping Point: Agreed and actual nurse staffing levels should be displayed.**

Staffing levels are reviewed and supplemented, with the use of bank and agency nurses, however shifts are not always filled. We were advised of occasions when band 5 nursing shifts are filled by band 3 healthcare assistants. Beds have not been closed due to staff shortage.

The surgical wards are interlinked, with surgical patients moving across the surgical floor from Ward 6C to the adjoining surgical Ward 6B. In order to ensure senior cover across the floor, during all shifts, a surgical sister band 6 and band 7 staff rota has been devised. However, until the new band 6 sister takes up post this cannot be fully implemented. There are further plans to review the rota, to ensure that one band 7 is free at all times.

Discussion, observation, and review of documentation identified that due to increased sickness, and ward activity, staffing within the unit during the inspection was insufficient to meet the ward needs. Ward 6B staff assisted in EmSU during times of increased pressure involving increased movement of patients.

The band 6 sister supports the ward sister through carrying out clinical duties and taking responsibility for staff training. Ward nursing staff take on the role of mentors and preceptors. Written information supplied during the inspection identified that staff supervision and appraisal are not up to date.

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

Overall staff morale was good; staff appeared happy working on the ward. Nursing staff felt supported and told us that they can raise concerns. Staff reported a number of issues which were affecting the running of the ward. These included the availability of decision making clinicians, staff skill mix, lack of a ward based pharmacy service, patient flow and delayed patient discharge.

Surgical core and registrar trainees described their experience as positive. However, foundation year one (FY1) doctors in Ward 6C felt disconnected from the rest of the team. Their rota allocations often see them move between areas on a weekly or daily basis resulting in breaks in the continuity of patient care. Furthermore, due to the pressures on middle grade cover, decision making is slower and access to senior staff can be hindered due to theatre requirements.

Medical staff told us that during times when the ward was under extreme pressure, they would have concerns about delays in processing and completion of documentation, including discharge scripts. However, medical staffing levels were not reported to otherwise compromise patient care, with systems in place to review patients in a timely manner.

**Recommendation: FY1 doctor rotas should be reviewed to ensure consistency of cover leading to better continuity of patient care.**

Nursing staff informed us that they work within a safe environment. Ward doors are locked at night and each bay and room has a call bell. Staff told us that security is quite quick to respond to incidents.

We were told that there is an AHP staffing resource issue across the site. Therefore services have to screen and prioritise patient referrals. There are no AHPs aligned to the ward but services can be accessed by phone Monday to Friday, 9.00am to 5.00 pm. Occupational therapists will only review patients when they have an estimated date of discharge. Physiotherapy services are available at weekends and patients with respiratory conditions are prioritised.

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

Staff told us that a more timely and early assessment and intervention from these services would assist with patient recovery, patient flow and discharge. There is no regular multidisciplinary ward meeting.

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

**Housekeeping Point: Staff should be familiar with reablement in order to engage this service to support patients for discharge home.**

**Staff training**

An induction programme was in place and most staff were happy with this, however one member of staff felt it could be longer. Currently the ward has three nurses starting their preceptorship programme and two who have almost completed the programme.

A range of mandatory and additional trust based training and external specialist practice courses is available to enable staff to fulfil their role which includes IPC, moving and handling, a surgical management module, head injury awareness, dementia awareness and MAPA. The training matrix and figures provided during the inspection indicate that staff attendance at mandatory training and additional role specific training, requires significant improvement.

The ward has a designated nurse development lead (NDL). Additional input from the NDL to provide training commensurate to their needs is vital and should be immediate and ongoing.

**Recommendation: All staff mandatory training should be up to date. Staff should have the opportunity to attend in house training commensurate with their role.**

**Housekeeping Point: There should be immediate engagement by the NDL to provide staff training.**

**Patient Flow**

All oncoming nursing staff attend handovers at 7.30am and 8.00pm followed by a safety briefing. The nursing handover was well led, informative, focused and structured. Handover information was in the form of electronic pre-printed and populated handover sheets.

The ward sister, or if unavailable, a designated ward nurse participates in the surgical ward round. Updates are given to all staff on the outcome of ward rounds at a mid-morning briefing. We were advised of an issue where doctors undertaking medical rounds do not always communicate with ward nurses the outcome and plan of care for their patients.

We observed ward based patient flow meetings and regular discussion between surgical ward sisters and the assistant services manager regarding the flow of patients in the ward and across the surgical floor.

There are two designated surgical consultants of the week; therefore there are two separate surgical ward rounds each morning. Surgical ward rounds occur at 8.30 am, following an 8.00 am surgical registrar handover. The surgical ward rounds start at different surgical wards and cross over, therefore reducing the number of doctors present on the ward at one time.

Surgeons, at consultant or registrar level, will review all patients again in the afternoon, unless in theatre.

If nursing staff have any concerns about a patient, a surgical on call registrar is available to provide assistance. There is no set time for the medical team to review patients.

A speciality escalation plan for EmSU was updated in January 2015; however this needs to be reviewed. During the inspection the ward was continually in escalation and we were informed that this is a regular occurrence. One of the reasons the EmSU does not function effectively is due to the number of medical inliers. During the inspection, wards 6C and 6B had a significant number of medical inliers, affecting the flow of surgical patients through the system from ED. On the evening of day one of the inspection, the increase in numbers of patients within the ED resulted in senior management staff from ED contacting Ward 6C to attempt to speed up the discharge of patients from the ward, to facilitate ED surgical admissions. We were informed by staff that they can feel under pressure to move patients out of the EmSU.

To function effectively, patients should be admitted, assessed and treated, discharged or admitted to an inpatient surgical bed within 12 hours of assessment in the EmSU, with no longer than one overnight stay. This was not occurring. Information provided demonstrated the continued and increasing use of surgical floor beds for acute medical patients.

The flow of patients should be from the EmSU to the main ward and across the surgical floor (Picture 6). We were informed that one bed should be kept free for overnight emergency surgery admissions. At the time of inspection we were informed that this bed was generally used for medical/inlier admissions.

Picture 6: EmSU six bedded bay

**Recommendation: Systems, processes and operational protocols including the speciality escalation plan which affect admission to and patient flow throughout the ward and across the surgical floor should be reviewed to improve their effectiveness.**

Nursing staff told us that although improving, there were still difficulties accessing speciality review from neurosurgery, particularly for head injury patients and especially overnight.

Staff are finding it difficult to identify a particular neurosurgeon to accept and review these patients. We were advised of one recent incident where a patient with a subdural bleed, waited eight hours 40 minutes to be seen by a neurosurgeon. The situation was only resolved following escalation to a co-director.

Medical and surgical staff also expressed concerns over ownership of patients within the EmSU. A medical patient who had been admitted to the ward told us that they were *'still in the dark about my condition'* as they had not been regularly reviewed.

**Recommendation: There should be timely review and ownership of all patients by senior clinical staff, with the plan of carefully communicated to ward staff and to patients.**

Patient discharge from the ward is also affected by issues such as: lack of pharmacy cover to check discharge letters and prescriptions, the time spent waiting for prescriptions, timely completion of discharge letters by medical staff, access to AHPs and social workers. Patients waiting for prescriptions can use the discharge lounge, however before going there they must be provided with a discharge letter.

**Recommendation: Access to AHPs, social work, pharmacy and medical staff should be improved to facilitate discharge.**

Written information provided indicates that out of 129 patients 49 waited between two to seven days and on two occasions over eight days for an magnetic resonance imaging (MRI) scan. We were advised that access to timely computerised tomography (CT) scans can also be an issue.

**Recommendation: There should be timely access to imaging investigations such as MR and CT scans.**

There have been certain initiatives identified to improve the delivery of care provided for patients. An EmSU improvement team has been established and there is a plan to have all day general surgery as, at present, there are afternoon surgery slots only. Ongoing improvement initiatives need to be further progressed to impact on the running of the ward.

**Communication**

The ward uses various methods to communicate and disseminate information to staff, such as safety briefings, handovers, ward meetings and e-mail access for all staff, with the exception of new staff. The last ward staff meeting was in November 2015. There is no standard agenda for staff meetings to ensure the quality and continuity of information shared with staff.

Twice daily safety briefings are in place. These are used to communicate information to staff and identify safety issues including staffing problems, incidents and equipment.

On inspection and following discussion with staff, this briefing appears to be a tick box exercise. There is no recording of the information disseminated to staff to ensure continuity and gaps were observed in the tick sheet to record that this safety briefing had occurred. We were also advised by staff that they were not always aware of the information detailed on the safety briefing. While the use of safety briefings is a positive way of communicating information to staff, the current system in place should be reviewed.

**Housekeeping Point: The system to ensure appropriate communication and dissemination of information to staff (including staff meetings and safety briefings) should be reviewed to assess its effectiveness.**

All medical staff have access to ECR to obtain up to date patient general practitioner (GP) information. We were informed that access for nursing staff is to be rolled out.

Audits of practice are carried out using a range of performance indicators which include; environmental cleanliness, hand hygiene, mattresses, pressure ulcers. Results are displayed at the ward entrance for patients, visitors and staff to view. Further figures are displayed for staff in relation to cardiac arrests, VTE risk assessment and falls.

Evidence was provided to show that action was taken to address any fall in compliance levels for example an environmental cleanliness audit achieved 80 per cent on 18 November 2015; re-audit achieved 95 per cent compliance on 25 November 2015.

**Safeguarding**

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

We were informed that the ward sister has been involved in Best Interest Case Conferences; staff have received feedback on the outcomes of these conferences.

The ward can admit children between the ages of 13 to 18 years. However, if there was ever a case of suspected child abuse, staff were not aware that the consultant paediatrician should be called immediately and child protection procedures commenced. Staff were not aware that additional safeguards are required for children, including completing an Understanding the Needs of Children in Northern Ireland (UNOCINI) assessment.

Training figures highlighted that attendance at safeguarding training should be improved. To date only 66 per cent of staff are trained in safeguarding children.

We were informed by the assistant services manager that as a result of the initial ward level feedback from RQIA, contact has been made with another area in the hospital, previously inspected by RQIA in order to share learning.

## 4.2 Is Care Safe?

### Environmental Safety

The environment was light, bright and free from hazards, with emergency exists accessible. Patient equipment was generally stored in designated areas, not accessible to the public. However, when not in use, observation trolleys were kept in the ward corridor. All single rooms had a privacy blind and a door, promoting minimum noise level. Nursing staff maintained visual contact with high risk vulnerable patients by placing them in bed bays close to the nurse's station.

We were informed that as a result of a ward reconfiguration, patient call bells in the adjoining ward will sound in Ward 6C but cannot be heard in the ward were they are being activated. Ward 6C staff are unable to silence the bells and have to advise the other ward that a patient is calling for assistance. This current system has the potential to be unsafe, with patients not being easily identified or receiving timely assistance.

**Recommendation: The call bell system should be fixed immediately.**

Documentation for the resuscitation trolley demonstrated that equipment checks are carried out daily and after use. The sharps box on the trolley had contents in situ and needed to be changed. Contact details for the resuscitation team were clearly displayed.

**Housekeeping Point: Staff should ensure that the sharps box on the resuscitation trolley is renewed after use.**

Picture 7: Pictorial door signage

The ward environment has not had a full assessment for dementia patients, however disabled sanitary facilities are available, with good pictorial door signage (Picture 7). Wall clocks have been purchased, but are yet to be erected.

**Recommendation: The ward should have a full dementia assessment carried out.**

We observed out of date ward risk assessments, for example manual handling. The ward sister acknowledged that these needed to be updated.

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

**Infection Prevention and Control**

The ward environment was generally in a good state of repair. Clinical hand wash sinks, alcohol rub and glove and apron dispensers were easily accessible, located near to the point of care. We noted clutter around the nurses station and greater attention to detail was needed when cleaning horizontal surfaces and clinical hand washing sink taps. Environmental cleanliness audits are carried out; following re-audit trust compliance rates were achieved. We were advised of the large number of discharge cleans carried out on the ward leading to an increase in cleaning activity for ward based patient and client support staff (PCSS). PCSS staff advised that it can be challenging to complete the necessary cleaning schedule.

We spot checked three pieces of patient equipment; observation trolley, portable electrocardiogram (ECG) machine and stored patient controlled analgesia (PCA) pump. All required cleaning or repair (Picture 8). Patient equipment cleaning schedules were not consistently recorded and regular audits were not undertaken.


Picture 8: Equipment requiring cleaning

**Housekeeping Point: Ward clutter, environmental and equipment cleaning should be improved. Patient equipment cleaning schedules should be fully completed and regular patient equipment audits carried out.**

The single rooms were spacious, with a clinical hand wash sink to promote good infection control practices. Contact infection prevention and control precaution notices were displayed appropriately.

We observed that the majority of staff carried out hand hygiene at the appropriate times, in line with the WHO Five Moments of Care. However, staff should ensure hands are washed after removing gloves and following contact with the patient environment. Generally staff complied with trust uniform policy; however some wore stoned rings and earrings. On one occasion a surgeon attended the ward in theatre scrubs and hat but with no theatre overcoat. While staff adhered to ANTT, there were occasions when some did not for example not leaving the intravenous (IV) hub for the appropriate time to dry after cleansing. We observed continual incorrect and over use of gloves for example by staff pushing beds. Staff did not always remove gloves and aprons between tasks.

**Recommendation: All staff disciplines should carry out hand hygiene in accordance with the WHO Five Moments of Care. All staff disciplines should adhere to trust policies for uniform, use of gloves and ANTT procedures.**

On review of documentation, we observed that for two out of three patients, a VIP chart was not in place for the management of their peripheral venous cannula, in line with best practice guidance.

If required, the ward will complete an incident form and participate in a root cause analysis for infection. The ward has infection prevention and control link nurses.

**Patient Safety**

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

Guidance on the management of the acutely ill patient was available. Patients' NEWS were generally well completed however not always within set timescales.

A Sepsis six screening tool is present on the back of the NEWS chart. Although staff were aware of the components of this tool, adherence is not audited.

**Recommendation: Compliance with Sepsis Six should be audited.**

The ward is in the process of introducing a falls safe bundle. The number of falls is currently monitored using ward incident data. A SSKIN care bundle is in place for patients deemed 'at risk' of pressure damage, (Braden score of greater than 18).

We found that consent forms and WHO Surgical Safety Checklists were well completed with the exception of one illegible signature on a surgical consent form. VTE risk assessments were completed for each patient reviewed and VTE prophylaxis was administered where required.

The trust provides theoretical training and assessment in relation to Haemoviligence. Documentation provided indicates that only 61 per cent of staff have been trained.

Staff told us that the band 7 and assistant services manager are supportive and take action when a safety concern is raised. Patient safety/medical alerts are printed and displayed on the ward notice board for staff to view.

There was sufficient patient equipment, which is maintained and replaced. There are plans to purchase a patient standing aid 'steady'.

Staff advised and we observed on the staff handover that consideration was given to placement, safety and vulnerability of patients. However, safeguarding information was not easily accessible for patients or visitors.

**Medicines Management**

Medicines, including IV medication were not always stored safely and securely. On one occasion, we observed IV medication left unattended in the clean utility room for 15 minutes (Picture 9). We also observed a porter delivering patient discharge medication pouches; these were left on the nurses' station, there was no receipt of delivery or secure storage by nursing staff for over 15 minutes.

Picture 9: Unattended medication

**Housekeeping Point: Discharge prescriptions should be signed for on delivery to the ward and stored securely until given to patients.**

Medicine cupboards were well laid out, however we observed and removed out of date medication. Some medicines were inappropriately stored, for example enoxaparin strengths were mixed; 40mg with 20mg and Lidocaine was stored with other IV medication. These issues were identified to the ward sister and immediately corrected.

**Housekeeping Point: Medication stock should be rotated and expiry dates checked.**

CDs were stored securely and administered safely, with a second signatory and two RNs at the bedside. However, we observed unsafe practice, with the potential to divert medication. When only 2.5 mg of oxynorm was drawn up from a 10mg ampule, the disposal of the remaining 7.5mg was not fully witnessed by a second nurse. Epidurals were stored inappropriately with IV patient controlled analgesia in the CD cupboard. This has the potential for staff to use incorrectly medication. The ward sister advised that this was due to space constraints; inspectors advised that this should be risk assessed by pharmacy.

**Recommendation: The disposal of unused CDs should always be witnessed.**

**Housekeeping Point: The storage of epidurals with patient controlled analgesia in the CD cupboard should be risk assessed.**

IV infusions were stored in their original boxes with good separation and potassium-containing solutions kept separately from other solutions.

The drug preparation area (clean utility room), while tidy and organised was small with insufficient space for the volume of medication prepared within the ward. A treatment room with work bench and storage cupboards is available within the ward; the use of part of this room for drug preparation should be explored.

**Housekeeping Point: Facilities for the preparation of medication should be reviewed.**

Observed medication administration was in line with good practice guidance. We observed IV medication prepared by one RN, checked by a second and administered with two RNs present at the bedside. With the exception of one occasion, IV syringes were labelled. IV medications were not reconstituted en masse; this is good practice. As medication is dispensed from the bedside locker, oral medication was administered directly to the patient and not left unattended.

In all medicine Kardexes reviewed, the delay or reason for omission for some medication was not recorded. Patient weight was not recorded and oxygen therapy was not prescribed with the correct administration record completed. On one occasion when a blood glucose level was outside the usual range, there was no recorded action. All patient allergy/medicine sensitivity status was documented. The trust currently does not have a self-administration of medication policy.

**Recommendation: Where a patient blood glucose levels is outside the usual range action taken should be recorded.**

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

**Housekeeping Point: Patients weight should be recorded on the medicine Kardex. Oxygen therapy when prescribed should have its administration documented.**

There is no ward based pharmacist or pharmacy technician. On occasion, pharmacy advice can be accessed from the pharmacist in Ward 6B, however due to work commitments, this input is very limited. An IMM service is not being implemented on the ward, from admission, during inpatient stay or as part of discharge. Medical staff prepare the patients discharge prescription.

**Recommendation: The ward should have pharmacy to facilitate effective integrated medicines management and ensure adherence to best practice.**

On discussion, we were told of patient involvement in decisions about commencement of new medication. However there was no evidence that patients' concordance with prescribed medicines is assessed on admission.

**Housekeeping Point: Patients' concordance with prescribed medicines should be assessed on admission.**

A list of critical medicines where timelines of administration is crucial was available. Staff we spoke to were unaware of how to obtain a critical medicine that is not available, to avoid omitted and delayed medicines.

There is evidence of medication incidents being reported. However staff report that they do not receive feedback or learning from these.

**Recommendation: All staff should be immediately updated on their role and responsibility in the safe storage, security, administration, prescribing and documentation of and related to medication. Staff practice should be monitored to ensure adherence to best practice.**

**Housekeeping Point: All staff should be familiar with critical medications. Learning from medication incidents should be reported back to staff.**

### 4.3 Is Care Effective?

**Nursing Care Records**

We found that a comprehensive nursing assessment and relevant risk assessments were in place, completed and reviewed. However, risk assessments did not always lead to the development of a care plan to provide instruction.

The nursing care records reviewed in the EmSU and the main ward were not always up to date and did not always reflect the nursing assessment or the care required for the patient, identified by the inspection team through observation.

Not all care records demonstrated that nursing staff had adequately carried out assessment, planning, evaluation and monitoring of the patient's needs.

This is vital to provide a baseline for the care to be delivered and to subsequently show if a patient is improving or if there has been deterioration in their condition. Nurse record keeping did not always adhere to NIPEC guidelines. Patient details, for example, healthcare number were not always recorded on documentation.

There was evidence of appropriate referral by nursing staff to the MDT. There was minimal documented evidence of involvement of patients and families in planning aspects of patient care or discharge, including involvement of the wider MDT.

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

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

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

**Medical Care Records**

The medical notes reviewed were poorly organised with missing pages and several instances of incorrect filing, including clinical note entries and fluid balance charts. It was difficult to find the current admission entries within the medical records. Whilst there was some evidence of discussions occurring between clinical staff and patients and their relatives, the content of these discussions was not documented. There was no evidence that management plans and investigation results had been explicitly shared with patients. Almost all entries from AHPs did not have a time recorded, and time was poorly recorded in entries from doctors. Not all pages were identified with patient name and hospital/healthcare number. Specific concerns and errors were relayed to the ward manager during the inspection. Discharge documentation was good and completed in a timely manner with a current list of diagnoses, management plans, investigation results and medications.

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

**Nutrition and Hydration**

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

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

We observed that there was no senior member of nursing staff to supervise or co-ordinate the meal service. All staff should participate and oversee meal service as part of their role. Service appeared unorganised and at times staff were unaware of individual patient requirements.

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

Protected meal times are not always adhered to. We observed staff completing cleaning duties and taking blood during meal service. Meals are served from a meal trolley and special diets or missed meals can be ordered directly from the catering department.

At breakfast service we observed that the meal trolley is shared with another surgical ward. This delayed meal service to patients. Lunchtime meal service begins with soup at 11.30 am; we considered this was too early for patients. On observation, meals appeared appetising; confirmed by patients. Tea, toast/pancakes are available from nursing staff at ward level, 24 hours a day as required.

Effective mechanisms were not in place to identify patients that require assistance at mealtimes. Information was passed on verbally from nurse and healthcare assistant to PCSS, who had to continually ask for guidance on patient dietary requirements and need for assistance.

We observed that when food was placed in front of patients, assistance, when required, was not always provided; for example we observed one patient attempting to cut their own food when they clearly needed help. Staff were not specifically allocated to assist patients and appeared preoccupied with other tasks. Staff were not evident in bays and did not check on patients in side rooms during meal service. We did observe some good practice with staff seated at the bedside to assist patients with their meal. Drinks were available at the bedside; however, over the course of the inspection we did not observe staff encouraging patients to drink. Fluids were served in clear flimsy plastic glasses, these are difficult to handle and have the potential to collapse on pressure, causing the content to spill.

**Recommendation: Effective mechanisms should be implemented to ensure patients receive the appropriate dietary requirements and assistance during meal times.**

**Housekeeping Point: All patients should be prepared for meals prior to meal service. Patients should be routinely encouraged and if necessary assisted to drink.**

Adapted cutlery or crockery was available for patients with limited manual dexterity.

There is no mechanism in place to identify or report a patient's intake at mealtimes. PCSS staff collect food trays, however there is no discussion with nursing staff if a patient does not eat a meal. Nursing staff should be involved in this process to allow for accurate recording of a patient's oral intake.

**Housekeeping Point: Effective mechanisms should be introduced to ensure nursing staff liaise with PCSS and monitor patient intake at meal times.**

Food and fluid charts were not completed consistently. However, patients who were nil by mouth/fasting were not kept fasting for long periods and were appropriately re- assessed.

The ward has introduced a monthly fluid balance documentation audit. The ward achieved only 66 per cent compliance for the week of the 12 December 2015.

**Housekeeping Point: Food and fluid charts should be consistently completed. Monthly fluid balance documentation audit should continue and improvement should be demonstrated.**

**Pain Management**

Patients appeared comfortable, pain relieving measures were available and in place. Staff responded promptly to patients' requests for pain relief. Pain medication was administered as prescribed. Documentation demonstrated that a pain score was not always recorded on the NEWS chart. A pain team is available for advice and support. In relation to pain management, one patient stated that staff were *'very good when I came back from surgery*'.

**Housekeeping Point: Pain scores should be completed at all times. Patient early warning scores should be completed within the set timescales.**

**Pressure Ulcers**

Patients appeared comfortable and pressure-relieving equipment was available.

A SSKIN care bundle is in place for patients deemed 'at risk' of pressure damage, with a skin assessment score for predicting pressure ulcer risk (Braden) greater than 18; however we noted gaps in the completion of the bundle.

We found that nutritional supplements were offered to adults 'at risk' or who have a pressure ulcer. Staff were able to access advice on wound care via the trust intranet and TVN service. When required, staff will contact the TVN for detailed advice and guidance. Pressure ulcers can be photographed by the TVN. Regular mattress audits are carried out to assess mattress integrity. New mattresses were purchased for the ward in 2014. Mechanisms were in place for the reporting, investigation and follow up of pressure ulcers.

**Housekeeping Point: SSKIN bundle documentation should be fully completed.**

**Promotion of Continence and Management of Incontinence**

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

We noted in one patients care records that the clinical indicators for catheterisation and other relevant information were not fully documented. Stool charts were completed. Staff have access to continence/stoma specialist services and stoma/incontinence aids were readily available.

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

## 4.4 Is Care Compassionate?

**Person Centred Care**

The senior nurse on duty was visible to support ward activities. During the course of the day the increasing activity on the ward, contributed to at times a disorganised atmosphere.

All patient bed spaces had a working call bell system, which was within easy reach. There was prompt response to call bells and requests for assistance. Patients moved freely around the ward as their condition allowed.

Patients' privacy and dignity was maintained when delivering care; room doors were closed, blinds or privacy curtains pulled and blankets used. Staff alerted patients prior to entering private areas such as the cubicle or the bathroom.

Patients' personal and oral hygiene needs were appropriately attended to and patients appeared comfortable and suitability clothed. We observed that personal items were available and easily accessible for patients to use. There was no toileting carried out at the bedside during meal service.

We observed staff, of all grades, displaying compassion and empathy to patients. Intentional care rounding or equivalent is not in place. These checks ensure that nursing staff carry out scheduled tasks or observations with patients to meet and anticipate their fundamental care needs. Extra staff can be requested if additional care interventions are required such as one: one nursing. However this may not always be possible due to availability of staff, especially at night.

**Recommendation: Intentional care rounding or a similar system to meet and anticipate patient care should be introduced.**

Due to the operational nature of the unit the EmSU six bedded bay is a mixed gender bay with shared gender sanitary facilities. However, the ward staff recognise this and will try to place patients in this situation for only a short period of time. This information is given to patients as part of the EmSU information leaflet.

A room is available for private conversation with patients. The room has comfortable chairs and a sofa bed which can be used by relatives for overnight stay. Hospital chaplaincy and advocacy services are accessible.

Confidentiality was maintained for patients' personal details on computer and on the ward electronic board. However, medical health care records were easily accessible and left unattended at the nurse's station.

**Housekeeping Point: Medical records should be filed away when not in use.**

**Communication**

There was good signage around the ward and a poster which identified staff designations. There was no information leaflet rack containing information for the public. Leaflets about the EmSU and advice on infections are available but not on display.

We found staff to be courteous to patients and relatives, with the majority of staff introducing themselves before carrying out conversations. Staff provided patients with information and explained the care or procedures they were to receive in a clear, easily understood manner. The lack of a name badges made it difficult for patients to identify staff; we were advised that these are on order.

**Housekeeping Point: All staff should wear name badges.**

Access to communication aids and interpreting services for patients with language barriers were available. There were no information leaflets available in different languages; however, these were accessible via the trust website. There was no information available in Braille. We observed and listened to staff speaking with patients; on occasions conversation could be easily overheard.

Staff should move closer to the patient so that conservations cannot be heard, rather than speaking loudly, sometimes at the end of a bed.

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

**Housekeeping Point: Information and leaflets within the ward area, both general and specific to that ward should be made available and easily accessible for patients and visitors.**

**End of Life**

Staff can access information on palliative and end of life care via the trust intranet HUB; however, there is currently no integrated care pathway in use at ward level. As part of its strategic priorities for 2014-17, the trust has set up both a steering and implementation group to implement the recommendations contained in the Living Matters, Dying Matters and End of Life Care Strategy, 2010-15.

24 hour a day palliative care advice is available from the palliative care team, and from the hospice during the out of hours period. Information supplied indicates that staff attendance at training on palliative care and care after death could be significantly improved.

At the time of inspection, there was one patient requiring palliative care intervention. Nursing staff liaised with family and the surgical team in order to ensure clinical review, treatment and care was carried out in a timely manner.

The assessment area and ward combined have seven single rooms, with ensuite facilities. Family members can, if required, remain with their relative while they are in the ward. A room is available for relatives and car parking permits can be issued.

Information and bereavement support systems were available for patients and carers before and after a patient dies; information leaflets should be readily available for relatives.

We viewed one letter from a relative about the care their family member received during end of life care. This letter expressed thanks to staff for the *'respect and practical compassion'* and *'outstanding care'* the patient and the family received. The letter also noted an *'amazing team and an outstanding attitude to care'*.

A DNAR order reviewed had not been appropriately completed; there was no endorsement by a senior decision making clinician and Part 7 was not completed. While there was reference to the next of kin as the responsible person and decision maker for the patient, there was no name documented.

**Recommendation: DNAR documentation should be fully completed.**

**Patient and Relative Questionnaire**

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

During the inspection a total of 15 questionnaires were administered in Ward 6C:

- 10 Patient Questionnaires
- five Relatives/Carers Questionnaires

The feedback received from patients and relatives/carers was positive. Patients were very satisfied with the standard of care they received; they thought staff were polite and addressed them by their correct or preferred name. They thought staff were courteous, compassionate and treated them with respect and dignity. Call bells were answered promptly and they received assistance when required. In general patients thought pain relief was provided in a timely manner. The ward was clean and the choice of food was good with fluids readily available. There was good staff hand hygiene.

Overall, patients thought there were enough staff to care for them and felt involved in decisions about their care. Patients knew who to speak to if they had any concerns. Patients felt that they were safe and that they received a good standard of care. They would be happy for a member of their family or a friend to be cared for in the ward.

Relatives felt welcomed and received information about their relatives' care. However, one relative was unsure of who to speak to and another did not feel involved in the planning of their relatives' care. One relative stated they had spoken to a nurse and was very happy with the conversation. All relatives thought the patients were receiving good care and were treated with respect and dignity.

Two relatives commented on the protracted length of time queuing to access the visitor car park. This is especially evident during peak afternoon visiting times, which clash with the many on site outpatient appointments. We were advised that any delay in access car parking impacts on relatives visiting time on the ward.

**Patient Comments**

*"Happy with everything."*

*Would like TV and better Wi-Fi*

*"All staff are very good and supportive."*

*All very pleasant. Very nice.*

*Staff "come immediately" when I call for assistance.*

*The temperature of the food was "on the low side, but very happy with the food. Good potions."*

*"Absolutely" enough staff to care for me. Very good.*

In relation to pain management "*felt staff were very good when I came back from surgery.*"

**Relative Comments**

*"Better communications between doctors on transfer."*

*"They should involve voluntary people to help elderly patient at meal times."*

*Spoke with nurse, and was very happy about the conversation.*

*''Staff fantastic.''*

**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 nine observations were carried out over four observation sessions. Overall staff interaction was good. Staff introduced themselves and gave explanations of the procedures they were carrying out, providing support and care and treating the patient as an individual.

Neutral and negative observations related to communication, privacy and dignity. Confidential conversations between doctors and patients were overheard and staff did not intervene appropriately to prevent a confused patient, who was pulling their bedcovers off, from exposing themselves. Staff were noisy when cleaning a mattress which affected a patient who was trying to sleep.

On two occasions staff failed to perform hand hygiene after patient contact.

The 10,000 voices patient experience initiative, while undertaken in some wards in the trust, has not extended to ward 6C.
Currently the ward does not gather any patient/relative views. There are plans to use the RQIA patient questionnaire in the future.

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

### 4.5 Conclusions for Ward 6C Surgical Ward

The senior nurse was identifiable to support ward activity. We observed that staff were compassionate, showing empathy to patients and positive interactions were noted.

The environment was light, bright and free from hazards. Staff maintained visual contact with high risk vulnerable patients.

Staff have access to a range of policies and procedures. An EmSU improvement team is reviewing the existing EmSU service model to improve the delivery of care provided to patients within the unit and ensure effective communication of EmSU clinical pathways across the trust.

Overall staff morale was good; staff appeared happy working on the ward. Nursing staff felt supported and told us that they can raise concerns with their direct line manager and senior manager for action.

The inspection identified areas for improvement in the systems and processes influencing ward activity and the delivery of care.

We identified issues that impacted on the running of the ward such as delayed patient discharge, lack of a ward pharmacist, inefficient patient flow, small clinical room, staff skill mix, and the availability of decision making clinicians. Medical staff expressed concerns about delays in processes during times of extreme pressure.

As ward activity increased, the overall impression of the ward was one of disorganisation. Staff did not always communicate with patients in a volume that ensured patient privacy.

The EmSU is not functioning as designed. Escalation processes to affect patient flow throughout the ward appeared ineffective. There is not always access to timely patient investigations and on occasions patient ownership and medical review were not timely.

Greater attention should be given to patient equipment and environmental cleaning. We observed that the majority of staff carried out hand hygiene and adhered to aseptic non-touch technique best practice.

All staff need to be updated on their role and responsibility for the safe storage, security, administration, prescribing and documentation of medication. Ward pharmacist input is required to facilitate effective integrated medicines management.

Nursing care records were not always up to date and did not always reflect the nursing assessment or the care required for the patient. Nurse record keeping did not always adhere to NIPEC guidelines. Medical notes were poorly organised with missing pages and several instances of incorrect filing, including clinical entries and fluid balance charts. Discharge documentation was good.

The system in place for the delivery of patients' meals requires review and improvement to ensure patients nutrition and hydration needs are fully met.

In general, patients and relatives were happy with the care they or their relative had received. Issues were identified in relation to communication and access to timely car parking.

Overall the findings of the inspection identified that Ward 6C requires improvement. We have made 25 recommendations and 27 housekeeping points for this clinical area.

### 4.6 Recommendations and Housekeeping Points

**Recommendations**

1. Communication with staff should be improved to ensure dissemination of learning in relation to SAIs, incidents, investigations and morbidity and mortality meetings.

2. Nursing staffing levels should be further reviewed, taking into account the acuity and specialist nature of the ward. The appointment of staff via HRPTS should be expedited.

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

4. FY1 doctor rotas should be reviewed to ensure consistency of cover leading to better continuity of patient care.

5. All staff mandatory training should be up to date. Staff should have the opportunity to attend in house training commensurate with their role.

6. Systems, processes and operational protocols including the speciality escalation plan which affect admission to and patient flow throughout the ward and across the surgical floor should be reviewed to improve their effectiveness.

7. There should be timely review and ownership of all patients by senior clinical staff, with the plan of carefully communicated to ward staff and to patients.

8. Access to AHPs, social work, pharmacy and medical staff should be improved to facilitate discharge.

9. There should be timely access to imaging investigations such as MR and CT scans.

10. The call bell system should be fixed immediately.

11. The ward should have a full dementia assessment carried out.

12. All staff disciplines should carry out hand hygiene in accordance with the WHO Five Moments of Care. All staff disciplines should adhere to trust policies for uniform, use of gloves and ANTT procedures.

13. Compliance with Sepsis Six should be audited.

14. The disposal of unused CDs should always be witnessed.

15. Where a patient blood glucose levels is outside the usual range action taken should be recorded.

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

17. The ward should have pharmacy to facilitate effective integrated medicines management and ensure adherence to best practice.

18. All staff should be immediately updated on their role and responsibility in the safe storage, security, administration, prescribing and documentation of and related to medication. Staff practice should be monitored to ensure adherence to best practice.

19. The recording in nursing care records and documentation should be improved to accurately reflect patients' needs and be in line with NIPEC best practice guidelines.

20. The quality and organisation of medical notes should be improved. Discussions with patients and families should be recorded.

21. Effective mechanisms should be implemented to ensure patients receive the appropriate dietary requirements and assistance **during** meal times.

22. Intentional care rounding or a similar system to meet and anticipate patient care should be introduced.

23. All staff should introduce themselves and communicate with patients in a volume and tone that ensure patient privacy.

24. DNAR documentation should be fully completed.

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

**Housekeeping Points**

1. The resolution of local verbal complaints should be recorded centrally.

2. There should be sufficient ward clerical cover to support the Band 7. Access to HRPTS should be reviewed and extended.

3. Agreed and actual nurse staffing levels should be displayed.

4. Staff should be familiar with reablement in order to engage this service to support patients for discharge home.

5. There should be immediate engagement by the NDL to provide staff training.

6. The system to ensure appropriate communication and dissemination of information to staff (including staff meetings and safety briefings) should be reviewed to assess its effectiveness.

7. Staff should ensure that the sharps box on the resuscitation trolley is renewed after use.

8. Ward risk assessments should be immediately reviewed and updated.

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

10. Discharge prescriptions should be signed for on delivery to the ward and stored securely until given to patients.

11. Medication stock should be rotated and expiry dates checked.

12. The storage of epidurals with patient controlled analgesia in the CD cupboard should be risk assessed.

13. Facilities for the preparation of medication should be reviewed.

14. Patients weight should be recorded on the medicine Kardex. Oxygen therapy when prescribed should have its administration documented.

15. Patients' concordance with prescribed medicines should be assessed on admission.

16. All staff should be familiar with critical medications. Learning from medication incidents should be reported back to staff.

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

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

19. All patients should be prepared for meals prior to meal service. Patients should be routinely encouraged and if necessary assisted to drink.

20. Effective mechanisms should be introduced to ensure nursing staff liaise with PCSS and monitor patient intake at meal times.

21. Food and fluid charts should be consistently completed. Monthly fluid balance documentation audit should continue and improvement should be demonstrated.

22. Pain scores should be completed at all times. Patient early warning scores should be completed within the set timescales.

23. SSKIN bundle documentation should be fully completed.

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

25. Medical records should be filed away when not in use.

26. All staff should wear name badges.

27. Information and leaflets within the ward area, both general and specific to that ward should be made available and easily accessible for patients and visitors.

# Inspection Findings:
# Emergency Department

## 5.0 Inspection Findings: Emergency Department

The new ED at the RVH opened on 19 August 2015 (Picture 10). It provides a 24-hour, seven day a week comprehensive emergency service. It is the regional trauma centre for Northern Ireland and accepts trauma transfers from other EDs, reflecting the regional specialist services provided on the RVH site.


Picture 10: Entrance to the new RVH Emergency Department

The ED is located on the ground floor of the critical care building; it consists of a four bedded resuscitation area, eight major treatment cubicles and two isolation rooms, seven minor treatment cubicles, two triage rooms and a dedicated ambulance receiving area for advanced triage. The footprint of the new department is 29, 500sqm which is 30 per cent bigger than the previous ED which has allowed for an additional resuscitation bay and much larger cubicles and waiting area.

### 5.1 Is the Area Well Led?

**Governance**

An ED clinical coordinator oversees the operational management and coordination of services provided within the ED. A band 7 sister, who is primarily office based, is responsible for the allocation of resources that facilitate unit function and management. On day one of the inspection, the band 7 sister was supported by two band 6 sisters who coordinated floor activities. One sister was stationed at the front of the department in the Minors area and the other at the back of the department in the Majors area. Throughout the inspection, the department sisters/charge nurses were visible and easily identified by wearing a distinctly coloured uniform and badges that highlight 'Nurse in Charge'. We were informed that the designated shift leader is either a band 6 or band 7 sister/charge nurse.

Nursing staff praised the support provided by a clinical educator and clinical coordinator and commented that there was positive engagement with senior management staff who were more visible and supportive. Throughout the inspection, staff morale was good and most staff reported that they felt supported and valued by the management team and empowered to raise concerns when appropriate.

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.

An open and transparent culture was displayed in relation to the investigation of formal complaints. Mechanisms were in place for staff to learn from department complaints. A thematic analysis of all complaints throughout the year was displayed for staff.

Staff were aware of the process to report incidents including SAIs and near misses. The Datix software system used by the trust allows for routine formal analysis of incident trends. An annual report of trust complaints and compliments was available on the trust website. Complaints and safety incidents including significant event audits (SEAs)/SAIs are reviewed at monthly emergency medicine business meetings. This information is disseminated to all staff.

Safety briefings, held in the communal office occur twice daily for nursing staff. The safety brief was led by the nursing shift lead. We observed an evening brief in which staff were given a quick update of the department patient status using a document entitled the 'ABC Emergency Department Handover Safety Brief'. This document should be updated, as it reflects areas of the old ED that no longer exist within the new department. The shift leader then recited a mix of safety and communication issues from a white board. The safety brief we observed could be improved as it lacked a clear structured agenda that is used to make staff aware of salient patient safety issues.

**Housekeeping Points: The use and format of the safety brief should be reviewed and improved. The ABC Emergency Department Handover Safety Brief document should be updated.**

Handover of specific patient information for oncoming and departing nursing staff is exchanged at the bedside. Staff cited that this process is more practical due to the high turnover of patients.

ED specific morbidity and mortality meetings occur monthly; they are consultant led and attended by an ED sister.
These meetings provided the opportunity to review adverse clinical events so improvement measures can be taken, as well as assisting in professional learning.

A number of quality performance indicators had been introduced within the ED, which are subject to continuous review at governance meetings.

These indicators include compliance with NEWS charts, SSKIN, sepsis and invasive device care bundles. The ED receives a formal report using a monthly balanced score card against these indicators and poor performance prompts an action plan and escalation of audit activity.

Staff were knowledgeable about how the department performs against these indicators. Audits of hand hygiene and environmental cleanliness were also routinely carried out; however they were not displayed within the ED for public viewing. We were informed that an area within the department has been identified to display this type of information.

Trust quality improvement targets for 2015-16 were displayed in the communal staff room for staff viewing. Targets included HCAI, cardiac arrest, VTE risk assessment, falls and pressure ulcers. All staff questioned were aware of these targets and the trust progress in achieving these targets.

The department had also participated in a number of audits in line with the Royal College of Emergency Medicine standards.

**DoH Targets for ED**

EDs throughout Northern Ireland are monitored in line with two overarching DoH 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.

At the time of the inspection, trust performance statistics and reports indicated that four hour and 12 hour performance targets were not being achieved. We note however that there had been ongoing improvement with these targets. Data provided by the trust highlighted that there had been a 10 per cent improvement with the four hour ministerial target and a significant reduction in 12 hour breaches from 325 patients to 25 patients throughout the months of August, September, and October 2015, when comparing the same period in 2014.

We were informed that key to these successes has been the redesigning of pathways in the ED, most notably the establishment of an advanced triage treatment by an emergency nurse or doctor (ATTEND) model operating within the ambulance receiving area and the opening of the CAU. These initiatives will be discussed in further detail within the report.

The target of 95 per cent of patients to be seen by a decision making clinician within 60 minutes was not being achieved. Throughout November 2015, approx. 57 per cent of patients were seen within this timeframe.

A patient's time to triage within 15 minutes of arrival at ED is a new DoH indicator introduced for 2015-16. Figures showed that this target was not being achieved, throughout November 2015; approx. 72 per cent of patients were seen within this timeframe.

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

**Recommendation: The trust should continue work to improve performance in line with DoH targets.**

**Staffing and Supervision**

We were informed that senior management has been proactive in the recruitment of nursing staff for the ED; 44 RN and 2 health care support workers (HCSW) have been recruited in the past year.

A total of 121.9 whole time equivalent (WTE) nursing staff has been agreed for the department as part of the commissioning process for the new building. There is currently 115.5 WTE nursing staff in place which equates to a shortfall of 6.35 WTE staff. The trust is in the process of recruiting band 3 HCSW to achieve their full complement of staff.

There are currently 8.76 WTE band 7 sisters/charge nurses (funded for 8.4) and 7.45 WTE band 6 sisters/charge nurses (Funded for 8.16). As previously discussed, there is a dedicated senior sister with an office based role, responsible for the allocation of resources that facilitate unit function and management. The remaining sisters/charge nurses provide floor based leadership for the day to day coordination of activities. Floor based sisters are also allocated office time to manage their team activities such as appraisal, supervision etc. We were informed that sisters do have sufficient time to undertake managerial duties and provide effective clinical leadership.

Staff retention within the ED had been an issue, although we were informed that this situation has now stabilised.

It was reported that retention has improved because staff employed in the ED had chosen emergency care at the recruitment stage whereas in previous recruitment drives staff were deployed to the department to address staffing deficiencies rather than choosing to go there. Recently, a number of staff had also left the ED to take up posts in the newly developed CAU. Bank and agency shifts supplement vacancies and absences. Absence/sickness levels are monitored and effectively managed. There is currently 1.5WTE absence due to sickness.

All band 7 sisters had recently received training in the management of absence which was delivered by the trust HR department. A HR call and information service was launched within the trust in November 2015 to provide staff with advice and support.

The trust had placed advertisements on their website to help with the recruitment of ED consultants, middle grade doctors, general practitioners with an interest in emergency medicine and ANPs. The trust has been successful in recruiting consultants; however the recruitment of middle grade doctors and ANPs continues to be a challenge.

Although the recruitment of new RNs to the department has been a positive step, nursing staff skill mix concerns have been highlighted, most notably within the resus area. We were informed that it is a particular challenge in the resuscitation area to provide a one nurse to one patient ratio for all four bays, as two out of the four RNs required for this area need to have over one year experience. This issue has been placed on the ED risk register. A review of the staff duty rota indicated that at times only three RNs are allocated to the resus area which does not allow a 1:1 ratio when all four bed spaces are filled. We were informed that on these occasions the contingency plan is to redeploy a RN from another area of the ED. Feedback from a staff focus group indicated that this is not always the case and at times there are 3 nurses for 4 patients.

To address concerns of skill mix and to support staff development, confidence and competence, senior nurses supervise nurses' qualified zero to one year and one to two years. The nurse allocating staff within the department is also provided with a template of the required minimal staff experience which is necessary for each area of the ED.

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

Medical trainees described their experience positively with opportunities provided to manage a wide range of emergency presentations. Trainees are closely supervised and consultants are very supportive. Trainees have Thursdays off to pursue continuing professional development opportunities and audit in the morning and attend regional emergency medicine teaching in the afternoon.

There were no reports of bullying or undermining and all trainees felt able to and were clear on how to raise concerns should the need arise. Trainees had no specific patient safety concerns. Induction was described as good and all trainees could meet with their educational and clinical supervisors and complete required work-placed based assessments.

The RVH still relies mainly on locum cover to provide middle grade coverage. These locums are almost all long term, well known and valued within the department.

Consequently, there is a reliable middle grade presence (ST3 or above) 24/7 including those in an ED training programme as well as those who are providing locum cover. An associate specialist coordinates the overall staffing rota. Close engagement with locums and locum agencies has resulted in a number of innovative approaches leading to a reduction in locum costs and more stable rota planning. Additional specialty doctor posts are being created. Templates of completed rotas were seen by the inspection team and all areas were staffed by Core Trainee, Registrar and Consultant grades.

There is dedicated physiotherapist, occupational therapist (OT) and social work support for the department from 9.00am to 5.00pm seven days a week. We were informed that there are sufficient trained reception staff to accurately record patients into the department and sufficient trackers to keep the symphony patient tracking system updated 24/7. The trust is also recruiting ED Support Officers (EDSO) to provide clerical, hospitality and environmental support within the department.

**Staff Training**

Newly appointed nursing staff have a two-week induction, followed by a six week supernumerary period in the ED which is facilitated by the clinical education facilitator. This was confirmed by new nursing staff when questioned.

All newly qualified staff recruited to the ED undergo a six month period of preceptorship. They are also required to complete a portfolio of learning evidence within one year, which is overseen by their preceptor and the clinical educator.

New nursing staff undertake Manchester triage training within their first three months of appointment. Initially, staff are allocated to triage where they work under the direct supervision of an experienced staff member.

After one year and once deemed competent in triage by the senior nurse or their mentor, staff will then work unsupervised and will take decisions to place patients, as dictated by their clinical need and in accordance with their Manchester Triage categorisation.

Compliance with mandatory training is monitored by the department sisters and the clinical education facilitator. The majority of staff have either received or are booked to attend mandatory training. Staff have had access to role specific training to ensure that they are able to meet the needs of the patients they deliver care to. Examples include: advanced life support, ECG workshops, major incident training, trauma intermediate life support (TILS) and delirium and dementia awareness.

The ED won the trust Chairman's award for development of a simulation training package. The package is called 'Insitu Sim' which facilitates the training of staff in real work situations, but using the controlled method of simulation. They use this method to induct staff into the new department.

On previous inspections of the old ED, staff identified security as an issue. We were informed of new security measures within the ED. They include: reduced access points, additional closed-circuit television (CCTV) cameras, access control cards, one relative per patient protocol, emergency request alarms and personal panic alarms for staff. Security staff reported that the security HUB is in close proximity to the new department, which has resulted in better response times and they now carry out hourly security walks through the ED. The majority of staff have also received MAPA training which was provided to equip staff to manage challenging and aggressive behaviours.

All staff were encouraged to participate in safety improvement initiatives. A number of staff were nominated champions of IPC, tissue viability, stoma care, mental health, oncology and end of life care.

**Patient Flow**

We were informed of a number of initiatives to improve patient flow through the ED.

Key improvements are the rapid triage of patients by a senior decision maker (ATTEND model) and the opening of the CAU. For those patients that are arriving by ambulance, the objective of the ATTEND area is to provide early access to senior clinical input, investigation, appropriate interventions and referral for specialist opinion as required. We were informed that since its establishment, ambulances have been turning around 14 minutes quicker than in the same period last year.

The symphony information technology (IT) management system is used to provide a comprehensive view of patient flow through the ED. It is used for tracking patient activity and the status of each individual patient within the department. A patient status board displays detailed patient information which includes patient name, time to triage, time seen by physician, time of investigations and bed request. It also displays the patient status against the four and 12 hour ministerial targets. The system is updated in real time 24/7 by all ED staff including the patient tracker.

We observed hourly walk rounds by the Consultant, nurse in Charge and tracker to review patient management options. There are also 'Board Rounds' three times per day carried out by the clinical team, supported by a Senior Nurse.

A RAPS is being piloted, which provides assistance for patients in the Belfast area that require a home from hospital service. It is available seven days a week between 8.00am to 10.00pm and responds to patients in the ED. The service also assists patients with practical support for up to three days.

The trust provides an acute care at home service that facilitates frail older patients to receive specialist care at home, therefore helping to prevent hospital admission.

The hospital discharge lounge has been extended and the criteria for use have been widened. This has allowed for more beds to be available for admissions via the ED.

A pilot initiative developed by the Belfast Trust is the Alcohol Recovery Centre (ARC) based within the Bradbury Wellbeing and Treatment Centre in Belfast. ARC will operate during the hours of 9.00pm to 08.00am on consecutive Friday and Saturday nights. The main aim of this initiative is to provide supportive measures to members of the public in recovery from heavy alcohol consumption. The ARC offers an alternative to the current transfer of intoxicated individuals to the Belfast Trust EDs.

Despite these new initiatives to improve patient flow through the ED, crowding was observed within the majors area throughout the inspection.

During the first morning of the inspection, we observed efficient and effective systems in place to manage the flow of patients through the department. Designated assessment and treatment spaces were sufficient to meet occupancy levels, ensuring that patient dignity, privacy and nursing care needs were being met.

On that afternoon however we observed an escalation in activity within the ED which resulted in the majors area being crowded. We observed that the number of patients occupying the majors area was beyond the capacity for which it was designed to manage at any one time. The number of patients on trolleys exceeded the number of designated assessment spaces, which caused the majors area to become quickly gridlocked with patients on trolleys, placed in very close proximity to one another, in and around the central work station. As a result, we observed an increase in patient anxiety as dignity and privacy became compromised and it became more challenging for staff to provide basic nursing care.

Medical staff raised concerns related to the assessment of patients in the majors area during times of crowding. The surgical team in particular highlighted that there was insufficient space to examine patients, no dedicated areas in which to move them for assessment and that privacy and dignity could not be maintained. Occasionally, when it was available, the plaster room was used for assessment.

We were informed that increased numbers and acuity of patients attending the ED were contributing factors to the crowding within the majors area. Exit block from the department combined with limited bed capacity within the majors area were also central factors. During this time, we observed reassessment of patients by senior clinicians in line with trust escalation procedures. We also observed senior managers within the department of who were actively working to remove any obstacles to flow from the department. We observed that later in the evening, pressures in the majors area had reduced, however not enough to meet designated occupancy levels as some patients remained on trolleys alongside the central work station.

We were informed that there has been a long delay in the review of the ED internal escalation plan for the new department.

**Recommendation: The trust should review the capacity of the majors area of the ED, in relation to the workload pressures which are being experienced at the hospital.**

**Recommendation: The trust should continue to review impediments to patient flow from the ED and ensure that there is early recognition and pre-emptive planning of resources at times of impending pressures.**

**Recommendation: The new ED internal escalation plan should be introduced.**

We were informed that demands on trust capacity had been increased following an ambulance divert to the RVH ED from the Ulster Hospital ED in the week prior to the inspection. A particular challenge reported was the difficulty in the repatriation of admitted patients to the South Eastern Health and Social Care Trust (South Eastern Trust).

**Recommendation: The trust should continue to work in partnership with all HSC trusts to review the obstacles to the repatriation of patients**

**Communication**

Through review of documentation and observation, inspectors noted that communication and dissemination of information to staff was good and is provided using various formats such as safety briefings, handovers, ward meetings, poster displays and via email. A quarterly ED newsletter is provided for staff. It reports on items such as: workforce, service developments, improvements, IPC issues, 10,000 voices, audit etc.
All medical and nursing staff have access to ECR to access up to date patient information.

The trust continues to monitor patient experiences within the ED through the 10,000 voices initiative. Key improvements extracted include:

- improve patient experience
- focus on our elderly patients
- improve the provision of comfort requirements
- provide food for patients 24/7
- improve communication with our patients

As part of their induction process, newly appointed nursing staff, shadow a patient through the ED. This exercise is used within the ED to identify exactly what happens during a patient visit to the department and to identify issues with the overall patient experience.

Hands-free, wearable communication devices have been introduced within the ED. The system enables staff to instantly contact other staff members from different locations in the ED without having to leave their area of work.

**Safeguarding**

Appropriate systems and processes reflecting legislation and local requirements were in place to safeguard patients from abuse. Staff are aware of the trust safeguarding lead and communication arrangements. The social worker and safeguarding nurse visit the department daily and review cases where a safeguarding concern has been identified.

In the event of suspected child abuse, staff were aware that the consultant paediatrician is called immediately and child protection procedures commenced. Within the ED, two consultants are trained in both adult and paediatric emergency medicine. Staff are aware that additional safeguards are required for children, including completion of an UNOCINI assessment.

At ED induction, all staff receive training on safeguarding vulnerable children and adults. The trust also provides an Adult Safeguarding Gateway Team for Older People which operates an open referral system.

## 5.2 Is Care Safe?

**Environmental Safety**

The environment was light and bright. This is a new building; regular reviews are carried out by the building project team who are available to deal with any snagging or evolving issues. During the inspection, damaged door guards on toilet doors were being replaced; displaced tiles caused by recent storms had been removed and were being replaced securely. At times, caution wet floor signs had themselves become hazards in corridors and should be removed as soon as possible. Staff wheeling trolleys had to stop and move the signs to the side to allow movement along the corridor.

Each patient cubicle is individually equipped, well-lit with a clinical hand wash sink. The clocks in some cubicles were not working; there was no clock in the seated area of majors; patients and relatives had to ask for the time. In the majors area there is only one toilet for patient use.

The ED was clutter free, patient equipment was stored in designated areas and only accessible to staff using a swipe card. Patient trolleys and wheelchairs were stored in designated bays along corridors. The trolleys and chairs have been fitted with a location tracking system. This makes it easier for staff to pinpoint and retrieve the trolleys and chairs. Staff did say that maintaining adequate numbers of wheelchairs at time of pressures can be a challenge. Resuscitation trolleys were accessible but daily checks were not carried out consistently. Contact details for the resuscitation team were displayed on every phone and posters displayed at nurses stations.

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

The only area affected by crowding was majors. Trolley and chair waits became an issue from mid-afternoon on day one and by early evening the area was grid locked. Patient observation in majors can be a challenge when there is crowding. There was no space between patients' trolleys. This hindered staff members' ability to manoeuvre patient equipment for routine observations and would have compromised staff's ability to respond to an emergency which required use of the resuscitation trolley.

Trolley waits in the majors area were observed on each day of the inspection.

**Infection Prevention and Control**

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

We observed that, at times of crowding, not all staff carried out hand hygiene at the appropriate times, in line with the WHO, five moments of care for example after contact with patients under contact precautions.
We were informed that it is a challenge to maintain IPC best practice when patients on trolleys are placed in close proximity to one another. This risk had been placed on the trust risk register.

There were some occasions when staff did not wear appropriate PPE such as when carrying used urinals and handling used linen. The ED does have infection control link nurses who attend meetings and disseminate information in relation to infection prevention to other ED staff.

**Recommendation: All staff disciplines should carry out hand hygiene in accordance to the WHO 5 Moments of care and use PPE appropriately.**

Picture11: Stained patient warming device

Nursing patient equipment cleaning schedules were not completed consistently or audited. Patient equipment at each bed space was clean and in good repair. However, communal equipment in the resuscitation area such as blood gas machine, drugs fridge, resuscitation trolley and patient warming machine were dusty and or stained (Picture 11).

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

Good practice was noted when blood cultures were taken; the date, time, site and clinical indication for obtaining was clearly documented.

**Patient Safety**

We observed that not all patients were wearing an identification arm band. We were informed that identification bands are only issued to patients that have communication difficulties or when a decision to admit the patient had been made. There is no specific department guidance that includes the criteria for the issuing of identification armbands. We observed a number of patients that should have been issued with an identification armband due to communication difficulties. This situation has the potential for identification errors to occur which could have serious consequences for patient safety within the ED. We were informed that the department is piloting yellow armbands to help identify those patients who are assessed as vulnerable e.g. patients with dementia.

**Recommendation: Clear and consistent criteria should be introduced for the issuing of patient identification armbands.**

Guidance on the management of the acutely ill patient was available. On most occasions NEWS charts were completed appropriately, however on one occasion a triggered response in accordance with the NEWS algorithm was not recorded.

A Sepsis Six care bundle is in place for the recognition and timely management of sepsis and monthly compliance audits are carried out. An audit in August 2015 highlighted 50 per cent compliance with the sepsis bundle. One of the main failings highlighted by the audit was compliance with the administration of antibiotics within one hour of arrival at the ED. A number of actions had been taken to address the issues identified which include: education and the use of the sepsis pathway, the use of sepsis boxes and stickers and focused sepsis weeks. During the inspection we observed that appropriate measures for at risk patients had been implemented in line with the sepsis bundle.

A fall safe bundle was not used within the ED. We observed that many of the fall prevention intervention elements of the bundle are implemented; however the introduction of the bundle may help reduce any variations in practices.

**Recommendation: A falls safe bundle should be introduced within the ED.**

VTE risk assessments were generally well completed however on one instance an assessment was not completed however VTE prophylaxis was prescribed and administered.

Staff were compliant with Blood Transfusion Competency Assessments and aware of their responsibility to complete blood transfusion record sheets. Patient safety/medical alerts were cascaded to staff by email and/or safety briefings and posted on the notice board in the staff communal office.

All patient areas have appropriate equipment, which is maintained and replaced when necessary.

Consideration is not always given to patient placement, safety and vulnerability. When the department was crowded some patients reported that they felt very vulnerable when they were placed in such close proximity to other patients such as those who appeared to be under the influence of alcohol. During department safety briefs, staff should be reminded of the safe placement of patients.

**Recommendation: Safety and vulnerability of patients should be considered when placing patients throughout the ED.**

The patient status board is updated and in conjunction with the Northern Ireland Ambulance Services (NIAS) information system which gives a 'real time' view of the patients in the ED and pending admissions.
For patients presenting to the department with self-harm, staff commence the regional deliberate self-harm care pathway. There are good interface arrangements with trust mental health services.

The trust provides a 'One Point of Referral For Mental Health' service. This is designed to receive all initial referrals for mental health assessment for patients from 18 to 65 years and is the gateway for all emergency, urgent and routine referrals for mental health assessment. A Community Mental Health Team for Older People service is also in operation. This service operates an open referral system for individuals over the age of 65 who are experiencing a mental illness and individuals of any age who are experiencing or have concerns about dementia. For patients in the ED that require a mental health assessment, a response time target has been set that 90 per cent of patients will be seen within two hours of arrival. Since November 2014, the trust has consistently achieved above this target.

Older people tend to present to the ED with non-specific presentations or frailty syndromes. Non-specific presentations include the presence of multiple comorbidities, disability and communication barriers. It is important for staff to recognise non-specific syndromes as they are markers of poor outcomes. The trust should consider the introduction of a recognised assessment tool to identify high risk older patients.

As part of the overarching Belfast Trust winter plan there is geriatrician reach-in to ED from the AMU.

The Royal College of Emergency Medicine clinical standards are being implemented within the department.

The trust delivers stroke thrombolysis, via a dedicated acute stroke team, both in hours and out of core working hours. Door to needle times have steadily improved to in 2014, an average of just less than 50 minutes. Staff receive specific training in thrombolysis, and have monthly reviews of those patients receiving lysis. There is a four-bedded hyper-acute stroke unit within a dedicated stroke-care ward.

**Medicines Management**

Medicines were stored safely and securely in designated cupboards. We noted that daily temperature checks of medicine fridges were not always undertaken. We observed that when a fridge temperature recorded out of range there were no documented actions.

**Housekeeping Point: Medicine fridge temperatures should be routinely recorded and appropriate actions recorded when temperatures are out of range.**

All intravenous infusions were stored in their original boxes or in appropriately labelled containers with potassium-containing solutions kept separately.

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

We noted good documentation for the administration of medication and medicine allergy/sensitivity status and reasons for delay or omissions in medication were appropriately recorded in the documentation.

An integrated medicines management service was not being provided within the ED. From the medicine kardexes reviewed we observed no evidence of medicines reconciliation on admission or during their ED stay.

Clinical pharmacy presence within the ED was limited as the allocated pharmacist had to cover other areas including the CAU. We were informed that plans are in place to increase pharmacy cover within the ED.

**Housekeeping Point: The trust should continue to implement plans to increase pharmacy cover within the ED.**

A list of or critical medicines, where timeliness of administration is crucial, was not displayed for staff guidance. There was evidence of compliance with best practice in the handling of critical medicines. Although there was a limited stock of critical medicines held within the ED, further stock could be accessed from the hospital pharmacy.

**Housekeeping Point: A list of critical medicines should be displayed for staff.**

We observed that a patient who was having oxygen administered did not have oxygen prescribed within their medicine kardex. We also note that patient weights were not being routinely recorded within medicine kardexes.

**Housekeeping Points: Oxygen should be prescribed before administration and the patient's weight should also be recorded on the medicine kardex.**

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

## 5.3 Is Care Effective?

### Nursing Care Records

It is the protocol within the ED that patients should have a nursing treatment plan commenced if they remain in the department for longer than two hours following a decision to admit them.

We observed that this was not routinely carried out. We also noted that patient risk assessments were inconsistently completed. We observed that a patient who had been admitted for treatment of infective diarrhoea did not have a completed IPC risk assessment.

ED nursing documentation audits are carried out monthly. The most recent audit highlighted that on 70 per cent of occasions the ED nursing documentation commenced and on 86 per cent of occasions the IPC risk assessment was completed.

**Recommendation: Patient nursing treatment plans and risk assessments should be completed as per trust policy.**

### Medical Care Records

Six medical notes in the ED were reviewed. Entries were legible, dated and clear with evidence of direct senior review from middle grade and consultant staff where appropriate. Clear assessment and management plans were documented and relevant laboratory and investigations results printed out and actioned where appropriate.

### Nutrition and Hydration

Patients within the ED and waiting for an inpatient bed are provided with meals as appropriate.

Nursing staff are responsible for ensuring that individual patient nutrition and hydration needs are met throughout their stay within ED. On most occasions we observed that the meal service is overseen by a senior nurse.

Choices of hot and cold meals are available at midday and in the evening; these include meals appropriate for special dietary needs, for example gluten free or soft diets. A small kitchen is stocked at all times with salads and sandwiches and with hot soup in the evenings for patients who may require food outside of the normal service times. The meals looked appetising and appropriate to the patient's needs.

All patients in cubicles and on chair waits were asked if they wanted a meal.

In most instances we observed that staff did not always prepare patients before serving meals. Patients were not positioned, nor received the means to clean their hands. Staff arrived with trays but had not put a table in place. Trays were left on the end of bed notes stands while staff looked for the clip on table tops. Staff stated that there were twenty table tops for forty trolleys. Table tops are stored under the patient bed trolley. Because of the constant movement of trolleys, table tops could be difficult to access. Patients sitting in the majors sub wait seated area had to rest their trays on their knees as no suitable surface was available. We observed that on most occasions there were sufficient staff to support and assist patients at mealtimes; however this became more difficult when the majors area was crowded.

A diabetic patient on a trolley in the overcrowded central area informed inspectors that lunch had not been provided. The inspector brought this to the attention of staff and the patient was given tea and sandwiches. However due to crowding of trolleys staff had difficulty in accessing the patient to ensure he was positioned appropriately for his meal and a table was not provided so the notes shelf at the end of the bed was used. On another two occasions patients who required assistance did not receive it until an inspector intervened. Adapted crockery, cutlery or drinking cups were not available for patients with reduced dexterity.

**Housekeeping Point: All patients should be prepared prior to meal service.**

**Housekeeping Point: Adapted cutlery and crockery should be available for patients with limited manual dexterity.**

It was good to observe that on some occasions, where a patient's relative was elderly the relative also received a meal. Vending facilities were available in the reception area.

Patients only received a drink with their breakfast. Fluids were not offered with their lunch or evening meal. Water dispensers were available in each area. In the majors area the water dispensers were in the locked pharmacy room and behind the clerical base, so not easily visible or accessible.

We did not observe staff giving encouragement to patients to drink; drinks were only given on request.

**Housekeeping Point: As appropriate, patients should be routinely encouraged with oral fluids.**

**Pain Management**

On most occasions we observed that patients appeared comfortable; pain relieving comfort measures were available and staff responded promptly to patients' requests for pain relief. However on one occasion, a patient that had been seated in the 'sub wait' area of majors for a number of hours and was visibly in pain and uncomfortable. His mother reported that:

*"I had to go to find someone to ask about getting some pain control for my son."*

Inspectors reported this issue to staff for appropriate action to be taken.

We observed that there was variation in the recording of pain scores on NEWS charts. A patient who could not verbalise their pain did not have a pain assessment completed, even though specific scales were available for use. The use of pain assessment scales for those patients who are unable to verbalise pain was reinforced at the safety brief observed as part of the inspection.

**Recommendation: All patients should be routinely assessed for pain. All staff should use appropriate pain assessment scales for those patients who are unable to verbalise pain.**

Prescribed pain medication was appropriate to patients' conditions and the effectiveness of the analgesia reviewed. A pain team is available within the hospital for advice and support.

We noted that not all patients are assessed for pain within 15 minutes of first contact with ED. Throughout the inspection we observed a number of ED flimsies that did not have a pain score completed at triage. We were informed that pain is a standardised question on the Manchester triage software however patients are only assessed for pain with this software, if they present with certain conditions.

**Recommendation: Staff should ensure that all patients attending triage are assessed for pain.**

**Pressure Ulcers**

Patients appeared comfortable and pressure-relieving equipment was available. A new airflow mattress that is compatible with ED trolleys was being trialled during the inspection.

A modified SSKIN care bundle was in place and completed for those patients identified with a pressure risk. The inclusion criteria to commence on the bundle include those patients that are assessed with reduced mobility, incontinence, sensory deficiency or a pre-existing pressure ulcer. The SSKIN care bundle includes a pressure ulcer classification tool.

When required, staff can contact the TVN for detailed advice and guidance. Medical photography is available to photograph pressure wounds. Pressure sore incidents are recorded on Datix incident software. Short root cause analysis forms are completed for all ED acquired pressure damages. This form is forwarded to the TVN service for review.

**Promotion of Continence and Management of Incontinence**

On most occasions staff were observed providing patients with the assistance to promote continence; however two patients reported that they had to ask several times before being assisted to the toilet. When patients were assisted to the toilet they were provided with the opportunity for hand hygiene after toileting.

**Housekeeping Point: Patients should be provided with prompt toileting assistance.**

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

**Housekeeping Point: A stool chart should be implemented for use as per trust policy.**

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

## 5.4 Is Care Compassionate?

**Person Centred Care**

Aesthetically there has been improvement in the majors area within the new ED however the layout, design and dimensions remain relatively unchanged from the previous majors area in the old department. Space remains limited within this area which heightens the congestion of the department during busy times.

There was a slight increase in noise levels when patient numbers increased, and on occasions when patient equipment alarms were not attended to timely by staff. Two patients complained about the noise of the alarms. A patient call bell system was in place in each of the cubicles; however they were not always positioned within reach of some patients.

**Housekeeping Point: Nurse call bells should be positioned within easy reach of patients. Staff should attend to monitoring equipment alarms in a timely manner.**

On many occasions we observed that patients waiting on trolleys and chairs, who required assistance, relied on calling out or having a relative voicing a request for help. We observed a patient on a trolley along the central work station in majors was unable to attract assistance when they required personal care. The relative of a patient in the adjacent trolley called for assistance on their behalf. Another patient on a trolley who required a commode had to ask on two occasions for assistance. Each time they were told that someone would assist them soon. It took over five minutes for staff to assist. A senior nurse who observed the request then spoke to the patient and moved them into a cubicle to deliver personal care.

Care rounding activities were in place; however during times of congestion and crowding they were limited. The dignity and privacy of those patients placed on trolleys alongside the central work station was compromised. We observed that a confused female patient on a trolley became exposed and another patent's relative had to request assistance.

A patient on a trolley at the central work station wanted to go to the toilet. He was mobile and partially dressed and did not ask for assistance.

He had to push the adjacent trolley to make space for him to stand on the floor and had no privacy pull on his track suit bottom.

In the sub wait area of majors we also observed issues with privacy and dignity. Some patients had medication administered, blood pressure was taken, and conversations with doctor/nurses in this area could easily be over heard. Some patients commented that they felt "*abandoned*" here and that "*no one came to check up on them.*"

Patient details on computer screens and white boards could not be easily viewed by members of the public. There was an issue for staff who could not easily identify and locate their patients. Identification was done by checking the yellow flimsy in the notes held outside the cubicle, at the end of the bed or by word of mouth.

**Housekeeping Point: A robust system should be introduced that identifies which cubicle or space that patients have been assigned within the ED.**

Patients complained that there was only one toilet in majors and at one stage we observed three patients waiting to use it. We were informed by patients and staff that the department was cold at night and that patients and relatives sitting at the bedside required blankets to keep warm. Staff told us that this issue has been raised with the estates services department and they are working to rectify the problem.

Both ED and NIAS staff advised that maintaining a constant supply of bed linen and in particular blankets and pillows during peak times can be a challenge.

**Housekeeping Point: The supply of bed linen and pillows should be reviewed and increased to meet demand when required. Issues in relation to the temperature of the ED should be expedited as a matter of urgency.**

**Communication**

Picture 12: Clear signage

Signage within the new ED was good; it clearly indicated the many areas within this large department for example minors, majors and relative's room. Each sign also gives a more detailed explanation of the area (Picture 12). Notice boards in the main waiting area clearly illustrated the patients' journey through the department.

We observed that staff were courteous to patients and relatives, however we note that they did not always introduce themselves on first contact.

Staff were able to be more discrete when speaking with patients in cubicles however when patients were placed in close proximity around the central work station in the majors area, discussions around medical conditions were easily over heard. Some staff were discreet when engaging with patients while other staff conversed with patients while standing at the foot of the bed; some checked documentation or carried out observations but did not speak to the patient.

**Housekeeping Point: Staff should introduce themselves on first contact when engaging with patients.**

**Housekeeping Point: All staff should communicate with patients in a manner, volume and tone that ensures patient privacy.**

The majority of staff had name badges though some nursing staff had still to collect their new ones. Information leaflets for relatives or visitors were not readily available. We were informed that the trust is to use one of the screens in the waiting area to display information about the trust and from the public health agency on health issues.

## End of life care

Information on palliative and end of life care is available via the trust intranet HUB; however, when questioned, staff stated they have no specific guidance to access on 'End of Life' care. Staff follow the practice of the longer serving members of staff. Work is required in fully implementing best practice guidelines from the College of Emergency Medicine for End of Life Care. The palliative care team is available 24 hours, on call. Other than induction training, staff do not receive specific palliative care training.

ED has a purpose built room to care for a dying patient while being supported by family or carers. The large room is located in a corridor away from the main ED. The room is homely, equipped with soft furnishings, space for a patient bed and tea point. There are two adjoining relatives rooms, a toilet and shower facilities. The room is also used following the death of a patient to allow the family to spend time with their relative in an appropriate and dignified setting (Picture 13).

Picture 13: Relatives Room

Information leaflets and support systems were available for patients and carers, for before and after a patient dies. We noted that staff displayed compassion and thoughtfulness, and a card is send to relatives one month after the death of a patient in ED.

Staff are aware of who to contact in the event that a wish to donate organs is expressed by the patient or family. Staff have recently received an update on organ donation referral. No patients were assessed as requiring a DNAR order during the inspection of the ED.

## Patient and Relative Questionnaires

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

During the inspection a total of 22 questionnaires were administered in ED:

- 13 Patient Questionnaires
- nine Relatives/Carers Questionnaires

In general, staff introduced themselves and addressed patients by their preferred names; patients felt staff were courteous and listened to their concerns. The questionnaires showed that about half of patients thought there was not enough staff to care for them and were unsure who to speak to about their concerns. Sometimes patients did not feel involved in the decisions about their care.

Overall, patients were happy with staff response times to call bells; although one patient reported that they hadn't been given a call bell. Two patients were happy with staff members assisting with personal care and two were not. Most patients thought they were given enough privacy when staff were discussing their condition or being examined. One commented "*definitely not when on a trolley*".

Although most patients thought staff did check on patient pain management and that pain relief was given in a timely manner, one person stated "*never*".

Patients thought the choice of meals was good. One patient had difficulty in accessing adapted crockery and cutlery and the majority of patients had problems accessing water throughout the day.

Patients felt the department was clean and that staff preformed hand hygiene before delivering care or treatment. However, patients did not feel they were given the opportunity to wash their own hands before meals or after using the toilet.

Most of the patients felt safe, although three replied "*not always or never*". One stated they felt "*abandoned*" another "*felt alone and unattended during the evening*"

Overall patients were unsatisfied with the information they were given regarding the period of time they were in ED, but were satisfied with the treatment and care they had received and would be happy for a relative or friend to be cared for in ED.

**Relatives**

In general, relatives felt welcomed. Most felt however that they had not received up to date information or been involved in their planning of care or who to speak to in relation to their relatives' care.

All felt their relatives had been treated with respect and dignity and that they were receiving a good standard of care but that there were not enough staff. They felt that the congestion, lack of cubicles and long waiting times in majors was impacting on their relatives' privacy and dignity and at times their care.

**Patients Comments**

*“I didn’t have to wait long to be triaged, and brought into minors, I have had a good explanation of what is happening. I have been delighted with the experience in ED today. I complement the staff.”*

*"I was brought in by ambulance to ED. Triaged quickly and then told to wait in the reception area on a chair. Cold and uncomfortable. My daughter had to ask for a blanket. There were other very elderly people in reception and some were distressed.”*

*“This experience has been very good/no complaints. While we've been sitting in the observation area anytime nurses pass they smile at you - it feels personal.”*

*“I am satisfied with the care given during this attendance at ED. I have been to ED previously on a number of occasions - but not to this new department. I feel this department works well.”*

**Relatives comments**

*“Other than basics, like a tea/coffee dispenser for relatives waiting for a long time. I have relatives who work in hospitals and are aware of the huge strain medical staff work under. These stresses and strains, whilst existing, are not evident to me. Staff are very professional and busy. A very busy department.”*

*“The staff are excellent in this unit and work very hard to try and maintain standards. The trolley wait is horrendous. The trolleys are literally touching each other. On the Sunday evening my father who has dementia was next to a lady with dementia also. She was removing her trousers and pants constantly and then putting her hands over to dad who was trying to comfort her. Where is Infection Control here. It is a totally unacceptable system. Again the staff do an amazing job under the circumstances.”*

*“Really efficient caring service. My mum came in with a fast heart rate and a heaviness in the chest. Very impressed with care and attention. This is the 3rd time I have attended with a relative and the care is always good. Explained everything to my husband and me.”*

*“More privacy needed for patients on trolleys.”*

*“My sister was brought in by an ambulance today and was very disappointed that over in the new A&E my relative still sat in the middle of the department on a stretcher.”*

*“The staff were extremely busy and as well as the cubicles being full there were also an additional eight patients on beds in the area. Communication could have been better with updates on what was happening with a patient.”*

**Observations of Practice**

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

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

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

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

Thirty observations were carried out over four observation sessions.

Some positive interactions were observed between medical staff and patients, good two way conversations including relatives were observed and on another occasion a medic demonstrated a sympathetic manner when dealing with a distressed patient.

Basic observations were in relation to minimal conversation between staff and patients during the meal service or when carrying out patient observation checks. For example staff did not introduce themselves and there was little conversation other than "*do you want some breakfast*". Patients were not prepared or made comfortable for breakfast and tables were only sought when the tray was brought to the bedside.

Nurses checked patient notes but did not always speak to the patient.
We observed a health care assistant taking a confused patient's temperature; she did not seek consent and the patient was startled and there was limited conversation.

Negative observations were in relation to confidential conversations which could be overheard by everyone in the surrounding area.

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

## 5.5 Conclusions for the Emergency Department

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

The new department was clean, uncluttered and aesthetically pleasing. We observed that staff were clearly committed to the care of their patients. Staff morale was good and staff reported that that they felt supported and valued by senior management.

We found that the overall leadership and governance arrangements within the emergency department were good. Complaints, incidents, audits and service performance information were discussed and actions agreed.

Senior management staff had been active in the recruitment of nursing staff for the ED however this presented challenges with staff skill mix.

We observed that when the department was busy the processes to promote flow of patients throughout the ED did not work effectively. Crowding within the majors area was a specific concern. At busy times, we observed that the number of patients occupying the majors area was beyond the capacity for which it was designed to manage at any one time. This made it difficult for staff to provide basic nursing care and maintain the dignity and privacy of patients. The trust had undertaken a number of steps to improve flow through the department.

Medicines were stored safely and securely and administered to the expected standards of practice. ED pharmacist cover should be improved to facilitate effective integrated medicines management.

Meals appeared appetising and appropriate to patients' needs however the coordination of the meal service needs to be improved. We also observed variations in the recording and completion of some nursing documentation.

Patients and relatives we spoke with were mainly positive about the care they received however at times when the ED was busy; issues were identified in relation to communication, staff shortages and waiting times

Overall we saw many examples of good practices within the ED however to improve the patient experience, further work is required to address the issues identified with crowding of the majors area.

We have made 14 recommendations and 17 housekeeping points.

## 5.6 Recommendations and Housekeeping Points

### Recommendations

1. The trust should continue work to improve performance in line with DoH targets.

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

3. The trust should review the capacity of the major's area of the ED in relation to the workload pressures which are being experienced at the hospital.

4. The trust should continue to review impediments to patient flow from the ED and ensure that there is early recognition and pre-emptive planning of resources at times of impending pressures.

5. The trust should continue to work in partnership with all HSC trusts to review the obstacles to the repatriation of patients.

6. The new ED internal escalation plan should be introduced.

7. All staff disciplines should carry out hand hygiene in accordance to the WHO 5 Moments of care and use PPE appropriately.

8. Clear and consistent criteria should be introduced for the issuing of patient identification armbands.

9. A falls safe bundle should be introduced within the ED.

10. Safety and vulnerability of patients should be considered when placing patients throughout the ED.

11. Patient nursing treatment plans and risk assessments should be completed as per trust policy.

12. All patients should be routinely assessed for pain. All staff should use appropriate pain assessment scales for those patients who are unable to verbalise pain.

13. Staff should ensure that all patients attending triage are assessed for pain.

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

**Housekeeping Points**

1. The use and format of the safety brief should be reviewed and improved. The ABC Emergency Department Handover Safety Brief document should be updated.

2. Staff should ensure daily checks are carried out on the resuscitation trolleys.

3. All patient equipment should be identified on cleaning schedules and schedules should be audited to ensure compliance.

4. The trust should continue to implement plans to increase pharmacy cover within the ED.

5. Medicine fridge temperatures should be routinely recorded and appropriate actions recorded when temperatures are out of range.

6. A list of critical medicines should be displayed for staff.

7. Oxygen should be prescribed before administration and the patient's weight should also be recorded on the medicine kardex.

8. All patients should be prepared for meals prior to service.

9. Adapted cutlery and crockery should be are available for patients with limited manual dexterity.

10. As appropriate, patients should be routinely encouraged with oral fluids.

11. Patients should be provided with prompt toileting assistance.

12. A stool chart should be implemented for use as per trust policy.

13. Nurse call bells should be positioned within easy reach of patients. Staff should attend to monitoring equipment alarms in a timely manner.

14. A robust system should be introduced that identifies which cubicle or space that patients have been assigned within the ED.

15. The supply of bed linen and pillows should be reviewed and increased to meet demand when required. Issues in relation to the temperature of the ED should be expedited as a matter of urgency.

16. Staff should introduce themselves on first contact when engaging with patients.

17. All staff should communicate with patients in a manner, volume and tone that ensures patient privacy.

# Focus Groups

## 6.0 Findings from Focus Groups

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

- a mix of band 5, and band 6 nurses and healthcare assistants from ED and AMU
- allied health professionals with representation from occupational therapy, physiotherapy, pharmacy, social work, dietetics and radiology
- senior managers, from a range of services
- support staff including porters, rapid response cleaning team, domestic services, catering and ward clerk
- a range of medical staff

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

### 6.1 Senior Management Focus Group

Senior managers told us about some of their current challenges. There remain areas which are affecting both patient flow and appropriate discharge such as:

- Ensuring timely access to diagnostic services e.g. CT scans and MRIs for emergency surgical patients in wards 6B and 6C, which can slow a patient's journey to discharge. There are initiatives that are being implemented albeit slowly, to improve the situation.
- The RVH is a regional hospital for many specialities and therefore accepts patients from all trusts. This creates difficulties with the prompt repatriation of patients to their own trust area. Discharges can be therefore be difficult as there can be different systems within each trust and a regionally agreed system would be of benefit.
- Currently the hospital is experiencing sustained pressure from receiving diverted patients from other trusts.

To help address these issues an impact discharge group has been set up with a stepped plan to provide safer flow. The QIP from the last RQIA inspection is well under way. The opening of the new CAU has also started to improve patient flow.

A job fair held in June 2015 recruited 390 new staff into the system. A significant number of these were for ED. To improve retention of staff exit interviews are now held. The reasons staff give for leaving are mainly moving closer to home or career progression. The main challenge is to ensure that all new staff receive the appropriate training to provide them with the necessary skills.

The hospital is moving to a position where the ward sister will be supernumerary. The challenge is then to ensure that they maintain effective clinical leadership. Work is ongoing with ward sisters regarding their staffing levels.

The group informed us that the introduction of the HRTPS system has created difficulties with the administration for new posts and has increased senior manager administration time. Many of the HR tasks have transferred to senior managers.

We were informed that new posts have to be created on the HRPTS structure, which can create delays and staff feel that the system is not user friendly. Managers expressed their frustration as alongside their day to day pressures they have no time to wrestle with this system. They told us that this is impacting on the time available to undertake quality improvement initiatives.

The group informed us of the new models of service for ED, CAU, and AMU, which have helped them plan for winter pressures and they are hopeful that they will be able to cope much better this winter. The group is aware that there will be difficult days; they feel that increases in numbers and diverts from other trusts will be their biggest challenge.

There are currently difficulties with a lack of applicants for Surgical Clinical Fellows. The number has dropped from 15 to nine Clinical Fellows. The recruitment of middle grade staff for ED remains an issue.

The trust is having difficulties in training enough ANPs as there are no suitable courses in Northern Ireland and they have raised this with the DoH.

The group was very clear that the vision and strategy for the hospital in relation to improving patient care is communicated to staff. We were informed of many examples including staff workshops and regular staff meetings, work with ward sisters on discharge and staffing levels, the Safety/Quality and Patient/Client experience Working Group and safety messages on the trust intranet. Use of the Quality Attributes Framework for clinicians, AHPs and managers has been beneficial and the Investors in People mock assessment was a valuable exercise for staff. A documentation group has been set up by trust nurses to focus on improving nursing documentation. A pilot area showed a 40 per cent improvement and as a result patients have also been more involved in discussions about their care.

The group felt well supported by line managers and the trust and told us they also support each other.

They felt challenged by the amount of work coming from other organisations and felt there was a need to rethink priorities for the service. They felt challenged at times by the scale and complexity of the regional service and felt that enhanced capacity for GPs would help with reducing patients need for admission and also facilitate discharge.

The group informed us of some new initiatives:

- a community project is to commence to improve flow of older persons to the community, especially during the winter pressures
- discharge projects such as a nurse facilitated discharge programme to commence in January 2016 and home for lunch campaign
- Bradbury Wellness Centre opened on 12 December 2015 and has prevented five patients from being sent to ED

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

### 6.2 Nursing Focus Group

All staff were aware of the trust vision and strategy for improving patient care and informed us of the five pillars designed to improve patient care and safety.

AMU staff told us that their biggest challenge was to ensure that patient flow did not compromise safety. AMU staff told us that there is some pressure from ED to admit patients.

ED staff told us that when the department is very busy there is not enough space in majors, trolleys are next to each other 'bumper to bumper' compromising privacy and dignity. They also told us that changing patients' position and carrying out vital signs observations was difficult at these times. Staff are concerned about patient safety when the department becomes so crowded and they are 'not able to deliver the care that you are meant to'. 'It's all about trying to prioritise and balance what you do'.

In ED, majors usually has four staff, however sometimes there are only three. Mornings build up slowly but from 11.00am it gets busy. Extra staff are provided, however nights can still be difficult as there are fewer staff. Staff felt that there should be equal numbers during both days and nights; there are also not enough doctors at nights. The lack of porters creates delays in transfers and bringing patients to imaging services.

Despite the improvement in the time for patients to be seen by the psychiatric liaison team and the provision of level one MAPA training for the majority of ED staff ,ED nurses told us that they felt that mental health support for patients could still be improved. They considered that staff were not adequately trained and didn't know how to effectively deal with patients if they are violent or abusing alcohol or drugs. Staff told us that it is very challenging when patients are violent to each other or to staff.

It can be extremely difficult to manage these situations and as security staff are not always there ED staff have to wait for the Police Services Northern Ireland to step in.

There is an attack alarm for staff to use in an emergency; however this is not always effective. The alarm does not indicate the area or room were help is needed. Staff told us that this can create chaos as they are running around trying to locate the area where the alarm was used. The assisted triage room in the waiting area is a particular problem and staff feel isolated there.

The group talked about handover arrangements. ED has safety briefings were staff are given a quick update of the staus of patients in the department. Staff informed us that in ED staff change their work areas at 3.00pm. This is an improvement as they previously changed areas two to three times a day. However, staff told us that when the department is very busy, especially in the majors area all information about patients may not be handed over.

In ED, ensuring appropriate skill mix of staff is difficult due to new starts. New staff should spend six weeks as a supernumerary. Staff told us that at times in majors there may be only one nurse with the appropriate clinical skills. The resuscitation area does not provide one to one nurse to patient staffing as often there are three nurses for four beds space. Staff felt that Emergency Nurse Practitioners should be working after 8.00pm.

There is a high turnover of staff in ED and in the course of the last year a number of senior staff have left. We were told that many nurses come to ED for experience and then move on to the other wards resulting in many new staff starting and leaving quickly.

In AMU, staffing levels are good; a few staff have left but this was seen as natural attrition. Since the ward has been split into two wards the working environment has improved and staff are more content.

AMU staff told us that patient care takes priority over targets and finance.

ED staff told us that waiting time targets can still cause pressures for staff to ensure that clinical need is not compromised.

ED staff felt that the transfer of patients between hospitals and from hospitals to home/nursing homes could be improved; there are delays as these are not a priority on the ambulance transfer list.

The group felt that mandatory training was good and they are encouraged to attend training. Regular supervision and appraisal was ongoing and they were facilitated to attend meetings. Staff told us that they felt supported by their line management.

AMU staff told us about their 7.30am safety briefing and about a 10.15 am meeting with OT, physiotherapy, and social work to discuss all patients.

At 11.45am the nurse in charge and consultant review the patients and decide on their readiness for discharge.

Staff in ED told us that following earlier RQIA inspections a number of improvement initiatives have begun. They have more staff, staff are more willing to help each other, senior staff are more visible and faster action is taken when ED is busy. Triage has improved and development of the CAU has also been a positive step.

AMU staff would like to have more freedom to 'order' extra staff if there is a clinical need for it. ED staff told us that it would help them if the wards started to take patients near handover times as currently this does not always happen.

AMU staff would be happy for their family and friends to be cared for on the ward/area. ED staff told us that it would depend on the day, Mondays are busy due to the number of GP referrals and waiting times can therefore be an issue. Staff feel that there is no problem with care but have a problem with patients having to wait on trolleys. The nursing staff work hard and try their best and work well as a team

### 6.3 Support Services Focus Group

Patient experience staff told us that when ED is very busy it is difficult for them to complete all of their duties. They also stated that the time allocated to clean rooms is not enough as they only have 10 to 15 minutes, and often with not enough notice. They stated that to clean a room properly takes around 45 minutes. Staff reported there was an issue with disposal of waste in the incorrect waste stream.

Catering staff informed us that there can be long delays in fixing some broken equipment. Porters told us of their problems with ensuring sufficient wheelchairs are available. Reception staff and ward clerks stated they were short staffed and also had to cover other wards, making it difficult to ensure their work was up to date.

The group told us that they provide their own cover for sickness and absence as bank staff are not available for them. Work is divided between staff or for longer absences the line manager prefers temporary contract cover.

Porters told us that for long term sickness agency staff cover shifts. These can be new staff or staff who have been used previously. The patient trackers feel their post is not understood properly. In ED they feel there is still some conflict between professional needs, money and reaching targets.

The group told us that they were not fully clear about the trust vision and strategy for improving patient care; however some were aware of the five pillars. The group stated that there is variation in how often staff meetings are held and they are not always available to attend, due to workload.

We were told that induction, mandatory training, appraisals and supervision were good. They stated that some supervisors have not yet carried out appraisals but these were planned for the future. Ward clerks felt that it would be good to have more opportunities for development as it is a very flat system for them.

The group felt well supported by line managers and the trust and told us they also support each other.

Ward clerks told us about their concerns regarding medical notes never arriving on the ward in time to ensure that the current admission is filed with the patient's previous notes.

Catering staff told us that the introduction of the red tray system to identify patients who require assistance with their meals in 7B and 7C has been very successful and should be rolled out to all other wards. In ward 7B from 7.00am to 11.00am they have help with breakfast.

Patient trackers told us of a pilot in ED. A band 2 and 3 care assistant brings all patients to x-ray which has been very successful in ensuring x-ray is processing patients. They also felt that in ED it was difficult to review practice and introduce new ideas as they were so busy.

Porters told us that new shifts are being introduced for ED. They spoke about the issue regarding the cleaning of wheelchairs as no one has responsibility for this. Patient trackers told us that the new patient tracking system in ED is a good improvement.

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

### 6.4 Allied Health Professionals Focus Group

The group informed us that one of their current challenges is to be proactive rather than reactive. Staffing can be a challenge and there is no staff bank for them to call on to alleviate staff shortages.

Social workers told us that they do not have time to complete all tasks because of the heavy caseload; some wards need two social workers. Occupational therapists stated that they have a small team looking after a lot of wards; they are short staffed, with lots of new demands on their service; many staff are on maternity and long term sick leave. There are backlogs and delays with discharges as AMU and ED get priority.

Physiotherapists also told us that they were short staffed and of the difficulties with prioritisation in their service in relation to new admissions and discharges. They are concerned that the patients in between are not getting enough attention and treatment.

Radiographers told us that scanning including CT is now available all week; however they are concerned that they will not have enough staff to maintain this service. The recruitment process is very long and the regional band 5 recruitment system is not working very well, as often they are not getting suitably qualified people. They also considered that scrutiny committees take a very long time.

Pharmacy staff told us that because of regional recruitment, staff may take a post but in reality they want to work closer to home. Time is invested in training these staff, only to have them leave. They stated that AMU is very busy and there is not enough time to complete their work. They work from 9.00am to 5.00pm which does not give enough time to see all patients; and they have to take advice from nurses as to which patients have to be seen, and who is to be discharged.

Dieticians told us that referrals are not timely; they are short staffed at weekends and the out of hours period is difficult to cover. Nursing staff are not completing MUST assessments correctly. They are concerned that patients who need to be seen are not being referred.

Junior staff work in the regional hospital (RVH) for experience and then leave to work in smaller local hospitals. The group informed us of issues created by the introduced of HRTPS. The system has created difficulties with filling new posts, due to increased administration time.

We were told of the difficulties with the centralised community access centre (CCAC) by social workers and occupational therapists. This is a new regional system but varies in different trusts and is not available out of hours. Only a limited pilot was carried out before the service began and, sometimes staff feel that the services required don't fit into the system for complex cases. They feel they do not see patients quickly enough to aid early discharge.

In the regional stroke unit, there are staffing issues; patients under 65 years do not have the proper access to reablement services.

The group spoke about the importance of training and keeping up to date, however are pushed to complete this. They stated that swallowing awareness training for nursing staff despite being mandatory is not happening. Any training at specialist level is not always a priority and they can't go.

We were told that there was good support from line management; some staff felt that they should push harder for more staff.

All were aware of the trust vision and strategy for improving patient care. They feel there needs to be more communication regarding seven day working. When other professionals such as nurses are under pressure, this can affect their work as it will take more time.

All staff would be happy for their family and friends to be cared for in the hospital.

## 6.5 Medical Staff Interviews/Focus Group

### Consultant Staff

Surgeons told us that one of their main challenges is the way the10 bedded EmSU is currently operating. The unit was opened in order to segregate elective and emergency surgical cases. There is no consultant in overall charge of the unit. There are two designated surgical consultants of the week and 18 rotating consultants, who review patients. There is a need for change with someone placed in overall control of the unit

We were told that there are usually a significant number of medical inliers, which affects the flow of surgical patients through the system. The unit also does not have any protected slots for imaging such as CT and MRI and this can delay assessment and discharge.

We were told that there has been an increase in patient numbers and also increased pressure from emergencies is making it more difficult to keep up with elective surgery cases. A lot of operations take place out of hours by the good will of surgical staff. Elective surgical capacity is an issue. There is a weekly impact group and these meetings have been beneficial in discussing these issues with other specialists.

There is a need for more discussion between surgeons and ED as there is an increase in Zero Length of stay. It is also difficult to examine patients in ED when it is crowded as patients are too close to each other; there are no other available facilities to examine the patients.

The CAU has a lack of resources to provide the service originally envisaged. There are not enough beds for the number of patients.

The AMU is very different than before with more management engagement. Tracking of patients has improved; integration of information has improved; morning meetings are now held to identify patients; IT is much better. Staff felt that there has been a vast improvement overall.

The opening of the CAU has resulted in the AMU catering for an older, more complex set of patients than previously. Sometimes patients are there outside the 24 to 48 hours target and may be there for up to 21 days. There has been some improvement in community placements; however, there are still delays in getting patients out to the community. The doctor stated that they have 16 patients at present, most of whom could be discharged, or are on the wrong ward. The unit could function much better if patients after 72 hours were moved on to their specialities.

Staff considered that there is a need for primary care to take on additional duties to prevent hospital admissions. Better communication is also needed with GPs in relation to discharges.

Staff felt that the ECR system provides better information than previous systems.

**Doctors in Training**

Trainees of all grades from Foundation Year 1 house officers through to senior registrars in Medicine, Surgery and Emergency Medicine were interviewed. Staff Grade and Associate Specialists doctors were also spoken with.

In the emergency department all trainees described their experience positively with opportunities provided to manage a wide range of emergency presentations. Trainees are closely supervised and there is a middle grade presence (ST3 or above) 24/7. Consultants are very supportive and trainees have Thursdays off to pursue continuing professional development opportunities and audit in the morning and attend regional emergency medicine teaching in the afternoon.

There were no reports of bullying or undermining and all trainees felt able and were clear on how to raise concerns should the need arise. Trainees had no specific patient safety concerns. Induction was described as good and all trainees could meet with their educational and clinical supervisors and complete required work-placed based assessments. The RVH still relies mainly on locum cover to provide middle grade coverage. These locums are almost all long term, well known and valued within the department.
An associate specialist coordinates the overall staffing rota. Close engagement with locums and locum agencies has resulted in a number of innovative approaches with reduction in locum costs and more stable rota planning. Additional specialty doctor posts are being created. Templates of completed rotas were seen by the inspection team and all areas were staffed by Core trainee, Registrar and Consultant grades.

Senior house officer and registrar trainees in medicine and surgery described their experience positively. One FY2 doctor who had just begun a rotation was able to contact medical teams easily via an in-house app that held bleep numbers and contact details securely. The main issue of concern raised related to the assessment of patients in the ED, particularly the Majors area when there were trolley waits. This was of most significance for the surgical team. There was insufficient space to examine patients, no dedicated areas in which to move them for assessment and privacy and dignity could not be maintained. Occasionally, when it was available, the plaster room was used for assessment.

Foundation year 1 doctors described a very positive experience working in 7B with excellent support from senior medical and nursing staff. However, FY1 doctors in 6C feel disconnected from the rest of the team. Their rota allocations often see them move between areas on a weekly or daily basis, with breaks in the continuity of patient care. Furthermore, due to the pressures on middle grade cover, decision making is slower and access to senior staff is restricted due to them being required in theatre.

Some FY1 doctors also noted challenges including: equipment break down; printing documents and getting access to patient records as they are assessed by so many disciplines.

The junior doctors stated that they are able to keep work based assessments up to date. However, this is more difficult for trainees working in 6F but they generally have managed to get enough done.

FY2 doctors usually have a handover to which FY1s are invited but usually don't go. However they do go on the ward rounds at 8.00am and 11.45am. They mentioned that some blood results take too long, for example biochemistry blood results can be sent at 7.00am not but returned until 5.00pm. They would also find it beneficial to have more phlebotomists.

There is no frail elderly unit which they think would improve patient care.

They stated that generally they would be happy for family or relatives to be cared for in the hospital; however not in ward 6F. Communication is not as good on 6F as it is on other wards.

### 6.6 Points for Consideration from Focus Groups

1. Timely access to diagnostic services such as CT scans and MRIs for emergency surgical patients to assist in the patient's journey to discharge.

2. A regional group should be set up to develop a more effective process for repatriation of patients back to another trust.

3. Additional pressure sustained in managing diverted patients from other trusts.

4. Review the difficulties created by the introduction of HRPTS in relation to increased administration time and recruitment.

5. Work with NIMDTA to explode solutions for the current difficulties with a lack of applicants for Surgical Clinical Fellows.

6. Exploration by the DoH in providing enhanced capacity for GPs which could help with reducing patients need for admission and facilitate discharge.

7. Provision of additional information to staff to ensure they are fully aware of each other's pressures to admit patients.

8. ED senior managers to review and speak with staff on their concerns regarding staffing levels in majors area, at nights and for the portering service.

9. Explore staff concerns regarding support for mental health patients and the management of violence and aggression to ensure that staff are adequately equipped to manage these situations.

10. Review the effectiveness of the attack alarm for staff in ED to ensure the alarm indicates the area or room where help is needed.

11. Review the capacity, demand issues and then explore the introduction of a bank system for support and AHP staff.

12. Inform the DoH of the difficulties and variations with the new regional centralised community access Centre (CCAC) system to ensure this is taken forward regionally.

13. Equity in the provision of reablement services for patients under 65 years.

14. Swallowing awareness training for nursing staff is undertaken as required.

15. PECs staff have sufficient time to clean a single room after patient discharge.

16. Speedy repair of equipment and provision of sufficient wheelchairs for porters.

17. Support staff facilitated to attend staff meetings.

18. Medical notes to arrive on the ward to ensure that the current admission is filed with the patient's previous notes.

19. Roll out in all wards the introduction of the red tray system to identify patients who require assistance with their meals.

20. The10 bedded EmSU is managed effectively with an identified surgeon in charge.

21. Review elective surgical capacity in response to the increase in patients and pressures from emergencies.

22. Facilitating more discussion between surgeons and ED to explore the increase in Zero Length of stay.

23. Review the function of the AMU in light of the changes in the turnaround of patients by the opening of the CAU.

24. Explore the reasons for delayed discharge in the AMU.

25. Design Foundation Year 1 rotas in 6C and allied wards to ensure that there is greater continuity of coverage by FY1 doctors.

# Theme: Inpatient Diabetes Management and the Clinical Assessment Unit

# 7.0 Theme: Inpatient Diabetes Management and the Clinical Assessment Unit

## 7.1 Inpatient Diabetes Management

A bespoke tool was developed by Dr Emma McCracken, SpR Endocrinology and Diabetes and Dr Hamish Courtney (Consultant Endocrinology and Diabetes) (see Appendix 2). This tool was used in wards 6B and 7C to collect data on the management of those who had diabetes.

Frequency of blood glucose monitoring was carried out at appropriate frequency. All relevant medications were correctly prescribed and administered in a timely manner. Patients who did not require referral to specialist diabetes services were appropriately managed on the ward and documentation was clear and uncluttered.

## 7.2 Clinical Assessment Unit

Consultant staff from the ED and acute medical teams have been instrumental in developing a CAU that caters for patients who require multi-disciplinary/ professional assessment or care, a period of assessment or treatment that may last >four but <24 hours, and services such as IV medicine administration. It provides an opportunity to hold review clinics for some ED attendees (e.g. for DVT/PE, fractures) and provides rapid access into specialty outpatient clinics. Good relationships with the radiology department ensure a number of protected scan slots which facilitate a smooth patient journey. The early consultant-led assessment and team work was highly praised by all staff members spoken to during the RVH visit.

Within CAU there is currently capacity for 30 patients. There is a discharge rate of 87 per cent from CAU and this translates to a reduction of 12 ED admissions per day.

Within the CAU there is only one private clinical assessment room and two rooms for mental health assessments. The type of patients admitted to CAU tend to be those with predominantly medical problems, although due to the consultant skill mix (including acute and emergency medicine as well as general surgery) patients presenting with conditions such as abdominal pain were starting to be managed in this setting. A defined list of exclusion criteria (that would otherwise mandate emergent or urgent specialist referral and review) guided the admissions policy. Noteworthy is the move to accepting and owning patients who do not fall into clear specialty categories. This culture of proactively managing admissions through the ED improves patient experience, safety and quality of care.

The CAU team, in conjunction with surgical colleagues are seeking to expand the CAU model to provide support for patients with predominantly surgical issues and so support the Emergency Surgical Unit.

The CAU model is to be commended as it is an example of data-driven and outcome-focussed care. The intention to improve bed capacity, reallocate some tasks (such as elective blood transfusion or venepuncture) to a dedicated Day Unit, and the provision of a service to appropriate patients with more surgical presentations are to be encouraged.

### 7.3 Recommendations for the Trust from the Clinical Assessment Unit Theme

1. The trust should explore the current remit and capacity of the CAU to include surgical referrals.

## 8.0 Next Steps

On the 16 December 2015, the RQIA inspection team provided detailed verbal feedback to each area inspected. This was followed by feedback to the Chief Executive, directors and senior managers on the key findings from the inspection.

This inspection report has been shared with the Belfast Trust for factual accuracy. Following publication of the report the trust had 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 Belfast Trust, DoH, Health and Social Care 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<br>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:**<br><br>• 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).<br>• Checking with people to see how they are and if they need anything.<br>• Encouragement and comfort during care tasks (moving and handling, walking, bathing etc) that is more than necessary to carry out a task.<br>• Offering choice and actively seeking engagement and participation with patients.<br>• Explanations and offering information are tailored to the individual, the language used easy to understand and non-verbal used were appropriate.<br>• Smiling, laughing together, personal touch and empathy.<br>• Offering more food/ asking if finished, going the extra mile.<br>• Taking an interest in the older patient as a person, rather than just another admission.<br>• 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:**<br><br>Brief verbal explanations and encouragement, but only that the necessary to carry out the task.<br><br>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.<br>• 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:**<br><br>• Putting plate down without verbal or non-verbal contact.<br>• Undirected greeting or comments to the room in general.<br>• Makes someone feel ill at ease and uncomfortable.<br>• Lacks caring or empathy but not necessarily overtly rude.<br>• Completion of care tasks such as checking readings, filling in charts without any verbal or non-verbal contact.<br>• Telling someone what is going to happen without offering choice or the opportunity to ask questions.<br>• Not showing interest in what the patient or visitor is saying. | **Examples include:**<br><br>• Ignoring, undermining, use of childlike language, talking over an older person during conversations.<br>• Being told to wait for attention without explanation or comfort.<br>• Told to do something without discussion, explanation or help offered.<br>• Being told can't have something without good reason/ explanation.<br>• Treating an older person in a childlike or disapproving way.<br>• Not allowing an older person to use their abilities or make choices (even if said with 'kindness').<br>• Seeking choice but then ignoring or over ruling it.<br>• Being angry with or scolding older patients.<br>• Being rude and unfriendly<br>• 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).

## Appendix 2 Inpatient Diabetes Management Proforma

### 1. Patient diabetes type

| | |
|---|---|
| Type 1 | ☐ |
| Type 2 | ☐ |
| Other (e.g. pancreatitis, steroid induced) | ☐ |

### 2. Diabetes treatment regimen on admission (tick all that apply)

| | |
|---|---|
| Insulin | ☐ |
| Tablets (oral hypoglycaemic agents) | ☐ |
| Non-insulin injectables | ☐ |
| Diet only | ☐ |

### 3. Type of admission

| | |
|---|---|
| Emergency | ☐ |
| Elective | ☐ |

### 4. Main reason for admission

| | | | |
|---|---|---|---|
| Non-diabetes related | ☐ | | |
| Diabetic ketoacidosis (DKA) | ☐ | Hyperglycaemia (not meeting criteria for DKA or HHS) | ☐ |
| Active diabetic foot disease | ☐ | Hyperosmolar hyperglycaemic state (HHS, previously HONK) | ☐ |
| Hypoglycaemia | ☐ | | |
| Other Diabetes related (please record) | | | |

## 5. Diabetes Control

| | | | | |
|---|---|---|---|---|
| Most recent HbA1c recorded in notes | | YES | | NO |
| Is the glucose chart available for review? | | YES | | NO |
| In the previous 7 days, on how many days has blood glucose monitoring been carried out | | | | |
| Please record number of nights in hospital if inpatient <7days | | | | |
| On how many days was frequency of monitoring appropriate?* | | | | |

**What level of control is appropriate for the patient?**

| | |
|---|---|
| Good control (i.e. 4-11mmol/l) | |
| Symptomatic control (e.g. terminal/palliative care, cognitive impairment, frailty) | |
| If good control is appropriate; how many "good diabetes days" in previous 7 days? (i.e. number of days where frequency of monitoring was appropriate, AND there was no more than one reading above 11mmol/l AND no readings less than 4mmol/l | |

### *Hypoglycaemia*

When managing hypoglycaemia, frequency of blood glucose checks will increase by necessity. Therefore, for purposes of the following questions, count only blood glucose readings separated by a 4 hour period (i.e if there were multiple checks carried out in a 4 hour period, this should count as only one episode)

| | | | | |
|---|---|---|---|---|
| Number of blood glucose readings below 4.0mmol/l in the past 7 days | | | | |
| Was the treatment of all hypoglycaemic episodes documented | | YES | | NO |
| Was the treatment of all hypoglycaemic episodes in accordance with local guidelines? | | YES | | NO |
| Number of episodes of hypoglycaemia requiring parenteral (IV or IM) glucose administration | | | | |

## 6. Prescribing and drug management

| | | | | |
|---|---|---|---|---|
| Is the drug chart (kardex) available for review? | | YES | | NO |
| **6a If on insulin, did any of the following errors occur: (if not on insulin, go to Q 6b)** | | | | |
| Insulin not written up | | YES | | NO |
| Incorrect name of insulin | | YES | | NO |
| Dose (number) unclear | | YES | | NO |
| Units abbreviated to “u” or written unclearly | | YES | | NO |
| Insulin or prescription chart not signed by prescriber | | YES | | NO |
| Insulin not signed as given by nursing staff | | YES | | NO |
| Insulin given/prescribed at wrong time | | YES | | NO |
| Insulin not increased when blood glucose persistently >11mmol/l and better glycaemic control appropriate for the patient | | YES | | NO |
| Insulin not reduced if unexplained blood glucose <4mmol/l | | YES | | NO |
| **6b If on oral hypoglycaemic agent(s), did any of the following errors occur (if not on OHA, go to Q 6c)** | | | | |
| OHA not written up | | YES | | NO |
| OHA not signed as given by nursing staff | | YES | | NO |
| OHA given/prescribed at wrong time (e.g. bedtime) | | YES | | NO |
| Wrong dose of OHA prescribed | | YES | | NO |

| | | | | | |
|---|---|---|---|---|---|
| | **No action taken when blood glucose persistently >11mmol/l and better glycaemic control appropriate for the patient** | | **YES** | | **NO** |
| | OHA not reduced if unexplained blood glucose <4mmol/l | | YES | | NO |
| **6c** | **If managed with dietary control alone, did the following occur** | | | | |
| | No action taken when blood glucose persistently >11mmol/l and better glycaemic control appropriate for the patient | | YES | | NO |

**7. Specialist services**

| | | | | | |
|---|---|---|---|---|---|
| | Was the patient reviewed by a member of the diabetes team while inpatient? | | YES | | NO |
| | Should the patient have been referred to the diabetes team?* | | YES | | NO |

**General Comments:**

## Appendix 3 Guidelines for Appropriate Frequency of Blood Glucose Monitoring

| **Metformin or diet alone** | **One or more check daily;<br>If long stay patient with stable control, once weekly or more is acceptable** |
|---|---|
| Once or twice-daily insulin/SU/DPP4 inhibitor/glitazone/SGLT2 inhibitors/GLP 1 analogues | Two or more checks daily |
| Unwell/unstable diabetes/basal bolus insulin | Four or more checks daily |

Criteria for referral to the diabetes specialist team (list not exhaustive)

| **Patient request** | **Sepsis** |
|---|---|
| Severe hypoglycaemia | Vomiting |
| Acute coronary syndrome | Foot ulceration |
| DKA/HHS | Unable to self-manage |
| Newly diagnosed diabetes | Parenteral or enteral nutrition |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