The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust

Royal Bournemouth Hospital

Quality report

Castle Lane East
Bournemouth BH7 7DW
Telephone: 01202 303626
www.rbch.nhs.uk

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This report describes our judgement of the quality of care at this hospital. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Overall summary

The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust provides healthcare for the residents of Bournemouth, Christchurch, East Dorset and part of the New Forest. It serves a population of around 550,000, and this rises during the summer. Some specialist services cover a wider catchment area, including Poole, the Purbecks and South Wiltshire.

The trust has two main locations: Royal Bournemouth Hospital and Christchurch Hospital. These are located about three miles apart on the South Coast. Most of the acute services are provided at Royal Bournemouth Hospital.

The trust has been inspected five times by CQC since it was registered in October 2011. It was in breach of the Health and Social Care Act 2008 in relation to the management of medicines in September 2011, but this was resolved in May 2012.

Children's care, midwifery, critical care and end of life care services at the hospital were good. (The children's service is limited to eye operations and the maternity service is a small midwifery-run unit.) In all services across the hospital, most staff were committed to the trust and eager to give good care to patients. Patients were complimentary about the care they received and the professionalism of staff on surgical services.

However, a number of services were not always safe, effective, responsive, caring or well-led. In particular we found that medical care (including care older people's care) was inadequate. There were widespread and significant negative views from patients and staff. The trust's Board had not focused sufficiently on improving or recognising these failures, or the urgent need to improve patient care.

Other services requiring improvements to patients' experience included A&E, surgical services and outpatients. The seriousness of the impact of poor care on patients outweighed the many positive comments we received about the hospital. A number of complaints had not been addressed sufficiently for people.

We were told about basic nursing care not being given to patients, in particular on medical care Wards 3 and 26. We heard about a patient who had had fluids and food restricted in error. We also heard from five patients who told us they had been left to wet or soil their beds.

Summary of findings

Overall summary (continued)

The hospital had a high occupancy rate and there had been ongoing use of escalation beds when a ward or unit was full. This was dangerous and could not meet any patient's needs.

The trust did not employ enough staff, even though it was fully aware that nearly all its beds were occupied all the time. We were told that there were 135 nursing and healthcare assistant vacancies at the end of September. While 65 posts had been filled by late October, the benefit to existing staff had not yet materialised, in particular for medical services. Some patients were still not receiving the care they needed in a timely manner, and there was an ongoing high risk of this continuing.

Patients who had suffered a stroke did not always have the fast access urgent treatment on the specialist unit that they needed.

Other issues we found were:

- Care planning and evaluation did not always contain all relevant information, and staff on duty did not always know the specific care needs of people.
- Mandatory training for staff was not always delivered on time, or they were not always suitably trained for the areas in which they might work, for example dementia care and assessing whether a patient is able to swallow.
- Security arrangements in A&E left staff feeling vulnerable.

We found the trust overall was not ensuring effective leadership and governance across the hospital.

Summary of findings

The five questions we ask about hospitals and what we found

We always ask the following five questions of services.

Are services safe?

Prior to our inspection visit we reviewed a number of factors relating to patient safety at the hospital. These included rates of infections, reporting incidents, the occurrence of 'never events' (errors in care that should never happen), reported deaths outside of expected limits. These indicated that care provided at the hospital might not be as safe as needed for patients.

We found that care was not always safe; both doctors and nurses at times felt unsupported and under too much pressure due to staffing levels and skill mix within the areas where they worked. This meant that on some medical wards, including for frail older people, patients were at risk of harm for example from incidents, or lack of fluids and nutrition. On surgical wards the medical staffing level at night was not safe. In outpatients there were a risk of cross infection. However the services that were safe included maternity, critical care, children's care and end of life care.

Are services effective?

Many parts of the hospital were effectively managed and applied recognised clinical guidelines or national standards. This meant that recognised best practice was used to deliver treatment that met patients' needs. However the A&E and medical care services were not effective. Also there is a need to ensure greater external scrutiny of some measures, for example mortality rates.

Are services caring?

Patients, their relatives and staff told us about incidents where patients had not been treated with dignity and respect. Some aspects of care were not met in a timely manner. This was found to be inadequate on medical care Wards 3 and 26 in particular and, although to a lesser extent, across medical services as a whole. Some people in the medical care wards, including older frail people, were left in soiled beds. However, there were many positive examples of caring in areas that included maternity, critical care, children's care, outpatients and end of life care.

Are services responsive to people's needs?

Children's care, critical care and end of life care were particularly responsive to people's needs. However, improvements in one part of the hospital were not necessarily shared across all services. Services tended to work in isolation. We found people were able to raise concerns and make complaints. However some people felt that when they made a complaint, the trust was dismissive of their concerns. This meant that they either chose to have care elsewhere or continued to feel dissatisfied. A&E, medical services and outpatients were less responsive to the needs of patients.

Are services well-led?

Children's care, maternity, critical care and end of life care were generally well-led. Many departments and wards had effective leadership. However the A& E department required improvements and medical care services in particular were inadequate in this regard. While there was clear communication between the senior management and the trust's Board, this was less apparent for other staff. This was affecting staff morale and individual professional accountability for some staff.

Summary of findings

What we found about each of the main services in the hospital

Accident and emergency

We found that the A&E service was not always safe and effective, because of the use of escalation beds and extra trolleys. Staff and patients were not fully protected from abuse because of the lack of robust security measures. Staff were caring about patients' needs, but were not always responsive. Patients with a stroke were not always given the urgent care they needed. A&E was well-led at department level, but there was evidence that the ongoing safety issues had not been resolved at board level.

Medical care (including older people's care)

We found that patients' care varied between the medical wards and units. The patient experience was worse on Ward 3 and Ward 26 than the rest, although there were concerns throughout. Some patients told us that they felt their care had not been delivered in a safe and dignified way.

Some had concerns about the numbers of nurses on the wards and felt that their care had been compromised by a lack of staff. We heard about a patient on Ward 3 who had had fluids and food restricted in error. We also heard reports from five patients who told us that they had been left to wet or soil their beds because staff were unable to attend to them in a timely manner. We spoke with some staff who felt that care was not always safe; they said that they felt unsupported and under too much pressure due to staffing levels and skill mix within the areas where they worked.

We found that the hospital had systems in place to monitor incidents and accidents, which allowed staff to analyse data to look for trends that could help them to improve patients' safety. We were shown examples of where this had changed practice. However, we found examples of incidents that staff had not reported through the reporting system. Staff told us they were fearful of the high bed occupancy and the pressure this placed on them.

Surgery

We found the safety of patients could be improved. We saw that staff were very busy and although patient care was safe, staff told us that they often worked with fewer staff than was needed. Staff told us they found this stressful and that sometimes patients had to wait for their care.

We saw that staff worked effectively and collaboratively to provide a multidisciplinary service for patients in their care. When patients needed care from several specialities of the hospital, this was done effectively to ensure the patients were well cared for.

We found staff were caring and the service responded to patients' needs. Patients were complimentary about the care they received and the professionalism and courtesy of staff. They told us that the service met their needs and that they felt well cared for by the nursing and medical staff.

At ward and theatre level the provision of care was well-led. However, levels of nursing staff set by the trust were not consistently met. We saw that junior surgical medical staff were not well supported overnight and the medical staff handovers of information at the change of shift were not sufficient to ensure safe practice. We had concerns that staffing levels for nursing and medical staff had been identified as insufficient, but action had not been taken. This is an area for improvement for the trust.

Summary of findings

What we found about each of the main services in the hospital continued

Intensive/critical care

The service was safe, effective, caring, responsive and well-led. We found that people were protected from the risks of infection, and changes to practice were made following learning from incidents. Care was planned and delivered to meet patients' assessed needs by staff that had appropriate skills and training. Patients were treated with dignity and respect and their privacy was maintained. Staff were aware of their roles and responsibilities and there was a clear leadership structure. However, patients were not always discharged promptly when they no longer needed intensive care.

Maternity and family planning

We found that the midwifery unit provided safe and effective care for women with a low risk of developing complications during birth. Feedback from women using the service was positive. They told us staff were exceptionally caring and helpful. The service was well-led. Women said they had been well supported throughout their stay in the unit. Improvements could be made where access to scans is limited.

Women using the midwifery-led maternity service can be assured of a good standard of care during their pregnancy and birth, and be confident that they will be supported in their chosen method of feeding their babies.

Children's care

Only children's eye surgery is carried out at the hospital. The Children's Eye Ward provided safe and effective care for children who had undergone ophthalmic surgery. Feedback from patients and their families was positive. They told us the service was very oriented to the care of young people. For example, colouring books were routinely offered during outpatient appointments.

The service was well-led and responded appropriately to the needs of the children. Children requiring ophthalmic surgery at the hospital can be assured of a good standard of care and their families can be confident that they will be supported during their child's stay in hospital.

End of life care

End of life care services in the hospital were safe, effective, caring, responsive and well-led. Improving end of life care had been a high priority over the last 12 months and good progress had been made on a number of important new initiatives. This included implementation of new personalised care plans for last days of life.

Our conversations with patients, their relatives and care staff provided evidence of good quality care and treatment. Patients and their relatives told us they were fully involved in care planning decisions and were regularly updated on changes in the patient's condition. All the staff we spoke with were knowledgeable, passionate and committed to providing high quality care for patients at the end of life and their families.

Outpatients

The outpatients department generally provided a caring and effective service for patients. There was much praise for the dedication of the staff. Feedback from patients was positive. The trust had not, however, been responsive about issues with waiting times and communication.

Individual clinics were well-led, with clinical staff taking responsibility for the organisation and arrangements as needed. However, quality assurance and risk management to ensure safety was not always supervised appropriately. There were infection control risks, for example the main outpatient reception, the floor sinks and the waste bins in the female toilets were not clean. The sluice room was cluttered with obsolete equipment and the hand wash sink and draining board was stacked with used clinical dressing packs. Staff entered the sluice with dirty packs, adding to the pile, and left without washing their hands. Staff were not clear about the measures in place to monitor infection control standards in the outpatient areas throughout the hospital.

Summary of findings

What people who use the hospital say

The most recent NHS staff survey from 2012 said most of the responses from the staff were better than expected or within expectations.

However, three areas of highlighted risk or elevated risk were identified: the percentage of staff agreeing that their role makes a difference; staff witnessing potentially harmful errors, near misses or incidents and the percentage of staff experiencing physical violence from patients, relatives or the public in the last 12 months.

Analysis of data from the CQC's Adult Inpatient Survey 2012 indicates that the trust scored within the expected range for all areas.

In July 2013, the trust had performed above the national average score on the Inpatient Friends and Family Test and the same as the national average for A&E.

There are 181 comments on the trust's section of the Patient Opinion website. Patients generally view the hospital as performing well and regularly praise the staff. The negative comments include concerns over waiting times and record keeping.

There were 13 CQC 'Share Your Experience' comments for the trust: 12 were negative and described staff as not listening to patients, a lack of care and a lack of understanding of patients' needs.

Areas for improvement

Action the hospital MUST take to improve

We have set compliance actions that we will follow up within three months of receiving the provider's action plan.

- All patients need to have their needs assessed and care delivered safely and in a timely manner by staff who are skilled to do so.
- At all times, patients must be treated with the dignity and respect they deserve and basic care needs must be met.
- The trust must reassure itself and stakeholders that all opportunities to drive quality improvement and quality assurance are taken.
- The trust must ensure that the required number of staff with the correct skills are employed and managed shift by shift, to demonstrate that there are sufficient staff to meet people's needs.

Summary of findings

Areas for improvement

Other areas where the hospital could improve

- The stroke pathway before patients are admitted to the stroke ward.
- Levels of nursing staff in wards, especially those caring for the frail elderly patients, did not reflect the dependency of patients. This meant there was a high risk and actual occurrences of patients not receiving the care they needed in a timely manner.
- Care planning and evaluation did not contain all relevant information and staff on duty did not always know the specific care needs of people.
- Staff did not have all mandatory training on time and or were not suitably trained for the areas in which they may work, for example, in dementia care, and to perform the necessary tests to assess whether a patient is able to swallow.
- Security arrangements in A&E leave staff feeling vulnerable.
- Escalation beds in AMU and A&E were considered dangerous and not fit for purpose.
- Junior medical staff in surgical services required more support out of hours.
- Patients did not always have informed consent by doctors who are fully aware of procedures.
- The mental health care pathway in A&E is not a 24-hour service.
- A&E does not always provide care for children from suitably-qualified staff at all times.
- Records for care and for incidents are not always completed in full and in a timely manner.
- The outpatient booking process was not always patient-focused and sometimes led to patients experiencing unnecessarily long waiting times.

Good practice

Our inspection team highlighted the following areas of good practice:

- Some aspects of end of life care were undertaken very well.

Royal Bournemouth Hospital

Detailed findings

Services we looked at: Accident and emergency; Medical care (including older people's care); Surgery; Intensive/critical care; Maternity and family planning; Children's care; End of life care; Outpatients

Our inspection team

Our inspection team was led by:

Chair: Dr Michael Anderson, Consultant Gastroenterologist

Team Leader: Joanne Ward, Care Quality Commission

The team of 22 included doctors, nurses, senior managers, other clinical specialists, CQC inspectors, patient representatives and Experts by Experience. Experts by Experience have personal experience of using or caring for someone who uses this type of service.

Why we carried out this inspection

We inspected this trust as part of our new in-depth hospital inspection programme. Between September and December 2013, we are using the new approach at 18 NHS trusts. We chose these trusts because they represented the variation in hospital care in England according to our 'Intelligent Monitoring' information. This looks at a wide range of data including patient and staff surveys, hospital performance information and the views of the public and local partner organisations. Under this model, The Royal Bournemouth and Christchurch Hospital NHS Foundation Trust was considered to be a high risk service.

How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

The inspection team always inspects the following core services at each inspection:

- Accident and emergency (A&E)
- Medical care (including older people's care)
- Surgery
- Intensive/critical care
- Maternity and family planning
- Children's care
- End of life care
- Outpatients.

Detailed findings

The lines of enquiry for this inspection were informed by our Intelligent Monitoring data. As part of the inspection process, we contacted a number of key stakeholders and reviewed the information they gave to us. We received information from people who use the services, the medical royal colleges, Monitor, Dorset Clinical Commissioning Group and Health Education England.

We carried out an announced inspection visit on 24 and 25 October 2013. We looked at the personal care or treatment records of people who use the service, and we observed how staff cared for patients and talked with people who use the services. We talked with carers and family members. We held seven focus groups with staff. We talked to and interviewed a range of staff including the Chairman, Governors, Chief Executive, Medical Director and Director of Nursing. We also carried out an unannounced inspection visit on 30 October 2013.

We placed comments boxes around the hospital and received more than 30 comments from people who used the service and staff.

We held a public listening event in Bournemouth on the evening of 24 October 2013. Around 85 people talked to us about their experiences and share feedback on how they think the trust needs to improve.

The team would like to thank all those who attended the focus groups and listening events and were open and balanced with the sharing of their experiences and their perceptions of the quality of care and treatment at the trust.

Are services safe?

Summary of findings

Prior to our inspection visit we reviewed a number of factors relating to patient safety at the hospital. These included rates of infections, reporting incidents, the occurrence of 'never events' (errors in care that should never happen), reported deaths outside of expected limits. These indicated that care provided at the hospital might not be as safe as needed for patients.

We found that care was not always safe; both doctors and nurses felt unsupported and under too much pressure due to staffing levels and skill mix within the areas where they worked. This meant that on some medical wards, including for frail older people, patients were at risk of harm for example from incidents, or lack of fluids and nutrition. On surgical wards the medical staffing level at night was not safe. In outpatients there were a risk of cross infection. However the services that were safe included maternity, critical care, children's care and end of life care.

Our findings

We found that the service were safe in the smaller services of midwifery services, children's care and critical care, and also for end of life care where accessed.

Across the services we inspected we found that systems were in place to assess patient needs and plan their care. We saw that staff completed documentation but not in all cases for medical patients as well as for patients having anaesthetic where there were some gaps.

The majority of comments received across the trust were very positive about their experience and about the staff however where this was not the case the impact on patients has been below expectations.

In A&E and the Acute Medical Unit, the safety risk related to how the volume of patients is managed, the risk of using spaces not designed for patient bed areas called escalation beds and extra trolleys, and the delay for some patients in having urgent access to stroke care. Staff and patients were not fully protected from abuse due to lack of robust security measures.

We spoke with some staff who felt that care was not always safe; they said that they felt unsupported and under too much pressure due to staffing levels and skill mix in the areas they worked. Staff told us they were fearful of the high bed occupancy and the pressure this put on staff.

Staff told us that often they worked with less staff than planned. Staff told us that patients are being admitted in higher volume with greater needs and that this does not appear to them to be monitored and staffing levels addressed to meet the increased need. We saw staffing diary records which demonstrated that in a period between 07 and 24 October 2013 one ward had multiple shifts which had not been covered by existing staff, bank staff or agency. Staff told us that "we usually can't fill short term sickness". Staff told us that because staff were deployed from other wards that sometimes they lacked the specific skills needed on that ward. They also explained that when using agency staff they were not able to use the Vitalpac recording system in use. This is an electronic system of recording patient information. The result of this was that there were in some cases three systems of recording taking place, electronic, tape recording and paper records. Staff felt this was unsafe and placed patients at risk of information being missed.

The Director of Nursing had implemented monitoring called the 'Safety Thermometer' to promote patient safety. Staff were able to explain how this system worked and show us the data produced. Some staff were unclear about how this data changed the practices on the wards. We saw data on incidences of pressure ulcers, numbers of patients contracting MRSA and patient falls. This showed that wards were monitored for safety. Where accidents or incidents had occurred staff had completed the Accident and Incidents form (AIRs) and these had been reviewed by the hospitals patient safety and governance department. Some ward staff told us that they received feedback from the audit of these forms. However, some staff said they did not know the outcome and they were not aware of any changes made as a result of this reporting system.

We looked at whether the hospital had safe staffing levels. Although patient satisfaction was generally good the staffing levels especially of qualified nurses was a concern across the hospital. The trust did not employ enough staff,

Are services safe?

even though it was fully aware that nearly all its beds were occupied all the time. We were told that there were 135 nursing and healthcare assistant vacancies at the end of September. While 65 posts had been filled by late October, the benefit to existing staff had not yet materialised. Some patients were still not receiving the care they needed in a timely manner, and there was an ongoing high risk of this continuing.

Vacancies were not all covered by bank or agency staff. The Director of Nursing told us how staffing levels were calculated using national guidelines and professional judgment and these were monitored electronically. However on a day-to-day basis shortfalls in staff numbers were not reviewed and unfilled shifts often remained. The Director of Nursing told us she was always supported to employ more nurses as needed and that a new advert was planned. Staff were moved from ward to ward and there was much reliance on staff good will. Patient dependency was not explicitly taken into account and was based more on bed numbers and average patient type.

On the unannounced inspection we looked at how the doctors were working and supported out of hours. We found this to be satisfactory for medical services with changes made recently and this was well received. However the junior doctor for five surgical wards was left unsupported through the night and patient care was at risk.

Appropriate equipment was available in the hospital and it was managed adequately.

The NHS staff survey 2012 demonstrated most of the responses from the staff survey were better than expected or within expectations.

From 1 April 2010 it became mandatory for NHS trusts in England to report all patient safety incidents. Our review of the number of incidents reported by The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust was 218 and mainly occurred in inpatient areas.

The trust had systems in place for infection control. Infection rates for C.difficile., MRSA were satisfactory when compared to other trusts.

Rates of new Venous Thromboembolism (VTE) throughout the period were predominantly below the national averages which is positive.

There were no never events at the trust September 2011 to August 2013. However at two never events had been confirmed for October 2013.

Falls with harm rates were below the national average for almost the whole of the period between August 2012 and August 2013.

For the majority of the period between August 2012 and August 2013, the trust's rates for pressure ulcers were above the England average. However, the trust performed better than the national average in November 2012, June and August 2013.

The trust had been above the national average for catheter and urinary tract infection rates for five of the months between August 2012 and August 2013. And slightly worse for six of the months for people over 70 years.

We discussed the findings with the Director of Nursing who expressed a concern and desire to improve patient care in respect of pressure ulcers, falls and urinary infections.

Are services effective?
(for example, treatment is effective)

Summary of findings

Many parts of the hospital were effectively managed and applied recognised clinical guidelines or national standards. This meant that recognised best practice was used to deliver treatment that met patients' needs. However the A&E and medical care services were not effective. Also there is a need to ensure greater external scrutiny of some measures, for example mortality rates.

Our findings

Prior to our inspection we reviewed data relating to the effectiveness of care provided at the Royal Bournemouth Hospital.

Our information showed the trust had a higher than expected hospital standardised mortality ratio. The higher mortality rates were one of the factors that prompted this inspection. The trust challenged these figures and stated their mortality ratio is within the Dr Foster accepted range for a trust of this type, as the Christchurch Hospital palliative care unit deaths are also included.

We examined mortality data. We found the trust had five mortality outliers which means they were much worse than expected in those areas. Four of these were considered data anomalies. At the time of our inspection there was one mortality outlier for chronic renal failure deaths that the trust was investigating. Another one for senility and organic mental disorders where the trust had produced an action plan to improve dementia care services across the trust and not just for those with later stages of dementia health issues.

During our inspection visit we looked at the areas where data suggested the mortality rates were higher than expected. The trust was able to explain the reasons for these rates as data issues but was undertaking an internal review in relation to chronic renal patient's death that was not yet concluded.

The trust had a consultant led Mortality Review Group established over a number of years with the aim of reviewing and learning from death rates. Mortality results had been escalated through the governance structure from internal groups to the trust Board. There was internal scrutiny of deaths however opportunities for a professional review by an external expert clinician had not been undertaken.

We saw that clinical guidelines were in line with national standards and applied and used by all staff in A&E. This meant that recognised best practice was used to deliver treatment that met patients' needs.

As a result of patients being placed in wards that did not specialise in their conditions we heard stories during our inspection from patients and relatives who felt that they had not received good treatment as a result of staff not being trained to meet with their specific needs. For example, we spoke with the relative of a patient on Ward 3 who told us that because staff suspected that their relative had a problem swallowing that they had not been able to feed them food or fluids orally. They told us that they were told that none of the staff on the ward where their relative was currently being cared for were able to perform the necessary tests to check their relatives swallow. They said that as a result of this their relative had spent four days on intravenous fluids awaiting a swallowing assessment. This could mean that patients were being unnecessarily prohibited from eating and drinking due to a lack of adequately trained staff on the wards that they were being cared for.

The trust was not in line with national expectations for stroke patients prior to admission to the stroke ward. All data showed the trust to be far below the national averages, including for CT scans completed in one hour and in 12 hours. It was also below expectations for admission to the stroke unit in less than four hours, for 90% being admitted to the unit, and for the treatment rate for thrombolysis.

Are services effective?
(for example, treatment is effective)

There were systems in place at the Royal Bournemouth Hospital to ensure paediatric clinical practice was evidence based. We saw that the paediatric service within the trust had recently been bench marked against clinical guidelines and best practice standards. We noted that where the standard was not being met actions were in place to rectify this. For example the National Service Framework for Children recommended that a Band 7 nurse was employed in any day care unit. This was not in place for the Children's Eye Ward. The issue was reviewed by the Director of Nursing and added to the trust's risk register for action within the last two months. We saw that clinical and paediatric information was readily available on the Children's Eye Ward and staff took an active interest in researching current best practice and developing local clinical guidance. This demonstrated that the paediatric service monitored the quality of care and treatment and took action to improve the service.

We saw that the trust participated in one of the two national paediatric clinical audits they were eligible for. This was for paediatric services in general rather than ophthalmic audits. This demonstrated that the trust took part in research which contributed to the development of evidence based practice.

Are services caring?

Summary of findings

Patients, their relatives and staff told us about incidents where patients had not been treated with dignity and respect. Some aspects of care were not met in a timely manner. This was found to be inadequate on medical care Wards 3 and 26 in particular and, although to a lesser extent, across medical services as a whole. Some people in the medical care wards, including older frail people, were left in soiled beds. However, there were many positive examples of caring in areas that included maternity, critical care, children's care, outpatients and end of life care.

Our findings

Prior to our inspection we reviewed information related to how caring was the trust. Analysis of data from the CQC's Adult Inpatient Survey 2012 indicates that the trust scored within the expected range for all areas. In July 2013, the trust had performed above the national average score on the Inpatient Friends and Family Test & the same as the national average for A&E.

There were 181 comments on the trust's section of the Patient Opinion website. Patients generally view the hospital as performing well and regularly praise the staff. CQC Share Your Experience highlights several positive comments. However some patient feedback via Patient Opinion included negative comments include over waiting times and record keeping.

Directly to CQC 12 of 13 Your Experience comments about the trust were negative and described staff as not listening to patients, there had been a lack of care and a lack of understanding of patients' needs.

During our inspection we held a listening event that was attended by more than 85 people. In the main we were told staff were caring. Patients were complementary about the care they received and the professionalism and courtesy of the staff.

Some people however told us very concerning stories of their experiences and how the trust had not cared about them or their relatives.

On medical Ward 3 we spoke with four patients who all reported to us that they had been incontinent of both urine and faeces because staff had not answered their bells when they had rung them for assistance to use the toilet. Three of these patients said that this had happened on multiple occasions. One patient said, "I feel humiliated, I have never wet myself before. I just can't wait, sometimes my bell rings for half an hour before they come. I have even done worse than that. Can you imagine what it feels like to have to have your bottom washed because you have messed yourself?" Another patient said, "The bell rings and rings and when they do come they say they are busy and will come back. But they don't. So I ring again and when they come they are annoyed I can tell from their faces, but what can I do?" Another patient who had been incontinent of faeces when their bell wasn't answered promptly told us, "There's no dignity, none at all in that".

The Hyper Acute suite on the stroke unit was mixed sexed. On the day of our inspection there were two female and one male patient in this bay. The patients in this bay all shared a toilet facility. We spoke with one patient staying in the bay during our inspection. They said, "I was shocked when I first got here and realised that I had to share with a man. It's not caused me too many problems as I just keep my curtains drawn around. However, it would be a different matter if I need to use the commode in here, I would not be happy with that at all." Mixed sex accommodation could mean that some patients may feel that their dignity has been compromised.

We looked at how staff promoted and protected patients' dignity and privacy. We saw in A&E one observation bay had mixed sex patients as did bays in AMU. This had not been documented on the risk register. Patients we spoke with said, "I find it quite embarrassing hearing conversations going on behind curtains as some of it is very personal, I can hear everything." Another said, "Staff try to cover people up, but obviously in a busy area like this, it can be an issue."

One woman who had recently given birth in the midwifery run unit told us "It's been amazing; the care has been brilliant, so attentive." They told us that they had planned to give birth in the unit and had been well supported throughout their stay in the unit.

Are services caring?

Children requiring ophthalmic surgery at the Royal Bournemouth Hospital can be assured of a good standard of care during stay and their families can be confident that that they will be supported during their child's stay in hospital.

In Critical Care we found that people were protected from the risks of infection and changes to practice were made following learning from incidents. Care was planned and delivered to meet patient's assessed needs by staff that had appropriate skills and training. Patients were treated with dignity and respect and their privacy was maintained.

End of life care services had been a high priority over the last 12 months and good progress had been made on implementing a number of important new initiatives. This included implementation of new personalised care plans for last days of life. Our conversations with patients, their relatives and care staff provided evidence of good quality care and treatment. Patients and their relatives told us they were fully involved in planning decisions and were regularly updated on changes in the patient's condition. All of the staff we spoke with were knowledgeable, passionate and committed to providing high quality care for end of life patients and their families.

Are services responsive to people's needs?
(for example, to feedback)

Summary of findings

Children's care, critical care and end of life care were particularly responsive to people's needs. However, improvements in one part of the hospital were not necessarily shared across all services. Services tended to work in isolation. We found people were able to raise concerns and make complaints. However some people felt that when they made a complaint, the trust was dismissive of their concerns. This meant that they either chose to have care elsewhere or continued to feel dissatisfied. A&E, medical services and outpatients were less responsive to the needs of patients.

Our findings

The trust was often below the national target for waiting times in A&E December 2012 to April 2013 of patients being admitted or discharged or transferred in four hours. Since May 2013 the trust has met or exceeded the target. However patients were moved within the same environment such as to an observation bay, cared for by the same team and are at this point an inpatient.

Some patients in England still wait too long for secondary care. We found prior to our visit that the Royal Bournemouth Hospital was within expectations however there were a number of patients unable to be discharged due to delays.

While the trust has an open approach to making a complaint people told us that they did not feel listened to and several were overwrought with their despair for the way the trust had responded to them and some felt that the trust were dismissive and so they chose to have care elsewhere. The complaints log from 1 April to 30 September had more than 170 entries, there outcomes varied from upheld, part upheld and not upheld or still ongoing. We noted that a patient complained to the trust in September 2013, the patient had been woken at 2 am and moved from a position in a bay to an escalation bed until discharge. They complained of the lack of privacy and lack of call bell. The trust upheld the complaint and recorded that the response to the complainant with regards to escalation beds that "this no longer happens" on Ward 2. This meant that the trust had not learnt from mistakes or sufficiently improved standards of safety for patients as escalation beds still exist elsewhere in the hospital.

Staff explained how they could access interpreters when required for people whose first language was not English. But told us this was sometimes a challenge due to time constraints. Staff told us how they had supported people from different cultures such as East European and Middle Eastern areas.

The majority of end of life care patients were seen on the same day they were referred to the specialist palliative care team or to the facilitator. At weekends and out of hours, advice was available from the specialist palliative care unit at Christchurch Hospital.

Medical and nursing staff spoken to on the wards all said they had good access to the consultant in palliative medicine, the specialist palliative care nurses and the facilitator. The trust had a shared consultant on-call rota with the specialist palliative care unit at Poole Hospital enabling 24 hour cover at all times. This helped ensure a responsive service was available at all times.

We spoke with the safeguarding children's lead who told us that the trust had improved awareness of the service it offered infants, children and adolescents as on investigation it was found that most of the departments in the hospital had dealings with children. They gave the examples of services from emergency care and radiology to dermatology and orthodontics that saw and treated children on a regular basis. A recent audit identified the actions the trust needed to take to ensure children across the trust were care for and treated according to best practice guidelines.

We were told that the design of the local maternity services throughout Bournemouth, Poole and Dorset had been subject to public consultation. The local Clinical Commissioning Group had organised a public event, which was attended by over 30 women who fed back their pregnancy and birth experiences. The Acting Head of Midwifery told us that the women gave powerful messages, both positive and negative and she was working on ensuring that staff heard these messages to inform their practice.

Are services well-led?

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action?)

Summary of findings

Children's care, maternity, critical care and end of life care were generally well-led. Many departments and wards had effective leadership. However the A&E department required improvements and medical care services in particular were inadequate in this regard. Overall the hospital was not well-led. While there was clear communication between the senior management and the trust's Board, this was less apparent for other staff. This was affecting staff morale and individual professional accountability for some staff.

Our findings

The Board has been stable for a number of years, as the Chairperson has been in post since 2010 and the Chief Executive since 2000. There is newly-appointed medical director.

There are no clinicians appointed as non-executive directors. There was regular contact with the other non-executive directors as well as the trust's governors.

The Chairperson and Chief Executive explained the risk management process, reporting of incidents, review of mortality data and how they share this with the Board. They undertake walk rounds of the hospital to gather the views of staff.

The hospital runs at above 90% occupancy and the demand for medical beds is increasing. The trust was developing plans for winter pressure but has not seen any reduction in occupancy in recent months.

The Chairperson and Chief Executive recognised the need to fill vacant posts but this had been subject to some delays. A number of junior nurses and doctors told us they are not always supervised or supported in their roles. Staff shortages had affected the uptake of mandatory training, as staff may be pulled out of planned training to work on wards and units. They also recognised the challenges of moving closer to providing a seven-day medical cover service.

We found that, in particular, the smaller services such as midwifery , children's care, critical care and end of life care were well-led. We found the A&E was well-led at department level, but there was evidence that the ongoing safety issues, such as staff security, had not been resolved at Board level. Staff had been told not to report incidents if the police were called to attend the unit.

Medical care services were inadequate and lacked effective leadership to identify and address issues. Some issues of inadequate care were well-known, for example those on Ward 3 and Ward 26 raised from staff feedback and patient complaints earlier in the year. These had still not been resolved by the time an external review they had commissioned took place in September, or by the time of our inspection in late October.

Surgical wards and theatres appeared well-organised and well-led. There were regular staff meetings to feedback updates and changes on the wards. We saw that governance arrangements were in place that enabled senior staff to look at incidents and trends over each aspect of surgical care to identify areas of risk and develop methods to manage those risks. The Director of Nursing met with senior nurses of the surgical units every month and information was cascaded through clinical lead staff to the surgical wards and departments. Staff told us they mostly felt communication was good and that they were able to access updates if needed.

Some junior medical staff said they were concerned about the availability of junior and middle grade medical staff to assist throughout the night time and weekends. At this time of year, the change in junior doctors has taken place and new and inexperienced doctors are working on the wards. We saw junior doctors working at night in isolation with a controlled access to a senior member of the medical staff. This meant that junior doctors on the surgical wards could go their entire shift without speaking to another doctor. This was not consistent with how medical services were managed elsewhere in the hospital.

Are services well-led?

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action?)

Before the inspection, the Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust informed us that they did not have any inpatient paediatric services. However there was a dedicated three-bedded children's ward for ophthalmic day cases. We spoke with the staff on the ward and they were all able to describe the leadership and reporting responsibilities. They were clear about how to escalate concerns and who was responsible for clinical governance arrangements.

The trust confirmed that the Board level executive with lead responsibilities for safeguarding children was the Director of Nursing and Midwifery and that there were named healthcare professionals with safeguarding children responsibilities and a nominated safeguarding children lead. Systems for safeguarding children were monitored by the trust's Safeguarding Committee, and the trust's Executive Board received an annual safeguarding report that included training for staff in safeguarding and how to deal with children who missed appointments. They told us that safeguarding processes across the trust were audited annually. There were suitable arrangements in place to safeguard children and young people from the risk of abuse.

We found that the hospital had systems in place for monitoring incidents and accidents and that these systems allowed staff to analyse data to look for trends that could help them to improve patients' safety. We were shown examples of where this had changed practice. However, we found examples of incidents that had not been reported by staff through the reporting system.

Accident and emergency

Information about the service

The accident and emergency (A&E) department provides 24 hour service seven days a week. It is known locally as the 'emergency department', with an attendance rate of approximately 70,000 patients a year. The department had two triage rooms, one paediatric room with two full time paediatric registered nurses, 10 minor cubicles (for less serious injuries), 13 major cubicles (for more serious injuries and illnesses) and a resuscitation room with three cubicles. There were also two four-bedded observation bays and a Deep Vein Thrombosis (DVT) bay. The department worked closely with a 52-bed acute medical unit (AMU), which took GP referrals and has patients from A&E for up to 72 hours. The Royal Bournemouth Hospital does not receive any trauma or paediatric emergencies.

We visited the emergency department during the day on both 24 and 25 October and in the evening of 30 October 2013.

We spoke to 20 people over all days of the inspection, as well as doctors, nurses, health care assistants, porters, paramedics and domestic staff. We talked to patients and staff about care, treatment and facilities and we also observed care being provided. We reviewed records during our visit.

Summary of findings

We found that the A&E service was not always safe and effective, because of the use of escalation beds and extra trolleys. Staff and patients were not fully protected from abuse because of the lack of robust security measures. Staff were caring about patients' needs but were not always responsive. Patients with a stroke were not always given the urgent care they needed. The A&E was well-led at department level, but there was evidence that the ongoing safety issues had not been resolved at board level.

Are accident and emergency services safe?

A&E was not always safe for patients and staff.

Security

Patients and staff had not been fully protected from the possibility of verbal or physical abuse. We looked at the records and audits of the department's incidents, complaints and near misses. From 1 January to 13 October 2013, there were 58 reported incidents of verbal and physical outbursts against staff from patients and in some instances other patients had been present.

Staff told us of recent incidents that had made them feel unsafe. One senior nurse told us, "We have had to call the police on more than one occasion to deal with violent and abusive patients." Another staff member said, "I do not feel safe." We tracked the dates given and found that these had not been recorded on the database. When we asked senior staff why, we were told that they didn't record incidents when police were called as they had been dealt with by external people. The external security service staff told us had been cancelled five months previously, and now staff had to call the porters for assistance. The trust told us the change was made in 2011. They told us that sometimes it could take up to 20 minutes for a porter to respond and that on occasions they had to remove a patent themselves, which they found distressing and frightening. They described how on one occasion they had to apply restraint measures that they have not been trained for. This meant that the service provided in the department was not fully protecting the staff and patients and was at times unsafe from patients' unpredictable behaviour.

Use of trolleys

We received information before the inspection that extra trolleys were used in the majors treatment area down the middle of the department. These were not in use during our inspection. This did not give patients any privacy while feeling unwell or allow easy access to emergency equipment. There were no curtains in this area. We did note that in general, staff were mindful of patients' privacy and dignity while treating them. Staff monitored how long patients spent on the trolleys and, where possible, they moved patients on to a bed.

Accident and emergency

Staff showed us the deep vein thrombosis (DVT) room, and told us it had been used frequently for patients overnight. They said that they need extra staff when it is used because it was a distance away from the main department.

Waiting times

The computer booking-in system tracked patients' waiting times. Staff showed us spikes in breaches of waiting times. We were told patients in the observations units were classed as being admitted to the hospital. When we visited the department on 24 October, 15 patients were logged on the majors IT system: nine had been waiting for over four hours. Seven patients were in rooms 12 and 13 and on observation bays that, although staffed by A&E, all were now inpatients. Staff had identified this as an unsafe breach on the trust's risk register.

Emergency equipment

We looked at the emergency equipment in the department. Staff had been trained to use it in line with their clinical job role. Doctors and trained nurses had attended training in advanced life support (ALS) and paediatric advanced life support (PALS). Staff were confident of their role in a medical emergency situation and explained the department's procedures to ensure a quick response to an emergency bell. The resuscitation trolleys were sealed ready for use. These were checked daily by staff and restocked immediately after use.

Portable suction machines were located around the AMU; these were not all ready for use. One had missing tubing and no suction catheter and another had been used but the tubing and catheter not replaced. We questioned a registered nurse who was responsible for checking that the emergency equipment was fit for purpose. We were told, "We check every morning if we have time." We were then told that it had not been possible that day. When we visited the AMU again on 30 October, we found that, for one of the resuscitation trolleys, the oxygen and portable suction machines were not fit for use as they lacked tubing, catheter and mask. This meant that patients were at risk from unsafe treatment.

Escalation beds

There were 55 patients in AMU overnight on 24 and 25 October. This meant that they had used three 'escalation' beds. These beds were in addition to the 52 bed places available and were placed in the middle of three separate bays. They did not have easy access to a call bell, oxygen or suction.

During our visit, there had been a medical emergency and staff were not able to get the resuscitation trolley to the patient in a bed space because of the position of the escalation bed. Staff had to push the patient on the escalation bed out into the corridor before they could attend to the emergency situation. They told us that they tried to ensure that patients in these beds were not clinically at high risk, but acknowledged that this was not always easy to manage. We spoke with patients in these beds; one patient told us, "It has not been the best experience, but the staff are fantastic." Another told us, "I am just grateful to be cared for."

Staff told us that this has been a great concern to them and that escalation beds had been used for five years. One staff member told us that "it is dangerous". A patient complained to the trust in September 2013, as they had been woken at 2am and moved from a position in a bay to an escalation bed until discharge. They complained of a number of matters including the lack of privacy and lack of call bell. The trust upheld the complaint and recorded that the response to the complainant with regards to escalation beds that "this no longer happens". This meant that the trust had not learnt from mistakes or sufficiently improved standards of safety for patients.

Staffing

On the evening of 30 October, we spoke with the emergency department consultant on duty about medical staffing levels. They had five full time consultants in post with one vacancy still to be filled. There was funding for 12 middle grade doctors but there were only seven in post. There were no registrars working in the department. Twelve junior doctors were on the rota, but six posts were vacant. This meant that they were working with fewer doctors than required. We were told that this had not affected the care given to patients. On the AMU there was a medical consultant on the ward to assess patients from 7pm to 10pm, which we were told improved care for patients. There was a consultant on call overnight to support staff.

Accident and emergency

Despite being busy and moving patients through the department, all staff were calm and focused on patients' individual safety. They shared their work experiences with us and the problems they faced in a busy unit, and were very passionate about their jobs and of how the department had progressed and the plans they had to improve.

Are accident and emergency services effective?

We found that services were not always effective.

Waiting times

Patients arriving in A&E on foot were assessed promptly by the triage nurse. The triage nurse could request an X-ray, which helped to meet patients' needs in a timely manner. We spoke with six patients in the waiting room for minors and we were able to track them through to their treatment. Four of these patients were very happy with their care. Their feedback included, "We were seen quickly and are very satisfied by the service." Another said, "We were seen quickly today but previously we have had to wait for three hours or more with no information of why we had to wait." On 30 October, we noted that despite empty cubicles in the minor's area, patients were kept waiting in the waiting room for up to three hours and were bought in once a nurse was available for them. There was not a clear explanation given to patients waiting, and this caused some to become agitated.

Caring for children

Children were seen with minor injuries and were triaged and attended to by paediatric nurse practitioners. If it was a serious medical problem, a doctor was immediately consulted and ambulances were arranged to transfer the children to Poole Hospital. There were two full time paediatric nurse practitioners who provided specialist cover for six days a week. The seventh day was covered by the staff in minors. The paediatric nurse told us that holiday cover was not provided for them, so when one of them is on leave, four days of the week would not have an appropriate paediatric nurse on duty. This placed children at risk of not having their needs met.

Multi-disciplinary working

We saw good examples of multi-disciplinary working within A&E and AMU. There were specific care and treatment pathways, which ensured that patients received the correct treatment and care. We talked to allied health professionals, including a speech and language therapist who told us of being involved at the beginning of, for example, the stroke pathway. We saw where social services accepted the senior nurse's referral to accept a safeguarding alert and initiate an investigation.

Senior staff acknowledged that the mental health pathway was not effective as it was not a 24-hour service. A patient who had received a psychiatric referral had been admitted at 7pm on 24 October 2013. They were still waiting to be seen by the psychiatric team at midday the following day. This patient had not received their normal medication at this point and we saw that they were anxious.

Treatment pathways

Patients' initial emergency treatment was prompt and efficient. However, we noted that secondary treatments were not attended to for some time. One patient had collapsed, and although staff had taken appropriate blood samples and X-rays, and had a full examination from a doctor, skin tears on their hands and other abrasions had not been cleaned or covered for six hours. We saw a graze and congealed blood on their cheek.

We also saw that a patient admitted on the GP admission route straight to AMU had been put on a bed to take initial blood samples but then asked to sit back out in the waiting room to wait for a further two hours without analgesia. This patient told us this had been a distressing time for them as they were "in agony" and "uncomfortable". We were told that this was due to a shortage of admission beds.

Patients with a stroke were held up in either A&E or the AMU, before being admitted to the stroke unit. Therefore they did not get the required tests, specialist care or treatment for their condition in a timely manner.

Accident and emergency

Patient records

We looked at patient records and treatment pathway plans on AMU, majors and observation units. The initial emergency admission proforma was clear and well documented by both doctors and nurses. Once admitted to AMU, a 14-day treatment plan was instigated. This included risk assessments for nutrition, skin integrity, venflon sites and falls. However, not all sections had been completed on the plans we looked at. This meant that patients may not have all their needs met.

There was a nil by mouth (NBM) policy in place; this care directive was written on a white board behind each patient's bed. This was also documented on the handover sheet. We identified that there were two people who were NBM.

We saw that fluid and intravenous fluid records were recorded and all but one was up to date. Nutritional intake had not been recorded and staff we spoke with were not sure if people had eaten. One patient who was frail told us that they could not remember whether or not they had eaten lunch. Two-hourly check lists were completed on all patients in a tick box format. These lacked a person-centred approach and did not reflect whether the delivery of treatment and care had been effective for individual patients. For example, pain relief was given but there was no record as to whether it had relieved pain effectively. Another patient who was admitted after developing seizures had been started on medication but there was no indication whether the medication was controlling the seizures.

Are accident and emergency services caring?

Staff approached patients in a calm and kind manner and took the time to talk to them and explain what they were doing and why.

Consent

One patient and their family told us that staff and treatment had been excellent and everything had been explained to them before it happened. We saw that staff asked patients for their consent before taking blood or moving them within the department. This meant that staff involved and consulted with the patient before undertaking tests and treatment.

Attitude of staff

Families who were accompanying their relative in the majors treatment area told us that they had been treated with kindness and had been kept informed of any development or changes. We spoke to five patients who had been admitted to the majors unit on 30 October 2013. They told us, "Excellent care", "seen very quickly" and "could not ask for better care", "totally respectful" and "very efficient and caring staff, I am waiting for results and then hopefully I can go home." One patient told us, "I feel a little exposed but I understand that I need to be seen."

The complaints register identified that the attitude of staff had been a source of concern in the department. These incidents had been investigated and appropriate action taken as necessary. The reception staff had also received training in customer care.

We saw that staff treated people who were confused or disorientated in a respectful and kind way. Staff engaged positively with one such patient on an observation ward, and returned them to a safe place.

Assessing mental capacity

We saw documentation that had some reference to patients' capacity on admission, but this was not always monitored through their stay.

On our visit to AMU on the night of 30 October, the nurse in charge told us that they had applied Deprivation of Liberty Safeguards for two patients in the last 24 hours. This meant they had closed the doors to prevent the patients at risk from leaving the safe environment of the ward. We looked at the completed paperwork with the nurse in charge, who talked us through the actions taken. There was clear evidence that the doctors had followed the right processes and completed the forms that were required. However, the nursing documentation lacked the detail of events that were found in the doctors' notes.

Training sessions on the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) had been provided for staff. These were both included in the induction programme for new staff. There were also laminated flow charts and files available in ward areas to help staff refresh their understanding and for reference. There were two link nurses for mental health for the department.

Accident and emergency

Dignity and privacy

We looked at how staff promoted and protected patients' dignity and privacy. We saw that there were mixed sex patients in one observation bay in A&E and in bays in AMU. This had not been documented on the risk register. Patients we spoke with said, "I find it quite embarrassing hearing conversations going on behind curtains as some of it is very personal, I can hear everything." Another said, "Staff try to cover people up, but obviously in a busy area like this, it can be an issue."

Are accident and emergency services responsive to people's needs?

While at team level the staff are responsive to people's needs, overall responsiveness is limited to the actions that the Board agree to.

Safety issues

Staff told us that they submitted risk alerts when the department and AMU were full to capacity and the DVT room and escalation beds had to be used. This had not yet been resolved in a satisfactory way.

The incident records showed that senior staff had put an action plan and safety risk assessment in place for the patient reception area in April 2013. This documented actions taken, including fitting a permanent safety glass screen to the reception area and relocation of a panic button. The staff saw this improvement. However this had not fully resolved the issue of the safety of staff and patients from aggression and abuse from patients.

Complaints

There was a process to monitor and review complaints and suggestions for improving the service. Complaints were audited, any trends were identified and action taken where necessary. For example, one complaint had led to action to improve the waiting time for discharge medication. The Pharmacy had introduced a two-hour turnaround for dispensing medication. We spoke with nurses who facilitated safe discharge home for those who required extra support. They told of working closely with the occupational therapist and physiotherapist to ensure that patients were safe and ready for discharge. For example, ensuring that those discharged with a walking aid were able to use them safely, and those who had steps and stairs were able to manage them. They also told us about ensuring that carers, family or professionals were fully involved in the planned discharge home.

Major incidents

The department was prepared to handle unforeseen major incidents. It had a Major Incident Response Plan, which had been reviewed and updated regularly. It rehearsed its response with an annual table top exercise and regular live major incident exercises.

Radiology

There were issues around radiology in relation to delayed diagnosis of patients admitted with a suspected stroke. Patients needed a computerised tomography (CT) scan within one hour of admission to the hospital. We were told that this did not always happen, because the radiology department did not have an agreement to accept CT request forms from non-medical staff. In other hospitals, nurses triage patients on admission to the emergency department, follow a checklist to see whether their patient may have had a stroke, and then complete a request form for a CT scan. Waiting for a doctor to make this initial diagnosis sometimes delayed patients receiving their scan. We were also told that only specifically trained radiographers were able to perform CT scans and that they were on call out-of–hours, although were not on site 24 hours a day. Any delay could significantly affect people's chances of recovery.

Are accident and emergency services well-led?

We found the A&E had clear leadership at department level, but there was evidence that the ongoing safety issues, for example staff security, had not been resolved at Board level. Staff had been told not to report incidents if the police were called to attend the unit. Overall this meant that A&E was not well-led.

Accident and emergency

Team working

Staff said they had very good leadership, which motivated the team. They told us there was an open culture where they could raise concerns and these would be acted on. Clinical and nursing staff were very dedicated and compassionate. Staff said they were proud to work at the hospital and be involved in improvements. We observed a strong team spirit and staff told us they worked well as a team. They felt empowered by the recent (past 18 months) changes to the senior management structure and felt that the department had improved.

Trust Board

We looked at clinical governance arrangements to assess whether there was staff engagement at board level and to determine whether assurance processes were in place to monitor patient safety. There were appropriate clinical governance arrangements to report and manage risk, and clear processes for escalating risks to the trust Board. However, this had not ensured that issues of safety were resolved.

Training

The department had led effectively to support staff with adequate training. Staff said they had received mandatory training, and there were opportunities for continuing professional development for nurses to enhance their skills such as developing advanced emergency care nurse practitioner roles.

There was evidence of regular teaching sessions for junior doctors. This included a protected two-hour weekly teaching session. Every doctor was supported by a clinical supervisor. Doctors confirmed to us they felt well supported and were able to approach their seniors if they had any concerns.

Performance monitoring

There were audits of performance, such as the time taken to receive results of scans and X-rays, which had improved significantly and provided an effective service to patients.

Medical care (including older people's care)

Information about the service

The acute medical care services at the Royal Bournemouth Hospital are provided over a number of wards and departments. They provide care and treatment for gastroenterology, thoracic care, coronary care, stroke care, and medicine for the elderly.

We visited wards and units during our inspection. We spoke with 32 patients, six relatives, and 51 members of staff over the two-day inspection. We also used information from comment cards completed in the waiting area of the hospital. We spoke with people who came along to an evening listening event, which we had arranged to provide people with a forum to raise any comments. Some people also came to the hospital over the two days who had heard we were there and wished to share their stories with us.

Summary of findings

We found that patients' care varied between the medical wards and units. The patient experience was worse on Ward 3 and Ward 26 than the rest, although there were concerns throughout due to staffing levels. Some patients told us that they felt their care had not been delivered in a safe and dignified way.

Some had concerns about the numbers of nurses on the wards and felt that their care had been compromised by a lack of staff. We heard about a patient who had had fluids and food restricted in error. We also heard reports from five patients who told us that they had been left to wet or soil their beds because staff were unable to attend to them in a timely manner. We spoke with some staff who felt that care was not always safe; they said that they felt unsupported and under too much pressure due to staffing levels and skill mix within the areas where they worked.

We found that the hospital had systems in place to monitor incidents and accidents, which allowed staff to analyse data to look for trends that could help them to improve patients' safety. We were shown examples of where this had changed practice. However, we found examples of incidents that staff had not reported through the reporting system. Staff told us they were fearful of the high bed occupancy and the pressure this placed on them.

Are medical care services safe?

We found that patients were often not safe.

Feedback from patients

During our inspection we discussed the safety of care with patients, their relatives and the ward staff. Some people wanted to discuss unsafe care with us. One person on Ward 3 told us that they had come to visit their relative on the ward and had been surprised to find that they had a sign above their bed saying 'Nil-By-Mouth', which told staff not to offer this patient food or fluids orally. The relative had questioned this with a nurse, who told them that their relative was due to undergo an investigation, which meant that they couldn't eat or drink. They then asked the nurse to find out what this investigation was. When the nurse returned they said that the patient was not in fact meant to be 'Nil-By-Mouth' but that the sign had been left on the bed from a previous patient. This meant that the patient had missed breakfast and lunch, and had not received fluids since their admission to the ward. The concerned relative went on to say that although this mistake was discovered at 2pm, when they returned to the ward at 7pm their relative had still not been given water to drink.

Another relative on the ward said that a nurse had asked them to assist with lifting their relative up the bed. They told us that they had refused to do this. If this person had agreed to help to lift their relative they could have put themselves, the nurse and their relative at risk of injury.

Staffing levels

Three members of staff on Ward 3 told us that they were concerned that the staffing levels were unsafe there. One trained nurse said, "There are times when I feel unsafe, care was compromised, and I was putting my PIN (Nursing and Midwifery Council registration) number at risk." Staff described staffing levels as, "horrendous", and said, "What stops us from doing a good job is when staffing levels are poor." When we discussed the recent changes that had been made to the management of the ward, and whether these made the staff member feel more optimistic about the ward's future, they said, "I am reserving judgement, because I have lost faith."

A member of staff told us about actions which had compromised patient safety and were being investigated by the trust. They told us that they had made a mistake because they felt under pressure and didn't have anyone

Medical care (including older people's care)

they felt they could ask for advice. They said, "I was on my own, I couldn't concentrate with all the noise in the ward and all of the bells going off, I was stressed out." Another newly-qualified member of nursing staff told us, "I have only been qualified for three weeks, I was straight on the ward and counted in the numbers, I didn't have any shadowing shifts." They went on to say, "The biggest problem on this ward is staffing. Today and yesterday I had 14 patients, this is just too many. At the weekend I had a particularly sick patient which meant that I neglected the care of all of my patients in another bay." We asked what the nurse meant by 'neglected' and were told, "I don't get to spend time in there learning about their worries and their concerns. I get upset about it; I like to have a relationship with my patients."

Patient records

We saw that patient records contained risk assessments for areas such as falls, malnutrition, and skin integrity; these records had mostly been completed. Patients were started on a 14-day care plan when they entered the ward and staff completed a series of tick boxes daily to indicate the care and checks that had been completed. Staff produced separate care plans that documented where people had specific care needs, such as wounds. In most cases, we found that staff had completed these care records as required. However, we did bring to the attention of ward sisters two cases where this had not happened. In one example on Ward 3 , there was no record that staff had completed a daily dressing. The ward sister was unable to tell us whether this dressing had been changed. On Ward 26, a patient told us that their wound had been assessed by the tissue viability specialist nurse, who had prescribed a particular dressing. However, they said that on the day the wound should have been dressed, it hadn't been. They had repeatedly reminded staff that their dressing needed changing throughout the day. When their wound was dressed two days later, the wrong dressing had been applied. If wound dressings are not renewed to the required frequency with the correct dressing, this could result in the wound not healing, deteriorating, or the wound becoming infected.

Medicines management

We found that policies were in place to administer medicines safely and that staff were aware of the policies. On the stroke ward, we were told that pharmacists visited the wards daily and checked that medicines were being stored and administered safely. We observed part of the stroke ward medication round. The nurse was careful when checking the identity of the patient, and we also saw that the nurse waited to ensure that the patient had taken their medication before they signed the medication record.

Equipment

In most ward areas, storage space for essential equipment was limited. Equipment was stored in ward corridors. On Ward 3 a member of staff told us that they often found the hoist was not charged and ready for use when it was needed because there were not enough electric sockets near to where equipment was being stored. If hoists were not charged, it could mean that patients would not be moved safely and in a timely manner when they needed assistance.

Safety monitoring

We saw the systems for collecting monthly data in the wards and units, which is measured using a standard NHS Safety Thermometer data collecting tool. This required staff to collect information on hospital acquired pressure ulcers, in-patient falls, hospital acquired venous thromboembolism, and urinary catheter associated infections. Most wards used a system of safety crosses to do this. Wards displayed this information, which enabled staff and visitors to see how the ward was performing against these safety criteria.

Are medical care services effective?

We found that services were mostly not effective.

Patients with dementia

All patients over the age of 75 were assessed for dementia, which happened within 72 hours of admission. If patients were diagnosed they were entered onto the dementia care pathway and their care was planned appropriately. The dementia nurse specialist for the trust told us that they meet patients following individual referral from the wards. They advised wards how to manage patients with dementia, and provided therapy, assessments and activities for patients. They also referred patients, where indicated, to community mental health teams. They told us that staff in the trust needed to express an interest in order to attend dementia awareness training, and that this meant that this training was not attended by all staff.

Medical care (including older people's care)

Assessment

Some patients and relatives felt that they had not received good treatment, as patients were being placed in wards that did not specialise in their conditions, and therefore staff were not trained to meet their specific needs. For example, the relative of a patient on Ward 3 told us that because staff suspected that their relative had a problem swallowing, they had not been able to feed them food or fluids orally. They were told that on the ward where their relative was being cared for none of the staff were able to perform the necessary tests to check their relative's swallow. As a result of this, their relative had spent four days on intravenous fluids awaiting a swallowing assessment. This could mean that patients were being unnecessarily prohibited from eating and drinking due to a lack of adequately trained staff on the wards where they were being cared for.

Stroke care

Once patients were admitted to the stroke unit they were offered a very good programme of treatment and rehabilitation. The unit was able to boast good audit score results for its assessments of swallowing, occupational therapy, and physiotherapy. The unit also supported patients with an early supported discharge, where appropriate. This meant that people were able to go home and be supported with their rehabilitation within the community setting.

The ward sister told us that they had attempted to trial an outreach team approach to ensure that stroke patients on other wards were seen by nurses and members of the multidisciplinary team (MDT) with specific stroke training. However, the trial had not been a success as the ward had not been able to release the nurse to the wards due to staffing pressures on the stroke unit.

All wards had MDT meetings at least once a week where patients' progress and treatment was discussed with the whole team responsible for their care. On the stroke unit we were shown an initiative called 'lunch club'. This was held on weekday lunchtimes to enable patients to be assessed and assisted with eating their midday meals. The ward sister told us that this was attended by nursing staff from the unit along with speech and language therapists and occupational therapists. This was an opportunity for collaborative working to assist patients with eating and drinking. The ward sister told us that they felt that care would be improved by occupational therapists and physiotherapists working fully over seven days. Currently a reduced service at the weekends is provided.

Are medical care services caring?

We found that medical services were not always caring.

Dignity

Four patients on Ward 3 all told us that they had been incontinent of both urine and faeces because staff had not answered their bells when they rung them for help to use the toilet. Three of these patients said that this had happened on multiple occasions. One patient said, "I feel humiliated, I have never wet myself before. I just can't wait, sometimes my bell rings for half an hour before they come. I have even done worse than that. Can you imagine what it feels like to have to have your bottom washed because you have messed yourself?" Another patient said, "The bell rings and rings and when they do come they say they are busy and will come back. But they don't. So I ring again and when they come they are annoyed – I can tell from their faces, but what can I do?" Another patient who had been incontinent of faeces when their bell wasn't answered promptly told us, "There's no dignity, none at all in that."

One relative talked to us about the poor care that their relative, who had a diagnosis of dementia, had received on one of the medical wards. They described their relative waiting so long for staff to answer their bell when they needed the toilet that they had, "Pulled their drip out so that they could get to the toilet themselves." The relative also described an occasion where the patient in the bed next to their relative was, "left on the bed completely naked with a soiled sheet underneath them"; they said that this meant that the man was afforded, "No dignity".

Nutrition

The same relative also described how their relative had often been left without a jug of water, and that despite them being able to eat independently, food and drinks had been left out of their reach and left to go cold. As a result, their relative had lost a significant amount of weight on the ward. When they asked about the weight loss they were told that staff had weighed their relative that morning, and they had weighed 90 kilograms. As they felt that this did not seem correct, they asked staff to weigh them again. On that occasion they weighed 69 kilograms. They said that the ward had given their relative a Malnutrition universal screening tool (MUST) score of zero after the first weight was recorded, which needed to be changed to a three after the second weight was

Medical care (including older people's care)

recorded. This score of three showed that their relative was at risk of malnutrition.

Patient feedback

Much of the feedback from patients related to how caring staff had been to them. Many patients were keen to share their positive experiences of some of the medical wards and units, and most of the patients that we spoke with had found that staff had been friendly, polite, and caring. One patient on Ward 9 told us that, "staff are very very friendly and nice, one lady is shouting out all the time and they are so patient and kind to her". A patient on the stroke ward said, "I admire these girls, you should hear the language that people use at them" "They (the staff) are so patient." Another patient said that, "Staff are so diligent and helpful, they give me confidence."

Choice and involvement

On some of the wards patients told us that they had been given choices around their care and that staff had spent time explaining their treatment to them. We saw that the stroke ward had a number of patient information leaflets displayed in the dining area, which explained facts about strokes and services available to them. On the stroke ward one patient said, "They always explained everything to me, and tell me how it will help with my rehabilitation". Another patient wanted to show us how they ordered their food on the touch screen. They said, "There's plenty of choice, I have nothing to complain about."

Mixed-sex areas

The Hyper Acute suite on the stroke ward was mixed-sex. On the day of our inspection there were two female patients and one male patient in this bay. All patients in this bay shared a toilet facility. The ward sister told us that people in this bay had never complained about sharing it with the opposite sex. We spoke with one patient staying in the bay during our inspection. They said, "I was shocked when I first got here and realised that I had to share with a man. It's not caused me too many problems as I just keep my curtains drawn around. However, it would be a different matter if I need to use the commode in here, I would not be happy with that at all." We asked the patient whether they had been asked whether they minded sharing the bay with a member of the opposite sex. They said, "No it wasn't mentioned. You just have to get on with it though don't you?" Mixed sex accommodation could mean that some patients may feel that their dignity has been compromised.

We saw examples of good discharge planning during our inspection. For example, the stroke ward also had a supported living flat. This had a small kitchen and bathroom and enabled staff to replicate the patient's environment when they returned home. If the patient was going to have a package of care when they returned home, the staff on the ward would replicate this package. This meant that before a patient returned home, staff were able to test with them the care that they would receive and it effectiveness, in a safe environment.

Are medical care services responsive to people's needs?

We found that medical services were not always responsive to people's needs.

Radiology

We were told that only specifically trained radiographers were able to perform CT scans and that they were on call although were not on site the department 24 hours a day. Any delay could significantly affect people's chances of recovery.

This department had its own patient consent forms for cardiology procedures, which are pre-populated with information on the procedure to be undertaken, stating the risk and the benefits. However, for interventional radiology for complex invasive investigations, whilst the trust has told us there are standardised consent forms for urology and vascular investigations, we were told by doctors that there were no standardised consent forms for complicated respiratory procedures. We were told junior doctors, who may not have received the required guidance about the procedures, regularly consent the patients, which puts them at risk of not giving informed consent.

Delayed discharge

Staff talked to us about patients' frustration at being in hospital when they no longer required treatment because staff were unable to organise discharges quickly. Staff told us that the main reasons for this were because patients with complex care packages could not be catered for within the community; and also the process of completing continuing health care assessments (funding assessments for people with health-related needs) was lengthy. They said delays in discharges meant that patients stayed in hospital for longer than they needed to. Our findings

supported this, with three patients on Ward 26 assessed as medically fit for discharge, one of whom had been in hospital for 120 days after being declared medically fit for discharge. This could affect the availability of beds for patients waiting to be admitted to the hospital.

Are medical care services responsive to people's needs?

We found that medical services were not well-led.

Learning from incidents

Staff reported incidents and accidents on forms, which were passed to the ward sister to investigate. Senior staff attended a monthly Risk and Governance (RAG) meeting where incidents were discussed. If trends were found, staff discussed ways to mitigate the risks. Messages from these meetings were fed back to staff at their ward meetings. We were shown examples of where practice had changed as a result of this feedback. For example, staffing rotas had been altered on a ward to ensure an extra member of staff was available at the time of day when most patient falls were occurring.

In response to staff asking for more feedback when they reported incidents, a ward sister had created a display in the ward office, which showed the action plans for each incident reported. This gave staff feedback on improvements to the service, and helped them to understand the importance of reporting incidents. This was not apparent in other areas of the hospital, which could mean that staff were not sharing areas of successful practice with other departments within the hospital.

Feedback from staff

We had varied responses from staff about whether services were well-led. They told us about their frustrations with staffing levels on the medical wards. On Ward 3 we were told, "The managers here don't care about their staff, and they don't care about their patients." On another ward, staff said that they had good leadership from their manager. However, the manager told us that they hadn't felt supported in their role and had had to, "learn on the job". One ward sister told us that they "would never leave the ward unsafe" but went on to describe how this often meant that they stayed late, never got their overtime recognised, and had no opportunities to take time back.

Staffing issues were raised by many patients and staff during our inspection. We were told that staff were constantly being moved around to cover shortages in other areas of the hospital, and that one manager held a bleep and they would sort out any staffing shortages and issues across the medical units and wards. One manager described staffing their ward as being, "on a wing and a prayer". They said that they were often holding out to the last minute to see whether their staffing gaps had been filled. Some staff told us that they were sometimes forced to work with a shortage of staff because staff could not be found for shifts.

Surgery

Information about the service

Surgical services at the Royal Bournemouth Hospital are provided as inpatient surgical wards, including a surgical assessment ward. There are day surgery/short stay units and a Treatment Investigation Unit. There is a main theatre suite and a specific theatre for ophthalmic surgery.

The hospital provides a range of surgery. These include orthopaedics, upper gastroenterology, bariatric surgery, colorectal, urology, vascular, endocrine, dermatology and breast surgery.

We visited the surgical inpatient wards, day surgery and theatres during the day on 24 and 25 October 2013. We also looked at some areas unannounced on 30 October. We spoke with 23 patients and five relatives in these areas during the inspection. We also spoke with 52 members of hospital staff. We observed care and safety practices being provided and looked at 10 sets of records relating to people's health and care needs. We also used information from focus groups, a listening event and comment cards to inform our inspection.

Summary of findings

We found the safety of patients could be improved. We saw that staff were very busy and although patient care was safe, staff told us that they often worked with fewer staff than was needed. Staff told us they found this stressful and that sometimes patients had to wait for their care.

We saw that staff worked effectively and collaboratively to provide a multidisciplinary service for patients in their care. When patients needed care from several specialities of the hospital, this was done effectively to ensure the patients were well cared for.

We found staff were caring and the service responded to patients' needs. Patients were complimentary about the care they received and the professionalism and courtesy of staff. They told us that the service met their needs and that they felt well cared for by the nursing and medical staff.

At ward and theatre level the provision of care was well-led. However, levels of nursing staff set by the trust were not consistently met. We saw that junior surgical medical staff were not well supported overnight and the medical staff handovers of information at the change of shift were not sufficient to ensure safe practice. We had concerns that staffing levels for nursing and medical staff had been identified as insufficient, but action had not been taken. This is an area for improvement for the trust.

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Are surgery services safe?

We found the safety of patients could be improved.

We visited seven wards to observe care being provided and look at records for patients. Patients told us that they felt safe and their comments included "I feel in safe hands" and "Everything seems ok so far, the staff know what they are doing."

Records

We saw that on admission, patients' needs had been assessed and care was planned to meet those needs. Patients' files contained nursing and clinical assessments, risk assessments, care plans and mental capacity assessments, where appropriate. These records were kept by the patient's bedside. A further file contained the medical details of a patient's care, any investigations and results and the daily plan of treatment, which included records of that care and treatment. The records were clear and well-maintained and included clear evidence of discussions regarding care and involvement of patients and relatives, when appropriate. Patients told us that they could read their notes kept at the end of their bed if they wanted to. Staff told us that the systems for recording worked for them and that they felt they had sufficient information to meet patients' needs.

We saw completed records of risks of skin damage, falls and infection, and areas of concern had a risk assessment and a plan of care in place. These risks were regularly monitored and updated and an overall audit was undertaken to monitor the level of each patient's needs. We saw that all audited information relating to infection control was fed back to the surgical units through monthly risk meetings to ensure that the service was aware of current information.

Infection control

All areas of surgical care were seen to be clean and mostly free from clutter. Patients told us that the cleaning staff were always visible and that "the wards were always very clean", that staff were "very fussy" and that "the nurses are forever washing their hands". We saw that infection control measures were followed and staff washed their hands and used protective equipment such as masks and aprons when needed. The theatre department had a specific corridor for removing contaminated equipment. However, this waste then had to leave theatre by the main exit door. Theatre staff said this does not pose a problem or infection control risk to patients as it is removed after surgery has finished.

Safety monitoring

The Director of Nursing had implemented monitoring called the 'Safety Thermometer' to promote patient safety. Staff were able to explain how this system worked and show us the data produced. Some staff were unclear about how this data changed the practices on the wards. We saw data on incidences of pressure ulcer and patient falls. This showed that wards were monitored for safety. Staff had completed Accident and Incidents (AIRs) forms, which were reviewed by the hospital's patient safety and governance department. Some ward staff told us that they received feedback from the audit of these forms. However, some said they did not know the outcome and they were not aware of any changes made as a result of this reporting system.

Staff told us that they felt the reporting of any accident, incident or concern was encouraged. The anaesthetic department had also implemented further gathering of events and incidents outside of the scope for notifying to promote and develop its safety practice.

Clinical guidelines

To keep patients safe, the department applied the surgical venous thromboembolism pathway, designed to reduce the incidence of thromboembolisms such as deep vein thrombosis (DVT).

Practices and procedures within theatres and recovery were safe. Appropriate checks were in place to ensure the safety of patients undergoing surgery. However, we noted that as part of auditing these checks, there was no clear record of the name of the person who made each check. This meant that there would be no accountability for an error in the checking process in theatre. We saw that the record of a completed World Health Organisation (WHO) checklist was not stored with the patient's clinical records, but stored separately in electronic format. We also saw that although the WHO checklist was audited, any results were not fed back to theatre staff to address any gaps or identified issues. This lack of addressing identified shortfalls did not ensure that systems in place were used to ensure practice was safe.

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The National Patient Safety Agency WHO Surgical Safety Checklist also states that the checklist should be completed for every patient undergoing a surgical procedure including local anaesthesia. Although we did not observe any procedure under local anaesthesia, a senior member of theatre staff told us that not all stages of the checklist were completed because it caused anxiety for the patient. This places patients at risk.

Staffing

Staff told us that they often worked with fewer staff than planned. They told us that patients are being admitted in higher volumes with greater needs, but that this does not appear to be monitored and staffing levels addressed to meet the increased need. We saw staffing diary records which showed that in a period between 7 and 24 October 2013, one ward had multiple shifts that had not been covered by existing staff, bank staff or agency. We saw that one trained nurse had been on long term sick leave. The staff on the ward had requested cover for this absence a week previously, but this had not been covered. This meant that staff were deployed from other wards to meet patients' needs. We saw that most surgical wards and departments, including theatres, were reliant on bank and agency staff to maintain a sufficient number of staff.

On the first day of our inspection, one ward was short of one trained nurse and one health care assistant for the morning, and was one health care assistant short for the afternoon. These shifts were not covered and staff explained that they worked harder to absorb the shortfall. On the unannounced part of our inspection, we saw a further ward was short of one trained nurse and one health care assistant on the late shift. One staff member told us "Sometimes documentation is not up to date due to time pressure."

Staff told us that they were pulled back off training to work on the wards because of staffing pressures. They said that because staff were deployed from other wards, they sometimes lacked the specific skills needed on that ward. They also explained that when using agency staff they were not able to use the Vitalpac recording system in use. This is an electronic system of recording patient information. This meant that there were in some cases three systems of recording being used – electronic, tape recording and paper records. Staff felt this was unsafe and risked information being missed for patients.

Training

Training was on-going and staff felt there was sufficient training for both mandatory areas and some specialist training to support their practice. We saw a forward planning prospectus for training on a wall on one ward. However, training in Human Factors had not been undertaken in either theatres or on the wards. Human Factors is the concept of understanding how workplace factors and human characteristics affect behaviour in relation in safety. These could include if staff were anxious or unhappy about anything. We observed a briefing and saw that staff raised any issues they had about the surgery to be performed.

On some wards, patients' needs were different to the speciality of the ward. The hospital refers to these patients as "outliers". Therefore, medical patients were being cared for on surgical wards because of a shortage of beds on a medical ward. We looked at how those patients were seen by the appropriate medical staff to meet their needs. Some wards had clear procedures for reviewing medical patients. However, the practice of having a team of medical doctors to specifically visit those patients was not well understood by all nursing staff. Some staff were unsure who was looking after their medical patients and said they often had to go through the notes to find out who was looking after them. They commented that they were not confident that the patients were seen daily and that it could be a different doctor each time. They did think that the patients were seen by consultants regularly. There was an inconsistent approach to this practice across all wards, as some nursing staff were not aware of the medical outliers medical team. This meant that staff may not approach the right medical team to care for these patients and care may be missed or inconsistent.

Some junior doctors felt they were understaffed, causing delays to the time it took to attend to patients. They told us that the amount of work meant that they often did not see patients for several hours. Overnight, one newly-qualified junior doctor is responsible for the surgical admissions unit and five surgical wards.

Handovers

We saw that there was a limited handover of information between medical staff at the beginning of their shifts. This handover was not formalised and was not attended by a senior doctor. We were told there was inconsistency about

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handover arrangements for surgical services at 11pm when the twilight shift junior doctor finished, but again there was no consistent formal handover arrangement. There is no electronic patient list to advise the junior doctors which patients need to be seen. This may place patients at risk if information is not communicated to the next medical shift. We concluded that there was a risk on some wards that the staff were not always able to attend to patients' needs in a timely manner and communication for medical staff was not consistent, which created a risk for patients. This is an area for improvement for the trust.

Are surgery services effective?

We found services to be effective.

Patient feedback

Patients felt that their treatment had been effective. They told us that they were happy with their care and treatment they and they spoke highly of the professionalism and dedication of the staff to providing care that met their needs.

Patients told us "I have had several ops at this hospital – no problems" and "Excellent care. No delays in the whole process, responsive and all of the staff were very polite."

Patients told us that they had been admitted and undergone surgery without too many delays. Patients and families both told us that they had felt involved at each step of their hospital admission and knew what was happening with their care. Patients said they had been reassured before going to theatre and had received pain relief immediately when needed, and that when they had asked for more information or help, staff had provided it.

Improvement initiatives

We saw that as a result of patient feedback, initiatives had been put in place to improve effectiveness of services for patients. For example, areas had been set aside for patients to have quiet conversation to protect their privacy and dignity. A system of 'Butterfly signs' had been implemented to enable staff to know when not to disturb patients who may have received bad news or needed privacy. Signs had been implemented for the night staff to know when a patient was having difficulty sleeping and so extra quiet measures were needed.

Complex health needs

Effective processes were in place to meet the needs of patients who were vulnerable. We saw that one patient with multiple complex needs was being overseen by one consultant who coordinated all aspects of their care between other consultants. While in hospital, the patient had their own carer from home and communication between all parties had been effective to enable the patient to feel safe. As a result of this effective working, the staff on the ward had developed a greater insight and means to communicate with the patient and staff felt that a more trusting relationship had developed.

Day surgery

The day surgery units demonstrated that they had effective systems in place to meet patients' needs without admission overnight. Recovery areas were well-equipped and the nurse-led units were well supported by medical staff if they needed further assistance. Systems were in place to manage overnight admission if staff were concerned that the patient was not well enough to go home.

Are surgery services caring?

We found surgical services to be caring.

We observed a positive relationship between staff and patients. We spoke with relatives and carers and they all confirmed that they had felt included in any discussions that were appropriate and felt staff had been professional and courteous.

At our unannounced inspection we heard staff on the ward talking to patients in a way that supported them to make decisions about the best way to make them comfortable and what they would like to drink. We overheard staff asking a patient "Is there anything else at all we can do to make you comfy?"

Patient feedback

Patients told us that all levels of staff were caring and considerate to their needs and wishes. Comments included "Nursing staff are excellent, very attentive, regular check-ups, call system works very well" and "the care has been lifesaving.", "No complaints whatsoever, everybody is well looked after, night staff very well too". Patients also told us that the hostess staff who support patients to have meals of their choice and the cleaning staff on the wards were also kind and helpful.

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Patients said they felt safe and comfortable and were treated with dignity and respect. They also told us that they felt they had received the support they needed during their visit to hospital.

Involving patients

We looked at records that recorded the views of the patient and, in some instances, their relative or representative, and saw that they were part of the nursing care plan for those patients. We also saw that audits of patients' views about their time in hospital were collated and the results made public outside the ward. This showed that the management of the hospital were keen to ensure that patients and relatives were involved in the development of a caring and supportive culture.

Dignity and privacy

Curtains were pulled around patients when care was being provided and a clip used to hold the curtains closed which stated "Care in progress".

We observed staff answering the telephone. They did not give out any details over the telephone and were careful when they discussed patients' care when on the ward. Records of patients' medical health were held in a trolley by the nurses' station, which was closed when left. This showed that staff respected the patient's confidentiality.

Are surgery services responsive to people's needs?

We found surgical services to be responsive to patients' needs.

Patient feedback

Patients told us that they felt the staff were responsive to their needs. They told us that sometimes they had to wait for attention because staff were busy, but generally they were happy with the time they waited for staff to attend to them.

Consent and capacity

Patients were clear about what they had agreed and consented to for the surgery they had. They told us that they were offered the opportunity to speak to a doctor if they had any questions.

We spoke to staff and looked at records relating to how patients with limited capacity were supported to be involved and included in decisions about their care.

When a patient was confused, decisions about their care were made in their best interest and whenever possible included the views and agreement of the person's relative or representative.

We saw an example of a patient who needed to have their level of capacity assessed to establish whether they could make decisions about their own care. Staff had recorded the actions taken and the people they had contacted, and provided a clear audit trail of how all decisions had been made.

We saw two 'Do Not Attempt Resuscitation' (DNAR) records in place. It was not clear whether staff had formally communicated with relatives, as this part of the form was incomplete.

Encouraging recovery

The hospital uses an "Enhanced Recovery Programme" to promote improved recovery and discharge. We saw measures recorded on corridors such as "walk here for your 40 metre walk" to encourage patients to progress and see their own improvements.

Patients on the Treatment Investigation Unit told us that the unit enabled them to spend less time as an inpatient as they had investigations and treatment on the unit and then returned home. Patients and staff told us they felt this met patients' needs more efficiently.

Asking for feedback

On each ward there was evidence that the views and feedback of patients had been requested, collected and made available for public view. We saw a "How are we doing?" board on several wards, which displayed patients'' responses to questions and included audits of complaints, falls and hand hygiene. Staff received feedback about audits at staff meetings, which included any comments or complaints from patients about negative aspects of care.

All patients and relatives told us they were aware of the complaints procedure. Although no-one we spoke to had raised a complaint, they all said they were confident enough to do so if needed.

Staff feedback

Nursing and medical staff told us of difficulties that affected the responsiveness of the service they provided. The increased demand on medical beds adversely affected the surgical department as patients were moved from medical to surgical wards because of bed shortages.

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Staff shortages meant that training was cancelled and training development reduced because of the demands on staff to work on the wards to cover shifts.

Staff also told us about the impact of delayed discharges due to multiple factors outside of the hospital, which were beyond their control. They said these factors meant that the patients may not get the treatment and care they needed without delay.

Are surgery services well-led?

We found that surgical services had clear leadership and were well-led at team level, but this had been limited to actions being agreed by the Board.

Patient feedback

Patients said the overall service was good and the surgical department at ward and theatre level appeared to be well-run.

Staffing

We saw that each ward had a nurse in overall charge each day, who was supported by further trained staff nurses and health care assistants. Nurse practitioners and medical staff were available by calling them by bleep.

Support for staff

Wards and theatres appeared well-organised. There were regular staff meetings to feedback updates and changes on the wards. The governance arrangements enabled senior staff to look at incidents and trends over each aspect of surgical care to identify areas of risk and develop methods to manage them. The Director of Nursing meets with senior nurses of the surgical units every month and information is cascaded through clinical lead staff to the surgical wards and departments. Staff told us they mostly felt communication was good and that they were able to access updates if needed.

Staff showed us how they report any concerns to senior management and told us that the culture at the hospital supported them to raise any issues without any detrimental effect to them.

Initiatives to support improved medical practice included regular morbidity and mortality meetings across specialities. The junior doctors considered this to be the norm and they were expected to present information, which supported them to develop their practice.

Staff concerns

Some junior medical staff said they were concerned about the availability of junior and middle grade medical staff to assist throughout the night time and weekends. At this time of year the change in junior doctors has taken place and new and inexperienced doctors are working on the wards. We saw junior doctors working at night in isolation with a controlled access to a senior member of the medical staff. This meant that junior doctors on the surgical wards could go their entire shift without speaking to another doctor. This was not consistent with how medical services were managed elsewhere in the hospital.

Junior doctors raised concerns that they did not have easy access to a more senior doctor between 11pm and 7am. They felt anxious that they may miss sick people through a lack of their own experience and told us that this made them feel vulnerable. One junior doctor told us "I don't know what a sick patient looks like yet." We heard comments including "it was pretty scary on my first few nights", "I've just got used to it now" and "none of my friends at other hospitals seem to be doing this to be honest." When asked if they ate during their night shift, one said "I try to now. I'll sit down for 10 minutes or something."

Junior doctors told us that they are often called to take blood from patients or insert cannulas (medical devices that provide lines for taking blood and administering medicines and fluids), as many ward staff can't do this. They were unaware that there was an appointed support worker overnight on the wards to do these tasks. One of the bed managers who coordinated services overnight acknowledged that some of the surgical wards would not bleep via the site team office (as was expected) and would bleep the junior doctor on duty directly. This meant that the tasks needing to be done overnight were not always allocated according to workload to support junior doctors.

Nursing staff expressed concerns about the pressures of not having the appropriate level of staffing to meet people's needs. They said the leadership of the hospital were aware of these concerns but had not supported staff to address the issues. On one surgical ward, four escalation beds (to support increased demand) were funded and staffed until June 2013, but had continued to be used to date without any funding for staffing. Staff told us that three further escalation beds were planned. Recruitment to date has not taken place to address the staffing needs for those beds. They said that staffing a ward in this way means that "safety has been compromised".

Intensive/critical care

Information about the service

The Critical Care Unit accommodated both the Intensive Care Unit (ICU) and High Dependency Unit (HDU). There were 12 beds on the unit, which could be used flexibly to provide care and treatment to critically ill patients or those requiring high dependency nursing care.

We visited the Critical Care Unit on 24 October 2013. We spoke with one of the six patients using the service at the time of our visit. We also spoke with two doctors, a physiotherapist, three staff nurses, two senior nurses and a member of the outreach team.

Summary of findings

The service was safe, effective, caring, responsive and well-led. We found that people were protected from the risks of infection, and changes to practice were made following learning from incidents. Care was planned and delivered to meet patient's assessed needs by staff who had appropriate skills and training. Patients were treated with dignity and respect and their privacy was maintained. Staff were aware of their roles and responsibilities and there was a clear leadership structure. However, patients were not always discharged promptly when they no longer needed intensive care.

Are intensive/critical care services safe?

The unit was safe and secure.

Security

We saw that access to the unit was restricted and entry was through an intercom, which ensured that only those who were authorised were admitted.

Equipment

Equipment, such as ventilators and medication pumps were standardised, which reduced the risk of error in using these medical devices.

Infection prevention

Patients were protected from the risks of infection. We saw that hand hygiene facilities such as hand washing basins, a surgical hand washing trough and hand sanitizers were available throughout the unit. Staff used disposable aprons and gloves, which were available in a variety of sizes, when supporting patients. The number of patients acquiring an infection was low.

The unit carried out audits of practice related to the prevention of infection. For example, staff hand hygiene practice was audited monthly. We looked at the hand hygiene audit results between May 2013 and August 2013 and found that the audit scores had recently deteriorated and the unit had achieved 60%. This meant that staff were not always performing hand hygiene as often as they should.

Awareness of good infection control practice was promoted using posters and notice boards on the unit, and also reflected in the unit's meeting minutes. We found that the unit and equipment was clean.

Reporting incidents

Staff were aware of how to report incidents, and changes to practice were made as a result of learning from mistakes. We spoke with four staff who were aware of the trust's paper-based incident reporting system. They told us that incident reports were sent to the trust's risk management department and to senior nursing staff for investigation. Staff felt empowered to raise concerns and were confident that they would be listened to. Medical staff told us that there were formal arrangements to discuss mortality and morbidity quarterly.

The unit's senior nurse told us that each incident was investigated and discussed at the unit's monthly meeting for clinical leads. We looked at the most recent minutes from these meetings and a summary of incident reports, which demonstrated that incidents were reported, discussed and changes to practice made where necessary. For example, we found there was a delay to implementing appropriate care for one patient with an infectious condition. This incident did not result in harm to the patient, however, the unit had made changes such as the requirement that only senior nursing or medical staff received laboratory results associated with infections. Staff were aware of this change in practice.

Staffing

The unit's staffing arrangements enabled safe practice. One patient told us, "You could not get better staff." The unit was staffed by six consultants specialising in critical care and it had an appropriate number of nursing staff in relation to the dependency of patients. Staff felt

Intensive/critical care

there were sufficient numbers of staff to enable them to deliver care safely. The senior nurse told us that agency or bank staff were not used on the unit and regular staff were offered overtime to cover any absences to ensure consistency.

The unit operated a two-shift system, nights and days, and staff rotated through this shift pattern together, with few staff allocated to permanent nights. The senior nurse told us that this enhanced team working and consistency as handovers were minimised. The senior nurse told us that all requests to backfill posts due to absence had been granted. The trust had a critical care outreach team, which supported the hospital 24 hours a day seven days a week.

Are intensive/critical care services effective?

The unit was effective.

Patients' needs were assessed and care was planned and delivered to meet their needs. We spoke with medical staff, including a consultant and registrar grade doctor. The consultant told us that they were involved in decisions to admit patients to the unit and that patients accessed the unit when required and without delay.

Patient feedback

Patients' needs were met; for example, one patient told us, "There is always a nurse to feed me and assist me. I am never rushed, they take all the time I need."

Care reviews

Patients' care and treatment was regularly reviewed and recorded. We were told that patients were medically reviewed routinely twice a day. We observed a ward round and saw that treatment decisions were reviewed and plans of care changed as necessary. For example, one patient told us, "They have just started me on some new pain killers." We looked at the care records of three patients and found that on-going assessment and delivery of care was recorded. For example, on-going monitoring of patients fluid intake and output and, where appropriate, level of sedation was assessed. We found that the unit measured a variety of patient observations, including their blood pressure and pulse, to enable early identification of any deterioration in their condition.

Multidisciplinary working

Patients were supported by an effective multi-disciplinary team. A physiotherapist told us that designated physiotherapy staff supported the unit twice a day. One patient told us, "I've not been out of bed for a while. The staff on the ward and the physic are helping me." Medical staff told us that there were close working relationships between the critical care outreach team, the emergency department and the unit. We were told that there was good access to interventional radiology. Six members of staff told us they felt they worked well as a team and that consultant decisions were consistent and that they were "a close knit team who think alike." However, we were told that there were occasional difficulties in identifying which medical consultant was involved in a patient's care and treatment.

Staff handovers

Staff received sufficient information regarding patients' needs to enable them to provide effective care and treatment. We found that the unit's shift pattern allowed for a 15-minute handover at the change of shift. We talked to four nursing staff and one therapist, who said they met at the change of shift and received information about each patient's condition. Following this meeting they had a bedside handover in relation to the patient whose care they were taking over. Therapy staff received a handover from the nurse in charge when they arrived at the unit.

Staff training

Staff received appropriate training to perform their roles effectively. One patient told us, "All I can say is these people here are brilliant. You cannot knock them." The unit had designated three members of staff as part of their education team, which included a lecturer practitioner, who had developed an in-house 'Principles in Critical Care' course, which was accredited by the local university. Staff felt they had received sufficient training to perform their jobs. For example, one member of staff, who had worked on the unit for approximately four months, told us that during their induction, they spent a month on the unit as an extra member of staff, and had been allocated a mentor to support them in developing competency by using a workbook.

A report of the unit's training for nursing staff showed that the majority had received appropriate training in topics such as fire safety, resuscitation and safeguarding.

Intensive/critical care

However, we found that 33 of the 59 staff detailed on the report had not completed training in falls awareness. They received regular appraisals and each was allocated a named appraiser. They told us they felt supported by senior staff and could ask them for support and guidance when needed. One member of staff said, "I have found the support amazing."

Quality audit

The unit submitted data to the Intensive Care National Audit and Research Centre (ICNARC), which produces comparative reports providing information on the quality of critical care. The report for the unit showed that the service performed within the expected range for most indicators. This meant that patients received a standard of care and treatment that was consistent with other units of this type.

Are intensive/critical care services caring?

The unit was caring.

Patients were treated with dignity and their privacy was maintained.

Patient feedback

One patient told us, "They pull the screens around. Privacy is not a problem." We saw that curtains were closed around patients' beds when they were receiving intimate care and signs indicating "care in progress" were used. However, 33% of patients provided feedback to the trust that they were not given enough privacy when discussing their condition and treatment. Patient feedback also acknowledged that privacy was difficult with only curtains separating bed spaces.

Attitude of staff

Patients were treated with consideration and respect. One patient said, "They are friendly, open and natural." We observed staff interact with patients in a sensitive and considerate manner. For example, one patient asked for information about his condition after a nurse had completed their observations. The nurse provided reassurance and information to the patient in a manner they understood.

Support for relatives

We saw that there was a room for relatives to use on the unit and staff told us that overnight accommodation could be provided to relatives on site.

In the waiting area we saw photographs of the beds and equipment used in the unit, which helped people prepare for their visit. Staff had developed a sign to attach to the privacy curtains to indicate when patients had received upsetting news, which helped staff to respond to patients appropriately and sensitively. This sign was a symbol of a butterfly, and therefore discreet.

Involving patients

Patients and their relatives were involved in decisions about their care and treatment. Staff told us that they kept diaries for patients while they were on the unit and also encouraged visitors to complete them. Staff reported that this was important especially when patients were using ventilators, as it helped them fill in the gaps when they no longer required intensive intervention. No diaries were in use at the time of inspection. Patient feedback to the trust indicated that they were involved as much as they wanted to be in decisions about their care and treatment.

Are intensive/critical care services responsive to people's needs?

The unit was responsive.

Patient feedback

Patients' needs were responded to promptly. One patient told us, "You can ask them for anything and they will do it." We saw that patients' requests were met by staff. For example, when one patient asked for a television, it was brought to their bedside immediately.

Patients were asked for feedback by posters displayed throughout the unit about how to make comments or complaints. Patient feedback cards were available in the waiting area with a box to deposit completed cards. The unit participated in the 'Friends and family test' and received four responses during September 2013 that patients were either 'likely' or 'extremely likely' to recommend the service.

Urgent care

The resuscitation trolley on the unit included appropriate equipment such as portable oxygen, airways and a defibrillator. Staff told us that this equipment was checked regularly and was the responsibility of the nurse in charge. Records demonstrated that the equipment had been checked daily. We found that equipment and emergency medicines were present and within expiry dates.

Intensive/critical care

Staffing

The unit had procedures to respond to fluctuations in demand and was fully staffed regardless of occupancy levels. During our visit there was a full complement of staff with the unit occupied just over half of its capacity. The consultant told us that if there was an increase in demand then the unit would temporarily go over capacity and would transfer out stable patients with the relevant consent. The senior nurse told us that there were virtually no transfers, however, there were staff specially trained to support patients during transfer.

Discharge

There was a risk that patients who were ready for discharge from the unit were treated in mixed sex accommodation as the unit did not have separate male and female facilities. It is not usual practice in critical care to have separate male and female facilities.

There was also a risk that patients' discharge planning may have been delayed. Staff told us that when a patient's condition had sufficiently improved they were not always discharged from the unit until a bed was available on a ward as the beds could not be reserved in advance. The outreach team told us that they followed up patients discharged to the ward and ensured good links with critical care.

Are intensive/critical care services well-led?

The unit was well-led.

Staffing

The leadership of the unit was visible. Nursing staff wore different uniforms according to their role and patients were able to identify different grades of staff on the unit. One patient told us, "It's excellent. You could not better it anywhere, from the top to the bottom."

Staff were aware of their roles and responsibilities and how to escalate concerns. The unit had a clearly identified leadership structure and a coordinator was available on each shift.

Where appropriate, staff had designated lead roles within the unit, for example, resuscitation and organ donation. They told us they were given additional responsibility when they felt sufficiently comfortable and experienced. One member of staff told us that they were the link nurse for spinal patients. This role involved attending training days and providing advice for staff on the unit about this lead area.

Staff were supported with their wellbeing. They told us that they could access the hospital's occupational health service and could refer themselves. They had the opportunity to support a different patient if they felt they needed to, although they also stated that this rarely happened.

Maternity and family planning

Information about the service

The maternity services at the Royal Bournemouth Hospital provide a midwifery-led unit for women with low risk pregnancies in the Bournemouth, Poole and Dorset area. The service comprises an antenatal clinic, three birthing rooms, four postnatal rooms and a postnatal ward with two beds. There are no family planning services.

The midwives deliver over 400 babies each year.

We inspected maternity services on 24 and 25 October 2013. We spoke with five women who were either attending the antenatal clinic or had recently given birth in the unit. We used information from comment cards and patient focus group meetings. We looked at health records, risk assessments, incident reports, minutes of meetings, rotas and training records, and we spoke to the staff working in the unit.

There are no specialist doctors trained in the care of pregnant women or new born babies on site. This means that if any complications arise in labour or following the birth, women and new born babies are transferred to Poole Hospital NHS Foundation Trust or University Hospital Southampton NHS Foundation Trust, where specialist services are available.

Summary of findings

We found that the midwifery unit provided safe and effective care for women with a low risk of developing complications during birth. Feedback from women using the service was positive. They told us staff were exceptionally caring and helpful. The service was well-led. Women said they had been well supported throughout their stay in the unit. Improvements could be made where access to scans is limited.

Women using the midwifery-led maternity service can be assured of a good standard of care during their pregnancy and birth, and be confident that that they will be supported in their chosen method of feeding their babies.

Are maternity and family planning services safe?

The midwifery unit was safe.

Accreditation and performance

The unit demonstrated a good track record on safety. We looked at the unit's activity since April 2012 and saw that mother and baby safety was within national expectations.

Maternity services achieved a pass in the NHS Litigation Authority CNST Level 2 clinical risk management assessments. This means that the unit has demonstrated there were appropriate policies and procedures in place to reduce risk and the policies were carried out in practice.

The midwifery unit achieved almost 100% in the two-yearly reaccreditation processes from the World Health and UNICEF Baby Friendly Initiative. This demonstrated that the maternity unit had sustained a high level of care and support for pregnant women and their babies since 2011 when the unit was first accredited.

Vulnerable women

The specialist midwife responsible for safeguarding vulnerable women told us about the Sunshine Team. They worked closely with women who were at particular risk of domestic violence and abuse during their pregnancy. They told us how all women were assessed during the antenatal period for any safeguarding concerns. If a concern was identified, extra care and support was put in place. This included working with the family, health visitors and social services to build rapport and improve outcomes for the whole family. The Sunshine Team worked closely with mental health providers, drug and alcohol services and children's services to safeguard women and families identified as being at risk from abuse. This meant that there were better outcomes for families who were assessed as being at risk.

Medicines management

One woman who had recently given birth told us that she always felt safe in the unit. For example, when any medication was administered, the staff always checked her name band.

Maternity and family planning

Access to the unit
We saw security measures to protect the new born babies, such as security bands and key pad access.

Infection control
Appropriate infection control measures included hand gel and public information notices about the importance of hand hygiene. The sluice area was clean, tidy and clutter free. Women in the unit told us the unit was always clean and tidy. The risks associated with infections were minimised as the maternity unit maintained a clean and hygienic environment.

Staffing
There were sufficient staff to provide safe care. The unit was staffed according to national guidelines and although staff sickness was an issue, the women using the service told us this did not adversely affect the care provided. Staff told us they worked well as a team and bank staff provided adequate cover to support the team. The midwives told us that if a woman on their caseload went into labour they would support her through her labour and birth – even if this meant missing breaks. The women we spoke with on the unit told us that there were always enough staff on duty throughout the day and night. They had no concerns about the staffing levels.

Are maternity and family planning services effective?

The midwifery unit was effective.

Clinical governance and audit
Systems ensured the clinical practice in the midwifery unit was evidence based. The trust's Maternity Clinical Governance and Risk Management Group met every three months to review guidance and current clinical guidelines. It was responsible for approving and reviewing maternity policies and procedures and ensuring these were carried out in practice through both national and local audits. For example, we saw an audit of the maternal transfer by ambulance, which included a review of 30 sets of notes. This found that there was good communication between the hospitals, although documentation could be improved. The report included recommendations to simplify how records are completed and the actions that had taken place. This demonstrated that the midwifery services monitored the quality of care and treatment and took action to improve the service.

The maternity unit participated in three of the four national clinical audits they were eligible for. It also took part in the Antenatal and New-born Screening Education Audit, which assessed education in local screening initiatives. This demonstrated that the maternity unit took part in research which contributed to the development of evidence-based practice.

Reporting incidents
The midwifery team demonstrated a good reporting culture over the previous year, with incidents reported and concerns escalated. The Acting Head of the Midwifery Unit explained how the unit learned from these incidents, which were reviewed and discussed within the Maternity Clinical Governance and Risk Management Group. A recent incident had been investigated and had led to a review of the relevant policies and procedures. We heard that although the outcome would not have been affected, there were lessons for the midwifery team in improving communication and ensuring that out-of-hours referrals and missed appointments were followed up. This learning was disseminated to the individuals concerned and discussed in general at team meetings.

Staff described the process for reporting incidents and said they received feedback following any investigation. They also told us that they felt well supported through the support and debriefing offered to the team following any incident. This demonstrated that the service had systems in place to learn from incidents and improve the standards of safety.

Access to care
The women we spoke with had accessed the midwifery service through their GP. Most women had received antenatal care from their midwife at their GP practice and had only attended this maternity unit for antenatal classes, scans and tests. Midwives told them that if a problem had occurred they would have been transferred quickly to Poole Hospital. Women told us that the community midwives had been very reassuring about the whole process and had explained all the available options without any pressure to make a particular choice.

Collaborative working
Staff told us how the midwifery service worked closely with the GPs and social services, especially in the care of vulnerable women. They gave us examples of how vulnerable women and their new born babies were

safeguarded through collaborative working. The maternity service supported multi-disciplinary working and worked in partnership with other organisations to ensure the needs of the expectant mother and her family were properly managed and met.

Patient facilities

The unit was well signposted and clutter free. The birth room had en-suite shower facilities with a birth pool and birth balls. The lighting had a dimmer switch but staff told us that they preferred to use the overhead examination light, which gave a softer lighting effect and was easy to reposition. There were no bathroom facilities on the postnatal ward and one toilet between four beds. There was no television on the postnatal ward. The general environment felt very clinical and did not present as a homely and relaxed atmosphere in which to give birth.

Training

Staff received appropriate training and development to enable them to deliver safe and effective care. Midwives maintained their own training and development portfolios. Staff told us about recent and planned training, including clinical updates such as training in obstetric emergencies, advanced life support, and the trust's annual mandatory training including manual handling, fire prevention and infection control. They said they found the practical elements and support from the consultant at Poole Hospital very useful. Their induction to the unit prepared them well for their first shift on duty. The women we spoke with told us that they felt the staff were competent and caring.

Midwifery staff were supported in their regular supervision and annual appraisal by several staff supervisors in a ratio of one supervisor to 15 midwives, which was within the accepted range. The supervision process was separate from the management of the unit and enabled the midwives to have honest debriefing and reflection sessions about their professional practice.

Are maternity and family planning services caring?

The midwifery unit was caring.

Continuity of care

Each midwife was linked with a different local GP practice, which aimed to have the same midwife follow the woman throughout her pregnancy and birth, although this wasn't always possible.

The women we spoke with told us they felt fully involved in their obstetric care. Although they did not always see the same midwife throughout their pregnancy, they told us that this hadn't been a problem. The women in the unit told us they had the opportunity to visit the unit before the birth, which they found very helpful. They told us how the staff always "go to extra lengths" to make sure they were coping and treated them with dignity and respect.

All the women told us that they had received sufficient information to enable them to make decisions about their care and treatment. They had spoken with the midwives during their antenatal appointments and discussed the benefits and problems associated with giving birth in the midwifery-led unit. They chose to give birth at the Royal Bournemouth Hospital for a variety of reasons, including its close proximity to their home, the fact it was smaller and offered a more personal service, and its good reputation.

Records

Maternity records included detailed information about the different maternity services offered at both The Royal Bournemouth and Poole Hospitals. Women were asked to sign to confirm they had understood the information, that they had had the opportunity to ask questions and discuss any concerns. They were then asked to indicate their first and second choice for their baby's birth – whether at home, in a midwifery-led unit or in hospital. The records contained all the information required to ensure good communication between healthcare professionals and a woman during her pregnancy and birth.

Maternity and family planning

The records stayed with the woman and followed her through the community antenatal appointments, the birth and for 10 days following the birth.

Information and advice

Women's records included useful information including the expected dates of various outpatient appointments and where they would take place. They also included advice on what to do and who to contact in an emergency. There was a checklist for staff for women with a raised body mass index who may be at risk through obesity. This included various tests and precautions, such as checking that the correct size equipment was available and giving lifestyle advice and information. There were various information leaflets available to pregnant women, including advice on breast feeding, smoking cessation and dietary supplements. Women using the service had easy access to advice and information to inform their maternity and lifestyle choices.

Patient feedback

Women praised the staff, telling us how helpful and caring they were in helping them to have positive birth experiences. One woman told us that it was her first baby and the staff had really helped her with breast feeding. She would not hesitate to return to the unit for any other births. Women told us of the kindness of the staff and one said that the midwife had even washed her hair after the birth. One woman said "I've had to use the buzzer loads and the staff always come quickly." All women told us they could not fault the unit. This demonstrated that compassionate care was provided in the unit.

Are maternity and family planning services responsive?

The midwifery unit at team level was responsive to women's needs, but it was restricted by decisions of the Board.

Consultation and feedback

The design of the local maternity services throughout Bournemouth, Poole and Dorset had been subject to public consultation. The local Clinical Commissioning Group had organised a public event which was attended by over 30 women who fed back their pregnancy and birth experiences. The Acting Head of Midwifery told us that the women gave powerful messages, both positive and negative, and she was ensuring that staff heard these messages to inform their practice.

People gave feedback on the quality of care in different ways, including a 'Family and Friends test'. There were also national maternity surveys and 'comment cards'. The midwives encouraged women to phone the unit at any time if they had concerns. This showed that the midwifery unit was committed to communicating with the women using the service to improve their obstetric experience.

Clinical guidelines and policy

We looked at the Maternal Transfer Guidelines and the Emergency Transfer Policy for New-borns. This policy was drawn up with the input of the Royal Bournemouth Hospital, Poole Maternity Unit and the Ambulance Service. The policy was approved by the Maternal Clinical Governance and Risk Management Group and detailed the actions needed to urgently transfer the women and new born babies requiring urgent medical treatment to a consultant-led service and a Neonatal Intensive Care Unit.

Staff were familiar with the policy and were able to describe the urgent actions needed to transfer unwell women and babies safely. Data showed that the transfer rate of women and babies needing urgent medical treatment was similar to other stand-alone midwifery-led units, and outcomes for women remained within national expectations. The unit had safe and effective systems to manage the care of women and new born babies who developed unexpected complications.

Patient feedback

Women receiving antenatal care in the unit told us that they were happy with the service in general, but found appointment times and dates to be inflexible. They did not have a choice of appointment dates as the unit was so busy. They gave an example of ultrasound scans only being available on Thursdays, which was not always easy to accommodate with other family and work pressures.

The midwifery unit had systems to meet people's religious and cultural needs. Staff explained how they could access interpreters when required for women and families whose first language was not English. But they told us this was sometimes a challenge due to time constraints. They had supported women from different cultures such as East European and Middle Eastern areas. They described how they were respectful of the individual woman's needs and were mindful of their privacy and dignity. This indicated that staff responded appropriately to women's individual needs.

Maternity and family planning

Are maternity and family planning services well-led?

The midwifery unit was well-led overall.

Joint working

The Maternity Clinical Governance and Risk Management Group looked at joint working for midwifery services between the Royal Bournemouth and Christchurch NHS Foundation Trust, Poole Hospital NHS Foundation Trust and University Hospitals Southampton NHS Foundation Trust. We saw that partnership working between the trusts was working well, although there was no formal agreement in place. All the staff and patients we spoke with were aware of the joint community and hospital maternity services offered by the trusts and were able to tell us where and how they would access the services.

There was no service level agreement (SLA) in place to record a common understanding about services, priorities and responsibilities. As there was no finance attached, a SLA could not be put in place for the joint maternity services. Instead, the Royal Bournemouth Hospital had included legal cover within contracts for any midwifery work staff may complete while in Poole Hospital.

Staffing

Senior staff in the trust's midwifery services had clearly-defined leadership roles. Although the post of Head of Midwifery Services was vacant, the Acting Head of Midwifery had been in post for some time and had given stability and leadership to the team during a period of challenge and uncertainty. We were told that she was nominated, and had won, the trust Leadership Award in the 2012 Staff Excellence Awards.

The midwifery staff praised her leadership skills and told us that "She is fabulous, the staff are happy and patients' needs are met." We spoke with other senior staff with designated responsibilities such as the Specialist Midwife for Safeguarding and Vulnerable women and the Antenatal and New-born Screening Coordinator. They were all clear about their role and remit, their areas of responsibility and who they reported to. They felt well-supported and their opinions were listened to. There were regular staff and management meetings to discuss issues arising in the midwifery unit. This demonstrated that the service was well-led.

Performance monitoring

The Maternity Clinical Governance and Risk Management Group were responsible for monitoring safety, quality and delivery of maternity services. The Acting Head of Midwifery told us that collecting data to monitor performance was embedded in the unit's culture as it had been a requirement for a long time. Meetings were held quarterly and reports from this group were fed into the trust's Board meetings through the Governance Committee and disseminated to staff through staff meetings.

Staff told us that communication from the Board down in the trust was good, but they did not always feel the trust listened to their concerns. They gave an example of their concerns about the proposed reconfiguration of the maternity service, which they told us was planned to take place within the next six months.

On the day of our inspection two midwives were off sick and staff had been moved to ensure safe staffing levels in the unit. The Acting Head of Midwifery confirmed that staff sickness was a problem and described the measures she had taken to monitor individual staff attendance and reduce sickness. This included moving to a different model of care, flexible shifts and defined caseloads to reduce stress. She described the positive team spirit throughout the midwifery service and told us that the midwives worked well together to ensure that the shifts were covered. However, although the staffing numbers reflected national guidelines of 1.2 midwives per birth, there was constant pressure to cover the gaps left by staff sickness. The midwives told us that the majority of staff absence was due to the midwives becoming pregnant. They told us that this was not such a problem as the bank staff were very good and were happy to take on shifts. There were actions in place to monitor and address staff sickness and absence.

Children's care

Information about the service

The Royal Bournemouth Hospital only provide paediatric care and treatment of children who have undergone surgery in the Children's Eye Ward. This comprises a three-bedded ward and bathroom facilities, which are directly opposite theatres and next to the adult ophthalmic ward.

There are no specialist consultants trained in the care of children on site. This means that if a general paediatric emergency arises, children would be transferred to Poole Hospital NHS Foundation Trust, where paediatric services are available.

We inspected the paediatric services at the Royal Bournemouth hospital on 24 and 25 October 2013. At the time of our visit there were no inpatients. We spoke with one patient and their mother in the ophthalmic outpatients. We used information from comment cards and patient focus group meetings. We looked at health records, risk assessments, incident reports, meeting minutes, rotas, policies and procedures, training records and spoke with the staff working in the unit.

Summary of findings

Only children's eye surgery is carried out at the hospital. The Children's Eye Ward provided safe and effective care for children who had undergone ophthalmic surgery. Feedback from patients and their families was positive. They told us the service was very oriented to the care of young people. For example, colouring books were routinely offered during outpatient appointments.

The service was well-led and responded appropriately to the needs of the children. Children requiring ophthalmic surgery at the hospital can be assured of a good standard of care and their families can be confident that that they will be supported during their child's stay in hospital.

Are children's care services safe?

The children's service was safe.

Incident reporting

The trust had systems in place for reporting and managing risk and patient safety through the central reporting process. The policies and procedures to support staff in reporting any untoward event were on the trust's staff intranet. The unit also had child-specific policies and procedures readily available to staff at the nurses' station on the ward.

Safety measures

The nurses' station had line of sight observations of all three beds. There were extra security measures in place to ensure children could not leave the ward unattended, such as door handles that were out of reach of young children. The play equipment was safe and suitable for a range of ages. The art and craft materials were kept locked away when not in use. This meant that the Children's Eye Ward was a safe and suitable environment for children to receive care and treatment.

Safeguarding

The trust lead for safeguarding children explained how all staff received training in recognising and responding to child abuse at induction and then on a regular basis as part of the mandatory training package. Senior staff received monthly reports that identified where there were gaps in safeguarding training. Any significant gaps were followed up by the safeguarding lead. The Safeguarding Children's Group met quarterly and worked to ensure all staff, including the paediatric nurses and staff working in Ophthalmology, were confident dealing with child protection issues. This demonstrated that children were protected by the trust with robust arrangements to safeguard vulnerable children.

Children's care

Risk assessment

There were checklists to ensure that each child received safe and appropriate care from admission through surgery to discharge. The admission process included assessing individual risks and checking that risk assessments had been completed. Infection control risks were considered as part of the risk assessment process. The nursery nurse told us how she ensured that toys were cleaned between clinics. This demonstrated appropriate risk assessments were in place to maintain children's safety.

Staffing

There were adequate numbers of appropriately skilled staff on duty on the Children's Eye Ward. We were told that children were not admitted to the ward unless there were paediatric nurses on duty. This was confirmed by looking at the wards duty rota. An information board displayed photos of the staff, explaining who they were. There was a named children's lead for the service and the ward employed specialist nurses such as paediatric nurses and a nursery nurse. The ophthalmic consultants had specialist interest in treating children's eye conditions.

Are children's care services effective?

The children's service was effective.

Clinical guidelines

There were systems to ensure paediatric clinical practice was evidence based. The paediatric service had recently been benchmarked against clinical guidelines and best practice standards. Where the standard was not being met, actions were in place to rectify this. For example, the National Service Framework for Children recommended that a Band 7 nurse was employed in any day care unit. This was not in place for the Children's Eye Ward. The issue was reviewed by the Director of Nursing and added to the trust's risk register for action within the last two months. Clinical and paediatric information was readily available on the Children's Eye Ward and staff took an active interest in researching current best practice and developing local clinical guidance. This demonstrated that the paediatric service monitored the quality of care and treatment and took action to improve the service.

The trust participated in one of the two national paediatric clinical audits they were eligible for. This was for paediatric services in general rather than ophthalmic audits. This demonstrated that the trust took part in research which contributed to the development of evidence based practice.

Joint working

The safeguarding children's lead told us how they met regularly with local social services and other health and social care providers at the local Safeguarding Board to discuss incidents and best practice. Any issues were brought back to the trust to pass on to relevant department leads. This meant that vulnerable children were protected by the trust working in partnership with other agencies.

Training

Staff received appropriate training and development to enable them to deliver safe and effective care. We spoke with a manager who explained that the paediatric nurses ensured they kept up to date with best practice in nursing children through close links with Poole Hospital's paediatric training and development programme. Nurses also spent time working on the paediatric wards at the other trust.

A manager told us that the staff received regular supervision and an annual appraisal. There were systems in place to support staff training and development.

Are children's care services caring?

The children's service was caring.

We saw 'thank you' cards and hand drawn pictures from the children displayed on the ward. One parent told us they were happy with the service provided and said it was very child-friendly and oriented towards young people.

Information and advice

There was easy access to information, help and advice for children and their families about their hospital visit and community support. Leaflets were readily available in the ward in various age-appropriate formats. There was general information about children's services and community support for example, information about a local

Children's care

support group for visually impaired young people. There was also more explicit information about eye conditions and what to expect on admission to hospital. A translation service was available if required.

The ward made the surgical procedure and stay in hospital less frightening for the child and their family, for example, by encouraging families to visit the unit before admission and allowing plenty of time to orientate the child and their relative to the ward. Relatives were encouraged to stay with the child throughout their stay. The child was able to take their family member and a favourite toy into the anaesthetic room. When the child started to regain consciousness after surgery, the relative was called back to the recovery area to support them. According to the child's age staff used dolls to explain what would happen to the child, with cannulas and tubing attached. They told us this meant that children and their families could be reassured that staff would support them to be fully involved in their child's care and treatment.

The ward was well signposted and presented as a welcoming environment to children and their parents. Curtains and soft furnishings were child-appropriate and with toys, books and play materials readily available. The nurses wore tabards decorated with children's motifs to be friendlier for young children.

Are children's care services responsive to people's needs?

The children's service was responsive to the needs of children and families.

Safeguarding

The safeguarding children's lead told us that the trust had raised awareness throughout the hospital of the safeguarding service for infants, children and adolescents, as most departments in the hospital dealt with children. For example, emergency care services, radiology, dermatology and orthodontics saw and treated children regularly. A recent audit identified the actions the trust needed to take to ensure children across the trust were care for and treated according to best practice guidelines.

Emergency care

The theatre manager was responsible for the care and treatment of children during surgery. He told us that the children had dedicated lists and were always treated as a priority. Information on paediatric resuscitation and the early warning signs for when a child might be becoming seriously unwell were displayed on a notice board for staff to access quickly. Specialist equipment was available to meet children's needs, including children's resuscitation equipment. This was kept just outside the ward to ensure children could not access the equipment. Training in intermediate paediatric life support for all theatre staff and paediatric nurses was updated annually. This demonstrated that children were kept safe through staff's awareness and training in paediatric emergencies.

Discharge arrangements

The ward had developed discharge policies and procedures, checklists and risk assessments for discharging patients to ensure their safety. Staff were able to describe the procedures to urgently transfer children who were unwell to Poole Hospital, even though this was an infrequent event. The ward had systems in place to manage the care of children who developed unexpected complications.

Cultural needs

There were systems to meet people's religious and cultural needs. Staff explained how they could access interpreters when required for children and their relatives whose first language was not English. This meant that staff responded appropriately to children's individual needs.

We were told that at times the ward was used to support other departments in the hospital when there was a shortage of inpatients beds. They had not needed to cancel any children's surgery because of adult medical patients being admitted to the ward, but it was a logistical challenge to ensure that the Children's Eye Ward was ready to admit children when needed.

Patient feedback

Children and their families could give feedback about the quality of care in the Children's Eye Ward through 'comment' cards. We saw information about how to make a complaint. The ward also used less formal methods to gauge the children's satisfaction with the care.

Children's care

Are children's care services well-led?

Overall, the children's service is well-led.

Before the inspection the Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust informed us that they did not have any inpatient paediatric services. There was a dedicated three-bedded children's ward for ophthalmic day cases.

We talked to senior staff with responsibilities for the safety, care and treatment of children in the hospital. Staff in the ophthalmic ward had clearly defined roles and responsibilities. There were systems in place to manage the safeguarding of children throughout the hospital proactively.

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Staff communication

Staff on the ward were all able to describe the leadership and reporting responsibilities. They were clear about how to escalate concerns and who was responsible for clinical governance arrangements. They told us that the ophthalmic team and theatre staff worked well together. There was good communication and they felt well supported on an individual and team basis. Weekly meetings enabled any issues or concerns to be discussed, along with the day-to-day management of the unit. Quarterly clinical governance meetings monitored the ophthalmic department's performance and discussed any issues. This demonstrated that the Children's Eye Ward had good systems of communication in place and the unit was well-led.

Safeguarding

The trust confirmed that the Board level executive with lead responsibilities for safeguarding children was the Director of Nursing and Midwifery and that there were named healthcare professionals with safeguarding children responsibilities with a nominated safeguarding children lead. The safeguarding children systems were monitored by the trust's Safeguarding Committee and the Board received an annual safeguarding report which included staff training in safeguarding and children who missed appointments. They told us that safeguarding processes across the trust were audited annually. There were suitable arrangements in place to safeguard children and young people from the risk of abuse.

End of life care

Information about the service

The Royal Bournemouth Hospital has an established specialist palliative care team led by a consultant in palliative medicine. The palliative care team provided services for adults with advanced, progressive, incurable illness. The team comprised three specialist nurses and an end of life care facilitator had been appointed on a 12-month contract, to be reviewed in February 2014.

The specialist nurses and end of life care facilitator worked across all wards and departments to support and advise other clinical staff on the care of patients with complex palliative care or end of life care needs.

There were 1,500 deaths a year at the hospital.

We visited six wards including three, four, five, nine, 27 and 28. We also visited the Stroke Unit, the hospital mortuary, the hospital chapel and multi-faith room. We reviewed the care records of seven patients at the end of life, observed the care provided by medical and nursing staff on the wards; spoke with two patients receiving end of life care and the relatives of two other patients. We also spoke with members of the hospital's specialist palliative care team, the end of life care facilitator and the hospital chaplain. We received comments from our public listening event and from people who contacted us separately to tell us about their experiences. We reviewed other performance information held about the trust.

The majority of patients receiving end of life care were cared for by nursing staff on the wards with support and advice from the end of life care facilitator, as required. Around 10% of patients had complex palliative care needs and were referred to the specialist palliative care team. However, most patients referred to the palliative care team were not at the end of life stage, but needed assessment and symptom control symptom control prior to discharge to their preferred place of care, which may be home, hospice or nursing home'

Summary of findings

End of life care services in the hospital were safe, effective, caring, responsive and well-led. Improving end of life care had been a high priority over the last 12 months and good progress had been made on a number of important new initiatives. This included implementing new personalised care plans for the last days of life.

Our conversations with patients, their relatives and care staff provided evidence of good quality care and treatment. Patients and their relatives told us they were fully involved in care planning decisions and were regularly updated on changes in the patient's condition. All the staff we spoke with were knowledgeable, passionate and committed to providing high quality care for patients at the end of their life and their families.

Are end of life care services safe?

Patients received a safe end of life care service. In response to national concerns regarding implementation of the Liverpool Care Pathway, the trust had replaced this with personalised care plans for last days of life. The personalised care plans were introduced to support good end of life care and prompt appropriate decision-making, communication and documentation. This helped to ensure a safe approach to each person's care.

We reviewed the personalised care plans of seven patients who were receiving end of life care on six different wards. All contained appropriate records about their medical and nursing needs, clear escalation plans if the patient's condition deteriorated communications with the patient and their family, and their end of life care wishes.

End of life care

Three records contained 'Do Not Attempt Cardiopulmonary Resuscitation' (DNAR) forms. All sections of the forms were completed appropriately and they were signed by a senior health professional. They included a summary of the communication with the patient, their relatives and members of the multidisciplinary team, as applicable. Completing the DNAR forms ensured that appropriate decisions were made about the care of these patients.

All end of life care that we observed was safe and appropriate to the needs of the patients concerned. For example, one patient was at risk of choking when swallowing. Although they had not had a stroke, they were transferred to the Stroke Unit because of the expertise of staff in this area.

We spoke with a range of staff on the wards including consultants, doctors in training; charge nurses/ward sisters, qualified nurses and health care assistants. All staff spoke highly of the support and advice provided by the end of life care facilitator and the specialist palliative care team. They told us the end of life care facilitator provided hands-on training on the ward as and when specific training needs were identified. For example, they had provided syringe driver training for nursing staff to ensure safe administration of pain relief medication.

Are end of life care services effective?

End of life care services within the hospital were effective.

Comments from patients, relatives and staff on the wards indicated that patients' needs were being met. This was backed up by evidence from the personalised care plans we reviewed.

National reviews

Following a national independent review of the Liverpool Care Pathway, the Department of Health had asked all acute hospital trusts to undertake an immediate clinical review of patients on end of life care pathways. After undertaking this review, the trust introduced personalised care plans for last days of life during the last four months. This was to support good end of life care and prompt appropriate decision-making, communication and documentation.

Following the National Dementia Audit, the trust developed an action plan to address a number of priority areas for improvement. This included identifying patients with dementia and training in end of life care for staff supporting these patients. We observed good practice on the wards, including early assessment and identification of people with a possible dementia. 'This is me' forms were completed to enable staff to understand the person's individual needs and how to support them while they were in an unfamiliar environment.

Care plans

Care needs relating to pain relief, nutrition and fluid intake were clearly documented in personalised care plans and daily care records showed that care was provided in accordance with these plans. We saw evidence of symptom control and other measures to ensure the patient was as comfortable as possible. All the patients we observed looked comfortable and well cared for.

Training

Ward staff said they had received training in mouth care for patients, moving and handling to keep patients comfortable and dignity of the patient after death.

Team working

One of the medical consultants explained that decisions on end of life care were made by a multi-disciplinary team. This included consultation with the specialist palliative care nurses, relatives and primary care professionals. One of the main decisions was when to move from active treatment of the patient's condition to palliative care. They said there was regular two-way communication between the wards and the palliative care team.

We spoke with the consultant in palliative medicine, two specialist palliative care nurses and the end of life care facilitator. It was clear they were highly specialised in their field and worked closely together as a dedicated team. There was evidence of good collaborative working with other clinical staff across all hospital wards. Every ward had an end of life care champion who met with the end of life care facilitator every month. End of life care champions cascaded good practice to colleagues on the wards.

End of life care facilitator

The end of life care facilitator visited wards twice a week to review any patients who were near the end of their lives and offer care, support or advice as required. The facilitator also provided 'hands-on' training as required, tailored to the needs and requests from each ward. This helped ensure the services provided to patients were effective.

End of life care

Clinical staff told us the palliative care team had become increasingly active in the hospital over the last 12 months. The end of life care facilitator was appointed in February 2013 on a 12-month project to help roll out the trust's plans for improving end of life care. This included establishing the new personalised care plans for last days of life and the rapid discharge of patients who wished to return home and had family support to do so.

The end of life care facilitator was originally employed for 25 hours a week on the medical wards, but this had recently been increased to a full-time role also covering surgical wards. Referrals from the wards to the end of life care facilitator were steadily increasing, but this was still a developing service. The end of life care facilitator received between 15 to 30 referrals a month. However, on their twice-weekly visits to the wards they found there were around 40 patients a month in the last two days of life. This meant a proportion of patients had not been referred to them or put on personalised end of life care plans in sufficient time. The personalised care plans for the last days of life are specifically designed for end of life care and are used in addition to the regular patient care plans used on the ward. The personalised care plans prompt doctors and nurses to check medication, symptom control and treatment decisions, mental capacity, advance decisions, DNAR forms, communications with the patient and/or their relatives, and to ascertain where the patient wishes to die if not in hospital.

We were told that all wards know how to look after patients who are near the end of their lives and the role of the end of life care facilitator was to provide extra support and advice. The facilitator also checked that a personalised care plan was used. The lack of a personalised care plan doesn't necessarily mean a patient did not receive appropriate end of life care, but it does raise the question why this was not used.

Improvement initiatives

There was a trust-wide End of Life Steering Group to drive change and facilitate education and training to ensure the end of life care pathways were effective. The group was to be re-launched and the trust's deputy medical director would become the new chair of the group.

Are end of life care services caring?

End of life care services in the hospital were caring and compassionate.

National survey results

The National Bereavement Survey 2011 collected people's feedback at primary care trust cluster-level. The Royal Bournemouth Hospital is in the Bournemouth, Poole and Dorset PCT cluster, which performed in the top 20% of all PCT clusters nationwide for the levels of 'respect and dignity' and 'quality of care'.

Patient and family feedback

We reviewed the personalised care plans for last days of life for seven patients in six different wards. The care records showed evidence of good quality care, which included notes of regular discussions with patients and their families. We were able to speak with two patients and the visiting family members of two other patients receiving end of life care. All were full of praise for the staff and the care provided, saying staff "went the extra mile" to ensure patient's needs were met and their family members were kept fully informed.

A relative whose spouse had a dementia and received end of life care at the hospital said "The nursing care was loving and caring. They looked after X and the rest of our family very well. We were always greeted and welcomed and they were flexible about visiting times. We received regular updates. I have good memories and when they died it was very peaceful." Another person's relative said "Communications with relatives are fabulous."

During our public listening event we heard about people's positive experiences of the hospital's palliative care and end of life care services. We saw a letter outlining one person's experience of the pathology laboratory and oncology unit, which stated "Despite poor accommodation the level of care and nursing was superb. We could quote the names of the consultants, the specialist nurses, the sister in charge and many other nurses (all of whom were as good as we could imagine) but our view is a culture of care exists in the unit which continues even when staff change."

End of life care

A member of the public who had experienced many of the hospital's services phoned us to say "We have nothing but praise for all of the staff from consultants to cleaners and catering staff. The area has an elderly population, the natural order of things means more people are near the end of their lives and many of them will unfortunately die in hospital."

The ward staff treated patients and their relatives with courtesy and respect, and had great empathy. All the patients we saw appeared comfortable and peaceful. We observed high standards of personalised end of life care and exceptional commitment from the charge nurse/ward sisters we spoke to. Ward staff highly commended the proactive involvement of the hospital's palliative care team and end of life care facilitator. We spoke with a group of six doctors in training, who said there was a "caring culture" throughout the hospital.

Bereavement service and chaplaincy

The chaplaincy department provided the hospital's bereavement service, with administrative support from the general office. We visited the hospital chapel/multi-faith room and spoke with one of the hospital's two chaplains. They operated a 24-hour on call system and aimed to be by a patient's bedside within an hour of a request for support. They described their role as being "to pray for the dead and comfort the living".

There were facilities to meet multi-faith spiritual needs, including an area for people of Muslim faith to wash before offering prayers, and a local Rabbi visited the hospital regularly.

The Chaplain directed people to the general office to collect death certificates and a bereavement pack containing important information and guidance on what to do after a death. This included contact details for external counselling and support services, funeral services, bereavement guides and advice.

The Chaplain worked closely with the office manager and other general office staff to help them understand issues associated with people's grief. They praised the work of the general office. Ward staff told us the Chaplain provided great support and comfort to people experiencing bereavement.

The Chaplain also managed the hospital mortuary and provided training and advice to the mortuary porters. We visited the mortuary and saw it was clean and tidy. There was a viewing room where relatives could pay their last respects. Requests for viewing were made through the general office, who then made arrangements with the Chaplain to collect the relative from the general office and escort them to the mortuary, while preparing them for what to expect.

Are end of life care services responsive to people's needs?

End of life care services within the hospital were responsive to people's needs.

Conversations with patients, relatives and ward staff showed clearly that the hospital was good at preparing families and patients for end of life care decisions. The personalised care plan records showed an individualised approach to each patient's care and active inclusion of patients and their relatives. Ward staff and members of the palliative care team said the trust had made end of life care a priority over the last 12 months. Staff said the end of life care facilitator and specialist palliative care nurses were very accessible and actively engaged on the wards.

Access to services

The majority of patients were seen on the same day that they were referred to the specialist palliative care team or to the end of life care facilitator. At weekends and out of hours, advice was available from the specialist palliative care unit at Christchurch Hospital.

Medical and nursing staff on the wards all said they had good access to the consultant in palliative medicine, the specialist palliative care nurses and the end of life care facilitator. The trust had a shared consultant on-call rota with the specialist palliative care unit at Poole Hospital, enabling 24-hour cover at all times. This helped ensure a responsive service was available at all times.

Discharge arrangements

The end of life care pathway was organised around each person's prognosis (life expectancy), whether they wished to return home, if they had family support, and whether they had specialist palliative care needs.

Patients with less than 48 hours to live, who wished to return home and had family support to do so, were put on the rapid discharge home to die pathway. These patients were discharged home within one working day.

End of life care

Patients with specialist palliative care needs, or who deteriorated rapidly, and had less than two weeks to live were transferred to the palliative care unit at Christchurch Hospital. Patients with the same prognosis but no specialist palliative care needs were cared for at the Royal Bournemouth Hospital. These patients were put on the personalised care plan for last days of life and were seen by the hospital's end of life care facilitator.

Patients with more than two weeks to live, who wished to return home and had family support to do so, and who had no specialist palliative care needs were put on the community health care fast track pathway. They were discharged home or to a nursing home once suitable community packages of care were in place. We were told access to community packages of care varied locally. The average time taken to arrange a community package of care was four to five days, however it could take up to 10 days. Patients that had less than 2 weeks to live were transferred to their preferred place of death with the support of Christchurch Hospital palliative care unit hospice or home care team.

Delayed discharge

Around a third of end of life care patients died in the hospital while waiting to be discharged on the community health care fast track process. The consultant in palliative care medicine told us this was recognised as a high priority area by the local Clinical Commissioning Group. They said a review of community end of life care services and a report was due in January 2014. Delay in accessing community-based intensive packages of care was the main concern identified in the end of life care pathway.

Assessment

The hospital was piloting the use of Assessment, Management, Best Practice, Engagement, and Recovery uncertain care bundles (known as AMBER) on the Stroke Ward. It is a tool to assess and manage clinical care for patients who deteriorate rapidly and whose recovery is uncertain. It helps clinicians decide when a patient should receive full medical intervention or alternatively move to symptom control and end of life care.

Its aim was to identify earlier when a patient's condition deteriorated and end of life care was appropriate. If the patient deteriorated an escalation plan was agreed, which enabled quicker response to the patient's changing condition. The consultant in palliative medicine said the implementation of end of life care escalation plans presented a major training issue for consultants and doctors in training.

Are end of life care services well-led?

We found end of life care services were well-led.

Steering group

The trust's recently re-launched End of Life Steering Group aimed to drive change and facilitate education and training in end of life care. With the deputy medical director as chair, we were told this group was influential in raising the profile of end of life care at senior management and trust board level.

All clinical staff told us improvement in end of life care had become a major priority for the trust over the last 12 months. There were fundamental changes in the care pathways for patients at the end of life, including the appointment of an end of life care facilitator to support implementation of the new personalised care plans for end of life care and other initiatives.

Staffing

The consultant in palliative medicine led the trust's specialist palliative care team and associated services. They demonstrated great vision, energy and commitment to palliative care and end of life care services. They were clearly very highly regarded by other medical and nursing colleagues around the hospital, and had influence in the trust.

The specialist palliative care nurses and the end of life care facilitator demonstrated high levels of specialist knowledge about their roles and were passionate about ensuring good quality care for patients at the end of their life.

The end of life care facilitator worked closely with the palliative care team but the management and supervision arrangements for the end of life care facilitator were unclear and complicated. They reported to three different managers for different aspects of their role. We felt there was insufficient clinical supervision and support for this important role. It would benefit from becoming part of the trust's mainstream palliative care team structure.

End of life care

Staff feedback

End of life care across the hospital was still a developing service. Many of the wards we visited were providing high standards of end of life care for patients and their relatives. We observed excellent leadership from a number of charge nurse/ward sisters on the wards visited. Staff said they were proud to work at the hospital and we observed a caring patient-focused culture on most of the wards we visited.

Feedback from clinical staff on the wards was very positive and they valued the support, training and advice provided by the end of life care facilitator. We were told the continuation of this post and the associated management arrangements are due for review by the trust in February 2014.

The trust was involved with the local Clinical Commissioning Group's review of end of life care services in the community. They were actively engaged with colleagues in the community to improve the pathway of care for people at the end of life. In this way, the trust was contributing to the leadership of end of life care services outside of their direct management control.

Outpatients

Information about the service

The hospital Outpatients Department (OPD) sees over 300,000 patients a year. Some patients visit the department for consultations or to undergo diagnostic tests such as endoscopies, X-rays and blood tests. Some minor procedures and investigations may also be carried out, such as biopsies. There are also clinics for prosthetics and appliances such as orthodontics.

The main OPD area consists of a central reception desk, waiting areas with facilities for light refreshments, male, female and disabled toilet facilities and clinical consultation and treatment rooms. The radiological services include X-ray services, ultrasound services, CT and MRI imaging and procedures undertaken under X-ray control.

We inspected the OPD services on 24 and 25 October 2013. We visited the main OPD, X-ray department, and orthodontics, and attended various clinics. We talked to 19 patients, used information from comment cards left in the reception area and talked to people attending a public engagement event. We looked at health records, risk assessments, incident reports, and minutes from meetings, rotas and training records. We also talked to 12 staff working in the various outpatient clinics and used information from staff focus groups.

Summary of findings

The outpatients department generally provided a caring and effective service for patients. There was much praise for the dedication of the staff. Feedback from patients was positive. The trust had not, however, been responsive about issues with waiting times and communication.

Individual clinics were well-led, with clinical staff taking responsibility for the organisation and arrangements as needed. However, quality assurance and risk management to ensure safety was not always supervised appropriately. There were infection control risks, for example the main outpatient reception, the floor sinks and the waste bins in the female toilets were not clean. The sluice room was cluttered with obsolete equipment and the hand wash sink and draining board was stacked with used clinical dressing packs. Staff entered the sluice with dirty packs. adding to the pile, and left without washing their hands. Staff were not clear about the measures in place to monitor infection control standards in the outpatient areas throughout the hospital.

Are outpatients services safe?

The outpatients department was not always safe.

Incident reporting

Incidents, near misses and allegations of abuse were reported through a central reporting process. Although diagnostic services such as X-ray had reported events, the OPD had few recorded untoward incidents over the past year.

The deputy general manager for the OPD told us that clinical risk was delegated to the clinical team leaders, who undertook the day-to-day management of the department. The clinical OPD staff told us that any incidents occurring usually related to falls. We asked what action they would take if a patient fell in the OPD and they clearly described the incident reporting process and the emergency treatment they would provide following an incident.

Outpatients

We explored an incident where a patient had a serious fall in the department. Staff told us it had been investigated, but they could not find a Slips, Trips and Falls risk assessment for OPD. They said that although the reporting culture was improving, there wasn't enough time to complete work in clinics as well as the additional documentation associated with incident reporting. They told us that issues were discussed at team meetings, but formal minutes of the meetings were not kept. Staff were aware of the trust's systems and processes to manage risk, however, it was unclear what actions took place to reduce the risk of recurrence.

Risk management

The X-ray department had robust risk management processes in place, which worked well in practice. Staff told us about the systems and processes in place to reduce radiological risks. There was an open reporting culture, which was evident by the number of incidents reported and the resulting action taken to reduce risks. The Radiation Protection Committee met twice a year to discuss any incidents. We saw an example of where such an incident had been immediately escalated through the trust's Clinical Governance Group. After an urgent meeting, measures were quickly put in place to reduce the risk of recurrence.

Safeguarding

The trust's lead for Safeguarding Vulnerable Children told us that she was working with various outpatient departments throughout the hospital that saw and treated children. She told us that training in safeguarding children was mandatory for all staff across the trust. The Safeguarding Children Group met quarterly and worked to ensure that staff were confident when dealing with suspected child abuse. We were told that the improved awareness of safeguarding had resulted in a higher number of referrals. Staff in the OPD clearly described the action they would take if they suspected child abuse, which included contacting the patient's GP. The trust had robust arrangements in place to safeguard children and vulnerable adults from abuse.

Infection control

Patients and staff were at risk of poor hygiene practices in the main outpatient department. Infection control policies and procedures were available for staff on the trust's intranet. Infection control was included in the 2013 Clinical Mandatory Training Programme, and all clinical staff were expected to undertake this training annually. There was a designated infection control lead in the department.

Hand gel and information on the importance of hand hygiene was available for patients. Patients told us that OPD services were always kept clean, tidy and hygienic.

However we had concerns about infection control. When we first visited the main outpatient reception, the floor, sinks and waste bins of the female toilet facilities were not clean and presented an infection risk. We checked several times during the day. The facilities were not attended to and their condition deteriorated further. The sluice room in the main OPD was cluttered with obsolete equipment and old picture frames on the floor, making cleaning difficult. We saw a bed pan and plastic jug on the floor under the sink. The hand wash sink and draining board was stacked with used dressing packs. Staff entered the sluice with dirty dressing packs adding to the pile, and exited without washing their hands. The OPD deputy manager was unaware what measures were in place to monitor infection control standards in the OPD departments throughout the hospital.

Staffing

There were sufficient staff on duty in outpatients to provide safe care. However, staff told us that maintaining a safe staffing level with appropriately qualified and experienced staff remained a constant challenge and that staff sickness had on occasions caused clinics to be cancelled. Staff told us how they valued the support of volunteers who took a lot of stress off the clinic staff during busy periods. They said that bank staff that were untrained in outpatients were used frequently. Long term sickness was a serious concern, which put additional strains on the OPD when they were at capacity for both clinic space and staffing. We found that lack of trained OPD staff was challenging and had led to the cancellation of clinics; however, staff worked hard to reduce the impact on patients using the service.

Outpatients

Are outpatients services effective?

The outpatients department generally provided effective care.

Risk management

The Royal Bournemouth Hospital had systems intended to ensure that staff adhered to clinical guidelines and recognised best practice through the Clinical Governance and Risk Management Group and staff training opportunities. However such guidelines were not always followed.

The deputy manager told us that she attended the group at a departmental level and any relevant information was then cascaded to the team. The department had initiated meetings to discuss issues such as risk management and best practice. One meeting had been held since August 2013, but formal minutes were not kept. Various staff members had individual responsibilities for different aspects of the performance management of the department, such as infection control, staff training, appraisals, staff duty rotas and managing the clinics.

Clinical staff told us that the trust required an annual risk assessment of the outpatients department. The Governance Audit Tool (a generic health and safety risk assessment) last took place in July 2013. Outstanding actions noted in July showed that the department had not completed any risk assessments. We queried the robustness of the audit, as although it documented that risk assessments had been completed following adverse incidents involving slips and trips, these were not in place.

Patient records

The clinical records completed in outpatients followed the patient through their care and treatment. The records were individual according to their care pathway. We looked at the urology screening and health questionnaire, which was completed during an outpatient appointment. This detailed the patient's medical, social and surgical history, and noted any allergies and lifestyle information. 'Baseline' observations were included in the patient's records, to be available when they were admitted for surgery. The records contained all the information required to ensure good communication between the patient and the healthcare professionals caring for them. We were told that record-keeping audits were not undertaken. Staff told us there was a good system in place to ensure that the appropriate records were available for the right clinic.

Patient information and advice

Patients accessing outpatient services did not always have easy access to advice and information to inform their hospital visit. Information in the main OPD mostly concerned transport arrangements and making complaints. There was an empty rack where public information leaflets could be provided and little information available about the hospital's services and how to access them. Other outpatients departments and diagnostic services did have more information available. For example, the pre-assessment clinic provided information about what to expect when coming into hospital for day surgery, this was also available in an easy to read format.

Although 16% of the local population was of ethnic origin, we did not see any information in other languages or any information about how to access information in other languages. Staff told us that interpreting and translation services were available if required. A child protection poster was available for use when children's clinics were held, but there was no information regarding children's centres or how to access help or advice. The hospital's website gave information about the outpatient services available and what patients could expect when accessing them.

Multi-disciplinary working

Outpatient services supported multi-disciplinary working and worked well in partnership with other departments and organisations to ensure the needs of their patients were properly managed and met. Staff told us how they worked with other departments in the hospital and with local GP surgeries and the ambulance service. Other outpatient services worked collaboratively within the community, depending on the speciality. For example, the Bournemouth Diabetes and Endocrine Centre (BDEC) service provided a community-based service for patients with new onset Type 2 diabetes. The service provided a foot care service and held joint clinics with the ophthalmology consultant.

Outpatients

Training

Staff received appropriate training and development to enable them to deliver safe and effective care. We spoke with the member of staff with responsibilities for overseeing the training and development of staff in the main outpatient department. Training records and files demonstrated that staff had opportunities to attend further training and development. The trust's annual training in subjects such as manual handling, fire prevention and infection control was mandatory.

Supervision and appraisals were managed by the staff member's immediate line manager and overseen by a clinical lead. Staff in diagnostics had more formal training and professional development opportunities, which were closely monitored by their line manager. We saw examples where staff were developing their skills and experience in new techniques such as diagnostic angiograms and reporting. There were systems in place to support staff training and development. Staff were supported through regular supervision and appraisals.

Are outpatients services caring?

The outpatients department is caring towards its patients.

Privacy

Staff generally respected patients' privacy and dignity. Treatment was provided in single consulting or treatment rooms and most staff were mindful of protecting patients' privacy. Staff told us they were aware that the main OPD reception desk was open to the public and it was difficult to maintain confidentiality. They told us that if needed, they would use an empty room for a confidential or sensitive discussion. However, this didn't always happen. In the Diabetic and Endocrine Clinic we saw a clinician discussing personal information with a patient with the door open. This did not respect the patient's privacy or confidentiality.

Responding to feedback

There were many opportunities for patients to feed back their experiences of the outpatient department, such as comment cards and details of the complaints process, which were readily available. Staff welcomed their input and used this to improve the service offered. An example was where a patient had noted in the comments book in reception that there were no facilities for fathers to change babies' nappies. Following this, baby changing facilities had been added to the disabled toilets.

Complaints

When asked how complaints were managed, the deputy manager showed us a complaints/incidents calendar and said that complaints were usually given to the Clinical Team Leaders to investigate, and then any learning was fed back at staff meetings or individually. An example was where improving communication was required when a clinic was running late.

Feedback from patients

Patients told us the reception staff were always helpful and provided clear information and advice. All the patients we talked to said they felt listened to and fully involved in their care and treatment. One patient attending the Orthopaedic Clinic told us it was "an exceptional service." Patients told us they didn't feel rushed. Another patient attending a pre-admission clinic told us that the nurses were kind and friendly and helped to reassure them about the admission process. All the people who spoke with us praised the dedication of the staff, telling us they were very friendly and caring with "excellent" attitudes, which gave them confidence and reassurance in their care and treatment. This demonstrated the outpatient service was patient-focused.

Are outpatients services responsive to people's needs?

The outpatients department was not always responsive to people's needs. A number of improvements could be made for a better patient experience.

Availability

The Outpatients Department (OPD) had expanded the service it offered and was now at capacity for the space and staff available. Main outpatient services did not usually operate in the evening or at weekends; although staff told us that they had on occasion undertaken clinics outside of the normal opening hours in response to an identified need. They gave examples of weekend clinics to deal with a backlog of surgical patients, and where patients in a breast screening recall had been asked to attend the hospital urgently. The X-ray department was

Outpatients

now providing seven-day cover in response to a growing need for out-of-hours demand and reporting. This is an example of responding to the needs of the population using OPD.

Waiting times

The booking process was not always patient-focused and sometimes led to patients experiencing unnecessarily long waiting times. We spoke with patients about the long waiting times that often happened throughout the outpatients services. One patient told us of waiting in X-ray for an hour and a half, although a sign said the delay was 45 minutes. Several patients told us about long delays for blood tests in the Pathology Department. An electronic sign and information notices indicated the expected waiting time. We saw delays for several clinics. When we asked why, we were told a consultant was at a meeting. Staff told us overbooking was accepted, as more than one person was often booked for the same time slot. They told us this wasn't fair and said clinics should run for longer rather than adding "multiple people at one time". They told us how they tried to defuse the situation when people became angry with the long wait. Staff frequently went into the waiting room to update patients on the expected appointment time and made cups of tea for those waiting an exceptionally long time. Some clinics were better than others at planning to reduce waiting times. Patients attending the Orthopaedic Pre-admission Assessment Clinic all told us that they didn't have long to wait and they were treated with "speed and efficiency".

Communication

One patient told us that the information on the appointment letter was not clear. They told us they were not certain they were in the right department. They told us that they had a similar letter previously, which told them to go to the wrong hospital. Another patient told us they had received a hospital appointment but they weren't sure what it was for, so they contacted their GP who told them. They told us "I hadn't received any information so I was a bit confused as to what the appointment was about."

Are outpatients services well-led?

The outpatients department was not consistently well-led.

Risk management

The deputy manager attended a range of management groups on behalf of outpatient services, including the Clinical Governance and Risk Management Group. However the added value of the groups could not be expressed by the department staff.

Management activity such as quality assurance and risk management were delegated to the senior nursing staff. The Clinical Team Leaders and their deputies told us how they monitored the quality of care and treatment in outpatients. Individual members of staff in the nursing team had delegated responsibilities, for example, one member of staff had responsibilities for infection control. We asked to see the infection control audits, but these were not available. We observed poor practice that the nursing team had not identified and had ignored as accepted practice. We had concerns that infection control was not being monitored effectively.

On the first day of our visit the most recent risk assessments we found were dated 2010. Staff could not tell us what action had been taken following any incident or who was monitoring the quality of care and treatment in OPD. On our second visit we saw the generic Governance Audit 2013, which was undertaken in July and two risk assessments. The audit identified that there were no risk assessments in place in the department. Clinical staff spent their time on the day-to-day running of the clinics. One senior staff member told us "We don't have the best service but we do our best with what we have." There was no evidence that risks were being proactively managed or that identified concerns were monitored and followed up. However, this was not the same for all outpatient services – for example, the Radiology Department demonstrated strong leadership and had an embedded risk management culture that protected patients from the risk of poor practice.

Outpatients

Children received care seen in various outpatient settings throughout the hospital but there were no paediatric risk assessments of the environment to make sure it was safe and suitable for them. For example, we saw maintenance men working in the department leaving their tools unsupervised close to young children. Staff were unaware that any special measures should be put in place to ensure that children were kept safe and that they received age-appropriate care while attending the hospital as outpatients. Few outpatient clinics or departments had child-friendly information available. The orthodontics department, which saw and treated children aged seven to 18 daily, was clinical in nature and did not present as a welcoming and friendly environment for young children. This had not been identified through any audit or monitoring of the quality of service.

Views of staff

Staff told us the OPD was a strong committed team who worked well together to ensure that patients' needs were met. They told us that that OPD's strength was the support that staff offered each other and how well they worked flexibly together as a team. They told us they had good relationships with their managers. Staff identified individual nurses in charge of certain clinics, such as orthopaedics, and told us how they were approachable and had a good overview of what was happening in the clinic. Most staff told us that although it was stressful, they felt the OPD was a good place to work.

Good practice and areas for improvement

Areas for improvement

Action the trust MUST take to improve

We have set compliance actions that we will follow up within three months of receiving the provider's action plan.

- All patients need to have their needs assessed and care delivered safely and in a timely manner by staff who are skilled to do so.
- At all times, patients must be treated with the dignity and respect they deserve and basic care needs must be met.
- The trust must reassure itself and stakeholders that all opportunities to drive quality improvement and quality assurance are taken.
- The trust must ensure that the required number of staff with the correct skills are employed and managed shift by shift, to demonstrate that there are sufficient staff to meet people's needs.

Areas of good practice

Our inspection team highlighted the following areas of good practice:

- Some aspects of end of life care were undertaken very well.

Other areas where the trust could improve

- The stroke pathway before patients are admitted to the stroke ward.
- Levels of nursing staff in wards, especially those caring for the frail elderly patients, did not reflect the dependency of patients. This meant there was a high risk and actual occurrences of patients not receiving the care they needed in a timely manner.
- Care planning and evaluation did not contain all relevant information and staff on duty did not always know the specific care needs of people.
- Staff did not have all mandatory training on time and or were not suitably trained for the areas in which they may work, for example, in dementia care, and to perform the necessary tests to assess whether a patient is able to swallow.
- Security arrangements in A&E leave staff feeling vulnerable.
- Escalation beds in AMU and A&E were considered dangerous and not fit for purpose.
- Junior medical staff in surgical services required more support out of hours.
- Patients did not always have informed consent by doctors who are fully aware of procedures.
- The mental health care pathway in A&E is not a 24-hour service.
- A&E does not always provide care for children from suitably-qualified staff at all times.
- Records for care and for incidents are not always completed in full and in a timely manner.
- The outpatient booking process was not always patient-focused and sometimes led to patients experiencing unnecessarily long waiting times.

This section is primarily information for the provider.

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Diagnostic and screening procedures. Treatment of disease, disorder or injury.	**Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Regulation 17: Respecting and involving service users** (1) The registered person must, so far as reasonably practicable, make suitable arrangements to ensure – (a) the dignity, privacy and independence of service users (2) The registered person must – (a) treat service users with consideration and respect. Patients, their relatives, and staff told us about incidents where people had not been treated with dignity and respect. Patient's requests for assistance to use the toilet had not been met in a timely manner causing them to be incontinent. People told us that they had seen a patient exposed with no consideration for their dignity.

This section is primarily information for the provider.

Compliance actions

Regulated activity	Regulation
Diagnostic and screening procedures. Treatment of disease, disorder or injury.	**Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Regulation 9: Care and welfare of service users** (1) The registered person must take proper steps to ensure that each service user is protected against the risks of receiving care or treatment that is inappropriate or unsafe, by means of – (a) the carrying out of an assessment of the needs of the service user; and (b) the planning and delivery of care and, where appropriate, treatment in such a way as to – (i) meet the service user's individual needs, (ii) ensure the welfare and safety of the service user Patients and their relative reported that they were restricted from eating and drinking by mistake. Planned care was not being delivered in respect to wound care. People reported that their relative was not supported to eat and drink on the ward.

This section is primarily information for the provider.

Compliance actions

Regulated activity	Regulation
Diagnostic and screening procedures. Treatment of disease, disorder or injury.	**Health and Social Care Act 2008 (RegulatedActivities) Regulations 2010 Regulation 10: Assessing and monitoring the quality of service provision.** (1) The registered person must protect service users, and others who may be at risk, against the risks of inappropriate or unsafe care and treatment, by means of the effective operation of systems designed to enable the registered person to – (a) regularly assess and monitor the quality of the services provided in the carrying on of the regulated activity against the requirements set out in this Part of these Regulations; and (b) identify, assess and manage risks relating to the health, welfare and safety of service users and others who may be at risk from the carrying on of the regulated activity. (2) For the purposes of paragraph (1), the registered person must – (b) have regard to – (v) reports prepared by the Commission from time to time relating to the registered person's compliance with the provisions of these Regulations, and (e) regularly seek the views (including the descriptions of their experiences of care and treatment) of service users, persons acting on their behalf and persons who are employed for the purposes of the carrying on of the regulated activity, to enable the registered person to come to an informed view in relation to the standard of care and treatment provided to service users The overall governance of the trust had not taken account of the experiences of patients and staff to improve the service provision. The Trust had not ensured all reporting systems were robust and findings acted upon in a timely way to improve patient care.