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 rating for this hospital

<table>
<thead>
<tr>
<th>Service</th>
<th>Requires improvement</th>
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</thead>
<tbody>
<tr>
<td>Accident and emergency (A&amp;E)</td>
<td>Requires improvement</td>
</tr>
<tr>
<td>Medical care</td>
<td>Good</td>
</tr>
<tr>
<td>Surgery</td>
<td>Good</td>
</tr>
<tr>
<td>Critical care</td>
<td>Good</td>
</tr>
<tr>
<td>Maternity and family planning</td>
<td>Good</td>
</tr>
<tr>
<td>Services for children and young people</td>
<td>Good</td>
</tr>
<tr>
<td>End of life care</td>
<td>Requires improvement</td>
</tr>
<tr>
<td>Outpatient services</td>
<td>Good</td>
</tr>
</tbody>
</table>

Letter from the Chief Inspector of Hospitals

The Northern Devon Healthcare NHS Trust operates across 1,300 square miles and provides both acute hospital care and community services. The North Devon District Hospital in Barnstaple provides a full range of district general hospital services.

We carried out a comprehensive inspection because Northern Devon Healthcare NHS Trust was an aspirant foundation trust. Trusts wanting to become a foundation trust have an inspection as part of that process. The inspection took place between 2 and 4 July 2014. An unannounced visit also took place on 14 July 2014.
The trust incorporates both an acute hospital setting and community locations, of which, some provided a limited level of acute service. For example, various clinics, including dermatology and gynaecology clinics. The acute report reflects the service provided at the North Devon District Hospital and does not include any of the community locations or locations providing services linked to the hospital.

Overall most areas of the inspection showed good outcomes for patients.

Improvements are needed to achieve a consistent performance in the Accident and Emergency department and to aspects of the End of Life care service provided in the acute hospital.

Our key findings were as follows:

- Patients and relatives were all clear that the care provided by staff at the North Devon Hospital was very good. They found the staff to be kind, supportive and helpful.
- There was a very positive atmosphere at the hospital. We found staff engaged with us and were willing to support the inspection process. Staff told us about an open and honest culture with strong teamwork.
- We saw the hospital was clean. However, the infection control policies of the trust were not consistently followed by staff.
- There were delays in admitting patients, a number of patients were not admitted to the most appropriate area (outliers) and the number of patients being moved at night raised questions about the overall effectiveness of night time arrangements. The CQC team felt that this was unusual given the relatively low bed occupancy rate in the district hospital.
- Nursing and medical staff training was encouraged and staff told us that, mostly, they were supported and encouraged to attend training to develop the care standards at the service. However, there was a lack of evidence of specialist qualifications and competency framework for nursing staff in A&E. There was also a lack of visibility of senior medical and nursing staff.
- We saw issues around recruitment including the challenge of attracting specialists to what is a relatively isolated part of the country. However, the trust showed creativity with solutions to recruitment issues. These also included participation in the Learning Disability Preparation for Employment Scheme.
- Mortality rates were not raised as a concern at this trust.
- Nutrition and hydration was managed well for patients although improvements are needed in this area in maternity services.
- Within the acute hospital there were aspects of safety and responsiveness that required improvement. The issues included medicines management and the environment in the surgical admissions lounge.

We saw several areas of outstanding practice, including:

- On Alex Ward, they had recently had a ‘street party’ for the patients there. Many of these patients were living with dementia and efforts had been made to use reminiscence to help them to enjoy the afternoon. Staff had dressed up in 1940s costume and appropriate music had been played. Photographs of this event were displayed in the ward and patients had clearly enjoyed themselves. This was evidence of outstanding, appropriate emotional support for the ward population. The nursing, medical, therapy and ward clerk staff on Alex went “all out” to deliver the street party. They planned it around their normal day to day work. Articles in the local paper showed very happy patients and staff who had dressed up and brought in specific reminiscence music for the occasion. Someone else made cakes.
- The acute paediatric team demonstrated excellent collaborative working providing end of life care for
children in their own homes

- Leadership and teamwork in theatre was exemplary, despite staff shortages.
- There was thoughtful and compassionate care for those patients living with dementia particularly on Alex Ward and Caper Wards where care was patient centred and holistic in its approach. A robust dementia policy ensured the highest standards of personalised care using all therapeutical staff was put in place. There had been an investment in staff to develop dementia care practice.
- The nursing leadership of the acute stroke service was very highly regarded by medical, therapy and nursing staff. Staff felt valued and the service itself was very patient focused placing a high value on emotional support.
- The Trust’s successful involvement with Project Search, an innovative scheme that supports young people with learning difficulties to find permanent work, was modelling excellent practice to local employers. The trust had provided 12 month internships to seven young people, all of whom had successfully completed the programme and had found permanent jobs, six of them with the trust in areas such as medical records and catering.

However, there were also areas of poor practice where the trust needs to make improvements.

Importantly, the trust must:

- Review and improve arrangements for the assessment and management of the prevention, and control of the spread of health care associated infection. This includes ensuring that suitable equipment is provided and used, that all areas are kept clean and tidy and ensuring that staff are consistently following trust policies.
- Evaluate and improve the effectiveness of the current patient flow and escalation policies. Action must be taken to improve the flow of patients from Accident and Emergency department and across the trust. The policies and procedures for patients who are not admitted to the most appropriate ward (outliers) need to be clear, focused on the best interests of patients and consistently applied. The criteria to be applied to decisions on the movement of patients and the protocols to be followed must be clear.
- Ensure that there are suitable arrangements in place for obtaining, and acting in accordance with, the consent of service users in relation to the care and treatment provided for them. The trust must make sure that staff are aware of and consistently apply these arrangements.
- Ensure that the facilities for the sonography service are such that the safety, privacy and dignity of patients can be maintained. Rooms used by sonography staff must have a system for calling help in the event of an emergency.
- Ensure that there is a system in place, supported by guidance, for the completion of HS A 1 (grounds for carrying out an abortion) and HS A 4 (abortion notification). These records must be completed accurately and consistently and forwarded to the Department of Health as required.

In addition the trust should:

- Ensure the implementation of pain assessments. We saw poor use of pain measurement as comfort rounds did not include pain assessment.
- Consider reviewing some areas of the environment including in A&E with regard to the lack of visibility of patients in the waiting area. Also the trust should consider plans to improve the facilities and environment in the intensive care unit, in order to achieve best practice standards and consider improvements to the facilities and environment in anaesthetic rooms to address infection control risks.
- Review medicines storage security arrangements in the intensive care unit to achieve best practice standards.
- The trust should also consider improving the environment of children’s services, as the environment
of the ward made it challenging to meet the differing needs of patients and parents, with no single-sex provision.

- Ensure a clear protocol for doctors to follow when caring for a deteriorating patient in the intensive care unit and surgery. There was no clear protocol, pathway, or standard operating procedure for the doctor’s responsibility for managing the deteriorating patient. There were also poorly implemented early warning scores (EWS) in A&E and the trust should consider how this is managed.

- Consider the management of clinical assessments in the A&E department. We saw there were long waits for clinical assessment of non-ambulance patients and no monitoring of waiting patients. The flow of ambulance patients was disjointed and not designed to meet national targets.

- Staff in A&E should be aware of clinical audits, and how the results compare with national standards.

- The trust should consider the deployment of senior staff in the A&E department; we saw a lack of visibility of senior medical and nursing staff. Nursing leadership was shared with other departments within the trust. There was limited support for junior staff needing advice in difficult clinical and organisational situations.

- The trust should also further ensure that all medical staff have job plans that are regularly reviewed as part of their appraisal process. We had difficulty in establishing specialist qualifications or a competency framework for nursing staff in A&E.

- Security staff should have suitable training to manage violence and aggressive behaviour safely in the A&E department.

- Demonstrate that the critical care service takes accountability for learning and improvement, with minutes and actions plans produced from clinical governance meetings.

- Consider information provided through external reviews and work with medical teams as suggested in the Royal College of Obstetricians and Gynaecologists (RCOG) report provided to the trust in March 2014 to ensure they engaged in processes designed to reduce the caesarean section and induction of labour rates.

- The trust should also consider that in light of the RCOG report the need to keep staff informed of the recommendations and actions to be taken.

- Consider the risks with the admission of young people requiring intensive mental health support. However, we are aware that this is recognised and that there are plans in place for an urgent assessment protocol.

- Ensure there is nutritious food available to parents and breastfeeding mothers, apart from breakfast cereal.

- Consider that Patients be met and admitted into the day surgery unit when they arrive and the overall experience of the day surgery unit be improved to ensure patients comfort, dignity and confidentiality.

- Ensure that Safety Thermometer data and patient assessments on wards be improved, to address the degree of patient harms from pressure ulcers and infections.

- Demonstrate that the surgical service takes accountability for learning and improvement by actions plans produced from clinical governance meetings.

**Professor Sir Mike Richards**  
Chief Inspector of Hospitals
Our judgements about each of the main services

<table>
<thead>
<tr>
<th>Service</th>
<th>Rating</th>
<th>Why have we given this rating?</th>
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<tbody>
<tr>
<td>A&amp;E</td>
<td>Requires improvement</td>
<td>The emergency department had a caring and committed team of staff with a strong team ethos. There was evidence that the department reported incidents. However, we were concerned that lessons learnt were not always fully embedded into practice. There were significant infection control issues within the department. The physical layout of the department and waiting times for nurse assessment did not ensure the safety of patients in the waiting room. The department was struggling to meet national targets for the handover of ambulance patients and the ability to admit or discharge patients within four hours. A trust-wide action plan to address these issues was commenced at the beginning of the year, but had lost momentum in the months prior to our inspection. Although staff worked well together, there was no clear management structure and nursing leadership was shared with other parts of the trust. Multidisciplinary working was good and staff felt well supported in their roles.</td>
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<tr>
<td>Medical care</td>
<td>Good</td>
<td>We found high levels of patient, relative and staff satisfaction with the care delivered across the medical wards. Although there was evidence of much safe practice, we had concerns about the practice of moving patients overnight. Overall, medical services were effective. There was a lack of consistency of effectiveness in overnight bed management, but there was also clear evidence of mechanisms of effectiveness in place throughout the directorate. On each unit we inspected, the delivery of care and treatment was compassionate and caring. We saw some outstanding delivery of care where staff had planned and held a street party on the ward for those patients living with dementia. Feedback from the friends and family test was high and supported by verbal feedback from patients relatives. Patients and relatives were actively involved in decision making about treatment, care and discharge. Relatives and patients commented positively on their experiences on the wards. Medical services were mainly responsive to local needs. There was an excellent provision of specialist</td>
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</tbody>
</table>
Service-delivery plans had raised a need for further dementia bed provision and the capital funding for this had been successful.

Overall, the medical services unit was well-led. Staff told us they felt well-supported by their managers and senior management team. They said that the quality of care and treatment delivered was of the utmost importance to the trust.

<table>
<thead>
<tr>
<th>Surgery</th>
<th>Good</th>
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<tr>
<td>Care and treatment provided by surgery services was safe and effective. Almost all patients and their relatives spoke highly of the service received and the care and treatment they received. Staff were caring, kind and considerate of their patients and treated them as individuals. Patient records were mostly done well, but some improvements were needed in pain and nutrition assessments. Patient assessments for safety risks needing improving in order to reduce pressure ulcer and urinary tract infection incidence. Infection control was mostly done well, but spot check audits for infection control on inpatient wards were not showing consistent improvement. Patient outcomes were good and mortality and infection rates were low. Operating theatres met targets for referral to treatment times in all surgical specialities. Staff learned from incidents and serious events and felt confident to report incidents. The surgical teams responded proactively and positively to adverse events to bring about improvements. Patient consent was obtained in accordance with legal requirements. People in vulnerable circumstances were safeguarded and patients were treated in their best interests. Staffing levels in theatre were not at full strength. New staff had been recruited but the current staff group were working extra hours to ensure continuity of the service as there were not enough agency staff available to provide cover. Staff were well trained and their competence was regularly assessed. There was strong and respected leadership in theatre and inpatient wards. Staff were committed to each other and their patients. Out-of-hours emergency surgery was led by consultants and there was adequate theatre time for anticipated emergency surgery or procedures. The environment of the surgical admissions lounge was poor in terms of the patient experience. This was with respect to patient comfort, dignity and confidentiality. The anaesthetic rooms should be improved to assist in infection prevention and control. Patient outliers and handovers between wards must be improved.</td>
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</table>
**Critical care**

**Good**

- Care provided by the critical care team was safe and treatment delivered was effective. Staff were caring and patients were treated as individuals. Their needs were met by considerate and compassionate staff. The service was well-led at both department, nurse and medical staff level. The team worked well together and this was commented upon by staff, patients and visitors.

  Patients were happy with their care and all the discussions we had with patients were overwhelmingly positive. There was good multidisciplinary input into patient care to enhance recovery and discharge from the unit.

  There were some instances of the discharge of patients not being at an optimal time. The majority of patients were not discharged at night, but some left the unit earlier than was ideal, to make room for unplanned emergency admissions. In busy times, some patients were discharged back to the wards to free bed space for more acutely-unwell patients. There was no step-down facility to a high dependency unit (HDU), as the hospital did not have a dedicated HDU.

  The unit was small and there had been no renovation to bring the unit up to modern standards of facilities and equipment since it was built in the 1970s. It was, therefore, not able to respond to all treatment, or integrated care pathways.


**Maternity and family planning**

**Requires improvement**

- The maternity and family planning services were found to be safe, effective, caring and responsive but required improvement in order to be well-led. The care and support offered to women and their families was compassionate, kind and informative.

  Staff referred to a Royal College of Obstetricians and Gynaecologists (RCOG) visit, commissioned by the trust in November 2013, to “obtain an external view of the impact of the medical team working on patient safety”. A report was sent to the trust on 4 March 2014 and an action plan developed by the trust. The developments from this report were needed to address long standing, complex relationship issues around this staff group.

  The trust did not consistently meet the legal reporting requirements of HSA1 (grounds for carrying out an abortion) and HSA4 (abortion notification), as required. There was no guidance, or an identified system in place to ensure records were completed both accurately and consistently.

  Rooms used by sonographers in the antenatal clinic were not big enough to allow for privacy and dignity of women to be maintained without the practitioner having to leave the room. The rooms did not have a system for calling for help in the event of an emergency.
The caesarean section and induction of labour rates were above the national average for a low-risk unit. The maternity unit were working to reduce the numbers, by promoting normal birth within the staff group and to pregnant women.

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<tr>
<th>Services for children and young people</th>
<th>Good</th>
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<tbody>
<tr>
<td></td>
<td>We found children’s services to be safe. Parents told us that staff were caring and we saw that children and their parents and carers were treated with dignity, respect and compassion. Ward areas and equipment were clean.</td>
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<tr>
<td></td>
<td>There were contingency plans in place if there were staff shortages and/or the wards were full. Patients requiring intensive mental health support were cared for by agency staff with mental health training. There was a multidisciplinary proposal for an urgent assessment protocol.</td>
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<td></td>
<td>There were thorough nursing and medical handovers that took place between shifts to ensure continuity of care and knowledge of patient needs. We saw evidence of outstanding collaborative working, both within the units and with the community paediatric nurses.</td>
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<tr>
<td></td>
<td>We found that the environment within the ward made it challenging to accommodate the differing needs of patients, of infants, including those whose mothers were breastfeeding, and of children and young people requiring care and treatment.</td>
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<tr>
<td></td>
<td>We saw evidence of planning for future sustainable children’s services and learning from incidents. We also saw how the service made good use of the skills and resources it had.</td>
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<table>
<thead>
<tr>
<th>End of life care</th>
<th>Requires improvement</th>
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<tr>
<td></td>
<td>We saw End of Life services were caring, responsive and well-led but required improvement in order to be safe and effective. We saw that the specialist palliative care team supported ward-based staff with end of life care and that they were committed to the development of staff in general areas to develop their end of life care skills and improve end of life care for patients across the trust.</td>
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<td></td>
<td>Treatment escalation plans (TEP) including do not attempt cardio-pulmonary resuscitation (DNA CPR) decisions were not always completed appropriately, a significant number that did not include documentation of treatment discussions with patients or relatives.</td>
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<td></td>
<td>We saw that not all patients at the end of life were having regular assessments of their pain. We saw one example of a patient who was in pain, but had not been routinely asked about pain relief.</td>
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</table>
We were told that staff were caring and compassionate and we saw that the service was responsive to patients’ needs, in particular, we saw evidence that rapid discharge home was arranged for patients at the end of life who wished to be cared for at home. Despite there being issues with capacity within the specialist palliative care team, staff were responsive to the needs of patients at the end of their life and we saw evidence of service planning to continue to meet those needs.

We saw evidence of good leadership of the specialist palliative care team, where they were highly visible, and focused on the education and development of good quality end of life care services. We viewed evidence of end of life care support at board level. However, we did not see evidence of proactive practical support in terms of creating capacity to enable the specialist palliative care team to deliver changes they had identified as necessary.

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<tr>
<th>Outpatient services</th>
<th>Good</th>
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<tr>
<td></td>
<td>The environment in the main outpatient department and associated clinic areas was clean, reasonably comfortable, well maintained and safe. Infection control procedures were not always followed by clinical staff in relation to the trust policy of ‘bare below the elbow’.</td>
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<tr>
<td></td>
<td>Staff were professional and promoted a caring ethos. Compassionate care was provided and staff interacted with patients in a friendly manner while treating people with dignity and respect.</td>
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<td></td>
<td>Patients said that they felt involved in their care. The booking and running of clinics was efficient, with limited waiting times for patients.</td>
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<tr>
<td></td>
<td>Staff were provided with leadership and an ‘open’ culture was promoted in which staff felt engaged with the trust. Staff took pride in the quality of care and treatment provided by the outpatient department.</td>
</tr>
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</table>
North Devon District Hospital

Detailed findings

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North Devon District Hospital

Services we looked at
Accident and emergency (A&E), medical care (including older people’s care), surgery, critical care, maternity and family planning, services for children and young people, end of life care, outpatients

Requires improvement

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Background to North Devon District Hospital

The Northern Devon Healthcare NHS Trust provides both acute hospital care and community services. The North Devon District Hospital in Barnstaple provides a full range of district general hospital services, including accident and emergency (A&E), critical care, coronary care, general medicine (including elderly care), general surgery, orthopaedics, anaesthetics, stroke rehabilitation, midwifery-led maternity care and a breast service.

The trust has a total of 644 beds, of which there are 341 at the district hospital in Barnstaple. The hospital has 2,111 staff.

From 2013 to 2014, the hospital treated 40,706 inpatients and had 553,748 outpatient attendances. The A&E department had 139,608 attendances.

Our inspection team

Our inspection team was led by:

**Chair:** Jan Filochwski, recently retired chief executive from Great Ormond Street Hospital for Children NHS Foundation Trust.

**Head of Hospital Inspections:** Mary Cridge, Care Quality Commission (CQC).

The team of 27 who inspected the acute hospital included CQC inspectors and a variety of specialists. These included a consultant physician in diabetes and acute medicine, a consultant in geriatric medicine, a surgeon in trauma and orthopaedics, an obstetrician, a consultant paediatrician, a deputy medical director, a junior doctor and an executive director of nursing and quality.

Further specialist support was provided by specialist nurses in governance and quality, a matron for clinical support, a deputy director of nursing, a lead nurse for critical care, children’s care, a palliative clinical nurse specialist and a student nurse. We also had the support of an expert by experience.

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.
- Medical care (including older people’s care).
- Surgery.
- Intensive/critical care.
- Maternity and family planning.
- Children’s care.
- End of life care.
- Outpatients.

Before visiting, we reviewed a range of information we hold about the hospital and asked other organisations to share what they knew about the hospital. These included the clinical commissioning group.
(CCG), the Trust Development Authority (TDA), NHS England, Health Education England (HEE), the General Medical Council (GMC), the Nursing and Midwifery Council (NMC), Royal Colleges and the local Healthwatch.

We carried out an announced visit on 2, 3 and 4 July 2014. We also undertook an unannounced visit on 14 July 2014.

During our visit, we held focus groups with a range of staff in the hospital, including nurses below the role of matron, Allied Healthcare professionals, junior doctors, student nurses, consultants and administration staff. Staff were invited to attend drop-in sessions. We visited ten wards and a variety of specialist units. We also visited the A&E department, medical assessment unit, critical care unit, theatres and seven outpatient clinics. We spoke with 84 patients and 26 visitors/relatives. We also spoke with 173 staff of all grades and one volunteer and looked at 65 sets of notes.

We held two listening events in Honiton and Barnstable, where patients and members of the public shared their views and experiences of the location. In Honiton on 26 June 2014, people shared their views and experiences of the community hospitals with us. In Barnstable on 1 July 2014 23 people shared their views about the North Devon District Hospital and about community services and hospitals. People who were unable to attend the listening events shared their experiences by telephone and email.

Facts and data about North Devon District Hospital

The trust consists of an acute hospital, North Devon District Hospital based in Barnstaple, which has 341 acute beds.

The North Devon District Hospital, as well as having acute beds, also provides secondary care services, including diagnostics, treatment and follow-up care, along with A&E, cancer care, orthopaedic surgery, paediatric and maternity services. The trust provides emergency care and minor injury units (MIU) across the community. The hospital provides medical and surgical care and has a stroke unit and wards providing dementia care.

North Devon has a population of 93,667. The trust serves 157,000 people in North Devon, plus 327,000 people in Eastern Devon (community only).

The demographics of northern and eastern Devon are broadly similar. However, Exeter has a significantly higher proportion of working-age people, and east Devon has significantly more older people, with more than a quarter aged 65 or older.

Northern Devon District Hospital Trust was last inspected in January 2014 and the hospital did not meet the standard for outcome 2: consent to care and treatment. This related to the use of do not resuscitate (DNACPR) records and their lack of full completion in the specific setting of Tiverton Hospital. We issued a warning notice. The community hospital this referred to has since been re-inspected and found to be compliant. We have looked at this issue at this inspection and in all areas inspected.
### Overview of ratings

Our ratings for this hospital are:

<table>
<thead>
<tr>
<th></th>
<th>Safe</th>
<th>Effective</th>
<th>Caring</th>
<th>Responsive</th>
<th>Well-led</th>
<th>Overall</th>
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<tbody>
<tr>
<td><strong>A&amp;E</strong></td>
<td>Requires</td>
<td>Inspected but</td>
<td>Good</td>
<td>Requires</td>
<td>Requires</td>
<td>Requires</td>
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<tr>
<td></td>
<td>improvement</td>
<td>not rated(^1)</td>
<td>improvement</td>
<td>improvement</td>
<td>improvement</td>
<td>improvement</td>
</tr>
<tr>
<td><strong>Medical care</strong></td>
<td>Good</td>
<td>Good</td>
<td>Outstanding</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
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<tr>
<td><strong>Surgery</strong></td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Requires</td>
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<td>improvement</td>
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<tr>
<td><strong>Critical care</strong></td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Requires</td>
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<tr>
<td><strong>Maternity &amp; family planning</strong></td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Requires improvement</td>
<td>Good</td>
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<tr>
<td><strong>Children &amp; young people</strong></td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
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<td>Good</td>
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<tr>
<td><strong>End of life care</strong></td>
<td>Requires improvement</td>
<td>Requires improvement</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Requires improvement</td>
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<tr>
<td><strong>Outpatients</strong></td>
<td>Good</td>
<td>Inspected but</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
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<tr>
<td></td>
<td>not rated(^1)</td>
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<tr>
<td><strong>Overall</strong></td>
<td>Requires</td>
<td>Good</td>
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<td>Requires</td>
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<td>improvement</td>
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**Notes:**

We are currently not confident that we are collecting sufficient evidence to rate effectiveness for both Accident and emergency and Outpatients.
### Accident and emergency

| Safe          | Requires improvement | | Effective | Inspected but not rated | | Caring      | Good | | Responsive  | Requires improvement | | Well-led    | Requires improvement | | Overall     | Requires improvement |

### Information about the service

The accident and emergency (A&E) department at the North Devon District Hospital is open 24 hours a day, seven days a week. It treats people with serious and life-threatening emergencies and those with minor injuries that need prompt treatment, such as lacerations and suspected broken bones. The A&E is a recognised trauma centre, although major trauma cases go directly to Plymouth. The department sees approximately 40,000 patients each year. The trust refers to their A&E department as the emergency department. For consistency with other CQC reports, it is referred to as A&E throughout this report.

The department has a four-bay resuscitation area. One bay is designated for children. The major treatment area has 10 bays, plus a children's treatment room. There is a three-bay minor treatment area and a discrete room next to reception for the assessment and triage of non-ambulance patients. There is also a dedicated room suitable for the assessment of people with acute mental health problems.

The A&E is supported by a medical assessment unit (MAU). Patients referred by their GP can be rapidly transferred to the unit once they have been initially assessed by A&E staff. The MAU is managed by the medical directorate, although nurses report to the same nurse manager as A&E nurses.

We visited over three weekdays and returned unannounced, at night, the following week. We observed care and treatment and looked at 18 treatment records. During our inspection, we spoke with 19 members of staff, including nurses, consultants, doctors, receptionists, managers, support staff and ambulance crews. We talked with five patients and two relatives.

### Summary of findings

The A&E department had a caring and committed team of staff with a strong team ethos. There was evidence that the department reported incidents. However, we were concerned that lessons learnt were not always fully embedded into practice. There were significant infection control issues within the department. The physical layout of the department and waiting times for nurse assessment did not ensure the safety of patients in the waiting room.

The department was struggling to meet national targets for the handover of ambulance patients and the ability to admit or discharge patients within four hours. A trust-wide action plan to address these issues had commenced in 2013, but had lost momentum in the months prior to our inspection.

Although staff worked well together, there was no clear management structure and nursing leadership was shared with other parts of the trust. Multidisciplinary working was good and staff felt well supported in their roles.
Are accident and emergency services safe?

Safety in the A&E department at North Devon District Hospital required improvement. There was evidence that the department reported incidents. However, we were concerned that lessons learnt were not always fully embedded into practice. The department was clean and tidy, but there were significant infection control issues, such as lack of hand-washing facilities and the decontamination of equipment. The physical layout of the department and waiting times for nurse assessment did not ensure the safety of patients in the waiting room.

Record keeping was good and staff had a good understanding of mental capacity and consent issues. There was a lack of security staff at night and at weekends. This, together with a lack of senior nursing staff at night, placed additional strain on staff working out of hours.

Incidents

- There were no Never Events (a Never Event is a serious, largely preventable patient safety incident that should not occur if the available, preventative measures have been implemented by healthcare providers) and no serious incidents in the A&E in the year preceding our inspection.
- The clinical lead for A&E was on leave during our inspection, but we asked one of the other A&E consultants to describe the current safety status of the department. The consultant found this difficult to describe and referred us to the consultant with responsibility for auditing the department’s performance. Other staff that we spoke with were also unable to tell us whether the department was regarded as safe or not.
- We looked at the A&E incident listing reports from 1 December 2013 to 31 May 2014. These had been logged on the hospital incident reporting system. In total, 163 incidents had been reported, which is similar to, or slightly higher than, other A&Es. The biggest category of reported incidents (41%) was patients brought to the A&E with pressure ulcers. The next most common incident (10%) was violence and aggression towards staff. The latter represented two to three incidents per month.
- We asked to look at minutes of a recent departmental governance meeting to see if there had been any learning from these incidents, or any action taken. We were shown the minutes of a meeting that took place on 8 January 2014, but they did not contain any references to these, or similar, safety incidents.
- We asked staff directly if they reported incidents. We received a varied response depending on the grade and profession of staff we spoke with. Junior staff said that they would report incidents, such as patients who were admitted with pressure ulcers, or safeguarding concerns, but rarely needed to do so. None of the staff that we spoke with could recall receiving feedback from any of the incidents that had been reported.
- A number of staff told us that they found it difficult to access and use the electronic incident reporting system. They thought that they might report more ‘near misses’ if the reporting process was easier. None of the junior staff that we spoke with knew what happened to an incident report once it had been entered on the system.
- We looked at minutes from two A&E nursing staff meetings held in April and June 2014 and found no discussion of, or learning from, safety incidents.
- We saw an A&E governance report dated September 2013, which contained two safety alerts that were discussed at the following governance meeting. This meant that medical staff had up-to-date knowledge of current safety concerns.

Cleanliness, infection control and hygiene

- During our visit, we found the department to be clean and tidy. We saw support staff cleaning the department throughout the day and doing this in a methodical and unobtrusive way.
- The resuscitation area and minor treatment area had adequate hand-washing facilities and we observed staff using them. However, hand-washing techniques were often rushed and did not follow the approved NHS hand-washing technique.
The availability of hand-washing facilities in the major treatment area was limited. There were three basins for 10 patient bays. Two of them were at the back of the department, which made them more difficult to access. This meant that it was difficult for staff to wash their hands as soon as necessary in the busiest part of the department.

Alcohol gel was available for hand cleaning in patient bays, but there was only one dispenser for the rest of the treatment area. This meant that it was difficult for staff to clean their hands when moving between different areas of the department and after using keyboards. We saw no evidence of staff using alcohol gel in this way.

The department had an infection control link nurse who carried out hand-washing audits. We looked at the results of past audits, which showed varying levels of hand washing. We were told that those audits with poor results were due to staff from other departments not knowing where to clean their hands in the A&E. There had been no comprehensive infection control audits carried out in the last six months.

The sluice in the major treatment area was clean and tidy. Most bedpans and urinals were disposable and the machine used for disposing of these was clean and well-maintained. We saw that some bedpans were not disposable and asked how they were decontaminated. We were told that they were emptied into a toilet adjacent to the sluice, rinsed under a tap and then cleaned with alcohol wipes. This decontamination practice was not sufficient to ensure that the items were cleaned and disinfected to the required standard to prevent the risk of cross infection.

The A&E nurse manager told us that she had asked the hospital's facilities manager to install a bedpan washer, but that no action had been taken at the time of our inspection. The nurse manager was not aware of any plan to install a bedpan washer in the near future. There was no evidence that this issue had been escalated to the hospital's infection-control nurse, or that it had been placed on the risk register.

In the sluice adjacent to the resuscitation room was a large skip type trolley, which contained empty boxes for recycling. The nurse assisting us told us that bags of dirty laundry were placed in this skip on top of the recycling as there was a space issue. There was no separate room for clinical waste, domestic waste or recycling.

In the sluice was a trolley with equipment, including incontinence pads. We were advised by the nurse that this was for personal care for patients in the resuscitation area. These were clean items in what was confirmed by the nurse as a dirty area.

On leaving the sluice, there was no access to a sink or hand-sanitising gel. Access to the sink and hand-sanitising gel were blocked by equipment. Each bay in the resuscitation room did not have immediate access to hand-sanitising gel with only the middle bay having access.

We saw that one of the storerooms contained some half-used bottles of sterile water. There was space on the bottles to record the time and date that they had been opened, but this had not been recorded. This meant that there was no way of knowing whether the sterile water was safe to use as these should only be used for up to 24 hours after opening.

A cubicle designated for people with dementia contained a very large sharps box. It had an opening on the top that was large enough for a small hand to be inserted. This meant that people with dementia could injure themselves on the needles and blades contained in the sharps box.

Environment

Although parts of the A&E had recently been modernised, the physical layout was still not safe. The design of the waiting area did not allow the triage nurse or receptionist direct line of sight to waiting patients. This meant that the condition of patients waiting to see a doctor could deteriorate without staff being aware.

In addition, we witnessed delays of up to 40 minutes in patients being assessed by a nurse. Therefore, there was a risk of sick and injured patients not being given appropriate attention.

A triage nurse told us that staff tried to overcome the problem by looking at the waiting room when they could, but the building design made this very difficult.

It has to be noted that the patients we spoke with during the inspection were accepting of the environment and spoke positively about the care and treatment they received.

A side room was available for patients who presented with a possible cross-infection risk. We saw this room being used appropriately.

There was a small x-ray department within the A&E. This was well equipped and easily accessible.
from all areas of the department.

- The major treatment area was small for the number of patients being treated within it. Staff areas were congested and it was not possible for patients on trolleys to be moved around easily. A number of smaller patient cubicles were used to store equipment.

**Equipment**

- There was a good range of resuscitation and medical equipment. This was clean, regularly checked and ready for use.
- Each bed space within the resuscitation area were designed and configured in exactly the same way. This allowed staff working within that area to be familiar with the bed space, which ultimately led to improved working during trauma and resuscitation events.
- There was a specific area for the resuscitation of children. This contained a wide range of equipment so that children of all ages could be immediately resuscitated.

**Medicines**

- We saw that medicines were stored correctly in locked cupboards or fridges. We found that controlled drugs and fridge temperatures were regularly checked by staff working in the department.
- Staff were observed to be administering intravenous fluids safely and correctly. They methodically completed details on the medication chart.

**Records**

- All patients’ records were in paper format and all healthcare professionals documented care and treatment using the same document.
- The records we looked at were clear and easy to follow. There was space to record appropriate assessment, including assessment of risks, investigations, observations, advice and treatment and a discharge plan.
- The department had a computer system that showed how long people had been waiting and what treatment they had received. However, the system was not updated in real time and was not a good indicator of how long people had been waiting.
- An audit of records was carried out by the nurse manager on a monthly basis. The content of the audit included whether the following information had been recorded: a full patient history, social history, previous medical history, a record of current medications the patient was taking, as well as any allergies the patient suffered from.
- There was poor compliance, with staff recording pain scores either before or after painkillers had been administered. Only 10% of the records audited had a pain score recorded.

**Consent, Mental Capacity Act 2005 and Deprivation of Liberty Safeguards**

- Consent forms were available for people with parental responsibility to consent on behalf of children who were not competent.
- We observed that consent was obtained for any procedures undertaken by the staff. This included both written and verbal consent.
- The staff we spoke with had sound knowledge about consent and mental capacity.
- Senior staff displayed a commitment to the use of new mental capacity assessment forms, although they were not able to show us any examples during the inspection.
- Where people lacked the capacity to make decisions for themselves, such as those patients who had arrived into the resuscitation department unconscious, we observed staff making decisions that were considered to be in the best interest of the patient. We found that any decisions made were appropriately recorded within the patient care notes.

**Safeguarding**

- Staff were aware of their responsibilities to protect vulnerable adults and children. They understood safeguarding procedures and how to report concerns. There was access to patients’ previous attendance history and to the child risk register.
- Records showed that all members of the nursing staff had attended recent training in child and adult safeguarding. This level of compliance is difficult to achieve and is to be commended.
• All clinical records for children contained a risk-assessment tool aimed at quickly identifying any concerns regarding child welfare. This had not been completed on any of the records that we looked at during our inspection. Despite this, we saw that many of the doctors’ notes did contain reference to risk factors for child abuse.

Mandatory training
• Mandatory training took place online and uptake was generally good.
• All staff had undertaken training in adult and child safeguarding and 98% had received dementia training.
• Only 50% of staff had been given training in the prevention and treatment of pressure ulcers. However, the staff that we spoke with demonstrated a good understanding of this topic.

Initial assessment and management of patients
• Patients arriving by ambulance as a priority (blue light) call were transferred immediately through to the resuscitation area, or to an allocated cubicle space. Such calls were phoned through in advance, so that an appropriate team could be alerted and prepared for their arrival.
• Patients arriving in an ambulance were assessed by a nurse from the major treatment area. The nurse was given a detailed handover by the ambulance crew in the corridor outside the major treatment area. Based on the information received, a decision was made regarding which part of the department the patient should be treated. Once transferred to a treatment bay, baseline observations were carried out and a triage category was calculated.
• All A&E departments in England are expected to receive and assess ambulance patients within 15 minutes of arrival. North Devon District Hospital had struggled to meet this target on a regular basis.
• The system for receiving ambulance patients was not effective. During our inspection, there were several occasions when ambulance crews and their patients were waiting in the corridor outside the major treatment area for more than 15 minutes. This was despite the fact that there was space in the major treatment area for more patients. We witnessed staff walking past the ambulance patient without enquiring if they were being attended to.
• We asked who was responsible for receiving ambulance patients and how they knew that an ambulance had arrived. (The corridor was not immediately visible from the major treatment area). We were told that it was whichever nurse was available and that there was a bell for ambulance crews to ring when they arrived.
• A national target had been set that stated that ambulance patients should be handed over to the care of A&E staff within 15 minutes. The hospital was failing to meet that target.
• Patients who walked into the department, or who were brought by friends or family, were directed to a receptionist. Once initial details had been recorded, the patient was asked to sit in the waiting room.
• Non-ambulance patients were assessed by a nurse in time order unless the receptionist thought that a patient needed to be seen urgently.
• During our inspection, we often saw patients waiting 20 minutes to be assessed by a nurse. During one afternoon, people were waiting 50 minutes to be clinically assessed.
• We asked if long waits for initial assessment happened frequently. Staff were unable to tell us with any certainty as the time from arrival to assessment was not audited.
• Guidance from the Royal College of Nursing and the College of Emergency Medicine states that: “Triage is a face-to-face encounter, which should occur within 15 minutes of arrival.” The A&E department at North Devon District Hospital was not meeting this standard.
• We asked the nurse manager if any audit had been undertaken to assess the scale of the problem and the reasons for it. We were told that this had not yet been possible, as it was difficult to release nursing staff for audit activities.
• We observed the triage of a patient (with their permission) and found it to be thorough and effective. The nurse had undergone specific training before carrying out the role and was able to request x-rays when indicated. Although the room maintained the privacy and dignity of patients, it was small and there was not enough space for patients’ relatives to sit down. This would cause particular problems for children or adults who needed help to communicate.
• We were told that children were given priority. If there was a long wait to be assessed by the triage
nurse, children need not wait and could be seen directly by a doctor. We were shown a child’s A&E record that demonstrated this.

- Very few children attended the department during our inspection and therefore we were only able to follow the progress of one in any detail. This child was assessed by the triage nurse within five minutes and was seen by an A&E doctor fifteen minutes later.

**Management of deteriorating patients**

- We were told that an early warning score (EWS) was used throughout the department. This is a quick and systematic way of identifying patients who are at risk of deteriorating. Once a certain score is reached, a clear escalation of treatment is commenced.
- We found that that EWS were not fully embedded in the A&E. The EWS was not recorded for every patient and we found one example of incorrect calculation.
- EWS had been audited in recent months and the findings of the audit were similar to ours. We saw minutes of a staff meeting held on 26 June 2014 asking nurses to pay more attention to the calculation and use of the scoring system. There had not been time since then to carry out another audit.
- We did witness a EWS being discussed at a handover meeting, but one patient’s high score was dismissed by a member of the medical staff. This illustrated the lack of consistency in the use of national early warning scores.

**Nursing staffing**

- Nurse staffing levels were based on historical establishments, which had been reviewed over time to take account of changing demand. A specific staffing tool was not used.
- We spoke to four members of the nursing staff at length and they all said that they enjoyed working in the department and were well supported.
- This was reflected in the sickness rate amongst the A&E nursing team which, in the year ending March 2014, was low at 1.9%.
- We were told that a significant number of new nurses had recently joined the department. We asked the trust to supply us with the staff turnover figures. We were told that these were not calculated at departmental-level.
- Nurses work 12-hour shifts, with eight nurses working during the day and six at night. A further two nurses work from 10am to 10pm.
- There was some concern amongst nursing staff that six nurses was not enough at night and a new ‘twilight shift’ was being considered.
- Nursing staff were supported by an A&E education facilitator, who was a senior member of staff who also worked clinically. This role coordinated the activities of student nurses within the department and helped to develop competency assessments for qualified staff.
- Although the department employed four band 7 sisters, or charge nurses, two of them acted as nurse practitioners and only took charge of the department on an occasional basis.
- We looked at the duty rota for the month of July and found that only 11 of 28 day shifts had a band 7 sister/charge nurse in charge of the department.
- We were told that, in general, band 7 nurses did not work at night. This is unusual, as activity at night can involve greater risk in emergency departments.
- Band 6 nurses were usually in charge of the A&E and we were told that a number of new grade 6 nurses had recently been appointed.
- The small numbers of grade 7 nurses that led the team on a day-to-day basis could result in a lack of appropriate decision making in complex situations. For instance, we saw that a patient who had suffered a major convulsion did not have their neurological condition monitored on a regular basis. On another occasion, a trauma patient was not assessed and monitored in line with local and national guidelines.
- There were not paediatric qualified nursing staff on each shift in the A&E but that one of the sisters did have a sick children’s qualification. Staff told us that when a child attended the department appropriate staff from the children’s ward would attend.
- When we looked at the duty rota for the next three weeks we saw that there were 19 occasions when the department would not be fully staffed. We were told that additional staff would be brought in from a bank of temporary NHS staff. It was rare for agency staff to be employed.
• During our inspection, there were two 12-hour shifts, which were not fully staffed. This resulted in staff being shared between two treatment areas. We noticed that there was not always a nurse available to transfer patients to a ward as soon as they were ready.

Medical staffing
• The department employed five consultants, who were present in the department from 8am until 7pm during the week and between 10am and 6pm at weekends.
• These hours increased during holiday periods to 8am until 10pm during the week and 10am to 10pm at weekends.
• Junior doctors spoke positively about working in the A&E. They told us that In-house teaching was well organised and comprehensive. During the day, there were usually two consultants on duty although they were not always visible within the department. Although junior doctors told us the consultants were supportive and always accessible and they knew that they could ask for advice for specific medical conditions, such as acute cardiac conditions, stroke or non-accidental injuries in children. They were not encouraged to ask for help when medical or management dilemmas occurred. We were told that the department had been awarded a new training post due to the positive feedback from previous doctors.
• There were no specific children’s doctors working in the department due to the relatively small numbers of children who attended. However, we were told that specialist children’s doctors were rapidly available if required.
• We saw consultants working clinically in the department, but did not witness any handovers aimed at ensuring the consultant in charge was aware of each patient in the main A&E department.
• There was always a consultant on call after normal working hours. We were told that they expected to be called in for cases such as serious trauma or urgent stroke thrombolysis. Staff told us that this worked well.
• Staff told us there were only two doctors on duty on a Friday evening, which was one of the busiest times of the week. This led to long waits for patients to see a doctor.
• We raised this with the A&E nurse manager, who told us that there were plans to introduce an increase in the number of doctors in the evening to three. The trust later confirmed that this increase in medical staff would start in August 2014.

Major incident awareness and training
• The hospital had a major incident plan (MIP), which had last been reviewed in May 2014. The MIP provided clinical guidance and support to staff on treating patients of all age groups and included information on the triaging and management of patients suffering a range of injuries, including those caused by burns or blasts and chemical contamination.
• Staff in the A&E department were well-briefed and prepared for a major incident and could describe the processes and triggers for escalation. Similarly, they described the arrangements to deal with casualties contaminated with chemical, biological or radiological material, or hazardous materials and items (HazMat).
• Regular training took place and we looked at the report of the last major incident ‘table-top exercise’ that took place in July 2013. This was organised by Public Health England and the scenario that was considered was an explosion and building collapse in a shopping centre. The outcome of the exercise was that patients were treated effectively and that good patient transfer took place. There were also some learning points, such as leadership, coordination and attendance at staff briefings.

Security
• There were limited numbers of security staff available to the A&E. The department did not have dedicated security staff. There were no security staff in the hospital during the day and only one at night. Nurses told us that it often took the night security officer a long time to attend the A&E if he was on the other side of the hospital site.
• Security staff had not undertaken control and restraint training. A&E nursing staff had been trained in breakaway techniques, but not the safe restraint of patients.
• Staff were concerned about the safety of patients and colleagues and we saw a number of incident reports regarding episodes of violence and aggression within the department.
• We were told that there were plans to employ more security staff, but that no commencement date had yet been established.

Are accident and emergency services effective?  

The A&E had an ongoing programme of audit, which encompassed both national and local audits. Policies and procedures were developed in conjunction with national guidance and best practice evidence from professional bodies such as the College of Emergency Medicine, the National Institute for Health and Care Excellence (NICE) and the Resuscitation Council UK. NICE guidelines were received by the hospital’s medical director, who then sent them to clinical leads in the appropriate specialty. Audit activity was stronger in medical disciplines, as a consultant had been able to take specific responsibility for assessing the effectiveness of treatment delivered in the A&E.

Evidence-based care and treatment

• The A&E department used a combination of NICE and College of Emergency Medicine guidelines to determine the treatment they provided. Guidance was regularly discussed at governance meetings, disseminated and acted upon, as appropriate. However, it should be noted that, although invited, very few nursing staff attended these meetings.
• A range of clinical care pathways had been developed in accordance with guidance produced by NICE. At monthly governance meetings, any changes to guidance and the impact that it would have on their practice was discussed.
• Medical staff were encouraged to undertake a clinical audit to assess how well NICE and other guidelines were adhered to. However, we could see no evidence of the results of these being discussed with the department as a whole.
• The A&E participated in a number of national audits, including those carried out on behalf of the College of Emergency Medicine. Results from the 2013 College of Emergency Medicine clinical audit relating to ‘consultant sign-off’ was compared with the same audit in 2011 to determine whether the A&E had made any improvements. The College of Emergency Medicine consultant sign-off audit measures a number of outcomes, including: whether a patient has been seen by an A&E consultant or senior trainee in emergency medicine prior to being discharged from the A&E when they have presented with non-traumatic chest pain (17 years of age or older), children under one year of age presenting with a high temperature and patients who present back to the A&E within 72 hours of previously being discharged by an A&E.
• Results from the 2013 audit show a number of improvements compared to 2011. In general, standards were equal to, or slightly better than, those recommended by the College of Emergency Medicine.
• There were clinical pathways based on national guidance for the treatment of certain conditions, such as stroke, pneumonia, and fractured neck of femur and the department audited compliance with these. Results of these audits were satisfactory.
• Particular mention should be made of the stroke pathway that required certain patients to receive critical treatment within an hour of arriving in the A&E. In many hospitals, these patients are transferred to a dedicated stroke unit. The stroke unit in the North Devon District Hospital did not have the facilities for rapid treatment and so A&E consultants had devised a treatment pathway that ensured this vital treatment took place in the A&E instead. We were told that it always took place with direct consultant supervision.

Pain relief

• The A&E participated in two College of Emergency Medicine audits, which included the management of moderate or severe pain. These were the management of patients presenting in moderate or severe pain caused by renal colic and the College of Emergency Medicine clinical audit into the management of fractured neck of femur.
• Although formal pain scores were not always assessed, four of the five patients that we spoke with reported that they had been offered appropriate pain relief. Records showed that this had been administered promptly and in line with hospital policy.
**Nutrition and hydration**

- A new system of regularly offering drinks and snacks to patients had recently been introduced. This was known as a ‘comfort round’ and was meant to take place every two hours.
- We saw staff offering refreshments during the course of our visit, although this was not always recorded in the patient record.
- Following the assessment of a patient, intravenous fluids were prescribed and administered when clinically indicated. However, the staff that we spoke with did not have any knowledge of recent NICE guidelines about intravenous fluid therapy and it was not included in the list of A&E clinical guidance that we were given.

**Patient outcomes**

- The department participated in national College of Emergency Medicine audits so that they could benchmark their practice and performance against best practice and other A&E departments. Audits included consultant sign off, renal colic, fractured neck of femur, severe sepsis and septic shock. Results were in line with recommended standards.

**Competent staff**

- Appraisals of both medical middle grades and consultants were being undertaken and staff spoke positively about the process.
- There were conflicting figures for the number of nursing staff that had received an appraisal in the 12 months prior to our inspection. There was no structured appraisal process and no regular records were kept, either in the A&E, or in the human resources department.
- One sister told us that she kept copies of the appraisals of the staff in her team, so that she could refer to them if necessary. However, this was not standard practice. Some members of staff kept their appraisal document at home, but were not always able find it when it was required for the following appraisal.
- We looked at the personnel files of five nurses who had worked in the department for more than a year. Only one had an up-to-date appraisal and none had a staff development plan that identified learning needs for the forthcoming year. This meant that there was no framework for monitoring the competency of nursing staff, or of identifying future learning needs.
- A number of band 6 nurses had recently been appointed. No-one that we spoke to knew how many had post-graduate A&E qualifications.
- We asked to see the personnel files of five nurses to check their qualifications, but found that no record was kept in the files that we were given. Nor did the files contain a job description or person specification. This meant that there was no description of the role that each level of nurse was meant to carry out, the responsibilities that this involved, or the qualifications required for each level of seniority.
- We were told that specific competency assessments had been developed to ensure that nurses have appropriate skills and knowledge for looking after patients in an emergency setting. We were given a number of box files containing competency documents for some of the nurses in the department. Although these documents were well thought out, few of them had been signed off by a senior member of nursing staff. It was, therefore, difficult to judge whether nurses had achieved specific levels of competency.
- In addition, there was no structured competency framework so that nurses and their managers knew when they were ready for increased levels of responsibility.
- We spoke with junior doctors, who told us that they received regular supervision from the emergency department consultants, as well as weekly teaching.
- Nurses that we spoke with told us that they had undertaken the Resuscitation Council’s Immediate Life Support course and others had also attended paediatric resuscitation training. However, we could find no records that demonstrated how many nurses had gained these qualifications.

**Multidisciplinary working**

- There was effective multidisciplinary working within the emergency department. This included effective working relations with speciality doctors and nurses, social workers and GPs.
- During the day, the mental health crisis team worked within the department to assess and treat
people with acute psychiatric problems. The senior nurse for the department attended meetings of the north Devon mental health liaison group.

- There was a good working relationship with the child safeguarding team and with the community paediatric team.

**Seven-day services**
- The department had access to radiology support 24 hours each day, with rapid access to computerised tomography (CT) scanning, when indicated.
- A&E consultants provided cover 24 hours per day, seven days per week, either directly within the department or on call.
- There was no acute cardiac care unit on the north Devon District Hospital site. Patients presenting with acute cardiac conditions were transferred to Exeter.

### Are accident and emergency services caring?

**Overall, the A&E provided a caring and compassionate service.**

We observed staff treating patients in the department with respect and consideration. Patients and their relatives and carers told us that they felt well-informed and involved in the decisions and plans of care. We saw that staff respected patients’ choices and preferences and were supportive of their cultures, faith and background.

### Compassionate care

- Throughout our inspection, we saw patients being treated with compassion, dignity and respect.
- People living with dementia and learning difficulties were given special consideration. Communication techniques were adjusted to help them understand what was happening.
- One person we spoke with said, “The care here is superb.”
- One parent we spoke with said, “We have been to the emergency department before. All of the staff are excellent.”
- The A&E department participated in the NHS Friends and Family Test. The latest results showed that 93% of people who took part in the survey would be likely or very likely to recommend the department to their friends or family. A reasonable percentage of people (24.6%) who attended the department took part. This is above average compared to the rest of England.
- The small size of the major treatment area meant that it was not always possible to maintain patient confidentiality. Telephones used by staff were close to patient areas. Although staff spoke as quietly as possible, we were able to hear telephone conversations with other clinicians throughout the department. It was necessary for these conversations to include patient names and so they were not completely confidential.

### Patient understanding and involvement

- The patients that we spoke with all said that they had been involved in the planning of their care and had understood what had been said to them.
- Patients and relatives told us that they had been consulted about their treatment and felt involved in their care.

### Emotional support

- We observed staff giving emotional support to patients and their families.
- Investigation reports following deaths in the department showed that relatives had been offered appropriate support.
Are accident and emergency services responsive?

Requires improvement

Once patients were within the treatment areas of the A&E their initial needs were responded to quickly and effectively. However, we witnessed long delays in triage nurse assessment for all patients and there was little evidence of a systematic approach to improving the patient flow through the department. In the year leading up to our inspection there had been increasing difficulty in meeting the national target of admitting or discharging 95% of patients within 4 hours. A trust-wide action plan had been commenced in 2013 to address this problem but it had lost momentum in the months immediately prior to our inspection.

Service planning and delivery to meet the needs of local people

- We were told that the department had an escalation policy, which described how it prepared in advance to deal with a range of foreseen and unforeseen circumstances where there was significant demand for services. However, the policy had never had to be implemented and the department had never closed or diverted ambulances to other hospitals.
- The clinical site manager visited the A&E three times a day to discuss patients who may need admission with the nurse in charge. Wards were identified at this point and capacity was constantly monitored.

Access and flow

- Since the beginning of 2014, the trust has not been meeting the national standard that requires 95% of patients in A&E to wait less than four hours to be admitted, transferred or discharged. In recent months, the percentage reached had varied from 84% to 93%.
- We had reviewed a copy of the trust’s initial improvement and recovery plan aimed at reducing the amount of time patients have to wait to be admitted or discharged. The work commenced in February 2014. We have asked the trust for a copy of the updated actions from this and the outcomes that have been achieved. Information provided did not demonstrate how the actions had been achieved to reduce breaches in A&E. There was an obvious awareness of the importance of the four-hour target amongst admitting teams of clinicians and ward staff and evidence that they are committed to achieving it. We heard a number of conversations between admitting teams regarding how they could best admit a patient to a ward within four hours.
- There was no evidence of recent, trust-wide guidance regarding how the target should be achieved and this sometimes led to patients being hastily admitted to wards in order to prevent a breach of the target. This resulted in patients and wards being inadequately prepared for admission. For instance, on one occasion, we witnessed a patient with the symptoms of septicaemia about to be inappropriately transferred to a medical ward. We also saw incident reports from wards stating that patients were transferred without necessary drugs being prescribed and without a full handover from A&E staff.
- During our unannounced inspection, the major treatment area was full for most of the time and the resuscitation room contained between two and three patients. Six of the ten patients in the major treatment area had been referred to a physician and needed to be transferred to the medical assessment unit (MAU).
- The nurse in charge had been told that there were only three empty beds on the MAU and it was unclear where the other medical patients would be admitted to.
- However, when we attended the evening bed management meeting, we were told that the hospital had fifty empty beds, including ten empty medical beds.
- When we looked at records on the MAU it became clear that very few patients had been transferred out to other wards in preparation for the evening and night shifts, despite a steady stream of referrals to the medical team from GPs and A&E.
- We noted that the admitting medical team did not always tell A&E that they had accepted a patient from a GP and that they would shortly be arriving in A&E. This put additional strain on nursing staff who were already dealing with a full department.
- At 9pm, the clinical site manager told us that they would start to transfer patients from the MAU to other empty beds in the hospital, so that patients waiting in A&E could be transferred to MAU.
- We asked why patients who wanted to go to sleep were being transferred between wards at night.
when staffing levels were lower than during the day.

- We were told that the evening ward round on the MAU did not finish until 8pm and it was not possible to transfer patients before then.
- Children and their parents had a separate waiting area that was well designed and contained a selection of toys suitable for different ages of children.

**Meeting people’s individual needs**

- Staff had access to translation services by way of a telephone interpreter system. They told us that the system worked well whenever they were required to use it.
- We were told that access to mental health services were good during the day when staff from the mental health crisis team would come to the A&E to assess and treat people with mental health problems.
- At nights and weekends, this service was not available and patients with mental health needs could wait a number of hours to be seen by specialist staff. If patients were experiencing a psychiatric crisis, their behaviour in the department could be very disruptive.
- Children’s needs were met by the provision of age-appropriate toys and activities, a separate waiting area and different pain-scoring tools. We noted, however, that the pain scoring tool was not always used.
- There was no information given to patients in the waiting room about waiting times. We were told that patients would be told if there was a particularly long waiting time, but did not witness this in practice. There were times, during our inspection, when patients were waiting up to an hour to be assessed by a triage nurse and nearly two hours to be seen by a doctor. Patients told us that they had not been given information about waiting times or the reasons for them.
- There was clear information about the department on the noticeboard in the reception area. This included coloured diagrams of the uniforms worn by different staff, so that people knew who was looking after them.
- There was a quiet sitting room where distressed relatives could sit in a private space.

**Learning from complaints**

- Complaints were handled in line with the trust policy. If a patient or relative wanted to make an informal complaint they were directed to the nurse in charge of the department. If the concern was not able to be resolved locally, patients were referred to the Patient Advice and Liaison Service, who would formally log their complaint and would attempt to resolve their issue within a set period. Patient Advice and Liaison Service information was available within the main A&E.
- Formal complaints were investigated by a consultant or the nurse manager and replies were sent to the complainant in an agreed timeframe.
- We saw that learning points from complaints were discussed at A&E governance meetings and at nursing staff meetings.

**Are accident and emergency services well-led?**

Staff of all grades enjoyed working in the department. They told us that there was an open and honest culture and excellent teamwork. However, there was a lack of visible leadership in the clinical environment. Lines of accountability were unclear and nursing leadership was shared with other areas of the trust.

**Vision and strategy for this service**

- The clinical lead for A&E was on leave during our inspection and so it was not possible to discuss his leadership strategy for the department. There was no specific nurse manager for the department. Nursing leadership was provided by a senior nurse who was also responsible for the medical assessment unit, the clinical site managers and three minor injury units in nearby community hospitals.
- All the staff that we spoke with said that they enjoyed working in the department and felt well supported. They were clear about what the department did well and where it could improve.
- The trust had very recently appointed a new chief executive and the director of nursing had been in post for only three months. Staff were not aware of their vision and values regarding the hospital and the A&E. The director of nursing had not yet visited the department.
Governance, risk management and quality measurement

- Quarterly governance meetings were held within the directorate and all staff were encouraged to attend, including junior members of staff. Complaints, incidents, audits and quality improvement projects were discussed. However, we noted that the only nurse present was the A&E nurse manager. We were told that it was difficult to release nursing staff to attend meetings, as this would lead to staff shortages in the department. Therefore, although nurses were invited to governance meetings, they rarely attended. There was no evidence that information from governance meetings was cascaded to nursing staff, either at meetings or by any other means.
- The A&E maintained a risk register, which fed into the divisional and, ultimately, the trust-wide risk register. We could see no evidence of this being discussed at governance meetings.

Leadership and culture within the service

- Leadership and management of A&E were shared between the clinical lead and the senior nurse manager.
- The senior nurse manager had recently taken on the management of clinical site managers. Nurses that we spoke with during our unannounced visit told us that this meant that A&E was responsible for the hospital at night.
- We asked the trust for confirmation of this and were told us that this assumption was incorrect. This meant that lines of responsibility were unclear which could lead to confusion in clinical decision making.
- We spoke with senior medical and nursing staff, all of whom were proud of the progress that had been made in the department in recent years. They felt that they had developed a modern department with strong teamwork and up-to-date practice.
- During our inspection, the nurse in charge of each shift was usually a band 6 nurse. A third of this group of nurses had recently been appointed and we asked the nurse manager how they were supported in their new role.
- We were told that, during the day, there was usually a more senior band 7 A&E nurse who could be called upon if difficulties arose. There were no specific guidelines to help staff decide when this should happen.
- We witnessed a number of occasions when the department was very busy or complex situations arose. The presence of senior nursing staff would have made these situations easier to deal with, but there seemed to be no awareness that their advice could be sought.
- There were no regular reviews of patients in the department by band 7 nurses to ensure that appropriate care and management was taking place.

Public and staff engagement

- There was no evidence displayed in the department of changes made as a result of patient feedback such as waiting times, NHS Friends and Family tests or PLACE (patient-led assessments of the care environment).
- The staff that we spoke with were not aware of any public engagement groups or other initiatives whereby input from patients was sought to help improve the overall A&E experience.

Innovation, improvement and sustainability

- There was evidence of innovation from senior medical staff. For instance, we were told that, in the past, there had been delays for patients waiting for urgent ultrasound scans. As a result, middle grade A&E doctors were being trained to undertake ultrasound scans within the department.
- Clinical placements had been arranged for middle grade and senior doctors in a major trauma centre and an anaesthetic department, in order to widen their experience and maintain up-to-date skills.
- Junior doctors were seen to be involved in the department’s ongoing audit programme.
Medical care (including older people’s care)

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Information about the service

The Northern Devon Healthcare NHS Trust provided inpatient services to those requiring treatment and care for general medicine, acute assessment, respiratory medicine, gastroenterology, stroke services, diabetes and endocrinology, oncology, cardiac care and care of the frail elderly and those living with dementia.

We inspected the medical assessment unit, the stroke unit, Victoria Ward, Staples Ward, Glossop Ward and Alex Ward and considered the environments there.

We spoke with 27 members of staff. These included clinical leads, service managers and senior nurses, ward staff and therapists, and medical staff of all grades. We also spoke with 22 patients and seven relatives.

We observed interactions between therapists, nursing and medical staff, patients and relatives. We also observed care episodes and looked at 17 sets of patient records. These included nursing assessments and daily records, medical notes, medication charts and documents relevant to do not attempt Resuscitation (DNAR) decisions.

We visited the discharge lounge based within Glossop Ward, and spoke with patients and staff there.

Before the inspection, we reviewed performance information from, and about, the trust.

We also received comments from people who attended the public listening events, or contacted us to tell us about their recent experiences.

Summary of findings

We found high levels of patient, relative and staff satisfaction with the care delivered across the medical wards.

Although there was evidence of much safe practice, we had concerns about the practice of moving patients overnight.

Overall, medical services were effective. There was a lack of consistency of effectiveness in overnight bed management, but there was also clear evidence of mechanisms of effectiveness in place throughout the directorate.

On each unit we inspected, the delivery of care and treatment was compassionate and caring. We saw some outstanding delivery of care where staff had planned and held a street party on the ward for those patients living with dementia. Feedback from the friends and family test was high and supported by verbal feedback from patients relatives. Patients and relatives were actively involved in decision making about treatment, care and discharge. Relatives and patients commented positively on their experiences on the
Medical services were mainly responsive to local needs. There was an excellent provision of specialist care for patients with a stroke or with dementia. Service-delivery plans had raised a need for further dementia bed provision and the capital funding for this had been successful.

Overall, the medical services unit was well-led. Staff told us they felt well-supported by their managers and senior management team. They said that the quality of care and treatment delivered was of the utmost importance to the trust.

Are medical care services safe?

Patients did not always receive safe care. Although there was evidence of much safe practice, this was not consistent across all wards.

We found an 'open' culture, where the reporting of incidents was supported and encouraged.

Standards of hygiene were high in wards and public areas, and some refurbishment was in place to provide dementia-appropriate accommodation.

Assessments of risk, and care plans were mostly appropriate, although these were not always fully completed. Daily records were up to date on all wards, although there was evidence of missing information in the records of a patient living with dementia. Consent for care and treatment was obtained by signature prior to the delivery of care.

Staffing levels were usually adequate. Where numbers of staff had been changed, this was clearly signposted on the ward information board.

Incidents

- There was a good incident reporting culture within the trust. Medical and nursing staff used the trust’s online incident reporting system appropriately. This was clearly evidenced in monthly ward newsletters where this was openly discussed. Incidents were recorded on Datix and reviewed by internal governance. Staples Ward told us they had showed a slight decrease in reported incidents such as falls etc once they started using the Safer Staffing tool in April.
- Governance meetings addressed the number, type and severity of these incidents and escalated to and shared with the senior management team, where required.
- Victoria Ward showed us a response plan to a medication incident. This provided guidance to staff of the situation and the response made. An action plan had been shared with staff to show where an error had been made, and learning discussions around this had taken place.
- Incidents reviewed during our inspection provided assurance that investigation of incidents had taken place at an appropriate level. Root cause analysis had taken place where necessary.

Safety Thermometer

- The NHS Safety Thermometer was a monthly snapshot recording of data specific to each unit. It included the prevalence of avoidable harms such as new pressure ulcers, catheter-related urinary tract infections (UTIs), venous thromboembolism (VTE) and falls.
- The directorate monitored this information weekly. It was displayed in an easy-to-understand format on a noticeboard outside every ward. Nursing staff did weekly audits of “harm-free care” and these results were reported on the ward information boards for the general public to read.
- Information about the NHS Friends and Family Test, number of patient falls and daily staffing levels were also displayed.
- The trust had a strategy for all patients identified as being at risk of falling. Actions were then put into place to minimise this risk. These included being measured for anti-slip socks and the use of low-rise beds. Most patients we observed who had been identified as being at risk were wearing the appropriate socks. One ward had run out of supplies, but these were supplied later that day.
Cleanliness, infection control and hygiene

- All wards and public areas were visibly clean.
- Domestic staff told us they had strict cleaning schedules on a daily, weekly and monthly basis and that these schedules were regularly checked for compliance by senior managers.
- Staff on the medical units were seen to comply with the ‘bare below the elbows’ policy, and there was a high degree of compliance with the use of personal protective equipment (PPE), such as the use of aprons and gloves.
- Nursing staff had attended infection-control training, and were supported by an infection control senior nurse.
- Side rooms were available for those patients who required treatment in isolation to prevent cross infection.
- Hand-sanitising gel was at every ward entrance and exit, and at the end of patients’ beds. Posters reminded people to use this.
- The trust’s infection rates for MRSA and Clostridium difficile (C. difficile) were readily available, and demonstrated good results, when measured against the average for hospitals in England.
- All patients were screened for MRSA on, or prior to, admission to reduce the risk of cross infection.

Environment and equipment

- Each ward we visited had appropriate moving and handling equipment, such as hoists. This enabled patients to be moved safely.
- Electrical equipment had been tested in accordance with the schedule and was clearly labelled to indicate this.
- Staff told us that, if they required any specialist equipment, this was made available to them.
- Victoria Ward was a specialist unit caring for patients with coronary heart disease. It had a dedicated supply of specialist infusion pumps and cardiac monitors. These were safely stored in a stock room.
- All resuscitation trolleys were checked and found to be in correct order. They were checked daily against a standardised list. This ensured that staff were familiar with the placing of the contents and meant that any necessary equipment could be restocked quickly.
- There was full access to a range of pressure-relieving mattresses to reduce any identified risk of skin damage to patients.

Medicines

- Medicines were mainly stored correctly, including in refrigerators, if required.
- However, on one ward we found an unlocked medication trolley, a controlled drug cupboard with the keys in it, and an unsecured room where medications were stored. The ward staff raised these as clinical incidents when they were discovered and appropriate actions were taken that day.
- Fridges were checked and were at the correct temperature range. These were checked and recorded daily.
- We observed patients being given medications. These were mostly given on time and all recommended checks were made prior to the administration of medications.
- Patients and relatives told us that the reason for medications was explained before being given.
- Although wards had protected drug administration round times, interruptions still occurred on a regular basis. Ward staff told us they had asked for ‘red tabards’ (to be worn by staff administering medication, identifying that they should not be interrupted), but had not received them.
- The medications that we checked were all within their expiry date, and kept at the correct temperature. Where bottles of liquid preparations had been used, the opening date had been written on the bottle, in accordance with trust policy.
- Diabetic patients benefitted from a new insulin-prescribing chart, which minimised the possibility of errors and led to safer practice. This chart had been entered into a national competition because of its application of excellent practice to patients.
Records
- Records were held in paper and electronic format. The paper records we observed were usually legible and were signed and dated correctly.
- Records were not always secured correctly. On Staples Ward and Victoria Ward, we saw patient records, with names clearly visible, sitting in an unlocked records trolley. On Victoria Ward, we observed a chest x-ray displayed on an unattended screen, with patient details visible on it. This did not ensure the privacy and confidentiality of all patients. This was immediately rectified when the staff were told about it.
- Standardised care plans and risk assessments were used. These were mainly fully documented, but some risk assessments were incomplete.
- Paper records contained consent forms for patients to sign to confirm their agreement to the delivery of treatment and care. Most of these were completed appropriately.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards
- Where patients had capacity, they were consented appropriately and correctly.
- If a patient was assessed as having a diagnosis of dementia or in a confused state, mental capacity tests were not always undertaken. This was more notable in overnight admissions, where we found that, in two cases out of three, this oversight had not been picked up on morning rounds.
- In the other case we observed, a patient had been admitted overnight and assessed as not having capacity. This was correctly documented.

Safeguarding
- There was a trust policy and training in place for the safeguarding of vulnerable adults.
- Staff we spoke with, including domestic staff based on the wards, were clear about their responsibilities if they had concerns over any type of abuse.
- All staff had either undertaken safeguarding training, or had been booked upon a date in the near future.
- Safeguarding procedures were clearly documented and were displayed on walls throughout the hospital.

Mandatory training
- All staff new to the trust had an induction period, which included mandatory training.
- All units had up-to-date information about their training programme and exactly how many staff had attended each training session throughout the year. This was verified by the trust's centrally-held figures.
- Where staff had not yet attended a mandatory study day this year, they had been allocated a date in the near future.
- Staff we spoke with told us the trust ensured people were up to date with mandatory training and that it was seen as important.

Assessing and responding to patient risk
- The medical wards used the modified early warning score (MEWS), a nationally-recognised tool identifying changes in observations that may indicate a patient’s changing state.
- Medical and nursing staff told us they were aware of the specific actions to be taken if patients reached “trigger points”.
- We observed this in practice. Nursing staff alerted medical staff to escalating scores and the correct response of increased vigilance and frequency of observations was usually implemented.
- On Staples Ward, a patient had been escalated to hourly measurement of urine output and hourly recording of observations. This had not always happened at the appropriate time, as the nurse looking after the patient also had other “escalated” patients to look after. The nurse in charge was aware of this and had tried to ensure these observations had been recorded by another nurse. This had been partially successful.
We observed MEWS charts and noted recordings were clear, accurate and used the escalation technique correctly.

The wards had a ‘sepsis’ pathway, which enabled early recognition of a deteriorating patient. This pathway included steps for early escalation and interventions and prompt stabilisation.

**Nursing staffing**

- Medical wards used a nationally recognised tool to assess the correct numbers of staffing for their individual needs. The Safer Nursing Care Tool used a matrix to identify numbers of patients with specific needs. This gave a total number of points for that shift and the nursing establishment was set against that using the e-Roster staffing programme.
- This tool noted increasing risk in deteriorating patients, or those with temporarily increased needs and provided documentary evidence that a higher number of staff or increase of skills mix was required to cover these situations.
- All wards displayed ‘actual versus establishment’ data on the board outside their ward. This meant that patients and relatives could be assured that the correct number of staff were on duty. This information also provided the assurance that, if the required number of staff was not on duty, then extra skills would be provided by the employment of another healthcare assistant for that shift.
- Staffing was sufficient to the ward workload as identified by the Safer Nursing Care Tool. For example, if patients required more nursing care because of a deterioration in their health, the workload tool could calculate how much extra nursing time would be required. This provided staff on the ward and their senior managers with an approximation of the staff and skills mix required for that shift.
- Patients and relatives we spoke with told us they did not usually have to wait for any care to be delivered and that nurses were able to deliver a high level of compassion.
- We noted that bells and jugs were always left within reach, and that staff took time to explain procedures. This was indicative of appropriate staffing.
- Staples Ward was extremely busy, although the staff numbers were correct for the days we inspected. They had two distinct types of patients: the acutely-ill elderly and patients living with dementia. Both these specific groups had very high staffing needs, which changed frequently.
- We observed nursing handovers on two wards. These were informative and accurate. There was a thorough description of the previous shift with specific information about each patient, including the plan for the following shift. Patients were referred to with dignity and respect at all times.
- Nurses told us that the use of bank or agency staff could be high, although there was a recruitment campaign to recruit and retain contracted staff.

**Medical staffing**

- The senior management team told us that recruiting medical consultants had been an ongoing challenge. Action plans were in place to actively address this and included recruitment from Europe.
- Some European medical staff of junior and middle-grade doctors were already in place and this was viewed as successful by the senior management team and by ward staff we asked.
- Staff told us that there were usually sufficient medical staff in place during dayshifts, night shifts and at weekends.
- There was limited, but sufficient consultant cover overnight and at weekends, but this was being actively addressed by the senior management team.
- Junior medical staff told us they sometimes had to move to cover specialities, as there was a known shortage of middle-grade doctors. However, they also told us they felt well supported by their senior staff and consultants.
- Nursing staff and patients told us that medical staff had a highly visible presence on the wards and were accessible when required.
- Some consultants were not specialists in their own right, but were highly experienced general consultants with a specific interest area.

**Major incident awareness and training**
• We spoke with senior managers and staff on all wards about major incident awareness and escalation procedures for incidents, such as fire safety and winter pressures. Senior staff had undergone training and were clear about their responsibilities in these events.
• Senior nursing staff on night duty had been given Advanced Life Support (ALS) training and this supported medical and nursing staff at nights and at weekends.
• Emergency plans and procedures were in place, and were known to staff.

Are medical care services effective?  

Overall, medical care services were effective. However, there was an inconsistency of efficient bed management, particularly overnight, and this sometimes impacted upon patients in the medical wards.

There was clear evidence of effective mechanisms of timely and appropriate pain relief. Any patient with a risk of dehydration or malnutrition had an appropriate assessment and follow up done. Patient outcomes on the acute stroke unit were good and innovative practice had been delivered from this unit to A&E. Diabetic patients benefited from a high level of speciality support.

Multidisciplinary working was in place and worked well for the benefit of patients. The elderly care wards did not have a consultant geriatrician in post, but employed an experienced consultant with an interest in geriatric medicine. The trust was aware of this lack of specific consultant and was actively addressing it with an ongoing recruitment campaign.

Evidence-based care and treatment
• The medical wards acted in accordance with guidance from the National Institute for Health and Care Excellence (NICE), for the treatment of patients who had a stroke or myocardial infarction (heart attack).
• Integrated care pathways, using expertise from a multidisciplinary team, were in place for stroke patients and the performance of these pathways was regularly monitored.
• The endocrinology service contributed towards national initiatives of good practice and innovation.
• Local audits were regularly undertaken to ensure that all clinical documents and assessments, such as the malnutrition universal screening tool (MUST) had been used in an appropriate and timely manner. These audit results were known by the staff and action plans were in place to address any concerns.

Pain relief
• All patients we asked told us they had pain relief given when they requested it. We observed many incidences of nursing and physiotherapy staff asking patients if the pain relief had been effective before commencing any care or therapy. This was evidence of good practice.
• Two relatives told us that patients were regularly asked if they required pain relief.

Nutrition and hydration
• Patients were weighed on admission and their nutrition and hydration status was recorded using the MUST tool. We noted one occasion where this had not happened. This was an overnight transfer, and the patient had not been weighed the following morning.
• Referrals to a dietician were made where concerns were noted.
• Stroke patients had assessments of their ability to swallow and were referred to the speech and language therapy team, or the dietician to ensure that they were provided with food in an appropriate form.
• Special diets, pureed food and supplements were available when an identified need had been established. Religious and cultural dietary requirements were catered for.
• Meals were delivered to the ward on a trolley (not in individual portions) and were given out by domestic staff. They checked that patients had sufficient portions for their needs.
• Support was given to help patients to eat and drink, and this was recorded on patient notes.
• Adapted crockery and cutlery was available to ensure that patients who needed them could remain as independent as possible.
• Patients we spoke with assured us the choice of snacks and meals was appropriate to their needs and appetites.
• All patients had access to drinking water within easy reach. Where people were not able to access this unassisted, care assistants made regular checks to ensure drinks were offered.

Patient outcomes
• The trust’s mortality rates were within the expected range.
• National clinical audits were completed and results demonstrated that the trust’s performance was broadly similar to that of other comparable trusts.
• The inpatient survey showed the trust was rated with better trusts for the involvement of patients in decision making.
• The readmission rate for elective general medicine showed a higher level than average. However, the elective medical ‘average length of stay’ was better than expected.
• The Sentinel Stroke National Audit Programme (SSNAP) audit had an overall rating of ‘D’. This equated to approximately 60-69% compliance on between October and December 2013. There were high scores for occupational and physiotherapy interventions, and for discharge planning and processes.
• The acute stroke unit had a target figure of 80% for patients to be cared for in a specialist unit. However, as the unit had established a stroke specific outreach team who assessed patients in the A&E, this initiated early care and a reduction in the need for inpatient care. The trust figure demonstrated the impact of the outreach team and the effective running of the stroke service.
• The heart failure audit showed less input from a specialist consultant than the England and Wales average.
• The National Diabetes Inpatient Audit, dated September 2013, showed an overall satisfaction rate by patients of 81% against an England and Wales average of 86%. Patients were treated and cared for by specialist diabetes teams.

Competent staff
• Most nursing and medical staff said they had regular clinical supervision and annual appraisals.
• Staff on specialist units, such as the stroke unit, the dementia unit and the coronary care unit had undergone specific training to increase their skills base.
• The stroke unit nursing staff had introduced an effective and innovative scheme where they actively worked with the A&E staff to undertake the initial assessments of patients suspected of having a stroke. This provided early identification for specific bed spaces, and delivered a high level of expertise to the patient. The effectiveness of this was seen in direct benefit of patient experience and the performance of the emergency and stroke unit nursing staff.
• All nursing staff had attended dementia training and many staff told us they found this effective.
• Junior doctors told us they felt well supported most of the time, with access to registrars and consultants for regular teaching.

Multidisciplinary working
• On every ward we inspected, we saw clear evidence of effective multidisciplinary working.
• Physiotherapy and occupational therapy staff were noted by their high presence on the ward, and staff told us that speech and language therapists, dieticians and psychologists were regular visitors.
• Pharmacy services provided a dedicated ward support.
• We observed ward rounds and noted that multidisciplinary staff attended.
• There was no provision of a critical care outreach team at this time, although discussions about this provision were underway.

Seven-day services
• There was consultant presence in the medical assessment unit from 8am until 8pm.
• Staff told us that the consultants were on call overnight on a rota basis, and would come in if necessary.
• Pharmacy services were available seven days a week.

Are medical care services caring?  

Outstanding ⭐

On each unit we inspected, the delivery of care and treatment was compassionate and caring. We saw some outstanding delivery of care where staff had planned and held a street party on the ward for those patients living with dementia.

Information obtained from national patient experience data, such as the NHS Friends and Family Test showed mainly good experiences of care. Noticeboards on wards displayed recent compliment cards from previous patients and their relatives. They praised the staff teams and wrote that they felt involved in their care.

Compassionate care

• The NHS Friends and Family Test results were above the England average with scores being high between 82 - 100%. Each ward we inspected displayed their results on a noticeboard for the public to view. We saw a letter on Alex Ward from a senior manager. It congratulated the staff on a recent NHS Friends and Family Test score and included some of the direct comments from patients and relatives. Staff on the unit told us they valued this observation of their work, and said it increased morale amongst staff.
• One patient we spoke with told us that: “The care was wonderful, extremely caring.” Another person told us that they had been very impressed when a physiotherapist took the time to fully explain the treatment plan with the patient, so that they knew what to expect, and the approximate timeframe in which it would be delivered.
• We saw people being treated with respect, dignity and compassion. Curtains were always drawn to deliver personal care and explanations given before care or treatment was delivered.
• A relative on Staples Ward told us that call bells were usually answered, “Quite quickly, even though staff are horrendously busy, day in, day out.” Another relative on the ward said, “My mum is happy with the care here. She doesn’t have to wait long to be seen by someone if she presses her buzzer.”

Patient understanding and involvement

• Patients told us they were regularly seen by nurses, doctors and therapists. They told us they felt well informed about their treatment and care. Relatives told us they had been given the opportunity to be involved in discussions about the care of their family member.
• Patients we spoke with said that physiotherapists, occupational therapists and discharge nurses ensured that the patient was aware of changes to plans and kept up to date with their treatment plans and discharge arrangements. They said they had been enabled to ask questions and felt that these had been answered adequately.
• Patients told us about the ‘Pathfinder’ discharge team who discussed potential discharge arrangements in great detail with patients and families.

Emotional support

• We observed that staff demonstrated the provision of emotional support by delivering many acts of kindness to their patients. On Alex Ward, a patient living with dementia was distressed because another patient had had a fall. While the fallen patient was being dealt with, a physiotherapist took considerable time to talk to the patient who was distressed. They listened to the patient and ensured they were safe and comfortable before continuing with their work. This was evidence of very good emotional support.
• On Alex Ward, they had recently had a ‘street party’ for the patients there. Many of these patients
were living with dementia and efforts had been made to use reminiscence to help them to enjoy the afternoon. Staff had dressed up in 1940s costume and appropriate music had been played. Photographs of this event were displayed in the ward and patients had clearly enjoyed themselves. This was evidence of outstanding, appropriate emotional support for the ward population. The nursing, medical, therapy and ward clerk staff on Alex went “all out” to deliver the street party. They planned it around their normal day to day work. Articles in the local paper showed very happy patients and staff who had dressed up and brought in specific reminiscence music for the occasion. Someone else made cakes. The acute stroke unit sister told us that emotional care was given high priority. She said that people who had had strokes could be very emotional. Because of this, staff went to great lengths to take the time to ensure their worries were discussed and, as far as possible, resolved.

- A relative on the stroke unit told us of the ‘outstanding’ emotional care given to them and to their family member.

**Are medical care services responsive?**

Good

Medical care services were mainly responsive to the needs of the population they served. Support for people with specialist needs was good, particularly for patients living with dementia or stroke. They were cared for in specialist units where multidisciplinary staff teams provided a high level of expertise.

We noted that, occasionally as a result of poor bed management decisions, sometimes patients were moved to another ward late in the evening or overnight. These moves were not always on the basis of the patients’ clinical need, but to “make space” for incoming patients on the medical assessment unit.

Medical and surgical patients were sometimes on the same ward, and although their needs were met, they were not always initially cared for in the most appropriate environment.

A service needs analysis had identified the need for the trust to provide more dementia-specific beds in an appropriate and specialist facility.

**Service planning and delivery to meet the needs of local people**

- Bed occupancy in the trust was noted as 85%. Occupancy rates above this percentage could start to affect the quality of care given to patients and the running of the hospital more generally.
- We found there was intermittently inappropriate bed management meaning that, although patients told us they felt well looked after, they had sometimes had inappropriately-late transfers to wards.
- The medical services unit had a new and extensive dementia strategy and this was used to plan and run appropriate services to this specialist group.
- Service planning had identified a need for more beds in a dementia-specific environment. Rebuilding was taking place to provide a new unit to be opened in the autumn, giving Alex Ward 10 more bed spaces. This was intended to reduce the clinical pressure on Staples Ward, where people living with dementia were mixed with the acutely-ill elderly, and to provide a high level of nursing expertise to the patients living with dementia.

**Access and flow**

- There was a central operational group of clinical site managers (senior nurses) who coordinated the capacity and bed availability within the trust. Each day, they liaised with all wards and senior managers to make decisions to ensure that patients were admitted to the correct clinical area on admission. This did not always happen, because of pressure on beds elsewhere in the hospital.
- Bed management meetings took place three times a day and patients were usually moved to an appropriate bed as soon as one became available. Patients were sometimes initially admitted to an area not appropriate to their clinical requirements, although they were visited by the appropriate medical, nursing and therapy staff while on these wards.
- These patients were monitored and moved to appropriate beds when they became available. However, we noted that elderly patients, some with confusion or living with dementia, had been
moved overnight. Although they had been moved to a dementia unit, the move overnight could have been unsettling to them and to the patients on the ward receiving them late at night.

**Meeting people’s individual needs**

- Patients with complex and changing needs were assessed by multidisciplinary teams at regular intervals. Treatment plans were put into place with times for actions to be taken. These were regularly checked to ensure the plan was updated appropriately.
- People living with dementia were looked after by staff with the appropriate training.
- All patients living with dementia had a *This is me* booklet on dementia care, which was appropriately completed. This alerted and informed staff of the specific needs, wishes and requirements of an individual who may not be able to easily express themselves.
- Explanatory leaflets in the hospital’s information service were available in several languages, and an interpreter service was available on request.

**Learning from complaints and concerns**

- All wards we inspected had clear sight of recent concerns or complaints. These were dealt with using the trust policy and senior ward staff fed back appropriate anonymised learning points in staff meetings. Action plans were drawn up in response to complaints to facilitate learning amongst staff.
- Staff also directed patients and relatives to the Patient Advice and Liaison Service. This was based within the hospital and easily accessible.
- Complaints and concerns leaflets were available throughout the hospital.
- Relatives and patients we spoke with told us they knew how to make a complaint.

**Are medical care services well-led?**

| Good |

Overall, the medical services unit was well-led. Staff told us they felt well supported by their managers and senior management team. They said that the quality of care and treatment delivered was of the utmost importance to the trust. We found evidence that staff were engaged with the culture of innovation and good practice.

**Vision and strategy for this service**

- The trust strategy of delivering quality care to everyone was understood by all staff we spoke to, including non-clinical staff such as porters, domestic staff and ward assistants.
- The medical care senior service managers told us the trust had an aim to have, “The right patient in the right bed, at the right time, with care delivered by the right people.” This concept was widely understood by staff of all grades in the medical unit.
- We spoke with staff from every unit we inspected and from all levels within the medicine division. They told us they were proud to work at their hospital and believed they delivered a high quality experience to the patients who attended there.
- One nurse told us that senior managers had not always listened to their concerns, particularly about nurse staffing levels, but that this was improving.

**Governance, risk management and quality measurement**

- Monthly governance meetings were held at senior-level, where performance indicators, such as the NHS Friends and Family Test, audit information and quality parameters were scrutinised. One staff member told us this information was “taken seriously, and if our hand-washing audit figure was down for that month, we would get a phone call about it”.
- Each ward we inspected had regular meetings to discuss concerns, complaints, performance against targets and staff training. The minutes of these meetings were widely available to staff who had not been able to attend. Risk management was high on agenda. Senior staff sent reminder emails to units re increases or decreases in their risks such as falls, insertion line checks etc. This was noted in team minutes and openly discussed with appropriate action plans.
- There were ward newsletters on the MAU and Staples Ward. These were informative and provided information sharing and plans for the future, so that staff were kept updated of ongoing issues.
- Quality dashboards were on display outside wards. This included information such as staffing, hand-washing compliance audits, infection control, and the focus of the month.

Leadership of service
- Medical staff told us they felt well-led by their senior clinical leads and that they were highly visible and approachable.
- Nursing staff had had a recent change of senior staff. One member of nursing staff told us that the senior managers had been “not always very visible”, but that this had “changed for the better”.
- Excellent ward leadership was found on the acute stroke unit and on Alex Ward. This was evidenced by a large number of spontaneous comments from medical, nursing and therapy staff, patients and relatives. We heard that these unit sisters worked clinically, demonstrating high standards of competence and performance and actively involved their staff in decisions about the running of the ward.
- One member of staff on the acute stroke unit said, “We are valued and supported by our ward sister and she is passionate that the team deliver the very best care we can.”
- Senior staff did not always seem fully aware of the number of ‘out of hours’ bed moves made by the clinical site management team during the evening and night. Where people living with dementia had been moved out of hours there was a lack of information about this for senior staff.

Culture within the service
- Nursing and medical staff told us they were fully aware of the Datix incident reporting system. A ward sister told us their nurses felt comfortable raising concerns in the knowledge they “would be listened to”.
- Staff said they were committed to delivering a high level of treatment and care. We observed many single instances of compassionate and timely care, even where staff were working within a very busy unit. On Staples Ward, a physiotherapist and nurse spent considerable time with a patient, then returned shortly after, to ensure the patient had fully understood the plan of action, and to ask if the pain relief given to her had worked effectively.
- There was an excellent degree of multidisciplinary working with medical, therapy and nursing staff working together for good outcomes for the patients. There was much respect shown between the disciplines, and clear evidence of well-engaged staff working with each other.

Public and staff engagement
- All wards we inspected demonstrated that patient experience data had been monitored and reviewed. Comments had been noted and acted upon to improve the service.
- Staff told us they felt engaged with senior staff. This was particularly evident on Alex Ward, where much discussion had taken place around the impending rebuild. Nurses and therapists told us their opinions of what was required had been actively sought by senior managers.

Innovation, improvement and sustainability
- There was some evidence of innovative practice. This was seen in the stroke unit where they actively worked together with the nurses in the A&E to provide a high standard of initial assessments for stroke patients.
- The diabetic patients benefited from a new drug chart that minimised the possibility of insulin prescribing/administration errors. This work had recently been entered into a national competition.
- Improvement to services was noted to be high on the trust agenda, as the dementia strategy was used to highlight a specific service need requiring considerable capital investment.
Surgery

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Information about the service

Surgery services at North Devon District Hospital included nine operating theatres. There were four general surgery theatres in the main theatre suite, which also housed the sterile services department (SSD), where surgical instruments were decontaminated and sterilised. The main theatres carried out emergency and trauma surgery and operated 24 hours a day, every day. There was an eye (ophthalmology) theatre, a gynaecology and breast surgery theatre, an obstetric theatre and two day surgery theatres.

There were four surgical wards in the main hospital, a day surgery unit, discharge lounge and surgical admissions lounge. The hospital performed around 60% of surgery as day case admissions, 25% was emergency surgery and 15% was elective (planned).

On this inspection, we visited the main theatre, the day surgery unit, the surgical admissions lounge and all the operating theatres and their postanaesthetic care units (recovery rooms). We visited the four wards and the discharge unit. We spoke with a full range of staff, including: theatre managers, ward managers, consultants, doctors, student doctors and nurses from different grades. We also talked with ward clerks, healthcare assistants, pharmacy staff, physiotherapists, and members of the cleaning staff. We met with patients, and their friends and relatives. We observed care and looked at records and data.

Summary of findings

Care and treatment provided by surgery services was safe and effective. Almost all patients and their relatives spoke highly of the service received and the care and treatment they received. Staff were caring, kind and considerate of their patients and treated them as individuals.

Patient records were mostly done well, but some improvements were needed in pain and nutrition assessments. Patient assessments for safety risks needing improving in order to reduce pressure ulcer and urinary tract infection incidence. Infection control was mostly in line with policy but spot check audits for infection control on inpatient wards was not showing should show consistent improvement.

Patient outcomes were good and mortality and infection rates were low. Operating theatres met targets for referral to treatment times in all surgical specialities. Staff learned from incidents and serious events and felt confident to report incidents. The surgical teams responded proactively and positively to adverse events to bring about improvements. Patient consent was obtained in accordance with legal requirements. People in vulnerable circumstances were safeguarded and patients were treated in their best interests.

Staffing levels in theatre were not at full strength. New staff had been recruited but the current staff group were working extra hours to ensure continuity of the service as there were not enough agency staff available to provide cover. Staff were well trained and their competence was regularly assessed. There
was strong and respected leadership in theatre and inpatient wards. Staff were committed to each other and their patients. Out-of-hours emergency surgery was led by consultants and there was adequate theatre time for anticipated emergency surgery or procedures.

The environment of the surgical admissions lounge was poor in terms of the patient experience. This was with respect to patient comfort, dignity and confidentiality. The anaesthetic rooms should be improved to assist in infection prevention and control. Patient outliers and handovers between wards must be improved.

**Are surgery services safe?**

Surgery services were safe. Incidents were being reported, investigated and learned from. Infection prevention control processes were mostly done well and service-acquired infection rates were low. Safety risks for patients as they related to nursing care, such as pressure ulcers and falls, needed improved records. The environments were safe, although the anaesthetic rooms should be improved for infection control. There was good use of surgical safety checklists.

Nursing staffing levels were generally safe and supported the needs of patients, and consultant cover was good. Staff had been recruited to vacant theatre staff posts, but staff were having to work extra shifts to maintain the capacity of the service.

Staff ensured patients’ rights were protected by appropriately using the provisions of the Mental Capacity Act 2005 and had a good knowledge for safeguarding vulnerable people. Consent was done well and the law was adhered to where valid informed consent was not obtainable at the time of need. Staff were well trained and supported.

**Incidents**

- The hospital had cause to recently report a Never Event in theatre. Never Events are serious, largely preventable patient safety incidents, which should not occur if the available, preventable measures have been implemented. This recent event related to surgery being carried out on the wrong site. This event had been thoroughly investigated and an action plan and lessons learned produced. The action plan had been implemented and associated learning had been shared with relevant hospital staff.
- From the incidents we reviewed, staff appeared open and honest about incidents they reported. We reviewed the surgery division incident reports from 1 December 2013 to 31 May 2014. There was a wide range of incidents reported in this period, numbering 734. These were of various types and mostly not serious. Serious Incidents were reported to the board each month for review and monitoring.
- There was evidence of learning from incidents. For example, there were concerns from staff in theatre about damage to the wrapping on sets of sterile surgical instruments, which meant they would need to be reprocessed and this had disrupted surgery in the past. This had resulted in a business case presented by theatre, and approved by the board, for steel tins to be procured for the storage of sterile instruments. The tins were in use and the improvement had resulted in savings and improvements in safety and efficiency. There was also a trend in incident reporting for patients remaining in recovery longer than they needed to be. This had resulted in the establishment of a discharge lounge, to enable some patients to move out from the ward to wait for discharge arrangements, such as medicines to take home or transport.
- Staff felt supported to report incidents. A senior nurse told us the feedback from reported incidents had improved. A recent report was discussed, which staff had made on behalf of a patient who was not treated as they should have been, in terms of privacy and dignity. The nurse had received feedback from senior managers and been involved in subsequent meetings to discuss the situation. They said they felt confident the matter had been responded to well and was not likely to recur.
- Mortality and morbidity was reviewed and discussed. Surgery staff took part in quarterly meetings when cases were discussed, as part of the clinical governance forum. There were, however, no
minutes made of these meetings. We were told by clinical staff that some actions and lessons arose from these meetings, but with no record or action plan from the meetings we were unable to determine who was accountable for any actions or learning, or whether anything had improved as a result.

Safety Thermometer

- Safety Thermometer data for surgical wards had varied results. Falls with harm were low with only three reported in the 13 months from May 2013 to May 2014. There were 20 new pressure ulcers in this period in general surgery, trauma and orthopaedics, and 13 new catheter and urinary tract infections. This was significantly worse than the national average.
- Staff were open about their safety results. Data for pressure ulcers, falls, staffing levels, hand hygiene and ward cleanliness were displayed on the entrance to wards for patients and visitors to see.
- The surgical wards unit had varied scores when they were audited for completion of safety data. In the week ending 6 June 2014, for example, the highlights, against an audit of 10 records on each ward falls and bed rail assessments had been fully completed, but there were gaps in nutrition and some thromboembolism assessments. None of the wards had achieved full compliance with documentation audits during any month in the first six months of 2014 and were not showing consistent improvement.

Cleanliness, infection control and hygiene

- The theatre complex was clean and equipment stored to enable effective cleaning. There was weekly washing of the walls, stock was in closed cupboards and areas below heavy, large pieces of theatre kit were clean as these were removed for cleaning below and behind them. The cleaning staff had a morning and evening checklist to follow. This included equipment, as well as the environment. There were cleaners also working on a nightshift who covered specific areas when they were either not in use or in limited use.
- In theatre, infection control was mostly in accordance with hospital policy, but some improvements were needed. In theatre, surgeons were using recommended antiseptic scrub. All clinical staff were wearing theatre blues (scrubs) and were 'bare below the elbow'. There was adequate placement of hand-sanitising gel and we observed good hand washing, particularly in the recovery room where we observed staff for 15 minutes. There were two areas where improvements should be made: there was sticky tape used in all areas of theatre to secure information to the walls. This included the anaesthetic rooms and the operating theatre. The deputy theatre manager acknowledged this and almost all the tape was removed during our visit and the sticky residue removed. The cupboards and doors in all the four anaesthetic rooms in the main theatres were showing signs of age and wear and tear. Although they were kept clean, the laminate surfaces were worn away at the edges in many places and the tops were chipped and scratched from use. We saw from evidence supplied by the trust that the operating theatres were not part of the regular spot checks for infection control.
- Surgical equipment could be tracked and traced. There was a system for determining which patients had been operated on using specific surgical sets. An example of this was selected at random and we were able to trace the history.
- Healthcare-acquired infection rates were low. Rates of acquired MRSA and *Clostridium difficile* (*C. difficile*) were lower than England averages. Any surgery performed on a patient with an infection was followed with a deep clean of that theatre. These patients were placed at the end of a surgical list, if possible, to minimise disruption.
- The majority of ward-based staff followed hospital uniform policy. Almost all staff were ‘bare below the elbow’ (to allow effective hand-washing), but we saw three members of staff wearing wrist watches.
- Wards were clean and infection control procedures monitored. Wards advertised their audits of hand hygiene and ward cleanliness. On our visits to wards, we saw hand hygiene for Fortescue Ward was 100%, Capener Ward was 86%, and King George V Ward was 86%. We observed good hand-washing regimes by all staff. Ward cleanliness on King George V Ward was 99% and 100% on Capener Ward. The hospital trust carried out spot checks on wards during the year. The results
from May 2014 showed hand hygiene on Fortescue and Capener wards was not adequate. Risk assessments on these wards and Tarka ward were not being completed at all times. Highlights from the wards visited in April and May 2014

- Ward-based cleaning staff were clear about their responsibilities. We found the wards to be clean and well organised. The cleaning staff said they felt included and part of the team. They were clear about how to clean and maintain rooms that were used for patient isolation, both during the patient stay and when they were discharged and the room needed a deep clean.

Environment and equipment

- Equipment in theatre was checked and validated. There was external validation of the laminar flow theatre (a theatre designed to circulate filtered air to minimise the risk of infection). The estate management schedule for a theatre we checked in full in the main theatre suite was appropriate.
- Surgical sets and endoscopes were effectively managed and securely stored. The operating theatre had recently invested in steel tins to store sterile surgical kit. This was following incidents with kits wrapped in more commonly used woven fabric being damaged and needing to be returned for resterilisation. The endoscopes were also packed in sealed kits and stored in a specialist cabinet.
- The operating theatre environment was secure and well laid out. The main entrance and doors to and from the recovery room were locked. Staff would come and meet visitors before permitting them access. All the fire doors were closed or on automatic closure in the event of a fire. The storage for flammable items was safely located and had been risk assessed. There were fire escape doors and staff were aware of the protocol for evacuation of theatre in an emergency.
- Resuscitation equipment was satisfactory. The resuscitation equipment we reviewed on the surgical wards had been checked regularly and was mostly satisfactory. However, on Tarka Ward there were tubes and airway equipment unpacked and left in the drawer, which contravened infection control measures.
- Equipment in use, or on standby, was mostly clean and maintained. We examined two infusion pumps on King George V Ward and they were marked with an in-date service and were clean. Drip stands were clean and free from the residue of tape used to hold lines or tubes. Two commodes we examined on King George V Ward (out of four) were not entirely clean, with small stains we identified as blood and urine. Equipment on Tarka Ward was checked and servicing was in date, and the items were clean.
- Most of the ward-based environments were well-maintained. On Tarka Ward, however, some of the sinks were not emptying and staff were unsure whether anyone had raised this to the estates staff or escalated the matter as an infection-control issue. Also on Tarka Ward, the controlled drugs cupboard had been directly placed above a sink. This meant prescription drug charts were being placed on the draining board and getting wet. Staff said this sometimes made the writing illegible.
- Staff were able to access specialist equipment for patients. For example, staff said it was easy to obtain air mattresses for patients at risk to developing pressure ulcers. The porters would organise the delivery of equipment and obtain either from the stores or other wards, as necessary.

Surgical safety

- The World Health Organization (WHO) surgical safety checklist was in use and the principles adhered to. This is a process recommended by the National Patient Safety Agency to be used for every patient undergoing a surgical procedure. The process involves a number of safety checks designed to ensure staff avoid errors including, for example, wrong site surgery, incorrect or missing equipment, and retaining foreign objects after surgery. We observed use of the checklist in theatre. Staff performed the steps of the checklist well, including the required reading out of the vital information, staff introducing themselves, and the sign-out process, where instruments were checked and any issues with, for example, equipment were raised. We reviewed a sample of audits of the WHO checklist, which were being done each week, and found them to show full compliance with the checklist.

Medicines
• Medicines were mostly managed safely. The hospital had an on-site pharmacy. Pharmacists and technicians visited the wards and theatres to maintain medicines and check stocks for shortages or expiry. Pharmacy staff told us their department was short of staff and they were not able to provide the service they needed to. They said this had led to frustrations on the wards when waiting for medicines for patients to take home, or deliveries of new medicines.

• Controlled drugs (CDs) were mostly well managed. We saw all storage was locked and keys held by an appropriate member of staff. On Tarka Ward, however, the keys were held with a general set of keys and not always with the nurse in charge. On Tarka Ward CDs were required to be checked every Sunday, but the checks indicated this was not done each week.

• Medicines were given appropriately. Prescription drug charts were clear, legible, completed appropriately and there were no gaps. We observed medicines being given by nurses safely. Patients’ identification was checked, the patient was told what the medicine was and what it was for. The dose was given and administration was witnessed, the drug chart was then signed and countersigned.

Records

• Patient records were all on paper and done with a variable degree of completion. In patient notes on wards, we found some records done well and others either not done, or not completed. On King George V Ward and Tarka Ward we looked at four sets of patients notes in each ward and found some risk assessments for malnutrition not completed. On the day surgery unit the four sets of notes we looked at were in good order. The preoperative checklists were completed, as were consent records, risk assessments for venous thromboembolism, allergies and intolerances.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

• Consent for patients undergoing surgery was done well. All the patients we met said they had signed consent forms following clear explanations from the consultant about the procedure. They said they had the opportunity to ask any questions, or raise concerns. Some patients said they had signed their consent form at their preoperative assessment, but had been asked to reconfirm their consent on the day of the procedure. Patients who lacked capacity were assessed and appropriate arrangements made for patients who could not give their own valid informed consent. We reviewed a case for a patient who lacked capacity and the notes and record of conversations with the patient’s family were clear and done well.

• Care and treatment was given to patients who could not give valid, informed consent in their best interests. General day-to-day care and treatment decisions, such as giving medications, giving personal care, nutrition and hydration and performing tests were made by the clinical teams. If more serious decisions were needed, the staff would hold best interest meetings with those people who could speak for the patient to hear all the views and opinions on future decisions. The assessment form for mental capacity and best interests was thorough. These were completed by the patient’s consultant and documentation was completed well.

• Staff understood and acted in accordance with the Mental Capacity Act 2005 if it was decided to temporarily deprive a patient of their liberty. Staff had received training in all aspects of the Mental Capacity Act 2005, including provisions for deprivation of a person’s liberty when it was in their best interests. Staff said the hospital trust was going to be shortly updating all staff on the recent ruling from the Supreme Court and how this would affect Deprivation of Liberty status.

Safeguarding

• Staff had been trained to recognise and respond in order to safeguard a vulnerable patient. Mandatory training was delivered every three years and most staff were up to date with their knowledge. Staff knew who to contact in the hospital if they had concerns relating to a vulnerable adult or a child. The clinical site managers were the lead for all safeguarding concerns out of hours.

Mandatory training

• The majority of training for staff in mandatory subjects was up to date (from data up to the end of
Assessing and responding to patient risk

- Deteriorating patients were managed using recognised assessments. The hospital trust had implemented use of early warning scores, which had been in use for over 10 years. This was a mechanism for calculating from certain indicators if a patient’s clinical state was deteriorating so further or new intervention was required. The system the hospital was using was based upon the national early warning score (NEWS) and included six simple physiological observations of the patient’s respiratory rate: oxygen saturation, temperature, systolic blood pressure, pulse rate, and level of consciousness. Patients with a score of six or above (although some staff said seven or above) were then reviewed more frequently and evaluated for further intervention. On wards the nursing staff would also complete a protocol, pathway, or standard operating procedure for the doctor’s responsibility for managing the deteriorating patient.

- Patient procedures were cancelled if there were any concerns about the arrangements for their aftercare. Staff on the day surgery unit said patients were risk assessed in relation to a number of areas and this included aftercare when they were discharged. If it transpired a patient did not have the appropriate care at home and this was not addressed previously (as circumstances may have changed), the patient was asked if they would agree to stay overnight (if a bed was available). If a bed was not available, or the patient refused, staff said the procedure would be cancelled in order not to subject the patient to any unacceptable risks. The patient would then have their needs assessed and a package of care arranged and the surgery appointment rearranged.

- Patient procedures were cancelled if clinical risks were not acceptable. An operation for a patient living with dementia had been cancelled for clinical reasons. A member of their immediate family said this had been explained clearly to both the patient and the relative. The relative said they had been concerned, as the patient was being discharged home for another 10 days and care had been cancelled. However, the ward had arranged an assessment from the physiotherapist and occupational health. The patient was, therefore, not being discharged home until all the arrangements had been put in place for them to return home safely.

Nursing staffing

- The was a good handover between nursing staff when shifts changed. Nurses had a formal handover session for half an hour at the start of each new shift. This included a safety briefing on all patients. Safety briefings were comprehensive and included:
  - Falls risks.
  - Pressure ulcer risks.
  - Confusion, dementia, wandering risks.
  - Early warning scores.
  - Nutritional risks.
Surgical staffing

- Resuscitation status.
- High-risk medications.
- Infection risks.
- Other risk factors (such as safeguarding, need for one-to-one support, patients with similar names).
- Allocation of staff.

Each nurse had a copy of the essential information about each patient, which they kept with them at all times. When a patient was transferred to another ward, a handover document was used with relevant information. This included the reason for the patient’s admission, their diagnosis, pressure area risks, mobility issues, early warning score and any infections.

- The hospital trust had examined and reported upon patient perception of nursing staff levels. In a report to the trust board in January 2014, the head of communications and patient experience reported upon 432 patients surveyed on their views of staffing levels. Patients were asked to comment on how busy staff were. The results from the surgical wards were:
  - Capener Ward – of 53 patients, 28 said staff were ‘as I would expect’ and 19 said ‘too busy’.
  - Fortescue Ward – of 69 patients, 35 said staff were ‘as I would expect’ and 28 said ‘too busy’.
  - King George V Ward – of 70 patients, 38 said staff were ‘as I would expect’ and 26 said ‘too busy’.
  - Lundy-Roborough ward – of 58 patients, 37 said staff were ‘as I would expect’ and 19 said ‘too busy’.

The top three reasons for the view of staff being too busy from eight predetermined options were staff having too much paperwork, the speed staff moved about the ward, and insufficient staff at night.

- Established nursing staff levels (how many staff were approved for the posts) were achieved in most areas. Information covering the four months from February to April 2014 showed the surgical wards Fortescue and King George V achieved their full-time equivalent (FTE) establishment levels. Establishment in Capener Ward had been increased from April 2014 and two of these 38 FTE posts were still unfilled at the end of May 2014. Staffing on Lundy-Roborough Ward was just over three staff posts short of 33 FTE posts. The day surgery was at establishment levels at the end of May 2014 and of the 103 WTE posts in main theatres, 101 were filled.

- There were a number of vacant posts in the operating theatre department. This was due to maternity leave, sickness and staff leaving. In the months February 2014 to May 2014, statistics provided by the hospital trust showed of the 6,056 staff shifts planned for theatres, only 5,330 were covered. This was a shortage of 12% of staff who did not fill planned shifts. The data the trust provided showed which shifts were then covered by bank or agency staff, but this information pertained to wards and not theatres. Staff told us that they had worked overtime to fill vacant shifts and hadn’t felt staffing levels were unsafe. There were new staff coming into post in September 2014, but during the interim period, many staff had worked this overtime through goodwill. Staff said agency staff could be used, but due to the nature of the department they were not always available with the right skills mix. Staff said they were “tired” and “worn out” and also “fed up”. Staff said the culture within the department and support from management was such that they wanted to support one another and this was greatly appreciated in the department.

- Shifts were not always filled on the wards. Data we analysed from March and April 2014 indicated that half the vacant shifts on surgical wards were not filled when offered to agency or bank staff. Staff on the wards told us this situation was not ideal, but they were rarely more than one member of staff down and staff would be moved around to optimise staffing cover.

Surgical staffing

- Surgical staffing posts were mostly filled. Trauma, orthopaedics and urology positions were filled. In other specialities at the end of May the position was as follows:
  - One FTE vacancy from 27 FTE posts in general surgery (4%).
  - Three FTE vacancies from 16 FTE posts in ophthalmology (19%).
  - Two vacancies from 20 FTE posts in obstetrics and gynaecology (10%).
  - Five vacancies from 35.68 FTE posts in anaesthetics (14%).

The posts were being advertised and senior management said the hospital was currently using locum doctors to cover most unfilled posts. Evidence showed there were no specific problems at...
the hospital with waiting lists for these surgical specialities.
- Anaesthetic staff were well supported. The anaesthetist on call would work a non-clinical shift the day following an ‘on call’ shift. This was demonstrated from a review of the rotas for July 2014. The anaesthetic clinical lead told us the team were flexible and accommodating when shifts needed to be changed.
- The hospital had consultant-led cover out of hours and at weekends. This included anaesthetists and surgeons. Emergency surgery was consultant-led and junior doctors on ward rounds confirmed there was 24-hour consultant presence in the hospital for advice, guidance and attendance.
- Handover and ward rounds were done well. At a handover meeting we attended, a review of cases for the week was presented by the consultant. The cases indicated the patients had undergone high quality surgery based upon the x-ray results. Cases were discussed that had been transferred to another provider for more specialist care. Consultants were able to demonstrate insight into obtaining the best level of treatment for their patients.
- The surgery division was normally able to arrange locum cover. We reviewed the records for locum doctors for the sixth months from January to June 2014. Most of the cover required was arranged and if this had not been possible, internal arrangements had been made to compensate.

**Major incident awareness and training**
- There was a hospital-wide major incident plan which included the theatre and consultant surgeon coordinator response. This included which ward was designated as receiving patients in a major incident.

**Are surgery services effective?**

Surgery services were effective. Theatre procedures followed national guidelines and patient outcomes were good. Patients were well cared for on surgical wards, although some pain and nutritional assessments and documentation should be improved. Staff were appraised to review their competence and staff were given good teaching and induction support.

There were good interactions between staff from different disciplines and the surgery services were effective out of hours and in emergencies.

**Evidence-based care and treatment**
- Theatre practices were based upon professional standards and guidelines. For example, National Institute for Health and Care Excellence (NICE) guideline [CG50] was used, relating to acutely-unwell patients in hospital: recognition of, and response to, acute illness in adults in hospital. For example, for patient observations and monitoring protocols. Every patient in theatre was warmed, under guidance from the NICE guidance. Surgeons were using a chlorhexidine gluconate (2%) and isopropyl alcohol (70%) scrub as an antiseptic agent, as recommended by NICE and the Medicines and Healthcare products Regulatory Agency (MHRA).
- The hospital participated in national audits. This included surgical-site infection (for NICE), hip fractures (for the National Hip Fracture Database – NHFD), bariatric surgery and lower limb amputation (for the National Confidential Enquiry into Patient Outcome and Death – NCEPOD), and emergency laparotomy (for the Royal College of Anaesthetists – RCA).
- Performance in national audits produced varied results. In the hip fracture audit in 2013, there was a very high rate of patients admitted to orthopaedic care within four hours (87.8% against the England average of 51.6%). The trust was slightly below the England average (87.3%) for surgery performed within 48 hours (81.6%). All patients (100%) were given a falls assessment. One area where the trust fell significantly below the England average was with the preoperative assessment of hip-fracture patients. The England average was 53.8%, but the trust achieved only 5.8%. As a result the trust was one of the worst performing trusts in England for delivering this aspect of best practice in fractured neck of femur orthopaedic surgery. Since this had been recognised, however, the hospital had recruited an orthogeriatrician and the performance was steadily improving. Results from the bowel cancer audit were good and clinical results were above those of the England
average. For example, 95% of records for patients having major surgery were completed (England average 79%), all patients (100%) were discussed at multidisciplinary meetings and 94% were seen by the clinical nurse specialist (England average 87.7%).

Pain relief

- The use of pain charts and assessments on the wards was not always consistent. We reviewed patient notes and found few pain assessments completed well. There were no audits of pain management records on wards, as audits focused on other safety areas. There was, however, a detailed and comprehensive guide to acute pain management. The guide had links to relevant documents for all staff dealing with acute pain. It included, for example, post-operative nausea and vomiting and the pain assessment tool.
- Patients told us pain relief was given promptly. A patient we met on King George V Ward said they had been prescribed pain relief by the doctor as required. They said the nurse had confirmed this was available to them and at what intervals it could be given. The pain relief had been given when the patient requested it. A patient said staff were "always asking if I was OK and not in any pain" and another patient said "after my surgery they gave me pain killers as regular as clockwork and I think I'm doing really well and feel quite comfortable”.
- The hospital had an acute pain team led by a consultant anaesthetist. The team included a clinical nurse specialist in acute pain management and an acute pain management nurse.

Nutrition and hydration

- Most documentation we saw to manage nutrition and hydration was satisfactory. Some malnutrition records were not done for all patients, but fluid balance charts were generally completed and monitored. There were comfort rounds on the wards to ensure patients had enough to drink and were drinking adequately. Patients we met said they were regularly asked by the nurses if they had enough to drink and encouraged to take regular fluids. Patients said they were offered hot drinks around four or five times per day.
- Most patients said they thought the food was good. Patients said there was a good choice. The food was hot and patients said they could ask for the size of meal they wanted. Three patients we met said the food had improved over the last few years.

Patient outcomes

- Patient Reported Outcome Measures (PROM) showed the majority of patients undergoing groin hernia operations and hip and knee replacement procedures had improved following their treatment. A patient who was being discharged following a hip replacement said: “I cannot fault the care.” They said the hospital’s ‘patient guide for hips’ was “great”, and, “I feel pretty confident and fine to go home. I’m not anxious and I thought I would be.”
- Most patients experienced a length of stay below the England average (top three specialities only by elective and non-elective surgery). This was an indicator of good outcomes for patients. The only speciality with a length of stay slightly over the England average was for non-elective urology patients. Readmission rates (patients needing to come back for corrective or further procedures) were low and below the England average for all surgical specialties. This included both elective and emergency surgery.

Competent staff

- Appraisal rates were meeting trust targets. The surgical division had exceeded the trust target of over 80% of staff being appraised as at 30 April 2014 in most areas, as follows:
- Nursing staff were given clear guidelines when they started work. We reviewed information for new staff in the operating theatres. There was a ‘welcome’ and ‘orientation’ booklet for nurses, which described the department, explained the role of mentors, the training programme, policies that were mandatory to be familiar with, and objectives for the first two weeks. The first week in the department was supernumerary for new staff, to give them a chance to get fully orientated. There
was a comprehensive induction booklet for new staff working in theatre recovery. This included important information, such as the functions of the two recovery units, dress code, patient moving and handling, studying and training opportunities and essential information relating to emergencies.

- Medical teaching was done well. In a teaching session, we observed the content and attendance was excellent. The teaching programme for the last few months was also reviewed. Attendance sheets were validated for staff. There were some criticisms from trainee doctors in 2012 and 2013 in information provided to us by the General Medical Council (GMC). This related particularly to anaesthetic services, trauma and orthopaedic surgery. The GMC provided a review of actions taken by the trust and reported in 2014 there was evidence of improvements being made through monitoring. There were also concerns from trainees in general surgery about clinical supervision. This was of particular concern in 2012, improved somewhat in 2013 and remained at a monitoring level in 2014.

- The doctors and consultants we met said the revalidation programme was well underway. This was a new initiative of the GMC, where doctors were required to demonstrate their competence in a five-year cycle.

- Student nurses received good teaching. Ward-round and ward-based sessions were described by a student nurse as “really good” and they said: “There has been a fantastic support for student nurses.” A student nurse in the day-surgery unit confirmed they had spent the first week observing care and getting orientated to the unit. They said staff were “supportive and approachable”. They were well supported by their mentor, who encouraged them to work at their own pace, but be confident and ambitious.

- New staff received good inductions. A relatively new member of senior management in one of the surgery divisions said their recruitment and induction to the department had been “very positive”. They had been able to identify their own learning and support needs and these had been respected. They had a one-to-one meeting with the deputy director of nursing, where they were encouraged in learning and development.

- Staff were able to undertake professional development. For example, the deputy theatre manager said they had been able to attend a university-based leadership course with no objections and was able to get study-time when needed.

**Multidisciplinary working**

- There was good multidisciplinary teamwork. Physiotherapists, pharmacists, speech and language therapists, surgeons, microbiologists and the respiratory and gastroenterology teams visited the wards regularly. There were dedicated physiotherapists who joined the handover sessions to discuss, for example, discharge and rehabilitation plans for patients. They were available also at weekends and out of hours.

- There were senior nurses in clinical nurse specialist (CNS) roles. This included, for example:
  - A palliative care CNS.
  - An acute pain management CNS.
  - A respiratory CNS.
  - A colorectal/stoma CNS.
  - A lung CNS.

**Seven-day services**

- Services were available out of hours and on weekends. The pharmacy team were on call and staff said the stocks of medicines were usually satisfactory. Physiotherapists worked at weekends and were available for ward rounds and on call to wards.

- Imaging services were available out of hours. This included Magnetic resonance imaging (MRI) scanners, x-rays and ultrasound services.

- The operating theatres, teams and back-up support were on standby for emergency surgery 24 hours a day.

**Are surgery services caring?** Good
Surgery services were caring. Patients were treated with consideration for their wellbeing, privacy and dignity. Staff were patient and kind, with anxious or confused patients. Patients and relatives spoke highly of the caring staff and the NHS Friends and Family Test results were very good.

Patients and relatives were involved in decisions about care and treatment and, where able, gave informed consent. Patients not able to provide informed consent were cared for in their best interests and in accordance with the law.

Compassionate care

- A surgical patient described staff as “outstanding” and said, “Everyone here will bend over backwards to help you. The surgery was amazing. I would definitely recommend them.” Another patient on a ward said, “The nurses are lovely and I don’t really want to go home.” A patient in the discharge lounge said their highlights were “the friendly atmosphere; the reassurance; and how everyone is open to questions”. We were told, “It’s really friendly here and we’re very lucky.” A patient on the day surgery unit said the staff had been “really polite and helpful. I would give them five stars”.

- Patients in recovery were treated with care and compassion. We observed care given to three patients in a 15-minute period in the main recovery unit. Patients were kept warm, were monitored for the whole period, and pain relief was given when nurses could see it was needed. We observed care being given to three patients in the recovery area of the day surgery unit. Nurses were attentive and professional. We observed a nurse telling a patient they had given them some pain relief and reassuring them. Another nurse explained to a patient how long they might “feel a bit groggy” and “we won’t let you go until you are fine”. All patients had one-to-one nursing support when they were waking up. Observations were carried out and charts were completed.

- Staff were thoughtful when dealing with vulnerable or anxious patients.

- The NHS Friends and Family Test results for the surgical wards were excellent. Tarka Ward had the best response rate at 40%. The other wards of Capener, Fortescue and King George V had just over 20% response rate. Almost all patients said they were either ‘extremely likely’ or ‘likely’ to recommend the ward to their family and friends, and the majority said ‘extremely likely’.

- Ward staff were kind and caring. We observed many interactions. For example, staff on Lundy-Roborough Ward were supporting an anxious patient with mental health needs. Staff were calm and reassuring. They knelt alongside the patient to talk with them at their level. They used touch and hand-holding to help settle the patient. Some of the other good interactions included:
  - Nursing staff on Fortescue Ward answered call bells in a timely manner.
  - There were positive and reassuring interactions with a patient from a physiotherapist on Lundy-Roborough Ward.
  - A doctor was smiling, warm and reassuring with a patient on Capener Ward.
  - Nursing staff on Capener Ward knew their patients well and patients appreciated this and felt welcome.

Patient understanding and involvement

- The hospital performed mostly ‘about the same’ as other trusts in the 2013 inpatient survey. This survey asked questions, such as having someone in the hospital to talk to about worries and fears; did the patient have enough emotional support, was pain well controlled and did you have confidence in the nurses and doctors. The one area where the trust performed better than other trusts was patients being involved as much as they wanted to be in decisions about their care and treatment.

- Theatre staff would give patients as much or as little information as the patient wanted to hear. Patients were able to hear just the basic information about what was required of them if they wanted to exercise their right not to know. Equally, there were DVDs of straightforward procedures (keyhole gall bladder surgery and hernia repair), which patients could view with their consultant if they wished.

- Patients receiving day surgery were given a good standard of information to take home. Patients were given a ‘discharge note’ saying what they needed to know or do about dressings applied.
stitches, bathing/showering, and pain management. Any outpatient appointments needed were also recorded. There was a leaflet for patients about pain relief after surgery, how to get information in other formats and how to contact the Patient Advice and Liaison Service. Staff said they could provide a range of information upon request and there were approved leaflets on the hospital intranet that could be quickly printed for patients or relatives to take home.

**Emotional support**

- Theatre staff would support the family and friends of patients who, in rare cases, died or would not survive surgery. The theatre manager explained how relatives would be able to come into theatre if they wished to and see the patient.
- Patients admitted to the day surgery unit were allocated to a named nurse for their stay.
- Counselling services or other emotional support was not routinely available to patients or their families.

**Are surgery services responsive?**

Requires improvement

Some aspects of the responsiveness of surgery services needed improvement. The provision of theatres was satisfactory, as demonstrated by meeting waiting times and good outcomes for patients. However, the surgical admissions lounge was a poor environment in terms of the patient experience. This was with respect to patient comfort, dignity and confidentiality. The administration of the day surgery unit should be improved, to reduce patient anxiety.

Access and flow in surgery was mostly satisfactory, but patients not admitted to the most appropriate ward needed to be managed to deliver the best outcomes for everyone concerned. Handover of patients between wards should be consistent and follow hospital-approved protocols.

The wards and theatres were able to meet the individual needs of patients and provided personalised care. There were telephone translation services available at short notice and support for people with cognitive impairment or other disabilities. There was some excellent care given to patients living with dementia, particularly on Capener Ward. There were resources for meeting the needs of the diverse population, which included tourists and visitors, but there was no collection of information in one place, so staff could follow hospital-endorsed recommendations. Complaints from patients were infrequent, but these were responded to and shared with staff to improve future care and treatment.

**Service planning and delivery to meet the needs of local people**

- The provision for operating theatres was usually satisfactory. However, the day surgery unit had limited provision with only two operating theatres. Day surgery was increasing as a service. Managerial staff described the shortage of theatre time in the day surgery unit as a “pressure point” and patients were, therefore, sometimes operated on in the main theatres. There was 24-hour cover for emergency operations. All theatres were available over the weekend and night for emergency surgery.
- The surgical admissions lounge (SAL) was not a good environment for patients. Patients arrived from the main corridor into a small administration area to be booked in. There was nowhere for patients to sit at this point. Patient confidentiality could be breached, as they could be overheard in this area by other patients. The unit led onto larger waiting rooms on either side of the room for male and female patients. These had small cubicles for patient use and otherwise chairs around the walls or in rows. Relatives were not permitted to accompany patients as there was not enough room. Patients were also booked in to arrive mostly at the same time. The lounge area could, therefore, become busy and one of the nursing team said “patients can wait here for hours”. The lounge accommodated some patients who were subject to a ‘trial without a catheter’ (TWOC). These patients were required to wait in the lounge area to check if they were passing urine safely when the catheter had been removed. This was monitored with a bladder monitor by a nurse. These patients were post-operative and, therefore, able to eat and drink. This would be in front of patients who were ‘nil by mouth’ and awaiting their own procedures.
• There was some confusion among patients in the day surgery unit. We were told there were no staff on the reception desk at 7:30am, which was when patients were asked to arrive. There were around 12 people sitting in the reception area when we visited and they said they were not sure what was happening. Eventually, a member of staff arrived and started to book people in. Patients said this had not helped their anxiety. Otherwise, the unit was well run. Relatives who accompanied patients were offered drinks and staff spoke kindly and reassuringly with patients and relatives.

Access and flow

• Surgery services performed well against waiting time targets. The referral to treatment times met the NHS England standard in all specialities. In May 2014, (the latest data set available) the percentages of patients receiving care within 18 weeks, against the NHS-operational standard of 92% was:
  • 92.1% in general surgery. Half of all patients were waiting less than six weeks.
  • 92.9% in trauma and orthopaedic surgery. Half of all patients were waiting less than five weeks.
  • 92.3% in urology surgery. Half of all patients were waiting less than six weeks.
  • 92.1% in ophthalmic surgery. Half of all patients were waiting less than seven weeks.

In May 2014, the majority of surgery was performed in trauma and orthopaedics. The hospital started treatment on 220 patients. Half of these patients started treatment within 10 weeks and 90.5% started admitted treatment within 18 weeks (NHS standard is 90%).

• At times of bed crisis, the hospital, which is in a fairly rural area, had used the day surgery unit for patients to remain in hospital overnight. There was a specific protocol for staff to follow describing when the decision to use the unit should be taken, who would approve this, minimum staffing levels and their required experience and the nature of the patient who would be suitable. The patient’s consultant needed to approve the overnight stay in the day surgery unit, and any stay could only be for one night. The divisional manager for surgery confirmed the day surgery unit had been used when there were winter pressures, but the protocol had been followed at all times. However, there was no audit of the protocols or collection of patient feedback to ensure the process was followed and was safe and effective.

• Preoperative assessment was an improving service. A new anaesthetist at the hospital had been revising the preoperative assessment process. Some assessments were done over the phone. Patients we met who had been involved in a telephone assessment said this was done well and had been much more convenient for them.

• The number of operations cancelled and the patients not treated within 28 days were very low. In 2013/2014, there were only two patients in this category. However, a patient wrote to us after our inspection saying they had just had their surgical procedure cancelled for the third time. The patient said the service he had received from the hospital left them “with no faith whatsoever in the service”.

• Day surgery rates were not always achieving the standards for length of stay. The major surgical specialities, such as trauma and orthopaedics, breast surgery, general surgery and urology were not achieving 90% of their cases as day surgery. Other specialties, such as colorectal, ophthalmology and upper gastrointestinal surgery were achieving, or exceeding, the 90% standard for operating on patients as a day case.

• Patient discharge was variable in timeliness. Patient discharge had improved with the establishment of a discharge lounge. The lounge had been opened on the fifth floor and staff said the area was not really big enough, but the service was, according to a member of staff, a “big improvement”. Staff said they were enabled to help relatives safely escort patients to their cars. The pharmacy protocol for delivering medicines for patients to take home was “within an hour of arrival on the lounge”. We were told this worked most of the time, although could be poor when the pharmacy was under pressure. Discharge of patients who were not suitable to leave, via the discharge lounge, was often delayed. Staff said the delivery of medicines for patients to take home was the biggest problem and far from ideal for patients who were receiving palliative care.

• The systems and procedures for patients placed on the undesignated ward (outliers) required improvement. A number of nursing staff, some in senior roles, told us separately how they felt pressured at times to admit patients who may not be appropriate to their ward. When we visited the
hospital, most of the surgical wards had medical patients admitted, although there were beds available on more appropriate wards. Staff told us some patients were better not being moved for their wellbeing, but agreed that patients were generally better cared for, in clinical terms, on wards and environments with relevant staff experience and facilities. Staff also told us the handover of patients from one ward to another had no formal consistent basis. Staff on Capener Ward had developed a transfer acceptance form to ensure patients were transferred safely. However, staff said there was no hospital policy or standard documentation to follow, so patients could and often did arrive without sufficient, or any, handover information.

- Some patients were moved at night. We were given examples of some patients living with dementia being moved after midnight to provide bed space on wards. Staff said they raised incident forms when this happened and senior nursing staff were made aware. Records showed 105 patients had been moved after midnight in the 12 months from July 2013 to June 2014. However, the data did not say which wards were involved.

Meeting people's individual needs

- Patients living with dementia were well supported. Staff on surgical wards used the *This is Me* document on dementia care, adapted from the leaflet produced by the Alzheimer’s Society. The document could be completed by the patient, or persons who knew the patient well. The document gave details of the patient for staff to read and absorb. It was written in the first person and included, for example, things that might upset the patient, how they liked to relax, what they liked to wear, and favourite foods and drinks. Additional information for the form had been developed by one of the healthcare support workers (HCSW). This HCSW was passionate about developing care for patients living with dementia and had been supported to attend two courses on dementia care. They were now working with the trust lead for dementia and supported to do so. On Capener Ward, staff had developed other resources. This included a ‘sock box’. Staff would give a patient living with dementia a box of socks that were unpaired. They had experienced anxious or agitated patients sit quietly with the box matching up the socks. There were also picture books on history or hobbies, postcards from different times or of different animals. A patient living with dementia in the day surgery unit was treated with kindness and respect by staff. Staff were kind and found a way to help the patient to understand what was happening and what they needed to do.

- Staff made sure people had clothes in which to sit-out on the ward. If a patient had come to the hospital with limited clothes or just nightwear, staff would access the hospital clothing store to find something clean and appropriate for them to wear. Staff first made sure this was acceptable to the patient or any relatives or friends who spoke for them. This clothing was also used to help with assessments for people being planned for discharge and for rehabilitation.

- Equalities and diversities were considered, although there was no specific resource in one place for staff to access. Staff were able to describe the areas of equality and diversity they had experience of supporting. They were knowledgeable about the strands of equality and diversity and what made each person an individual. As an example of some individual care, staff said they were able to provide vegetarian, vegan or halal diets for patients. Staff would respect different cultures and religious needs by, for example, providing only male or female staff if this was important to the patient. Resources were available for people who had impaired vision or hearing.

- There were translation services available. Staff could use a telephone translation service, which, we were told, was available with short notice. The unit was able to arrange face-to-face translation with appropriate notice.

- Staff had access to a network of support for patients’ spiritual needs, both within the hospital and from the local community. The chaplaincy based at the hospital visited the wards regularly and specific visits could be arranged. There was a chapel at the hospital, which had times set aside each week for use by Muslim people.

- The trust had staff experienced with supporting patients with learning disabilities. The wards and surgery services were able to access specialist nursing staff for advice and assistance. Carers and relatives were encouraged to attend the unit and provide advice and support.

Learning from complaints and concerns

- Staff learned from complaints. One example from Capener Ward was following the loss of a
patient’s hearing aid. Staff organised small boxes to be provided and placed on a patient’s locker to prevent loss and this had improved the problems. Another complaint involved dignity to patients from dislodged clothing or patients looking unkempt. Nursing staff now ensured patients were covered, wearing appropriate underwear and felt comfortable.

Are surgery services well-led?

Surgery services were well-led. The theatre team had exemplary leadership and a strong team ethic. Wards were well-led and senior staff were respected and led by example.

There were governance arrangements for auditing and monitoring services. There was, however, no written evidence of actions or learning from clinical governance meetings and who would be accountable for change and development. Staff learned from things that did not go well and celebrated and recognised success.

There was candour among staff in theatres and wards in relation to risks. Problems and emerging concerns would be escalated to senior management without hesitation. The values and behaviours of the staff at local-level were respected, known and understood.

Vision and strategy for this service

- The senior management, matrons, senior nurses and consultants were committed to their patients, staff and wards and theatres. Nursing staff team leaders were well supported and well respected by their own teams. All staff we met were committed to high quality, compassionate and safe care and treatment.

Governance, risk management and quality measurement

- Staff contributed to the quality and risk reviews. There was a corporate risk register in use, but this contained serious incidents requiring investigation, and other risks identified by staff were not included. There were clinical governance meetings held each quarter, although staff attendance was informal. Staff told us a wide range of topics were discussed and presentations received. Staff performance was discussed, as were Safety Thermometer results, trends and any arising actions taken. Sickness absence, training, staffing issues and incidents were discussed. We were concerned there was no record of these meetings, so any actions or learning coming from those things discussed was not recorded. There was no evidence to support any improvements made or who was accountable for change and development.

Leadership of service

- There was a strong leadership culture within the operating theatres. The manager and deputy manager of surgery services had patient-focused values and a strong commitment to their staff. The senior staff led by example and demonstrated their personal accountability for the service and their staff. When asked about values, the deputy theatre manager commented: “We are all patients.” The theatres teams were committed to each other and to their patients.
- There was strong committed leadership on the wards. All the staff we met said they were proud to work for the trust, their ward, and in their specialism. Staff said they were well supported and part of a strong team.

Culture within the service

- Team members in theatre felt valued and appreciated. We met a number of members of the theatre team, including consultants and anaesthetists, operating department practitioners, nurses, managers and administrators. Staff would get together for planned social events and there was
formal, but also less formal, low-key support for staff from each other. We talked with a group of seven staff from all disciplines in theatre. They told us they were proud to work at the hospital and would recommend it to family and friends. There was a low turnover of staff and many had worked at the hospital for a long time.

- Staff had regular team meetings. There were meetings with departmental staff, heads of department, senior nursing forums. Staff in theatre had a departmental meeting each week. Minutes from the meetings were circulated to those staff who were not able to attend. Regular agenda items included information to be disseminated from other meetings, incidents, complaints, and compliments. Staff said the meetings were well attended and there was a good sharing of information and learning from adverse events. There was an excellent newsletter produced for staff on Capener Ward, with useful information and reminders on current topics.
- The hospital had a choir, which performed locally to raise funds for charity.

Public and staff engagement

- Staff were able to share their own suggestions and comments. The theatre team had a suggestion box established recently by the theatre manager. There were between 20 and 30 suggestions and comments each month. These were discussed at staff meetings and the theatre manager said many had been addressed and openly discussed. For example, staff had asked if they could work in specific clinical areas to enhance their skills and when and where possible, this had been achieved.
- There had been no routine engagement with patients in theatre to hear their views or feedback. Staff said there had not been any formal requests from patients or relatives to understand their experiences of theatre for at least the last two years. Patients were asked informally, and any complaints or suggestions listened to and fed back to staff.
- All staff we met felt they had a voice and their opinions were valued and heard.

Innovation, improvement and sustainability

- There had been some excellent improvement in surgical set safety in theatre. The use of the new steel trays to house instruments and equipment had improved efficiency and would lead to cost savings in the future.
- There were some plans to improve, or develop, the service, although these would be now presented to the new executive team being established at the hospital trust for review. The patient notes and all associated clinical work, such as medicine administration, were all done on paper records. There was no plan to upgrade these to more secure efficient electronic records.
- The team working in theatre and surgical wards had strong shared values, but there were no longer-term objectives for the teams to work towards.
Critical care

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<tr>
<th>Category</th>
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<tr>
<td>Safe</td>
<td>Good</td>
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<td>Effective</td>
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<td>Caring</td>
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<td>Responsive</td>
<td>Requires improvement</td>
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<td>Overall</td>
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Information about the service

The intensive care unit (ICU) is a six-bed ward which offers care to both highly dependent patients and those who are critically ill. The unit admitted around 200 patients a year and had cared for patients in an age range from 0 to 97 years. The unit is located, as is good practice, adjacent to the main operating theatre suite. When we visited, the unit was able to care for up to six intensive care patients (described as level 3) but was normally configured for four intensive care beds and two high dependency beds (level two). The unit had three side rooms and a bay with three beds, screenable by curtains.

On this inspection, we visited the ICU on Wednesday 2 July and Friday 4 July 2014. We spoke with a full range of staff, including consultants, doctors, trainee doctors and nurses from different grades, including the matron and nurse in charge. We spoke with cleaning staff and the ward administrator. We met with patients who were able to talk with us, and their friends and relatives. We observed care and looked at records and data.

Summary of findings

Care provided by the critical care team was safe and treatment delivered was effective. Staff were caring and patients were treated as individuals. Their needs were met by considerate and compassionate staff. The service was well-led at both department, nurse and doctor-level. The team worked well together and this was commented upon by staff, patients and visitors.

Patients were happy with their care and all the discussions we had with patients were overwhelmingly positive. There was good multidisciplinary input into patient care to enhance recovery and discharge from the unit.

There were some instances of the discharge of patients not being at an optimal time. The majority of patients were not discharged at night, but some left the unit earlier than was ideal, to make room for unplanned emergency admissions. In busy times, some patients were discharged back to the wards to free bed space for more acutely-unwell patients. There was no step-down facility to a high dependency unit (HDU), as the hospital did not have a dedicated HDU.

The unit was small and there had been no renovation to bring the unit up to modern standards of facilities and equipment since it was built in the 1970s. It was, therefore, not able to respond to all treatment, or integrated care pathways.
Are critical care services safe?

Critical care services were safe. Incidents were being reported, investigated and learned from. Infection-prevention control processes were mostly done well and unit-acquired infection rates were low. Safety risks for patients as they related to nursing care (such as pressure ulcers and falls) were being monitored and tracked. The environment was safe, although it did not meet the current Department of Health building guidelines for critical care units in almost all areas. Records were well documented and analysed for emerging risks and possible deterioration of the patients’ conditions.

There were some issues to be considered around secure storage of medicines and pharmacy cover needed to be improved. Nursing staffing levels were generally safe and supported the needs of patients, and consultant cover was good. Staff ensured patients’ rights were protected by appropriately using the provisions of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. Consent was done well and the law was adhered to where valid, informed consent was not obtainable at the time of need. Staff were well trained and there was excellent coverage from staff with advanced life support training in both adults and children.

Incidents

- The unit had cause to report a ‘Never Event’ (a serious, largely preventable patient safety incident that should not occur if the available preventative measures have been implemented by healthcare providers) in the year 2013/2014. This recent event related to a piece of a guide wire being retained after the removal of a tracheostomy. This event had been thoroughly investigated and an action plan and lessons learned produced. The actions had been added to the trust risk register and learning, audit and actions were ongoing.
- From the incidents we reviewed, staff were open and honest about incidents they reported. We reviewed the ICU incident reports from 1 December 2013 to 31 May 2014. There was a mixed category of incidents reported with no particular identifiable trend. We saw staff reported when they made an error, such as giving a low dosage of medication or the wrong type. This was an infrequent occurrence. Incidents categorised as 'serious' were investigated through a significant event audit. We reviewed one audit undertaken by the matron of ICU and the incident had been thoroughly investigated with all the relevant parties involved. There were action items and lessons-learned shared with staff.
- Mortality and morbidity was reviewed and discussed. The unit held quarterly meetings as part of the clinical governance forum when cases were discussed. There were, however, no minutes made of these meetings. We were told by clinical staff that some actions and lessons arose from these meetings. But with no record or action plan from the meetings, we were unable to determine who was accountable for any actions or learning, or whether anything had improved as a result.

Safety Thermometer

- Safety Thermometer data for ICU was showing low risks and no specific concerns. There had been only one new unit-acquired pressure ulcer in the last 12 months and one acquired venous thromboembolism. There were no falls with harm. In the 13 months from May 2013, there were 11 months where there were no patient harms reported.
- Staff were open about their safety results. Data for pressure ulcers, falls, staffing levels, hand hygiene and ward cleanliness was displayed on the entrance to the unit for patients and visitors to see.
- The unit had high scores when audited for completion of safety data. In the week ending 6 June 2014, for example, the ICU had scored 100% for completion of risk assessments, action plans, fluid balance charts, care plans, and consent. This was against the audit of 10 records. The unit had scored 100% for three of the six audits in the year so far. The three fully compliant scores came after a drop to just below 60% in February 2014.
Cleanliness, infection control and hygiene

- The unit and equipment was generally clean, tidy and well organised, but small. The ICU was built in the 1970s. The unit did not comply with the requirements for modern critical care units in terms of space, equipment and storage. There was limited space for storage, but nursing and cleaning staff were ensuring areas were kept clean and well organised. There were numerous wires to and from equipment behind bed spaces. Staff had minimised these and were aware of the need to manage them when the clinical areas were being cleaned.
- Cleaning of the unit was checked. The unit was audited by the contract cleaning company and scored highly. We looked at the criteria for cleaning and some of the equipment, such as wall clocks, was not listed. When we examined two of the wall clocks, they were dusty and had the appearance of not being dusted for over a week. The sister in charge cleaned all the clocks immediately. We noticed there were some medicines stored on top of the cupboards behind the nurses’ station. The top of the cupboard and the boxes were very dusty and there was some residue from sticky tape on the cupboard doors. We saw sticky tape used in places to hold information to walls in clinical areas, which can pose an infection risk. The matron cleaned the tops of the cupboard and doors immediately.
- The infection rates for the unit, as reported through the ICNARC, were low, as with most similar critical care units in England. There had been no unit-acquired MRSA or infections in blood since early 2013 (when there were a small number) and no acquired C. difficile since early 2012.
- There was reasonable compliance with trust policies in relation to infection control. Staff were ‘bare below the elbow’, although one doctor was wearing a wristwatch in clinical areas. All staff uniforms were clean and in good condition. When appropriate to do so, staff wore gloves, aprons, eyewear and masks. There was good adherence to disposal of personal protective equipment (PPE) when caring for patients in isolation. We observed good hand-washing techniques. Hand-wash sinks were supplied with hot water, soap and paper hand towels. There was hand-sanitising gel at the entrance to the ward and we observed staff and visitors using this when arriving and leaving the unit. This was also available at patient bedsides, in side rooms and other clinical areas and rooms, such as the sluice.

Environment and equipment

- Security of the unit was good. The ICU was locked and visitors were required to use an intercom, identify themselves upon arrival and would be met by staff. There was also a CCTV camera just outside the unit at the entrance door for further identification of visitors.
- There was enough equipment for the services provided to patients in most situations. There were enough ventilators for four patients with one spare on standby, or five patients without a spare being available. Other ventilators could be borrowed or rented, if required, to enable to unit to care for six ventilated patients. We saw from the incident report from 1 December 2013 to 31 May 2014 there were two occasions reported when an emergency (for example, unplanned) sixth ventilated patient needed to be brought to ICU and there was no ventilator available. The ability to ventilate six patients was, therefore, not available in an unplanned emergency.
- Resuscitation equipment was available and checked. We reviewed the nature of the checklist and regular checks and they were completed as required.

Medicines

- Medicines were managed safely, although some storage in the ICU did not meet best practice in terms of security. The controlled drugs were stored in a locked unit and the keys held by the nurse in charge at all times. The other medicines were in unlocked and unlockable cupboards behind the nurses’ station. A small number were on top of the cupboards. Although this provided easy access to medicines for staff, the lack of general security did not meet regulatory requirements. During the times we visited the unit, this area was not left unattended and all visitors were met and supervised. However, a storage cupboard which led onto a clinical storage room was unlocked during our visit and visitors could potentially have accessed both these rooms without being seen. Medicines requiring refrigerated storage were appropriately stored. Staff assured us the temperature of the refrigerator was checked each day, although they were unable to locate the checklist for July 2014.
We saw the lists completed, however, for the preceding months of 2014.

- Medicines were accurately recorded and dispensed. We reviewed the controlled drugs, such as opiates, and found the registers to be an accurate report of the stocks held. The entries were made as required in that the administration was related to the patient and was signed appropriately, new stocks were checked and signed for and any destruction of medicines was recorded. Staff were aware of the change in classification of medicines and we saw staff had been informed of, and acted upon, the latest requirement to store an opiate analgesic as a controlled drug. We checked 30 different medicines in the general cabinets and found them all to be in date, well organised and in good condition. The expiry dates and batch numbers of the medicines matched the boxes they were stored in. We did, however, find a box on top of the cupboard with two syringes of a medicine used as an anticoagulant, which were out of date by six months. These were immediately removed and disposed of by the matron.

- The units had support from the pharmacy team, but we were told there was insufficient time for the pharmacists, or pharmacy technicians, to provide more than a basic service at the current time. This was due to staff changes and staff vacancies in that team. We noted from an incident report that the ICU had reported an incident with a lack of a sedative and painkiller to administer to patients though a nightshift. Staff on duty said this was, however, not a regular occurrence and there were no other, similar incidents reported in the same period.

- Medicines were safely administrated and patient records we reviewed showed medicines given when they needed to be. Any gaps in administration shown on the charts were appropriately explained. Administration was signed by two members of the nursing staff.

**Records**

- Patient records were maintained safely. We reviewed two sets of patient notes and found the nursing notes to be up to date and well completed. Current notes were multidisciplinary, in that they had entries inputted by all professional staff into patient care. Risk assessments and the care plans were well completed. In the records we saw, the hospital notes were, however, not easy to follow. We observed a doctor attempting to navigate a set of notes to gain an understanding of a patient they were meeting, but were not familiar with. We observed it was not easy to use the notes for an overall summary of the patient’s stay in ICU.

- Bedside notes and charts were up to date and clear. Vital signs were well documented, along with cardiac and respiratory indicators. Neuropathic indicators, such as pain and pupil reaction were well documented. Prescription drug charts were clear and complete. The trust generic drug chart was used for patients with additional ICU-specific drugs recorded on the patients' bedside observation chart. Drugs were appropriately signed for and discontinued drugs were signed and dated at the date of discontinuation and crossed through.

- Patients were given appropriate risk assessments. There were care-plan booklets for risk assessments at different intervals, such as seven days and 14 days. The care plans included the malnutrition universal screening tool (MUST) score, a pressure ulcer risk assessment tool, use of anti-embolism stockings, moving and handling risks, falls prevention, and bedrail assessment.

- Records for patients with additional needs were maintained. We reviewed the notes for a patient with a learning disability. The notes included a mental capacity assessment, a copy of the 'hospital passport' (a document with important information about the patient provided by the patient and any care workers), and information on the patient’s next of kin.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

- Care and treatment was given to patients who could not give valid informed consent in their best interests. General day-to-day care and treatment decisions, such as giving medications, giving personal care, nutrition and hydration and performing tests were made by the clinical teams. If more serious decisions were needed, the staff would hold best interest meetings with those people who could speak for the patient to hear all the views and opinions on future decisions. The assessment form for mental capacity and best interests was thorough. These were completed by the patient’s consultant.

- Patients were able to give their consent when they were mentally and physically able. Staff acted in accordance with the law when treating an unconscious patient, or in an emergency. Staff said
patients were told what decisions had been made, by whom and why, if and when the patient regained consciousness, or when the emergency situation had been controlled.

- Staff understood and acted in accordance with the Mental Capacity Act 2005 if it was decided to temporarily deprive a patient of their liberty. Staff had received training in all aspects of the Mental Capacity Act 2005, including provisions for depriving someone of their liberty in their best interests. Staff said the hospital trust was shortly going to be updating all staff on the recent ruling from the High Court and how this would affect deprivation of liberty status.

Safeguarding

- Staff had been trained to recognise and respond in order to safeguard a vulnerable patient. Mandatory training was delivered every three years and most staff were up to date with their knowledge. The matron for critical care knew the names and contact details of those people appointed by the hospital to lead on both adult and child safeguarding. The matron clearly described those acts and omissions in patient care that would constitute abuse, and signs, both physical and mental, that a patient might exhibit if they were being abused. This included more obvious signs, such as bruising or pain, and less obvious signs such as withdrawal or fear of staff or visitors. Staff were clear about their responsibilities to report abuse, as well as how to do so.

Mandatory training

- The majority of training for staff in mandatory subjects was up to date (from data up to end April 2014). Staff said they were responsible for ensuring that they completed their training, although this was checked and reviewed by the matron or their manager. In some subjects, such as infection control, all staff were up to date with their annual training. The course that most staff needed to renew was in safeguarding adults.

Assessing and responding to patient risk

- The hospital trust had implemented use of early warning scores, which had been in use for over 10 years. This was a mechanism for calculating from certain indicators whether or not a patient’s clinical state was deteriorating, and if so, whether further or new intervention was required. The system the hospital was using was based upon the national early warning score (NEWS) and included six simple physiological observations of the patient’s respiratory rate, oxygen saturation, temperature, systolic blood pressure, pulse rate, and level of consciousness. Patients with a score of six or above were then reviewed more frequently and evaluated for further intervention.

- Patients were monitored for different indicators. For example, each patient could be subject to capnography, which is the monitoring of carbon dioxide in respiratory gases. This was available to all patients, but used as a rule on all patients for transfers and procedures, such as insertion of a tracheostomy for monitoring the end-tidal carbon dioxide to ensure the tube is in the correct place.

Nursing staffing

- The unit followed the staffing standards from the core standards of the Intensive Care Society and the British Association of Critical Care Nurses guidance for the staffing of critical care units. There was one nurse for each patient needing intensive care (level 3) and one nurse for two patients needing high dependency care (level 2).

- Establishment of nursing staff was almost fully recruited. The trust establishment (how many staff were approved for the posts) was 33.01 and at the end of May 2014 the actual number was 32.44. There was, however, a fairly high level of sickness when compared with the NHS England average. The matron said this usually meant the supernumerary sister in charge of the unit worked more clinical time than management time, or agency staff were drafted in to cover.

- The unit was mostly safely staffed. The plan was for six nurses on the day shift and reducing to five at night. Staff rotated in order. They worked a mixture of both day and night shifts. Staff could be drafted in if the acuity of patients increased (for example, if there were more level 3 patients needing one-to-one nursing care). This was a small unit with only six beds and one member of staff not arriving for work was therefore a larger percentage than it would be on a large ward, so it could
make a significant difference. There were occasions when the unit was short of staff when unplanned absence could not be covered. We saw this had been reported once in the period December 2013 to May 2014 on the incident report. The matron said they did not often have access to bank staff, but would use agency staff to cover vacancies. Most of the agency staff were known to staff and understood the running of the unit.

- The was a good handover between nursing staff when shifts changed. Nurses worked long shifts (by choice) and had a formal handover session for half an hour at the start of each new shift. Each nurse had a copy of the essential information about each patient, which they kept with them at all times. This included: the bed number, name and age of the patient, their consultant, how long they had been in ICU and important information, such as allergies, infections, and key clinical indicators. There was a formal handover of the patient and bed space to the nurse coming on duty.
- There was a good skills mix on the unit. There was a comparably high portion of more senior nurses. The matron was rostered for 75% of time in management roles and 25% spent in clinical care. For band 6 posts there were 3.47 whole time equivalent (WTE) nurses funded and for band 7, 5.47 WTE-funded posts. There was always a band 6 or 7 nurse on each shift. There were 29.46 WTE band five nurses. The unit had a healthcare assistant during the day to assist the nurses. They were responsible for checking equipment and had been trained to do so. They also arranged the menu options for patients and helped with the delivery of personal care.

Medical staffing

- The ICU was consultant-led. There were two ward rounds each day, led by the consultant with input to the morning ward round from other relevant staff, including junior doctors, nurses, pharmacists and Allied Healthcare professionals.
- There was good consultant cover. There were eight consultants working in rotation in the ICU. Two of these eight consultants were intensivists (doctors specialising in critical care medicine). There was a minimum of 15 programmed activities of consultant time committed to the ICU each week. There was 24-hour cover by a named consultant with appropriate experience and competence. In daytime hours, the consultant covering ICU did not have other clinical commitments. There were eight trainee doctors also on rotation in the department.
- There was a good consultant to patient ratio. There was one consultant on duty in the general critical care unit for six beds (which was significantly below the recommended ratio of one consultant for 15 beds). The consultants were fully committed to the critical care units when they were on call or on duty and did not have other responsibilities within the hospital to attend to.
- The unit had used locum doctors to cover vacancies in consultant posts. Unit managers said using regular locum doctors had provided consistency of care. The hospital was in the process of recruiting intensive care doctors.

Major incident awareness and training

- There was a hospital-wide major incident plan, which included intensive care and anaesthetic response. The policy referred staff to an action card that would be used in the event of a major incident.

Are critical care services effective?

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Recognised guidance for the care and treatment of critically-ill patients was followed by the units. Patients were assessed regularly for pain, nutrition, hydration and effective care or treatment. The unit took part in some clinical audit work, in order to determine if patient care was effective when compared nationally. The unit also contributed to the Intensive Care National Audit and Research Centre (ICNARC) data collection. This enabled the service to be judged on important clinical indicators against other comparable units and the national picture. The service compared well with other units in terms of outcomes, including low mortality rates.

Nursing and medical staff were appraised to judge their competency and professional development. There was good multidisciplinary work, with support provided to the unit by a range of professionals. The hospital
did not support a critical care outreach team, but had support from the resuscitation team, although only during day-time hours, from Monday to Friday. There were suitable arrangements for out-of-hours support from other services, such as physiotherapy, imaging and pharmacy.

Evidence-based care and treatment

- Recognised clinical guidance was followed. Policies used to determine treatment provided in the critical care units were based upon the National Institute for Health and Care Excellence (NICE) guidelines, the Intensive Care Society and the Faculty of Intensive Care Medicine guidelines. Staff demonstrated use of, for example, NICE guideline [CG83] – rehabilitation after critical illness and NICE guideline [CG50] – acutely unwell patients in hospital: recognition of, and response to, acute illness in adults in hospital. NICE guideline [CG50] was used, for example, for patient observations and monitoring protocols, as well as patient transfers.
- The unit participated in organ-donation work. The hospital trust had an organ donation committee and the unit had a specialist nurse for organ donation. The organ donation rates for the unit were, however, very small with only one donation in the six months up to December 2013.
- The unit had contributed to national audit programmes. Data had been provided to the National Emergency Laparotomy Audit (NELA) and the Tracheostomy Care Study in 2013/2014.

Pain relief

- Pain relief was well managed. Pain scores were documented in patient records, using recognised techniques and measures. Nursing staff said, and we observed, that patients who were awake were regularly checked for pain. Patients also confirmed this happened. Pain was also managed by prophylaxis, which is to anticipate pain and provide relief in advance.

Nutrition and hydration

- Nutrition and hydration was managed effectively. Patient records we reviewed on the general units were well completed and safe protocols were followed. Fluid intake and output was measured, recorded and analysed. The method of nutritional intake was recorded and evaluated each day. Energy drinks and food supplements were used for patients who needed them.

Patient outcomes

- Quality indicators for patient outcomes were good. The data provided to the Intensive Care National Audit and Research Centre (ICNARC) showed that, when compared to similar units, rates for patients readmitted to the unit were low (although there was a small increase in early readmissions at the end of 2013). This indicated patients were being discharged from the unit when it was clinically effective to do so. For patients being transferred to other units, the service had a rate similar to that of other comparable units. This was transfers for clinical reasons, such as needing more specialist treatment and included children who were cared for before being retrieved to paediatric intensive care units at specialist hospitals.
- The unit had low mortality rates when compared with similar units. This included when patients were ventilated on admission, admitted with severe sepsis or pneumonia, following emergency surgery, or admission with trauma, perforation or rupture. Deaths among elective-surgical patients were rare and had been zero for the last two years. The unit mortality in the first six months of 2014 was 15.5%, which was below the hospital ratio of 19.3%. Rates of mortality had increased in 2014 (the same period in 2013 was a ratio of 9.6%), but the trend was relatively stable. The rate was below the expected death rate for a unit of this type by a number of different measures. The ICNARC ratio was 0.57 and APACHE II (Acute Physiology and Chronic Health Evaluation II) measure was within expectations.

Competent staff

- Staff were evaluated for their competence. Nursing staff appraisals were slightly below trust targets. At the end of April 2014, the ICU had achieved 76.3% against the trust target of 80%.
• The doctors and consultants we met said the revalidation programme was well underway. This was a new initiative of the General Medical Council, where doctors were required to demonstrate their competence in a five-year cycle.

• There were comprehensive induction checklists for new staff. There was one designed for permanent staff and students and another for flexible workers, such as bank and agency staff. There was also a checklist for infection and prevention and control for all new or returning staff.

• Staff were given the opportunity for specialist training. Fifty-seven percent of the nursing staff had a post-registration critical care qualification and 34% had a high-dependency care qualification. Two of the nursing staff were currently undertaking their critical care courses at the local college. All ICU staff were trained in adult and child intermediate life support. The band 6 and 7 nurses had all completed their Advance Life Support (ALS) and European Paediatric Life Support (EPLS) training.

Multidisciplinary working

• The critical care unit did not have an outreach team. An outreach team is a recommendation jointly of the Faculty of Intensive Care Medicine and Intensive Care Society core standards. It is usually a team of senior nurses with a background and experience in critical care. They are used within the hospital to provide advice and guidance for staff caring for patients in other wards who may be showing signs of deterioration. They also visit patients who have been discharged from critical care back onto a general ward. Having an Outreach team is a recommendation and not a requirement. Hospital trusts can use their judgement of their expected clinical risks to provide a similar service in a different way. The hospital trust had therefore decided not to follow the Outreach is model, but to use the resuscitation team for advice and support and to ensure staff on the general wards were skilled in managing the care of the deteriorating patient. The resuscitation team had been involved with early warning score breaches since November 2013. This team placed a strong emphasis on ward staff being able to recognise the acutely unwell or deteriorating patient. Ward staff were then learning to escalate and manage these patients appropriately, rather than their care be taken over by another remote team. Although we saw a good use of early warning scores used to monitor any deteriorating patients and there was an escalation tool, there was no clear protocol, pathway, or standard operating procedure regarding the doctor’s responsibility for managing the deteriorating patient. Some clinical staff we spoke with were not entirely clear about what services the resuscitation team provided and how to use them.

• There were lead consultants in the service for specific clinical areas. For example, the unit had a consultant clinical lead for acute pain management.

• There was good multidisciplinary teamwork. Physiotherapists, pharmacists, speech and language therapists, surgeons, microbiologists and the respiratory and gastroenterology teams visited the units regularly. There were four dedicated physiotherapists who joined the handover sessions to discuss, for example, weaning plans and goals for the day for patients. They were available also at weekends and out of hours.

• As there was no outreach team, there was no specific follow up of patients who had been discharged to a ward. The unit and the hospital was, however, relatively small and we were told, at both unit and ward-level, that nursing and medical staff cooperated well with one another when patients moved between wards.

Seven-day services

• There was an experienced consultant on call to the service out of hours. Consultants worked on rotation and were responsible for ensuring the unit had good clinical cover from junior doctors at all times when a consultant was not on duty on the unit.

• Most facilities were available out of hours. The unit had an ultrasound machine, which could be used at all times and use of a portable x-ray machine. There were pharmacy services from an on-call pharmacist and physiotherapists worked on weekends.
Are critical care services caring?

Comments from patients, relatives and carers about the care they had received were overwhelmingly positive. Patients were cared for by dedicated, kind and caring staff. We saw and overheard sensitive and considerate interactions between staff and their patients. Patients were treated with privacy and dignity. Patients and relatives were involved in decisions about care and treatment and, where able, gave informed consent. Patients not able to provide informed consent were cared for in their best interests.

Compassionate care

- Staff practiced and understood the principles of delivering compassionate care to patients receiving intensive care. This included supporting patients who were confused or anxious. Staff said they would talk to a patient and tell them their name, smile, be relaxed and try and help patient relax. We met with a relative of a patient with a learning disability. They said the staff had been patient and thoughtful and had quickly adapted to the needs of the patient.

- All the patients we met told us their care had been good. We met two patients who had returned to the unit who had been invited to come back to meet staff who cared for them in the unit when they were critically ill. One patient said, “The staff were brilliant,” and another said, “I have nothing other than praise for them all and nothing whatsoever to complain about.” A relative said, “We all feel [the patient] could not be in better hands.”

- Relatives and carers we met said staff had met with them soon after they arrived the first time, and had updates on each subsequent visit. All visitors we met said they had been given time with the nurses and doctors to ask questions and this had been done in a private room if appropriate.

- We observed care being delivered with privacy and dignity for patients. Nurses and healthcare assistants were talking to patients and their relatives with kindness and compassion. We observed curtains being drawn around any patient receiving personal care, or where conversations with clinical staff were private. Curtains were clipped together and had ‘no entry’ signs to prevent other staff or visitors entering without first considering a patient’s privacy.

Patient understanding and involvement

- Patients felt included and involved in decisions when they were able to be. The patients we met said they had been asked for their consent for any treatment and their opinions for any decisions to be made. This included the parents of a child who had given their consent for treatment. They said the child had been included in discussions about them, when appropriate, and was able to understand what was being discussed. Patients and relatives told us staff had given them the advantages and disadvantages of any proposed options, including the risks and benefits.

- Patient confidentiality was mostly done well. In the units we visited, we did not overhear information about patients where other patients or visitors could easily hear. There was one comment about a patient written up on a whiteboard in the patient’s bed space that did not provide confidentiality or dignity for the patient. When this was discussed with staff they agreed this comment should not be on a whiteboard visible to others and it was removed. There were also patient notes stored in an uncovered trolley, which was not in the immediate vicinity of the nurses’ station and the guardianship of the notes could have been compromised.

- Staff understood the principles of delivering compassionate care to patients receiving intensive care. This included supporting patients who were unconscious. Staff said they would talk to a patient and tell them their name, the date and time of day. They would then tell them what they were going to do when delivering care, and why. They would explain, for example, when medicines were given, when staff changed at handover, or if the patient was being moved to another department for a test. The matron said the values they wanted for the unit was the patient to be given the best care, the standards of care to be the best they can be, patients and their families to be treated as individuals and patients and relatives to feel safe and relatives feel they have a friend with them.
Emotional support

- Former patients who had been nursed at level 3 (intensive care) were able to come back to the unit to meet with staff. The unit ran follow-up visits for patients who had been discharged from the unit and/or hospital usually some months previously. Not all patients wanted to return, but many did. We met with two patients who had come back for a follow-up review and we sat in and observed the discussion between the patient, their friend, a consultant and nurse. The patient then visited the unit and was greeted with enthusiasm and warmth by other staff. After their visit the patient told us the meeting had helped and given them more of an insight into time in critical care.
- The unit was using ‘patient diaries’ for friends and families to record their visits or significant events. These diaries were not as well-developed as others we had seen and staff were not using these to record events for the patient to look back upon when they were discharged.
- Staff looked at ways to support patients and their families. The unit had a ward clerk who worked on week days. The ward clerk greeted patients and their relatives and was warm and approachable. The ward clerk had put together an information pack for families and visitors if patients were transferred to other acute hospitals, such as in Bristol or Exeter, giving them relevant information about, for example, the hospitals, hotels, and transport.
- Counselling services or other emotional support was not routinely available to patients or their families.

Are critical care services responsive?

Requires improvement

The critical care unit was relatively small and not able to respond at all times to the need to admit or discharge patients at the most appropriate time. The unit did not meet the modern standards for critical care in terms of equipment, space and facilities. There were no shower or bathroom facilities for patients or any disabled-access toilets. The unit was, however, about to open a new relatives’ room, which had been funded from charitable donations. This was a significant improvement upon the existing facilities, but had taken five years to develop.

The unit was able to meet the individual needs of patients and provided personalised care. There were telephone translation services available at short notice and support for people with cognitive impairment or other disabilities. There were resources for meeting the needs of the diverse population, which included tourists and visitors, but there was no collection of information in one place, so staff could follow hospital-endorsed recommendation. Complaints from patients were infrequent, but these were responded to and shared with staff to improve future care and treatment.

Service planning and delivery to meet the needs of local people

- When comparing the unit to other, similar, services and local populations, the unit was relatively small and, although safe, did not meet the requirements for modern critical care facilities. As with many district hospitals, the unit was not able to meet some clinical needs, such as care for patients who required dialysis, or some brain-injured patients. Certain categories of patients who needed specialist services would, therefore, be transferred to appropriate units.
- The hospital did not have a separate high dependency unit and, therefore, at busy times relied upon care on wards; transfers to other hospitals; caring for patients in the recovery room, or discharging patients when it would be preferred to keep them slightly longer. The service also had no outreach team for patients who were deteriorating, or moved out of ICU, so was limited in the aftercare it could provide.
- The ICU environment was safe, but did not conform to modern building standards. The relatives’ room, for example, was small and not very welcoming. This had led to a new room being developed in the unit, using charitable funding. This was divided into three separate rooms (two with sleeping facilities) and a small kitchen area. The room was a significant improvement on the existing facilities. It was due to be opened towards the end of July 2014. There were limited facilities for disabled people and there was no toilet with disabled access on the unit.
- There was no shower room for patients and limited bathroom facilities for visitors staying overnight.
(although there were plans to improve these). Patients would need to visit a ward if they wanted a shower or bath. The bed spaces were small and did not meet the required size, as recommended by the Department of Health Building Note 04-02. Senior staff said these issues had been raised through the trust risk register and one clinician described how long they had been there as “forever”.

- The hospital had the ability to temporarily increase their capacity to care for critically-ill patients in a major incident, such as a pandemic flu crisis or serious public incident. The hospital was able to make up to 16 beds available for critical care. This would involve suspending other services, such as surgery and using recovery rooms and anaesthetic rooms.

- There was a good response from consultants when new patients were admitted. Each patient was seen within 12 hours, at most, by a consultant.

**Access and flow**

- The critical care unit was a small unit with just six beds. The occupancy of these beds for the first six months of 2014 was 78.8%. This was down from an occupancy rate of 84.6% for the same period in 2013. The distribution of bed capacity in, for example, the three months from October 2013 to December 2013, showed the unit had mostly five beds occupied (35% of the time), followed by six beds 28% of the time, and 4 beds 24% of the time.

- The discharge of patients from the unit was sometimes not done at the optimal time. Studies have shown discharge at night can:
  - Increase the risk of mortality.
  - Disorientate and cause stress to patients.
  - Be detrimental to the handover of the patient.

Discharges made out-of-hours (between 10pm and 7am) were at levels that were similar to other units and this trend had been in a similar range for the last two years. Prior to that, night discharges had mostly been significantly above comparable rates, so improvements had been made. There was a relatively high number of patients discharged more than four hours after they were fully ready for discharge (around 25%). This was mostly due to the lack of a ward bed for transfer. However, this rate was still below comparable units, as this was a feature of most similar critical care units, but it had doubled in the first six months of 2014 when compared to the same period in 2013. Staff said, in their experience, this situation had not often prevented another patient being admitted to the ward. Staff told us they transferred out between 20 and 30 patients to other critical care units each year, which was supported by Intensive Care National Audit and Research Centre (ICNARC) data. There had been 13 transfers in the first six months of 2014, although this was similar to comparable units.

- Some patients were discharged from the unit too early. One situation had been reported as an incident because it involved two patients being transferred to a ward around 24 hours before it was optimal. This was due to pressure to take unplanned emergency patients. The data from ICNARC reported early discharges often being higher than those from comparable units.

**Meeting people’s individual needs**

- Equalities and diversities were considered, although there was no specific resource in one place for staff to access. Staff were able to describe the areas of equality and diversity they had experience of supporting. They were knowledgeable about the strands of equality and diversity and what made each person an individual. As an example of some individual care, staff said they were able to provide vegetarian, vegan or halal diets for patients. Staff would respect different cultures and religious needs by, for example, providing only male or female staff if this was important to the patient. Resources were available for people who had impaired vision or hearing. Staff we spoke with said all patients would be treated and cared for as individuals and adjustments would be made to ensure the outcomes for patients were as good as they could be.

- There were translation services available. Staff could use a telephone translation service, which we were told was available on short notice. The unit was able to arrange face-to-face translation with appropriate notice.

- Staff had access to a network of support for patients’ spiritual needs, both within the hospital and from the local community. The chaplaincy based at the hospital visited the wards regularly and
specific visits could be arranged. There was a chapel at the hospital, which had times set aside each week for use by Muslim people.

- The trust had staff experienced with supporting patients with learning disabilities. The critical care unit were able to access specialist nursing staff for advice and assistance. Carers and relatives were encouraged to attend the unit and provide advice and support. We met a patient with a learning disability and their relative. The relative said staff had been kind and thoughtful with the patient. They said they (the relative) had been asked to complete a document called ‘Getting to know ……’, which described for staff things like what the patient wanted to be called, their hobbies and interests, likes and dislikes and their general physical and mental health.

Learning from complaints and concerns

- Staff addressed and learned from complaints and concerns. The unit received few complaints or concerns. Informal concerns or complaints were dealt with by staff on duty and the matron either took responsibility to address these, or was informed about how they had been managed. Formal complaints were redirected to the hospital’s Patient Advice and Liaison Service who initiated an acknowledgment. The complaint was then passed to the relevant person in the unit to respond fully. We tracked one recent complaint and saw it had been thoroughly investigated. All the relevant parties had been involved, including the patient’s GP. An action plan had been produced to address the areas needing to be improved. The complainant had been provided with a detailed response. Learning from the issues raised had also been shared with wider staff groups.

Are critical care services well-led?

The critical care team was well motivated and supported. The medical and nursing leadership were strong and well respected. There were governance arrangements for auditing and monitoring services. There was, however, no written evidence of actions or learning from clinical governance meetings and who would be accountable for change and development. Staff learned from things that did not go well and celebrated and recognised success.

There was a duty of candour among staff in critical care services in relation to risks. Problems and emerging concerns would be escalated to senior management without hesitation. The values and behaviours of the staff at local-level were respected, known and understood.

Vision and strategy for this service

- The critical care leadership team reflected the requirement to deliver safe, effective, caring, responsive and well-led care and treatment. The senior management, matron, senior nurses and consultants were committed to their patients, staff and unit. Nursing staff team leaders were well supported and well respected by their own teams. All staff we met were committed to high quality, compassionate and safe care and treatment.

Governance, risk management and quality measurement

- Staff contributed to the quality and risk reviews. There was a corporate risk register in use, but this contained serious incidents requiring investigation, and other risks identified by staff were not included. There were clinical governance meetings held each quarter. Staff told us a wide range of topics were discussed and presentations received. Staff performance was discussed, as were Safety Thermometer results, trends and any arising actions taken. Sickness absence, training, staffing issues and incidents were discussed. We were concerned there was no record of these meetings so any actions or learning coming from those things discussed was not recorded. There was no evidence to support any improvements made or who was accountable for change and development.

- There was good staff awareness of unit performance and staff were encouraged to improve practice. This had led to an initiative by the band 6 nurses who organised a quarterly study half-day
session for the nursing team. This included a review of information from the local critical care network, updates on projects or discussions about new initiatives. Staff were made aware of the latest Intensive Care National Audit and Research Centre (ICNARC) data results, which was reported at the meeting by the unit data coordinator.

Leadership of service

- The service was well-led by staff respected by their peers and those they managed. Staff told us their values and patients were at the centre of their descriptions. Staff also said how they valued their teams and the work they did. The leadership by the matron was strong and we witnessed how the matron led by example. Staff spoke highly of the lead consultants and felt teamwork and mutual support was strongly-led.

Culture within the service

- There was a strong culture of teamwork and commitment in the critical care unit. All the staff we spoke with said the strength of the unit was a friendly and cohesive team. We had the same comments from senior management, the cleaner, the nursing team, consultants and the ward clerk. Patients and relatives also commented on the positive nature of the staff they met. Comments about staff culture included, “They are respectful of patients, families and each other,” and, “They treat everyone as individuals and I get the sense it’s as they would want to be treated. They seem to walk in our shoes.”
- There would be appropriate and rapid action to deal with issues of performance among staff. The matron said staff would enter a capability pathway if they did not complete their mandatory training, or there were other performance issues. There were human resource procedures to be followed and support available for disciplinary matters that needed to be escalated to senior management.

Public and staff engagement

- Due to the nature of critical care there was no general public involvement with how the service was run, but patients and their relatives were asked to comment on their care. A feedback form had been designed for the unit and was collated by a volunteer member of staff. There was no analysis of these feedback reports though, or any trend analysis to drive practice improvements. Those comments we saw, however, were positive and complimentary of the service.
- All staff we met felt they had a voice and their opinions were valued and heard. This included the dedicated member of the cleaning team we met in the unit. They said they felt part of the team.

Innovation, improvement and sustainability

- Clinical governance groups were responsible for reviewing critical care procedures and ensuring best practice was used and delivered.
- There were no current plans to improve or develop the service. The patient notes and all associated clinical work, such as medicine administration, were all done on paper records. There was no plan to upgrade these to more secure, efficient electronic records.
- The team working in critical care had strong, shared values, but there were no longer-term objectives for the team to work towards.
Maternity and family planning

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Information about the service

Northern Devon Healthcare NHS Trust provided maternity care at North Devon District Hospital. Community midwifery services were provided throughout north, east and west Devon and north Cornwall.

Facilities within the hospital (Ladywell Unit) included:

- Antenatal, postnatal care on the 18-bed Bassett Ward, which comprises of bays of three beds, side rooms with en-suite facilities and an overnight room for woman and their partners if required. A two-bed day assessment unit was run from Bassett Ward between the hours of 9am until 5pm, five days a week. (The hospital has a level 1 special care baby unit. This is covered within the ‘children’s and young persons services’ section of the report).
- A birth suite comprised of six rooms, two of which included a birthing pool. There was one dedicated obstetric theatre and recovery area.
- An antenatal clinic.
- Community Midwifery services.
- Ultrasound facilities within the antenatal clinic. Staffed by sonographers provided by the radiology department.
- Triage, which occurs on Bassett Ward.
- The trust have level 1 UNICEF Baby Friendly Initiative status and were aiming to achieve level 2.

Between 1 April 2013 and 31 March 2014, there were 1,570 births across the whole of the service, which included 61 home births and eight births described as being before arrival at the hospital.

Summary of findings

The maternity and family planning services were found to be safe, effective, caring and responsive but required improvement in order to be well-led. The care and support offered to women and their families was compassionate, kind and informative.

Staff referred to a Royal College of Obstetricians and Gynaecologists (RCOG) visit, commissioned by the trust in November 2013, to “obtain an external view of the impact of the medical team working on patient safety”. A report was sent to the trust on 4 March 2014 and an action plan developed by the trust. The developments from this report were needed to address long standing, complex relationship issues around this staff group.

The trust did not consistently meet the legal requirements of HSA1 (grounds for carrying out an abortion)
and HSA4 (abortion notification), as required. There was no guidance, or an identified system in place to ensure records were completed both accurately and consistently.

Rooms used by sonographers in the antenatal clinic were not big enough to allow for privacy and dignity to be maintained without the practitioner having to leave the room. The rooms did not have a system for calling for help in the event of an emergency.

The caesarean section and induction of labour rates were above the national average for a low-risk unit. The maternity unit were working to reduce the numbers, by promoting normal birth within the staff group and to pregnant women.

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<th>Are maternity and family planning services safe?</th>
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Midwifery levels were sufficient to provide one-to-one care and support to women in labour, meaning they provided a safe service. There was 24-hour medical cover, seven days a week. However, the labour suite had 40 hours per week of designated consultant cover, but not always presence, despite the Royal College of Obstetricians and Gynaecologists (RCOG) desired standard for a service delivering fewer than 2,500 women per year. The antenatal guidelines for caesarean section, or induction of labour were reported as not always being followed by consultant obstetricians and middle-grade doctors, meaning there was a higher rate of caesarean section and induction of labour than the trust expected.

All areas within the maternity service were tidy, with equipment stored in locked rooms or appropriate corridor space. Some of the facilities within the maternity unit were small and cramped, for example, consulting rooms used for consultation between patients and medical staff and for ultrasound scans. This meant staff had to leave the room when patients were preparing for, or dressing following, their consultation or scan, putting patients at risk if they felt unwell or fell when being left unsupervised. This issue had been identified on the trust risk register since 2009. Staff told us they reported incidences via the electronic reporting system. They were not always clear about what incidences to report and told us they did not always get feedback after reporting an incident.

We found the way the midwifery teams were organised ensured mandatory training was always attended, due to good advance planning and the staffing numbers sufficient to ensure all shifts were covered when staff were attending training. There were dedicated practice development midwives, who monitored attendance and organised training sessions. All midwives must have access to a supervisor of midwives (SoM) at all times, (according to the Nursing and Midwifery Council Midwives rules and standards - rule 12, 2004). The ratio of SoM to midwives was 1:17. This was worse than the recommended ratio of 1:15.

**Incidents**

- All staff stated that they were encouraged to report incidents and were aware of the process to do so. Staff were knowledgeable about how to report incidents.
- Incidents were reported on the trust’s electronic incident reporting system. The head of midwifery told us staff were aware of the type of incidents to report. Staff reported that they were not always clear about what incidents needed reporting. We saw copies of a newsletter called *Risky Business*, produced by the risk midwife, detailing incidents that had been investigated and changes to practice that were recommended as a result. The newsletter was made available to all staff. Staff were able to describe learning from incidents and changes in practice that had been implemented as a result. Some staff said they did not have time to read the newsletter. Other staff said they sometimes felt incident reporting investigations pointed the finger at individuals and were not constructive.
- Biweekly operational risk meetings took place. Details of incidents reported were received for review by senior midwives, the head of midwifery and the risk management midwife, who ensured investigations occurred as necessary. Serious incidents were escalated within the organisation to the organisational lead for risk. We saw these were highlighted as part of the maternity governance programme.
- Staff received an email of acknowledgment whenever they reported an incident. Midwives told us they did not always get feedback after they had reported an incident and were not sure what had
been done with their information, or had not seen any positive changes as a result.

- The maternity services patient safety forum minutes from April 2014 stated there were 17 significant event audits outstanding at the time, but no recurring themes had been identified.
- There had been no reported Never Events (a serious, largely preventable patient safety incident that should not occur if the available preventative measures have been implemented by healthcare providers) in the maternity services in the past 12 months.
- Perinatal mortality and morbidity meetings took place monthly. We saw the minutes for February 2014. Case reviews were discussed, with learning points detailed for each one. We noted that two of the six obstetrics and gynaecology consultants attended.

Safety thermometer

- We saw incidences of new venous thromboembolism’s (VTE), urinary catheters and urinary tract infections (UTIs) were reported via the Safety Thermometer system. The trust rates for VTE and UTIs were consistently below the England average.

Cleanliness, infection control and hygiene

- Incidents of infection were reported as required.
- MRSA incidences in the trust were higher than the accepted range and *C. difficile* rates were within an acceptable range. Maternity services were not identified as outliers for these infections.
- We saw staff observing good hand-hygiene practices and using gloves and aprons, where necessary. This was readily available in all of the departments we visited. There were hand-washing sinks available throughout the departments with liquid soap, paper towels and pedal bins at each one.
- Liquid hand-sanitising gel and notices encouraging its use were displayed at the entrances to all of the maternity departments.
- The results of the internal hand hygiene audits were displayed on large boards at the entrance to the labour suite and Bassett Ward.
- We saw midwifery and medical staff adhering to the ‘bare below the elbows’ policy.
- The ward and departments we visited and equipment were clean. We saw evidence that equipment had been cleaned and marked with stickers to indicate when it had been cleaned and who had undertaken the task.
- The ward and units we visited were very clean and there were no odours. Patients we spoke with all said they thought the units were clean. Maternity support workers and domestic staff told us they worked well together to ensure rooms were cleaned effectively.

Environment and equipment

- Entry to the labour suite and Bassett Ward was via a swipe card by staff and via a locked door, controlled by a bell for visitors.
- All areas within the maternity service were tidy, with equipment stored in locked rooms or appropriate corridor space.
- Some of the facilities within the maternity unit were small and cramped, for example, consulting rooms used for consultation between patients and medical staff and for ultrasound scans. This meant staff had to leave the room when patients were preparing for, or dressing, following their consultation or scan. This put patients at risk if they felt unwell or fell when they were left unsupervised. This issue had been identified on the trust risk register since 2009. It had also been the subject of risk register discussion during the maternity services patient safety forum meetings.
- There was one obstetric theatre and dedicated recovery space. Midwives reported there was sufficient equipment to meet patients’ needs and for use in emergencies.
- Emergency equipment was checked and documented daily by a band 6 midwife.
- Emergency resuscitation equipment was available for both mothers and babies and was regularly checked.
- There was an overhead hoist over each birthing pool. This enabled swift evacuation of a woman
from a pool in the case of emergency and ensured the safety of staff was maintained.

Medicines

- Medicines were stored in locked cupboards.
- Medicines that required storage at a low temperature were stored within a specific medicines fridge. Not all of the temperatures were checked or recorded daily. During the inspection, the matron ensured all staff were aware of the need to check and record the fridge temperatures daily. They showed us the forms to be used and said they would check that the temperatures were being recorded on their weekly ‘matron’s walk around’ of the labour suite and ward.
- Nitrous oxide, for pain relief was piped into the delivery rooms.
- Stronger analgesia was available for women in labour.
- Midwives told us they received support from the onsite pharmacy, when required.

Records

- Patients had hand-held records from their initial booking through to completion of their postnatal care by the midwives. Hand held means that staff have direct access to notes carried by the patient as opposed to sometimes a practitioner not being able to access relevant notes on a computer due to difficulty with pick up or no access to a computer.
- Medical records were obtained in the antenatal period to allow staff to look at the woman’s history and review the details of previous deliveries. The notes were held securely in the unit until the postnatal period.
- Concerns were raised with us prior to the inspection that notes had sometimes been left unattended, which had compromised confidentiality. We did not see any notes unattended in the reception area, or any other part of the Ladywell Unit we visited.
- Audits of record-keeping formed part of each midwife’s annual supervisory review. Record keeping had not been identified as an area of concern.
- The antenatal and newborn screening coordinator described the challenges faced trying to collect data for local and national requirements from in-house records and community midwives records. They added that a new electronic system was going to be introduced trust-wide and this would make data collection easier and, in turn, ensure its accuracy.
- We saw modified emergency obstetric warning score (MEOWS) documents and baby check records prior to discharge being completed appropriately.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients were asked to sign appropriate consent forms. At the time of the inspection, there were no women without capacity to consent to their procedure.
- Midwifery staff we spoke with showed a good understanding of the Mental Capacity Act 2005 and its relation to decision making in the antenatal, labour and postnatal period.

Safeguarding

- A midwife with responsibilities for safeguarding had been in post for seven months. Systems in place to identify vulnerable people from the local community and in the holidaymaker population were in place. Working relationships with organisations in the wider community were being established.
- Safeguarding peer group meetings had been established and the topic of safeguarding and the Mental Capacity Act 2005 were being discussed at one-to-one/supervision sessions, to ensure it remained in staff members’ minds.
- There were clear pathways for the escalation of concerns to senior staff and the director of nursing, if required.
- Staff were aware of their responsibilities with regards to safeguarding and had undergone training at the appropriate level - 85% of midwives had achieved level three in child protection training.
- Staff noticeboards throughout the hospital displayed information about safeguarding and how to
raise safeguarding concerns.

- Medical staff reported that, recently, the safeguarding procedures had been made more robust.

**Mandatory training**

- We found the way the midwifery teams were organised ensured mandatory training was always attended, due to good advance planning and the staffing numbers being sufficient to ensure all shifts were covered when staff were attending training.
- Compliance with mandatory training was good. There were dedicated practice development midwives who monitored attendance and organised training sessions. Staff said access was good and midwives received the trust’s mandatory training as well as obstetric emergency skills training, neonatal and adult resuscitation.
- Midwives who were newly qualified, undertook a period of preceptorship. During this time, they had access to extra support and training.
- Staff undertook at least five training days per year. Topics included infection control updates, moving and handling training (sessions provided weekly and staff rostered to attend accordingly), basic life support and safeguarding.
- Additional skills training could be accessed if recognised through appraisals and supervision sessions.

**Assessing and responding to patient risk**

- All staff attended obstetric emergency skills training. The unit used PROMPT (Practical Obstetric Multi-Professional Training) an evidence-based multi-professional training package for obstetric emergencies. We attended two sessions running during the inspection. They were well attended, well organised and informative.
- The service used the modified emergency obstetric warning score (MEOWS) system. Staff we spoke with were able to describe at what point care needs would be escalated to a doctor.
- Staff used the Situation, Background, Assessment, Response (SBAR) communication tool when handing over or discussing concerns.
- The maternity unit was consultant-led. However, high-risk women and babies, for example, following antenatal diagnosis of foetal abnormalities, were referred to and cared for at one of the bigger units in Exeter, Bristol or Plymouth, where they had specialist teams and access to neonatal intensive care units.
- The antenatal guidelines for caesarean section or induction of labour were reported as not always being followed by consultant obstetricians and middle-grade doctors, meaning there was a higher rate of caesarean section and induction of labour than the trust expected. The trust expected their emergency caesarean section rate to be below 12%. It had been above 12% for eight out of the last 12 months. The England average rate for emergency caesarean section is 14.6%. The trust expected their induction of labour rate to be below 15%. It had been above 15% for all of the previous 12 months.

**Midwifery staffing**

- The unit often employed student midwives who had trained at North Devon District Hospital only and had not worked in units that experienced high-risk births.
- Midwives reported there were sufficient staff on the unit to provide one-to-one care to women during their labour. The ratio of midwives to births was 1:30. The Royal College of Obstetricians and Gynaecologists latest advice (Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour, October 2007) says there should be an average midwife to birth ratio of 1:28 births. We were not made aware of any plans to increase the midwife numbers.
- There was no midwife-based in antenatal clinic. Midwives told us this sometimes caused problems when maternity support workers, sonographers or medical staff wanted to ask advice or pass on some information. Although there was a lead midwife for public health, community and antenatal, with an office based next to the antenatal clinic.
- At the entrance to each ward, a large display board detailed the expected number of staff on duty and the actual number on duty. We saw the actual numbers of staff was as expected in all areas.
Staff told us they used NHS Professionals to fill any vacant shifts and the same staff were used regularly which provided consistency for the permanent staff.

- All midwives must have access to a supervisor of midwives (SoM) at all times, (according to the Nursing and Midwifery Council Midwives rules and standards - rule 12, 2004). The ratio of SoM to midwives was 1:17. This was worse than the recommended ratio of 1:15. Supervisor of midwives are required to carry out annual reviews with all midwives. All midwives we spoke with had received a supervisory review and were aware of how to contact a supervisor if required. There was supervisor of midwives contact details on noticeboards in the labour suite and Bassett Ward.

Medical staffing

- There were six consultants (one of whom was a locum) supported by a team of medical staff. They were employed to provide both obstetric and gynaecological work. There was one full-time consultant post vacant at the time of the inspection. The lack of recruitment into this post was added to the risk register in April 2014.
- The labour ward had 40 hours per week of designated consultant cover, but not always presence, despite the Royal College of Obstetricians and Gynaecologists (RCOG) desired standard for a service delivering fewer than 2,500 women per year.
- There was medical cover 24 hours a day, seven days a week. Midwives and middle-grade doctors told us consultants came in if they were called, adding that they did not need to call on them too often.
- There was anaesthetic cover for the birth suite seven days a week, 24 hours a day. Out of hours anaesthetic cover was shared with the intensive care unit. However, staff reported few delays in accessing anaesthetic support when needed, for example, to provide an epidural to a labouring woman.

Major incident awareness and training

- Midwives and medical staff undertook training in obstetric and neonatal emergencies training at least annually.
- The trust had major incident plan that had been updated in May 2014.

Are maternity and family planning services effective?

The maternity and family-planning services provided effective services. Staff followed nationally-recognised policies and procedures. However, staff told us some medical staff did not always follow recognised policies and procedures, meaning induction of labour and caesarean section rates for a low-risk unit were higher than the national average. Outcomes were monitored and there was work underway to reduce the caesarean section and induction of labour rates.

Women had choices regarding pain relief in labour. There was an anaesthetist available 24 hours a day for women who chose to have an epidural.

Communication between obstetric, anaesthetic, neonatal and midwifery staff was described as good. Some staff told us communication between the senior team and some groups of staff was not always good. We were given examples of multidisciplinary working with external groups that included smoking cessation, drug and alcohol teams, domestic violence and obesity.

Evidence-based care and treatment

- Policies and procedures were available on the trust’s intranet.
- Policies and guidelines had been developed in line with both National Institute of Health and Care Excellence (NICE) and the Royal College of Obstetricians and Gynaecologists (RCOG) guidelines.
- Staff reported undertaking monthly hand-hygiene audits and infection-control audits and the results
were seen displayed on Bassett Ward and in the delivery suite.

- The risk lead midwife supported the maternity service, including the community. They developed a program of audits across the year, undertaken by midwives and obstetricians. Audits were primarily undertaken by midwives, though there was a desire to encourage more medical participation.
- A vaginal birth after caesarean section (VBAC) clinic was run by senior midwives. Women were referred to these clinics early in their pregnancy so they could be given the necessary information to make decisions as to their preferred form of delivery, following a previous caesarean section. The current rate of VBAC was 4.33%.
- The unit used PROMPT (Practical Obstetric Multi-Professional Training) an evidence-based multi-professional training package for obstetric emergencies.
- We were told that some of the medical staff did not always follow national or local guidelines when deciding on the best form of delivery for women. This led to higher than expected caesarean section and induction of labour rates.

A review of the service by the Royal College of Obstetricians and Gynaecologists (RCOG) was commissioned by the trust and carried out in November 2013. The report recommended the trust stopped carrying out amniocentesis procedures at the unit. This was because the number of procedures carried out at the unit were not sufficient to maintain the clinician’s skills. The RCOG recommends that a practitioner carries out a minimum of 30 procedures a year and the consultant at North Devon District Hospital only carried out approximately 20 per year. They were stopped in December 2013 and alternative arrangements made for patients who required the screening test.

Pain relief
- There was anaesthetic cover 24 hours per day, seven days per week, providing women with the option of an epidural if they chose. Midwives reported women did not have to wait more than 20 minutes to see an anaesthetist. The delivery rooms had piped nitrous oxide (ENTONOX®) supplied. In addition, opioid analgesia was available to labouring women, if required.

Nutrition and hydration
- Women were encouraged to breastfeed. Breastfeeding initiation rates for deliveries that took place in the hospital for April 2013 to March 2014 were reported as 73.04%, in line with the average national rate.
- There was a milk storage fridge for expressed breast milk and made-up feeds. Breast pumps were available to women who were expressing milk.
- There was an infant feeding coordinator, who trained midwives and maternity support workers in aspects of breastfeeding and bottle feeding. They also advised and supported parents of babies who had special feeding needs.
- The trust had level 1 UNICEF Baby Friendly Initiative status and were aiming to achieve level 2.

Patient outcomes
- The maternity service had a quality dashboard, which was reviewed monthly at the maternity services patient safety forum meeting. This used a red/amber/green flagging system to highlight areas of concern. This was provided to us prior to the inspection.
- The maternity services achieved a normal vaginal delivery rate of 62.17%. The national average for normal vaginal deliveries was 60.7%.
- Over the 14 months prior to our inspection, the total number of caesarean sections (CSs) was flagged as either red or amber 11 times, meaning the unit was carrying out too many CSs for a low risk unit. However, the number of instrumental deliveries (forceps or ventouse) only showed as red or amber for four of the previous 14 months, meaning the unit could increase the number of instrumental deliveries, which, in turn, could help to reduce the CS rate. Work was underway to attempt to address this by encouraging normalising birth. It was felt amongst the midwives that the medical teams were not engaged in the process of normalising birth.
- The induction of labour (IoL) rate was recorded as being between 23.7%, just above the national rate of 20%. This was flagged as red for the past 14 months against the trust’s own goal of 15% rate for induction of labour. There was work underway to ensure medical staff were aware of best
practice guidelines in terms of normalising birth, reducing IoL and CS rates. It was felt, among the midwives and some of the medical staff, that women could ask for an IoL or CS and medical staff would agree to their wishes without much discussion about the benefits to the mother and baby of normal vaginal deliveries.

- The home birth rate was 3.89%, above the national average of 2%.
- The number of women booked for their pregnancy and birth care before 12 weeks and six days gestation was 89.71%, in line with the national average of 90%.

Competent staff

- Preceptorship midwives were rotated through all areas during their preceptorship period, to ensure they had the skills and confidence to work in all areas of the service.
- Every midwife had a named supervisor of midwives. A supervisor of midwives is a midwife who has been qualified for at least three years and has undertaken a preparation course in midwifery supervision (rule 8, Nursing and Midwifery Council – NMC –l 2012). They are someone that midwives go to for advice, guidance and support, and they monitor care by meeting with each midwife annually, (Rule 9, NMC, 2012) auditing the midwives’ record-keeping and investigating any reports of problems/concerns in practice. All midwives we spoke with had received an annual supervisory review.
- All midwifery staff we spoke with were aware how to contact a supervisor of midwives at all times. The birth suite staff room and the ward had noticeboards indicating who the supervisors of midwives were, who was on call and how to contact them.
- Staff reported they regularly had appraisals and personal development review (PDR) meetings. The head of midwifery and the unit matron spoke of the importance of regular appraisals and PDRs.
- The trust had introduced a band 7 coordinator development pack. The trust said the pack had been “designed to assist midwives undertaking the role of delivery suite coordinator as a development, returning to post or new appointment”. The antenatal and newborn screening coordinator had meetings with other screening coordinators in the region, to share ideas and best practice advice. They told us there was access to role-specific training and no problem attending training as one of the midwives from the day assessment unit deputised in their absence. Antenatal and neonatal screening governance meetings took place bimonthly.
- The perinatal team routinely provided maternal and infant mental health training for midwives.
- We were told, and the RCOG report mentioned, that all speciality doctors had been permanently assigned to a consultant, hence there was no rotation, resulting in limited opportunities for learning and development.

Multidisciplinary working

- Communication between obstetric, anaesthetic, neonatal and midwifery staff was described as good. Some staff told us communication between the senior team and some groups of staff was not always good.
- Obstetric multidisciplinary team meetings were held monthly. We saw the minutes of these meetings. Agenda items included: case reviews, learning points and discussion around perinatal and maternal statistics.
- A multidisciplinary approach was used to develop new guidelines. Although it was noted that obstetricians did not always attend the guidelines group, or make comments electronically when invited to do so.
- Staff told us community midwives phoned in daily to the postnatal ward to find out if any of their patients were going to be discharged that day. They said that, as a result, they knew the community midwives well and they worked together as a team. Community midwives reported good team working and said there was good support amongst the midwives and maternity support workers.
- We heard about, and saw, good working relationships between the midwives, maternity support workers and sonography staff.
- We saw the medical team had an obstetrics and gynaecology handover each morning and evening. The meeting included the labour ward coordinator. A written report had recently been
introduced and was proving popular with all staff.

- The perinatal team were based in the antenatal clinic and worked alongside the obstetric and midwifery teams, GPs, mental health teams, children’s social workers and health visitors.
- We were given examples of multidisciplinary working with external groups that included smoking cessation, drug and alcohol teams, domestic violence and obesity.
  There was an office used by the antenatal and newborn screening coordinator, perinatal mental health team and maternity support workers running clinics. Staff reported that this led to good multidisciplinary working. They added that it was difficult to maintain privacy during phone calls with patients and the phones ringing constantly was a distraction.

**Seven-day services**

- Access to the single obstetric theatres was available at all times. The general theatres supplied the theatre team. Out-of-hours consultant cover was provided by on-call consultants. Midwives told us the consultants attended the unit, if required.
- There was access to an anaesthetist at all times for epidural pain relief or emergency caesarean sections.
- There was an on-call pharmacy facility when the main pharmacy was closed.

<table>
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<tr>
<th>Are maternity and family planning services caring?</th>
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<td>The service provided was caring. Staff provided compassionate care and emotional support to women and their partners. Since May 2013, the maternity services have offered a perinatal team who provided support and advice to women (and their families) who had mental health needs. The results of the NHS Friends and Family Test (that were available) showed most respondents were likely to recommend the service to friends and family.</td>
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The antenatal clinic consulting rooms were cramped, meaning there was no room for privacy curtains. This meant women’s privacy and dignity was sometimes compromised. The “quiet room” in the antenatal clinic, used for relating bad news or counselling, was not welcoming and was clinical in nature.

Women having a termination of pregnancy for foetal abnormalities were sometimes moved to the gynaecology ward if the day unit was closed and the process was not completed. Staff were not always trained or prepared to care for these women.

**Compassionate care**

- In the CQC maternity service survey, 2013, women were asked about their care at the hospital. The trust scored about the same as other trusts for all aspects of maternity care, including antenatal, during labour and birth and in the first few weeks after birth.
- The available results of the NHS Friends and Family Test showed most respondents were likely to recommend the service to friends and family. Results were on display on the noticeboards in the labour suite and Bassett Ward. The response rate for the trust was low and the trust was actively encouraging staff to ask patients to complete the forms.
- Throughout our inspection, we witnessed women and their partners being treated with compassion, dignity and respect.
- Patients and their families that we spoke with told us they were happy with the care and support provided. Comments included: “I was never left alone unless I wished to be,” and, “I had brilliant care, I can’t praise it enough,” and, “I had one-to-one care and was never left alone, I wouldn’t change anything.”
Patient understanding and involvement

- Women were involved in their choice of birth at booking and throughout the antenatal period. Women spoke with said they had felt involved in their care, they understood choices open to them and were given options of where to have their baby.
- Women carried their own records throughout their pregnancy and postnatal period of care. They were given information leaflets at booking and there was access to a wide range of leaflets and links to useful websites on the trust’s own website.
- A maternity services liaison committee (MSLC) had recently been set up and was actively recruiting patients to represent the user views on the committee. The Department of Health says each trust providing maternity services should have a MSLC that includes the provider, the commissioning body and local people who have used the services.

Emotional support

- Chaplaincy care was available. Details of how to contact the service were available throughout the Ladywell Unit.
- Since May 2013, the maternity services had a perinatal team who provided support and advice to women (and their families) who had mental health needs.
- Staff on Bassett Ward told us they had good working relationships with the community midwives and local GPs, so felt they were able to handover any concerns they may have about a woman’s wellbeing on discharge.
- The antenatal and newborn screening coordinator described how they supported women and their families when they had received bad news. They were able to provide counselling sessions in person at North Devon District Hospital, or over the telephone. They said that current resources did not allow them to visit people at home or one in of the trust’s 17 community hospital settings.
- The gynaecology day surgery unit undertook terminations of pregnancy for foetal abnormalities from 16-weeks’ gestation. If the process was not completed when the day unit was closing, women had to be transferred to the gynaecology ward (that was not limited to gynaecology patients) where staff were not always trained or prepared to care for these women.

Privacy and Dignity

- The antenatal clinic was cramped. Consulting rooms were small, with no space for curtains or screens so that consultants and sonographers had to wait outside the room while women dressed or undressed, as required. This meant that privacy and dignity could sometimes be compromised.

Are maternity and family planning services responsive?

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<td>The services provided were responsive to the needs of the local people. The service offered a day assessment unit and triage facilities. There were two birthing pools available in two delivery rooms. We were told succession planning was underway to ensure there were enough midwives trained and employed to cover the posts made available by several midwives who were due to retire over the next couple of years. Information was available regarding the trust and maternity services on the trust’s website. Translation services were available. This mainly involved the use of telephone interpretation services. The trust did not employ a bereavement specialist midwife, but had a midwife with an interest in bereavement. We were told better facilities for parents who had suffered bereavement would be available once the refurbishment of Bassett Ward was completed.</td>
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Service planning and delivery to meet the needs of local people

- The service was planned and delivered to meet patients’ needs, for example, women could elect for delivery at home, or at North Devon District Hospital. Ultrasound scanning clinics took place Monday to Friday in the antenatal clinic. There was a day assessment unit for women who had reduced foetal movements and could attend for cardiotocography (CTG) monitoring. Glucose screening was undertaken Monday to Friday in the day assessment room, to screen women identified as high risk, for evidence of diabetes in pregnancy. There was a triage facility used to identify if women were in labour and could be sent home, or if they needed to stay in the unit.
- There were two birthing pools available in two delivery rooms.
- There was one dedicated obstetric operating theatre. We were told there was access to a second theatre in the gynaecology day surgery unit, if necessary, but this had never been identified as a problem.
- Staff told us that if the labour suite was busy, staff were redeployed from Bassett Ward to help. Staff on Bassett Ward said this sometimes left them short staffed. They gave examples of helping a woman with breastfeeding, but being called away to answer the ward phone or doorbell because the maternity support worker had been taken to work on the labour suite.
- We were told succession planning was underway to ensure that there were enough midwives trained and employed to cover the posts made available by several midwives who were due to retire over the next couple of years.
- The antenatal and newborn screening coordinator had been asked to develop a business plan with a view to increasing their hours, or recruiting an extra member of staff to meet the increasing demands of the national screening programmes and data collection requirements.
- The lead midwife for public health, community and antenatal described how the service was working with local groups to increase awareness of the importance of smoking cessation support. She added a smoking cessation midwife had just been appointed to work with local groups and within the unit to educate women, their families and maternity staff. Work was also ongoing around domestic violence and obesity, as well as the risk of diabetes in pregnancy.

Access and flow

- The unit had a higher bed occupancy compared to the England average of 58.6%. It was 79.8 % in the last quarter of 2013. The trust did not have any midwife-led birthing units in their large geographical patch, so all women who chose to have a hospital birth attended the North Devon District Hospital. At certain times during the year, the population increased, with tourists visiting the area and unexpectedly going into labour. The trust was aware of this and had summer and winter pressure plans in place, if necessary.
- Women were booked for their pregnancy and birth care by their community midwife in one of the numerous clinics held in local GP surgeries or community hospitals run by the trust. They only attended North Devon District Hospital for their dating scan and obstetrician consultation and then once again for a scan later in their pregnancy.
- Staff reported that the day assessment unit and triage system reduced the need for women to be admitted to the labour suite of Bassett Ward unnecessarily.
- We saw that some midwives were trained to carry out baby checks prior to the child being discharged home. This meant women did not always have to wait for a paediatrician to see them and could, therefore, often be discharged earlier.
- Midwives reported there were not enough single rooms available on Bassett Ward if a partner wanted/needed to stay overnight.
- The unit had no dedicated bereavement facility, although there was one single room that could be used by a couple if required.
- There was one small room in the antenatal clinic, which staff called the “quiet room”, for when women and families had received bad news or were being counselled. The room was not welcoming and was clinical in nature.
Meeting people’s individual needs

- Information was available regarding the trust and maternity services on the trust’s website.
- Translation services were available. This mainly involved the use of telephone interpretation services. We were given examples of when and how the service had been used.
- Some leaflets were available to print off in other languages, for example, antenatal screening literature.
- The trust did not employ a bereavement specialist midwife, but had a midwife with an interest in bereavement. We were told better facilities for parents who had suffered bereavement would be available once the refurbishment of Bassett Ward was completed.
- Patients were able to stay in Bassett Ward antenatal clinic if they required daily monitoring, due to distances and time spent in attending the hospital each day.
- There was a midwife with a special interest in disabilities and mobility who could be asked for advice, as required.
- There was a learning disability team in the trust who could be asked for advice and support if required.

Learning from complaints and concerns

- Staff told us informal complaints were directed to the person in charge at the time. If they were not able to deal with the issue we were told patients were advised of the Patient Advise and Liaison Service. We saw information about how to contact Patient Advice and Liaison Service on the units we visited.
- All formal complaints were dealt with using the trust policy. The investigation would be overseen by the head of midwifery. They were included in patient safety forum meetings and the risk midwife would make staff aware of the outcomes and any action needed to be taken via the Risky Business newsletter and in meetings with relevant people.
- Staff told us learning had taken place, following formal complaints investigations and practice had changed accordingly. They said any new practice introduced was subject to internal audit programmes.

Are maternity and family planning services well-led?

In order for the maternity and family planning services to be described as well-led, improvement was required. The service had a well-defined governance structure. Meetings existed that oversaw activity, performance, quality, safety, audit and risk. Issues were escalated to the trust, as required. Midwives told us lead clinicians responded to the guidelines group, but most of the consultants did not.

Staff referred to a Royal College of Obstetricians and Gynaecologists (RCOG) visit, commissioned by the trust in November 2013, to “obtain an external view of the impact of the medical team working on patient safety”. A report was sent to the trust on 4 March 2014 and an action plan developed by the trust. The developments from this report were needed to address long standing, complex relationship issues around this staff group.

Midwives told us they felt very supported by the lead midwife for normal birth and inpatient services.

The trust did not consistently meet the legal requirements of HSA1 (grounds for carrying out an abortion) and HSA4 (abortion notification), as required. There was no guidance, or an identified system in place to ensure records were completed both accurately and consistently.

Staff were looking forward to the proposed developments of the antenatal clinic area and Bassett Ward. They said that this, however, was a long time coming and felt like the improvements were always being “put off” due to lack of money. They had no knowledge of when the developments were to take place.
Vision and strategy for this service

- Staff were aware of the organisational strategy at trust-level and within maternity services. Staff spoke with us they felt the vision and strategy for the maternity services was to develop normal birth and to upgrade the facilities in the antenatal clinic area and on Bassett Ward.
- Plans were in place for the development and improvement of the service. The trust wanted to reduce their rates of caesarean section and induced labour. An action plan had been developed as a result of the Royal College of Obstetricians and Gynaecologists (RCOG) visit in November 2013, and the subsequent report. This included plans to review the consultants on-call rota with a view to enhancing teamwork by October 2014. This also included a review of clinical risk management to develop a more inclusive and positive culture. Plans were in place to begin regular meetings and communications between the lead clinician for obstetrics and gynaecology (O&G), the head of midwifery and the divisional general manager, in order to work more effectively with the clinical workforce. This was supposed to be in place by July 2014. However, during our inspection, we were told these meetings had not yet been set up.

Governance, risk management and quality measurement

- The service had a well-defined governance structure. Meetings existed which oversaw activity, performance, quality, safety, audit and risk.
- Performance and outcome data was reported and monitored via the service performance dashboard.
- There were regular governance meetings, including: supervisor of midwives, maternity services liaison committee (newly established), perinatal mortality and morbidity meetings, maternity audit, antenatal and neonatal screening governance meetings, biweekly operational risk meetings and guidelines meetings.
- Staff and managers told us they thought there was a robust audit cycle.
- The maternity service had a risk register that described nine risks, most of which were due to be actioned by the end of June or July 2014. Staff were generally aware of the contents of the risk register. The risk midwife produced a newsletter (Risky Business) that described any new serious untoward incidences (SUI), outcomes of investigations and actions to be taken as a result.
- We were told there was no sense of urgency by some of the medical staff to address significant issues such as the caesarean section and induction of labour rates. This could have an impact on the safety of women and their unborn babies as good practice guidance developed nationally and adopted locally was not always being followed.
- Midwives told us lead clinicians responded to the guidelines group, but most of the consultants did not. This meant that the guidance was not always updated in line with good practice as quickly as it ought to be. They added that consultants did not engage in the assessment to achieve level 2 CNST status.
- Completion of HSA1 (grounds for carrying out an abortion) and HSA4 (abortion notification), as required, was not consistent and there was no guidance, or an identified system in place to ensure records are completed both accurately and consistently. We looked at eight sets of notes and found six had a signed HSA1, but in two no HSA1 form could be found. The HSA4 form was not seen in seven out of the eight records reviewed indicating they had been submitted to the Department of Health.

Leadership of service

- Staff described the lead midwife for normal birth and inpatient services as “visible” and “supportive”. They knew the head of midwifery and clinical lead for their service, but not the clinical director for the service. They said they could contact the head of midwifery when required.
- Lead midwives were seen in clinical areas and had a good awareness of activity within the service during the inspection. Staff were clear about who their manager was.
- We spoke with the lead clinician for obstetrics and gynaecology (since November 2013). They said they met with the clinical director occasionally, but more often with the divisional manager for surgery and the head of midwifery.
- In September 2012, the divisional structure of the trust was realigned. This meant the women’s and
children’s division was disbanded and the obstetrics and gynaecology team joined the surgical specialties division. Medical staff reported that this meant they felt like they were the “bottom of the pile”. They also said they did not very often see the clinical director who was a vascular surgeon. Following the RCOG report, the trust said in their action plan there were no plans to change the divisional structure.

- A review of the service by RCOG was commissioned by the trust and carried out in November 2013. This was to “obtain an external view of the impact of the medical team working on patient safety”. The report was received by the trust on 4 March 2014 and an anonymised version and the action plan the trust had developed was shared with staff at the end of June 2014. Despite the fact that many of the staff had been interviewed during the visit, they told us they had not had any feedback or involvement in the action plan that had been developed. Staff we spoke to were unhappy with the delay and felt that changes suggested in the action plan could have been implemented earlier if they had received the report earlier. The perceived delay in letting the staff know about the report, the manner in which it was sent by email with no explanation, and the fact that it was a redacted version, staff told us, had all increased their anxiety. The trust told us the delay had been due to changes in senior management at the trust over the last few months.

- The recommendation from the report to stop carrying out amniocentesis procedures at the unit was carried out immediately. This was because the number of procedures carried out at the unit were not sufficient to maintain the clinician’s skills. The RCOG recommend a practitioner carries out a minimum of 30 procedures a year and the consultant at North Devon District Hospital only carried out approximately 20 per year. A second recommendation to formally check and review doctor’s competencies in undertaking screening and early pregnancy scans was also put in place in December 2013.

- Despite previous recommendations by the National Clinical Assessment Service (NCAS) and the RCOG report that the medical staff should all have job plans, many still did not have one. The clinical lead told us they were going to work with the clinical director to encourage the medical teams to ensure that they had job plans. They said this was going to begin to be addressed during appraisals, which were due to take place. They added that discussions about managing the medical staff rota differently were also going to be discussed during appraisals and could be part of some people’s job plans.

Culture within the service

- Staff were aware of the whistleblowing policy and were encouraged to raise any concerns they may have. They told us they had confidence in raising concerns.
- Staff spoke of an open, supportive and friendly culture, with good teamwork, although Bassett Ward staff reported they felt like “second best” because they always had to give up staff for the labour suite when they were busy. This never seemed to be reciprocated when labour suite was quiet and Bassett Ward was busy.
- Staff spoke passionately about the service and it was clear from all we spoke with that they enjoyed working at the trust.
- The RCOG report described the ongoing (since 2010) issues relating to working arrangements for associate specialist grade (SASG) doctors. The issues included arrangements for leave, more time for continued professional development and inequalities in contracted hours of work. In 2011 a business case to increase the number of SASG doctors from four to seven was successful. Issues still existed regarding the introduction of a new rota, designed to address some of the issues noted above. Despite attempts to resolve these issues the new rota had still not been introduced. The RCOG report also commented that midwifery and medical staff perceived a blame culture in the risk management process making the working environment sometimes uncomfortable.

Public and staff engagement

- A maternity support liaison committee (MSLC) had recently been established. The department of health says each trust providing maternity services should have a MSLC that includes the provider, the commissioning body and local people who have used the services. The purpose of a MSLC is
to contribute to the improvement of maternity care and facilities for parents and babies. Staff told us they were actively attempting to recruit people who had used the maternity services to be involved with the committee.

Innovation, improvement and sustainability

- Staff were looking forward to the proposed developments of the antenatal clinic area and Bassett Ward. They said that this, however, was a long time coming and felt like the improvements were always being "put off" due to lack of money.
- There was a feeling amongst the staff that innovation and improvements did not always happen, due to the attitude of some of the consultant group.
- Midwives were pleased to tell us about the success of the North Devon perinatal team. The team was based in the antenatal clinic alongside midwives.
- A smoking cessation midwife had recently been appointed to provide support and help to give up or reduce smoking to women and their families. They supported staff, helping and supporting women to reduce, or give up smoking.
- We were told of plans to introduce advice and support with external agencies around obesity and the attendant risks to the pregnant woman and unborn babies.
Services for children and young people

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<td>Safe</td>
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Information about the service

North Devon District Hospital has one 12-bed children’s ward, the Caroline Thorpe Ward, with a mixture of surgical and medical beds. Within the Caroline Thorpe Ward there is an additional two-bed high dependency unit (HDU), a four-bed children’s assessment unit and the local neonatal unit with seven cots proving level 1 care. The hospital provides a children’s outpatient service and a community nursing service. Paediatric care is provided in the accident and emergency department (A&E) and has been reported on in the A&E section of this report.

There are currently eight consultant paediatricians, with a further two planned to join by October 2014. The consultants have a range of specialist interests, including: child protection, children in care, neonatology, child development and community paediatrics, eating disorders, oncology, haematology, gastroenterology, respiratory and cystic fibrosis, cardiology, diabetes and endocrinology, renal, epilepsy and allergy.

During this inspection, we visited the day surgery unit, the high dependency unit (HDU), the Caroline Thorpe Ward, the neonatal unit and the children’s outpatient department.

We spoke with seven patients or relatives, a Bliss volunteer and 25 members of staff, including: senior and junior doctors, nursing staff (including specialist nurses), healthcare assistants, senior managers and ward staff. We observed care and treatment and the environment. We received performance information and looked at policies and care records.

Summary of findings

We found children’s services to be safe. Parents told us that staff were caring and we saw that children and their parents and carers were treated with dignity, respect and compassion. Ward areas and equipment were clean.

There were contingency plans if there were staff shortages and/or wards were full. Patients requiring intensive mental health support were cared for by agency staff with mental health training, there was a multidisciplinary proposal for an urgent assessment protocol.

There were thorough nursing and medical handovers that took place between shifts to ensure continuity of care and knowledge of patient needs. We saw evidence of outstanding collaborative working, both within the units and with the community paediatric nurses.

We found that the environment within the ward made it challenging to accommodate the differing needs of patients and infants, including those whose mothers were breastfeeding, and of children and young people requiring care and treatment.

We saw evidence of planning for future sustainable children’s services and learning from incidents and saw how the service made good use of the skills and resources it had.
Are services for children and young people safe?

| Good |

There were procedures in place for children and young people to have safe care. There were contingency plans if there were staff shortages and/or if the wards were full. Patients requiring intensive mental health care were looked after by agency staff with mental health training. There was a multidisciplinary proposal for an urgent assessment protocol. The reporting of incidents was satisfactory and staff learnt from feedback.

We saw that staff received safeguarding training. The management of medicines was satisfactory and there were effective procedures in place to manage the deteriorating patient.

Ward areas and equipment were clean and staff had a good understanding of infection prevention and control. There were thorough nursing and medical handovers that took place between shifts to ensure continuity of care and knowledge of patient needs. Consent was obtained before any medical or nursing interventions.

Incidents

- Staff told us that there had been one recent serious incident that was currently being investigated.
- All staff we spoke with told us that they knew how to report incidents and were supported and encouraged to do so. Themes from incidents were discussed at staff meetings. We saw evidence that policies and procedures were amended to reflect the learning from incidents.
- The paediatric service was involved in the monthly perinatal mortality meeting. Weekly teaching sessions by the senior medical staff reviewed complex cases. Both senior and junior staff attended and told us that these were useful for learning.

Safety Thermometer

- The Safety Thermometer data we saw for the past year showed that the children’s services reported above 90% for delivering harm-free care.

Cleanliness, infection control and hygiene

- The areas we visited during our inspection were clean. We observed staff washing their hands between patients and the appropriate use of hand-sanitising gel.
- There was a routine, structured programme of cleaning in place. We saw daily and weekly cleaning schedules were completed and regular auditing checks undergone. This meant that the Caroline Thorpe Ward was cleaned and audits were routinely completed to ensure clinical cleanliness was maintained.
- The staff we spoke with had a good understanding of trust policies regarding infection prevention and control.
- Patients at risk of, or suffering from, an infectious illness were cared for in single rooms to reduce the risk of spreading infection.

Environment and equipment

- Staff, patient and visitor access to the Carol Thorpe Ward was controlled via an access control system using an entry phone and/or swipe card and a camera so that staff could see who was requesting entry. Staff we spoke with told us that access could be a problem in the evenings when there was no ward clerk available.
- Neonatal staff we spoke with told us that the limited space in the unit meant transferring high dependency patients with their equipment to other areas was a problem.
- Equipment, including the resuscitation equipment, was regularly checked and cleaned. There was adequate equipment to ensure patients’ safety.
**Medicines**

- Medicines were stored correctly in locked cupboards or fridges when necessary. Controlled drugs were stored in separate, locked cupboards. This meant access to medicines, including controlled drugs, was controlled and medicines were stored securely.
- There were two pharmacists allocated to Caroline Thorpe Ward and the ward received a daily visit. Staff we spoke with told us that medication could take up to four hours to be available after patients had been discharged with patients having to wait in the playroom.
- Medication prescribing errors were investigated and appropriate actions were taken to reduce the risk of similar occurrences happening.

**Records**

- During our inspection, we noted that records were kept securely and were accessible to healthcare staff as appropriate.
- We reviewed five sets of patients’ records. We noted that the nursing care plans were comprehensive and person-centred and that relevant risk assessments had been completed. The records we saw were clearly set out, legible, dated and signed.
- We saw evidence of the use of appropriate care pathways and protocols. The staff we spoke with showed us how they accessed the policies on the trust’s intranet and had developed an electronic paediatric resource file that both the doctors and nursing staff could access. We saw evidence that the policies were regularly reviewed and amended, in line with new national guidance.

**Consent**

- We saw that children admitted for surgery had a correctly completed consent form. Children who were competent to give consent were included in the process and there was space for older children to sign to say they had given consent. Staff had a good understanding of the Gillick competence guidelines. (These are guidelines to assess whether a child under the age of 16 has sufficient maturity and capacity to consent to treatment).
- Children and parents we spoke with told us that they were well informed about the procedure and the likely outcome. We heard verbal consent being obtained before care was delivered.
- The neonatal unit had a comprehensive information booklet for patients and carers about consent, with a form setting out what care and procedures the parents and carers agreed to.

**Safeguarding**

- The nursing and medical staff that we spoke with could explain what they would do if they had any child protection concerns.
- There were clear policies and procedures for the care of children with previously identified or potential child protection concerns, the trust worked in partnership with the local safeguarding children board (LSCBs).
- Safeguarding training at level 3 had been completed by 90.3% of all nursing staff within children’s services.
- Some staff that we spoke with told us that there were challenges in meeting the needs of young people who required intensive mental health support within a general paediatric ward and that this could impact on the safety of other patients.
- The children and parents we spoke with told us they felt safe and had no concerns.
- The staff we spoke with told us that they were able to refer children for whom they had safeguarding concerns and they would be assessed in a timely manner. Staff spoke of being involved in safeguarding multiagency meetings and completing appropriate referrals or assessments.

**Mandatory training**

- Mandatory training had been completed by 78% of nursing staff within the Caroline Thorpe Ward.
Statutory training, including: equality and diversity, health and safety, infection control, manual handling, fire and preventing slips, trips and falls, had been completed by 86% of the nursing staff within the Caroline Thorpe Ward.

- All nurses on the children’s unit had completed resuscitation training.
- The neonatal unit staff (nursing and medical) linked with staff from the regional neonatal network.

Management of deteriorating patients

- Caroline Thorpe Ward, the children’s ward, used the paediatric early warning score (PEWS). The neonatal unit used the neonatal early warning score. These tools were used effectively to identify changes and determine if there was deterioration in a patient’s condition.
- We saw completed observation charts that showed observations had been undertaken within appropriate time frames. The staff we spoke with told us what action would be taken if patients scored higher than expected.
- The staff we spoke with told us that the high dependency unit (HDU) which provided care for critically-ill children was part of the regional critically-ill children’s network. The HDUs procedures were guided by criteria from one of the participating hospitals with a paediatric intensive care unit.
- The hospital had a good relationship with the local retrieval services for both children and neonates. This was a service that manages the transfer of sick children to intensive care units in other hospitals.

Nursing staffing

- Staff we spoke with told us and we saw evidence of contingency plans for staff shortages to ensure there was a safe environment for the care of children and neonates and working staff. The neonatal unit had been closed for one day in the week before our inspection, in line with the children’s services contingency plan.
- Integrated working between paediatric and neonatal nursing staff was promoted. Paediatric nurses we spoke with told us that some staff were about to complete a neonatal nursing module.
- We saw evidence of, and the lead nurse told us that, staffing numbers on the ward were consistently in line with Royal College of Nursing recommendations.
- There were two vacancies in the neonatal unit. These were covered by a bank contract and a new contract. Some of the ward manager’s hours were not covered, with the post holder now having a part-time role as the interim lead nurse for neonatal and paediatrics. Shortfalls in staffing numbers were usually covered by the service’s permanent staff. We were told that the children’s service experienced difficulty in recruiting staff.
- We observed a comprehensive nursing handover between shifts, with relevant information being passed on. Allocation of patients was based on the nurse’s skills, experience, their previous day’s working and the patient’s needs. This meant that patient’s needs were met by an appropriate member of staff.
- Staff from HDU were also able to sometimes offer support to the A&E department when a child was admitted there and to the adult intensive care unit (ITU).
- Staff we spoke with told us that when young people were admitted who required intensive mental health support, they were able to book agency nurses with mental health training to care for them. Outside office hours, there could be delays in the provision of mental health trained staff.
- The community paediatric nursing team comprised of just under five whole time equivalents (WTEs) with a small shortfall in the hours allocated for the service.
- The day surgery unit had two paediatric nurses on shift to care for the children being treated there.
- The children’s outpatient department was staffed by nurses with both paediatric and adult nursing qualifications.

Medical staffing

- There were currently eight consultant paediatricians, with a further two planned to join by October 2014. The consultants had a range of specialist interests, including: child protection, children in care, neonatology, child development and community paediatrics, eating disorders, oncology, haematology, gastroenterology, respiratory and cystic fibrosis, cardiology, diabetes and
endocrinology, renal, epilepsy and allergy.

- The children’s ward was covered by a consultant of the week and an attending consultant, Monday to Friday, 9am to 5pm, Saturday and Sunday all day and night. It is covered by a resident consultant and a middle-grade doctor, Monday to Friday evenings.
- Staff we spoke with, told us there was a shortfall in medical staffing, but that all the work, including the on-call rota and the routine clinics, were covered with existing staff and locum cover. Nursing staff told us that the use of locum doctors could mean some lack of continuity. There was no information that indicated that medical staffing was having an adverse impact of the safety of children receiving treatment at the hospital.
- Staff we spoke with told us they felt vulnerable in caring for young people with acute mental health needs, more so outside the office hours of the child and adolescent mental health service. A joint working group, with other agencies, was looking to address the issue of urgent assessment for these patients.
- Medical handovers were completed three times a day during weekdays and once a day at the weekend, we observed a morning handover and saw evidence of appropriate discussion, which ensured continuity of care.
- Visiting consultants from tertiary centres provided specialist input for children with complex or rare conditions, or where the consultants within this hospital did not provide a service, for example: ear, nose and throat surgery.

**Major incident awareness and training**

- The trust had a trust-wide incident response plan and a paediatric incident response plan. The staff we spoke with were aware of their specific role in the event of a major incident.

**Are services for children and young people effective?**

Children’s services were effective, and children were treated according to national guidance. The children’s service had a clinical audit and effectiveness programme and complied with national audits.

There were good examples of multidisciplinary working and of using clinical pathways and tools. There were procedures in place to ensure competent staff and we saw evidence of high appraisal completion rates.

**Evidence-based care and treatment**

- Children were treated according to national guidance, including those from the National Institute of Health and Care Excellence (NICE) and Royal College of Paediatrics and Child Health (RCPCH). The policies and procedures used within the department were based on national guidelines and were up to date. We saw evidence that policies were reviewed regularly and that learning from incidents was reflected in changes to policies and procedures.
- The children’s services were linked into a local regional network. Medical and nursing staff had developed an electronic paediatric resource file using resources from these networks and national guidance that both the doctors and nursing staff accessed.
- We saw documented evidence in patients’ records that the pathways set out were being used and national guidance was being adhered to.
- The lead nurse for the neonatal unit and paediatrics spoke of the need to develop the local policy for transitional care. This is an initiative that allows a baby with minor problems to be nursed alongside their mother while receiving treatment. It also reduces neonatal admissions and improves mother/infant bonding.

**Pain relief**

- Pain assessment tools were incorporated into the children’s services pathways and we saw evidence that these were completed. Older children and parents that we spoke with assured us that they were given pain relief medication frequently. Medication charts seen showed that
analgesia was prescribed and administered regularly. Staff monitored whether the pain relief medication had adequately relieved the child’s pain.

- The play specialist understood the value of adequate preparation and the use of distraction techniques and was available to help in reducing the children’s pain and distress during procedures. Nursing staff recognised the analgesic effect of a parent’s presence for babies and young children.

**Nutrition and hydration**

- Breastfeeding was encouraged on both the neonatal and children’s wards. The trust was at stage one of the Unicef Baby Friendly Initiative in supporting parents with breastfeeding and was in the process of applying for stage 2 accreditation. Separate rooms were not always available for mothers to breastfeed and mother’s privacy could not be guaranteed if the ward was busy with children and young people with differing needs.
- We saw in the patient notes we looked at that there were care plans and risk assessments to monitor that patients were adequately nourished and hydrated.
- Staff we spoke with told us there was good support available from a paediatric dietician to support those children with nutritional problems and from an infant feeding coordinator.
- We observed that a trolley service, with drinks and snacks, was available for children and young people at certain times of the day, in addition to the breakfast, lunch and evening meals. Meals were not provided for parents staying with their children. This included women who were breastfeeding their infants who were paediatric patients. Overnight, there was no nutritious food available and the hospital canteen was closed.
- We saw that the majority of the complaints received by the paediatric service were from parents about the lack of access to nutritious food.

**Patient outcomes**

- Evidence showed that the children’s service had a clinical audit and effectiveness programme and complied with national audits including the audits for the national diabetes paediatric audit, Epilepsy12 audit (childhood epilepsy), paediatric asthma, and the national neonatal audit programme. We saw evidence of the annual report of the National Neonatal Audit Programme and the latest annual report, including data for North Devon District Hospital.
- We saw in the latest national paediatric diabetes audit that for this service the results for the two main indicators were very close to those of the England & Wales average. Whilst in the National Neonatal Audit Programme we saw that the service was meeting the expected standard in the results of four of the five audit questions. We saw evidence of an action plan to improve neonatal care in line with NICE Quality Standards.
- There was no evidence of risk regarding readmission rates to the neonatal unit.

**Competent staff**

- Junior medical staff reported that they had access to a comprehensive teaching programme, but that sometimes it was hard to be released to attend, due to work pressures. The General Medical Council (GMC) 2014 reported that there had been a ‘significant improvement’ for paediatric medical staff access to educational resources.
- Senior nurses provided supervision to student nurses. Staff we spoke with told us they had supervision via team meetings and group safeguarding children supervision where they could discuss and reflect on work practice. One member of the nursing staff who joined one month prior to our inspection reported being very well supported and showed their comprehensive induction and training programme.
- The hospital was responding to the national shortage of neonatal nurses and cross working between the paediatric and neonatal units, as well as supporting paediatric nurses to complete neonatal modules.
- Medical staff adhered to the protocols of the specialist tertiary hospitals and had good access to specialist advice when providing care to children with complex or rare conditions.
- Membership of regional networks, such as the neonatal network and critically-ill children’s network
allowed for the sharing of best practice and updating of knowledge.

- In June 2014, 91% of staff on the Caroline Thorpe Ward, 92% of staff in the neonatal ward and 71% of staff in the community paediatric team had completed their annual appraisal. The staff we spoke with told us that they found their appraisal meaningful and that they were able to agree on their objectives and reflect on their achievements.

**Multidisciplinary working**

- The children’s ward had a paediatric dietician, two pharmacists, a specialist paediatric diabetic nurse and a cystic fibrosis specialist nurse to support staff. A CLIC Sargent specialist nurse was available who supported children locally, who were undergoing treatment for cancer in other hospitals. During our inspection, two physiotherapists visited the children’s ward.
- The nurses in the children’s outpaent service had had additional training to do more tasks, such as taking bloods. They could also be paged to give advice to those outpatient clinics such as ear, nose and throat and opthalmology, where children are seen that are not within the children’s outpatient department.
- A school teacher was employed by the trust and worked school hours. A play therapist worked for the service and their work would include distraction techniques while a child was being treated.
- The community paediatric nursing service worked in partnership with a wide range of health and social care professionals to ensure that the needs of sick children were met. Staff we spoke with told us that they worked closely with specialist nurse colleagues, such as the paediatric diabetic nurse, the paediatric continence nurse, health visitors and school nurses. One exemplary piece of work they undertook was supporting children at the end of life, in partnership with the complex care team, the staff at the local hospice as well as the hospital consultants and hospital nursing staff.
- Staff told us that the local North Devon Children’s Centre (previously Sure Start) visited the Caroline Thorpe Ward once a week, to support parents and advise on local activities and facilities for families.
- Staff we spoke with told us that when young people were admitted requiring intensive mental health support the staff were able to book agency nurses with mental health training to care for the young person.

**Seven-day services**

- The children’s ward and the neonatal unit were open seven days a week. The outpatient department and day surgery ward were open Monday to Friday only.
- Nursing cover was the same seven days a week. Medical cover changed out of hours. The children’s ward was covered by an attending consultant (of the week), Monday to Friday, 9am to 5pm. Then, Saturday and Sunday all day and night. Monday to Friday evenings were covered by a resident consultant, with the nights covered by an on-call consultant. There were middle-grade doctors on call for all shifts other than when the consultant was resident. Tier 1 doctors (foundation grades 1 and 2 and ST 1 and 2) did not work overnight, meaning that the children’s unit was covered by more senior staff at all times.
- The Child and Adolescent Mental Health Services (CAMHS) team only operated Monday to Friday. There was no access to child mental health support during the weekend or evenings.
- The community paediatric nursing team provided a five-day service, but had identified a need and a business case to expand to have a seven-day working service.
- The parents that we spoke with on the children’s ward and neonatal service, told us that they received the same level of care whether it was during the weekend, day or night.

**Are services for children and young people caring?**

Parents told us that the staff were caring, children and their parents/carers were treated with dignity, respect and compassion. The ward had open visiting times for family and parents could stay overnight.
Parents were involved in making decisions about the care and treatment of their child and told us that they got good emotional support from both nursing and medical staff.

Compassionate care

- All of the patients we spoke with were very positive about the care they had received. One parent told us staff were “very caring, [we] knew what to expect, what was going on”. Another parent said, “Cannot fault a single thing.”
- The paediatric ward used the NHS Friends and Family Test and these were sent completed to the trust’s patient experience team, while the neonatal unit had devised a patient experience survey. The ward also conducted a matron’s walkabout, where parents and children were asked for their views on the service provided. We saw a selection of responses, mostly they were very positive about the care and support they received from staff. Any areas of concern were identified with an action plan to address the issue.
- During our inspection, we observed all staff care for children and parents/carers with kindness and respect. The care was unhurried.
- For those who were inpatients, parents were encouraged to visit and spend time with their children.
- We observed a consultant surgeon having collected a child from the paediatric ward and was walking with them into the theatre area. The surgeon was kind and reassuring to the child and helping to make them feel less anxious.

Patient understanding and involvement

- Children and their parents were involved in decisions about their care and treatment. Staff we spoke with had a sound understanding of the Gillick competence guidance (these are guidelines to assess whether a child under the age of 16 has sufficient maturity and capacity to consent to treatment) in relation to consent by children and ensured competent children were offered the opportunity to make decisions relating to their care.
- We saw, in one young person’s records, a copy of a letter that had been written to him by one of the hospital consultants outlining treatment options. In another patient’s records, we saw a ‘wishes’ document setting out the outcome of a ‘best interests’ meeting showing the plan of care the young person wanted.
- The play specialist was used to support children to understand their illness and any procedures.
- The parents we spoke with told us that they were encouraged to ask questions and were kept well informed and felt reassured by staff.
- During each shift, patients would have an allocated, named nurse who was responsible for their care.

Emotional support

- Parents that we spoke with told us that they felt they got good emotional support from both nursing and medical staff and that their children were well supported emotionally.
- The play specialist worked with children to help them in adapting to the new environment and to the hospital experience.
- During our inspection, we met the Bliss (a charity working to provide care and support for premature and sick babies and their families) volunteer who came to the neonatal unit once a week, to support any parents, if they wished for this assistance. The volunteer reported that parents spoke favourably of the care and support they received from the children’s ward and the neonatal unit and felt supported by staff.
- Families were supported by community nurses and consultants in the event of a death. The community paediatric nurses were able to offer bereavement visits for bereaved parents.
## Are services for children and young people responsive?

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The services were responsive to the needs of children and young people using the service. Access was good, and the needs of all different kinds of child patients were met appropriately. We noted some outstanding practice in some areas. This included the community paediatric service, where they worked with other agencies to support children and their families in end of life care.

The environment within the ward made it challenging to accommodate the differing needs of patients, infants (including those whose mothers were breastfeeding) and children and young people who required care and treatment. It was particularly challenging to achieve same gender bays. Parents were unable to access nutritious food and breastfeeding mothers were not provided with nutritious food.

### Service planning and delivery to meet the needs of local people

- During periods of increased admissions, or staff shortages there was a contingency plan to ensure that there was a safe environment for the care of children, neonates and working staff. Staff told us that, in the week before our inspection, the neonatal unit had been closed for one day, in line with the children’s services contingency plan. The contingency plan set out clear actions, using other resources available in the trust. One of these was the potential use of the community paediatric team to prevent admission and to support earlier discharges.

- Integrated working between paediatric and neonatal nursing staff was promoted in order to meet the needs of the patients. Paediatric nurses we spoke with told us that some staff were about to complete a neonatal nursing module.

- The community paediatric team showed evidence of how they had reduced admissions to the ward. We also heard outstanding examples of the nurses in this team working together with the complex care team to provide end of life care as the child and family had wanted. This team also provided support for those children using technical equipment to manage their health and provided care on a collaborative basis with other services.

- The community paediatric team had been unsuccessful in the business plan they put forward to offer 24-hour cover to further reduce admissions.

- We found little available storage for equipment in some areas. We saw equipment stored in corridors and in the room used by parents, where folded parent’s beds were stored.

- We saw that the playroom had been recently refurbished with facilities for both adolescents and young children. Staff we spoke with told us that this refurbishment had been funded by a local children’s charity and that adolescent patients had an allocated time for sole use of the playroom. There was a school room used by the full-time school teacher.

- The environment within Caroline Thorpe Ward made it challenging to accommodate the differing needs of patients and of infants, including those whose mothers were breastfeeding, as well as children and young people who required care and treatment. Staff we spoke with told us it was particularly challenging in achieving same gender bays and in being able to support and treat a young person who required intensive mental health support on the ward.

- We saw bed bays and cubicles that were not big enough to accommodate parental beds. There was a small room for parents to use.

- In the day surgery unit we saw that children were treated in an environment that was adapted with stickers and pictures for when they used it and this was opposite a well-stocked play area.

### Access and flow

- Staff who we spoke with told us there were avoidable delays in the discharging of children, mainly due to children having to wait in the playroom for their medication, before being able to leave the hospital. These delays could be for up to four hours. There was good discharge planning with a checking system evidenced in the patients’ records.

- Caroline Thorpe Ward had 12 beds, with a mixture of surgical and medical beds. Within Caroline Thorpe Ward there was an additional two-bed high dependency unit (HDU), a four-bed children’s assessment unit and the local neonatal unit with seven cots providing level 1 care.
- The day surgery unit booked children first on the list by age and condition/urgency and was looking into moving the ear, nose and throat surgery list into the morning to avoid unnecessary admissions onto the children’s ward.
- GPs could directly refer children to the four-bed children’s assessment unit. In the contingency plan, this assessment unit could be used solely to accommodate inpatients if the rest of the beds were occupied. Medical staff we spoke with told us that 50% of admissions came through the A&E.
- The children’s outpatient department monitored and had a clear action plan for those who did not attend an appointment.
- Some parents told us that parking was a concern, both the charges and the distance from the car park to the children’s ward.

Meeting people’s individual needs
- The environment within the Caroline Thorpe Ward made it challenging to accommodate the differing needs of patients and parents of infants, including those whose mothers were breastfeeding, as well as children and young people up to the age of 18 requiring care and treatment. Staff we spoke with told us it was particularly challenging in achieving same gender bays and in being able to support and treat young people who required intensive mental health support.
- A recent serious incident was being investigated about the care of a young person who was close to transferring into the care and treatment of adult services. Learning from this incident was being used to further develop the management of transition into adult services.
- Staff we spoke with had contact with the Child and Adolescent Mental Health Services (CAMHS) team (the CAMHS service was supplied by another provider) and referred all children who were admitted with self-harm, alcohol-related illness or drug misuse to this team. However, the CAMHS team only operated Monday to Friday, 9am to 5pm. There was no access to child mental health support during the weekend or evenings. A joint working group was looking to address the issue of urgent assessment for these patients.
- Children with special needs were assessed on admission and a nursing care plan developed to address their needs.
- We noted that young people up to the age of 18 were cared for within the service. A recent serious incident was being investigated, and learning from this was being used to further develop the management of young patients’ transition into adult services. We saw that the majority of the complaints received by the paediatric service were from parents about their lack of access to nutritious food. Parents were encouraged to visit and spend time with their children. The ward had recently introduced breakfast cereals that parents could access. There was no other nutritious food available for parents on the ward. At night, there was no catering service in the hospital.
- For mothers who were breastfeeding their inpatient infant, there was no provision of nutritious food. Separate rooms were not always available for mothers to breastfeed and mothers’ privacy could not be guaranteed if the ward was busy with children and young people with differing needs.
- There was a small room just off the ward for parents to sit and make drinks in. However, because of the lack of storage space, fold-up beds were stored in this room when not in use so that parents could sleep alongside their child on the ward, where space allowed.
- Information was available about what to expect on the ward, and leaflets/printouts that explained certain conditions, treatments and procedures they could have, were available.

Learning from complaints and concerns
- The staff we spoke with knew the process to follow if someone wished to make a complaint.
- We saw evidence that complaints were addressed in an appropriate and timely manner. Discussions about complaints took place at directorate and ward-level. We saw that themes to the complaints were identified and some actions taken at a ward-level.

Are services for children and young people well-led?  

Good
We saw evidence of planning for future sustainable children's services and learning from incidents. There were regular clinical governance meetings held to assess the outcome of any audits, complaints, or incidents and quality improvement initiatives. Information from the meetings was cascaded to other staff during team meetings.

Nurses were positive about the culture at a team-level, but they told us they felt the trust did not appreciate children’s’ and families’ needs. We saw that the service made good use of the skills and resources it had.

**Vision and strategy for this service**

- The trust had introduced a new policy six months before our inspection: ‘Speak Up, Speak Out’, which encouraged staff to report any concerns or incidents. The trust recognised the importance of staff reporting incidents, thinking about what had happened, what was learnt from it and what could be done to prevent it recurring. The staff we spoke with told us that incident reporting was now done online. There was feedback to learn from and the culture of the trust now was less “blame and shame” and more positive.
- Many of the staff we spoke with told us that senior management did not seem to recognise the specific requirements needed for children’s services, for example, facilities and catering for parents staying with their inpatient children.
- Many of the staff were unhappy with the children’s service sitting within the medicine and paediatrics division, rather than the original women and children’s division.

**Governance, risk management and quality measurement**

- There were regular clinical governance meetings held to assess the outcome of any audits, complaints or incidents and quality improvement initiatives. Information from the meetings was cascaded to other staff during team meetings.
- A ward dashboard showed the current status of a variety of indicators for the children’s wards.
- There was a wide range of audit and governance activities, including serious incident reviews, complaints reviews, and national paediatric and neonatal audits.
- Learning from events, incidents and complaints was incorporated into training, if required.
- There was one risk associated with the children’s service on the trust-wide risk register. This was the risk of absence of a named doctor in safeguarding. During our inspection, we clarified the new arrangements for providing a ‘named doctor’ and that this role was now covered.
- We learnt in our inspection that a recent serious incident was being investigated. Learning from this was being used to further develop the management of transitioning patients into adult services.

**Leadership of service**

- There was a defined leadership structure in place for both nursing and medical staff. Some of the ward-manager hours were not covered, with the post holder now having a part-time role as the interim lead nurse for neonatal and paediatrics.
- There was a general lack of confidence among staff that information from the ward-level to the trust board was always fully considered. Staff we spoke with told us that there was no named non-executive for children’s services and that they did not feel children’s services were fully recognised. The majority of nursing staff told us that the trust did not appreciate children and families’ needs. In particular, the need for greater ward space and proper facilities.

**Culture within the service**

- The staff we spoke with told us that the culture within the neonatal and children’s units was good at a local-level and that staff supported each other well.
- The children’s experiences were seen as the main priority by the staff working within the children’s service. We observed that staff were approachable and worked together well as a team.
- Staff worked well together in multidisciplinary teams to provide holistic care to children. Medical staff respected the views and professional opinions of the nursing staff.
Public and staff engagement

- Regular, recorded staff meetings showed that the trust engaged with staff. This meant there was a process for feeding information from the trust to staff working in the children’s services and for staff to voice concerns and issues to the trust board. However, staff on the wards did not always feel that mechanisms for the trust to feedback information were consistently effective.

Innovation, improvement and sustainability

- We saw evidence of planning for future sustainable children’s services and how the service was working towards the standards outlined by the Royal College of Paediatrics and Child Health (RCPCH) 2011 guidelines that all acute and general paediatric services should achieve. There had been difficulties in recruiting to the vacant community paediatrician role – this is a national problem. After a number of failures to appoint, the team had adopted a different approach, by developing subspecialty interests amongst the current and newly appointed consultants, who will cover the community paediatric service and duties. The development of two trust doctors, rotating between the A&E and paediatrics with six months in each, made posts “more attractive” and was a considered approach to succession planning. By taking this pragmatic and innovative approach, a long-term solution had been provided, as well as developing a more inclusive team.
- The neonatal unit had a well-used admission documentation set, which encouraged, and leads to, best practice. A joint paediatric and adult pathway was being developed following ‘Paediatric Diabetes Best Practice Tariff Criteria’ approval. This meant that the service was fulfilling specific national criteria to ensure best practice in the care and treatment of those with diabetes as set out by national guidance. By fulfilling these criteria the service would receive an annual payment for the treatment of every child or young person with diabetes. Staff told us that further joint paediatric and adult pathways were being proposed for future approval.
- Children’s services had experienced problems in recruiting neonatal nurses. To make the best use of the skills and resources and their colocation, paediatric nurses were being offered neonatal modules to facilitate integrated working between the paediatric and neonatal units.
End of life care

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Information about the service

The Northern Devon Healthcare NHS Trust has a specialist palliative care team with a high level of specialist knowledge, service delivery and strategic planning. The team comprises of one part-time palliative care consultant and one part-time clinical nurse specialist with a second full-time clinical nurse specialist post that was currently inactive, due to long-term absence. In addition to these clinical posts, there was also a part-time administrator.

During our visit to Northern Devon Hospital, we spoke with members of the specialist palliative care team, a bereavement support officer, mortuary staff, porters, medical staff, ward managers and frontline ward staff. We visited a number of wards across the trust, including Victoria Ward, Glossop Ward, Staples Ward, King George V Ward, Alex Ward and Capener Ward. We also visited the medical assessment unit, accident and emergency (A&E), outpatient services, the intensive therapy unit, the acute stroke unit, the bereavement support office, the mortuary and the chapel. We reviewed the medical records of eleven patients at the end of life and observed care provided by medical and nursing staff on the wards. We spoke with six patients and four relatives about their experience of receiving end of life care. We received comments from our public listening event and reviewed other performance information held about the trust.

Summary of findings

We saw End of Life services were caring, responsive and well-led but required improvement in order to be safe and effective. We saw that the specialist palliative care team supported ward-based staff with end of life care and that they were committed to the development of staff in general areas to develop their end of life care skills and improve end of life care for patients across the trust.

Treatment escalation plans (TEP) including do not attempt cardio-pulmonary resuscitation (DNA CPR) decisions were not always completed appropriately, a significant number that did not include documentation of treatment discussions with patients or relatives.

We saw that not all patients at the end of life were having regular assessments of their pain. We saw one example of a patient who was in pain, but had not been routinely asked about pain relief.

We were told that staff were caring and compassionate and we saw that the service was responsive to patients’ needs, in particular, we saw evidence that rapid discharge home was arranged for patients at the end of life who wished to be cared for at home. Despite there being issues with capacity within the specialist palliative care team, staff were responsive to the needs of patients at the end of their life and we saw evidence of service planning to continue to meet those needs.

We saw evidence of good leadership of the specialist palliative care team, where they were highly visible, and focused on the education and development of good quality end of life care services. We viewed
evidence of end of life care support at board-level. However, we did not see evidence of proactive practical support in terms of creating capacity to enable the specialist palliative care team to deliver changes they had identified as necessary.

### Are end of life care services safe?

There was a multidisciplinary specialist palliative care team available five days per week, with the hospice providing support out of hours. End of life care on the wards was provided by the ward staff who reported that they were able to provide end of life care.

Training relating to end of life care was offered across the trust, with a significant number of staff having attended training and further study days planned. We saw that mortuary services were provided in line with safe infection control and lone working practices and that staff had access to appropriate equipment in order to work safely. We saw that medicines were provided in line with guidelines for end of life care.

We saw evidence of end of life decisions having been made without the documentation of discussion with patients. We viewed guidance on the use of treatment escalation plans (TEPs) that was unclear in relation to responsibilities with regard to this. Our findings showed that TEPs that included DNA CPR decisions were not consistently being completed appropriately. We found that 11 of 44 TEP forms had no documented discussion with patients or family members in their notes and that on Staples Ward, mental capacity assessments were not consistently undertaken when capacity had been identified as an issue on the TEP form.

We saw examples of patients’ notes where TEP forms had not been completed and DNA CPR decisions had not been made when patients had conditions that put them at high risk of end of life. One relative we spoke with told us they were surprised a DNA CPR decision had not been documented in the notes, as the decision had been made on a previous admission. Another patient had been identified as nearing the end of life by a doctor on the ward, but there was no documentation in their notes and the doctor was unable to tell us if this had been discussed with the patient.

On two of the wards we visited, we found patients who had DNA CPR decisions documented in their notes and nursing staff were not aware of this. Also, their handover notes did not include that these decisions had been made. This meant that patients who had made a decision not to be resuscitated could have had CPR commenced on them.

### Incidents

- We saw evidence of learning in the mortuary relating to lone working. We were told that people were encouraged to visit during working hours, but that there were systems in place for people to visit out of hours when necessary. These systems included the use of safety alarms and requesting support from the site manager when required.
- We were told that transfers of patients from one ward to another out of hours were recorded and that while there may not be a specific focus on end of life care, senior nurses would review the reason for transfer with a view to minimising out of hours transfers.

### Cleanliness, Infection control and hygiene

- We saw that the wards and mortuary we visited were clean and well maintained. We saw that patient areas were covered in easy-to-clean materials that allowed hygiene to be maintained.
- We observed staff using personal protective equipment (PPE) and saw that hand-washing and sanitising facilities were available for use by staff and visitors in all clinical areas.

### Environment and equipment

- We observed the use of syringe drivers on the wards and saw that appropriate and timely checks were in place to ensure that these were working safely.
- Staff we spoke with told us there were no problems obtaining appropriate equipment for patients at the end of their life.
- We saw equipment available for the use of transporting deceased patients to the mortuary, including concealment trolleys, bariatric equipment, an electric trolley and a hoist.
- We spoke with porters responsible for transporting deceased patients to the mortuary. They told us that equipment was available to transfer patients safely.

**Medicines**

- We viewed ‘Symptom Management’ in the *Palliative Care Guidelines*, available in clinical areas. This document had been written by the palliative care consultant and had been distributed through the trust’s internal website. These guidelines included the use of medicines in the management of symptoms, including pain, nausea, breathlessness and anxiety. We saw that these guidelines were due for review at the time of our inspection.
- We saw that an end of life care plan that was being piloted to replace the Liverpool Care Pathway incorporated medication guidance to manage symptoms effectively in easy-to-follow flow diagrams.
- We saw that patients at the end of life were prescribed medicines to manage their symptoms, in line with the guidance available.
- We were told by ward staff that medication for end of life care was available on the wards and was easily accessible.
- We were given an example of when out of hours advice was needed regarding a patient’s end of life care medication and how this was achieved through contacting the out-of-hours hospice phone line and the on-call pharmacist.

**Records**

- We viewed risk assessments that were carried out on admission. These included: the identification of nutritional risk, pressure ulcer risk and the risk of falls. We saw that these assessments were used to underpin the care planned and that control measures, including regular comfort rounds were in place to minimise risk to patients.
- Across the wards we visited, we found that paper records were in use and stored in filing boxes at the nurse’s stations on the main ward, or, in some cases, in a corner of the patient bays.
- We were told that an end of life care register was accessible in some areas of the hospital, including in A&E. However, A&E staff we spoke with were not aware of this, although they told us they were able to access patients’ notes easily, usually within 30 minutes of arrival in A&E.
- We saw that a palliative care team strategy incorporated efforts to increase the access to the end of life care register by the end of the year.
- We were told that the use of the Liverpool Care Pathway was due to be phased out by 14 July 2014 and that a new end of life care plan was being piloted on Glossop Ward, Staples Ward and Victoria Ward. Of the eleven patients we saw at the end of their lives, we saw the care plans in use for only three of them. We did not see the Liverpool Care Pathway in use.
- We saw treatment escalation plans (TEP) in use that included a resuscitation decision record. Of the 44 TEP forms we viewed, a number were incomplete. Of the incomplete TEP forms, 11 had no documentation of any discussion with patients or relatives and we saw that some had no mental capacity assessment when the patient had been identified as lacking capacity.
- There was no signature space for patients or their relatives to sign on the TEP that treatment decisions had been discussed with them. We saw that, while the form prompted staff to document discussions in the medical notes, this was not always done.
- We viewed weekly audit reports of TEP forms that demonstrated some improvement in the documentation of the rationale of treatment decision making, the use of mental capacity assessments and documentation of best interests’ decisions and discussion with patients/relatives.
- We viewed a guidance document titled ‘Treatment Escalation Plans (TEP) Top Tips and FAQs’ that was ambiguous in relation to clinical responsibilities to discuss treatment decisions with patients.
- We identified two patients on Glossop Ward and two patients on Staples Ward, where nurses were unaware of do not attempt resuscitation decisions that were documented in the patients’ medical notes, but not on nursing handover sheets.
Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We were told by staff that the Mental Capacity Act 2005 assessment forms were available in clinical areas and on the hospital intranet.
- We saw an example of an in-depth mental capacity assessment form that included a section to detail the nature of the decision being made.
- Determination of capacity included a section on whether the impairment was likely to be permanent or temporary and, if temporary, a prompt was in place to assess the likelihood of capacity returning.
- The assessment included whether or not the person was able to understand information, retain information, assess information to make a decision and if they were able to communicate the decision.
- We viewed a section on the form that included the name of the person who could make a decision or be involved in a decision on behalf of the patient and we saw that best interest decisions and referrals to independent mental capacity advocates (IMCAs) were included as part of the process.
- We viewed some examples of mental capacity assessments being documented thoroughly. In particular, we viewed good examples of assessments from the occupational therapy team.
- We viewed audit data that demonstrated some improvement in the documentation of mental capacity assessments and decision making, however, we saw that there continued to be issues with completing documentation and we viewed inconsistent records where people were identified as lacking capacity on a TEP form and a full assessment had not been completed.
- We spoke with the palliative care consultant and medical director, who told us that they continued to push for mental capacity assessments to be completed appropriately by sending out information and guidance via email. They told us that, as a result of the audits being carried out, they had changed how feedback was given, including sending out individual emails to lead clinicians responsible for mental capacity assessments to ensure more personal feedback.

Training

- We were told by the team that, while end of life training was not mandatory for all staff, provision of education around end of life for ward staff staff was considered to be a significant aspect of the role of the team.
- We viewed the strategy of the specialist palliative care team that detailed their facilitation of the roll out of ‘Principles of End of Life Care’ training for 185 trust staff to date, with a further eight training days planned.
- The clinical nurse specialist told us they were striving for end of life care to be promoted as the responsibility of all staff.
- We saw examples of nursing staff and healthcare assistants who had attended training to become end of life care link workers for their ward or unit.
- We were told that end of life care link workers attended meetings with the specialist palliative care team every other month and cascaded information and innovations to staff at ward-level through handovers and ward meetings.
- The specialist palliative care clinical nurse specialist told us there were reciprocal training arrangements between the trust and the Northern Devon Hospice for specific training, such as the use of syringe drivers.

Management of deteriorating patients

- The specialist palliative care CNS told us that patients who are recognised as deteriorating, or dying, could be commenced on the Liverpool Care Pathway version 12 (up to 14 July 2014), or the new end of life care plan that was being piloted. We were told that not all patients were commenced on a specific end of life plan and that some would be cared for using standard care plans on the wards, if their symptoms were manageable.
- We did not see evidence of the Liverpool Care Pathway in use at the time of our visit, but we did review the records of three patients who were on the pilot end of life care plan. The end of life care plan comprised both medical and nursing plans and included a section to document that recognition of dying had been discussed with the patient and next of kin.
- We viewed treatment escalation plans (TEP) that included a question about life expectancy and
signposted staff to end of life guidelines, a Preferred Priorities of Care plan and information on advance care planning decisions.

- Do not attempt resuscitation (DNACPR) forms were usually correctly completed, including details of conversations had with the patient or relatives.
- Decisions in relation to resuscitation of patients were documented well. In those we saw on the surgical wards decisions around whether to resuscitate a patient had been discussed with the patient and/or their relatives. The reasons for any decision were recorded and the appropriate forms signed, dated and placed at the front of a patient’s hospital notes. At handover, staff were aware of any patients who had decisions in relation to resuscitation not being attempted in certain circumstances. Staff we spoke with also knew the final decision rested with the patient’s doctor and the form indicated only the patient’s wishes or those of their family in limited circumstances. We saw that documentation relating to when a patient was deteriorating was inconsistent, as were documented discussions with patients and their families.
- The specialist palliative care clinical nurse specialist (CNS), who told us they believed there was a degree of confusion about what constitutes end of life care and that the specialist palliative care team had worked on looking at what other NHS trusts did in terms of good practice in identifying end of life in a way that is timely and supports patient and family involvement.
- Implementation of the amber care bundle (an alert system to identify patients who were not responding to current treatment or Assessment Management Best practice Engagement Recovery uncertain care bundles) was scheduled to be implemented in order to support patients that were assessed as deteriorating in health or where recovery was uncertain. The specialist palliative care CNS told us they were on a list for implementation of the amber care bundle, but that they did not know when this would begin. We were told that there had been discussions with another south west NHS Trust to develop a joint initiative.
- We viewed one example of a patient who had information relating to an advance care planning decision in their medical records.

Nursing staffing

- One part-time palliative care CNS was currently available across the trust. However, an additional full-time post was currently inactive, due to long-term absence.
- We were told that there were plans to recruit to the team a few weeks prior to our visit, but that there were issues around spare capacity to support someone new into post, so this was scheduled to be revisited in August.
- Link nurses we spoke with told us they had been given time to focus on promoting care for people at the end of life as part of their additional training and role as an end of life link on the wards.
- We saw that, on many wards, there were more than one end of life link worker, for example, on Victoria Ward there were two link nurses and one healthcare assistant.

Medical staffing

- One part-time palliative care consultant was available across the trust, with close cross-organisational working arrangements with the palliative care consultant at North Devon Hospice.
- Out-of-hours specialist medical support and advice could be sourced through the North Devon Hospice by junior doctors and other staff, as required.
- The specialist palliative care consultant provided support to junior medical staff during working hours and had produced guidelines for symptom management in palliative care for all staff in acute and community settings.

Are end of life care services effective?  
Requires improvement

The trust was engaged in planning services in line with national guidance, with action plans incorporating areas where development was required. We saw that the Liverpool Care Pathway (LCP) was being phased out by July 14 2014, although some staff we spoke with believed that the LCP had already been
taken out of circulation. We viewed new end of life care plans that were being piloted on three of the wards and that these included guidance on areas that had been identified as requiring improvement as part of the National Care of the Dying Audit for Hospitals (NCDAH).

Nursing staff were using general care plans on wards where the new end of life care plans were not being piloted and that these general care plans included pain management plans. Not all patients who were at the end of life were having regular assessments of their pain, despite pain assessment tools being available. One patient we spoke with told us they were in pain, but that staff did not routinely ask them about it. We were told that pain would be assessed as part of routine comfort rounds for people at the end of their life, but when we viewed the documentation used we saw that an assessment of pain was not included in the comfort round prompts that were documented.

Evidence-based care and treatment

- Use of national guidelines from the national End of life Care Strategy (2008) published by the Department of Health, sets out the key stages of end of life care, applicable to adults diagnosed with a life-limiting condition. The NICE end of life care quality standard for adults (QS13) sets out what end of life care should look like for adults with life-limiting conditions.
- We viewed plans to develop an end of life strategy group, to be led by the palliative care consultant, in order to implement the strategy. We saw that local strategies were informed by the national guidance.
- We spoke with members of the specialist palliative care team, who told us they had incorporated the NICE end of life care quality standard for adults (QS13) into their plans for improving supportive and palliative care for adults. We viewed a quality standards status dashboard that stated that implementation of the quality standard was to be led by the specialist palliative care team and that, due to capacity issues as a result of staff shortages, the initial focus was to be on the identification of the dying patient.
- We viewed treatment escalation plans and a newly developed end of life care plan that incorporated good practice guidance in terms of principles of care and elements of the Gold Standards Framework.
- Of the 11 patients we saw at the end of life, three were receiving care as part of a pilot for the end of life care plan. We were told that not all patients at the end of life would necessarily receive care as part of the plan, however, the specialist palliative care team acknowledged that there had been some confusion around the phase out of the Liverpool Care Pathway and whether it could be used or not, but that they believed this was a national issue, rather than purely a local one.
- We were told that the Liverpool Care Pathway was due to be phased out by 14 July 2014 and saw that an end of life care plan was being piloted at the time of our inspection. We saw that the end of life care plan incorporated aspects relative to national guidance, such as recognition that the patient is dying, advance decisions, symptom management, involvement of the patient and their family and spiritual and emotional wellbeing.
- We saw evidence, across all the wards and departments we visited, that the specialist palliative care team supported and provided evidence-based advice to other health and social care professionals in areas, such as symptom control.

Pain relief

- We were told that patients commenced on the personalised care plan for the last days of life would have their pain assessed, along with other symptoms to promote effective management.
- We viewed pain assessment documentation for patients on admission and we saw pain management care plans in use for patients who experienced pain to help staff to manage their symptoms.
- We saw patients who received both regular and 'as required' analgesia and we saw pain assessment charts available on the wards we visited. The pain assessment charts included a visual analogue pain scale (0-10) and an Abbey Pain Scale for the cognitively impaired, which included assessments of a patient’s vocalisation, facial expression, behavioural change, body language and any physiological changes.
- Of the patients we viewed at the end of life, we saw inconsistencies in relation to pain management
and the use of the tools available. We viewed records of patients who were prescribed analgesia, but it was not always clear from the documentation how their pain was assessed and the effectiveness of pain relief evaluated.

- While there were pain assessment charts available, these were not always used and when pain relief was administered there was not always an evaluation record of its effectiveness.
- One patient we spoke with on Staples Ward told us that they were in pain and that staff did not routinely ask them if they required pain relief. The patient told us, “No one asks me, I have to ask for drugs when they come round.”
- We were told that regular comfort rounds and assessments were carried out on people based on clinical need, although we noted that the assessment of pain was not included in the documentation of this.

Nutrition and hydration

- We were told that end of life care patients could eat and drink normally and would carry on doing so until their condition changed.
- We viewed results of the 2014 National Care of the Dying Audit (NCDAH), which demonstrated that, of patients where there was recognition of dying and they had the ability to take part in discussions around nutrition and hydration, these discussions took place in only 17% of cases.
- As part of the trust’s action plan as a result of the NCDAH, we saw that nutrition and hydration assessments and discussions were to be included in new end of life care plans, alongside a review of current training content.
- We saw that the new personalised care plan for the last days of life included an assessment of hydration and nutrition according to patient need and in order to maintain comfort.
- We saw that all patients were assessed using a malnutrition universal screening tool (MUST) on admission. From this, their nutrition and hydration needs would be incorporated into a care plan as required that would include closer monitoring of nutrition and hydration intake.
- The specialist palliative care CNS told us that patients who were unable to take oral fluids would have a multidisciplinary team assessment as to the value of fluids. We saw one example of a patient who was receiving subcutaneous fluids to help manage their symptoms.

Patient outcomes

- The hospital contributed to the National Care of the Dying Audit, 2014. The trust performed well in the areas of: access to specialist support for care in the last hours or days of life, dying medication protocols around symptom control and protocols promoting patient privacy.
- Areas where the trust did not perform well included: trust board representation, assessment of the spiritual needs of the patient and care of the dying continual training and audit.
- We viewed an action plan dated 3 June 2014, which focused on tackling all of the areas where the trust did not perform well. Progress against the plan was subject to regular review. We saw that progress with expansion of the specialist palliative care team had not been achieved, due to issues with funding. We saw that action had been incorporated into the plan to look at alternative, achievable methods for increasing support offered by the team.
- We spoke with the palliative care consultant and CNS, who told us that the Liverpool Care Pathway would be phased out by 14 July 2014 and that an end of life care plan was being implemented, following consultation and involvement of ward and clinical staff.
- We viewed communication that was sent to all staff informing them of the change to the care of the dying guidance and documentation. We viewed posters and guidance on noticeboards in hospital wards. Staff we spoke with on the wards were aware of the new care plan coming in, but were not always aware that they could continue to use the Liverpool Care Pathway, in the meantime, up until 14 July 2014.

Competent staff

- Specialist palliative care staff told us they were supported through one-to-one support, appraisals and continuing professional development days.
- Both the palliative care consultant and the CNS had attended training in advanced communication
skills and that reciprocal training arrangements existed between the service and the North Devon Hospice for additional training, as required.

- There were plans to make the principles of end of life care training day mandatory and we were told that 185 trust staff had attended the course.
- We saw that end of life link nurses and healthcare assistants had been given time to attend meetings and focus on initiatives to improve the care experience of patients at the end of life.
- We viewed training plans to extend the principles of end of life care training and to develop communication skills training around end of life care for Ward-based staff.

**Multidisciplinary working**

- A multidisciplinary team meeting was held on alternate Fridays with staff from North Devon Hospice.
- Patients known to the specialist palliative care multidisciplinary team who had been discharged or died were discussed at these meetings and discussions included preferred place of care and the development of clear treatment plans.
- The lung, upper gastrointestinal and colorectal multidisciplinary team meetings were attended by the palliative care consultant.
- Across the wards we visited, we saw evidence of multidisciplinary discussions to guide staff on patient management issues. On Victoria Ward, we observed a consultant ward round that incorporated a multidisciplinary discussion about a patient’s symptoms that included onward referral to another specialist consultant.

**Seven-day services**

- The specialist palliative care team was not currently staffed or funded to provide a seven day a week face-to-face service. We saw, in an action plan against the results of the National Care of the Dying Audit (NCDAH), that plans were in place to: recruit to a further CNS post, explore the possibility of obtaining psychology input for end of life care and continue to develop the ward link nurse system.
- We were told that out-of-hours staff could contact the North Devon Hospice for advice and support and ward staff told us that this system worked well, with additional support available from the on-call pharmacist, if advice was needed around end of life care medication.
- Staff we spoke with on the wards told us they felt confident in the support they received from the specialist palliative care team and that staff responded very quickly to referrals. We were told that the CNS would often attend the ward on the day the referral was made.

### Are end of life care services caring?

**Good**

We observed patients being cared for with dignity and respect. Medical and nursing staff were seen to be compassionate and caring and we saw examples of staff involving patients and their families in their care. Patients we spoke with told us that staff were caring and looked after them well. We saw that staff had been trained in communication skills and that bereavement support services provided people with support, as needed.

**Compassionate care**

- We spoke with three staff who were end of life link workers within their work area. They told us that they were given time to focus on improving care for people at the end of their life. Link workers we spoke with were very enthusiastic about the work they did to improve the quality of care for people at the end of their life.
- We saw initiatives on the wards that included ensuring access to personal toiletries for people at the end of their life. A link worker told us that they were focused on ensuring people’s time at the end of life was spent peacefully and with dignity.
end of their life was as comfortable as possible.

- End of life link nurses we spoke with told us that, while the wards had visiting times, these were flexible, especially when someone was at the end of their life, so that family members and friends could visit when they like.
- We were told that, when possible, patients receiving end of life care would be offered a side room, if this was available. We saw one example of this in action on Glossop Ward.
- We observed staff spending time with patients to fully explain certain aspects of their treatment and care. We witnessed one doctor asking what a patient did for a living and subsequently providing the patient with information in mechanical terms, so that they might better understand.
- We spoke with a bereavement support worker, who talked us through the processes they would use to support relatives following their bereavement. We saw examples of care that was compassionate, caring and focused on supporting people as much as possible during difficult times.
- We were told that the chaplaincy service included multifaith access to support for people on end of life care and their families.
- We spoke with patients who were mostly positive about their experience of care and who told us that staff were kind and caring.
- We spoke with medical staff who told us they had received training in breaking bad news and they gave us examples of how they did this, including having a nurse present and giving people time to ask questions at their own pace.
- We observed staff treating patients with dignity and respecting their privacy. We observed the use of curtains being pulled around bed spaces and we saw that, where possible, side rooms were used if someone was at the end of life.

Patient understanding and involvement

- We observed good examples of patients and family members being involved in care, including medical staff taking time to explain things and discuss options.
- The bereavement officer carried out the administration of a deceased patient’s documents and belongings, issuing the Medical Certificate of Cause of Death, providing practical advice and signposting relatives to support services.
- Staff told us that they involved patients and their families as much as possible in decisions about treatment and care. However, this was not always documented in patients’ notes. Staff told us that not every discussion was documented, but that people were routinely involved in care decisions.
- We observed a member of the medical team speaking with a patient and their relatives on Victoria Ward and saw that time was spent answering questions and providing reassurance.
- We spoke with patients and family members, who told us that, on the whole, they felt involved in care decisions and kept informed of what was happening.
- We were told by staff that when a person who is at the end of life wishes to go home to die then staff will work with the Pathfinder team so that the patient can return home with the care and support they need.

Emotional support

- The clinical nurse specialist had completed the training necessary to enable them to practice at level 2 for the psychological support of patients and carers.
- We viewed information given to patients and relatives that included contact numbers of where they could seek additional emotional support.
- We received feedback from patients and relatives that was mostly positive in the way that staff provided emotional support.
- We observed staff being caring in their approach and taking time to speak with patients while caring for them.
- We saw new documentation that prompted staff to ask patients about their cultural, religious and spiritual beliefs as part of end of life care planning. This had been an area that had been identified as being in need of improvement, following feedback from the National Care of the Dying Audit of Hospitals.
During our inspection, we saw examples of staff contacting the chaplaincy for additional support for people at the end of their life. We were told that the service was responsive to people’s needs and was not dependent on belonging to a particular faith group.

We were told that volunteers were available through the chaplaincy to provide emotional and spiritual support.

Some patients we spoke with were very positive about the care and support they received.

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### Are end of life care services responsive?

All patients requiring end of life care could have access to the specialist end of life team. We saw that 216 referrals were made to the service in the last year, resulting in 712 patient contacts. Of those, 48% were for patient support, 16% for assessment, 10% for symptom control, 13% for liaison with other agencies and the remaining referrals for advice or carer support. Ward staff we spoke with told us that the specialist palliative care team were responsive, often seeing patients on the same day as referral. While we saw that there were no plans to develop a seven-day service, we were told that the out-of-hours support received from the local hospice was good.

We were told there were good relationships between the hospital and hospice staff and we saw that bimonthly meetings enabled staff from both services to discuss patients and work together. We saw evidence of the rapid discharge to the patients’ preferred place of care with good, responsive services coordinated by the hospital Pathfinder service in relation to discharge home.

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### Access

- All patients within the trust, who required palliative or end of life care, had access to the team, Monday to Friday, from 8am to 4.30pm. There was out-of-hours specialist telephone support for hospital staff from the North Devon Hospice.
- We saw from referral guidelines that the specialist palliative care team aimed to see all referrals within two working days and all urgent referrals within one working day. Ward staff we spoke with told us that, generally, if a patient required urgent referral, then the specialist palliative care CNS would try and see them as quickly as possible, sometimes attending the ward within the hour.
- We saw from the specialist palliative care team strategy that referrals could either be faxed (non-urgent) or telephoned (urgent). We saw that expert support for patients with an advanced, progressive life-threatening condition could be referred for support with persistent symptoms, management of complex emotional, psychological or social issues and end of life care.
- We also saw that patients with a life-limiting condition, who had complex needs, could be referred at any time during their illness for complex symptom management, support to patients and families/carers with complex needs and support of patient choice of how they live and where they die.
- In 2013/2014, 216 patients were referred to the specialist palliative care team, which resulted in 712 contacts.
- The bereavement officer carried out the administration of a deceased patient’s documents and belongings, issuing the Medical Certificate of Cause of Death, providing practical advice and signposting relatives to support services. The bereavement office could be contacted between 9am and 4pm, Monday to Friday.
- We were told that parking was available to relatives of people who were inpatients for extended periods at a reduced rate, and that reduced rate parking tickets were valid for five days and could be shared among family members who were visiting.
Discharge arrangements

- Systems were in place to facilitate the rapid discharge of patients to their preferred place of care relevant to their need and individual circumstances. Strong links and ongoing communication between the specialist palliative care team and the North Devon Hospice included regular discussions about patients known to the hospital and hospice teams as well as bed availability and the appropriateness of hospice referral, in line with a patient’s wishes.
- Ward staff told us that patients, alongside family members, were encouraged and supported to make a decision about where they would like to die. We were told that the specialist palliative care team supported both staff and patients/families in this process.
- We were told that the Pathfinder team worked with patients and their families to arrange rapid discharge home when patients choose to leave hospital to spend their last days of life at home. Staff told us that arrangements were made so that patients were supported, with additional care, equipment and support from other services, as necessary.

Meeting people’s individual needs

- We viewed an information leaflet that the specialist palliative care team had developed, informing people of the changes that could occur in the last days and hours of life. We also viewed an information leaflet for families whose relatives are receiving end of life care. The information leaflet allowed patients and relatives to find out more about the care and services provided by the team.
- We were told that the specialist palliative care team assessed patients and undertook an assessment of specialist palliative care needs, which included: symptom assessment and management, psychological needs, complex spiritual needs, complex social and advance care planning.
- The specialist palliative care team supported carers by providing support for complex issues that could not be supported by the ward team.
- Staff we spoke with were able to tell us the processes involved in caring for patients after death. We were shown a checklist that highlighted all the necessary documentation, including: wrist bands, a notification form and questions about tissue donation.
- We were told by the bereavement support officer that a bereavement support booklet was given to family members at the time of death by ward staff and that they were encouraged to call when they were ready. If the bereavement support team hadn’t heard from a relative within a few days, staff would make contact with them. We were told that people were encouraged to call as often as they needed and that while viewings of the deceased were encouraged during office hours, it was possible to arrange out-of-hours viewings, if necessary.
- Ward staff told us that visiting times were waived for end of life care patients and family members and friends were encouraged to visit when they liked. Where possible, side rooms and family spaces were created so that people could stay.
- The mortuary staff told us they had access to multifaith leaders through the hospital chaplain and that efforts were made to ensure that people were supported in line with their religious and spiritual beliefs.
- The mortuary manager told us that the viewing room had been designed to accommodate ritual washing as required and we were told that, where possible, arrangements would be made to release a body within 24 hours, where there were specific religious and cultural needs.
- Bereavement support staff told us that family members were encouraged to guide the end of life care process for their loved ones.
- The viewing room we saw was clean, fresh and provided facilities for relatives, such as comfortable seating, water and tissues. The suite was neutral, with no religious symbols, thus accommodating all religions. We were told by the bereavement officer that they supported families during the viewing and would ensure that relatives knew what to expect and were safe.
- We visited the mortuary viewing room and staff showed us how they made the environment as comforting as they could. We were told that visitors were enabled to spend time with the deceased and that staff were on hand for emotional support as needed.
Learning from complaints and concerns

- Staff we spoke with told us that if a patient or relative had concerns about care being delivered, they would try and address the issue at the time, in order to resolve the concerns as quickly as possible.
- During our visit, we did not see evidence of formal complaints specifically relating to end of life care.
- We reviewed the patient experience annual report for 2013/2014 and saw that one particular issue, relevant to patients at the end of life and their relatives, was the issue of parking. We saw that, in response to comments about the cost of parking, the trust produced guidance for patients and relatives on how to reduce the cost of parking to less than £1 per day. One relative we spoke with confirmed that this was the case, telling us that they were given lower-priced car parking access because they were visiting the ward frequently over several days.
- We saw that a patient experience programme was in operation across the trust and was overseen by the director of nursing. From this programme, a bimonthly learning from patient experience group (LPEG) was held and attended by representatives from all clinical, nursing, managerial and corporate directorates. The LPEG was a specialist advisory group of the clinical governance committee. It discussed trends in patient experience feedback and assessed priorities ahead.

Are end of life care services well-led?

Good

Leadership of the specialist palliative care team was good, with good team working and cross-organisational relationships with the local hospice and community teams. We saw evidence of the specialist palliative care team developing staff at ward-level to improve end of life care services. We saw that quality and patient experience was seen as a priority with staff feedback about support from the specialist palliative care team being good.

We viewed a palliative care strategy and action plans that incorporated national guidance and recommendations. We saw plans in place to develop an end of life group and to nominate individuals at board-level to be designated with specific responsibility for end of life care. We viewed evidence of end of life care support at board-level. However, we did not see evidence of proactive practical support in terms of creating capacity to enable the specialist palliative care team to deliver changes they had identified as being necessary.

Leadership of service

- There was good leadership of the specialist palliative care team, led by the palliative care consultant.
- We found that the end of life care engagement between the specialist palliative care team and ward staff to be of a high standard and we saw that this helped to spread the importance of end of life care throughout the hospital.
- We found that the training and support offered to end of life link nurses on the wards helped to embed end of life care as an important priority throughout the hospital.
- We saw evidence that the specialist palliative care team was highly visible on the wards and clinical areas and we were told by many of the nursing staff that the support they received from the team was responsive and timely.
- We saw evidence of trust board involvement in end of life care in the form of meeting minutes relating to the use and phasing out of the Liverpool Care Pathway, the implementation of an end of life care plan and the results of the National Care of the Dying Audit of Hospitals 2014 (NCDAH).
- We viewed an action plan from the results of the NCDAH that included a task of nominating a trust board member and lay member with specific responsibility for end of life care by October 2014.
- We saw that implementation of the action plan from the results of the NCDAH was the responsibility of the end of life group, but that this group was not yet functioning.
• We saw that there was verbal support from the trust board for the development of end of life care services. However, we did not see evidence of proactive practical support, in terms of creating capacity to enact and deliver changes recognised by the specialist palliative care team.

• We viewed a strategy that included actions to implement the recommendations of the End of Life Care Strategy (Department of Health, 2008) and we saw that some progress had been made, however, we were told that capacity issues within the team were impacting on the implementation of the strategy.

• We viewed examples of how patient stories were presented to the trust board in order to help provide momentum for change in relation to quality-improvement activities. We viewed one example of an end of life patient story being presented to the board.

Culture within the service
• All the staff we spoke with talked positively about the service they provided for patients. Quality and patient experience was seen as a priority and as everyone’s responsibility. This was very evident in the specialist palliative care team and their patient-centred approach to care.

• We found that staff had a ‘can do’ attitude, which meant that staff were very patient-centred and wanted to deliver good care through good training and support. The specialist palliative care CNS was very committed to developing the skill of staff on the wards in terms of end of life care and this was evident in the approach of the end of life link staff that we spoke with.

• Across the wards we visited, we saw that the specialist palliative care team worked well together with nursing and medical staff and there was a very responsive approach from the specialist palliative care team in relation to ensuring support for ward staff on end of life issues.

• We saw that time had been spent developing the culture of recognition of end of life and discussion of end of life care issues as part of the audit of treatment escalation plans (TEPs), including resuscitation decisions, advance care planning decisions and patient and family involvement. Both the palliative care consultant and the medical director told us that they believed that the cultural shift required involved competing clinical priorities and that they were committed to continual learning and improvement.

Vision and strategy for this service
• We viewed a strategy for the palliative care team that focused on service development and continued implementation of national guidance and recommendations.

• The palliative care consultant told us of plans to review the service later this year, to include issues around capacity and how best to support people at the end of life.

• We were told that one of the main aspects of the future vision for the service was around supporting good quality end of life care across the trust where all wards had key staff working who had received specialist training in end of life care.

Governance, risk management and quality measurement
• We found that the specialist palliative care team had regular team meetings in which issues and general communications were discussed. We were told that biweekly meetings between hospital, hospice and community end of life care teams were held to discuss patient and service issues.

• An annual operational policy, with aims and objectives was in place and we saw that regular reviews of progress were undertaken.

• We viewed audits of TEPs that included identification of the areas where improvements were required. We were told that the palliative care consultant had taken responsibility for overseeing the audit and liaising with relevant clinicians when areas for improvement were required.

Innovation, learning and improvement
• The development of the principles of end of life care training for hospital staff had helped to raise awareness of good end of life care across the hospital.

• The development of end of life care link nurses helped to ensure that end of life care was delivered
and supported by staff who had access to up-to-date information and a support network to develop good quality services through attendance at bimonthly link nurse meetings.

- We viewed examples of ward-based innovations from end of life link staff including providing access to toiletries and improving mouth care for patients at the end of life.
- The introduction of an end of life care plan in place of the phased out Liverpool Care Pathway had been developed with input from ward staff and we viewed posters and information on noticeboards in ward areas with up-to-date information provided.
- The implementation of TEPs that incorporated decision making around advance care planning decisions, place of death and DNA CPR forms helped to raise awareness of good end of life care decision making. The audit and review of the TEP forms was ongoing and, while problematic in terms of consistent use, demonstrated a commitment to learning and improvement.
- The development of a strategy for the specialist palliative care team incorporated learning and development from local and national sources, although it required review and development in terms of a specialist palliative care team capacity for implementation.
Outpatients

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<tr>
<th>QUALITY AREA</th>
<th>RATING</th>
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<tr>
<td>Safe</td>
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<td>Effective</td>
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<td>Caring</td>
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<td>Responsive</td>
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<td>Well-led</td>
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<td>Overall</td>
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Information about the service

The North Devon District Hospital provided an outpatient service of approximately 400,000 first and follow-up appointments over the 12 months prior to our inspection.

There were two main outpatient areas near the hospital main entrance, and clinics are also located throughout the hospital. There are several different waiting areas. Individual clinics were run with their own reception desks, with some locations running two clinics. The administrative staff were located throughout the individual clinics. The department was managed on a daily basis by a manager for administrative staff and a nurse team leader.

During our inspection, we visited the clinics for rheumatology, orthopaedics, audiology, fractures, oncology, ophthalmology and urology. We met with 18 staff, including: receptionists, nursing staff, healthcare assistants, consultants, and therapists. We met with the management team for the department. We spoke with 15 patients and three relatives. We looked at the patient environment and observed waiting areas and clinics in operation.

Summary of findings

The environment in the main outpatient department and associated clinic areas was clean, reasonably comfortable, well maintained and safe. Infection control procedures were not always followed by clinical staff in relation to the trust policy of staff being ‘bare below the elbow’.

Staff were professional and promoted a caring ethos. Compassionate care was provided and staff interacted with patients in a friendly manner, while treating people with dignity and respect.

Patients said that they felt involved in their care. The booking and running of clinics was efficient with limited waiting times for patients.

Staff were provided with leadership and an open culture was promoted, in which staff felt engaged with the trust. Staff took pride in the quality of care and treatment provided by the outpatient department.

Are outpatient services safe?

We found the outpatient departments (OPD) to be safe, clean and well maintained. All staff had been trained in incident reporting and were up to date with their mandatory training. Safe staffing levels were identified and maintained. Patients told us they thought the outpatient department was safe place to visit for treatment.
While we saw that regular hand-hygiene audits were completed, as well as full infection control audits, we observed that the trust policy of ‘bare below the elbow’ was not always followed by all staff.

Incidents

- There had been four serious incidents reported in the outpatient department over the previous 12 months.
- Staff we spoke with understood how incident reporting was carried out. Staff confirmed they received feedback from incidents regarding any learning that was required. One example was a mistake that had been made over the booking of an appointment. Clarification was provided to the staff on the procedure that was to be followed. Managers told us that they encouraged staff to report incidents and believed they used the incident process to improve learning.
- Staff we spoke with were aware of the trust whistleblowing policy and told us they knew how to access information online about the procedure to follow.

Cleanliness, infection control and hygiene

- We visited the waiting areas for all of the clinics and also saw three of the consulting rooms. All were clean and well maintained. Patients we spoke with told us they thought the hospital was always clean and expressed no concerns about the risk of infection.
- Staff told us that if additional cleaning was required the request was responded to promptly. We were also told that when maintenance was required that impacted on health and safety, action was taken quickly.
- We saw that hand-hygiene audits were regularly completed and the most recent audit had scored the department at 100% compliant. However, throughout the two days we spent in the outpatient department area we saw at least 20 clinical staff that did not adhere to the trust policy of ‘bare below the elbows’. For example, we saw several clinicians wearing wristwatches. The managers of the reception and the clinical staff told us they would always challenge staff directly under their responsibility who did not adhere to the policy on infection control.
- In the main entrance to the outpatient department, which is also the main hospital entrance, there was a sign reminding people of the importance of hand hygiene. There were however, no hand-sanitising gel dispensers prominently located in this concourse or in the main outpatient waiting areas. We saw that hand-sanitising gels were available on the reception desks in the clinic waiting rooms and also in the consulting rooms. There were no posters on display reminding staff of the ‘bare below the elbows’ policy.
- Staff completed infection control training as part of their core mandatory training and all staff we spoke with said they were up to date with this.
- The toilet facilities were regularly checked and cleaned and this was recorded. The facilities we looked at appeared clean and hygienic.

Environment and equipment

- The outpatient clinics were located throughout two floors of the hospital building. We visited all of the clinic areas and all were comfortable and well maintained, although there were not enough chairs in the eye clinic for all the patients to be seated. Part of the hospital were the main waiting areas were located had been renovated in recent years and the clinics off this area were well signposted and easily accessible to patients.
- Resuscitation equipment was located at various locations in the outpatient department. All equipment was checked daily by staff and these checks were recorded. We saw a sample of this recording for one set of equipment. The equipment was also checked regularly by the hospitals resuscitation team.
- We saw that equipment used in the clinical areas was correctly serviced and maintained and that records were kept. We looked at a sample of equipment, which had been labelled and dated to identify when it had been serviced. Audits were completed on the servicing of equipment.
Medicines

- Medications were securely stored in the clinics where these were required. We looked at the storage in two clinics. We saw that the correct protocols and procedures were in place for the storing of controlled drugs where this was required. A clinical nurse specialist in one clinic explained how the creams and lotions were monitored, organised and stored on a daily basis and then audited every four weeks.
- There was no system in place for the auditing of medication across all of the outpatient department. We were also told that audits and inspections of medication in the outpatient department were not undertaken by the hospital pharmacy department.
- Patients we spoke with told us they received appropriate information about the medication they were prescribed and that changes in medication were explained to them.

Records

- The patient records were held in the reception area for each clinic. Records could be moved between clinics by hand or by using a lockable trolley. We saw that notes were not left unattended and when on the reception desk they were placed face down to promote confidentiality. We observed notes being transported through the department in a safe way.
- We were told by nursing and reception staff that it was rare for a set of notes to be unavailable for any reason.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients were consented appropriately and correctly. Patients we spoke with told us that the clinical staff asked for consent before commencing any examination or procedure. We observed staff asking for consent.
- Patients were given sufficient information before their surgery to enable them to make an informed decision prior to signing the consent form.

Safeguarding

- All the staff we spoke with told us they had completed safeguarding training, which was part of the required mandatory training for the trust. Information about safeguarding was displayed in several of the waiting areas. Staff were clear about the process to follow if they felt they needed to report a concern.
- We were told of a recent example were a healthcare assistant had reported a concern regarding a patient who did not attend a scheduled appointment. This was followed up by the senior staff who wrote to the relevant GP.
- Patients we spoke with told us they thought the hospital was a safe place to visit for treatment.

Mandatory training

- All staff were required to complete mandatory training, which included fire safety, infection control, moving and handling and safeguarding. Staff we spoke with explained how they monitored their own updates but would also receive reminders from their managers when updates were due. The managers explained how they checked mandatory training, usually as part of the annual appraisal process.
- We spoke with a receptionist and a healthcare assistant who had been recruited within the last four months of our visit. Both told us they were well supported during the completion of their initial training by their line manager. A new healthcare assistant had received training in competencies over and above the required mandatory training.

Assessing and responding to patient risk

- Nursing staff, healthcare assistants and receptionists were present in all the waiting areas for clinics and were able to notice patients who appeared to be unwell. Staff explained how people could be taken to a private area or room and given a drink. If required, the staff member would
arrange for a doctor to see the patient.

- During our visit, we observed staff managing a situation where a person visiting the hospital had collapsed in one of the waiting areas. The staff responded quickly and managed the situation in a professional manner. The area was screened off and nursing staff attended to the person.
- We observed that in none of the clinics were there any safety metrics being publicly displayed about the performance of the department, for example, waiting times, clinic and appointment cancellation rates, did not attend rates (DNA), or infection control audits.

Nursing staffing

- The managers explained the process for organising the staffing of the department. A traffic light system was used to identify the levels that were required, with rotas being completed two months in advance. The rota was planned to try and put staff with specialised knowledge in the areas where their skills and experience were best utilised.
- Staff we spoke with told us the staffing was usually well organised and the right levels were in place. Two of the nursing staff thought they needed more time allocated to complete their administration.
- Healthcare assistants had the opportunities to upskill, so they complete additional work, such as administering eye drops, taking blood and doing certain types of dressings. Healthcare assistants we spoke with told us they were not asked to complete tasks for which they had not been trained.

Major incident awareness and training

- The trust had a major incident plan in place. This had been recently reviewed and updated version had been sent to the trust board for approval in May 2014. The managers of the outpatient department had completed training on major incident planning.
- All staff completed training in fire safety, as part of the trust’s mandatory training. Nominated staff were designated fire wardens with allocated responsibilities in the event of an emergency.

Are outpatient services effective?

We have reported on effectiveness for outpatient services below. However, we are not currently confident that, overall, CQC was able to collect enough evidence to give a rating for effectiveness in outpatient departments.

We observed that patients were receiving effective care and treatment. Information about national guidelines, trust policies and procedures were effectively cascaded through the department.

People received care from suitably qualified staff that were appropriately trained and appraised. There was evidence of multidisciplinary working, which promoted effective patient treatment.

Evidence-based care and treatment

- We were told that guidelines, such as NICE guidelines, were followed where appropriate. There was a morning meeting held every day for outpatient staff and any new guidance, or procedures, were highlighted during this meeting. Nursing staff told us that the manager would also email staff directly about any changes and in some circumstances had provided printed copies of information for staff. The team leader for outpatient services explained that part of their role was ensuring that information about new guidelines and procedures were effectively disseminated throughout her staff team.
- Staff were aware of how to access policies and procedures online. Staff told us how new practice guidance could also be cascaded through the specialist area they were working in.
Competent staff

- Some clinics were nurse-led and these included ophthalmology, oncology, rheumatology and Parkinson’s. For these clinics, there were nurse protocols and processes in place to ensure competency.
- All staff we spoke with confirmed they received annual appraisals from their line manager. While some staff said they had formal supervision meetings with their managers, the majority of staff did not. There was no system or policy in place that required staff to have regular formal supervision meetings with their line manager. All staff we spoke with told us they were well supported by colleagues and by their managers.
- We spoke with a consultant working in the orthopaedic outpatient clinic. They told us they thought they had an “excellent team” of staff in the clinic. They thought everyone communicated well, supported the patients appropriately and that there was an excellent working environment.
- Staff we spoke with were positive about training opportunities. Two therapists told us they had been supported to undertake postgraduate diplomas in their specialist areas. A healthcare assistant explained how they had recently completed extra training around medical terminology and were planning to undertake further training on undertaking wound dressings.

Multidisciplinary working

- We saw evidence of good multidisciplinary working. For example, the audiology department worked, at times, with the paediatrics department to provide hearing tests for premature babies. They also had links with community social work teams to provide services to people who were unable to visit the hospital.

Are outpatient services caring?

We found that treatment was provided in a caring and compassionate manner. We observed that staff throughout the department treated patients, relatives and visitors in a respectful manner. All the patients we spoke with told us the staff were caring and polite.

Patients told us they were given sufficient information about their treatment and were fully involved in making any decisions about their care.

Compassionate care

- We spoke with 15 patients and three relatives during our inspection visit. Everyone we spoke with was very positive about the approach of the staff. We were told that staff treated people with respect and were polite and caring. Comments included, “The staff are brilliant. I cannot fault any of the ones I have met,” and, “Everyone is friendly and helpful and always answer your questions,” as well as, “All the staff seem excellent, really helpful.”
- One patient explained how the consultant had explained in detail their treatment options and ensured they had all the information they required. We observed a nurse explaining paperwork to a patient attending their first appointment, following a diagnosis of their illness. Everything was explained very calmly and they also ensured the patient and their partner had the correct phone numbers should they need to ring for more information. They were told to contact the clinic if “they were worried about anything at all”.
- People we spoke with told us they felt listened to and were given sufficient information about their treatment.
- Patients’ confidentiality was respected. Patients and staff told us there were always rooms available to speak to people privately and confidentially.
- Throughout the two days we visited the outpatient department, we observed nursing, healthcare and receptionist staff interacting in a positive and caring manner with patients. We saw that enquiries made at the reception desks were responded to in a polite and helpful manner. We saw patients being redirected to other clinic locations with a clear and reassuring approach. We observed that the main reception desk to the hospital, located next to main outpatient department, had to deal with a regular flow of enquiries. We saw that everyone was treated in a helpful and
Patient understanding and involvement

- Patients we spoke with told us they felt involved and informed about their care. Patients told us they thought they were given sufficient information to help them make any decisions they needed to make. We were told that treatment options were clearly explained.

Emotional support

- Staff explained how they tried to provide support to patients who were given distressing news. One nurse explained how they ensured they were with the patient when the consultant spoke with the person. They would also make sure they stayed with the person afterwards to ensure there was no delayed reaction.
- Information was displayed in the various waiting areas about any support services that might be appropriate. This included helpline numbers and support networks for specific disease areas.

<table>
<thead>
<tr>
<th>Are outpatient services responsive?</th>
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<tr>
<td>Outpatient services were responsive to people’s needs. The department was meeting the national target for patients to receive treatment within 18 weeks of an initial referral. Additional clinics were scheduled to increase the capacity to meet patient demand. Some of these were organised in the evenings and on Saturdays, which provided improved patient choice. The clinics generally ran on time, or with a small waiting time. Patients were kept informed of waiting times and, if necessary, would be offered an alternative appointment. Staff responded to people’s individual needs and supported people to successfully attend clinics for treatment.</td>
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Service planning and delivery to meet the needs of local people

- From April 2014, the department had introduced an extended working day, meaning that some clinics started earlier and ran into the early evening. Evening clinics were also being run on two nights a week and all day on Saturdays. These included neurology, cardiology and urology. These clinics were organised to meet the increased demand for services and improve patient choice. The nurse team leader told us these clinics were usually fully booked.
- At the time of our inspection, the department was four weeks into the trial of a system of having one booking clerk dealing with all clinic cancellations. This had streamlined the process and staff believed it was proving effective. This initiative was the result of an incident that had been reported following the cancellation of clinics.
- We were told by the management team that an increase in staffing had been agreed for the ophthalmology department. They had identified that, due to some changes in the running of the department, additional staff were needed.
- The management team of the department had completed a report on the skills mix in outpatient services, which has been submitted to the director of nursing. The report outlined the changes that had been implemented and details of the future staff skills needs.

Access and flow

- The department was meeting the national target time for the 18-week patient pathway of referral time to initial treatment. The data showed the department was consistently above the 95% target.
- The average waiting time for a first appointment was between two and 11 weeks, with the longest wait being for ophthalmology clinics.
- The department was not always meeting the two-week target for urgent cancer referrals (whereby people should be seen by a specialist within two weeks of a GP referral). However, the target for
people waiting less than 31 days from diagnosis to first definitive treatment was being met. We were told that for patients who may have missed the two-week target were offered an appointment within three weeks. At this visit, they were also offered an ‘imaging’ appointment, which meant they did not have to arrange an additional visit for this service on another day.

- The department had done an audit of clinic waiting times and this showed that the majority ran on time. On the days we visited, we saw some clinics were running between 10 and 15 minutes late and this information was clearly displayed for patients.
- We spoke with two patients who were attending the department regularly to have blood tests completed. They both said they thought the service was well organised and that they rarely waited longer than 10 minutes. One person explained how his appointments were booked around the time he was able to attend using public transport.
- The hospital used an external service for the booking of first appointments. Patients we spoke with were generally satisfied with the choice of appointments and the length of wait. One person we spoke with was unhappy that they had been sent two letters, each with different times.
- The department ran hub clinics at some of the community hospitals, but the specialised clinics were all based at the North Devon District Hospital. Hub clinics included physiotherapy, elderly care, audiology and urology.
- The majority of the clinics were running on time during the two days we visited. When clinics were running late this information was written above the reception desk and we also saw staff explaining to people when they arrived if a clinic was running late. Staff told us the surgical clinics could at times run up to an hour late. Two of the nursing staff told us that when clinics ran late they ensured the patient knew the waiting time and people were given the option of rebooking their appointment if they needed to leave.
- We spoke with a consultant, an audiologist and a specialist lead nurse about appointment bookings. All said they felt the system was working well and that clinics were seldom over booked.

Meeting people’s individual needs

- When providing treatment for people living with dementia, staff tried to ensure that a relative or carer was present. If a person was on their own staff were able to get support from the hospital adult social care team. We spoke with a relative of a person living with dementia who was attending an orthopaedic clinic. They were very positive about the approach of the staff. They told us that it helped that the clinic ran on time and the waiting had been kept to a minimum.
- Patients with a learning disability had this identified in their notes and electronically in the system. If required, staff could request support and input from a hospital learning disability nurse. Information about this service was also displayed in the waiting areas of the main clinics.
- The department provided information in large print for visually-impaired patients.
- All the surgical clinics provided chaperones for patients and information about this was displayed in the clinics we visited.
- If required, staff had access to a telephone translation service.
- Patients we spoke with told us they were allocated enough time with staff when they attended their appointments. Clinicians were informed about their medical histories. Patients told us they had been sent information prior to attending clinics and were also given further information to take away with them. One patient told us “the information and advice has been really good”. We observed a nurse explaining the content of some written information about treatment and ensuring the patient had the hospital phone number if they needed to discuss anything they did not understand. Patients who were attending for gall bladder surgery were invited for a double appointment where they would have the opportunity to watch an information video and ask any questions. This also provided the chance to provide consent prior to their operation.
- Patients we spoke with were positive about the outpatient clinic service. Patients and relatives we spoke with told us they were satisfied with the treatment and the approach of the staff. People made positive comments about nursing staff, healthcare assistants, receptionists and consultants. Only one patient we spoke with said they were not entirely happy with the treatment they had received. They had arrived to have treatment in the ophthalmology clinic, but were unable to be treated as the machine was not working. The clinic had unsuccessfully tried to contact the patient to inform them of the problem.
- We spoke with two members of the hospital nursing staff who had recently used the outpatient
department for their own treatment. One told us that they thought the treatment they had received had been “superb” and that the clinic they had dealt with had been “very professional” and well organised.

- Information was provided verbally by the clinical staff and there were also a wide range of information leaflets provided. Some of these were produced by the hospital or a specific department and some were from external agencies.

Learning from complaints and concerns

- The Patient Advice and Liaison Service was located in the main reception area of the hospital near the main waiting areas for the outpatient department. Information about this service was displayed in several of the waiting areas, but not all of them. For example, there was no information about raising complaints or Patient Advice and Liaison Service in the oncology or ophthalmology clinic waiting areas.
- Staff said they would deal with concerns directly if they could, by talking to patients, but would direct them to the Patient Advice and Liaison Service if this was required. The management team received information about complaints from the hospital complaints manager.

Are outpatient services well-led?

Leadership was provided to the staff working in the outpatient department. Staff were clear about their areas of responsibility and the lines of accountability. Managers and senior staff were approachable and staff felt listened to and able to contribute.

There was an open culture within the department and staff understood and identified with the trust values. There were regular staff meetings and information was communicated between different groups. Staff were kept informed of changes and developments.

Vision and strategy for this service

- The trust values were displayed behind every reception desk and also the front page of the staff intranet site. All staff we spoke with had an awareness of the values that were being promoted.
- Staff were aware of the trust magazine Pulse, which was available to patients. The magazine was available electronically and carried a range of information about developments and future plans for the trust.
- Staff told us they also received information bulletins via email from the chief executive of the trust.

Governance, risk management and quality measurement

- There was a clear management structure for the outpatient department, which was located in the clinical support services directorate. The assistant general manager of the directorate met every two weeks with the managers of the outpatient department.
- There were individual governance meetings held for each speciality, but not for the outpatient department as a whole.

Leadership of service

- All staff we spoke with were clear about the lines of management and told us they felt well supported by their managers. Staff said that information was regularly communicated from management at their team meetings and also via email.
- The management team of the department met every two weeks, but we were told there was regular contact between the team on a daily basis.
- The manager of the administration staff said she visited every clinic on a daily basis to speak to staff. The nurse team leader also visited the clinic every day to see staff. They also occasionally provided support to some clinics.
Culture within the service

- All staff we spoke with told us they felt part of the outpatient services team and valued in their role. Staff were positive about the service they provided to patients and the wider community.
- Staff made positive comments about the care and treatment provided. A nurse who had received both inpatient and outpatient treatment described her care as “superb”. Another healthcare assistant told us they enjoyed working in the department because of the “teamwork” and “friendly environment”. Several staff told us they would recommend the hospital as a place to work. Staff also commented they thought there was an open culture within the working environment.
- A consultant we spoke with told us they thought the communication between the different professionals was “excellent” and that it helped promote a “very positive working environment.”
- Staff we spoke with told us they felt able to raise concerns and discuss issues with the managers of the department.

Public and staff engagement

- At the time of our inspection, the outpatient department had not completed a patient survey of the whole department. Two clinics we visited, audiology and physiotherapy, explained how they conducted their own surveys of patients who used their clinics.
- Staff we spoke with said they felt engaged with the trust and could share ideas or concerns within their peer group and with their manager. Staff were given trust messages directly, via email, and through bulletins on screen savers. Staff we spoke with said they felt well informed of developments and issues within the hospital and the wider trust.

Innovation, improvement and sustainability

- The department hoped to have electronic patient records in place within the next two years. We were told by the management team that they were looking at plans to introduce electronic patient check-ins, but there was no timeline on this at the present time.
Outstanding practice

We saw several areas of outstanding practice, including:

- On Alex Ward, they had recently had a ‘street party’ for the patients there. Many of these patients were living with dementia and efforts had been made to use reminiscence to help them to enjoy the afternoon. Staff had dressed up in 1940s costume and appropriate music had been played. Photographs of this event were displayed in the ward and patients had clearly enjoyed themselves. This was evidence of outstanding, appropriate emotional support for the ward population. The nursing, medical, therapy and ward clerk staff on Alex went “all out” to deliver the street party. They planned it around their normal day to day work. Articles in the local paper showed very happy patients and staff who had dressed up and brought in specific reminiscence music for the occasion. Someone else made cakes.

- The acute paediatric team demonstrated excellent collaborative working providing end of life care for children in their own homes.

- Leadership and teamwork in theatre was exemplary, despite staff shortages.

- There was thoughtful and compassionate care for those patients living with dementia particularly on Alex Ward and Caper Wards where care was patient centred and holistic in its approach. A robust dementia policy ensured the highest standards of personalised care using all therapeutic staff was put in place. There had been an investment in staff to develop dementia care practice.

- The nursing leadership of the acute stroke service was very highly regarded by medical, therapy and nursing staff. Staff felt valued and the service itself was very patient focused placing a high value on emotional support.

- The Trust’s successful involvement with Project Search, an innovative scheme that supports young people with learning difficulties to find permanent work, was modelling excellent practice to local employers. The trust had provided 12 month internships to seven young people, all of whom had successfully completed the programme and had found permanent jobs, six of them with the trust in areas such as medical records and catering.

Areas for improvement

Action the hospital MUST take to improve:

- Review and improve arrangements for the assessment and management of the prevention, detection and control of the spread of health care associated infection. This includes ensuring that suitable equipment is provided and used, that all areas are kept clean and tidy and ensuring that staff are consistently following trust policies.

- Evaluate and improve the effectiveness of the current patient flow and escalation policies. Action must be taken to improve the flow of patients from Accident and Emergency department and across the trust. The policies and procedures for patients who are not admitted to the most appropriate ward (outliers) need to be clear, focused on the best interests of patients and consistently applied. The criteria to be applied to decisions on the movement of patients and the protocols to be followed must be clear.

- Ensure that there are suitable arrangements in place for obtaining, and acting in accordance with, the consent of service users in relation to the care and treatment provided for them. The trust must make sure that staff are aware of and consistently apply these arrangements.

- Ensure that the facilities for the sonography service are such that the safety, privacy and dignity of patients can be maintained. Rooms used by sonography staff must have a system for calling help in
the event of an emergency.

- Ensure that there is a system in place, supported by guidance, for the completion of Health and Social Care Act 2008 1 (grounds for carrying out an abortion) and Health and Social Care Act 2008 4 (abortion notification). These records must be completed accurately and consistently and forwarded to the Department of Health as required.

**Action the hospital SHOULD take to improve:**

- Ensure the implementation of pain assessments. We saw poor use of pain measurement as comfort rounds did not include pain assessment.
- Consider reviewing some areas of the environment including in A&E with regard to the lack of visibility of patients in the waiting area. Also the trust should consider plans to improve the facilities and environment in the intensive care unit, in order to achieve best practice standards and consider improvements to the facilities and environment in anaesthetic rooms to address infection control risks.
- Review medicines storage security arrangements in the intensive care unit to achieve best practice standards.
- The trust should also consider improving the environment of children’s services, as the environment of the ward made it challenging to meet the differing needs of patients and parents, with no single-sex provision.
- Ensure a clear protocol for doctors to follow when caring for a deteriorating patient in the intensive care unit and surgery. There was no clear protocol, pathway, or standard operating procedure for the doctor’s responsibility for managing the deteriorating patient. There were also poorly implemented early warning scores (EWS) in A&E and the trust should consider how this is managed.
- Consider the management of clinical assessments in the A&E department. We saw there were long waits for clinical assessment of non-ambulance patients and no monitoring of waiting patients. The flow of ambulance patients was disjointed and not designed to meet national targets. Staff in A&E should be aware of clinical audits, and how the results compare with national standards.
- The trust should consider the deployment of senior staff in the A&E department. We saw a lack of visibility of senior medical and nursing staff. Nursing leadership was shared with other departments within the trust. There was limited support for junior staff needing advice in difficult clinical and organisational situations. The trust should also further ensure that all medical staff have job plans that are regularly reviewed as part of their appraisal process. We had difficulty in establishing specialist qualifications or a competency framework for nursing staff in A&E.
- Security staff should have suitable training to manage violence and aggressive behaviour safely in the A&E department.
- Demonstrate that the critical care service takes accountability for learning and improvement, with minutes and actions plans produced from clinical governance meetings.
- Consider information provided through external reviews and work with medical teams as suggested in the Royal College of Obstetricians and Gynaecologists (RCOG) report provided to the trust in March 2014 to ensure they engaged in processes designed to reduce the caesarean section and induction of labour rates.
- The trust should also consider that in light of the RCOG report the need to keep staff informed of the recommendations and actions to be taken.
- Consider the risks with the admission of young people requiring intensive mental health support. However, we are aware that this is recognised and that there are plans in place for an urgent assessment protocol.
- Ensure there is nutritious food available to parents and breastfeeding mothers, apart from breakfast cereal.
• Consider that Patients be met and admitted into the day surgery unit when they arrive and the overall experience of the day surgery unit be improved to ensure patients comfort, dignity and confidentiality.

• Ensure that Safety Thermometer data and patient assessments on wards be improved, to address the degree of patient harms from pressure ulcers and infections.

• Demonstrate that the surgical service takes accountability for learning and improvement by actions plans produced from clinical governance meetings.
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.

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<th>Regulated activity</th>
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<tr>
<td>Termination of pregnancies.</td>
<td>The provider did not ensure that service users were protected against the risks of unsafe or inappropriate care and treatment arising from a lack of proper information about them by means of an accurate record regarding each service user. This shall include appropriate information and documents relating to the care and treatment provided to each service user. Regulation 20 (1)(a), the Health and Social Care Act 2008 (Regulated Activities), regulations 2010 – records. How the regulation was not being met: Completion of HSA1 (grounds for carrying out an abortion) and HSA4 (abortion notification) were not consistent and there was no guidance, or an identified system in place to ensure records were completed both accurately and consistently and, when required, forwarded to the Department of Health. Regulation 20 (1)(a), the Health and Social Care Act 2008 (Regulated Activities), regulations 2010 – records.</td>
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<tr>
<td>Treatment of disease, disorder or injury</td>
<td>The registered person did not have suitable arrangements in place for obtaining and acting in accordance with, the consent of service users in relation to the care and treatment provided for them. Regulation 18, Health and Social Care Act 2008 (Regulated Activities), regulations 2010 – consent to care and treatment. How the regulation was not being met: We saw evidence of end of life decisions having</td>
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been made without documentation of, or discussion with, patients. We viewed guidance on the use of treatment escalation plans (TEPs) that was unclear in relation to responsibilities with regard to this. TEPs that included do not attempt cardio-pulmonary resuscitation (DNA CPR) decisions were not consistently being completed appropriately. Mental capacity assessments were not consistently undertaken when capacity had been identified as an issue. Decisions about resuscitation were not consistently communicated to nursing staff. Regulation 18, Health and Social Care Act 2008 (Regulated Activities), regulations 2010 – consent to care and treatment.

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<td>Treatment of disease, disorder or injury. Surgical procedures</td>
<td>The provider did not take proper steps to ensure that each service user was protected against the risks of receiving care or treatment that was inappropriate or unsafe by the planning and delivery of care and, where appropriate, treatment in such a way as to meet the service users individual needs. Regulation 9 (1)(b)(i) and (ii) of the Health and Social Care Act 2008 (Regulated Activities), regulations 2010 – care and welfare of people who use services. How the regulation was not being met: The policies and procedures for patients not being admitted to the most appropriate ward (outliers) were not consistent or supportive of patients or staff at all times. There was no hospital-wide protocol for the safe handover of patients to other wards and how and when this should, or should not be done. Regulation 9 (1)(b)(i) and (ii) of the Health and Social Care Act 2008 (Regulated Activities), regulations 2010 – care and welfare of people who use services.</td>
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<td>Treatment of disease, disorder or injury Diagnostics and screening</td>
<td>The registered person did not ensure that service users and others had access to premises where a regulated activity was carried out, which were protected against the risks associated with unsafe or unsuitable premises by means of suitable design and layout. Regulation 15 (1)(a), Health and Social Care Act 2008 (Regulated Activities), regulations 2010 – safety and suitability of premises.</td>
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How the regulation was not being met:

Rooms in which sonographers carried out their work were not sufficient in size. They did not have curtains or screens to maintain privacy and dignity without the practitioner having to leave the room. There was no system in the rooms for calling for help if a woman fell ill, or the sonographer felt threatened. Regulation 15 (1)(a), Health and Social Care Act 2008 (Regulated Activities), regulations 2010 – safety and suitability of premises.

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<td>Treatment of disease, disorder or injury</td>
<td>The registered person did not ensure that effective operation of systems, designed to assess the risk of, and to prevent, detect and control the spread of, healthcare-associated infection. Regulation 12 (2)(a), Health and Social Care Act 2008 (Regulated Activities), regulations 2010 – cleanliness and infection control. How the regulation was not being met: Not all staff, in all areas, followed the hospital’s ‘bare below the elbows’ policy. The availability of hand-washing facilities in the major treatment area of A&amp;E was limited. Within A&amp;E, alcohol gel was available for hand cleaning in patient bays, but there was only one dispenser for the rest of the treatment area. There had been no comprehensive infection control audits in A&amp;E carried out in the last six months. There were no sluice facilities for non-disposable bedpans in A&amp;E. There was no separate room in A&amp;E for clinical waste, domestic waste or recycling.</td>
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