

## Hinchingbrooke Health Care NHS Trust

# Hinchingbrooke Hospital









## Quality Report

Hinchingbrooke Park  
Hinchingbrooke  
Huntingdon  
Cambridgeshire  
PE29 6NT  
Tel: 01480 416416  
Website: [www.hinchingbrooke.nhs.uk](http://www.hinchingbrooke.nhs.uk)

Date of inspection visit: 16 - 18 Sept, Unannounced  
visits on 21 and 28 Sept 2014  
Date of publication: 09/01/2015

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.

## Ratings

<b>Overall rating for this hospital</b>	<b>Inadequate</b>	
Urgent and emergency services	<b>Inadequate</b>	
Medical care	<b>Inadequate</b>	
Surgery	<b>Requires improvement</b>	
Critical care	<b>Good</b>	
Maternity and gynaecology	<b>Good</b>	
End of life care	<b>Requires improvement</b>	
Outpatients and diagnostic imaging	<b>Good</b>	

# Summary of findings

## Letter from the Chief Inspector of Hospitals

The Care Quality Commission (CQC) carried out a comprehensive inspection which included an announced inspection visit between the 16 and 18 September 2014 and subsequent unannounced inspection visits on 21 and 28 September. We carried out this comprehensive inspection of the acute core services provided by the trust as part of Care Quality Commission's (CQC) new approach to hospital inspection.

Hinchingbrooke Hospital is an established 304 bed general hospital, which provides healthcare services to North Cambridge and Peterborough. The trust provides a comprehensive range of acute and obstetrics services, but does not provide inpatient paediatric care, as this is provided within the location by a different trust. The trust is the only privately-managed NHS trust in the country, being managed by Circle since 2012. The Trust's governance is derived from the Franchise Agreement and Intervention Order approved by the Secretary of State for Health. This approach empowers all members of staff to take accountability and responsibility for the planning and implementing of a high quality service.

Prior to undertaking this inspection we spoke with stakeholders and reviewed the information we held about the trust. Hinchingbrooke Health Care NHS Trust had been identified as low risk on the Care Quality Commission's (CQC) Intelligent Monitoring system. The trust was in band 6, which is the lowest band.

The hospital was first built in the 1980s. It was the first trust in the country to be managed by an independent healthcare company, Circle, which occurred in February 2012. It is led by a multidisciplinary team of clinical and non-clinical executives partnered with a non-executive Trust Board. However we found that the trust was predominantly medically led but a new director of nursing had been appointed four months prior to our visit and was beginning to address the input of nursing within the hospital.

We found significant areas of concern during our inspection visit which we raised with the chief executive, director of nursing, head of midwifery and the chief operating officer of the trust and the next day with the NHS Trust Development Authority. We were concerned about patients safety and referred a number of patients to the Local Authority safeguarding team. Since the inspection the Trust Development Authority have given the trust significant support to address the issues raised in this report. CQC served a letter which informed the trust of the nature of our concerns in order that action could be taken in a timely manner. CQC also requested further information from the trust as we considered taking urgent action to reduce the number of beds available on Apple Tree Ward. However the trust took the decision to reduce the number of beds as part of their action plan and so this regulatory action was therefore not necessary. The matter has been kept under review and the CQC has undertaken two unannounced inspections, attended the Annual Public Meeting [i.e. the Annual General Meeting] on 25 September 2014 and held two follow up meetings with the trust to ensure that action have been taken.

The comprehensive inspections result in a trust being assigned a rating of 'outstanding', 'good', 'requires improvement' or 'inadequate'. Each core service receives an individual rating, which, in turn, informs an overall trust rating. The inspection found that overall; the trust has a rating of 'inadequate'.

Our key findings were as follows:

- We found many instances of staff wishing to care for patients in the best way, but unable to raise concerns or prevent service demands from severely impinging on the quality and kindness of care for patients. In both maternity and critical care we noted good care, focused on patients' needs, meeting national standards.
- The provision of care on Apple Tree Ward, a medical ward, was inadequate and there were risks to patient safety. This required urgent action to address the concerns of the inspection team.
- There was a lack of paediatric cover within the A&E department and theatres that meant that the care of children in these departments was, at times, increasing potential risks to patient safety.

# Summary of findings

- The senior management team of the trust are well known within the hospital; however, the values and beliefs of the trust were not embedded, nor were staff engaged or empowered to raise concerns by taking responsibility to 'Stop the Line'. Stop the line is a process which empowers all members of staff to raise immediate concerns when they believe that patient safety is being compromised. Initiating a "Stop the Line" facilitates management support to the area identified and action to address the issue.
- There was a lack of knowledge around Adult Safeguarding procedures, Mental Capacity Act and Deprivation of Liberty processes.
- A response to call bells in a number of areas, in Juniper Ward, Apple Tree ward and the Reablement Unit for example, was so poor that two patients of the 53 we spoke to in the medical and surgical areas stated that they had been told to soil themselves. A further one patient advised that they had soiled themselves whilst awaiting assistance. We brought this to the attention of the trust and they investigated. However neither CQC nor the trust could corroborate these claims.
- Risk assessments were not always reflective of the needs of patients in surgery and medical wards. This was evidenced by review of 46 sets of notes of which 19 were found to have incomplete information or review.
- Infection control practices were not always complied with in A&E Apple Tree ward, Cherry Tree ward, Walnut ward and in the Treatment Centre.
- Medicines, including controlled drugs, were not always stored or administered appropriately in A&E, Juniper ward, Apple Tree ward or Cherry Tree ward.

We saw several areas of good practice including:

- In both maternity and critical care we noted good care, focused on patients' needs, meeting national standards.
- The paediatric specialist nurse in the emergency department was dynamic and motivated in supporting children and parents. This was seen through the engagement of children in the local community, in a project to develop an understanding of the hospital from a child's perspective, through the '999 club'.
- The support that the chaplaincy staff gave to patients and hospital staff was outstanding. The chaplain had a good relationship with the staff, and was considered one of the team. The number of initiatives set up by the chaplain to support patients was outstanding.

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

Importantly, the trust must:

- Ensure all patients health and safety is safeguarded, including ensuring that call bells are answered in order to meet patients' needs in respect of dignity, and patient's nutrition and hydration needs are adequately monitored and responded to.
- Ensure that staffing levels and skill mix on wards is reviewed and the high usage of agency and bank staff to ensure that numbers and competencies are appropriate to deliver the level of care Hinchingsbrooke Hospital requires.
- Ensure that the arrangements for the provision of services to children in A&E, operating theatres and outpatients areas provided by the trust, is reviewed to ensure that it meets their needs, and that staff have the appropriate support to raise issues on the service provision.
- Ensure records, including risk assessments, are completed, updated and reflective of the needs of patients.
- Ensure the care pathways, including paediatric pathways, in place are consistently followed by staff.
- Ensure an adequate skill mix in the emergency department and theatres to ensure that paediatric patients receive a service that meets their needs in a timely manner.
- Ensure that there are sufficient appropriately skilled nursing staff on medical and surgical wards to meet patients' needs in a timely manner.
- Ensure medicines are stored securely and administered correctly.
- Improve infection control measures in the Emergency department and medical wards to protect patients from infection through cross contamination.

# Summary of findings

- Ensure staff are trained in, and have knowledge of their responsibilities under the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS).
- Ensure that patients are treated with dignity and respect.
- Ensure that all staff are adequately supported through appraisal, supervision and training to deliver care to patients.
- Ensure pressure ulcer care is consistently provided in accordance with National Institute for Health and Care Excellence (NICE) guideline CG:179.
- Ensure that catheter and intravenous (IV) care is undertaken in accordance with best practice guidelines.
- Ensure patients are treated in accordance with the Mental Capacity Act 2005.
- Ensure that the staff to patient ratio is adjusted to reflect changing patient dependency.
- Review the 'Stop the Line' procedures and whistle blowing procedures, to improve and drive an open culture within the trust.
- Standardise and improve the dissemination of lessons learnt from incidents to support the improvement of the provision of high quality care for all patients.
- Ensure that all appropriate patients receive timely referral to the palliative care service.
- Ensure action is taken to improve the communication with patients, to ensure that they are involved in decision-making in relation to, their care treatment, and that these discussions are reflected in care plans.
- Review mechanisms for using feedback from patients, so that the quality of service improves.

In addition, the trust should:

- Review the checking of resuscitation equipment in the A&E department, and across the trust, to ensure that it occurs as per policy.
- Take action to reduce the overburdensome administration processes when admitting patients into the acute assessment unit (AAU).
- Review intentional rounding checks to ensure that they cover requirements for meeting patient's nutrition and hydration needs.
- Involve patients in making decisions about their care in the A&E department.
- Review the training given to staff, and the environment provided, for having difficult discussions with patients.
- Review translation usage in A&E, to ensure that patients receive information appropriate to their needs.
- Provide adequate training on caring for patients living with dementia, to improve the service to patients living with dementia.
- Discontinue the practice of adapting day rooms in rehabilitation wards to use as additional inpatient bed spaces.
- Review the clinical pathways for termination of pregnancies in the acute medical area.
- Review the policy on moving patients late at night.
- Review the out-of-hours arrangements for diagnostic services, such as radiology and pathology, to ensure that patients receive a timely service.
- Review mechanisms for fast track discharge, so that terminally ill patients die in a place of their choice.

**Professor Sir Mike Richards**  
**Chief Inspector of Hospitals**

# Summary of findings

## Our judgements about each of the main services

### Service

#### Urgent and emergency services

### Rating

Inadequate



### Why have we given this rating?

The emergency department at Hinchingbrooke Hospital was inadequate in respect of the safe and well-led domains. We could not be assured that there were sufficient assurance processes in place to demonstrate that patients were not at high risk of harm when we inspected. There was minimal incident reporting and recording within the emergency department. We could not see that completed incident reports had a clear 'lessons learnt' approach. We looked at equipment which was visibly clean, but found that some equipment was not maintained to the manufacturer's recommendations with service labels highlighting that a service was due. Medication was not securely stored appropriately, and daily checks on emergency resuscitation trollies were not carried out by staff. Staff vacancies were covered with bank and agency staff which accounted for over a quarter of the staff numbers. Paediatric cover for children in this department was not sufficient to cover 24 hours, and staff did not have the competency to care for children when paediatric nurses were not on duty. Since our visit the trust has employed paediatric agency and bank staff to cover 24 hours. Clinical outcomes and monitoring of the service showed that the trust was not outliers when compared to others however we found that the provision of care was not assured by the leadership, governance or culture in place during our inspection. Patients were routinely triaged within the waiting room area with no consideration for their privacy or dignity. This practice was not in line with departmental expectations; the trust does provide a private room suitable for triage and expects staff to offer patients a choice. There was a senior member of nursing staff who was designated as a shift co-ordinator, and we found that the priorities and management of the department were weak. When busy, two staff told inspectors that they accepted that they could not give the care that they would wish to do so. We heard one patient request assistance and a member of staff told them that

# Summary of findings

they did not have time but would return. However after 30 minutes the patient stated that no one had returned. We raised this issue to a member of staff who assisted the patient.

The department was not responsive to the needs of all of the people who used it. Children had no separate waiting area and treatment rooms designed for children were not always used for them. There were higher than the England average number of people who left the department before being seen due to long waiting times and those who were to be admitted also spent considerable lengths of time in the department. The escalation protocol was not used effectively to reduce patients waiting times

Mental capacity assessments were being undertaken appropriately, and staff demonstrated knowledge around most of the trust's policy and procedures. We saw that staff were rushed with their workload, but took the time to listen to patients, and explain to them what was wrong and any treatment required. The staff we spoke with were proud to work in the emergency department.

## Medical care

Inadequate



Medical services were inadequate because we found poor emotional and physical care which was not safe or caring. This was not reported by leaders of the service to the trust management therefore we judged the leadership to be inadequate. Services were not caring because people were not treated with dignity or respect. We were also concerned that people were not being treated in an emotionally supportive manner. Hand hygiene and infection control techniques were poor. Staffing numbers were not always reflective of patient dependency. Examples of treatment without consent were identified on one patient who lacked mental capacity but we found an under recognition of patients who may lack capacity throughout the medical wards. Services were not effective because pressure ulcer prevention and treatment was not always provided in line with NICE guidelines. There were no seven day services provided by the hospital. The service was not responsive; we found that medical patients were not always classed as outliers despite requiring specialised care. This

# Summary of findings

meant that the frequency of review by their own consultant might be reduced. The Medical Short Stay Unit and the Reablement Centre were not utilised for their intended purpose. The service was not well-led. We found that the culture of identifying, reporting and escalating concerns was not open. We found that teams were not engaged or felt enabled to raise concerns. We wrote to the trust to express our concerns and with the support of the Trust Development Authority action underway to address these.

## Surgery

### Requires improvement



The surgical services require improvement because there were significant risks and deficiencies evident across four areas of our inspection domains. The safety of patients was at risk due to delays in nurses attending when patients call for help. In Juniper Ward there was a clear consensus from many patients that they were not cared for safely because it took too long for nurses to respond, in particular at night time. However the trust produced data which demonstrated that the average response time in the week prior to our visit was on average four minutes, this meant that this may have been an emerging issue. We found that there were continuing problems of medication not being administered as prescribed. Nursing care records and plans did not always reflect the current needs of the patient, or have clear guidance of the care to be provided.

Patient outcomes were good in certain respects, such as low incidence of pressure ulcers, and low readmission rates indicating successful overall treatment. Many issues were evident and had been identified by the trust, but action had not been taken to improve the issues or actions taken had not been effective. It was not evident that staff could easily raise issues they were concerned about, either in their own teams or across professional boundaries.

## Critical care

### Good



Critical care services were good overall. We found that services were safe, as competent medical, nursing and other professionals worked effectively together to ensure safety. The environment was cramped and old, which meant that staff had to work flexibly and efficiently to ensure cleanliness,

# Summary of findings

safety, and privacy and dignity for patients. The service is effective as staff followed clinical guidance and locally agreed protocols. Performance data showed that there were few incidents of harm.

The service was caring as patients and relatives told us that staff were very supportive. There were systems available to provide follow-up emotional support if required. Critical care services were responsive because a range of detailed assessment records were used to prompt staff to meet patients' individual needs. Children were cared for in the Critical Care Centre, but this was a temporary measure to provide urgent support until specialist care was arranged. The service was well-led, as staff worked well as an integrated team to provide very specialist care within the unit, and also to patients requiring aspects of intensive care in other ward areas. Audit work was established by the outreach staff to monitor the overall management of deteriorating patients in all wards.

## Maternity and gynaecology

Good



The current level of maternity services provided to women and babies by Hinchingsbrooke Hospital were good. The maternity unit provided safe staffing levels and skill mix, and encouraged proactive teamwork to support a safe environment. We saw that there were arrangements in place to implement good practice, learning from any untoward incidents, and an open culture to encourage a focus on patient safety and risk management practices. The trust is working towards achievement of Level 2 Unicef's Baby Friendly Initiative

All permanent staff were appropriately qualified and competent to carry out their roles safely and effectively in line with best practice. There were detailed and timely multidisciplinary team discussions and handovers, to ensure women and babies care and treatment was co-ordinated and the expected outcomes were achieved. Staff in all roles put effort into treating women with dignity, and most women felt well-cared for as a result. Staff in the hospital and community were flexible in working practices and responding to the needs of women and babies. We found the midwifery leadership model encouraged co-operative,



# Summary of findings

supportive relationships among staff. Staff reported that the managers and supervisors ensured that they felt respected, valued, supported and cared for. Staff contributions and performance were recognised and celebrated.

## End of life care

### Requires improvement



End of life care service require improvements as patients are at risk of not receiving safe or effective treatment that meets their needs. Do not resuscitate forms were not completed correctly, the palliative care team were over stretched which meant that staff were not effectively trained and patients did not receive the levels of care they could expect. These risks were not recorded on a risk register as there was not one specific to end of life care. We were told that there were no associated end of life care risks.

'Do not attempt cardio-pulmonary resuscitation' (DNA CPR) forms were completed, but a high percentage had not been appropriately signed by a consultant. In many instances, we found that DNA CPR decisions had not been discussed with the patient or their representatives. Assessments had not been completed when the reason given for not discussing decisions with patients was recorded as the patient lacking capacity. Documentation was found to be poor throughout the service. Ward staff training in end of life care was lacking, and no one we spoke to on the wards had advanced communication training, however the palliative care team did have this training.

The specialist palliative care team was well-led, and had worked hard to improve end of life care throughout the hospital. The team had put together a business case to increase staffing within the team, in order to ensure that they could provide an equitable, effective and safe end of life care service, that was available 24 hours every day. The chaplaincy service provided outstanding care to patients and support to the nursing staff on wards. Most of the hospital wards were providing end of life care and therefore this report should be read in conjunction with the medical care report.

# Summary of findings

## Outpatients and diagnostic imaging

Good



We found outpatients to be safe. Medicines and prescription pads were securely stored, although we found a small amount of medicines within the trauma and orthopaedic outpatient clinic, which were being stored along with cleaning fluids and other items. The outpatient areas we visited were clean, and equipment was well maintained. Staff vacancies were being managed appropriately. Patients were appropriately asked for their consent to procedures. On most occasions records were available for patient clinic appointments. The service in outpatients was caring. Patients received compassionate care, and were treated with dignity and respect. The outpatient service was responsive to people's individual needs. Patients were seen within national waiting times. Staff told us that clinics were rarely cancelled. Translation services were available for people who did not speak English, and all the staff we asked about this were able to tell us how to access these services. Complaints were handled appropriately, and action was taken to improve the service. Outpatient services were well-led and there was good local leadership of clinics. Patient feedback was used to improve the service, and there was innovation in some service areas, such as one-stop clinics in gynaecology.

# Hinchingbrooke Hospital

## Detailed findings

### Services we looked at

Accident and emergency; Medical care (including older people's care); Surgery; Critical care; Maternity and family planning; End of life care; Outpatients

## Contents

Detailed findings from this inspection	Page
Background to Hinchingbrooke Hospital	11
Our inspection team	12
How we carried out this inspection	12
Facts and data about Hinchingbrooke Hospital	13
Our ratings for this hospital	15
Findings by main service	16
Action we have told the provider to take	94

## Background to Hinchingbrooke Hospital

Hinchingbrooke Hospital is an established 304 bed general hospital, which provides healthcare services to North Cambridge and Peterborough. The hospital provides a comprehensive range of acute and obstetrics services. The trust does not provide general inpatient paediatric care, as this is provided within the location by a different trust. However children are seen in the A&E department, operating theatres and in outpatients by Hinchingbrooke Health Care NHS Trust staff. The trust is the only privately-managed NHS trust in the country, being managed by Circle since 2012. The Trust's governance is derived from the Franchise Agreement and Intervention Order approved by the Secretary of State for

Health. This approach is intended to empower all members of staff to take accountability and responsibility for the planning and implementing of a high quality service.

The average proportion of Black, Asian and minority ethnic (BAME) residents in Cambridgeshire (5.2%) is lower than that of England (14.6%). The deprivation index is lower than the national average, implying that this is not a deprived area. However, Peterborough has a higher BAME population and a higher deprivation index.

The Care Quality Commission (CQC) carried out a comprehensive inspection which included an announced

# Detailed findings

inspection visit between the 16 and 18 September 2014 and subsequent unannounced inspection visits on 21

and 28 September and attended the Annual Public Meeting on 25 September 2014. The trust had been identified as a low risk through CQC's intelligence monitoring.

## Our inspection team

Our inspection team was led by:

**Chair:** Jonathan Fielden, Medical Director, University College London Hospitals

**Head of Hospital Inspections:** Fiona Allinson, Care Quality Commission

The team included CQC inspectors and a variety of specialists: nine CQC inspectors, one medical director, a head of governance, six medical consultants, one junior doctor, six senior nurses, a student nurse, and two 'experts by experience'. (Experts by experience have personal experience of using or caring for someone who uses the type of service that we were inspecting.)

## 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 announced inspection visit took place between the 16 and 18 September 2014, with subsequent unannounced inspection visits on 21 and 28 September and attended the Annual Public Meeting on 25 September 2014

Before visiting, we reviewed a range of information we held, and asked other organisations to share what they knew about the hospital. These included the clinical commissioning group (CCG); Monitor; NHS England; Health Education England (HEE); General Medical Council (GMC); Nursing and Midwifery Council (NMC); Royal College of Nursing; College of Emergency Medicine; Royal College of Anaesthetists; NHS Litigation Authority; Parliamentary and Health Service Ombudsman; Royal College of Radiologists and the local Healthwatch.

We held a listening event on 16 September 2014, when people shared their views and experiences of Hinchingsbrooke Hospital. Some people who were unable to attend the listening event shared their experiences with us via email or by telephone.

We carried out an announced inspection visit between 16 and 18 September 2014. We spoke with a range of staff in the hospital, including nurses, junior doctors, consultants, administrative and clerical staff, radiologists, radiographers and pharmacists. We also spoke with staff individually as requested. We carried out unannounced visits on Sunday 21 September to Apple Tree Ward, Thursday 25 September to the Annual Public Meeting, and Saturday 28 September 2014 to the emergency department, Juniper and Apple Tree Wards. During these unannounced visits we spoke with staff, patients and relatives.

We talked with patients and staff from all the ward areas and outpatient services. We observed how people were being cared for, talked with carers and/or family members, and reviewed patients' records of personal care and treatment.

We would like to thank all staff, patients, carers and other stakeholders for sharing their views and experiences of the quality of care and treatment at Hinchingsbrooke Hospital.

# Detailed findings

## Facts and data about Hinchingsbrooke Hospital

### Beds

304 (260 General and acute, 38 Maternity and 6 Critical care)

Inpatient admissions

Outpatient attendances 93,000 (2012/13)

A+E attendances 38,813 (2013/14)

Births 2,193 births April 2013 March 2014

Deaths 493 (April 2013 – March 2014) 102 (April 2014 – June 2014)

Annual turnover £111.5m

Surplus (deficit) -£1m

### Intelligent Monitoring

Elevated risk scores in well led 1

Risk score in well led 1

Total risk score 3

Individual risks/elevated risks

- NHS Staff Survey - KF7. The proportion of staff who were appraised in last 12 months (01-Sep-13 to 31-Dec-13)

### By Domain

#### Safe

Never events (April 2013 -May 2014) 0

Serious incidents (STELs) (April 2013- May 2014) 41

National reporting and learning system (NRLS) (April 2013- May 2014)

Deaths 5, Severe 31, Moderate 86 Total 122

Effective:

HSMR: IM Indicator: No evidence of risk

SHMI: IM Indicator: No evidence of risk

Caring:

CQC inpatient survey 2013:

The trust scored average for all 10 sections.

- In Subsection 4: The hospital and ward the trust scored below average question 19. Did you feel threatened during your stay in hospital by other patients or visitors?

Cancer patient experience survey 2012/13:

Of all 68 questions the trust scored

- In the highest 20% of all Trusts for 6 questions
- In the lowest 20% of all Trusts for 8 questions

Responsive:

Bed occupancy: In Q1 2014 the trusts average daily bed occupancy for all General and Acute beds was 82.7% which is less than both the England average of 89.5% and the 85% percent standard where it is suggested level of patient care would be affected.

length of stay:

April 2013 to March 2014

- Elective
  - Trust Average = 4 days
  - England Average = 4 days
- Non-Elective
  - Trust Average = 6 days
  - England Average = 7 days

A+E: 4 hour standard:

IM Indicator: Composite indicator: A&E waiting times more than 4 hours (05-Jan-14 to 30-Mar-14) - No evidence of risk April 2014 – May 2014

- Average A&E 4 hour waiting time target is 96%

Out of 52 weeks which ended in 2013/14, the trust missed the 95% target 13 times. Hinchingsbrooke was above the England average in 38 of 52 weeks, or 73% of the time. However the current year to date figure is just over 95% which is in line with the expected average.

Cancelled operations: The proportion of patients whose operation was cancelled (01-Jan-14 to 31-Mar-14) - No evidence of risk

18 week RTT

IM Indicator: Composite indicator: Referral to treatment (01-Mar-14 to 31-Mar-14) - No evidence of risk April 2013 – March 2014

# Detailed findings

- 18 week RTT consistently above operational standard of 90%

Well led:

Staff survey

Of all 28 questions the trust scored

- Above average for all NHS Trusts for 2 questions
- Below average for all NHS Trusts for 13 questions

Sickness rate

IM Indicator: Composite risk rating of ESR items relating to staff sickness rates (01-Apr-13 to 31-Mar-14) - No evidence of risk April 13 – Dec 13

- Average Trust sickness rate was 4.2% while that for England was 4%

The trust's average sickness rate was greater than that for England for seven out of nine months.

GMC Training Survey 2014: Out of 12 survey areas the trust scored within the interquartile range (so about average) for 11, but was significantly worse than expected for one area, which was Feedback.

GMC - Enhanced monitoring (01-Mar-09 to 21-Apr-14)

# Detailed findings

## Our ratings for this hospital






Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
<b>Urgent and emergency services</b>	Inadequate	Not rated	Requires improvement	Requires improvement	Inadequate	Inadequate
<b>Medical care</b>	Inadequate	Requires improvement	Inadequate	Requires improvement	Inadequate	Inadequate
<b>Surgery</b>	Requires improvement	Requires improvement	Inadequate	Good	Requires improvement	Requires improvement
<b>Critical care</b>	Good	Good	Good	Good	Good	Good
<b>Maternity and gynaecology</b>	Good	Good	Good	Good	Good	Good
<b>End of life care</b>	Requires improvement	Requires improvement	Good	Good	Good	Requires improvement
<b>Outpatients and diagnostic imaging</b>	Good	Not rated	Good	Good	Good	Good
<b>Overall</b>	Inadequate	Requires improvement	Inadequate	Requires improvement	Inadequate	Inadequate

### Notes

<Notes here>

# Urgent and emergency services

Safe	Inadequate	
Effective	Not sufficient evidence to rate	
Caring	Requires improvement	
Responsive	Requires improvement	
Well-led	Inadequate	
<b>Overall</b>	<b>Inadequate</b>	

## Information about the service

The emergency department (ED) at Hinchingsbrooke Hospital provides a 24 hour, seven day a week service to the local area. Patients present to the department either by walking into the department via the reception area, or arriving by ambulance. The department has facilities for assessment, treatment of minor and major injuries, a resuscitation area and a children's provision ED service. There is an acute assessment unit (AAU) within the same directorate, for which patients are admitted for up to 24 hours.

Our inspection included two days in the emergency department as part of an announced inspection, and an unannounced visit on Sunday 27 September 2014. During our inspection, we spoke with clinical leads from medical and nursing disciplines for the department. We spoke with six members of the medical team (of various levels of seniority), seven members of the nursing team (of various levels of seniority) and administration staff. The emergency department sees, on average, just over 100 patients in any given day. During our inspection, we spoke with 13 patients and undertook general observations within all areas of the department. We reviewed the medication administration and patient records for patients in the emergency department.

On average, the emergency department saw around 38,800 patients a year between 2013 and 2014, which equated to around 746 patients a week.

The emergency department is a member of a regional trauma network. The hospital does not provide any other hyper-acute services.



# Urgent and emergency services

## Summary of findings

The emergency department at Hinchingsbrooke Hospital was inadequate in respect of the safe and well-led domains. We could not be assured that there were sufficient assurance processes in place to demonstrate that patients were not at high risk of harm when we inspected. There was minimal incident reporting and recording within the emergency department. We could not see that completed incident reports had a clear 'lessons learnt' approach. We looked at equipment which was visibly clean, but found that some equipment was not maintained to the manufacturer's recommendations with service labels highlighting that a service was due. Medication was not securely stored appropriately, and daily checks on emergency resuscitation trolleys were not carried out by staff. Staff vacancies were covered with bank and agency staff which accounted for over a quarter of the staff numbers. Paediatric cover for children in this department was not sufficient to cover 24 hours, and staff did not have the competency to care for children when paediatric nurses were not on duty. Since our visit the trust has employed paediatric agency and bank staff to cover 24 hours.

Clinical outcomes and monitoring of the service showed that the trust was not outliers when compared to others however we found that the provision of care was not assured by the leadership, governance or culture in place during our inspection. Patients were routinely triaged within the waiting room area with no consideration for their privacy or dignity. This practice was not in line with departmental expectations; the trust does provide a private room suitable for triage and expects staff to offer patients a choice. There was a senior member of nursing staff who was designated as a shift co-ordinator, and we found that the priorities and management of the department were weak. When busy, two staff told inspectors that they accepted that they could not give the care that they would wish to do so. We heard one patient request assistance and a member of staff told them that they did not have time but would return. However after 30 minutes the patient stated that no one had returned. We raised this issue to a member of staff who assisted the patient.

The department was not responsive to the needs of all of the people who used it. Children had no separate waiting area and treatment rooms designed for children were not always used for them. There were higher than the England average number of people who left the department before being seen due to long waiting times and those who were to be admitted also spent considerable lengths of time in the department. The escalation protocol was not used effectively to reduce patients waiting times

Mental capacity assessments were being undertaken appropriately, and staff demonstrated knowledge around most of the trust's policy and procedures. We saw that staff were rushed with their workload, but took the time to listen to patients, and explain to them what was wrong and any treatment required. The staff we spoke with were proud to work in the emergency department.

# Urgent and emergency services

## Are urgent and emergency services safe?

Inadequate



The emergency and urgent care services were judged as inadequate because safety systems, processes and standard operating procedures were not fit for purpose. We found that there was significant bank and agency use within the department, equipment was not always maintained and medicines areas were not secure despite CQC raising this as an issue. Staff were not utilising the system for reporting of incidents as this process too long, this meant that there was no improvements made to the service as issues could not be analysed and trends identified. The 'Stop the Line' process designed for ensuring senior management support to staff in cases where patient safety was a risk was not utilised by staff as they saw it as ineffective. There were substantial and frequent staff shortages. We found that children were not always assessed by staff who had received training for triaging them, and children shared the same emergency department waiting area as adults, which was not in line with 'Children and Young People in Emergency Care Settings 2012' standards. We were concerned that the department had not used an acuity tool to determine the number of children's nurses required to safely staff the department. Since our inspection the trust has employed agency paediatric nurses to support children's services within this department.

Staff were aware of the challenges within the department regarding service provision against demand, and were working towards addressing those challenges.

### Incidents

- The hospital reported one serious incident (SI) to both the National Reporting and Learning System (NRLS) and the Strategic Executive Information System (STEIS), relating to the accident and emergency department between 2013 and 2014.
- We asked staff directly if they reported incidents and had knowledge of the reporting system. The incident data supplied to the CQC during inspection shows that the emergency care centre reported 256 incidents since April 2013, accounting for only 4% of the total incidents

reported. Staff indicated that this low level of reporting reflected the amount of time it took to complete reports and the limited feedback on outcomes or closure of reported incidents.

- We spoke with senior nursing staff, who could not demonstrate to us evidence of learning from incidents. Staff told us that the trusts 'Stop the Line' policy is ineffective, and involvement by executive management did not always happen. (The trust employs an initiative called 'Stop the Line', which aims to empower any member of staff to raise concerns regarding patient experience or safety.)
- The department holds monthly clinical governance meetings, with a regular agenda. Both clinical and nursing staff are invited to attend these meetings. We attended a clinical governance meeting during our inspection, and found no nursing staff present. There were doctors present representing senior, middle and junior grades. We were told that feedback and actions are then taken to a consultants meeting. We looked at previous clinical governance meeting minutes and pathway tracked an action point whereby a fracture was not diagnosed. We then observed a consultant provide education to other doctors around this issue and signing off the action point where required to report back at the next meeting.
- The department displayed key safety related issues in the public areas; However, This information did not inform people who use the services of any measurement, assessment, lessons learnt to improve the safety of the care provided.

### Cleanliness, infection control and hygiene

- Evidence provided by the trust demonstrated a high level of compliance with hand hygiene practices across a number of months, as observed during hand washing audits, however we observed limited personal protective equipment and hand hygiene practices in use during our inspection. Not all staff were witnessed to be wearing gloves, or washing their hands between dealing with patients.
- We observed during our inspection that patients who may have an infection, or were awaiting confirmation of any infection, were nursed within a side room on the acute assessment ward. During the period of our observations we did not see treatment rooms routinely cleaned between patients.

# Urgent and emergency services

- We noted during our inspection that there were hand cleaning stations within all treatment areas; however, some dispensers were empty, including the main entrance for patients entering the emergency department treatment area. We observed ambulance staff remove dirty linen and clean ambulance stretchers within the same area that patients were handed over, and could not see a specific area identified for this activity.

## Environment and equipment

- Resuscitation equipment was available and clearly identified. There was a specific children's equipment trolley. Not all resuscitation trollies had been checked daily, and we noted on one trolley that daily checks had been only been carried out during September 2014 on 2, 5 and 11.
- Treatment cubicles were clean and well equipped with appropriate lighting.
- We looked at equipment which was visibly clean but found that some equipment did not have maintenance labels attached to it. The trust provided a schedule of maintenance and we could see that 94% of equipment had in fact been maintained. The trust stated that there had been previous issues with labels being incorrectly applied to the lead of the equipment rather than the main body. The trust has reported that this practice has now been amended. Whilst this schedule shows equipment to be serviced the inspectors found that at least 12 pieces of patient assessment equipment, such as defibrillators and blood pressure monitoring equipment, did not have the date of the last PAT test or servicing and that some had stickers which stated when the last test was undertaken and some when the next test was due.
- The children and young people's areas department was not fully compliant with standards for 'Children and Young People in Emergency Care Settings 2012'. We saw that the children's department was not dedicated only to children and young people. This meant that children waited in the general A&E waiting area, were triaged in the same system as adults, and were treated in areas where adults were seen. Staff raised concerns to us that this was not safe for children, but told us that the department was planning a renovation inclusive of a separate paediatric A&E department; however, neither staff nor documents could confirm when and how this was going to happen. We were therefore not assured that the environment was suitable for purpose.

## Medicines

- During our inspection, we checked the records and stock of medication, including controlled drugs, and found some discrepancies with regards to controlled drug management as outlined below. Appropriate daily checks were carried out by qualified staff permitted to perform this task.
- We found that the outer door of the cupboard housing the locked controlled drug cupboard could be opened; the controlled drug cupboard and medicines remained secure but this potentially allowed access to the controlled drug book, which could enable tampering with the documentation confirming the issue of controlled drugs. Therefore medicines were inappropriately stored. We also found the drug fridge within the resuscitation area unlocked which contained a selection of muscle relaxants. We were told that there was an ongoing investigation with regards to an ampoule of diamorphine that could not be accounted for. This had been formally reported and was being investigated.
- We looked at patient prescription charts, which were completed and signed by the prescriber and by the nurse administering the medication.
- On a number of occasions during our inspection we observed insecure drug cupboards, including an outer door on a controlled drug cupboard, and a storage room containing intravenous fluids with the door propped open. We spoke with the nurse and a senior manager around the associated risk of this practice, and requested that it be addressed straight away, and we were assured that this would be actioned. On the second day of our inspection we again found, on numerous occasions, the intravenous fluid store door open and insecure.
- Fridges to store appropriate medication did not have the temperature recorded and checked on a daily basis, and the fridge was not locked.
- The trust reported that they were awaiting delivery of digital locks and have replaced all locks with digital lock to ensure security of these areas. The trust states that these are now in place.

# Urgent and emergency services

## Records

- We looked at 14 sets of patient notes during our inspection. One of the sets of notes highlighted delays in the recording of patient observations. One patient arrived in the department via ambulance and did not have an initial recording of observations for 53 minutes.
- All of the notes we looked at had completed observations taken, with regular re-assessment, which were recorded.
- During our inspection we observed that the emergency department notes and acute assessment notes were stored securely. Notes were easily defined between clinical observations and nursing/medical notes. Documentation was of a high standard, with legible notes, and in line with best practice guidance. Children had a thorough history recorded, as well as further assessments of their risks and needs, a diagnosis, and a treatment plan. The records reflected the holistic needs of each child.
- We saw, within the accident and emergency notes, that risk assessments were undertaken in the department when patients were in the department for some time (it is recommended by the Royal College of Nursing that if patients are in an area for longer than six hours a risk assessment for falls and pressure ulcers should be completed).
- We observed that intentional rounds took place by nursing staff on the admissions unit but not within the accident and emergency unit. This is where staff check on patient's welfare at regular periods throughout the day.

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

- Staff were knowledgeable about how to support patients who lacked capacity. They were aware of the need to assess whether a patient had a temporary or permanent loss of capacity, and how to support patients in each situation. If there were concerns regarding a patient's capacity, the staff ensured that the patient was safe and then undertook a mental capacity assessment.
- According to the emergency department mandatory training database, all nursing and medical staff had undergone their mental capacity training.
- We observed nursing and medical staff gaining consent from patients prior to any care or procedure being carried out.

- There was a robust practice in place to support people with drug and alcohol misuse, with referral to the appropriate supporting mechanisms available.
- Staff obtained patient and/or parental consent appropriately. The trust had appropriate policies in place in relation to consent to treatment in children. Staff were knowledgeable about Gillick competence. These guidelines are tools used to assist professionals in determining whether a child is mature enough to make their own decisions about care and treatment.
- The trust stated that one child had waited 19 hours to be seen by the CAMHS in the department. The trust ensured that the safety needs of the child had been met during this time through appropriate escalation and actions taken. However the trust needs to work in partnership with local partners to address children's mental health needs. CAMHS delays are a recognised issue across the region, and this is discussed at the combined safeguarding paediatric clinical governance meetings.
- Records confirmed that at times the department was seeing a high number of paediatric attendances with a history of self-harm. For example in 2013, 94 children attended the department with a history of self-harm, and in 2014 to date, there have been 13 attendances.

## Safeguarding

- The emergency department had a safeguarding lead within the department who was knowledgeable, and demonstrated underpinning knowledge of both safeguarding children and vulnerable adults.
- We looked at training records, and saw that all nursing and medical staff had undergone mandatory safeguarding training at an appropriate level.
- All safeguarding concerns were raised through an internal reporting system. The concerns were reviewed at a senior level to ensure that a referral had been made to the local authorities' safeguarding team.
- The staff we spoke with were aware of how to recognise signs of abuse, and the reporting procedures in place within their respective areas.
- There was a team within the trust dedicated to children's safeguarding. Staff gave examples of how they and the safeguarding team had worked effectively with other children's services, including the local authority, to actively safeguard children. Staff said that the safeguarding team were highly visible and effective.

# Urgent and emergency services

- Systems were in place to safeguard children, including a screening tool used during initial assessment, which identified those children at high risk. There were audits in place which demonstrated that this tool was not always being used effectively; however, we saw that an action plan was in place to support improvements. This system had also been implemented in other areas of the hospital.

## Mandatory training

- We looked at mandatory training records, which showed us that staff received core subject mandatory training, such as manual handling, fire safety, safeguarding, and basic life support. However, we spoke with medical staff who told us that they did not receive a comprehensive induction; for example, doctors received presentations with regards to spinal immobilisation assessment, but the practical assessment was not carried out.
- Mandatory training was provided in different formats, including face-to-face classroom training. Staff told us that there was limited time allowed to complete learning. One member of staff told us that they rarely got to see the staff that they should be mentoring and meeting with, due to workload, and not being permitted a day to complete this, due to low staffing availability to back fill.

## Management of deteriorating patients

- There were appropriate systems in place to assess and monitor patient risk. The emergency department operates a national early warning score (NEWS), and this is used to alert clinicians of any deterioration in a patient's condition.
- The service had implemented a paediatric early warning score (PEWS) system for varying ages of child. Early warning scores are generated by combining the scores from a selection of routine patient observations, such as pulse, respiratory rate, respiratory distress and conscious level. Different observations are selected for children and adults due to their naturally different physiological responses. If a child's clinical condition is deteriorating, the 'score' for the observations will (usually) increase, and so a higher or increasing score gives an early indication that intervention may be required. There were display boards visible to the public which explained the PEWS system.
- We observed that the department operates a triage system of patients presenting to the department either

by themselves or via ambulance, and patients are seen in priority, dependent upon their condition. Children were seen as part of this triage system and did not have a separate area for triage.

- Paediatric audits received from the trust show that 99% of children receive an assessment within the target of 15 minutes. However during our inspection parents told us that the service needs "a separate A&E for children", and that "the waiting time in this department [for children] is unacceptable". During our inspection we observed that one child waiting more than 15 minutes to be assessed; this was a very unwell child who required prompt assessment. We immediately brought this to the manager's attention, and appropriate action was taken.
- Patients arriving as a priority call are transferred immediately through to the resuscitation area. Such calls are phoned through in advance (pre-alert), so that an appropriate team are alerted and prepared for their arrival.
- We looked at a pre-alert form with regards to a pre-alert that occurred during our inspection, and found that the forms had been completed fully, with any clinical observations recorded, estimated time of arrival of the ambulance to the accident and emergency department, and details of who took the information over the telephone from the ambulance service.

## Nursing staffing

- Information provided by the trust indicated that the establishment for the emergency department was not operating at the required whole time equivalents (WTE), with a number of qualified nurse posts vacant. Senior staff acknowledged that they were looking at the RCN 'BEST' policy to understand their staffing needs. The current vacancy percentage across the emergency department at the trust is 26%. Bank and agency staffing were used to support at times when there were known gaps in the rota. The use fluctuated but was around 3% of total staff in the department.
- Staffing records confirmed that there was only one junior paediatric nurse who worked full time to cover the entire department. There was also a senior paediatric sister who worked full time; however, their role was supernumerary, although they told us that their role was adaptable, so they could work a clinical shift, as required. Staff told us that other registered nurses who were not children's nurse qualified, provided emergency care to children when a paediatric nurse was not on

# Urgent and emergency services

shift or available. These nurses had obtained additional training, such as Advanced Paediatric Life Support qualifications. However, the Royal College of Nursing (2013) guidance advises that there must be a minimum of one registered children's nurse available at all times in emergency departments. This meant that the service was not following national guidance in regard to safe staffing numbers.

- We found that a specific paediatric acuity tool had not been used to determine safe nurse staffing levels. This meant that the service had not planned the establishment of the paediatric nurses it required to provide safe care for children and young people. Senior managers told us that due to the increased number of paediatric attendances recently, paediatric staffing in A&E had been identified on the A&E risk register.
- Senior managers told us that the nurses who were triaging at the front desk in A&E were not always trained in paediatric assessments. This is not in accordance with the national standards set out in 'Children and Young People in Emergency Care Settings 2012', which states that nurses who are responsible for triaging children must undergo an assessment of competencies in the anatomical, physiological and psychological differences of children. We were not assured that all staff assessing children were competent to deliver such care.
- We raised these concerns to the trust who took action in temporarily employing additional qualified paediatric nurses in the department. Since our inspection the trust has employed paediatric agency nurses to ensure that the department has 24 hour cover with children's nurses. Adverts to recruit paediatric nurses are currently being drafted.
- We observed that there was a professional handover of care between each shift.
- All bank and agency staff received local induction prior to starting their shift.

## Medical staffing

- The department currently has 14 whole time equivalent (WTE) doctors, who are present in the department, with consultant cover available from 8am until 9pm. There are middle grade doctors and junior doctors overnight, with an on-call consultant system.
- Within the emergency department, we saw that there was a better ratio within the doctor staffing skill mix than the England average. The emergency department

provided a whole time equivalent of 28% within consultant level (England average of 23%), 43% within middle grade doctors (England average 39%), and 29% within junior grade level doctors (England average 25%).

- We looked at the doctor's rota, and saw that the middle grade doctor utilisation level was consistent in using doctors who had received the trust induction programme, and were familiar with the department and protocols.
- The emergency department currently has no clinical director, and this was identified as a risk by the department and senior managers. This has caused a limitation within the scope of practice and development of the department, with regards to leadership and interaction with other directorates in the trust.
- During our observation within the clinical governance meeting, we were told that junior doctors had not received a full induction into the emergency department, as two days induction had been condensed to one day, and elements of practical scenarios, such as for cervical spinal immobilisation and management, were delivered by presentation rather than with hands-on practice.

## Major incident awareness and training

- All major incident equipment was available and we saw that it was checked on a regular basis
- We requested evidence of training for major incidents for all staff within the A&E department. We were provided with training data for nursing and medical staff. This demonstrated that staff had completed major incident training and that 70% of nursing staff had completed chemical, biological, radiological and nuclear training. We were also told that all staff completed major incident training, as part of their induction.

## Are urgent and emergency services effective?

(for example, treatment is effective)

Not sufficient evidence to rate

We do not currently rate this aspect of the service however we found that the department used a range of policies, procedures and pathways which reflected national guidance to ensure that patients received good

# Urgent and emergency services

care and outcomes from treatment. However care plans and care pathways were not always followed by nursing and medical staff. Results of audits were not always available for staff to learn and develop practice from.

## Evidence-based care and treatment

- Departmental policies were easily accessible, which staff were aware of and reported they used. A range of emergency department protocols were available, which were specific to the emergency department.
- There were further trust guidelines and policies operating within the emergency department and acute assessment unit, such as sepsis and needle stick injury procedure. We saw treatment plans which were based on the National Institute for Health and Care Excellence (NICE) guidelines.
- We found reference to the College of Emergency Medicine (CEM) standards, and spoke with medical staff who demonstrated knowledge of these standards.
- We looked at the process followed with regard to admitting patients, and found that the acute assessment unit (AAU) was not aligned to the emergency department processes. We saw that when admitting patients into the AAU, there were six processes to record the admission. We asked why the system was not streamlined and were told that it was to overcompensate for information technology (IT) failure.
- We examined co-ordinated and integrated pathways for children's services, which ensured collaborative working between A&E and the children's ward within the hospital run by another trust.
- Staff demonstrated that they practised evidence-based care. During our inspection we observed a paediatric burns patient and were assured that their care was delivered in line with current burns and scalds guidance issued by the National Institute for Health and Care Excellence (NICE).

## Nutrition and hydration

- During our inspection we pathway-tracked a patient's care plan against the care they received. Entries into the care plan were inconsistent and care pathways were not followed. For example, diabetic care was observed to be below what is expected. One care plan stated 'diabetic patient, consider providing food'. We spoke with this patient and were told that they had not received a regular meal and were provided biscuits at an unreasonable time.

- We observed that intentional rounding was taking place within the acute assessment unit; however, this focused on observations being taken and we did not witness any checks that food or drink were offered. During our inspection we did not see any intentional rounding taking place within the emergency department.
- We observed catering staff within the AAU offering breakfast to patients who had been in the unit overnight.
- We found that fluid charts had not been fully completed, with observation times missing.
- We found that children's nutrition and hydration needs were not always met.

## Patient outcomes

- The emergency department took part in national College of Emergency Medicine audits, and they were able to provide us with the results of these, but there was no evidence that they had used the results to assess the effectiveness of their department.
- The College of Emergency Medicine recommends that the unplanned re-admittance rate within seven days for accident and emergency should be between 1-5%. The national average for England is around 7%. The trust has consistently performed well against unplanned re-admittance since January 2013. Their rate in February 2014 was just below 6%.
- At local level, a number of audits within the children's A&E services had been conducted. This included documentation audits which demonstrated good compliance with national standards. During August 2014, the documentation audit revealed that 100% of notes reviewed included the child's name, school and investigations undertaken. Other audits included the use of the safeguarding tool. This meant that the trust was actively monitoring the quality of its service.

## Competent staff

- Appraisals of both medical and nursing grades were undertaken, and staff spoke positively about the process and said that it was of benefit. The trust is currently going through a change within their appraisal system and process; therefore figures are not reliable at the time of our inspection.
- We saw records which demonstrated that both medical and nursing staff were revalidated in basic, intermediate and advanced life support.

# Urgent and emergency services

## Multidisciplinary working

- Medical and nursing handovers were undertaken separately, during the nursing handovers which occurred twice a day, staffing for the shift was discussed, as well as any high risk patients or potential issues. Medical handover occurred twice a day, and was led by the consultant on the A&E floor.
- There was a clear professional conjoined working relationship between the emergency department and other allied healthcare professionals within other departments and hospitals. For example, the mental health teams provide intervention from community services to enable patients to be discharged home with an appropriate care package and support from other hospitals.
- Staff we spoke with were aware of the protocols to follow, and key contacts with external teams. We witnessed a professional patient experience, from transition from the care of the ambulance service to the accident and emergency staff.

## Seven-day services

- There was a consultant out-of-hours service provided via an on-call system.
- Accident and emergency offered all services, where required, seven days a week.
- We were told by senior staff within the A&E department that external support services are limited out of hours, and it often proves difficult at weekends, which has an effect on patient discharges and care packages.

## Are urgent and emergency services caring?

Requires improvement



There were times when people did not feel well supported and cared for therefore we have judged caring as requiring improvement. Some people told us that they were concerned about the ways staff treated them. We received 17 comment cards from this department. Twelve comments indicated that patients were not always treated with respect and in one stated that they were not believed when receiving treatment; however, Friends and Family feedback and the national A&E patient survey

commissioned by the CQC contradicts this finding. Staff in the department focused on the task in hand rather than ensuring that patients had information about their care and treatment.

We saw patients getting frustrated that they were waiting extended periods for treatment and lack of information; however staff reported that they wished they had more time to care. The department has worked hard to increase the Friends and Family Test response rate; during our inspection we did find Friends and Family Test questionnaires in view, and available within the ambulance triage and reception areas.

## Compassionate care

- We saw that nursing staff were busy, and this was demonstrated in the lack of time that each nurse was able to spend with an individual patient for whom they were providing care. We spoke with staff and they told us that they were frustrated that they could not provide sufficient time at the patient's bedside to understand each patient's full needs.
- The trust performs better than the England average for the NHS Friends and Family Test (the Test was introduced in 2013 and asks patients whether they would recommend hospital wards, A&E departments and maternity services to their friends and family if they needed similar care or treatment). The trusts performance is better than the average for the accident and emergency department.
- During our inspection we saw three occasions whereby patients had to wait a considerable amount of time when they called for a nurse via a call bell in the cubicle, and when the nurse arrived there was very little compassion shown. For example, we saw that a nurse spoke abruptly to the patient and was rushed in spending time with the patient and told the patient that they were very busy. We informed a hospital manager about this.
- Out of 17 comment cards completed by patients during our inspection 16 contained negative comments. We saw some significant concerns about the lack of compassionate care. One patient felt that their condition was not taken seriously despite later finding out that they were suffering with a serious condition. We informed the director of nursing about some of these comments.
- The national A&E patient survey commissioned by the CQC, which had a trust response rate of 35% compared



# Urgent and emergency services

with a national response rate of 34% and that was responded to by 293 patients who had used the trust's emergency department services, contradicts our comment card findings, with patients scoring the trust at 9/10 for patients feeling they were treated with dignity and respect, an increase from 8.5/10 in 2012.

## Patient understanding and involvement

- Patients told us that they did not always feel informed about the care they were receiving, and had to ask nurses and doctors to update them, rather than staff keeping patients informed. The patients we spoke with told us that staff were polite when speaking to them. During our inspection there were delays during the day for patients waiting to see a doctor. We did not observe staff explaining to patients if there was going to be a delay in seeing a doctor, what the reason for that delay was, and how long they would have to wait to be seen.
- One person in the waiting room told us “there are too long waiting times and the screen to tell people information is out of view and I can't see it from the waiting area”. Another person told us that they had not heard their name being called, and when they brought this to the attention of the triage nurse they were told that they would just have to wait, without being asked what was wrong.
- We received a number of concerns in respect of the care of diabetic patients within the department. People attending the listening events prior to the site visit told us that despite asking for food and/or insulin staff lacked an appreciation of their need for these to control their blood sugar.
- The department arranged the nursing staff into teams that looked after specific areas; this did not always facilitate a better patient experience. For example, one nurse we spoke to told us that when the department is understaffed, patients may wait for a longer period, as nurses are not moved around, and remain working in the one area.

## Emotional support

- We spoke with staff about their understanding of bereavement services offered within the emergency department, and we were told that staff call upon the chaplaincy service.

- During our inspection we spoke with staff, including reception staff, and asked what training they had received to deal with distressed people that attend the emergency department; we were told that no training was provided to initially support these people.
- There was limited information available to support people during a time of bereavement, and also taking into account religious and cultural needs.

## Are urgent and emergency services responsive to people's needs? (for example, to feedback?)

Requires improvement 

Services do not always meet the needs of patients therefore we have judged the responsiveness of the service as requiring improvement. There were shortfalls in the services for children in terms of the waiting room and the treatment areas which were not exclusively used for children despite being decorated for them. There were a higher than the England average number of people who left the department before being seen and those who were due to be admitted waited long periods of time before being taken to a ward. It was unclear as to the actions taken by the department to address this.

The department struggled with surges of activity, which occur on a regular and potentially anticipatory basis. The escalation protocol is insufficient, and does not provide a sufficient or measurable safe response, as evidenced by patients waiting above fifteen minutes within the ambulance triage area whilst ambulances are waiting to handover. However the hospital was generally meeting the national four hour target to see and treat patients.

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

- We were told by senior staff within the department of who, within the site team, should be contacted when there were delays to patient flow. There was an internal 'live' electronic system of monitoring to evaluate and manage the effectiveness of patient flow to assist with bed demand.
- During periods of demand, the department started to struggle; there was a lack of co-ordination within teams, resulting in a failure to achieve a better patient

# Urgent and emergency services

experience and flow through the department. For example, we witnessed nursing tasks that were overdue to be completed and no ownership of patient centred care with staff not knowing the condition of patients under their care when there was a telephone enquiry. We also saw patients waiting to be transferred out of the department and when we spoke to a senior nurse about the cause of this we were told that it's like this all the time and they shrugged their shoulders.

## Access and flow

- On average, the trust maintains the 95% target of assessment of people within four hours of arriving in the emergency department. There have been seven occasions of breaching the 95% target between April 2013 and April 2014. Prior to the week of our inspection, the trust achieved 86.5% of patients seen within 4 hours.
- The trusts percentage of emergency admissions via the emergency department, waiting 4-12 hours from the decision to admit until being admitted, have been consistently worse than the expected England average of 5%. The trusts emergency department had an average of 20% of patients waiting 4-12 hours from the decision to admit to being admitted.
- The national average for percentage of patients that leave the department before being seen (recognised by the Department of Health as potentially being an indicator that patients are dissatisfied with the length of time they are having to wait) was 26% (July 2013 – July 2014). The England average was 16%.
- Patients, parents, staff and our observations confirmed that patient flow throughout the service was not always seamless, because there was not a separate pathway for children and young people.

## Meeting people's individual needs

- Staff we spoke with were unaware of the translation service available for those patients whose first language was not English. Within the department we were told by staff that it was not possible to request a translator. The staff we spoke with told us that they would usually use other staff members to translate.
- There were no information leaflets available for many different minor injuries. Those that were provided were available in English.

## Learning from complaints and concerns

- The A&E department advocates the Patient Advice and Liaison Service (PALS), which is available throughout the hospital.
- Information was available for patients to access on how to make a complaint, and how to contact the Patient Advice and Liaison Service.
- All concerns raised were investigated, and there was a centralised recording tool in place to identify any trends emerging.
- We did see that learning from complaints was within the agenda of the clinical governance meeting, and was discussed amongst the doctor peer group; however, this was not disseminated to the whole team in order to improve patient experience within the department.

## Are urgent and emergency services well-led?

Inadequate

During the period of our inspection, we were not assured that governance procedures that would maximise the opportunity to identify, report and learn from incidents to improve services were followed in the emergency department. The department has a lower than expected rate of incident reporting, at 4% of the trust's overall rate. Staff reported that this was reflective of the time it takes to complete reports coupled with lack of feedback from the incidents reported. The trust stated that they had recognised this and invested in web-based incident reporting and risk management software to reduce administrative burden on frontline staff and facilitate improved triangulation and learning from incidents. Patient outcomes data and the CQC's own national A&E patient survey confirm that the trust is not a negative outlier in respect of harms or patient experience. The trust's performance in July 2014 fell to 92.9%; its first monthly drop below a 95% achievement. Year to date figure was 95.2%, which compares favourably with other NHS trusts and is not indicative of a poorly managed service.

The trust were clear about the vision and values, and produced many leaflets on these, that they and its staff subscribed to however there was a lack of awareness of these within the department. Governance procedures

# Urgent and emergency services

were not being followed in respect of reporting incidents, and improving services in response to these. Whilst risk were identified and audits undertaken there was little evidence that these were addressed or used to improve services.

The front line leadership was not robust enough to flex to the needs of the department. We saw that the organisation of staff to manage the department was ineffective at times of increased demand. There was poor collaboration between teams during these times which impacted on the safety, caring, effective and responsiveness of the service. Universally throughout the department, there was an acceptance of a lower standard of care due to pressure, but staff were concerned by the departure of numerous senior managers within the emergency department. The staff we spoke with demonstrated an attitude of commitment, but morale was low.

## Vision and strategy for this service

- The future vision of the accident and emergency department was not embedded within the team, and was not well described by all members of staff we spoke to including managers. This included the development of the A&E department and its growth plans in building size and development of children's services it may offer.
- The children and young people's service within A&E did not have a clear vision and strategy with identifiable aims and objectives. Whilst staff told us that there were trust plans to renovate and separate children's A&E, records did not support this happening in a timely way. We could not be provided with any dates or business plans for completion of this work when we spoke with a senior manager. Staff also told us that "these plans have been on the cards for years but nothing happens".

## Governance, risk management and quality measurement

- Monthly departmental meetings are held. We were provided with minutes of the previous meetings held. There was a set agenda for each of these meetings, with certain standing items.
- Within the minutes, the top risks were discussed, There did not seem to be any embedded concern around the management of the risk register including current updates or any regular review within an accepted time frame.

- A live information dashboard was displayed within the emergency department and acute assessment unit at Hinchingbrooke Hospital for the public to see; we spoke with staff about quality indicators and there was a lack of demonstrable knowledge.
- The trust held three monthly children's clinical governance meetings in partnership with Cambridgeshire Community Services NHS Trust. Staff said that this was an opportunity to learn and discuss complex cases and incidents. We were concerned that these meetings were not occurring frequently enough. This meant that there could be missed opportunities in relation to improving and learning from practice. We were also concerned that the most senior person attending from children's services at Hinchingbrooke Health Care NHS Trust was the lead nurse for safeguarding and/or the senior paediatric nurse from A&E. This meant that there was an absence of senior management at the clinical governance meetings.

## Leadership of service

- There was an evidential departmental team, which was respected and led by the divisional head of nursing for emergency and urgent care.
- The senior management team were interviewed separately, and the conclusions drawn from the interviews were that the leaders visions were not aligned, and at the time of the inspection there was a lack of joint ownership of the issues faced by the department. For example, a number of key leaders have left the department, including the emergency department matron. A decision was made to have one matron looking after both the acute assessment unit and the emergency department.
- During our inspection, we observed that there was a disengagement of leadership from the emergency department matron, with regards to the priorities and management of their department. This disengagement impacted upon the effectiveness and responsiveness of the department.
- The senior paediatric nurse of A&E was dedicated, enthusiastic and inspiring. They demonstrated clear leadership principles and the trust's values. Staff spoke highly of their seniors. They said that they felt respected, valued and incredibly supported by the senior paediatric nurse.
- Staff we spoke to in other departments told us that the most senior professional, with regard to paediatrics at

# Urgent and emergency services

Hinchingbrooke Hospital, was the senior paediatric nurse in A&E. The paediatric nurse was evidently taking the lead and influencing many positive, trust-wide paediatric decisions. However, they were not supported appropriately, as there were no senior managers, in relation to paediatric service provision, above them. This lead nurse reported directly to the divisional head or director of nursing.

## Culture within the service

- The high percentage of consultants within the emergency department contributed to the cohesive working within the medical staff. There was an executive director for the emergency department and medical services but staff felt that the lack of an identified senior leader for this service had the potential to impact on the culture within the service working with other directorates in the trust and external stakeholders.
- We spoke with nursing staff, and universally, throughout the department, there was an acceptance of change and aspirations to improve. Staff believed that with departmental improvements and redesign, a better working environment would be created in which to care for patients and raise morale.
- Staff told us that the trust has policies and procedures in place to protect both patients and staff, but they are not effective. For example, one member of staff told us that the trust has a 'Stop the Line' procedure, and when they try to use it they are made to feel that they are to blame, and that they have done something wrong when instigating 'Stop the Line'. Another member of staff told us that they were told to "just get on with it" when using the 'Stop the Line' procedure. ('Stop the line' procedure is a policy that is in place throughout the trust whereby any staff member who may witness an unsafe practice being carried out or concerns around health and safety

can instigate and invoke the 'stop the line' policy. There is a senior executive on call each day who will attend and deal with any issue as appropriate within trust policy and procedure)




## Public and staff engagement

- The emergency department scored consistently better than the England average in the Friends and Family Test.
- The trust confirmed that feedback was given to staff in a number of ways, however the staff we spoke to told us that they do not get department feedback from staff surveys.
- We asked if the A&E department engages with members of the public within a forum and were told that there is no forum for this other than completing a feedback card and handing it in to the trust.

## Innovation, improvement and sustainability.

- Information for all staff about the trust's vision and strategy was available but staff were not aware how to access it. Staff told us that they were not aware of updates or amendments on the department's priorities and performance
- The lead paediatric nurse in A&E had developed an innovative new scheme, which was designed to engage young children from the local community with the hospital. Children from local primary schools are taken on a tour of the hospital, and get the chance to experience some hands-on activities with regard to how the hospital works, and gain insight into the varying job roles. This scheme had been effective, and had also been rolled out to include children and adults living with learning disabilities. The nurse had been awarded an Executive Board Certificate of Recognition for her outstanding work in this area.

# Medical care (including older people's care)

Safe	Inadequate	
Effective	Requires improvement	
Caring	Inadequate	
Responsive	Requires improvement	
Well-led	Inadequate	
<b>Overall</b>	<b>Inadequate</b>	

## Information about the service

The medical care services at Hinchingbrooke Hospital comprise of five areas. Cherry Tree ward is a 30 bed ward caring for elderly patients with acute medical conditions. There is also a focus on dementia care, within a dementia-friendly environment. Walnut Ward takes patients with acute medical conditions, but has a specialist interest in respiratory conditions. Apple Tree Ward has 25 beds, and focuses on rehabilitation after treatment of acute illnesses, such as stroke. The Medical Short Stay Unit is a 30 bed ward that cares for patients with a range of medical conditions, for up to three days. The ward also provides a short stay service for gynaecological conditions. The Reablement Centre is a 25-bedded non-acute unit. It provides care for patients with confirmation of their medical fitness for discharge. Patients admitted to the ward do not necessarily require rehabilitation and are a mix of patients requiring long term residential nursing care provision in the community, as well as those returning to independent living arrangements.

Monitoring had not indicated any increased risk in respect of pressure ulcer, urinary tract infections or falls with harm. The Trust has a low incidence of hospital acquired pressure ulcers and falls with harm. We had been notified by stakeholders prior to this inspection that there were concerns around infection control practices, and cleanliness in the medical areas.

We visited all of the medical areas as part of this inspection over two days. We returned to visit Apple Tree Ward on

both unannounced visits. We examined 15 sets of patient records; spoke with 23 patients, 10 relatives or carers, and 28 members of staff, including doctors, nurses and support staff.

# Medical care (including older people's care)

## Summary of findings

Medical services were inadequate because we found poor emotional and physical care which was not safe or caring. This was not reported by leaders of the service to the trust management therefore we judged the leadership to be inadequate. Services were not caring because people were not treated with dignity or respect. We were also concerned that people were not being treated in an emotionally supportive manner. Hand hygiene and infection control techniques were poor. Staffing numbers were not always reflective of patient dependency. Examples of treatment without consent were identified on one patient who lacked mental capacity but we found an under recognition of patients who may lack capacity throughout the medical wards. Services were not effective because pressure ulcer prevention and treatment was not always provided in line with NICE guidelines. There were no seven day services provided by the hospital. The service was not responsive; we found that medical patients were not always classed as outliers despite requiring specialised care. This meant that the frequency of review by their own consultant might be reduced. The Medical Short Stay Unit and the Reablement Centre were not utilised for their intended purpose.

The service was not well-led. We found that the culture of identifying, reporting and escalating concerns was not open. We found that teams were not engaged or felt enabled to raise concerns. We wrote to the trust to express our concerns and with the support of the Trust Development Authority action underway to address these.

## Are medical care services safe?

Inadequate



Patient's using the medical services were at risk from avoidable harm or abuse in Apple Tree ward. Staff throughout the service were not always adhering to the National Institute for Health and Care Excellence (NICE) Guideline CG:179 'Pressure ulcers: prevention and management of pressure ulcers', because we found little evidence that preventative measures were consistently being implemented. Care plans for monitoring of cannula sites and catheters were not always being completed. Infection control protocols were not being adhered to. We observed poor hand-washing technique between patients, and poor practice of hand hygiene by medical and nursing staff between patients.

Where patients had the mental capacity to consent to treatment, consent was taken. Where patients did not have the capacity to consent, best interest procedures in accordance with the Mental Capacity Act (MCA) and the Deprivation of Liberty Safeguards (DoLS) were not always undertaken prior to treatment being given.

Whilst the staffing number had been met, the quality and competence of these staff members varied; we noted that many of the concerns that we raised to the senior management team related to the bank and agency staff members on duty. Nurse staff levels are calculated based on patient to staff ratio. This model of staffing was not reflective of patient needs, and wards were not able to complete basic nursing tasks due to patient dependency outweighing the staffing numbers.

### Incidents

- Staff were able to provide us with examples of when they had reported incidents, and understood what constituted an incident.
- We spoke with a range of staff across the service, and found that staff were aware of how to report incidents. However nurse on one of the wards told us "we are always told to do incident forms, but who has the time and nothing changes, therefore we don't do them". A junior doctor (CT1) on another ward told us that they had had to report an incident the day before our inspection. This doctor told us that they had to get a

# Medical care (including older people's care)

nurse to report the incident because they didn't know how to do it. The doctor did not know the process for reporting incidents, or how the outcomes of incidents reported were fed back.

- In the 12 months preceding the inspection there had been two unexpected deaths and 14 serious incidents reported from the medical care services, including older people's care. Of the serious incidents, five involved pressure ulcers that had been acquired whilst under the care of the trust, four involved patient falls, and one was due to serious infection.
- Lessons were learnt from incidents, we observed information on notice boards and on the monitor screens displayed in the wards detailing what incidents or concerns had been reported and what action the trust had taken to make improvement.
- Mortality and morbidity was monitored by the clinical leads for the service. The Staff discussed mortality at ward meetings with the meetings being led by the lead consultant. Mortality levels were within the expected range for the size of the hospital.

## Safety thermometer

- Pressure ulcers prevalence in medical areas has been consistently high in the period between May 2013 and May 2014, with 85 reported pressure ulcers at grade 2, 3 or 4, however the trust states that 53 patients had been admitted to the wards with pressure sores from the community. We reviewed three serious incident investigations in relation to pressure ulcers, and found that they were completed through with lessons learnt identified.
- The medical care service has reported 44 catheter-associated urinary tract infections (UTI's) between May 2013 and May 2014. This is higher than the England average.
- We examined the records of six patients who had catheters in situ on Apple and Cherry Tree Wards. We found the recording of catheter care to be poor. Staff informed us that they were required to check on patients' catheters during their 'care around the clock' on each shift; however, they could not demonstrate or assure us that they undertook those checks. Two patients with catheters we spoke to on Cherry Tree Ward raised concerns to us that their catheters were causing

them discomfort, and staff had not returned to check on them. We raised this with the senior sister on Cherry Tree Ward, who assured us that they would address the patient catheter concerns.

- The service had a lower than England average number of patient falls resulting in harm to the patient. We observed that where patients were identified as high risk of falls, additional staff were booked to observe the patients, to minimise the risk of falls.
- We examined the cannula site recording and cannula sites of patients who had cannulas in situ. This is a measure on monitoring site infection risks. On Apple Tree Ward we observed that three people with cannulas had their sites bandaged, and therefore the cannula site was not visible. Two patients we spoke with informed us that their cannula was causing them discomfort. All three patients did not have a completed cannula care management plan in place. It is best practice to have these plans in accordance with the 'Department of Health (2007) Saving Lives: reducing infection, delivering clean and safe care. High Impact Intervention no 2, Peripheral intravenous cannula care bundle'.

## Pressure ulcer care

- During examination of 15 sets of records across all medical areas, we found that only four pressure ulcer assessments had been completed correctly. We also found that in five cases where pressure-relieving equipment was required, this had not been provided to the patients. Therefore, we were not assured that lessons learnt from pressure ulcer investigations were embedded, or that practices were improving.
- On Apple Tree Ward we observed one patient who was at risk of their skin breaking down. Their pressure ulcer assessment had been incorrectly calculated because a key medication had not been considered. We also found that they were not on pressure-relieving equipment, including an air mattress, as required by the outcome of their assessment.
- A second patient on Apple Tree Ward had skin that had broken on their legs, for which they were receiving regular treatment in the community. This person's assessment had also been incorrectly calculated and appropriate equipment had not been provided. When escalated to the matron, the person was re-assessed. However, during the unannounced inspection, we returned and found that the patient had sores which were grade 2 on their leg, which had not been assessed

# Medical care (including older people's care)

or treated. A swab for infection had been undertaken on 16 September, but the result had not been received or chased by the team six days later. This meant that there was a potential delay in treating any infection that may have been present.

- We found that some staff were not classifying the grade, size or type of pressure ulcer, as defined by the 'European Pressure Ulcer Advisory Panel' (EPUAP). In three sets of notes that we reviewed, we found that staff had not classified the grade, size or type of pressure ulcer. There were no defining factors on the wound type, size, depth, colour, temperature, or if the area was blanchable or non-blanchable.
- We examined the training matrix for the trust, and found that staff were provided with training on tissue viability. However, evidence found throughout the inspection challenges how robust the training methods provided to staff are, as they have been unable to demonstrate competency around tissue viability in all medical ward areas.
- Patients who were identified as being at risk of pressure ulcer development, and required support with repositioning, should have been supported to do this during the 'care around the clock' rounds. We found inconsistencies in the recording of the turns and repositioning of patients. We spoke with two members of staff about this on Cherry Tree Ward, who informed us that they were unsure whether the previous shift had repositioned patients.

## Cleanliness, infection control and hygiene

- Visual observations of the ward areas showed that they were clean, and cleaning was being regularly undertaken.
- We examined clinical equipment, including four commodes, two mattresses and resuscitation trolleys across the wards, and found them to be cleaned to a good standard.
- The medical area had had a recent increase in the number of reported *C. difficile* cases. We were aware of concerns from stakeholders prior to our inspection regarding the infection control practices within the medical care service. We observed care between staff and patients, and found that care was not being provided in accordance with the trust's own infection control policy.
- There had been no MRSA infections reported in the previous 12 month period.

- On Cherry Tree Ward we observed staff on three occasions come away from a patient, write in the patient notes, then remove their apron, and then wash their hands. This meant that the notes had been cross-contaminated.
- On Cherry Tree Ward we observed a consultant doctor exit a side room, where a patient was being treated for *C. difficile*, write in their notes on the notes trolley, then remove their apron and use alcohol gel prior to going to another patient. The consultant did not wash their hands with soap and water, which is the most effective method of controlling the spread of *C. difficile* between patients.
- On Apple Tree Ward and on Walnut Ward we observed staff walking around the bays to care for patients, then exiting the bays whilst still wearing gloves and aprons when this was not required. On Walnut Ward we observed nurses wash their hands before removing their aprons; in one instance we observed a bank nurse wash their hands in the patient toilet area, then remove their apron and leave the bay. We raised our concerns to the senior sisters in charge of each ward.
- On Apple Tree Ward we intervened to prevent a final year student nurse from preparing an injection after undertaking a patient intervention, without washing their hands in between.
- We saw that patients were not given the opportunity to clean their hands prior to eating their food.
- We observed that a majority of staff adhered to the 'bare below the elbows' protocol defined in the trust's policies. However, we observed two staff members wearing watches and three female staff members with jewellery on their hands that contained jewels. These members of staff were providing care to patients when the jewellery was identified.

## Environment and equipment

- Equipment was cleaned regularly, on Walnut, Apple Tree, Medical Short Stay and the reablement wards we visited.
- Resuscitation trolleys and equipment were checked, and records were kept.
- All sharps bins were dated, signed, and were not overfull.
- We observed that some patients had bed rails in situ across all wards visited. Some bed rails were older style and clipped on to the side of the bed. These bed rails had larger gaps between the rails and risked



# Medical care (including older people's care)

entrapment. We examined eight bed rail risk assessments for patients who had the older style bed rails in place. We found that the assessment did not determine what the appropriate bed rail type for the patient was. On Apple Tree Ward we observed one patient with their arm and leg through the bed rails. Therefore, the use of bed rails was not always safe because the assessment for use did not cover all associated risks of bed rail use

## Medicines

- We found that the storage and monitoring of medicines was appropriate. Fridge and room temperatures were being regularly recorded. All items stored matched in tally to those recorded as given from the records. The controlled drugs were checked and all accounted for.
- On Cherry Tree Ward we identified one medication error, where a patient had been prescribed both regular and ad hoc paracetamol. We identified that this person had been administered over the recommended dosage of 4g per day. We raised this with the person in charge, and with the lead consultant. We saw positive action taken by both to report the incident, to inform the patient and their family, and to undertake tests to ensure that no harm came to the patient.
- On Apple Tree Ward we identified three patients who had not received their medicines on time. One patient was to receive antibiotics for an infection. The antibiotics had been missed from the medicine rounds on more than two occasions. We examined the medication chart, which confirmed what we had been told by the relatives of this patient.
- On Apple Tree Ward area we found that the medicines fridge was being monitored on a daily basis, but had been out of range since July, and no action had been taken by staff to report it or resolve it. Medicines within the fridge on this ward were not being managed appropriately, and patients were at risk of receiving medicines that could have been compromised. We escalated this concern immediately to the ward matron.
- On Apple Tree Ward area we found that the medicine trolleys used to transport medicines to patients were overstocked, and were kept in an unhygienic manner. Dust and debris was visible, both on the inside and on the outside of the medicines trolley. One of the trolleys had three bags of a patient's own medication being stored in it.

- All the medicines we looked at were within their expiry date. We saw that staff were dating and signing bottles of liquid preparations, such as antibiotic syrup and eye drops, at the time of opening. However, on all of the medical wards we inspected we found that staff were not dating and signing the bottles of oramorph on opening. On Walnut Ward we found that insulin had not been dated and signed on opening. These preparations should be used within a specified number of days once opened. These medicines were not managed appropriately, and patients were at risk of receiving medicines that had expired.

## Records

- All records were in paper format. Nursing notes were generally kept on the wall outside the patient bay, observation charts were retained at the end of patients' beds, and medical notes were stored in trolleys on the ward areas.
- Healthcare professionals completed the records, and good examples of multidisciplinary entries were seen in the records to guide other professionals.
- The quality of conversations being recorded with patients, together with visiting professionals advice, including dietician, and speech and language therapy services, was good.
- The quality and consistency of the medical staff notes was variable, with some doctors writing being illegible to read.
- Admission checklists and patient safety checks were not consistently completed, and risks around falls, venous thromboembolisms, and moving and handling, were varied, with some noticeable gaps in recording. This was especially evident on Apple Tree and Cherry Tree wards

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

- Patients were consented appropriately and correctly, where people were able to give their consent to care and treatment.
- We examined the training matrix provided by the trust, which showed that the training requirement in consent, the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) was not routinely monitored as a mandatory subject. We spoke with staff who confirmed that they had completed training in MCA and DoLS online through an e-learning module.
- We identified one patient who had been referred for review by the adult safeguarding lead, due to

# Medical care (including older people's care)

challenging behaviour and the need for additional support. On the first day of our inspection we found that they were in bed and asleep or quiet for a majority of our visit, which was a contradiction to the entries in the notes and information from the family regarding this person's behaviour. We identified, through examining their records, that they had been given a sedative medicine. There was no best interest assessment or mental capacity assessment referred to in the records, prior or post administration of this medicine, despite the patient lacking the mental capacity to consent to receive this medicine. A referral to the DoLS team does not sufficiently cover the requirements of the Mental Capacity Act or Deprivation of Liberty Safeguards. The trust state that the capacity assessment was undertaken and the relatives spoken with on the phone but that the doctor did not document this in the notes. Following our inspection the trust commissioned an independent audit of this case that concluded that the medication given was appropriate but documentation of assessments did not refer to either best interest or mental capacity assessment.

- We identified, through examination of 15 sets of medical notes on Cherry Tree Ward, Apple Tree Ward and in the Reablement Centre, that there was an under-recognition of delirium. Therefore, no clear interventions were identified, and this placed patients at risk of inappropriate treatment when they do not have capacity. We established, through speaking with staff and examining the training records, that staff had not received any awareness training on delirium.

## Safeguarding

- There was a lead nurse for safeguarding. However, when we spoke with staff, only some senior staff knew of the safeguarding lead. Most staff we spoke with were not aware of their presence.
- On Apple Tree Ward, during our observations we observed an agency nurse enter a patient's bay whilst they were asleep. The curtain was drawn and no introductions or consent were heard to be given or received. The staff member then proceeded to wash the patient with little interaction. We heard the patient say 'ouch you are hurting me'. We reported our concerns to the matron in charge to ensure that appropriate action was taken immediately.
- During the inspection, two members of the inspection team observed two different members of staff move

people in an unsafe manner. The manoeuvre used is known as a drag lift. A drag lift is when the carer/person pulls a patient up by pulling/dragging them under their arms. In once instance this manoeuvre whilst not lifting the patient was used to reposition the patient. This can cause shoulder and spinal pain in the patient and carer and is classed as abuse by Age UK.

- We were not satisfied that safeguarding concerns were always identified, or safeguarding alerts made when they should have been. Throughout our inspection we saw staff speaking to patients in an abrupt manner, and we saw unsafe moving and handling practices were being undertaken in Apple Tree ward that we inspected.
- Since our visit the trust has requested an independent review of safeguarding from another trust. This visit found that whilst the decisions made around safeguarding and mental capacity had been correct the documentation of these decisions was poor. The trust have altered the job role of the safeguarding lead and introduced new systems to highlight to management on a daily basis those patients who may be vulnerable

## Mandatory training

- Mandatory training for the service is classed as fire safety, infection control, moving and handling, information governance, Safeguarding Adult's level 1, Safeguarding Children level 1, and equality and diversity. In acute medicine around 79% of staff had received training. Within care of the elderly services 68% of staff had received mandatory training.
- Locally, staff informed us that they had online access to other training courses, including health and safety and training on the Mental Capacity Act. Records of attendance for this training was not routinely monitored, and we found the uptake of this training locally was sporadic.

## Management of deteriorating patients

- The medical wards used a recognised national early warning tool called NEWS. There were clear directions for escalation printed on the reverse of the observation charts, and staff spoken to were aware of the appropriate action to be taken if patients scored higher than expected, and may need intervention.
- We looked at completed charts and saw that staff had escalated patients' conditions correctly, and in most

# Medical care (including older people's care)

cases, repeat observations were taken within the necessary timeframes. There were some gaps in the recording of routine observations on Cherry Tree Ward and Apple Tree Ward.

- There was a critical care outreach team, who were present on site seven days a week. The team could be contacted by any member of staff, and their contact details were accessible on all wards, as well as on the observation recording document. The ward staff reported that the outreach team were responsive to the patient's needs.
- Staff on several wards told us that when they escalated concerns regarding a deteriorating patient to the medical team, they were quick to respond at any time of the day, and would respond swiftly.
- On Walnut Ward we observed staff intervene at the early signs of a patient's health deteriorating due to a life threatening complication (pneumothorax). The action was swift and resulted in a positive outcome for the patient

## Nursing staffing

- The wards had recently completed the Shelford safer staffing tool. Currently, in each area staffing levels were calculated based on patient to staff ratio, which equated to approximately one nurse to eight patients during the day. This model of staffing was not reflective of patient needs, and wards, including Cherry Tree and Apple Tree, were not able to complete basic nursing tasks, due to patient dependency outweighing the staffing numbers. Therefore, there was an insufficient number of staff on duty to support dependency.
- Nursing numbers had been assessed for each ward. However, this was inflexible and staffing levels were not co-ordinated according to the patient's dependency or needs. Staffing cover was provided through the use of temporary agency staff, while new permanent staff were recruited into posts.
- During July, of the staff on duty in all medical wards, between 12% and 29% were agency or bank staff. In August, the percentage of bank and agency used was between 9% and 26%. There was a higher use of agency staff on Apple Tree Ward and Cherry Tree Ward.
- All nursing staff told us that the trust had difficulty recruiting and retaining staff, although we met many

staff who had worked at the trust for many years. One told us "we can't keep staff". Doctors we spoke with were aware of some nursing shortages, and reported that they were kept informed of nurse vacancies.

- Ideal and actual staffing numbers were displayed on every ward we visited. During our inspection, boards indicated that, in the main, the ideal numbers of staff were maintained on those days. On Apple Tree Ward, there was a shortfall of a nurse and a support staff member for an afternoon shift. The matron told us that she was trying to fill the shifts with temporary staff.
- Agency staff had an induction when they commenced their shift, which covered the ward layout, emergency procedures, and information to assist them with patients' care.
- Four patients we spoke with raised concerns about the non-English speaking nursing staff. Patients all reported to us that the staff were "lovely", but shared that they were unable to communicate with the staff. The trust confirmed that action was underway to provide support to those staff to improve their English.

## Medical staffing

- Currently, there were ward rounds seven days a week on the Medical Short Stay Unit. There was an acute medical consultant on the unit from 8am to 8pm. After 8pm and at the weekends there was on-call consultant cover only.
- We spoke with a range of junior medical staff, who reported that working hours and shift time were better than any other training placement that they had been on. No concerns were reported by staff on medical staffing numbers.
- Daily ward rounds were consultant-led throughout medicine, except for weekends, which had limited consultant rounds. We found that there was a handover from consultant to consultant, and from junior doctor to junior doctor on each shift.
- We observed MDT ward rounds, which were thorough, well organised, and well attended.

## Major incident awareness and training

- The trust had established an emergency planning steering group to provide assurance to the board that plans established were updated regularly. These plans had been developed in conjunction with the local health economy.

# Medical care (including older people's care)

- Staff within the local departments were unclear of the specific requirements of their role during a major incident. Staff were able to show us where the major incident plan was, and who they would contact if they needed advice.

## Are medical care services effective?

Requires improvement



Medical care services were not effective as people were at risk of not receiving effective care or treatment. Care plans did not always reflect current evidence based guidance in cannula care. Patients were offered a variety and choice of food; however, fluid balance monitoring was not always effective. There were gaps in the management arrangements and support for staff in regards to supervision. We found that agency nurses and student nurses were not always supervised sufficiently which led to poor care being delivered. Outcomes for diabetic patients was below the national standard and patients we spoke to on site and at our listening events supported that care for patients with diabetes was not as good as it could be due to lack of understanding of the condition amongst nursing staff.

There was no on site seven day cover for medical staff; cover was provided on-call and not on site. With the exception of support for respiratory services, there were no occupational therapy or physiotherapy support services at weekends. There were also reported delays around medicines, due to the pharmacy closing at 4.30pm, and not working at weekends. However there were good arrangements for multidisciplinary team working. The service had undertaken local and national audits. Length of stay is in line with the England average for emergency medical admissions.

The change in the facilities on Apple Tree Ward and the Reablement Centre did not effectively support discharge from hospital. The service had increased bed capacity by five beds on each ward, and taken away rehabilitation facilities. This had had a negative impact on the length of stay for patients.

## Evidence-based care and treatment

- The medical care service used a combination of National Institute for Health and Care Excellence (NICE) and Royal College of Nursing guidelines to determine the treatment they provided. Local policies were written in line with this and other national guidelines, and were updated every two years, or if national guidance changed.
- There were specific care pathways for certain conditions, in order to standardise the care given. Examples included falls, sepsis and infections such as MRSA.
- There were care bundles in place to ensure that treatment for the most common conditions, such as chest pain, reflected best practice and national guidelines

## Pain relief

- We observed staff provide medicines during the visits; when medicines were administered, pain relief was offered to the patient or given as prescribed. We examined 15 medicine charts which supported our observations.
- Three patients on Cherry Tree Ward and four patients on Apple Tree Ward told us that they regularly had to wait for their medicines. Two patients on Cherry Tree Ward told us that staff were "very busy" and did not give them their pain relief in a timely way. On Apple Tree Ward four patients all reported to us that there were delays in receiving pain relief, despite requests to staff. They informed us that they believed this was because there were not enough staff on duty.

## Nutrition and hydration

- We observed on all wards that regular fluids were provided. However, we observed that the recording of fluid intake was not consistent. For example, on Apple Tree Ward we noted a patient was on a fluid balance restriction of 1500mls per day. This patient informed us that they had to remind staff of their fluid balance because staff were not keeping track of what the patient had already had.
- We observed a patient on Cherry Tree Ward who had three drinks provided to them during our observation period; all three were removed by staff during the course of our observation, and no details of the amount of fluid taken were recorded in the patient's notes. This patient was on fluid restriction, and therefore fluid intake recording was required.

# Medical care (including older people's care)

- On day one of our inspection we observed on Cherry Tree Ward that fluids were out of the reach of eight patients. We spoke with staff, who ensured that people had drinks nearby. We noted that four patients had drinks out of reach during the second day of the inspection.
- Patients were positive about the choice and quality of food offered to them. Patients reported that the food they were given was of a good quality. During the inspection we spoke with 23 patients about the food. All were mostly positive about the food; comments received included “food is nice”, “there is a good selection”, “they make me salads, I do like their salads”.
- Whilst all patients were complimentary about the quality of the food and the options, we received feedback from three people that there was no option on portion size, and meal portions were often larger than they could manage.

## Patient outcomes

- Standardised relative risk of readmission for the trust and Hinchingsbrooke Hospital was lower than expected for all specialties, other than clinical haematology which had a value of 107. The ratio of observed to expected emergency readmissions is multiplied by 100. Value below 100 is interpreted as a positive finding, as this means there were less observed readmissions than expected.
- The Myocardial Ischaemia National Audit Project (MINAP) is a national clinical audit of the management of heart attack. The MINAP audit showed that the hospital provided data as part of this audit, but no results specific to the hospital were available at the time of our inspection because they did not provide a dedicated cardiac service.
- National Diabetes Inpatient Audit (NaDIA) participation showed that the trust performed worse than expected on five out of 22 questions, with the trust performing worse than expected in questions covering foot care, meal timing and staff knowledge. During our inspection we spoke with patients who corroborated this audit result.
- Length of stay at Hinchingsbrooke Hospital is in line with the England average for emergency medical admissions.
- Walnut Ward is the medical ward which provides specific respiratory care, including non-invasive ventilator care (NIV). During the inspection we were informed that patients on NIV could be placed in other

- wards around the hospital, and there was an inpatient being NIV treated outside of Walnut Ward at this time. The staff on the other medical ward were not as competent as those trained on Walnut Ward. Other ward staff are supported with NIV management by Critical Care Outreach Practitioners of staff from Walnut.
- The medical care wards currently have a high occupancy rate of patients. To accommodate this increase, the Reablement Centre and Apple Tree Ward had converted their day rooms into additional patient bays. This had directly impacted the quality of care being provided to patients who required reablement to facilitate their discharge.
- The trust provided us with a list of all ongoing and completed audits during their past year. Most were in line with expectations, except venous thromboembolism (VTE), which locally showed poor results on Cherry Tree and Apple Tree Wards.
- The majority of national and local audits were ongoing. Where completed audits identified areas for improvement in clinical effectiveness and outcomes for patients, there were action plans in place to address issues raised.
- The in patient survey showed that the trust was performing in line with national expectations in all areas of the questionnaire.

## Competent staff

- Nursing staff and medical staff we spoke with had received an appraisal within the last year. We examined the appraisal data, which showed that 87% of acute medicine staff, and 79% of care of the elderly staff had received an appraisal.
- Doctors reported appraisal and revalidation taking place according to General Medical Council guidelines.
- Bank and agency staff working at the trust are trained by their respective agencies. The management team on the wards were clear on the procedures for feeding back about competency of bank and agency staff. We were provided with examples of when agency staff had not performed in a competent way, and what action the hospital had taken to ensure that improvements were made. We observed, in a case where a nurse had inappropriately moved a patient by performing a drag lift on them, that this person had been reported to their agency, and the ward had requested that this person was not sent back to the trust.

# Medical care (including older people's care)

- We were made aware during the inspection that the nursing establishment had raised concerns about the quality of care provided by some agency workers. On discussion with senior nursing staff this information had been escalated to the senior management team, who were reviewing the concerns raised about agency workers.

## Facilities

- On Apple Tree Ward and in the Reablement Centre, the day room facilities had been changed into additional ward bays, to allow for times of high capacity. The day rooms on both wards were for rehabilitation, and were where allied health professionals, including physiotherapy and occupational therapy teams, provided rehabilitation support, to enable a quicker discharge into the community.
- Both wards had increased their bed capacity by an additional five beds, and had not had rehabilitation facilities available for over two months. We spoke with the nursing and medical staff about the change of these facilities to beds. We were informed by staff that they felt the change in facilities had directly impacted patients' length of stay, as they were receiving less enablement therapies. Therefore, the change in facilities was not effectively supporting the discharge of patients from hospital.
- The trust participated in patient-led assessments of the care environment (PLACE). The hospital scored slightly below average for food, privacy, dignity and well-being.

## Multidisciplinary working

- There was clear evidence of multidisciplinary team (MDT) working on the ward. There was regular input from physiotherapists, occupational therapists and other allied health professionals, when required. The level of information from MDT teams in patient records was comprehensively detailed, with clear plans and instructions.
- There was evidence that the trust worked with external agencies, such as the local authority, when planning discharges for patients. However, senior staff reported that discharges were often delayed when dealing with some social services departments. We were informed of an example of a patient who had been an inpatient for over 100 days, despite being medically fit for discharge. The trust reported that this was a situation beyond the control of the trust. This patient's discharge plans were escalated by the MDT to the executive team for action at

a higher level, we observed entries from the discharge coordinator, nursing and medical staff regarding these plans in the person's medical records, though the person remained an inpatient at the time of our inspection.

- We found that the services were accessing the local authority Deprivation of Liberty Safeguarding team to approve and review DoLS applications for patients who lacked capacity to make decisions regarding their care.

## Seven-day services

- There was a medical presence on the wards seven days a week. Consultants' ward rounds took place daily in some areas, such as in the Medical Short Stay Unit, and in other wards at least once on a weekend. Medical patients on other wards would be seen by on-call physicians if they became unwell, or if there were concerns about deterioration. We noted that the trust was reviewing a business case to support the need for acute physician cover on site, seven days per week.
- Patients were seen by allied health professionals during week days. Support services, including physiotherapy and occupational therapy services, were not available at the weekends. Nursing staff informed us that they aimed to follow care plans at weekends, to continue rehabilitation therapy with patients; however, they often did not have the time to complete this.
- Physiotherapists who gave respiratory support were available on a call out basis at the weekends, and were called in when required for Walnut Ward.
- There was a daily ward round on the medical assessment unit (MAU), including at weekends. Medical patients on other wards would not be seen routinely, and would be seen by on-call physicians if they became unwell, or if there were concerns about deterioration.
- All medical care areas reported challenges with access to the pharmacy service after 4.30pm daily, and at the weekends. All areas reported to us that the lack of pharmacy support led to delays in treatment and patient discharges.

## Are medical care services caring?

Inadequate



Patients were not treated on Apple Tree ward with compassion therefore we have judged this aspect of the service inadequate. On Apple Tree Ward we observed poor

# Medical care (including older people's care)

patient experiences, and from our observations of care on the ward we established that people were not treated with dignity or respect. We also found that on the Reablement Centre a patient who's needs had not been met and left them feeling undignified. We were concerned that people were not being treated in an emotionally supportive manner. We heard patients talk negatively about the interactions that they had with staff on Apple Tree ward. Some patients were afraid of certain nursing staff on this ward. We heard some staff being rude to patients or being dismissive of them. Some patients and relatives on Apple Tree and Cherry Tree wards felt that they were not involved in their care. We spoke with 23 patients during the inspection, and the majority, 17, were complimentary about the care they received from their local hospital but we spoke with, saw and heard extreme examples of where care was inadequate.

## Compassionate care

- In the June 2014 NHS Friends and Family Test results, three wards scored above the England average of 72%, for people who would recommend the hospital wards.
- Between September 2013 and January 2014, a questionnaire was sent to 850 recent inpatients at Hinchingsbrooke Hospital, with responses received from 413 patients. The ward areas scored on average with all other hospitals in England for care and treatment with dignity and respect.
- We spoke with 23 patients during the inspection, and most were positive about the care they received from their local hospital.
- We observed good examples of one-to-one care of a patient living with dementia on Cherry Tree Ward. The health care assistants approach to the patient needs was calm and respectful.
- We observed that the way medicines were administered by the staff nurse to patients in the Reablement Centre was done in a caring and respectful manner. The staff member took the time to explain each medicine and why it was needed to all patients we observed who asked

## Patient understanding and involvement

- The majority of patients and relatives we spoke to stated that they felt involved in their care. They had been given the opportunity to speak with the consultant or the doctors looking after them. However we found that those without mental capacity did not always have

their best interests discussed with family. We spoke with a family of one patient who lack capacity who informed us that they were not involved in best interest decisions being made for their relative.

- Some patients on Apple Tree Ward and Cherry Tree Ward told us that they had not been involved in their care. One said "they tell me what I need and then change their mind but don't tell me". Another patient told us "I don't know what is going on", whilst another said "I am told to take my tablets, but they don't tell me what they are for".
- Some patients and relatives said that they were unaware of the arrangements for their discharge home. Some people made comments such as "no one tells us what is happening", and "we are told different things by different staff", "it seems like no one knows what is going on".

## Emotional support

- Patients' emotional well-being, including anxiety and depression, were assessed on admission to each ward area, and appropriate referrals for specialist support were made, where required.
- Clinical nurse specialists were available to offer advice and support to patients and relatives about diagnosis and treatments.

## Dignity and respect

- On Cherry Tree Ward we observed that patients' cleanliness and hygiene were not always maintained. This related to the cleanliness of people's hands and fingernails. We observed five patients who had long fingernails, with dirt underneath them; their hands were also unclean. On examination of three of the patient records, there was no evidence to support the patient requirement of cleanliness and nail care.
- Our 'expert by experience' observed a poor interaction on Apple Tree Ward between a staff member and a patient. We observed the staff member push a tray table towards a patient after they pushed it away; this was repeated several times; when the staff member pushed the tray back, soup spilt down the front of the patient. The staff member was then rude towards the patient for the soup being spilt. This patient was treated in an undignified and emotionally unkind manner.
- We observed a lunch time meal on Apple Tree Ward. We saw that patients received help to eat their food where it was required, but this was not always done in a way that respected the dignity of the patient. We observed a

# Medical care (including older people's care)

health care assistant helping one patient to eat some soup. The health care assistant did not engage with the patient and stood over them. We observed that the health care assistant was abrupt with the patient, and did not respond to the patient's attempts to communicate that they did not want any more of their meal. We observed this health care assistant assisting two people to eat their meals at the same time.

- We completed a SOFI observation on Apple Tree Ward at the time that the night shift changed over to the day shift. Short Observational Framework for Inspection (SOFI) is a specific way of observing care to help us understand the experience of people who use the service, including those who were unable to talk with us.
- We heard the audible interactions of a patient who was washed behind a curtain in the morning. The agency staff member entered the bay and did not ask for consent to wash the patient, and did not introduce themselves to the patient. The patient was heard to ask "who are you?" We also heard the patient ask if they were clean and they said "I don't feel clean"; this was not answered by the staff member who, after a short silence, instructed the patient to "roll on your side".
- During breakfast we observed three members of staff standing over the patients whilst supporting them with their food. The food was provided to the patient at a fast pace, and gave them little chance for rest in between. Two of the three staff members did not offer the patients a drink during the breakfast. This is an undignified way to provide support at meal times to a patient.
- We spoke with each individual staff member, who proceeded to sit down and provide support to eat; however there continued to be little or no interaction with patients.
- We spoke with five people on Apple Tree Ward about their food. One patient told us that the portions were too large and they struggled to finish them. They also told us that they were "told off" when they did not eat all of their food. When this was explored further with the patient, they informed us that "staff tell me off if I don't eat everything". They were concerned about this, and said that they felt they must eat all their food.
- During our observations in the morning we saw a patient being supported by a staff member who was standing up and leaning over them. We heard the staff member say to the patient "don't misbehave you know

what happens when you misbehave". We later asked the patient what they thought the staff member meant by this; the patient became withdrawn and was unable to provide us with an answer.

- A patient on Apple Tree Ward, who required support during the night to go to the toilet told us that staff were "often too busy". They said "they tell me to go in my bed and they will change me when they have time". This patient was able to give an example of waiting twenty minutes for a nurse, by which time they had already opened their bowels and wet the bed.; the nurse advised them that they had to wait and it then took another twenty minutes before they were cleaned. The patient told us that they felt their dignity had been taken away.
- A patient who was immobile with back pain said that they had waited over an hour in the Reablement Centre for their call bell to be answered when they required the toilet, and it had been too late when the nurses attended. This patient told us "I try to let them know as early as I can but they don't come, I don't feel good about it".
- Overall, the patients we spoke with reported that they felt the care was good on Apple Tree Ward. Our own observations led us to conclude that patients on this ward were not consistently treated with dignity or respect or in an emotionally supportive and personalised manner. We were so concerned that we made a referral to the local authority's safeguarding team.
- We visited on the following Sunday lunchtime and found that the number of beds on the ward had been reduced. The staff available provided assistance with eating the Sunday dinner with dignity and respect and engaged in meaningful conversation with patients. We saw that call bells were responded to promptly and patients were reassured appropriately. One patient told us that the care they received had greatly improved since our last visit.

## Are medical care services responsive?

Requires improvement



The medical care services were not sufficiently responsive to the needs of all patients. The Medical Short Stay Unit and Reablement Centre were not utilised for their intended



# Medical care (including older people's care)

purpose. This was because they were often utilised as general medical wards so patients using these wards did not always get the therapy required to improve. Medical patients were not always classed as outliers in medical areas despite requiring specialised care. This meant that patients did not always get to see their consultant team during their admission and that potential treatment for their individual condition may be affected. Patients reported high numbers of overnight moves between wards. This was disruptive to all patients and not in line with the trusts policy. Some patients did not find it easy to raise their concerns, they were unaware of the complaints procedure. Staff stated that they did not get feedback from complaints that had been made.

There was access to specific support for people who had more complex needs, such as dementia and learning disabilities. Patients had access to the support services they needed, such as to therapists when they needed them.

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

- All medical wards were medical wards with small elements of specialist areas. Walnut Ward provided some respiratory and cardiac care, Cherry Tree Ward provided inpatient care for people with dementia, Apple Tree Ward provided rehabilitation stroke care. However, due to capacity, these services were not always used to their potential, with people being moved to other wards not in this speciality.
- A medical termination of pregnancy service was provided on the Medical Short Stay Unit. The service was provided to women at less than 12 weeks of pregnancy, and covered chemically-induced terminations only. This service was provided in consultation and joint working with the gynaecology service. However, we did not see any formalised care plan or care pathway for the undertaking of this service on the Medical Short Stay Unit despite the trust stating that there was one. The pre-planning and arrangements were undertaken through gynaecology.

## Access and flow

- Bed occupancy was above the national average of 89% at the time of our inspection.
- The average length of stay for medical care was above the national average. This was attributed to issues relating to the accessing of care packages and care

facilities in the community. Between April 2013-April 2014 the number of patients waiting to receive a care package in their home was 19%, against the England average of 10%; the number of patients waiting for a completion of assessment for further care was 44%, against an England average of 19%. These care issues resulted in delayed discharge as planning for discharged only occurred once the patients was medically fit for discharge.

- The medical care service was working with the commissioners and local authority across two counties, to find placements in the community for patients awaiting discharge. There was confusion amongst families on the discharge arrangements into the community for their relatives. Five relatives we spoke with felt that communication from all stakeholders, who were involved in discharge, was poor.
- Referral to treatment times (RTT) for all medical specialties, including gastroenterology, cardiology and geriatric medicine, were all meeting standards, with most services achieving 100% compliance with RTT, with the exception of gastroenterology and gynaecology, who achieved 98.3% respectively.
- If a patient in medical services was placed on a surgical ward, they would be classed as an outlier. However, when a medical patient required a specific service, such as respiratory care, but was placed on the stroke ward, then they were not classed as an outlier. This meant that those patients, who should see a specific consultant for their condition, did not see them outside of the specialist ward area. Consequently, the trust reported that patients did not always get to see their consultant team during their admission.
- On the Medical Short Stay Unit patients reported that they could be moved at any time of the day, including at night time. The trust policy recommends that patients are not moved after 9pm at night; however, patients had experienced bed moves out of hours due to capacity issues. We spoke with senior nursing and medical staff on the ward who informed us that this did take place however they aimed to avoid this where possible. The trust do not currently measure the number of transfers that take place after their deadline time of 9pm.
- The Medical Short Stay Unit is a medical area, ideally used to provide care to patients for a period of up to 72 hours. We found that on the ward, four patients had been on the ward for over a week, and in one case, over two weeks. We were provided with examples by staff of

# Medical care (including older people's care)

recent patients who had been on the ward for more than one month. This supports the view that the patient flow within the hospital is affected because the Medical Short Stay Unit is not able to be responsive due to hospital bed capacity issues.

- The Reablement Centre is meant to be a ward that provides support to people to get back into the community. At the time of our inspection, 14 of the 24 patients on the ward were long-term nursing care patients, and were not on the ward to use the rehabilitation services. This was due to delays in discharge arrangements which may be out of the control of the hospital however the trust reported that this did prevent people who required rehabilitation from using the services provided by this specific rehabilitation ward.

## Meeting people's individual needs

- We observed call bell times on each ward throughout the visit. We noted that in the Reablement Centre, out of 25 beds observed, that nine patients did not have patient call bells within reach. We raised this with staff, who checked and ensured that call bells were placed within reach.
- The trust has recognised from patient feedback that they need to audit a baseline of call bell response times and make improvements. However, they had not planned to start this project until October 2014.
- A learning disability hospital liaison nurse specialist was employed to provide support and advice to patients, relatives and staff.
- Support was available for patients living with dementia and learning disabilities. Despite some staff telling us that there was a specialist dementia team the trust has since confirmed that they do not employ a specialist dementia team.
- Some leaflets and patient information were available in different languages on request. Translation services were also available to be accessed 24 hours per day. Staff could demonstrate to us, when asked, how these services were accessed.
- Most patients on Apple Tree Ward and Cherry Tree Ward said that they often did not know who their named nurse was, although this information was written above their bed.
- The Reablement Centre at the time of our inspection the area was single-sex in each bay, because the ward was

being used as an inpatient long-stay medical area, rather than as a rehabilitation service. This was due to capacity within the hospital, and capacity for beds within the community.

- The environment in each ward visited had been refurbished. Cherry Tree Ward had been refurbished with dementia-friendly themes, including different colours and signs to meet the needs of a person with dementia
- Pastoral care and multifaith support was available to people on the wards. There was a twenty four hour per day seven days per week chaplaincy service available to people to meet all faith needs.
- We viewed the food menus provided to patients on the ward, these contained options for vegetarians, gluten free and halal. One patient we spoke with requested specific foods that were lower in salt or sugar. These were provided with their preferred dietary option. This was supported by observing the food they were provided at lunch which was specifically created for them.

## Learning from complaints and concerns

- The complaints process was outlined in information leaflets, which were available on the ward areas. Five patients told us that they had been provided with information on how to raise concerns. However, this was not consistent practice on all ward areas.
- Senior nursing staff told us that complaints about their areas were discussed at their meetings. We saw evidence of this in the meeting minutes. Nursing staff told us that they were not always made aware of complaints, and did not receive feedback about complaints, or learning from these. They also told us that providing feedback was difficult, as it was not possible for all staff to attend meetings.
- We spoke with two families of patients who were raising official complaints during our inspection. Both complaints related to missed medicines on medication rounds. They told us that they felt they were being listened to, and that action would be taken.

# Medical care (including older people's care)

## Are medical care services well-led?

Inadequate



We could not be assured that the delivery of high quality care was assured by the leadership and governance arrangements in place in the medical care services. We found that the culture of identifying, reporting and escalating concerns was not open. We found that teams were not engaged, or felt enabled to raise concerns. We identified serious concerns around the treatment and safeguarding of patients on Apple Tree Ward; when raised to the leadership team of the ward, they did not wish to raise it to a higher level, or through their reporting of concerns strategy called 'Stop the Line', as they felt it could be managed locally.

Prior to leaving the trust on 18 September 2014 we reported our concerns to the local safeguarding authority. The following day we informed the Trust Development Agency (TDA) and held a management review. We decided to request further information as we were considering taking enforcement action under our powers under Section 31 of the Health and Social Care Act 2008 to reduce the number of beds available on Apple Tree ward. However the trust took steps to do this and to improve care as seen during our two unannounced inspections. Since our inspection the TDA have given the trust significant support to address the issues highlighted in our letter of immediate concerns to the trust. We continue to monitor actions taken by the trust.

Locally, nursing staff were positive about the leadership of nursing on Walnut Ward; however, nurses felt that nursing leadership was lacking on Cherry Tree Ward and Apple Tree Ward; the trust confirmed that the Divisional Head of Nursing was on long-term sickness leave. Medical staff felt that they were well supported by the clinical leads and consultants within the service. Junior medical staff had good access to leadership, education and development through the clinical teams.

### Vision and strategy for this service

- Senior nursing staff we spoke with said that they did not feel involved in the decision-making processes within the hospital. The structure within the directorate, and within the trust, was clinically-led by medical staff, and lacked nursing engagement.

- All staff spoken with were aware of the vision and strategy for the service, and referred to the messages sent out by the trust management team and by Circle.
- The medical service has a five year strategy plan, which focused on community engagement, and the need to provide more residential support to the elder population.

### Governance, risk management and quality measurement

- Wards used a quality dashboard and Safety Thermometer to measure their performance against key indicators. Where wards were consistently falling below the expected levels of performance, action was taken to improve performance by the nursing leader's clinical leaders and specialist nurses.
- There were regular governance meetings; however, most junior staff we spoke with were unsure of how governance worked to improve patients care. For example, there have been concerns regarding the care of patients on Juniper Ward in the surgical service. Staff we spoke with were aware that there had been concerns, but did not know what was being done to improve the service. This meant that lessons learnt were not being embedded across the hospital.
- Governance meetings covered areas for concern, complaints, nursing indicators, and plans for improvements in the safe delivery of patient care.
- We reviewed the risk register for the medical service and found that issues we had identified were not listed on the risk register.

### Leadership of service

- All nursing and medical staff felt engaged in how the service could work together through the clinical lead for the service. Medical staff of all grades were positive about the clinical leadership shown by the clinical lead for medicine.
- Senior nurses within medicine said that they felt confident in the director of nursing, who had been recently appointed within the previous three months. Nursing staff were supportive of the management demonstrated by the nursing leadership on Walnut Ward; however, other staff felt that the nursing leadership on the other medical wards was not as visible as they could be. We were concerned about the nursing leaders on Apple Tree Ward. When concerns regarding the safeguarding and treatment of adults on

# Medical care (including older people's care)

the ward were raised, the nursing leadership deal with the concerns that were raised locally, and failed to escalate the concerns appropriately to the senior management team to get additional support.

## Culture within the service

- The trust has a whistleblowing policy, as well as the 'Stop the Line' procedure, for staff to raise concerns. 'Stop the Line' is a slogan borrowed from the manufacturing industry, where every worker on the shop floor has the power to bring the production line to a halt if they sense any risk to safety. In a hospital setting, this means that all staff have the power and responsibility to 'Stop the Line' on any activity which they think could harm a patient. 'Stop the Line' is one of four initiatives to improve hospital safety, as part of Circle's 16 point plan at Hinchingsbrooke Hospital.
- We spoke with most staff about the 'Stop the Line' initiative, and all could give an example of when they would use the procedure; most scenarios involved safe staffing levels. Staff we spoke with felt that it would have to be a serious or significant event to invoke the procedure; we found that staff did not feel empowered or able to 'Stop the Line'. When asked why they would not use the procedure, no specific answers were given. We therefore felt that the culture of reporting concerns within the trust was not as open as it could be.
- We spoke with the senior nursing leads on Apple Tree Ward about our observation findings and our concerns, and whether they would consider this a case to 'Stop the Line'. We were informed that whilst it did meet the criterion, they would not 'Stop the Line' because they could resolve it locally. This is not in accordance with the trust's 'Stop the Line' procedure.
- We escalated our concerns to the executive team, including the chief executive. The chief executive declared that the CQC team had called a 'Stop the Line' into the concerns on Apple Tree Ward. A meeting was called to review the concerns, also known as a 'swarm'. 'Swarms' aim to gather all the relevant people together to discuss a matter of particular importance, This meeting was attended by the senior leads for the service

and for the trust, to discuss the concerns. The meeting addressed points including staff exclusion and the need to increase staff levels on the ward. However, the meeting did not include the importance of the need to review the institutional culture on the ward. We were therefore not fully assured how effective the meetings were.







## Public and staff engagement

- The medical care service regularly sought feedback from people who use the service. They demonstrated success in obtaining feedback, with achieving an above England average response rate to the Friends and Family Test, and the NHS inpatient survey.
- Each ward had a board displaying the latest response information, along with a 'you said, we did' message, responding to suggested areas of improvement.
- Staff were aware of the improvement plans and changes to be implemented within the trust. However, on a local level, some staff felt disengaged from the leadership when the focus was on capacity as they believed that the focus was on the targets rather than the delivery of care.

## Innovation, improvement and sustainability

- The refurbished improvements of Cherry Tree Ward, which were specific to those with dementia, were innovative to improve the care of older persons.
- There were plans to improve the cardiology care on Walnut Ward, with the service opening six beds specifically to provide monitored cardiology care. The plans included staff training and development in cardiology skills.
- Following the inspection, we returned to undertake unannounced inspections on Apple Tree Ward on two occasions. We noted that the management team had kept to their agreed bed numbers and had increased staffing numbers. We were also informed that the service did not plan to re-open beds in the near future. However, at this time we are not assured that the improvements on Apple Tree Ward can be sustained.

# Surgery

Safe	Requires improvement 
Effective	Requires improvement 
Caring	Inadequate 
Responsive	Good 
Well-led	Requires improvement 
Overall	Requires improvement 

## Information about the service

The surgery service at Hinchingsbrooke Hospital includes surgical and orthopaedic wards. Operating theatres include main theatres, gynaecology and obstetrics, and the treatment centre. The treatment centre also accommodates the pre-assessment and day surgery ward. The hospital saw 18,106 patients in this directorate in 2013-14. Surgical service provision includes general surgery, orthopaedics, trauma care, ear, nose and throat (ENT), gynaecology, ophthalmology, and urology.

We visited all surgery services as part of this inspection, and spoke with five medical staff, four ward or team managers, 36 registered nurses, other health professionals and health care assistants. We also spoke with two specialist and lead nurses within the surgical service. We spoke with 30 patients, and examined 16 patient records, including medical notes and prescription charts, as part of this inspection.

## Summary of findings

The surgical services require improvement because there were significant risks and deficiencies evident across four areas of our inspection domains. The safety of patients was at risk due to delays in nurses attending when patients call for help. In Juniper Ward there was a clear consensus from many patients that they were not cared for safely because it took too long for nurses to respond, in particular at night time. However the trust produced data which demonstrated that the average response time in the week prior to our visit was on average four minutes, this meant that this may have been an emerging issue. We found that there were continuing problems of medication not being administered as prescribed. Nursing care records and plans did not always reflect the current needs of the patient, or have clear guidance of the care to be provided.

Patient outcomes were good in certain respects, such as low incidence of pressure ulcers, and low readmission rates indicating successful overall treatment. Many issues were evident and had been identified by the trust, but action had not been taken to improve the issues or actions taken had not been effective. It was not evident that staff could easily raise issues they were concerned about, either in their own teams or across professional boundaries.

# Surgery

## Are surgery services safe?

Requires improvement 

Improvements were required in safety of the surgery service. We found that risk assessments were poor, there was a lack of changes made to care plans when patients conditions changed and children were not receiving appropriate care in the operating theatre as there were no dedicated lists or they were not grouped together at the start of a list. In ward areas, we found poor completion of documentation of care. Although risk assessments relevant to the patients were mostly in place, these were sometimes inaccurate, and there was no respective plan of care, or the plan was not reviewed as the patient's condition changed. We found that there were continuing problems of medication not being administered as prescribed. There were some areas in the care of children being infrequently carried out therefore some staff may not have been regularly practised in techniques; however, outcomes data has identified no area of concern in respect of patient safety.

There was an incident reporting system in place, and reports of the performance were displayed for staff, patients and visitors to examine. Safety checklists were used in operating theatres, and theatre staff were given feedback on quality of care. We found that in ward areas, the regular observations of patients were carried out, and early warning scores completed to identify patients at risk of deteriorating condition. Ward areas appeared clean and usually uncluttered. There was good use made of hand-cleaning systems.

### Incidents

- Data for 2013-14 showed that the surgical service had low rates of pressure ulcers and falls, which are general indicators of quality of care.
- Data for 2013-14 showed that there were 10 serious incidents within this core service. These were mainly slips, trips or falls, and grade 3 pressure ulcers.
- We spoke with ward managers in three surgical wards. There were clear arrangements for reporting of incidents. Staff were informed of any incidents at ward meetings and handovers.
- In operating theatres, incidents were collated and discussed at clinical governance meetings every two

months, but also at two weekly staff meetings, and on noticeboards at the entrances to operating theatres. Changes to practices or procedures, or recent serious incidents or near misses, were discussed at a team briefing session, as required.

- Mortality and morbidity meeting were held monthly to discuss recent cases where patients had died or care had not progressed as planned. Medical staff also attended governance meetings every two months. Risks and safeguarding issues were discussed and any key learning fed back to medical teams.

### Safety thermometer

- We saw that safety reports were displayed for staff, patients and visitors to view in each ward area.
- Ward managers showed us the audit checks they made monthly on key indicators of patient safety and quality of care. Staff in surgical services were given information about incidents and complaints, and staff confirmed this and knew the rates of infection or falls in their clinical areas. Staff were aware of the causes of and rates of infection or falls in their clinical areas and causes of incidents. We saw that staff followed procedures and they recorded their regular checks on patient's position to prevent pressure ulcers or patient falls.

### Cleanliness, infection control and hygiene

- There were sufficient hand-washing facilities, and supplies of cleansing lotions for hand washing at entry points to clinical areas, and within the wards and bays. We saw that ward staff used personal protective equipment, and washed hands at appropriate moments in providing care. We saw that all staff used the hand washing facilities provided on entering and leaving ward areas.
- In the ward areas there were sufficient side rooms to allow for isolation when necessary. Juniper ward had five side rooms out of the 30 beds. There were no patients on isolation at the time of our visit but nurses described the precautions they would take. We spoke with one patient who had initially been isolated due to an unknown infection risk. The patient described precautions that nurses and visitors had taken on entering and leaving the room. We found these to be appropriate.
- Data for 2013-14 showed that the surgical service had low rates of catheter-related urine tract infections.

# Surgery

- We observed good cleaning arrangements and procedures in operating theatres. Staff cleaned areas and equipment between cases, and equipment and consumables followed a clear flow through from clean to dirty areas.
- There were inconsistent facilities for hand washing in different operating theatres. Staff were maintaining safety by using scrub sinks to wash hands where needed, but there were no alcohol gel stations outside some entry points to the department. Taps for hand washing and scrubbing up were 'non touch' in main theatres, but this was not the case in the treatment centre theatres. However the trust reported that these taps were compliant with current guidance.
- We examined storage areas for medication in ward areas and found appropriate security and temperature checking was in place. We observed that nursing staff were careful to keep medications locked safely when they were not in attendance.
- In ward areas we found there was good support of pharmacy. We saw that pharmacy staff visited the wards and checked through prescription charts to ensure appropriate supply of medication and advice to nursing and medical staff. Pharmacy staff were aware that medication omissions had been occurring in surgical wards and said that where this happened they discussed the recording issue with nursing teams.

## Environment and equipment

- We examined checklists and resuscitation equipment in the surgical wards and operating theatres. Resuscitation equipment in each ward was checked routinely, and there were clear records to evidence that this had been completed.
- Ward areas had emergency resuscitation equipment trolleys easily available in main corridor areas. We examined these and saw they had been checked routinely and were safe and ready for use.
- In operating theatres, recovery staff checked and signed daily, to show key equipment and trolleys were safe and ready for use

## Medicines

- We found that in Juniper Ward there were medication omissions which meant patients were not receiving the expected treatment, and their health and welfare could be at risk. One patient said they had been worried that they were not given their usual pain control tablet, and also missed a regular aspirin tablet for three days. The patient was known to have a risk of thromboembolism. We discussed the case with the pain specialist who advised that these tablets could and should have been given despite the order for clear fluids in this patient. Another patient's medication chart showed no record of a prescribed anti-embolism injection without any documented reason for the omission.
- We discussed the omissions with staff, who said that the specific omissions we noted in charts for the week prior to our visit had not been identified before our inspection and would be recorded on the trust incident reporting system.

## Records

- We examined 16 patient care records in ward areas and operating theatres. We found that staff in surgical wards had completed standard documentation as appropriate for their patients. This included documents assessing the risk of pressure ulcers, nutrition, moving and handling, and venous thromboembolism. However, we found that risk assessments were not always reviewed as the patient's condition changed, and that respective care plans were not always detailed enough. Five records reviewed in Birch ward had no follow up review of the initial assessment of risk of venous thromboembolism when they should have been reviewed. However data provided by the trust showed that patients were not at an increased risk of developing a venous thromboembolism under their care. This meant that staff may not provide the appropriate care to meet the changing needs of patients.
- There were gaps in care planning for pressure ulcer prevention. We found that risk assessments for skin integrity had only minimal detail of the care to be put in place to prevent pressure ulcers developing. The trust had sufficient pressure relieving equipment available for staff to use. Risk assessments for skin integrity were completed on admission. We examined nine care records where an elevated risk of developing pressure ulcer had been identified but there was no plan of care completed for staff to follow that was related to the identified risk. We saw that staff entered a record of skin integrity checks and other personal care each shift. There were records on charts to show that the patient's position had been checked or changed. However it was not evident from care records that a clear plan had been decided following risk assessment. Staff told us that

# Surgery

they were given information about key risks and the care to be provided at handover, and on handover sheets. This meant there was a risk that staff might not be aware of patient care needs to prevent pressure ulcers. However the trust had a low rate of pressure ulcers acquired in care.

- There was good documentation of pre-assessment for patients preparing for surgery. Key risk information was also provided to the anaesthetist and surgeon as an alert, where this would improve patient safety. We saw that a risk of venous thromboembolism had been noted at pre-assessment for two patients who we spoke with. This information had been reported clearly in the care plan and medical notes.

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

- We saw in patient records that consent to surgical procedures had been clearly discussed with, and signed for, by patients.

## Safeguarding

- Staff in surgical services knew how to report safeguarding concerns to their manager to protect patients from abuse. Staff in ward areas were able to show us the policy and procedures for the safeguarding of vulnerable adults. Staff knew there was a safeguarding lead for the Trust and would use this person for advice where needed. In operating theatres staff showed us the policy section on the intranet including safeguarding of vulnerable adults and children.
- We spoke with the matron in a ward area about a patient who considered that another patient who was confused and agitated had been handled roughly back into bed at night time by nursing staff. The matron told us they would take appropriate action to investigate, would inform the safeguarding lead and follow Trust procedures for reporting. The overall review of this matter was not yet concluded.
- A patient in day surgery ward told us they felt they had been handled roughly by a junior member of staff. We found that the ward manager was aware of this, and was investigating the issue.
- We found that there was no dedicated operating for children or that they were placed on the beginning of an operating list. This meant that there was risk to children that the appropriate staff were not available. There was no paediatric-trained theatre nurse employed since a

nurse had retired in May 2014. Some staff had an interest in paediatric care, and had completed specific paediatric training courses, including safeguarding of children to Level 3. During our inspection only 16 out of 31 staff had undertaken Paediatric Intermediate Life Support training. When we raised this with the trust they took action to ensure that children were safe within the operating theatre department.

## Mandatory training

- There were good arrangements to enable staff to attend mandatory training. Staff told us that they were supported to complete mandatory training by their managers. Some staff told us that they had undertaken some computer-based training in their own time.
- Records for the year to March 2014 showed that staff across surgical teams had attended statutory training on moving and handling, safeguarding of adults and children, and information governance with around 90% of staff completed these sessions. There were comparatively low rates of attendance at basic life support ranging from 40% to 80% for the surgical teams. This meant that staff in surgical areas where patients could be at risk of collapse were not fully updated in basic life support.

## Management of deteriorating patients

- We found there was accurate use of early warning scores on observation charts in the ward areas we visited. Staff in wards and operating theatres were aware of the procedure for early warning scores, and the process for escalating information and action to ensure prompt response to deteriorating patients.
- We saw that theatre teams were using the World Health Organization's (WHO) '5 steps to safe surgery checklist', which is designed to prevent avoidable mistakes; this was an established process with the teams. We observed effective communication during a team briefing prior to the surgical list. Audit results showed that post operation debriefs were completed only after 92% of operations. This meant that opportunities for learning could be missed. Overall audit results for WHO checklist from March to July 2014 ranged from 97 to 100%. The audit results shared with staff also highlighted issues such as the formality of team brief and that all staff questions had been addressed before the procedure went ahead. This meant that the theatre teams continually monitored and reported on processes to prevent avoidable mistakes.



# Surgery

- The patients paper section of the theatre record showing the time that a patient left the operating theatre was not being completed by theatre or recovery staff. This meant that individual records were not fully completed despite it being completed in electronic format.
- In operating theatres staff kept clear count of disposables and other items, to ensure that all items were accounted for at the end of the procedure. This was a clear visual safety procedure to prevent foreign bodies being left in the patient. Records were made in care plans and signed as accurate by two designated staff. Staff told us of a case where a patient had been required to remain in an operating theatre while checks were made. The remaining item was located and removed.
- Delicate airway procedures in the operating theatres were infrequently carried out on children. This meant that staff may not have been regularly practiced in the techniques due to low numbers of children using the surgical service. Staff told us that they were aware of the need to maintain competence. Since our inspection the trust reports that enhanced support for consultants dealing with emergency paediatrics has been put in place and a facility to provide mentored practice with elective paediatric anaesthetics offered.
- Patients in the acute trauma surgical unit also told us of delays in call bells being answered. We observed the call bell response time on two occasions during the daytime, and noted that it took ten minutes for a nurse to attend patients requiring the toilet.
- Ward managers told us that replacement staff were recruited to maintain the agreed safe staffing levels when there was vacancies. In operating theatres we saw that staffing levels met the guidance from the Association for Perioperative Practice, with two scrub personnel where required, one anaesthetic staff and one circulating staff member. Operating department practitioners told us that staffing levels were maintained at safe levels. The team would not allow operations to proceed without the required safe complement of staff.
- We saw that additional staff were arranged when a specific need was identified, such as several patients at risk of fall. Where an acutely ill or confused patient required constant supervision or monitoring, a member of staff was allocated. Additional staff, such as agency, were arranged when required. We spoke with an agency nurse who had been caring one to one with a patient who was agitated and confused and at risk of falling.
- We spoke with an agency nurse, who told us they had mandatory training checked prior to working in the surgical ward areas, and they had been given clear guidance about the ward area and procedures such as for emergencies when they arrived for work. The nurse said they had worked in the ward and other wards in the hospital on previous occasions.

## Nursing staffing

- Staff in surgery wards and operating theatres told us that they usually had sufficient staff. There were specified staffing levels for each ward area, dependent on bed numbers and types of patients. Staffing rotas that we examined showed staff levels had been maintained for the two weeks prior to our visit. On the night shift there were three registered nurses and two or three health care assistants on a 30 bed surgical ward. Additional staff were used where patients with higher dependency or were in the ward.
- However, we found that many patients in wards told us there were not enough staff, in particular on night duty, which meant that patients had to wait too long for call bells to be answered when they required care or support. The majority of the patients we spoke with on Juniper Ward told us of this issue. Patients were very clear that during the night shift it was often over 30 minutes before patients were attended to when they rang the call bell.

## Medical staffing

- Data showed that in surgery there was a higher proportion of consultant grade staff at 42% compared with the national average of 40%. There was lower proportion of registrar level staff at 8% compare to the England average of 38%. Junior and middle grade staff made up 50% of the medical staffing compared with 24% nationally. There was a total wte of 84 medical staff in surgical services.
- Patients told us that they had regular reviews of their care by medical staff, and were aware who the consultant was leading their plan of treatment
- We saw that consultant staff visited ward areas regularly to see patients, and ensure progress of patient pathways.
- There was support of specialists from the critical care unit if staff had concerns about a deteriorating patient.

# Surgery

## Major incident awareness and training

- Staff in operating theatres showed us detailed plans and procedures to follow in the event of a major incident. There was a file of the major incident plan held in main theatres office and staff also showed us the full plan on the intranet in operating theatres. We saw that staff contact numbers had been updated as staff joined the team so that additional staff could be called to help in a major incident.
- Some ward staff were unsure of where the information was located about major incidents, but told us that contact numbers were kept by their manager, and they could be called to support if needed in a major incident.
- Operating theatres used an electronic system for operating lists. There were clear arrangements to use printed lists if the IT system failed.

## Are surgery services effective?

Improvements were required in effectiveness of the surgery service. We found that there were a number of areas which required improvement including a lax approach to fluid management, gaps in care records, and ineffective communication between shifts. This meant that information about patients' needs was not always consistent. The multidisciplinary team worked well together but patients told us that the medical staff had not recognised the issues in nursing care. Patients said that medical staff were aware of lapses in communication leading to delayed diagnostic testing, and missed medications for example. We saw that managers were aware of trends showing missed medications and incident reports provided by teams about staffing levels. There were no plans in place to resolve the issues with missed medication although these continued to be monitored by the pharmacy teams.

In general, the data showed that surgical admissions were successful, in that patients were discharged following treatment, and had not been readmitted. Pre-assessment of patients and planning of operations lists was effective in screening and preparing patients for surgery.

## Evidence-based care and treatment

- We saw that NICE guidelines were followed for care of patients in the surgical service. Additional guidance was available to staff to ensure good practice in managing care.

- Specialist nursing staff described the NICE guidance that was followed for care of patients relating to pain control and hip fracture management. We saw that documentation in care records to guide staff each day post operatively for hip replacement followed NICE guidance for recovery. Therapy staff told us they followed guidance for mobilisation following surgery. We found that guidance was followed on good practice in stoma care in collaboration with local clinical networks.
- The operating theatre team used the intranet routinely for staff to easily locate and refer to policies and procedures.
- Infection control policies were clearly displayed including hand washing throughout clinical areas. In operating theatres the uniform policy was displayed to remind staff of infection control measures related to uniforms worn out to different parts of the hospital.
- Surgical staff held monthly mortality and morbidity meetings, and there were governance meetings every two months to learn from experience. Medical staff told us that risks and safeguarding issues were discussed. There was regular feedback from these meetings at staff meetings and daily briefings if required. Medical staff told us that they knew how to escalate issues if needed. The 'Stop the Line' procedure used to invoke if a serious concern was raised by any member of staff had been used by theatre staff. The successful use of the process had given staff confidence to speak out if they had any concerns for patient or staff safety.

## Pain relief

- There was an established system to ensure post-operative pain of patients was managed effectively. A pain specialist nurse visited patients in ward areas to assess the pain with the patient, and support nursing and medical staff to revise pain control where required.
- We saw that pain control was managed, using agreed guidance in folders on each surgical ward, although this was only specified for patients following an operation. Patients on surgical wards who had not undergone surgery were not routinely referred for pain management advice but the trust reported that these patients were referred as required.
- We spoke with patients who had been assessed by the pain specialist nurse. Patients told us that their pain was well managed following surgery.

# Surgery

- Two patients who had not had surgery told us that their pain had not been managed well. One person said that they had a syringe driver with pain control which had, on two occasions, become empty of the medication, leaving them for some hours without any control of their pain. Another patient with chronic back pain told us that they had to wait several times for over half an hour, for 'as required' medication. This was because nurses had not answered the call bell quickly enough.
- One patient told us that ward nursing staff had not administered some of their pain medication in the first two days of their admission, due to the patient being on clear fluids. However, the pain specialist nurse told us that part of the medication could have been administered in order to maintain the comfort of the patient.
- We saw that patients were usually offered drinks regularly during the daytime. Staff who undertook this task were aware of who was able to take drinks. We spoke with staff providing drinks and found that they were also part of the nursing care team and fully aware of patient's nutritional needs such as diabetic or supplementary diet. We saw that patients had water available with clean jugs and beakers. There were clear notices above the beds where patients were designated 'nil by mouth'.

## Patient outcomes

### Nutrition and hydration

- We saw that risk assessments had been completed in care records, to check if patients required extra support or monitoring for their nutrition and hydration. We found that fluid charts and food intake records were mostly completed and summarised accurately.
- However, in three cases where we had observed care in the ward, and spoken with relatives who had been in attendance, we saw that fluid intake had been poorly estimated. We saw also that calculations of total fluid intake were not always accurate.
- One visitor told us that they had been concerned about developing dehydration in their elderly relative. They said they had been asking for several hours for a doctor to review the patient's condition and to ensure adequate hydration. Another relative told us that they had been with a patient for four hours, trying unsuccessfully to get them to take a drink, and nurses had not offered any support. We saw that the ward was busy, with staff attending another acutely ill patient. We spoke at length with the relative and examined the care record. Charts of fluid intake had not been completed since the previous evening, the relative had been with the patient from 6am to 11am trying to get the patient to drink through the morning. We saw that the patient's position was difficult for drinking, it was only after nurses supported the patient with personal care and changed position that fluids were taken. We found that rough estimates of fluid intake were then added to a fluid intake chart.
- Data showed that in 2013-14 the length of stay for patients undergoing bowel surgery was worse than the England average. 83% of patients stayed in hospital more than five days compared with the national figure of 69%.
- Data showed that in 2013-14 the length of stay for patients undergoing hip fracture surgery was slightly worse than the England average. The mean length of stay was 22 days compared with the national figure of 19 days
- Data showed that in 2013-14 the ratio of observed readmissions was lower, which was better overall, when reviewing all types of surgical patients, at Hinchingbrooke than the expected rate compared to the England average. This is an indicator of effective treatment and discharge planning. However for elective orthopaedic and ophthalmology cases in 2013-14 the relative risk of readmission was slightly higher than the expected figure for the year. We saw that discharge checklists were completed in case records for the patients where we examined the notes of patients who had a complex condition or continuing need for support after discharge.
- The National Audit of patients with bowel cancer in the Trust had shown that 28% of patients were seen by a nurse specialist compared to a national average of 88%; however, this data related to a historical period when the specialist covered only part time hours. The specialist nurse role is now full time and 95% of patients know their specialist nurse, which is higher than the more recent national average of 91%.
- A high proportion, 54%, of patients who had bowel cancer had their surgery carried out as an emergency, compared to the national average of 18%.
- In the national hip fracture audit the service had worse than the England average of 96% performance for

# Surgery

having a specific falls assessment as 75% of patients with hip fracture were recorded as having the assessment. A falls audit, undertaken by the trust in August 2014, did not specify the patient diagnosis but returned a falls risk identification rate of 91% across seven wards. Areas for improvement, together with planned actions, were included in the audit report.

- The trust had better than average performance for development of pressure ulcers at 1.5% compared to the national average of 3.5%.
- The trust had better than average performance at 91% for making bone health assessments of patients compared to the national average of 85%.

## Competent staff

- We saw detailed documents that staff in operating theatres used to ensure competency in specific duties. A competency booklet for scrub practitioners and theatre support workers covered the competencies related to perioperative care and specialist surgery, such as orthopaedics or ophthalmology. Staff completed competency checks for new skills, but told us that there was no review of competencies. This could mean that staff lose skills not practised and checked regularly, and may not undertake skills safely: however the trust told us that staff were issued with a revised competency pack between July and August 2014, which involves completing a separate annual review document.
- In a focus group including five theatre staff we heard there was good access to training, they worked as a supportive team and staff felt able to ask for support if they required advice. New staff in operating theatres were employed under a probationary period, with checks on competencies at three monthly intervals for six months.
- Two health care assistants we spoke with told us that they had annual training updates on key skills. This included taking observations and use of the early warning scores to ensure nursing and medical staff were alerted if patient's condition was deteriorating.
- Medical staff told us that they had good facilities and systems for personal development, and this had meant some staff developing in their career through to consultant level. Facilities included video links from operating theatres to seminar rooms, to enable observation and shared learning from current practice.

## Multidisciplinary working

- Staff in operating theatres told us that there was effective working across paediatric services of the trust and the Cambridgeshire Community Trust staff, who managed the paediatric wards on the same location. There were meetings every two months to discuss collaboration on paediatric services.
- Staff told us that there was good multidisciplinary working in ward areas to plan care and promote effective discharge. We saw that there were ward team meetings early in the day at handover which included therapy, nursing and medical staff. Notes were taken and key care issues were noted in a communication book in addition to patient records.
- Specialist nurse advice was available to staff regarding infection control, and pain management. These staff provided clinical updates to link nurses for cascade within the ward teams.
- Patients told us about communication issues that had caused delay in their diagnostic tests. One patient on a ward told us that they had waited four days for an ultrasound scan. They said they had been to the scan department three times, only to be turned away and sent back to the ward due to mistakes in bookings. Another patient told us they had been taken to a procedure room only to be told they would have to go back to the ward and wait another three days until antiembolism medication had worn off. The trust supplied evidence which demonstrated a low level of delayed diagnostic tests, with eight incidents occurring in the previous 18 months.
- There were some problems for patients regarding communication of care needs between shifts of staff. In Juniper Ward, one patient, and relatives of two other patients, told us that they felt there was poor communication about aspects of care. They said they had to remind staff of key aspects of care or treatment that had changed, but which the staff on a new shift had not been aware of. Two patients told us that they felt they had to manage their own care, remind staff for example about problems with infusions, to ensure treatment was consistent. One of these patients said there was a risk that other patients, who were not so aware, or able to articulate their concerns, may receive inconsistent care.

# Surgery

## Seven-day services

- There were clear arrangements for medical staffing. Doctors of grades FY1 and FY2 told us there was consistent consultant cover when required, including for advice out of hours.
- Staff in surgical areas told us that patients needing urgent X-ray at weekends sometimes had to wait for several hours due to the availability of on-call radiography staff, in particular, if X-ray support was required in operating theatres. This was the case when we visited out of hours, staff in A&E stated that patients were awaiting x-ray due to the radiographer being in operating theatres.

## Are surgery services caring?

Inadequate



'The surgical service was rated in this domain as inadequate as, although many areas of surgical care provision were meeting or exceeding required standards, patients' basic needs were not being met in all cases. 17 out of 30 surgical inpatients told us that they had to wait unacceptably long periods when they called for assistance. This resulted in some patients not receiving care at the expected level required to protect their dignity. Two patients told us that they had been told to soil themselves and a further one patient stated that delays resulted in patients soiling themselves. Five patients told us that there was little time for nurses to provide emotional support and explanations about care to patients and relatives, although it is recognised that this is not a role limited to nursing staff. Fifteen patients also told us that they had had experiences of nurses being kind and considerate in providing care.

## Compassionate care

- Patients told us that most nurses and staff were kind and compassionate, but that there were many times when the care had been poorer quality than they expected. A comment that many patients gave was the delay in being attended to when calling for help. Patients also described a lack of attention to other issues such as keeping the bed area clear when patients were unable to get out of bed. One patient and relative said the bed had been surrounded by numerous urine bottles by the end of a day as they had been asked to keep samples for measuring.
- Many patients across all surgical wards told us that they had to wait half an hour or longer when they were bed-bound but required a nurse to use the toilet. The trust provided evidence of a call bell audit undertaken by the trust on Juniper ward in the week prior to our visit that indicated that waiting times ranged from 2 to 8 minutes, with an overall average of 4 minutes from call to response. The concerns raised with us by patients may have been a recently emerging risk however this could not be confirmed.
- Two patients in surgical wards reported that care staff had responded briefly to the call bell, advised the patient to go to the toilet in the bed, and that they would be made comfortable as soon as they were able to attend the patient. The patients said that nurses were caring and supportive at these times but they could not attend quickly enough to help maintain the patient's dignity. Staff agreed that at night time they often found it difficult to respond quickly enough to calls from patients. They explained this might happen if there were staff on breaks and remaining staff were busy with other patients.
- Three patients in Juniper Ward told us that they had to go out of their bay to find a nurse to help patients who had been calling for help but the call bell was not answered. There were quiet sliding doors across bays which helped to maintain a quiet environment for rest in bays. Patients said this meant the nurses could not easily hear patients calling out for help when the call bell was not used; however, this was not substantiated via nursing staff
- There was agreement among the 12 patients we spoke with on Juniper Ward that the response of nurses to call bells was routinely poor at night time. They told us that they were aware nurses were busy with other patients at such times.
- In March, May and June 2014, the score of the Friends and Family Test of whether patients would recommend the service on Juniper Ward was between 61-66%. For other surgical wards where data was available, we saw the score was over 95% for the same months.
- In operating theatres we saw that the privacy and dignity of patients was protected. Curtains were used if patients were sharing the same bays in reception and recovery areas. Clear notices were used on curtains in these instances to designate the patients behind curtains to support good patient identification.

# Surgery

- One patient on the acute surgical and trauma ward said that they had been on seven wards in the first three days of admission, and had been moved at 12.45am, 3am and 5am on different days. The patient recognised the needs of more acutely ill patients, but said it had been disruptive to rest and sleep early in their admission.

## Patient understanding and involvement

- Patients told us that nurses introduced themselves at the handover of shifts. Patients said, however, that there was little continuity and there had been many different nurses across the shifts in the week.
- The views of patients were taken into account in operating theatres. Staff had used a survey to gather views of patients about anxiety and feelings through the procedure. As a result of feedback, more time was allowed for patients to talk with the anaesthetist or surgeon in the perioperative period. Additional patient satisfaction surveys were being undertaken at the time of our inspection.
- Patients told us that the care provided by nursing staff was not effective, due to poor response to call bells and lack of continuity of information from day to day, meaning they had to ensure for themselves that staff were providing consistent care. One patient told us that they felt medical staff had not recognised or tried to address these issues in the nursing teams.

## Emotional support

- Patients in Daisy Ward told us they were cared for with compassion, and staff responded well to their needs. Two patients told us that in Juniper Ward the nurses had little time to provide emotional support. They said nurses were kind and supportive when they were able to attend patients. They told us that nurses only had time to provide the technical and physical care. One relative told us that they had to ask several times before staff found a person who was able to explain the treatment and plan of care.
- We saw that parents accompanied their children through to the anaesthetic room prior to surgery, and were able to be with children as they awoke from their operations.
- In the pre-assessment unit, patients were met by a member of the nursing team, and directed to the appropriate room for their appointment. Patients told

us that this was reassuring and welcoming. We saw that patients were given adequate time to answer questions, and to ask if they were unsure about their forthcoming operation or procedure.

## Are surgery services responsive?

Good



Surgical services were good, because we found examples across the service that showed flexibility and improvements to enable access to the service. Patients with learning disabilities were supported effectively to access surgical care. There was a good surgical pre-assessment service, which was designed to ensure time to capture relevant information, to promote safety, and to provide a seamless experience for patients.

We found that patient feedback had not been used effectively to identify issues and plan improvements to basic care provision.

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

- The trust was meeting 18 week referral to treatment times (RTT) for all surgical specialities.
- There was an effective pre-assessment department, which supported patients in preparation for their operation. There was good flexibility in pre-assessment to provide this service in a way or place that was convenient for patients. Pre-assessment was being offered to some patients as a telephone service where appropriate. In the pre-assessment unit, the staff identified when clinic appointments were available, and made these available to the outpatients department. This meant that some patients were able to have their pre-assessment for admission on the same day as the decision to admit was made in the outpatients clinic.
- Patients for surgical team care were regularly cared for on medical wards. Three patients in the orthopaedic ward told us that they had been moved several times before arriving on the surgical ward. This was a reflection of high occupancy of beds in the hospital and how patients were accommodated if admitted in an emergency. Although a nurse in charge of acute trauma ward stated it was rare to move patients at night we were told by patients that they had moved at night when beds were needed for emergency admission.

# Surgery

## Access and flow

- There were clear arrangements and procedures for access to the surgical service. Patient booking for surgery and surgical lists was managed effectively. Operating theatre lists were managed by the consultant surgeons, with administration support, and in collaboration with surgical practitioners and theatre teams. This intensive planning meant that there were few cancellations of patient operations. Where theatre lists overran elective patients were operated on using the capacity of the emergency theatre teams. Since July 2013 any patients whose operations were cancelled had their procedure rebooked within 28 days.
- Data showed that in 2013-14, the delay from referral to treatment (RTT) was consistently better than the England average and national standard of 90%. All surgical specialties were meeting RTT standard of treating patients within 18 weeks. All specialties at Hinchingsbrooke were over 90%. General Surgery 92.2%, Trauma & Orthopaedics 91.9% Plastic Surgery 97.0% ENT 94.4% Urology 99.7% Ophthalmology 95.4%.
- Ward managers and staff told us that discharge planning was reviewed regularly. The plans were discussed with patients during medical staff ward rounds. Progress on discharge arrangements was checked by the team in daily briefings, handovers and multidisciplinary meetings. This process was confirmed by therapy and pharmacy staff in ward areas. We found also that discharge checklists were completed in the care records that we reviewed.

## Meeting people's individual needs

- The operating theatre team held a Saturday club for children to look round the facility prior to coming in for a procedure. There were bays decorated to help children feel relaxed within the clinical area.
- There was good flexibility in supporting people, such as vulnerable patients with complex needs. Patients who were identified as being vulnerable in any way, such as frail, confused or with learning disabilities, had specific attention paid through the use of a checklist, to assess capacity, the patient's understanding, and any anxiety about the procedure. Additional support was considered and planned at the pre-assessment stage with the patient and relatives where appropriate. Staff in the operating theatre described their flexibility in providing support for a patient who had a complex

mental health condition. The patient had been anxious about anaesthetic and theatre rooms, and so had been anaesthetised in the recovery area before being taken through for the procedure.

## Learning from complaints and concerns

- Ward managers and staff in surgical wards told us that they used complaints to learn lessons and improve the service. However, we found that patients in all areas discussed problems with us, such as poor response to call bells, and lack of time to talk with patients. There had been clear indications that satisfaction was reduced for three months earlier in 2014 but the reasons for this had not been established or tackled in the relevant ward area.
- Patients knew how to complain and said they would speak to the nurse in charge or the ward Matron. They told us about some complaints they had made. One patient had complained about noise from outside the ward window which had not been stopped quickly at the time, but the patient had been reassured that the issue had been investigated and the cause of the noise had been dealt with.

## Are surgery services well-led?

Requires improvement 

Surgical services required improvement because, although there were some systems in place to audit quality of care, they had not supported improvement. The staff and managers were aware of medication errors but a clear plan for improvement had not been developed. Documentation audits were being completed and reported but we found they were ineffective at identifying gaps in care planning. Patient feedback had clearly indicated a reduction in satisfaction from March 2014, but this had not been met with any plan to improve services. We found patients were still dissatisfied in some aspects of the service.

Although staff told us that they felt able to speak up if they were concerned, there were no comments from staff to the inspection team about the problems of responding to call bells in time, or having time to provide emotional support to patients. Staff raised concerns regarding the level of care they were able to provide by completing incident reports but it was not clear to staff that these were acted upon.

# Surgery

## Vision and strategy for this service

- Staff in the surgical service were aware of the trust campaigns to ensure staff provided individualised care to patients and visitors. Staff in wards were aware of the vision to provide 'better healthcare' for the local population.
- Theatre staff we spoke with in focus groups told us that they were aware of the 'Stop the Line' initiative. They had used the process successfully to protect a patient and this had given them confidence they would be supported. Theatre staff knew of plans for upgrading of operating theatres, they told us about investment already made to renew equipment, and were aware of continued move towards day surgery and keyhole surgery. They told us of intentions to provide local services where possible in the Trust and of the specialist surgeons that had joined the Trust.

## Governance, risk management and quality measurement

- We found that there was a lack of action taken by managers to address known issues. An example of this was in respect of medication omissions which continued to be reported but little or no action was taken by managers to address these.
- Although the ward managers had audited care records, the process had not identified weaknesses in risk assessments and the plans of care that we identified during the inspection. This meant that audit processes had been ineffective in improving the care records to promote better care.
- We observed in operating theatres that there was good local leadership and flexibility of working to maintain safety. Where a patient had arrived late, the anaesthetist and surgeon agreed to have a mini briefing for that case prior to the procedure later in the session.
- In operating theatres, we saw that staff were supported by managers to focus on key areas of performance that maintained patient safety.
- Risk registers included an item about the environment in operating theatres which affected the ease of cleaning of some surfaces. There was a capital plan in place to improve the relevant parts of the premises.

## Leadership of service

- 'Stop the Line' had been effectively used at team level in operating theatres. They felt assured that managers had responded appropriately to their request.

- In operating theatres, the absence levels of staff had been reduced by 50% in the year prior to our visit. This was due to clear monitoring, and support for staff, in collaboration with personnel and occupational health staff. Flexible contracts had been implemented where appropriate, to enable staff to continue in service.
- There was a new appraisals system in place which meant that rates of completion were 70% in operating theatres. It had been 85% before the new system. Managers said they were working on ensuring all staff were appraised using the new system.

## Culture within the service

- Medical staff in surgical services told us they were well supported by seniors and considered it was a good working environment.
- Nursing staff told us they felt supported by their managers. They said they felt able to speak openly if they had a concern. There were clear problems raised by patients with inspectors, but there were no incidents reported that staff had raised concerns regarding the level of care they were able to provide.
- Staff in operating theatres stated they felt it was a supportive work environment; they were encouraged to attend training and felt they could raise issues in the team or during procedures if required.

## Public and staff engagement

- Data showed that patients on Juniper Ward were more willing than those in other areas to provide feedback on their experiences. The feedback from Juniper ward also showed that in March, May and June they were significantly less likely to recommend the service to friends and family. In our inspection we found many patients in this ward were dissatisfied with the care they had received.
- Although there was clear evidence that patients were unhappy with the service on Juniper ward, it was not clear how staff of the ward or trust managers intended to tackle the issues of missed medication, poor emotional support and lack of continuity of care. This meant that managers had not responded to recent negative patient feedback and information that indicated the problems that could be leading to patient dissatisfaction at the time of our inspection.
- Staff had been involved by the trust in developing the overall strategy. Two staff said they had attended workshop to discuss the 'better healthcare' plans.









# Surgery

## **Innovation, improvement and sustainability**

- A survey in operating theatres, used to gather views of patients about anxiety and feelings through the procedure, had led to improvement in service. As a result of feedback, more time was allowed for patients to talk with the anaesthetist or surgeon in the perioperative period.
- The team in the pre-assessment department were providing a flexible and responsive service, and continuing to develop ways to enable easier access for patients. They told us they were planning provision of the service in rural areas, such as Doddington, to be more convenient for patients from that area.

# Critical care

Safe	Good	
Effective	Good	
Caring	Good	
Responsive	Good	
Well-led	Good	
Overall	Good	

## Information about the service

The Critical Care Centre at Hinchingsbrooke Hospital has nine beds. The centre provides both level 3 care, that is for patients requiring one-to-one support, such as those requiring artificial ventilation, and level 2 and level 1 beds for high dependency care. Designated staff in the team have an additional role as an outreach specialist across the site. This is to manage the care for patients that have a deterioration of their condition. The critical care service has four consultants, providing cover 24 hours a day, seven days a week.

As part of our inspection we spoke with two consultant medical staff, seven registered nurses, including a clinical educator, pharmacist, resuscitation officer and the lead nurse for the Critical Care Centre. We spoke with three patients and two relatives. We observed the care and treatment patients were receiving, and viewed five sets of care records.

## Summary of findings

Critical care services were good overall. We found that services were safe, as competent medical, nursing and other professionals worked effectively together to ensure safety. The environment was cramped and old, which meant that staff had to work flexibly and efficiently to ensure cleanliness, safety, and privacy and dignity for patients. The service is effective as staff followed clinical guidance and locally agreed protocols. Performance data showed that there were few incidents of harm.

The service was caring as patients and relatives told us that staff were very supportive. There were systems available to provide follow-up emotional support if required. Critical care services were responsive because a range of detailed assessment records were used to prompt staff to meet patients' individual needs. Children were cared for in the Critical Care Centre, but this was a temporary measure to provide urgent support until specialist care was arranged. The service was well-led, as staff worked well as an integrated team to provide very specialist care within the unit, and also to patients requiring aspects of intensive care in other ward areas. Audit work was established by the outreach staff to monitor the overall management of deteriorating patients in all wards.

# Critical care

## Are critical care services safe?

Good



Critical care services were safe. This was because staff managed the use of the space, maintained cleanliness and order, and followed procedures to prevent cross-infection. Medical and nursing staff levels were maintained at safe levels, although the cover across to the aligned coronary care unit meant that cardiology staff were needed to support at times to maintain safe medical cover. We saw that nursing staff were flexible in managing peaks in workload. Contingency arrangements were in place if safe staffing levels were not able to be maintained.

We found that patients care was risk assessed, monitored and provided in a safe environment. Safety thermometer data showed that there were few incidents of actual harm to patients from the care they received and this together with the outcomes in the ICNARC report provided reassurance that patients had not suffered harm.

### Incidents

- Medical and nursing staff told us that they were aware of how to report incidents. There was a culture in the team that risks were raised and managed. There had been a review of the infection control concerns related to the environment which had led to a capital plan to commission a new critical care department.
- If children were admitted to the Critical Care Centre (CCC) this was reported as an incident for review, as there were risks in caring for children in the adult critical care unit due to the relative inexperience of staff who were not routinely caring for sick children. There were clear arrangements with Addenbrookes Hospitals paediatric service for advice or to transfer children when this would be the safest option.
- The most frequently reported incidents were delayed discharges to ward areas due to bed occupancy pressures in the hospital.
- Staff had reviewed reports about insulin medication errors. In analysis these had been shown to be clinical judgement about changes made to prescriptions. Raising the issue through incident reporting had led to discussion with physicians and clear protocols being established for changes to insulin prescriptions.

### Safety thermometer

- The Safety Thermometer information for May 2013 to May 2014 showed no falls reported, and a small number of pressure ulcers reported in the past year. There were five avoidable pressure ulcers reported from the CCC in the 15 months prior to our visit. Staff used a detailed care bundle to assess and monitor skin integrity
- Safety Thermometer data showed there had been two catheter infections reported between March 2014 and May 2014. These were patients that had been admitted to the unit with infections. We saw that care bundle checks were in place for patients with urinary catheters.
- There were no reports of MRSA or C.difficile infections in the critical care centre.

### Cleanliness, infection control and hygiene

- The environment of the unit was assessed by the trust as requiring upgrading to meet infection control standards. A new department was in construction, and the older unit, which was in use at the time of our visit, was to be decommissioned early in 2015. We saw that cleaning procedures and staff practices meant that infection risk was managed. Staff observed good hand-washing technique, and used personal protective equipment appropriately to prevent the transfer of infection.
- Intensive Care National Audit and Research Centre (ICNARC) infection control data showed that there was no issue with infection prevention and control. In June 2014 the critical care areas achieved 100% compliance with hand washing audits. This had been the same for the previous two months.

### Environment and equipment

- There was equipment easily available for intubation and intravenous access. There was bedside equipment available for rapid access if required. Resuscitation equipment was readily available, and we saw this had been checked routinely, including defibrillator pads being in place ready for use.
- Equipment was visibly clean and clearly labelled ready for use. We saw that electrical testing labels were within date for equipment on the unit.
- There were two kidney support machines available, which staff told us were regularly used. A third machine had been leased during our inspection visit due to patient needs.

# Critical care

## Medicines

- We saw that the stock check of medications in the controlled drug cupboard had been signed for as checked daily. Medications for resuscitation were checked daily with the emergency equipment.
- A pharmacist was included in the daily multidisciplinary team discussions, which meant that expert advice was available to the team, including medication interactions, dosages and route of administration.
- In May 2014 there had been nine medication errors and in June 2014 there had been three errors reported. Analysis of the reports had showed the decisions by nursing staff was to maintain clinical safety where there had been unexpected changes in prescriptions. This had been led to improved protocols for insulin prescribing.

## Records

- Risk assessments were completed in care records. We found that documents were fit-for-purpose and completed accurately. We saw that assessment records were completed appropriately, and also provided prompts to staff to follow local protocols and evidence-based care.
- There were appropriate detailed records made for each patient daily of the care bundles checks and observations, including ventilator checks. Staff also recorded their checks on blood results, sepsis actions such as blood cultures or swabs, and sedation rates.

## Safeguarding

- Staff told us that they were aware of the procedure to be followed to report any cases of suspected abuse of vulnerable adults or children.
- Only 79% of staff had received training in adult safeguarding but 93% had attended safeguarding children training (June 2014). The trust acknowledged that there were problems with safeguarding training and had a lead nurse who was undertaking this.

## Mandatory training

- We saw that mandatory training had been 98% completed by the staff in the Critical Care Centre. Staff in the critical care team had also completed a range of training in competencies and certificates, such as for the care of the critically ill child.
- There was a part time nurse clinical educator employed in the team who spent time supporting staff, supervising in practice and providing training sessions specific to critical care.

## Management of deteriorating patients

- We observed care in the unit, and reviewed documentation. We saw that patients were well managed. We saw that documentation was designed to guide staff in the assessment of patients and planning of discharge.
- Staff made very detailed assessments of patient's needs and risks to their health and welfare. This included data collection related to infection, skin integrity and nutritional status. Records were available to prompt staff in managing patients admitted with learning disabilities.
- There were separate staff in the unit who provided an outreach service, supporting critically ill patients in other ward areas to reduce the likelihood of admission to the Critical Care Centre, or co-ordinating admission to the centre where required. This was a service provided seven days from 8am to 8pm.
- The specialist outreach staff in the centre had developed a policy for the use of early warning scores and the management of deteriorating patients. This was part of the service provided to the ward areas. The service included undertaking audits of the use of early warning scores and providing feedback to ward teams.
- Escalation and management of deteriorating patients in the critical care unit was through close monitoring and management of all critically ill patients. The nursing staff and junior medical staff had clear routes to escalate to the consultant staff for the unit.

## Nursing staffing

- We checked staffing levels against recommendations of The Intensive Care Society Core Standards 2013. We found that there were appropriate levels of staff. There are five level 3 beds and four level 2/1 beds. These beds are used flexibly depending on patient need. Three of these beds are nominally coronary care beds. The expected number of staff per shift is six registered nurses and one healthcare assistant on a day shift and five registered nurses and one healthcare assistant on a night shift. At times when coronary care patients were also in the unit the staff levels could be approaching capacity. On the second day of our visit this was the case for the morning shift but additional staff were scheduled for the afternoon, the following three nights and days to ensure safety. The matron for the unit and clinical educator were not counted in the nurse staffing and so

# Critical care

initial contingency for increased patient dependency could be covered by these staff undertaking clinical duties. We observed this was the case on the second day of our visit.

- At times when the safe capacity was likely to be exceeded the contingency arrangement of non clinical transfer to another critical care centre would be put into action.
- There was a good skill mix on the unit, with 60% of staff being specialist trained registered nursing staff. There was a matron on the team, and a part-time clinical educator which was a good ratio for the number of staff employed.
- Staff told us that it was difficult to secure the services of specialist agency staff if they needed to supplement staff levels, for example, due to sickness.

## Medical staffing

- The service was covered by four intensive care consultants. Consultant anaesthetist cover was 24 hours a day, seven days a week. Cover was maintained and supported by cardiologists when coronary care patients were in any of the three allocated beds.
- There was medical cover for the coronary care beds situated alongside the unit, including cardiology input. There were no medical staff trainees in the unit, but escalation of problems from the FY1 doctor was effective.
- Intensive care medical staff took responsibility for management of coronary care patients in the aligned unit at times. Cardiologists were available to support when both units were full, and the pace of work was very heavy to cover medical reviews and management across both areas.

## Major incident awareness and training

- Staff were aware of the major incident plan for the trust. This was available on the trust intranet. We found that the policy document was up to date but there was insufficient detail to guide CCC staff during an incident. There were no ready printed action cards for individuals in the critical care unit to follow in an incident. The policy had only limited information to advise staff in the CCC what action to take in case of major incident. Staff told us about the training events which were common for all staff in the trust, but this training did not include

any specific guidance for CCC staff. The CCC could be an essential part of the major incident response for the trust but it was not clear how this facility would be prepared to manage critically ill patients.

- There were training events which were common for all staff in the trust.

## Are critical care services effective?

Good



Critical care services were effective. Audits showed that patients were more likely to have better outcomes within the critical care centre than other areas of a similar size. However audits also showed that the level of dependency of patients admitted was lower than other units of a similar size. We saw good multidisciplinary working, using clear guidance and protocols, which led to good outcomes for patients. Some patients had longer admissions in the centre than required, due to limited bed availability on other wards. However, longer stays in the centre could mean that patients took longer to return to their usual level of mobility and independence.

## Evidence-based care and treatment

- The Critical Care Centre submitted data for national audit and performance review, such as Safety Thermometer and Intensive Care National Audit and Research Centre (ICNARC) reports.
- Staff had developed policies for different types of ventilator support for patient's breathing, both in the Critical Care Centre or in other ward areas.
- We saw that care bundles were used to ensure effective assessment of risk for ventilated patients, tracheostomy, central venous and peripheral infusion sites, urinary catheters and skin care. Documentation showed that staff checked these care requirements twice each day to promote safety and reduce the likelihood of infection.
- When children were admitted to the Critical Care Centre, the care was provided in close collaboration with the specialist paediatric service, which would then rapidly have taken over the care as the child was transferred to a specialist children's intensive care unit.

## Pain relief

- Staff kept close monitoring on sedation rates for level 2 and 3 patients who were under the care of the anaesthetists.

# Critical care

- The pain specialist nurse was available as required to support patients post-operatively in all ward areas.

## Nutrition and hydration

- Critical care included detailed management of patient's nutrition and hydration, dependent on the needs of the patient. Pharmacy staff supported decision-making about route of administration of medications. Daily checklists included checking the cleanliness and integrity of feeding lines and equipment.
- Patients were given detailed advice, for after the critical phase of their illness, to promote recovery.
- Staff told us that support for kidney function was used regularly as part of the care provided to critically ill patients.

## Patient outcomes

- Latest ICNARC data shows that most patients admitted to the unit were level 2 patients although a quarter were level 3 requiring the most support from the critical care team.
- ICNARC and APACHE II data both show that mortality in the unit is below the national average meaning that patients survive better at Hinchingbrooke Hospital.
- The average length of stay for a patient in the critical care centre was around 5 days but there were generally higher number of delayed discharges when compared to similar units.
- In recent months there had been no unit acquired infections which meant that patients could expect better outcomes.

## Competent staff

- We spoke with the clinical educator, who told us that 57% of staff had had their appraisal in the last year, but this is in the context of a new appraisal system. All appraisals had been completed in the previous year.
- Staff had packages of training and checks to follow, to evidence their competence with technical skills required in their role.
- Staff were able to access specialist training through Anglia Ruskin University, and shared with other hospitals in the area.

## Multidisciplinary working

- The availability of the microbiology service was limited at the time of our visit. Due to staff leaving the microbiology service was provided by locum cover at the time of our inspection. This meant that there had

been no microbiologist on multidisciplinary discussions and patient planning, and no visits to the unit by microbiologist to review practices and advise on sepsis issues.

- Pharmacy staff supported team discussions about appropriate medication for patients in the centre. The pharmacist provided advice and checks on compatibilities of drugs including reviewing overall medication treatment. In addition the staff used the advice of an antibiotic specialist pharmacist.
- The staff in the unit also provided an outreach service. The service was delivered to high standards and used current guidelines.
- The trust resuscitation officer was based in the Critical Care Division and pain control specialist nurse supported when needed for post-operative patients

## Seven-day services

- The outreach service was provided seven days per week, from 8am to 8pm.
- Staff told us that consultants were available to support the care of patients at all times.
- The service was able to order X-ray imaging out of hours, but this could be delayed as there was only one radiographer available out of hours for the hospital site. Staff did not give this as a current problem.

## Are critical care services caring?

Good



The service was caring. Patients and relatives told us that they were cared for with compassion and dignity. The service had a follow-up clinic, at which patients were offered a range of support to help them rehabilitate following the trauma of needing intensive medical care.

## Compassionate care

- We saw that care was provided in a compassionate way in the approach to patients and relatives.
- We observed that although there was limited space in the Critical Care Centre, staff were careful to preserve the patient's dignity and privacy as much as possible.
- Two relatives told us that they had been very anxious when the patient had been in accident and emergency and the admission unit, but felt relaxed and well

# Critical care

supported when the patient was in the Critical Care Centre. They said that staff had provided good information, had been very caring, and the facilities were excellent for caring for the patient.

## Patient understanding and involvement

- Patients told us that care in the critical care unit was very good. They said there was good information provided about the service and about their condition.
- We observed staff working very closely with family members and patients on admission, explaining the care processes and allowing them time to ask questions. Patients and relatives told us they felt very well supported in the unit compared to their anxiety when passing through other departments and wards prior to admission onto the CCC.

## Emotional support

- There was open visiting to the unit for relatives, to promote continued communication with relatives and patient although critically ill.
- Patients who had a prolonged admission to the Critical Care Centre were offered a rehabilitation service provided by a consultant and nurse. The clinics provided follow-up support to patients after discharge, and this included support for emotional needs after critical care or traumatic experience. This was a well-established and comprehensive package of support. Feedback from patients was posted in the unit for staff to view. Staff had taken note that some patients had been disturbed by the general level of noise in the unit.

## Are critical care services responsive?

Good



The unit was responsive to patients' needs. Patients in critical care were provided with a comprehensive package of care following a detailed assessment of needs. Children were cared for in urgent situations prior to transfer to a specialist service.

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

- We found that the staff of the critical care centre were flexible in managing the patients requiring this additional intensive care. When cardiology patients

were in the three allocated beds there was additional support used from cardiology medical staff. In addition the nursing staff could be supported by the matron and clinical educator if required. We saw on the day of our visit that another manager with clinical background in intensive care was also supporting for a short period.

- The unit had nine open critical care beds. Between January and March 2014 the average bed occupancy rate for adult critical care beds in Hinchingsbrooke Hospital was 98%.
- We saw that training in the unit provided by the clinical educator had included discussion about mental capacity and supporting vulnerable patients and families through an admission to the critical care centre.

## Access and flow

- Admission to the unit was predominantly an unplanned event from the other ward areas or emergency admission. Over half the patients did not receive a visit by the critical care team prior to admission to the unit. Around a third of patients were seen by the outreach team prior to being admitted to the critical care centre. Patients from ward areas that had deteriorated were seen by the outreach nursing team or medical staff from the critical care centre.
- The problems of discharge from the unit meant that some patients stayed for longer than would be usual on an intensive care unit. This was due to the pressure on beds throughout the hospital. This meant that patients who were ready to be moved to a normal ward area had to stay in the Critical Care Centre. In view of the cramped environment and lack of toilet or shower facilities, the unit was not appropriate for continued rehabilitation once the patients had recovered from a critical phase of illness. This meant that patients who had recovered sufficiently to be able to use a bathroom continued to have washes and use a commode by the bedside. This could delay rehabilitation and recovery.
- The limited space and lack of toilet facilities meant that movement of patients through the unit, and using the commode, could result in patient's privacy and dignity being difficult to protect. There were three side rooms with all other bed spaces being in line of sight of each other. This promotes a high level of observation by all staff. We saw that staff made efforts to protect dignity by using curtains as needed and respecting privacy when curtains were drawn.

# Critical care

## Meeting people's individual needs

- The outreach service was provided seven days per week from 8am to 8pm. This meant that patients with complex needs could be reviewed rapidly, and assessed for management in the ward, or admission to the Critical Care Centre if required.
- The Critical Care Centre provided care for children. This was usually for a short period until paediatric care could be arranged at a more specialist unit. Staff told us that it was unusual to care for a sick child for more than eight hours. In such cases, a paediatric-trained consultant and nursing staff would be in attendance. We saw that staff had all been trained in advanced paediatric life support and related qualifications.
- The service provided follow up to patients to support rehabilitation after being in intensive care.
- To support patient's recovery after discharge they were provided with a detailed booklet, with a wide range of information to help understand the effects on them of being in intensive care. The booklet included advice on exercise, nutrition and sleep pattern or mood changes.

## Learning from complaints and concerns

- The views of patients were used to discuss patient stories and inform future practice on the unit.
- We saw that there were very few complaints. Staff actively sought the views of patients. We observed staff discussing care with family members and patients on admission. We spoke with family members after this and found they felt able to ask questions about the service.

## Are critical care services well-led?

Good



The service was well-led because there were clear working arrangements that promoted consistent provision of care. There was a strong multidisciplinary approach to the service, and staff told us they were valued as part of the work of the team.

## Vision and strategy for this service

- The future of the unit, when in the new build facility, was not clearly described. Staff we spoke with were unaware of the plans for the unit. The trust stated that were plans

for ten beds in the new unit. New cardiology consultants were considering plans to place cardiology beds in other ward areas which would reduce the dependency on the intensive care service.

## Governance, risk management and quality measurement

- Key performance indicators were discussed in the unit by the clinical lead, head of nursing and business manager. The key issues were reported through to the integrated governance committee. We heard discussion at the meeting about the issues that critical care centre were having discharging patients back to the ward areas. However the clinical lead did not receive support from this panel in undertaking any action to resolve this issue.
- The combined theatre and critical care risk register had only one item on it relating to critical care areas. This related to the availability of an anaesthetist to attend any cardiac arrests in the hospital. Whilst action had been identified to be taken the review of this risk was set for June 2015.
- ICNARC data was collected and submitted in a timely manner. This showed that the outcomes for patients on the critical care centre were positive.
- Safety Thermometer data was used to enhance outcomes and improve the quality of care for patients admitted to the critical care centre.
- Staff said they had not used the 'stop the line' process but that in the specialist unit they raised issues and discussed clinical decisions as part of their professional role in managing critically ill patients whose condition could change rapidly.

## Leadership of service

- There was a consultant lead from the unit on the trust board. This meant close links between clinical activity, and the executive group who managed strategic planning, for the trust overall, and the intensive care service specifically.
- The care for critically ill patients was a network arrangement of all the clinical professionals involved. We saw that specialist staff were proactive in developing protocols and monitoring the adherence to agreed guidance.
- We saw that the unit Matron was approachable and credible with staff including taking clinical duties when required to support staff.



# Critical care

## **Culture within the service**

- Staff told us that there was strong multidisciplinary working in the service, and that they felt they could raise issues and suggestions when needed. There was good collaboration between consultant staff to ensure safe management of patients.
- We observed there was a good atmosphere in the unit with staff providing views openly and discussing patient care and organisational issues with the Matron and medical staff.

## **Public and staff engagement**







- Staff told us that their views were sought regarding service planning and development. They said they had been included in the commissioning of the new department.

- We saw that patient feedback from the post discharge clinic was being recorded on a display board in the CCC. Some patients had commented about noise which had led to the purchase of quieter pieces of kit such as quiet closing bins.

## **Innovation, improvement and sustainability**

- There was a potential risk to sustainability given the current staffing availability to provide the overall consultant, medical and nursing cover when the new facility was opened.
- Medical staff told us that it was their intention that in the development of the new critical care unit in early 2015 there would also be some monitored beds allocated within other ward areas. This would clarify the role for the critical care service in the new build facility. These plans were not finalised yet.

# Maternity and gynaecology

Safe	Good	
Effective	Good	
Caring	Good	
Responsive	Good	
Well-led	Good	
<b>Overall</b>	<b>Good</b>	

## Information about the service

The maternity service at Hinchingsbrooke Hospital includes births at home, and births at the hospital, offering both high risk (consultant-led) and low risk (midwife-led) packages of care to women. The hospital managed 3,218 hospital births and 96 home births since April 2013.

The inspection team included one inspector, a specialist midwife nurse adviser and a consultant obstetrician adviser. During our inspection; we spoke with 41 staff, seven patients and three partners. We visited the antenatal and postnatal wards, early pregnancy and day assessment unit, gynaecology and labour wards. We received comments from our listening events, and from people who contacted us to tell us about their experiences. We used information provided by the organisation and information that we requested, which included feedback from young people and women using the service about their experiences.

## Summary of findings

The current level of maternity services provided to women and babies by Hinchingsbrooke Hospital were good. The maternity unit provided safe staffing levels and skill mix, and encouraged proactive teamwork to support a safe environment. We saw that there were arrangements in place to implement good practice, learning from any untoward incidents, and an open culture to encourage a focus on patient safety and risk management practices. The trust is working towards achievement of Level 2 Unicef's Baby Friendly Initiative

All permanent staff were appropriately qualified and competent to carry out their roles safely and effectively in line with best practice. There were detailed and timely multidisciplinary team discussions and handovers, to ensure women and babies care and treatment was co-ordinated and the expected outcomes were achieved. Staff in all roles put effort into treating women with dignity, and most women felt well-cared for as a result. Staff in the hospital and community were flexible in working practices and responding to the needs of women and babies. We found the midwifery leadership model encouraged co-operative, supportive relationships among staff. Staff reported that the managers and supervisors ensured that they felt respected, valued, supported and cared for. Staff contributions and performance were recognised and celebrated.

# Maternity and gynaecology

## Are maternity and gynaecology services safe?

Good 

The current safety of maternity service provided to women and babies by Hinchingsbrooke Hospital was good. The trust provided safe staffing levels and skill mix, and encouraged proactive teamwork to support a safe environment.

There were arrangements in place to implement good practice, learning from any untoward incidents, and an open culture to encourage a strong focus on patient safety and risk management practices. Staff had identified the things that were most important to delivering safe care in their area, and had established standard operating procedures that reflected national and professional guidance.

### Incidents

- We looked at incident reporting policies, a database which included maternity incidents raised by staff, and safety meeting minutes, and found that there were arrangements in place for reporting patient/staff safety incidents and allegations of abuse, which were in line with national guidance.
- We found maternity services current incident reporting system was part paper-based and part electronic, and separate from the rest of the organisation. We were advised that the reporting system was being upgraded to Datix in the near future, to ensure a consistent, effective approach across the trust.
- There were 897 maternity incidents reported in the last year. The five top incidents were shared with staff and action plans to reduce the risk of reoccurrence were highlighted in the clinical risk management bulletin July 2014 such as :an increase in sampling incidents resulting in fail safe clerks employed to monitor, report and action sample issues also increased monitoring and case reviews due to the numbers of unexpected admissions to special baby care unit (SCBU)..
- We saw minutes from the Monthly Perinatal Mortality Meetings which showed discussions and case reviews by multi-disciplinary teams to consider any changes to practice to improve outcomes for patients.

### Safety thermometer

- The maternity unit was open in their reporting practices. We saw the clinical performance dashboards for obstetrics such as Venous Thrombosis Screening (VTE), numbers and types of births, 3rd and 4th degree tears, post-partum haemorrhage (PPH) and sepsis numbers were reported. We saw that the VTE quality assessment reports June 2014 were satisfactory. Clinical risk management bulletins were also displayed for staff reference, and key performance indicators, such as infection control practices were on the information boards for the public. The risk lead midwife could show actions being taken where results were outside of the standard such as increased PPH numbers where quarterly audits and increased staff education were highlighted to ensure early recognition and appropriate management of the mother.
- We saw staff had access to guidelines and risk management meeting minutes on the intranet and the head of midwifery noted weekly senior clinical meetings were actioned to review all adverse deliveries and update staff to ensure appropriate practice changes were implemented where required.
- There was a programme of risk based audit carried out to monitor adherence with the standard operating procedures. We saw that action was taken as a result of findings, such as “inadequate information for formula feeding mothers” - Action for staff to note it is mandatory that mothers have 1-1 discussion/demonstration

### Cleanliness, infection control and hygiene

- We found no concerns during the inspection of the maternity unit. Ward areas appeared clean and we saw staff regularly wash their hands and use hand gel between patients. 'Bare below the elbows' and isolation policies were adhered to. A recent hand hygiene audit scored 100%, and 'I am clean stickers' were on equipment.
- We looked at a recent reported infection outbreak, and noted appropriate actions taken to safeguard patients. There was good staff awareness regarding practices implemented to manage the situation recorded in risk bulletins and risk registers.
- Hand hygiene audits showed that the unit was awarded 100% for hand washing.

# Maternity and gynaecology

## Environment and equipment

- There were adequate storage facilities and levels of equipment for safe monitoring of women and their babies.
- Resuscitation equipment was in line with national guidance and checked regularly. We raised with the provider concerns regarding the distance of the resuscitation trolleys to some key clinical areas. The trust confirmed that it had undertaken time tests and that all trolleys were accessible within three minutes.

## Medicines

- Staff we spoke with were aware of medicine management policies for reference purposes, and monitoring systems were in place to pick up medication errors.
- We saw that locked drugs cabinets were in place for controlled drugs, we noted that some intravenous fluids were stored in unlocked cupboards, and we reported this to the trust at the time. The trust reported that they were awaiting delivery of digital locks and have replaced all locks with digital lock to ensure security of these areas. The trust states that these are now in place.

## Records

- The record system included the use of nationally-recognised medical records, which was noted as good practice.
- Maternity Notes were reviewed, and we found they included physical risk assessments, which were completed to safeguard patients.
- We saw that records were handled safely to support data protection practices.

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

- We saw good consent practices in line with national Royal College of Obstetricians and Gynaecologists (RCOG) guidelines. Patients told us that they were well informed regarding the risks, such as for elective caesarean sections and the use of epidurals. Partners told us that they felt involved where necessary in the decision-making process.
- We noted that Mental Capacity Act and Deprivation of Liberty Safeguards (DOLS) awareness was currently not included in the Trust induction or mandatory training programme for clinical staff although some midwives said they had received awareness training in capacity management

- It was reported that there was a vulnerable women's lead midwife who worked closely with the mental health teams to pick up mental capacity issues. We saw a list of vulnerable women highlighted for additional support in the clinical office for staff reference.

## Safeguarding

- We found that the trust identified the things that were most important to protect people from abuse and to promote safety. There were effective safeguarding policies and procedures on the intranet for staff reference, which staff we spoke with were fully aware of and could explain the reporting process where concerns were raised.
- The training records showed that appropriate safeguarding training was being provided. The provider had a flagging system to show when staff were due for refreshers, and there was current compliance with trust policy at 86%.

## Mandatory training

- Mandatory training was regularly monitored, with triggers in place to pick up non-attendees. The current levels were 85%, and staff noted the content was appropriate.

## Management of deteriorating patients

- Staff knew how to activate escalation processes, which work well; for example, drafting in additional staff to cover increasing levels of demand, or responding to warning signs of rapid deterioration of patients.
- The maternity department knew how to escalate concerns about women having difficult labour and figures confirmed that the number of interpartum transfers out of the unit was within accepted limits.
- All staff knew what to do in an emergency situation, and praised the introduction of blue (need for paediatrician) and yellow (paediatrician not required) emergency codes, to ensure that the right people were present to support where needed, which increased the confidence of the team.

## Midwifery staffing

- Midwife to birth ratio is 1 to 28 births; when management and specialist midwives are included this rate improves further to 1 to 25 births. Staff gave examples of increased staff numbers when demand was high, such as calling community midwives into the hospital, and that managers were responsive to

# Maternity and gynaecology

changing needs and circumstances, such as cover for long-term sick leave or study leave. There were on-call community midwives for home births, and emergency care each night.

- Ratio of supervisor of midwives to midwives was 1-15, which meets the national standard.
- We saw that midwifery staff were confident that managers ensured the right staffing levels and skill-mix across all clinical and non-clinical functions. Managers told us that currently there was a high level of maternity leave amongst staff, which continued to impact on midwifery services. The midwifery-led birthing unit does not currently have a dedicated team because of this.
- We saw staffing levels displayed for patient reference, which was good practice. Most patients we spoke with were very positive about the approach to safe care on the unit.

## Medical staffing

- Doctors we spoke with noted that the right medical staffing levels and skill-mix across all clinical disciplines were sustained at all times of day and week, to support safe, effective patient care and levels of staff wellbeing. There was 60 hours consultant cover, with full on-call support out of hours and at weekends. We saw that the medical staffing for the unit was appropriate for the current levels of activity.

## Are maternity and gynaecology services effective?

Good 

There was good evidence of research and an ethos of shared learning. National guidance was being implemented, and monitoring systems to measure performance were in place. Care was consistently delivered in line with evidence-based, best practice guidance and professional standards. Patient outcomes were within normal parameters; there were no outliers raised in the data packs when benchmarking against other trusts nationally.

All permanent staff were appropriately qualified and competent to carry out their roles safely and effectively in line with best practice; we saw good examples of succession planning to develop staff. The number of staff receiving continual professional development and clinical

supervision was satisfactory; the appraisal rates were improving. There were detailed and timely multidisciplinary team discussions and handovers, to ensure patients' care and treatment was co-ordinated, and the expected outcomes were achieved. There was good collaborative working with partners and other agencies.

## Evidence-based care and treatment

- The provider had funded posts for a research lead midwife and practice development midwife. Audit outcomes were presented regularly through the clinical risk management bulletin for practice developments such as: Bereavement Services in maternity services SANDS which indicated the need for additional multidisciplinary staff training. Another example was Supplements given in clinical practice-Baby friendly initiative which highlighted limited uptake in antenatal hand expressing.
- Staff showed us that there was a process for identifying relevant legislation, current and new best practice, and evidence-based guidelines and standards, in line with Royal College of Obstetricians and Gynaecologists (RCOG) guidelines (including Safer Childbirth: minimum standards for the organisation and delivery of care in labour). These were then reviewed and approved through appropriate channels before being implemented.
- We spoke with one doctor who had recently become the Strategic Clinical Network Lead for high risk obstetric care within the Eastern Clinical Research Network (CRN: Eastern), and will lead the development of CRN: Eastern clinical activity within this specialty; to encourage local clinicians across the region to participate in clinical research network portfolio studies, build upon local clinical strengths, and research interests and priorities, which was noted as good practice.
- Staff had identified the things that were most important to delivering safe care in their area, and had established standard operating procedures that reflect national and professional guidance, which included, infection control practices, information management and World Health Organization checklists, amongst others.

## Pain relief

- A range of options were available to help patients cope with pain, ranging from self-administered entonox, to a 24-hour epidural service. Patients told us that their pain was managed well.

# Maternity and gynaecology

## Patient outcomes

- There was strong evidence of local and national audit activity, with staff reporting tools such as risk bulletins, and risk and integrated governance meeting minutes on practice changes to improve outcomes for patients. Staff we spoke with were well informed on evidence-based care and new treatments, such as the introduction of complementary therapies to help stimulate labour and reduce anxiety in post-date patients.
- The trust had a better than the England average number of caesarean section births at 7%. The national average is 10%. Emergency caesarean section rates were also lower at 12% rather than 14% nationally. This meant that more women were able to give birth naturally.
- Readmissions to the maternity and neonatal units and the rate of Puerperal sepsis and other puerperal infections were within normal parameters; there were no outliers raised in the data packs when benchmarking against other trusts nationally. Outcomes were clearly displayed on the electronic ward boards, such as the number of natural births and caesarean sections monthly.
- There was ongoing monitoring of the top risks, such as third and fourth degree tears and post-partum haemorrhage; and support was provided from the supervisors of midwives regarding practice developments to improve outcomes for patients.
- Breastfeeding initiation rates were 82%, although this dropped below national levels to 55% in August 2014 at discharge. Additional initiatives were being encouraged to improve this.

## Competent staff

- Staff told us that no agency staff were used currently and the bank is made up of trust staff. All permanent staff were appropriately qualified and competent to carry out their roles safely and effectively in line with best practice. Staff told us that there were effective induction programmes, not just focused on mandatory training, for all staff, including students and midwifery care assistants. We were shown competency-based assessments, which all midwives are required to complete. We looked at the annual maternity two day update programmes, which included updates in service-specific care, such as infant feeding, and care of diabetes, and noted that the current rate of attendance

- was 93% of midwives and 84% of doctors. Specialist lead posts were actively encouraged, such as specialist midwives caring for women with gestational diabetes and providing breastfeeding support.
- The provider had mechanisms in place to ensure appropriate levels of supervision and appraisal of all staff, and revalidation of doctors. The appraisal rate across the division was under target at 63%, as a new system was being put in place.
- Students and midwives confirmed that training was provided as part of the local induction process, and also through the Acute Deteriorating Patient Course (ADP), life support programmes and patient transfer courses.

## Multidisciplinary working

- We saw examples of stakeholder events, such as Cambridgeshire and Peterborough CCG 5 Year Strategy; Children and Maternity Stakeholder Conference in June 2014. The event achieved the objectives set, which were to engage effectively with a wide range of stakeholders and to put in place a review process across three regional maternity units to shape future pathways of care.
- Staff we spoke with, including community midwives and students, were aware of the midwifery strategy and the importance of joined-up working with health visitors, GPs and school nurses, to support patients care pathway, both in hospital, and back in the community.
- We found by observing ward areas, and listening to focus groups and individual doctors, midwives, support workers and administration staff, that there were detailed and timely multidisciplinary team discussions and handovers, to ensure patients' care and treatment were co-ordinated, and the expected outcomes achieved. Care and treatment plans were recorded and communicated with all relevant parties to ensure continuity of care.
- Doctors and midwives confirmed good working relationships with the staff in the special baby care unit which is run by Cambridgeshire Community Services NHS Trust. Meetings and handovers were patient focussed and integrated to include smooth transfer processes.

**Are maternity and gynaecology services caring?**

# Maternity and gynaecology

Good



Staff in all roles put effort into treating patients with dignity, and most patients felt well-cared for as a result. The majority of patients we spoke with, and those close to them, were encouraged to be involved in their care, treated as equal partners, listened to and were involved in decision-making at all levels.

There were positive views from a breadth of patients and those close to them about the care provided, which were supported by the views of the staff. Care was women-centred, and parents sensitively supported where bereavement occurred. The provider encouraged lead specialist midwives to develop services, such as complementary therapies to induce labour and reduce anxieties.

## Compassionate care

- The majority of patients told us that staff responded compassionately to discomfort and emotional distress in a timely and appropriate way. However, we did receive a significant complaint regarding breastfeeding support and staff attitude during the inspection, which had been highlighted previously in the maternity survey. The trust is working towards achievement of Level 2 Unicef's Baby Friendly Initiative and recent audits undertaken to support that process have demonstrated good breast feeding support and staff attitudes.
- There were concerns around the NHS Friends and Family Test (FFT) returns (numbers) from patients in maternity. There were action plans to improve this, including more training into FFT for maternity services. However actual scores in all three sections, antenatal, postnatal and birth, were above the England average at 76, 76, 84 respectively. Results obtained showed that 75-84% of women were extremely likely to recommend the service, as of July 2014.
- In the 2013 Maternity Survey the hospital scored above average in the question relating to women being treated with dignity and respect. In all other aspects the hospital was rated as average. We saw good examples of staff interacting well with patients and partners and that there was consideration for privacy and dignity requirements during the inspection.

## Patient understanding and involvement

- Patients told us that they were involved in decision-making, and understood the care and treatment they received. The vast majority were positive regarding the professionalism and support provided by the clinical and non-clinical staff.
- We saw evidence of feeding and antenatal education, the initiation of feeding, and ongoing support for parents. Patients told us that they were offered a tour of the facilities prior to birth to help their understanding and involvement.

## Emotional support

- Patients were aware of 24 hour access to advice from the midwives, and one-to-one care throughout labour, and we saw there was good chaplaincy support for multiple faiths. One patient admitted for bed rest complimented the calm caring approach of the staff who reduced her anxiety on admission.
- There was a bereavement midwife in post, and staff were familiar with bereavement protocols and counselling support opportunities for parents where required.

## Are maternity and gynaecology services responsive?

Good



The responsiveness of the maternity service was good. There were good mechanisms for information sharing with external commissioners and stakeholders, to provide co-ordinated and integrated pathways of care. Staff in the hospital and community were willing and flexible in working practices around responding to the needs of patients.

People who use the service were asked about their spiritual, ethnic and cultural needs, and their health goals, as well as their medical and nursing needs. Their care and treatment was planned and delivered to reflect these needs, as appropriate. The provider was open and transparent about how it had dealt with complaints and concerns, and the managers were aware and action plans were in place to encourage improvement based on patient feedback.

# Maternity and gynaecology

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

- The delivery unit has 10 dedicated birthing rooms, including a birthing pool. There are also a variety of mats, cushions and birthing balls to assist with mobility and comfort in the early stages of labour.
- We saw, through minutes of meetings and responses from focus groups, that the provider encourages engagement with commissioners of maternity services, health visitors, school nurses, GPs, relevant groups, people who use services and those close to them, to provide co-ordinated and integrated pathways of care for pregnant women.
- Doctors and midwives confirmed good working relationships with the staff in the special baby care unit, which is run by Cambridgeshire Community Services NHS Trust. Meetings and handovers were patient-focused and integrated to include smooth transfer processes. There were service level agreements in place to support the service, but further development was required, as parts of the current practice rely on goodwill as opposed to formal undertaking. The trust told us that the service level agreement with the trust providing paediatric cover is to be reviewed as working practices have altered since its last review two years ago.
- Open days had been actioned, which included question sessions with consultants, and tours of the wards to ensure women were aware of the services provided in the maternity unit at Hinchingsbrooke Hospital. The unit is currently working towards Unicef's Baby Friendly Initiative award at level 2, which requires demonstration that all staff are educated to the same standard and continually audit services to promote and sustain breastfeeding.

## Access and flow

- Hinchingsbrooke Hospital's MDAU (Maternity Day Assessment Unit) is an outpatient assessment area for pregnant women who have antenatal concerns, including reduced foetal movements, raised blood pressure and/or protein in their urine. We spoke with a pregnant woman admitted for monitoring, who was impressed with the access and timely admission.
- There was a lead midwife, who worked jointly with health visitors and mental health services to ensure appropriate services were available for vulnerable

women. Community midwives we spoke with told us that services provided in the community were flexible enough to fit in with people's lives where possible, such as work and family commitments.

## Meeting people's individual needs

- People who use the service were asked about their spiritual, ethnic and cultural needs and their health goals, as well as their medical and nursing needs. Their care and treatment was planned and delivered to reflect these needs, as appropriate. Women told us they were encouraged to reflect their wishes for birth in the birth plan. A recent initiative was to support partners staying on the units where requests were made, with the consent of other patients if in a shared environment.
- Verbal, electronic and written information that enables patients to understand their care, was available to patients and their relatives in ways that met their communication needs. The provider ensured that the needs and wishes of people with a learning disability, or of people who lack capacity, were assessed and monitored appropriately. The hospital has a learning disabilities liaison nurse to support people whilst in hospital, and also in preparation for discharge back into the community. There were also interpreting services available.
- The clinic organisation and counselling support for women undergoing termination of pregnancy was good. Outpatient care for medical termination of pregnancy was also good; however, where day-case or inpatient care was required for early pregnancy problems, and medical or surgical termination above nine weeks, the service did not always ensure appropriate placement in a planned gynaecology bay to support these patients' needs sensitively. We understand that the provider is currently reviewing provision to improve this. Disposal of foetal tissue was in line with national guidance.
- Specialist clinics with lead specialist midwives, including diabetes, foetal medicine, and pre-operative assessments, were available to support patients.
- A complementary therapy service had been introduced to induce the labour of women whose pregnancy has post dates in order to avoid medical induction of labour.
- A birth afterthought service is offered to support women and families post fetal loss, during pre pregnancy



# Maternity and gynaecology

planning and the ante natal period and post birth. Vaginal birth after caesarean section (VBACS) clinics were available to support women in their care pathway

## Learning from complaints and concerns

- People we spoke with knew how to raise concerns or make a complaint. Staff told us that they encouraged people who use services, those close to them, or their representatives, to provide feedback about their care, although we noted response rates were low. Complaints procedures and ways to give feedback were available.
- We saw in recent meetings in August 2014 that complaints were reviewed to encourage learning. The attitude of some members of staff had been highlighted as a concern, which was corroborated by a patient we interviewed during the inspection. The managers were aware and action plans were in place to encourage improvement.

## Are maternity and gynaecology services well-led?

Good



The majority of maternity staff understood the corporate vision, and also the maternity strategy for developing the services at Hinchingsbrooke Hospital. Risks at team and management level were identified and acted upon, and staff recognised their role within the risk management system. The culture was open and transparent; staff were clear where they were performing well, but also fully aware of areas for improvement, such as breastfeeding rates.

We found the midwifery leadership model encouraged co-operative, supportive relationships among staff, and compassion towards people who use the service. There were good examples of staff and service user involvement in design and future developments for the maternity unit. Staff reported that the managers and supervisors ensured they felt respected, valued, supported and cared for. Staff contributions and performance were recognized, and celebrated, which is good practice.

## Vision and strategy for this service

- The senior executive team provided inspectors with a statement of vision and values encompassing key elements of the NHS constitution, such as compassion,

dignity, respect and equality, with quality a key priority. The majority of maternity staff understood the vision and strategy, and also the maternity strategy for developing the service.

## Governance, risk management and quality measurement

- We saw through meetings and staff consultation that risks at team and management level were identified and captured, and staff recognised their role within the risk management system. We saw examples of recommended actions such as for Post Partum Haemorrhage (PPH) -quarterly audits> 2000mls to ensure appropriate actions and lessons learnt were fed back via skills drills and mandatory training. Another concern was 48 incidents where non-compliance with policy was an incident cause. Non adherence and specific trends were identified in the clinical risk management bulletin July 2014 to raise staff awareness.
- Staff understood the views of patients about their care. Concerns or best practice were shared to improve performance. We saw a user-friendly women's health staff website, which provided full reports on risk meetings, quality assurance practices, strategies, the trust-wide 16 point plan for improvements, and practice changes.

## Leadership of service

- The staff reported positive leadership from the head of midwifery, who knew her staff, played to their strengths, and developed them as individuals within the midwifery service, which was noted as good practice.

## Culture within the service

- The culture was open and transparent; staff were clear where they were performing well, but also aware of areas for improvement, such as breastfeeding rates. There were no surprises; staff were consistent in what the key risks were, and this fitted with the current risk profile for the maternity unit.
- Staff showed us the "stop the line" procedure which anyone could initiate to stop and act immediately with the team to rectify problems. Staff we spoke with noted they would use if necessary but had not needed to initiate to date.
- Staff were consulted on service designs and upgrades to premises through multidisciplinary meetings, focus groups and emails. They were encouraged to be

# Maternity and gynaecology

involved in service developments, such as the design for a new bereavement suite, which also encouraged service user involvement, which was noted as good practice.







## Public and staff engagement

- The bereavement steering group encouraged service user attendance and participation in design and policies, as did the labour ward forum and Maternity Services Liaison Committee (MCSL) meetings, which was noted as good practice.
- We reported that the response rate to the Family and Friends Test was low; the results obtained showed that 75-84% of women were extremely likely to recommend the service, as of July 2014.

## Innovation, improvement and sustainability

- The trust is reviewing and considering alternative maternity IT systems, to improve information systems and records management, that are compatible with the patient delivery system in place currently. The community teams would also benefit, as their current electronic information systems were limited.
- The maternity service could demonstrate that they were monitoring capacity and forward planning. There had been a drop in delivery rates in the last year, and the commissioners are undertaking a 5 year planning review of the provision of maternity services across the three maternity units in their commissioning area.

# End of life care

Safe	Requires improvement	
Effective	Requires improvement	
Caring	Good	
Responsive	Good	
Well-led	Good	
<b>Overall</b>	<b>Requires improvement</b>	

## Information about the service

Hinchingbrooke Hospital provides end of life care throughout the trust, as there are no dedicated palliative care beds. The hospital has a dedicated palliative care team, which consists of three specialist nurses and a palliative care consultant. This team co-ordinate and plan care on the wards for patients at end of life, and are available Monday to Friday, 9am-5pm, excluding Bank Holidays. Out-of-hours consultant support is provided by the on-call medical consultant.

We inspected four wards where end of life care was provided; these were Apple Tree, Walnut, Juniper and Cherry Tree Wards. We also visited the bereavement centre, the chapel of rest, and the mortuary. During our inspection, we spoke with 15 patients and relatives, and 34 members of staff, including nurses, doctors, health care assistants, mortuary technicians, the chaplain, and staff in the bereavement centre. We also spoke with one of the specialist palliative care nurses and the palliative care consultant. We observed interactions between patients, their representatives and staff, considered the environment, and looked at care records. Before our inspection, we reviewed performance information from, and about, the hospital.

## Summary of findings

End of life care service require improvements as patients are at risk of not receiving safe or effective treatment that meets their needs. Do not resuscitate forms were not completed correctly, the palliative care team were over stretched which meant that staff were not effectively trained and patients did not receive the levels of care they could expect. These risks were not recorded on a risk register as there was not one specific to end of life care. We were told that there were no associated end of life care risks.

'Do not attempt cardio-pulmonary resuscitation' (DNA CPR) forms were completed, but a high percentage had not been appropriately signed by a consultant. In many instances, we found that DNA CPR decisions had not been discussed with the patient or their representatives. Assessments had not been completed when the reason given for not discussing decisions with patients was recorded as the patient lacking capacity. Documentation was found to be poor throughout the service. Ward staff training in end of life care was lacking, and no one we spoke to on the wards had advanced communication training, however the palliative care team did have this training.

The specialist palliative care team was well-led, and had worked hard to improve end of life care throughout the hospital. The team had put together a business case to increase staffing within the team, in order to ensure that

# End of life care

they could provide an equitable, effective and safe end of life care service, that was available 24 hours every day. The chaplaincy service provided outstanding care to patients and support to the nursing staff on wards.

Most of the hospital wards were providing end of life care and therefore this report should be read in conjunction with the medical care report.

## Are end of life care services safe?

Requires Improvement 

End of life care took place on general ward areas throughout the trust, and required improvement. The specialist palliative care team told us that they were under-resourced to be able to provide safe palliative care, and to roll-out education to equip staff on the ward to provide safe and effective end of life care. 'Do not attempt cardio-pulmonary resuscitation' (DNA CPR) forms were completed, but 10 out of 15 we reviewed had not been appropriately signed by a consultant. In many instances, we found that discussions relating to DNA CPR were not recorded. It was therefore difficult to ascertain whether DNA CPR discussions had taken place with patients or their representatives. We also found that these issues were not addressed on any risk register.

We found that staff had received very little or no training in relation to the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS), and assessments had not always been appropriately undertaken when a patient was said to lack capacity as a reason for not discussing DNA CPR decisions with them. There was limited information in care plans. End of life care training had only just been rolled out amongst staff within the trust, but the specialist palliative care team were struggling to meet demand with their current resources.

### Incidents

- We spoke with one of the specialist palliative care nurses about incident reporting in relation to end of life care. They said that they rarely reported incidents relating to end of life care, but gave an example of a time when they had 'stopped the line' because of poor standards of care.
- There was no risk register specific to end of life care, and the specialist palliative care team told us that there were no identified risks in end of life care. However, the specialist palliative care team also told us they were under-resourced and this could impact on the safety of end of life care throughout the hospital.

### Cleanliness, infection control and hygiene

- We saw that staff in the mortuary had sufficient access to personal protective equipment (PPE) and there were adequate hand-washing facilities.

# End of life care

- We saw that the mortuary was visibly clean.

## Environment and equipment

- Staff reported that equipment required to care for patients at the end of their life was available when it was needed. Ambulatory syringe drivers were not kept on the wards, but staff told us they could be accessed from the equipment library as required.
- The trust used ambulatory syringe drivers for patients who required a continuous infusion to control their symptoms, and these met the current NHS Patient Safety guidance. This meant that patients were protected from harm when a syringe driver was used to administer a continuous infusion of medication, because the syringe drivers used were tamperproof and had the recommended alarm features.

## Medicines

- The trust had a comprehensive anticipatory prescribing policy, and we were told by staff that patients who required end of life care were written up for anticipatory medicines. (Anticipatory medicines are medicines that are prescribed in case they are required.)
- The palliative care team gave advice on anticipatory prescribing when it was required.
- We saw that anticipatory medicines were prescribed when they were required.
- The National Care of the Dying Audit May 2014 showed that over half the patients treated by the trust were receiving PRN (as required) medication for the five key symptoms that may develop during the dying phase.
- The specialist palliative care team told us that medication could be accessed in a timely manner for patients who had expressed a preference to die at home.

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

- Throughout our inspection we looked at patient records. We found that in some instances, where DNA CPR decisions had not been discussed with patients, this was documented as being because the patient did not have capacity, and the reason given for this was that the patient was too unwell. We saw no evidence that a mental capacity assessment had been undertaken in any of the patient records we looked at.

## Records

- Information Governance training was included in the trust's mandatory training programme.
- We reviewed 15 'do not attempt cardio-pulmonary resuscitation' (DNA CPR) forms throughout four of the wards we inspected. We found that DNA CPR forms were not always completed in line with national guidance published by the General Medical Council (GMC). We saw that whilst all of the forms had been signed by a junior doctor, ten of the forms had not been countersigned by a consultant.
- We also saw that on nine occasions discussions about DNA CPR and levels of treatment had not been documented. Only on one occasion did we see that ceiling levels for treatment had been documented in the patient's notes. We were therefore unable to establish whether discussions about DNA CPR and levels of treatment had taken place with the patient or, where the patient lacked capacity, their representative.
- The trust undertook audits of DNA CPR forms. We saw the audit from September 2013 to September 2014. This audit showed that 66% of DNA CPR forms that had been completed had been discussed with either the patient or their family, and 41% of forms had a reason why no discussion had taken place with the patient or their family. This was well below the trust's expected standard of 100%.
- Ward staff were confused as to which documentation they should be using to care for patients at the end of their life

## Mandatory training

- The National Care of the Dying Audit (May 2014) scored trusts out of 20 for the continuing education, training and audit of staff in care of the dying. Eighteen per cent of participating organisations, including this trust, scored zero compared to an England average of seven. The trust has told us that it had, in the week of our inspection, implemented a training programme to address this deficit.
- End of life care training had not been included as part of the trust's mandatory training programme. However, the specialist palliative care team told us that end of life care was going to be included for all new starters, and that it was going to be mandatory, as of September 2014.
- Staff we spoke with on the ward areas told us that they would value more training on end of life care.

# End of life care

- The specialist palliative care team told us that they would like to provide more training but they also realised this was difficult due to under-resourcing within the team.

## Management of deteriorating patients

- The wards we inspected used a recognised early warning tool to identify when patients were deteriorating.
- Specialist support was available for staff on the wards from the specialist palliative care nurse when required. Out-of-hours support could be accessed from the consultant on-call.
- One of the specialist palliative care team told us that they review referrals, and urgent referrals were usually seen the same day.

## Nursing staffing

- The hospital specialist palliative care team at Hinchingbrooke Hospital included three specialist palliative care nurses, who were 2 whole time equivalents (WTE). These nurses supported ward staff, who were delivering end of life care.
- These nurses provided support from 9am until 5pm, from Monday to Friday. It was felt that this was insufficient to support the needs of patients requiring end of life care, and a review had taken place to assess the level of specialist palliative care nurses required to provide a good quality end of life care service. At the time of our inspection, a business case had been submitted for approval of another 2.5 WTE specialist palliative care nurses at the hospital, in order to enable specialist palliative care support 24 hours a day.
- Patients requiring end of life care were nursed on general wards throughout the trust. Staff told us that wards were regularly short staffed. One member of staff told us that they felt staffing levels were at a minimum and that this was affecting patient care.
- The wards used high numbers of bank and agency staff to fill gaps in the rota which put patients at risk of receiving care that was not consistent.
- One of the specialist palliative care team told us that there were generally issues on a Monday morning following no specialist cover over the weekend.

## Medical staffing

- The overall care of each patient was managed by the consultant who was relevant to each patient's condition.

- There was a 0.5 WTE specialist palliative care consultant, who covered three sessions per week at Hinchingbrooke Hospital. When the specialist palliative care consultant was on annual leave or sick leave, there was presently no specialist cover at this level. It was felt by the palliative care consultant that medical cover for the palliative care team was insufficient, and a review had taken place to assess the level of medical staffing required to provide a good quality end of life care service. At the time of our inspection, a business case had been submitted for approval for another specialist palliative care consultant to cover another five sessions at the hospital.
- Specialist palliative care advice about symptom control was not available out of hours. Out-of-hours advice about symptom control was available from the consultant on-call rota, which covered several hospitals

## Major incident awareness and training

- The mortuary technicians told us that they had a contingency plan in the event that the mortuary became full. The trust had an agreement with another hospital and with a local undertaker, and was aware of the circumstances under which they should use this plan.

## Are end of life care services effective?

Requires Improvement



End of life care services were not effective throughout the trust and required improvement. Staff at ward level were not competent in caring for people at the end of their life, because they had not received the training required to enable them to undertake this role. None of the staff at ward level, or in the bereavement office and mortuary, had received advanced communication training to enable them to have difficult conversations with patients or their representatives. Specialist palliative care nurses did have further training in this area. Staff did not always refer patients to the specialist palliative care team in a timely manner, and the palliative care team told us that there were often problems in relation to end of life care following weekends when the team were unavailable. The trusts bereavement policy referred to the Liverpool Care Pathway despite this policy being updated in September 2014. The

# End of life care

trust were slow to roll out the Amber care bundle which meant that patients did not receive timely effective care as staff were confused as to what the care pathways should be.

The specialist palliative care team were not able to deliver an effective education programme, roll out initiatives, care for patients and undertake the required audits with the resources they presently had. A business case had been drawn up to expand the team, with a vision of providing an, effective and equitable 24 hour service, seven days a week. All of the staff we spoke with told us that the specialist palliative care team were incredibly supportive and that they had a good presence.

Patient's pain relief was prescribed and palliative care nurses were able to prescribe these medications. Patients reported through the national care of the dying audit that the trust was performing well in this area from the patients' perspective.

## Evidence-based care and treatment

- The specialist palliative care team based the care they provided on the NICE Quality Standard 13 – End of Life Care for Adults. This quality standard defines best practice in end of life care for adults.
- Following the withdrawal of the Liverpool Care Pathway, the specialist palliative care team had introduced a care in the last days of life tool. This was a holistic tool which included an initial medical assessment and an initial nursing assessment. However, not all staff we spoke to on the wards were aware of the tool, or which documentation they should be using for patients at the end of their life.
- The trust had local guidelines and policies in place that were up to date and based on the NICE guidance. However, the trusts bereavement care policy had been reviewed in September 2014, but still contained reference to the Liverpool Care Pathway as a related policy and procedure. This could be confusing for staff, as this pathway is no longer in use throughout the trust. Staff also told us that since the withdrawal of the Liverpool Care Pathway, they were not always sure which documentation they should be using.
- A number of initiatives were being rolled out throughout the trust to support the NICE guidance. For example, the AMBER care bundle was being rolled out to support the identification of patients with an uncertain recovery. This was being rolled out by a bank nurse just one day a

week. It was felt that this was insufficient to effectively roll out the AMBER care bundle and support staff to implement it on the wards. At the time of our inspection, a business case had been submitted for approval of a 1.0 WTE AMBER care facilitator.

## Pain relief

- There were clear guidelines for prescribing pain relief in end of life care.
- Nursing and medical staff told us that they would contact the specialist palliative care team for advice about appropriate pain relief, if required.
- The specialist palliative care nurses were being supported to become nurse prescribers. One specialist palliative nurse told us that the doctors were very responsive at prescribing their instructions.

## Nutrition and hydration

- The trust had participated in the National Care of the Dying Audit (May 2014). The results showed that the trust was identified as being better than the England national average at reviewing patient's nutrition and hydration requirements at the end of life. The England national average for reviewing patient's nutritional requirements was 41% and the trust scored 53%, and for reviewing patient's hydration requirements 50% and the trust scored 70%.
- We saw that nutrition and hydration needs were included in patients' individual end of life care pathways.

## Patient outcomes

- The trust participated in the National Care of the Dying Audit 2014. The results reflect what we found in that referral to the specialist team was delayed, education and audit was poor and that a formal feedback process for relatives was not in place.
- Preferred place of death was being audited, as it was a CQUIN for end of life care. (Commission for Quality and Innovation (CQUINs) are frameworks to improve quality of service and better outcomes for patients.) A quality audit of patients preferred place of death had been undertaken in December 2013. Of the 27 patients included in the audit, 89% had expressed a preference for their place of death; 88% of these patients died in their preferred place

## Competent staff

- The specialist palliative care team told us that six members of staff had attended Quality End of Life Care

# End of life care

for All (QELCA) training, where they had spent five days at St John's Hospice. The aim of the QELCA programme was to empower generalist nurses to return to their area of work equipped to make a difference to the experience of patients dying in hospitals and their relatives/carers. They were starting to identify staff who were passionate about end of life care, to act as champions in the ward areas.

- With the exception of the specialist palliative care team, none of the staff we spoke with had received training or support with their communication skills, to enable them to be more confident in having discussions with patients about their end of life care. Specialist palliative care nurses have attended the Advanced Communications Course and have, alongside all Cancer Specialist Nurses and Consultants in the field of cancer, been trained to Level 2 in psychological assessment.
- The specialist palliative care team were well supported by their manager, and their nursing and medical appraisals were up-to-date.
- The staff in the bereavement office had undertaken training in counselling, one as long as 15 years ago, the staff had not been supported to access advanced communication training.

## Multidisciplinary working

- The specialist palliative care team worked in a collaborative and multidisciplinary manner.
- Spiritual and religious support was available from the chaplaincy team, and bereavement support was available from the bereavement centre.
- There were regular multidisciplinary team meetings to discuss patient care needs.
- The specialist palliative care team had good links with palliative care services in the community.
- The trust used an electronic recording system to enable the recording and sharing of people's care preferences and key details about their care. This ensured care was co-ordinated and delivered in the right place, by the right person, at the right time.
- Staff told us that they knew they could get support from the specialist palliative care team if required.
- All of the staff we spoke with told us that the specialist palliative care team were incredibly supportive and that they had a good presence.

## Seven-day services

- The specialist palliative care team were available Monday to Friday, from 9am to 5pm.

- Out-of-hours advice about symptom control was available from the consultant on-call rota, which covered several hospitals.
- The chaplaincy service provided 24 hour, on-call support seven days a week for staff, patients and their representatives.

## Are end of life care services caring?

Good



Patients and their representatives generally spoke positively about the care they received. The specialist palliative care team were passionate about the services they provided, and recognised there was a need to improve end of life care services throughout the trust.

Chaplaincy staff were visible within the trust, and the chaplain told us that they could access religious representatives from all denominations as required. Staff around the trust spoke highly of the support provided by the chaplaincy team. The trust had a dedicated bereavement office, where two bereavement officers supported families through the formal processes following a patient's death. Staff in the bereavement office and the mortuary demonstrated compassion and respect, while preserving the dignity and privacy of patients after death. The caring approach by the mortuary and bereavement staff that we observed was outstanding. However, it was not clear through documentation that patients were involved in the decision-making process at the end of their lives, despite patients reporting through the patients survey that they were involved.

## Compassionate care

- Patients told us that they were generally happy with the care they received. One patient told us "they [the staff] are dedicated to their jobs, some of them are angels".
- Throughout our inspection we observed interactions between staff and patients. Although we saw that some patients were treated with dignity and respect, this was not consistent throughout the trust.
- The trust took part in the 2014 National Care of the Dying Audit. The trust scored better than the England average for the indicator, 'health professional's discussions with both the patients and their relatives/friends regarding their recognition the patient is dying'.



# End of life care

- During our inspection we visited the mortuary and spoke with the mortuary technicians. On discussion, staff were able to demonstrate compassion, respect and an understanding of preserving the dignity and privacy of patients following death.
- We visited the bereavement office and spoke with one of the bereavement officers and with chaplaincy staff, who demonstrated compassion and respect for patients and their families. The trust may like to note that staff responsible for supporting families post bereavement had not undertaken any recent training to prepare them for this role.
- We spoke with portering staff who were responsible for transporting patients to the mortuary following death. The portering staff we spoke with were knowledgeable about their responsibilities for ensuring patients were treated with dignity and respect following death. The portering staff we spoke with assured us that patients were treated in a respectful and dignified manner at ward level prior to being transferred to the hospital mortuary.
- The mortuary staff we spoke with assured us that they had no concerns relating to the way in which patients had been treated at ward level following their death.

## Patient understanding and involvement

- We could not ascertain that patients and their families were involved in making decisions about their end of life care. We looked at 15 sets of patient records throughout the wards we inspected, and we saw that on nine occasions discussions were not recorded that these had taken place with the patient or, where the patient lacked capacity, their family.
- The trust took part in the National Care of the Dying Audit (May 2014). The results showed that the trust was identified as being above the England national average which was 75% in relation to health professional's discussions with both the patient and their relatives/friends regarding their recognition that the patient is dying. The survey also identified the trust as being above the England national average which was 64% for communication regarding the patient's plan of care for the dying phase.
- The specialist palliative care team told us that patients at ward level were not always referred to them in a timely manner. This could compromise the patient's opportunity to make decisions relating to end of life care, and their preferred place of care and death.

## Emotional support

- Although the specialist palliative care were trained in advanced communication to ensure sensitive discussions could take place, staff at ward level, including doctors were not. This meant that when the specialist palliative care team were not available, patients, and those identified as being important to them, may not have been given the opportunity to be involved in communication and decisions about treatment and care to the extent that the dying person wants.
- The chaplaincy staff offered bereavement support to relatives, as well as spiritual support to patients and families, although this service was stretched to ensure that a service could be provided 24 hours a day.
- The chaplaincy team also offered pastoral, emotional and spiritual support to all staff throughout the trust.

## Are end of life care services responsive?

Requires Improvement



Services at the end of patients' lives were not always responsive to the individuals need. The referral criteria was vague, and one of the specialist palliative care team told us that patients were sometimes referred too late. We saw evidence of this on one of the wards we inspected. This meant that patients may not always receive the palliative support they require in a timely manner.

The specialist palliative care team was working hard to ensure that every person receiving end of life care had a positive experience. Patients who were referred to the specialist palliative care team were seen according to their needs. The specialist palliative care team told us that they would always try to see urgent referrals the same day. We were informed of some areas of outstanding practice in relation to the responsiveness of the chaplaincy service and bereavement services.

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

- People requiring end of life care were cared for throughout the trust. There were no designated beds or wards for patients who required end of life care.

# End of life care

- Staff told us that they always tried to care for patients requiring end of life care in side rooms. During our inspection we saw one patient who was dying in a bay because the ward did not have a side room available.
- Staff told us that they would always try to accommodate relatives where possible.

## Access and flow

- Patients requiring specialist palliative support were referred to the specialist palliative care team by staff at ward level. Not all staff were clear about the referral criteria, and one of the specialist palliative care team told us that patients were sometimes referred too late. We saw evidence of this on one of the wards we inspected. This meant that patients may not always receive the palliative support they require in a timely manner.
- One of the specialist palliative care team told us that there were often delays in seeing patients if they had been referred over the weekend, and how quickly patients could be seen would depend on how many specialist staff were in the hospital at the time.
- The specialist palliative care team had an expectation that everyone who was dying should be referred to them.

## Meeting people's individual needs

- In A&E, the lead nurse had developed keepsake boxes for when a child had died. In the boxes were candles, paper with seeds embedded so that family and carers could plant them in memory of their loved one, clay prints to capture hand and foot prints, and other memory items. These boxes were used throughout the hospital when needed, although sourced from A&E. The nurse explained how they had raised the money to fund the boxes through local supermarket charity initiatives.
- We visited the chapel and saw that it was set up to cater for people of all faiths. The hospital's chaplain told us they had excellent links with representatives from all faiths, and also supported people who did not have a faith.
- We saw that a memorial service took place within the chapel on the first Wednesday of every month for people who had experienced a pregnancy loss. Following the service, families were invited to join the chaplain for a walk to a memorial ribbon tree at Hinchingsbrooke Park, where they were given the opportunity to tie a ribbon on the oak tree.

- We saw there was a season's garden by the chapel, which had been very carefully thought out to ensure there was interest in the garden all year round. The chaplain told us that patients and their families were able to access the garden. However, we found that the garden would not be accessible to patients who were unable to get out of bed, as the entrance to the garden would not allow this.
- Staff in the bereavement office told us that they had numerous resources available to support people of all ages and faiths following the death of a patient. We saw they had numerous different books for children of all ages who were bereaved.
- Discussions around preferred place of care and death did not always take place with patients. The palliative care consultant told us that whilst staff were having these conversations with patients who had received a diagnosis of cancer, they were not always happening with patients who had other terminal conditions. It was recognised that this was an area that needed more work.
- One of the palliative care team told us that rapid discharge planning was a problem if patients, who had previously not had a package of care identified, wanted to be cared for and die at home. Although these patients were fast tracked for continued health care funding, it could take a long time to arrange packages of care. This meant that patients may not have always been discharged to their preferred place of care in a timely manner.
- Support was available for people living with dementia.
- We did not see any patients who did not speak English, but staff told us that translation services were available within the hospital.
- Chaplaincy staff were visible within the trust, and the chaplain told us that they could access religious representatives from all denominations as required. Staff around the trust spoke highly of the support provided by the chaplaincy team.
- The trust had a dedicated bereavement office, where two bereavement officers supported families through the formal processes following a patient's death. There was a dedicated room where relatives could be seen in private.

## Learning from complaints and concerns

- The specialist palliative care team told us that they rarely received complaints relating to end of life care.

# End of life care

When complaints were raised, they were mainly about communication and lack of information. Staff were not able to provide us with any examples where learning had taken place as a result of complaints relating to end of life care.

## Are end of life care services well-led?

Good



The end of life care services were well-led. The specialist palliative care team were a small, passionate and dedicated team. They had devised a business case to develop end of life care services, and ensure that patients and their families or carers had a good experience of care, and were given choices at the end of life. Although the specialist palliative care team had a vision and strategy for end of life care within the trust, this had not been formalised or shared throughout the trust, so staff in the ward areas were not aware of the vision and values for end of life care.

At the time of our inspection, there was a plan to develop a bereavement survey to engage the public in providing feedback to improve services for end of life care.

There was a strong improvement culture within the specialist palliative care team; services were being developed in line with national guidance, and there was participation in national quality assessment to measure outcomes. The specialist palliative care team were trying to do their best with the resources they had at their disposal.

### Vision and strategy for this service

- Although the specialist palliative care team had a vision and values for end of life care, this was not written down or formalised, and had not been embedded amongst staff who were delivering end of life care at ward level throughout the trust. This had been partly due to under-resourcing within the palliative care team.
- The specialist palliative care team had identified gaps in the service offered and had prepared a business case to develop a sustainable, safe palliative care service with 24 hour access by December 2014.
- The trust was registered with the Transforming End of Life Care in Acute Hospitals Programme. This was a programme aimed at improving end of life care within

acute hospitals. The specialist palliative care team had worked hard to try to meet the key enablers, but expressed that it was difficult without the resources required.

- The specialist palliative care team had attempted to roll out the AMBER care bundle across four wards. (The AMBER Care Bundle is a tool that facilitates decision-making about patients whose condition is deteriorating, and are clinically unstable, with an uncertain outcome. It provides a systematic approach to manage the care of hospital patients who are facing an uncertain recovery, and who are at risk of dying in the next one to two months.) This had proven difficult because the team were relying on a bank nurse to deliver training once a week. The business case had requested an AMBER Care Bundle facilitator and a palliative care discharge planner to cover a seven day working week.
- One of the specialist palliative care team told us that it was difficult to deliver clinical care, education, undertake audits and work on strategic planning.

### Governance, risk management and quality measurement

- We were told us that there was no specific risk register for end of life care throughout the trust.
- We saw that there was an action plan to develop and improve end of life care services across the trust.
- We saw that audits were taking place in line with CQUINs that had been set for end of life care.
- There was an end of life steering group, which was attended by the medical director and met once a month, and there was now a direct link with the trust board.

### Leadership of service

- Locally, there was strong leadership within the specialist palliative care team. The team was led by a palliative care consultant, who was clear about what effective and safe end of life services should look like. The team were pushing to improve access to palliative care for non-cancer patients and generalist palliative care. The specialist palliative care team were, however, struggling to role enable effective delivery of education to staff at ward level, due to lack of resources. This had been identified, and a business plan had been drawn up to increase the levels of specialist staff.

# End of life care

- All of the staff we spoke with were aware of the specialist palliative care team, and spoke highly of them.
- The specialist end of life care team were passionate about providing staff within the ward areas with the tools they needed to ensure patients and their families received a good end of life care experience.
- The palliative care consultant told us that their new manager was responsive to the needs of the team.

## Culture within the service

- Staff we spoke with thought highly of the specialist palliative care team. They spoke highly about the service they provided.
- Staff reported positive working relationships with the team.
- Staff within the specialist palliative care team spoke positively about the service they provided for patients, and expressed a desire to be able to provide a seven day service.
- The specialist palliative care team, the bereavement officers, mortuary staff, and the Chaplains were very proud of the difference they made to patients, and their relatives and friends.






## Public and staff engagement

- The specialist palliative care team were doing their best to engage staff at ward level in end of life care training.
- The specialist palliative care team told us that they were developing a bereavement survey, so they could receive ongoing feedback on the experience of patients and carers, to help ensure good care was identified, and so that areas where improvements could be made were acted upon.

## Innovation, improvement and sustainability

- The specialist palliative care team acknowledged that there was work to be done to improve end of life care services throughout the trust. A business case had been developed to improve the staffing levels that were needed to sustain the service. Extra medical and nursing staff were needed to continue to provide the service levels identified.
- The chaplain and the bereavement officer explained the plans to move the bereavement office nearer to the mortuary, in order to lessen the need to travel through a long hospital corridor to the viewing area.
- The bereavement officer told us that bereaved relatives did not have to pay for car parking when they came back to the hospital following the death of a patient.

# Outpatients and diagnostic imaging

Safe	Good	
Effective	Not sufficient evidence to rate	
Caring	Good	
Responsive	Good	
Well-led	Good	
Overall	Good	

## Information about the service

The majority of clinics at Hinchingsbrooke Hospital are provided from the treatment centre, and saw 147,286 patients last year. Some outpatient departments are also located in the main hospital. Throughout the outpatient department we inspected audiology, the diabetic clinic, ophthalmology, gynaecology, radiology, ear, nose and throat (ENT), cardiology, trauma and orthopaedics. In addition to consultant-led clinics, there are nurse-led clinics across a range of specialities. Outpatient clinics run from Monday to Friday.

During our inspection we spoke with 18 patients and relatives, and 23 members of staff, including nurses, health care assistants, receptionists, the head of operations, and medical staff. We observed interactions between patients and staff, and considered the environment. Before our inspection, we reviewed performance information from, and about the hospital.

## Summary of findings

We found outpatients to be safe. Medicines and prescription pads were securely stored, although we found a small amount of medicines within the trauma and orthopaedic outpatient clinic, which were being stored along with cleaning fluids and other items. The outpatient areas we visited were clean, and equipment was well maintained. Staff vacancies were being managed appropriately. Patients were appropriately asked for their consent to procedures. On most occasions records were available for patient clinic appointments.

The service in outpatients was caring. Patients received compassionate care, and were treated with dignity and respect. The outpatient service was responsive to people's individual needs. Patients were seen within national waiting times. Staff told us that clinics were rarely cancelled. Translation services were available for people who did not speak English, and all the staff we asked about this were able to tell us how to access these services. Complaints were handled appropriately, and action was taken to improve the service. Outpatient services were well-led and there was good local leadership of clinics. Patient feedback was used to improve the service, and there was innovation in some service areas, such as one-stop clinics in gynaecology.

# Outpatients and diagnostic imaging

## Are outpatient and diagnostic imaging services safe?

Good



On the whole, we found outpatients to be safe. Medicines and prescription pads were securely stored, although we found that a small amount of medicines within the trauma and orthopaedic outpatient clinic were being stored along with cleaning fluids, methylated spirits, a lighter and batteries. The outpatient areas we visited were clean, and equipment was well maintained. Staff vacancies were being managed appropriately. Patients were appropriately asked for consent to procedures. Staff told us that people with complex needs would usually be accompanied by a relative or carer. If there were concerns about ability to consent staff would contact their safeguarding lead. Records were generally available for patient's clinic appointments.

### Incidents

- The trust had an electronic incident reporting system in place. Staff said that they could access the hospital's incident reporting system, and understood their responsibilities with regard to this. We were assured that staff were reporting incidents appropriately.
- There had been three serious incidents reported in outpatients. Two related to radiology, and one to a drug incident. Action had been taken to address the issues raised by these serious incidents through a comprehensive review of training and equipment requirements.
- Staff told us that they received feedback about incidents that had been reported. Any improvements to service or alterations to practice were implemented within the department

### Cleanliness, infection control and hygiene

- Clinical areas were visibly clean throughout the treatment centre.
- We observed sufficient infection control equipment, including gloves, aprons and hand sanitiser, throughout the department.
- We saw that equipment was cleaned between patients.

- Staff followed the hospital's infection control policy. We observed staff regularly washing their hands, and using personal protective equipment, such as gloves and aprons, when required.
- Staff adhered to the trusts 'bare below the elbows' policy.
- We saw that infection control audits took place throughout the department, and action plans were put in place if a problem was identified

### Environment and equipment

- The outpatient department was a purpose built department with its own dedicated main entrance.
- Public areas inside the department were modern and well maintained.
- There was generally enough seating in most areas, but the department had identified problems with seating in the cardiology outpatients area, as the seating was hard and uncomfortable.
- We observed that clinical and non-clinical areas were uncluttered.
- Resuscitation equipment was immediately available for use throughout the department, and checks were up to date for the equipment we inspected.

### Medicines

- Medicines and prescription pads were securely stored and appropriately managed in most of the areas we inspected. The prescription pads were signed in and out and there were strict controls relating to who could access them. They were signed in and out and checked by two members of staff. One of which was the person authorised to prescribe.
- However, we looked at the storage of medicines in the orthopaedic outpatients department, and found they were being stored along with cleaning solutions, batteries and a lighter. This was escalated to the matron of the department, who told us that this was because of lack of storage. She assured us this would be rectified.
- We saw that fridge temperatures were checked and recorded daily in all of the areas we inspected.
- There were no controlled drugs in any of the outpatient areas we inspected.

### Records

- Staff told us that it was unusual for them not to have notes available when patients were seen in clinic.

# Outpatients and diagnostic imaging

- Patients confirmed that they had not experienced any problems with notes not being available for clinics.
- Staff confirmed that some information would be available electronically, so patients would always be seen if their notes were not available.
- The trust did not audit records within the department to assess whether they were always available for clinics.
- We saw that records in the clinic areas were kept securely, so that they could not be accessed by people who do not have the authority to do so.

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

- The staff we spoke with had not received any training in relation to the Mental Capacity Act and the Deprivation of Liberty Safeguards (DoLS).
- Patients told us that staff always asked their permission prior to undertaking procedures.
- We saw that staff gained consent from patients before undertaking procedures such as taking blood.
- We did not meet any patients within the outpatient department who lacked the capacity to make decisions throughout our inspection
- Staff could contact the safeguarding lead if they had any concerns about patients in relation to consent and capacity.

## Safeguarding

- Staff told us that they received safeguarding training. Records we reviewed confirmed this.
- There were up-to-date children's safeguarding policies and procedures in place, which incorporated relevant legislation. Staff gave examples of when they had acted to safeguard children. We were assured that staff were acting appropriately, and in accordance with national safeguarding legislation. For example, we observed a list detailing times when children had not attended their appointments. The sister in one area showed us documentation and was able to clarify that appropriate safeguarding practice had taken place.
- Staff were knowledgeable about their role in safeguarding, and confirmed that they had recently received safeguarding training. Records we reviewed confirmed this.
- There was a team within the trust dedicated to children's safeguarding. Staff said that the safeguarding team were approachable and easily accessible. .
- Systems were in place to safeguard children. In the fracture clinic, a safeguarding screening tool was used

during initial assessments, which identified those children at high risk. This tool had been implemented following its successful use in the A&E department. In all outpatient areas staff confirmed that they followed the trust's robust policy in relation to children who did not attend their appointment. Staff gave examples of when they had used this protocol, and confirmed that when there were subsequent concerns, they had liaised with the child's health visitor, school nurse or GP appropriately.

- The manager in the fracture clinic said that they regularly attend the two monthly children's safeguarding meeting, which was led by the lead children's safeguarding nurse. Staff in other areas of the hospital which offered children's outpatient services confirmed that they did not have an opportunity to feed into, or get information from these meetings.

## Mandatory training

- The outpatients department sat within the Eyes, Ears, Nose and Throat (EENT) division. The records provided for this department showed that over 95% of staff had attended mandatory training apart from safeguarding adults training and equality and diversity. We were unable to see figures for the outpatient department alone. However the matron told us that she monitored training and ensured that people attended, this accorded with what we saw.
- The trust told us that they were aware of the need to improve attendance at this training. The EENT division records showed that around 88% of staff had attended this training.
- Staff told us that they had received recent training in paediatric cardio-pulmonary resuscitation (CPR). Records we reviewed confirmed this.

## Nursing staffing

- The outpatients department was staffed by a mix of registered nurses and health care assistants. Each clinic was generally run by one registered nurse and one health care assistant. Throughout our inspection of the outpatient department, clinics were seen to be steady. Although staff told us that some clinics could be very busy.
- There had been staffing shortages due to long-term sickness and compassionate leave. These shifts were

# Outpatients and diagnostic imaging

either being covered by the internal staff as overtime, or by bank staff. The department only used bank staff who were known to them, and who had the particular skills required of the clinic they were working in.

- Due to the expansion of the department, the ear, nose and throat (ENT) team had already recruited an additional member of staff, in order to be fully staffed for the relocation of the ENT service.

## Medical staffing

- Medical staffing was provided by the relevant speciality running the clinics in outpatients. Medical staff were of mixed grades. There was always a consultant to oversee the clinics, and junior staff felt supported.

## Major incident awareness and training

- There were business continuity plans in place to ensure that the delivery of services was maintained.

## Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

We report on effectiveness for outpatients below. However, we are not currently confident that overall, CQC is able to collect enough evidence to give a rating for effectiveness in the outpatients department.

## Evidence-based care and treatment

- Clinical specialities worked in accordance with good practice and national guidelines such as the National Institute for Health and Care Excellence (NICE) guidance.
- Staff were aware of how to access policies and procedures within their departments.
- Policies and procedures were updated regularly, and were easily accessible to all staff. Staff demonstrated that they practised evidence-based care. During our inspection we were shown the pathway for primary and secondary orthoptic vision screening assessments for children within the local area. We were assured that this service was reflecting national best-practice standards as issued by the Royal College of Ophthalmologists.

## Patient outcomes

- The department was offering one-stop clinics in hysteroscopy. This meant that patients could be seen quickly, assessed and treated, instead of having to wait for results and come back to the hospital for treatment.

- New to follow-up patient ratios were benchmarked nationally, and indicated whether patients were being effectively managed, and if outpatient appointments were being used efficiently to reduce repeated attendance. The new to follow-up ratios for Hinchingsbrooke Hospital were much better than the England average figures.

## Competent staff

- Training records confirmed that staff, including doctors, had received an appraisal in the last year.
- Staff on the reception desk told us that they had not received any training in relation to communication skills or conflict resolution, but often had to deal with people who were upset.
- There were staff within the hysteroscopy clinic who had received communication skills training to enable them to break difficult news to patients.
- Some staff, such as specialist nurses, had undertaken training specific to their role.

## Multidisciplinary working

- We saw evidence of good collaborative multidisciplinary team working in the diabetic clinic, where patients were seen by a diabetic nurse, dietician and a podiatrist.
- Nurse-led clinics ran alongside consultant clinics.

## Seven-day services

- The outpatients department ran from Monday to Friday. There were no evening or weekend clinics.

## Are outpatient and diagnostic imaging services caring?

Good

The service in outpatients was caring. Patients received compassionate care, and were treated with dignity and respect. Audits of privacy and dignity were taking place throughout the department. Patients and relatives commented positively about the care provided from all of the outpatient's staff.

## Compassionate care

- Throughout our inspection we saw patients being treated with compassion, dignity and respect. We saw staff were welcoming towards patients as they entered the department.



# Outpatients and diagnostic imaging

- We observed staff acting appropriately and kindly towards children who were waiting in the ophthalmology and fracture clinic.
- We saw that patients privacy and dignity were respected. We saw staff knocking on clinic doors and waiting to be invited to enter.
- Within the radiology department we saw that changing facilities were separate for males and females. There were separate cubicles with curtains screened across to help to preserve privacy and dignity.
- Chaperones were available throughout the department as required, and their use was recorded by the clinician.
- We observed a patient who was distressed as they were checking into the department. We were able to hear everything that was said by the patient and the reception staff. This meant that patients and their conversations could be overheard in the reception area of the department. Staff on reception told us that this was a problem if people were standing close to the desk, and that they always tried to ask for minimal information to mitigate risks associated with confidentiality.
- Matrons within the outpatients department were auditing privacy and dignity throughout the department.

## Patient understanding and involvement

- Throughout the service, patients and children said that they felt involved, and understood the care and treatment provided. One parent told us “the staff explain everything”.
- We spoke with patients in the department, who told us that they had been kept informed of their care and the plans for their future treatment. They told us that staff had answered their questions and had given them enough time to discuss their care.
- We observed that patients were given time to discuss their treatment and more time was allocated to patients where more sensitive information was discussed.
- Written information about their condition was readily available for patients to take away.

## Emotional support

- We saw how a patient who was distressed was supported in a very sensitive and respectful manner.
- Patients we spoke with were positive about the support they received from staff throughout the outpatients department.

- The staff we spoke with were all sensitive to the potential for people to require emotional support while attending the outpatients department, and knew of the areas within the department where that support might be required.

## Are outpatient and diagnostic imaging services responsive?

Good



The outpatients service was responsive to people's individual needs. Overall, patients were seen within national waiting times. Delays in clinics were explained to patients. Staff told us that clinics were rarely cancelled. There was support for people with a learning disability or dementia. Translation services were available for people who did not speak English, and all the staff we asked about this were able to tell us how to access these services. Complaints were handled appropriately, and action was taken to improve the service.

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

- There were plans in place to relocate ENT services to a purpose-built ENT department, as clinic space was limited due to the hospital taking on more services within the department. There was a business plan in place, and the relocation was due to take place by December.
- Staff were supported by bank staff, as a very last resort to cover sick leave and compassionate leave. The department would only use bank staff that were known to them. The department had recently recruited a new member of staff ready to support the relocation of ENT services.

## Access and flow

- Senior staff told us that the trust operated a strict six weeks' notice of cancellation of clinics. They also told us it was very rare for clinics to be cancelled, and they were therefore not audited. However, information provided by the trust indicated that cancellation of clinics was being monitored and these varied between clinics.
- The department ran a 'choose and book' service, which gave patients a number of appointments from which they could choose. Patients could receive text reminders for appointments if they so wished.

# Outpatients and diagnostic imaging

- Did not attend (DNA) rates for the trust were better than the England average.
- With an average of 99% the referral to treatment times (RTT) of 18 weeks and waiting times for the trust were generally better than the Operational Standard of 95%. However, the percentage of people waiting less than 62 days from urgent GP referral to first treatment for all cancers had dropped below the England average by 8% in quarter 1 of 2014- 2015. The operations manager told us that this related to urology breaches, which were shared with another hospital.
- We saw that where clinics were overrunning, staff kept patients informed.
- There had been problems with waiting times in cardiology, and these had been reviewed, with an action plan being drawn up to address the issue. The action plan had been put into action and the changes were being monitored for effectiveness.
- The trust did not audit clinics to see whether they regularly over ran.

## Meeting people's individual needs

- Whilst some areas, such as ophthalmology and radiology, had suitable separate waiting areas for children, including toys and a television, other areas within the hospital that provided children's outpatient services did not. Parents that we spoke with in the ophthalmology outpatients and radiology area said "the waiting rooms are great" and "just what is needed to keep the children preoccupied whilst waiting". Outside the fracture clinic the children's waiting room had minimal toys to keep children entertained or distracted whilst waiting for treatment. In some areas we visited children were given stickers, bravery awards, or teddies after they were seen.
- In some areas we visited, although not all, we observed appropriate and child-specific information leaflets about certain conditions and treatment. For example, in the ophthalmology outpatients department we observed a leaflet entitled 'Your child's first visit to the eye clinic'.
- During our visit we tracked the pathway of a child attending radiology who lived with severe learning disabilities. We observed that the service had been adapted to meet his specialist needs. For example, radiology had provided a specific appointment for this person, during a less busy period within the department. We also observed that the service had

pre-planned the appointment, and had a hoist ready, together with a senior radiographer. This meant that the patient did not have to wait and was cared for safely. The child's parent told us "we come here a lot and the service is always very good".

- Staff within the department told us that there was an interpreting service in the hospital, and they knew how to access this.
- We saw that leaflets could be obtained in different languages, but could not be obtained in braille.
- People with mental health conditions or learning disabilities were not flagged up prior to coming in to clinic. However, there was a learning disabilities link nurse within the hospital, who would let the outpatients department know if they were aware of any patients coming in. There was a quiet room available if this was required.
- Staff explained that patients with complex needs were usually accompanied by carers or family members. Access was available for patients in wheelchairs or those who used walking aids.
- The environment in the outpatients department was spacious and bright.
- We also found seating to be uncomfortable in the ophthalmology department. We also observed the waiting area to be insufficient within this department, as visually impaired patients often brought another person along with them when attending appointments.
- Patients were given a bleep so they could leave the department for a coffee. They were alerted via the bleep when they were required to attend their appointment. There was a coffee shop, where patients could buy refreshments, but refreshments were not offered in the department.
- Bariatric equipment was available if it was required.
- Staff were responsive to the emotional needs of patients, and could contact the chaplain if this was required.
- The outpatients department had a quiet room for patients who may have received difficult news. We saw that this was in use at the time of our inspection.

## Learning from complaints and concerns

- Staff told us that complaints were shared with them in order that lessons could be learned. Staff also told us that compliments were shared with them so they knew what they had done well.

# Outpatients and diagnostic imaging

## Are outpatient and diagnostic imaging services well-led?

Good 

Outpatient services were well-led and there was good local leadership of clinics. There was a business plan to expand and relocate services. Patient feedback was used to improve the service and there was innovation in some service areas, such as one-stop clinics in gynaecology.

### Vision and strategy for this service

- The head of operations demonstrated a vision for the future of the service, and was aware of the challenges it faced.
- All of the staff we spoke with were aware of the vision for the future of the service.
- We saw that there was a business plan for the redevelopment and relocation of services within the outpatients department. There was a plan to relocate the ENT department by December 2014.

### Governance, risk management and quality measurement

- There was a separate risk register for individual outpatient clinics, and risks were being appropriately monitored.
- Incident reporting and analysis was taking place.
- There were local departmental audits happening within the outpatients department, but there were no audits that encompassed the outpatients department as a whole.

### Leadership of service

- There were boards throughout the services we visited which displayed photos of the local leadership team within each department.
- We found that local leadership was good, staff were supported in their role and staff told us that senior staff including the matrons would assist with clinics at busy times.

- In each area we visited we found that there was an allocated lead professional for the children's services being offered within that department.
- Staff told us they found their managers supportive and approachable. All of the staff we spoke with told us they were happy in their roles.

### Culture within the service

- In each area we spoke to the lead nurse or manager for the service. All staff were professional, open and honest with inspectors, and positive about working in their department. Staff acted in a professional manner, they were polite and well-mannered to patients and inspectors. They were open about the areas they were proud of and described what worked well within their department. They were also honest about the areas that required improvement.
- There was a positive ethos and mutual respect observed between colleagues.
- The team worked well to support each other. They were flexible and committed to providing a positive patient experience.

### Public and staff engagement

- We observed that patient feedback systems, including surveys, were available for patients and those caring for them, throughout the services we visited.
- We observed interaction between patients, their representatives and staff. Staff were able to respond to the needs of patients using the outpatients department.

### Innovation, improvement and sustainability

- The department had expanded, and had business plans in place for redevelopment and relocation of services; staff within the department were aware of the redevelopment plans.
- Waiting times in the ophthalmology department could be long due to the nature of some of the investigations, and the waiting area could become congested. Patients were given beepers so they could go elsewhere in the hospital whilst they were waiting. They were called via their beeper when they were due to be seen.

# Outstanding practice and areas for improvement

## Outstanding practice

- In both maternity and critical care we noted good care, focused on patients' needs, meeting national standards.
- The paediatric specialist nurse in the emergency department was dynamic and motivated in supporting children and parents. This was seen through the engagement of children in the local community, in a project to develop an understanding of the hospital from a child's perspective, through the '999 club'.
- The support that the chaplaincy staff gave to patients and hospital staff was outstanding. The chaplain had a good relationship with the staff, and was considered one of the team. The number of initiatives set up by the chaplain to support patients was outstanding.

## Areas for improvement

### Action the hospital MUST take to improve

- Ensure all patients health and safety is safeguarded, including ensuring that call bells are answered in order to meet patients' needs in respect of dignity, and patient's nutrition and hydration needs are adequately monitored and responded to.
- Ensure that staffing levels and skill mix on wards is reviewed and the high usage of agency and bank staff to ensure that numbers and competencies are appropriate to deliver the level of care Hinchingsbrooke Hospital requires.
- Ensure that the arrangements for the provision of services to children in A&E, operating theatres and outpatients areas provided by the trust, is reviewed to ensure that it meets their needs, and that staff have the appropriate support to raise issues on the service provision.
- Ensure records, including risk assessments, are completed, updated and reflective of the needs of patients.
- Ensure the care pathways, including paediatric pathways, in place are consistently followed by staff.
- Ensure an adequate skill mix in the emergency department and theatres to ensure that paediatric patients receive a service that meets their needs in a timely manner.
- Ensure that there are sufficient appropriately skilled nursing staff on medical and surgical wards to meet patients' needs in a timely manner.
- Ensure medicines are stored securely and administered correctly.
- Improve infection control measures in the Emergency department and medical wards to protect patients from infection through cross contamination.
- Ensure staff are trained in, and have knowledge of their responsibilities under the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS).
- Ensure that patients are treated with dignity and respect.
- Ensure that all staff are adequately supported through appraisal, supervision and training to deliver care to patients.
- Ensure pressure ulcer care is consistently provided in accordance with National Institute for Health and Care Excellence (NICE) guideline CG:179.
- Ensure that catheter and intravenous (IV) care is undertaken in accordance with best practice guidelines.
- Ensure patients are treated in accordance with the Mental Capacity Act 2005.
- Ensure that the staff to patient ratio is adjusted to reflect changing patient dependency.
- Review the 'Stop the Line' procedures and whistle blowing procedures, to improve and drive an open culture within the trust.
- Standardise and improve the dissemination of lessons learnt from incidents to support the improvement of the provision of high quality care for all patients.
- Ensure that all appropriate patients receive timely referral to the palliative care service.

# Outstanding practice and areas for improvement

- Ensure action is taken to improve the communication with patients, to ensure that they are involved in decision-making in relation to, their care treatment, and that these discussions are reflected in care plans.
- Review mechanisms for using feedback from patients, so that the quality of service improves.

## Action the hospital SHOULD take to improve

- Review the checking of resuscitation equipment in the A&E department, and across the trust, to ensure that it occurs as per policy.
- Take action to reduce the overburdensome administration processes when admitting patients into the acute assessment unit (AAU).
- Review intentional rounding checks to ensure that they cover requirements for meeting patient's nutrition and hydration needs.
- Involve patients in making decisions about their care in the A&E department.
- Review the training given to staff, and the environment provided, for having difficult discussions with patients.
- Review translation usage in A&E, to ensure that patients receive information appropriate to their needs.
- Provide adequate training on caring for patients living with dementia, to improve the service to patients living with dementia.
- Discontinue the practice of adapting day rooms in rehabilitation wards to use as additional inpatient bed spaces.
- Review the clinical pathways for termination of pregnancies in the acute medical area.
- Review the policy on moving patients late at night.
- Review the out-of-hours arrangements for diagnostic services, such as radiology and pathology, to ensure that patients receive a timely service.
- Review mechanisms for fast track discharge, so that terminally ill patients die in a place of their choice.

This section is primarily information for the provider

## Compliance actions

### Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Surgical procedures Termination of pregnancies Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing  <b>There were insufficient numbers of staff with the required skills, experience and knowledge to meet the needs of patients. For instance:</b>  In A&E, there were insufficient paediatric nurses to maintain 24 hour cover for children using the service.  Inflexible staffing arrangements were in place in the medical directorate to meet the needs of patients.  There was a lack of staff, particularly on night duty, to meet the needs of patients in the surgical wards.  In critical care, the level of staffing currently in place would have enabled six level 1 patients at any one time. The unit had nine beds; there was a lack of agency and bank staff to flex the numbers of nursing staff to care for patients.  The palliative care team could only support patients between the hours of 9am and 5pm during the weekdays due to staffing levels.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Surgical procedures Termination of pregnancies Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services  <b>The provider is failing to take proper steps to ensure that care plans are in place, which are regularly updated to reflect service users changing care needs, so that service users are receiving care that is appropriate and safe.</b>  <b>The provider is failing to carry out assessment of needs to ensure that the care delivered meets their needs and is planned for.</b>

This section is primarily information for the provider

## Compliance actions

The provider is failing to plan and deliver care that meets the needs of service users who are at risk due to pressure area, catheter care, intravenous (IV) care and the risks associated with bed rails.

### Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983  
Diagnostic and screening procedures  
Maternity and midwifery services  
Surgical procedures  
Termination of pregnancies  
Treatment of disease, disorder or injury

### Regulation

Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers

The provider is failing to take proper steps to implement a safeguarding system that protects service users from the risk of harm.

The provider must ensure that all complaints are identified and responded to in a timely manner.

The provider is failing to implement an effective quality and monitoring system to identify potential non-compliance within the service to improve its delivery and provide care that is safe.

### Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983  
Diagnostic and screening procedures  
Surgical procedures  
Treatment of disease, disorder or injury

### Regulation

Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse

The provider is failing to take proper steps to identify the possibility of abuse and put measures in place to prevent it before it occurs.

The provider must ensure that they take proper steps to respond to any allegation of abuse.

The provider is failing to ensure that when any form of control or restraint is used in the carrying on of the regulated activity, that they have suitable arrangements in place to protect service users against the risk of such control or restraint being unlawful.

The provider is failing to ensure that staff employed to support them to carry on the regulated activity have been trained in the use of ethical control and restraint.

This section is primarily information for the provider

## Compliance actions

### Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Diagnostic and screening procedures

Maternity and midwifery services

Surgical procedures

Termination of pregnancies

Treatment of disease, disorder or injury

### Regulation

Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control

The provider is failing criterion 2.1 of the Health and Social Care Act 2008 Code of Practice On The Prevention And Control Of Infections And Related Guidance. Under criterion 2.1, with a view to minimising the risk of infection, the trust failed to ensure that staff were adopting good infection control techniques and hand washing between patients, including patients with established C. difficile.

We found staff were not washing their hands in A&E Apple Tree ward, Cherry Tree ward, Walnut ward and in the Treatment Centre.

### Regulated activity

Diagnostic and screening procedures

Surgical procedures

Treatment of disease, disorder or injury

### Regulation

Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services

The provider is failing to ensure the dignity of service users. The provider, in relation to Apple Tree Ward and Juniper Ward, is failing to treat service users with consideration and respect.

### Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Diagnostic and screening procedures

Maternity and midwifery services

Surgical procedures

Termination of pregnancies

Treatment of disease, disorder or injury

### Regulation

Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records

The provider is failing to ensure that records that pertain to the care of patients accurately reflect their care and treatment plans. Records were completed to a poor standard, with gaps and omissions in care plans and risk assessments found throughout medicine, emergency and surgery areas.