WM QRS West Midlands Quality Review Service

NHS

Review of Critical Care Services

South Birmingham Health Economy

Visit Date: 1st December 2010 Report Date: June 2011

INDEX

INTRODUCTION

ABOUT WEST MIDLANDS QUALITY REVIEW SERVICE

West Midlands Quality Review Service (WMQRS) has been set up as a collaborative venture by NHS organisations in the West Midlands to help improve the quality of health services by developing evidence-based Quality Standards, carrying out developmental and supportive quality reviews - often through peer review visits, producing comparative information on the quality of services and providing development and learning for all involved.

Expected outcomes are better quality, safety and clinical outcomes, better patient and carer experience, organisations with better information about the quality of clinical services, and organisations with more confidence and competence in reviewing the quality of clinical services. More detail about the work of WMQRS is available on http://www.wmqi.westmidlands.nhs.uk/wmqrs/.

This report presents the findings of the review of, Critical Care services based at Royal Orthopaedic Hospital NHS Foundation Trust which took place on 1st December 2010. The purpose of the visit was to review compliance with WMQRS Quality Standards for:

- Critical Care Services, Version 2, April 2010

The purpose of these standards and the review programme is to help providers and commissioners of services to improve clinical outcomes and patients' experiences by improving the quality of services. The report also gives external assurance of the care within the Health Economy which can be used as part of organisations' Quality Accounts. For commissioners, the report gives assurance of the quality of services commissioned and identifies areas where developments may be needed.

The report reflects the situation at the time of the visit. The text of this report identifies the main issues raised during the course of the visit. Appendix 1 lists the visiting ream which reviewed the services at the Royal Orthopaedic Hospital NHS Foundation Trust. Appendix 2 contains the details of compliance with each of the standards and the percentage of standards met.

ACKNOWLEDGMENTS

The WMQRS and the Midlands Critical Care Network would like to thank the staff of the Royal Orthopaedic Hospital for their hard work in preparing for the review and for their kindness and helpfulness during the course of the visit. Thanks are also due to the visiting team and their employing organisations for the time and expertise they contributed to this review.

ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST - HIGH DEPENDENCY UNIT

General Comments and Achievements:

This was a 12 bedded high dependency unit (HDU) with eight beds in the main ward area and a further four beds in side rooms at the opposite end of the ward. The unit provided specialised care for patients requiring orthopaedic interventions with or without other co-morbidity. The unit did not provide level III care and was therefore not fully equipped to do so. The unit had achieved low infection rates and a low rate of non-clinical transfers. There was a strong ethos of team-work and good leadership. Staff were enthusiastic and were delivering a high standard of care in a warm and friendly atmosphere that appeared calm and controlled. The layout of the beds enabled good visibility but made compliance with 'same sex' guidance difficult.

Immediate Risks: None

Concerns:

1 Patient privacy and dignity was compromised by the lack of single sex facilities. Patients did not have access to toilet and bathroom facilities separate from staff facilities. Staff were working hard to overcome the physical limitations of the building and their detail when caring for patients segregated only by curtains showed a genuine appreciation of patients' need for privacy and dignity.

2 Out of hours support to the HDU was provided by general anaesthetists (40%) and there was no evidence that they were doing CPD of relevance to their work on the HDU.

3 The senior nurse on the night shift was often required to hold the hospital bleep as well as being included in the HDU nursing numbers. This reduced the nurse: patient ratios on the HDU.

4 Nursing staff on the HDU could not demonstrate that they had the appropriate competences for their work on the unit.

5 Children and young people were regularly admitted to the HDU. It was not clear that staff had appropriate competences for the care of children. The Trust should ensure that standards for the care of critically ill children are being maintained.

Further consideration:

1 The practice development nurse role was vacant at the time of the visit and the funding for this post was being used to cover maternity leave absence. The HDU senior nurse was endeavouring to sustain staff education but arrangements for formal education programmes, development of competences and

staff induction were not robust. This should be kept under review to ensure that staff continue to have and maintain appropriate competences.

2 The majority of admissions to the unit are for elective post-operative care. The booking system for elective beds did not appear to be working effectively. As a result, last minute bed management, cancellations and changes to staffing levels were being required. The need for change to the booking system should be considered.

3 The nursing establishment was based on a 5.5 day unit (closing at midday on Saturday and re-opening at midday on Monday). The service had expanded to a seven day a week service and the medical and nurse staffing establishment should therefore be reviewed.

4 The unit collected CCMDS and basic activity data but did not have data on the level of care and dependency. As a result, skill mix and nurse: patient ratios could not be adapted to suit the dependency of the patients. Because the unit cares for level 2 patients only, joining ICNARC may not be the best solution. A system for collection and use of levels of care and dependency data to assist workforce and capacity management should be considered.

5 Several of the guidelines and protocols were not in a standard Trust format and several were inconsistent with respect of formatting and review dates. Several very good policies and guidelines were in draft form and follow-through to finalisation and full implementation will be important.

6 Theatres and the critical care unit should consider the appropriate use of cardiac output monitoring as this may lead to an improvement in cardiac output monitoring.

7 One room functions as both a waiting room for relatives and visitors and a consultation room. Improved facilities for relatives and visitors should be considered.

8 Information leaflets about the HDU were not available. Mechanisms for obtaining feedback from patients and their carers may also benefit from review. Quality rounds and real time surveys were working well and reviewers noted that the unit receives very few complaints and frequent compliments.

9 There was no evidence of multi-disciplinary operational meetings. Professional groups meet at a strategic level but there was no forum for operational issues to be discussed.

Good Practice:

1 Good progress had been maintained on the productive ward. A lead had been identified and good progress had been maintained since initial implementation.

APPENDIX 1 MEMBERSHIP OF VISITING TEAM

Dr Tony Whitehouse	Consultant Anaesthetist	University Hospital Birmingham NHS Foundation Trust
Angela Himsworth	Nurse Lead	Midlands Critical Care Networks
Jeff Osborne	Service Improvement Lead	Midlands Critical Care Networks
Sarah Vickers	Service Improvement Facilitator	Midlands Critical Care Networks

APPENDIX 2 COMPLIANCE WITH THE QUALITY STANDARDS

ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST - SOUTH BIRMINGHAM HEALTH ECONOMY

Analyses of percentage compliance with the Quality Standards should be viewed with caution as they give the same weight to each of the Quality Standards. Also, the number of Quality Standards applicable to each service varied depending on the nature of the service provided. Percentage compliance also takes no account of 'working towards' a particular Quality Standard. Reviewers often comment that it is better to have a 'No but', where there is real commitment to achieving a particular standard, than a 'Yes but' – where a 'box has been ticked' but the commitment to implementation is lacking. With these caveats, table 1 summarises the percentage compliance for each of the services reviewed.

Table 1 - Percentage of Quality Standards met

Service	Number of Applicable QS	Number of QS Met	% met
Critical Care - Trust-wide	**99**	**54**	**55**

CRITICAL CARE

Ref	Quality Standard (QS)	Met?	Comments
EC-201	Lead consultant and lead nurse A nominated lead consultant and lead nurse who also provide critical care services should be responsible for critical care services within the Trust.	Y	
EC-501	Occupancy of critical care unit/s Average bed occupancy in units providing level 2 and 3 critical care should not normally exceed 85%.	N	87.7%
EC-701	Trust-wide critical care group Each Trust should have a critical care delivery group or equivalent involving at least: a. the lead consultant and lead nurse for each critical care area b. a representative of the Outreach Team c. member of the Trust Executive Board responsible for critical care.	Y	The Trust-wide group had merged with the Resuscitation Committee.
EC-702	Critical incident reporting As part of the Trust-wide system, there should be a mechanism for analysing critical incidents. This mechanism should involve critical care unit/s and the outreach team.	Y	

Ref	Quality Standard (QS)	Met?	Comments
EC-703	Annual analysis of services Within the last year the Trust should have undertaken an annual analysis of services, including: a. night-time discharges b. non-clinical transfers c. hours of level 2 and 3 care in inappropriate settings d. time when one bed is available to receive a level 3 patient e. occupancy levels f. workload of outreach team g. future plans for service developments.	N.	Some of this information was captured separately. No yearly analysis of services had been undertaken.
EC-704	Annual analysis of services – action plan The annual analysis of services should have been discussed at the Trust critical care delivery group (or equivalent) and an agreed action plan developed.	N	As EC-704
EC-705	Hospital bed management There should be clear links between the critical care unit and the hospital bed management system, including escalation procedures.	N	
EC-706	Satisfaction survey A survey of patients' and/or relatives' satisfaction with the Trust's critical care services should have been undertaken, discussed at the Trust-wide critical care delivery group (or equivalent) and at least one action agreed.	N	
EC-799	Document control All policies, procedures and guidelines should comply with Trust document control procedures.	N	
EN-101	Pre-admission Arrangements should be in place for offering pre-admission visiting, leaflets or videos for patients and relatives prior to relevant elective admissions.	N	This standard was met in part by Pre Operative Assessment Clinic. Further work needs to be carried out.
EN-102	Admission (1) For admissions, relatives should, where possible, be welcomed by a member of staff within 15 minutes of their arrival in the unit and given a brief summary of what may happen in the next two hours.	Y	
EN-103	Admission (2) A doctor and/or nurse should, where possible, discuss the patient's condition with the family within two hours of their arrival in the unit. This discussion should be documented in the patient's notes.	Y	

Ref	Quality Standard (QS)	Met?	Comments
EN-104	Information Culturally sensitive information should be available for families covering at least: a. admission b. organisation of the unit, including availability of single sex facilities c. direct telephone number(s) d. parking e. visiting arrangements f. facilities for making drinks and light refreshments g. accommodation and facilities for overnight stay h. 'hotel' charges i. facilities for children and people with disabilities who are visiting j. how to contact the unit k. usual arrangements for communication about the patient's condition l. how to arrange a discussion with a doctor about the patient's condition m. availability of interpreters n. involvement of families in care, including participation in the delivery of care and presence during interventions o. discharge p. follow-up arrangements, including a contact number for advice q. access to benefits advice and social services. r. availability of other support services (for example, chaplains, help with care of relatives and pets) s. useful websites, support groups and other sources of information.	N	Work was in progress. Reviewers were informed that verbal evidence that a group was looking at this work. Currently use ROH Trust-wide information leaflet but this does not include HDU information. This will be included in the future.
EN-105	Refreshments Relatives should be able to access drinks and light refreshments within the hospital at all times.	Y	
EN-106	Facilities for overnight stay Access to residential accommodation with at least one bedroom for relatives from the unit should be available. This should include telephone and shower facilities and access for people with disabilities.	Y	
EN-107	Patient communication Appropriate communication aids should be available to enable patients to communicate with their family and with staff.	Y	Emotion Cards were used for adults and paediatric patients.

Ref	Quality Standard (QS)	Met?	Comments
EN-201	Nurse staffing (1) The unit's nursing establishment and nursing rosters should be appropriate to the anticipated number of level 2 and level 3 patients.	Y	Nurse staffing was adequate but was in need of review. The establishment was initially based on the unit opening 5.5 days per week which had subsequently increased to 7 days. Senior nursing staff had to hold the hospital bleep and they were not supernumerary. Many shifts were partly covered by bank or agency staff. Staffing levels: Mon – Fri 3 trained : 1 untrained Weekends 2 trained : 1 untrained
EN-202	Nurse staffing (2) In units with 6 or more beds, there should be at least one supernumerary nurse in charge on each shift.	N	
EN-203	Nurse staffing: continuity of care Nursing staff allocations should be organised to give reasonable continuity of care and flexibility between care of level 2 and level 3 patients.	Y	
EN-204	Nurse staffing: monitoring Arrangements should be in place for monitoring and reviewing sickness, vacancy and turnover levels of nursing staff providing bedside patient care	Y	
EN-205	Nurse training (1) All nursing staff should either have or be working towards competences in critical care appropriate to their role within the unit.	N	Trust wide competence were achieved within the HDU, including, IV, Oral and CD competence. No specific Band 5 or 6 competency packages were available. Current ITU programme was run in conjunction with UHB. PDN was only 0.5 wte. Staff were doing as much as they could but appropriate competencies were not yet in place.
EN-206	Nurse training (2) On each shift there should be a minimum of one nurse who is studying for or has achieved a formal qualification in critical care for every four level 2 patients / every two level 3 patients.	N	Future Development.
EN-207	Administrative and clerical support Administrative and clerical support should be adequate for the number of beds and the usual level of care provided.	N	Ward Clerk cover was only 28.5 hours per week Monday - Friday.

Ref	Quality Standard (QS)	Met?	Comments
EN-208	Professional development team There should be a professional development team responsible for continuing professional development of nursing, HCAs and ancillary staff providing critical care services. This team should be involved in delivering level 1, 2 and 3 programmes of education, training and development.	N	Establishment was 0.5 WTE Band 7 PDN but funding was being used to fund maternity leave cover.
EN-209	Rotation Suitably qualified nurses on the critical care unit should have the opportunity to rotate into the outreach team.	N	Current staffing did not allow this. Plans were to start rotation in December.
EN-210	Consultant staffing: weekday daytime On weekdays there should be at least 1 ITU trained or experienced consultant every 8 beds usually providing level 3 care / every 16 beds usually providing level 2 care. This consultant's sole role for the day should be the care of critically ill patients and s/he should not have responsibilities elsewhere. An ITU trained or experienced consultant is someone who has a CST/CCST or equivalent in critical care or someone who undertakes regular day-time sessions on the critical care unit. All ITU trained and experienced consultants should be undertaking regular CPD of relevance to their work on the critical care unit.	Y	Staffing was 0.5 WTE per day for the 12 bedded HDU.
EN-211	Consultant staffing: evenings, nights and weekends There should be at least one ITU trained or experienced consultant available for each unit at evenings, nights and weekends.	N	Approximately 60% of consultants had training. There was not evidence that others were undertaking CPD of relevance to their work on the HDU.
EN-212	Other medical staffing There should be at least 1 non-consultant doctor dedicated to critical care services for every 8 beds usually providing level 3 care / every 16 beds usually providing level 2 care. This doctor's sole role for the day should be the care of critically ill patients and s/he should not have responsibilities elsewhere.	Y	
EN-213	Other medical staff: training All non-consultant medical staff should have or be working towards competences appropriate to their role on the unit. All non-consultant medical staff should be undertaking regular, relevant CPD.	N	This work was in progress with approximately 50% compliance at the time of the visit.
EN-214	Medical staff: continuity of care Medical staff rotas should be organised to give reasonable continuity of care.	N	Rotas were not organised to give continuity of care.
EN-215	Induction All new critical care staff should have induction programmes. For medical staff, this induction must include their responsibilities in relation to the outreach team.	N	Induction did not cover all disciplines.

Ref	Quality Standard (QS)	Met?	Comments
EN-216	Training All staff employed in the critical care unit should have an assessment of their training needs at induction and annually thereafter as part of their annual appraisal.	Y	
EN-217	Staff support Policies should be in place covering: a. family-friendly working / rostering arrangements for all staff b. safety and security of staff c. access to occupational health and other support mechanisms for all staff d. professional mentorship or support for all clinical staff (which could include clinical supervision).	Y	
EN-218	Team building The unit should encourage and enable team building activities.	Y	A range of activities was undertaken.
EN-301	24 hour access 24 hour access should be available to: a. on-site imaging service b. endoscopy service c. physiotherapy d. pharmacy e. pathology services f. spiritual care g. domestic cleaning.	Y	a) yes b) yes c) yes on call available d) yes e) yes go to Q.E.H f) yes g) yes on-call available.
EN-302	Daily sessional support Daily sessional support should be available from: a. physiotherapy b. pharmacy c. nutritional support	N	a) yes b) yes c) only twice a week.
EN-303	Links with other services Effective links should be in place with: a. occupational therapy b. speech and language therapy c. acute pain management d. counselling services e. bereavement services f. interpreters / cultural liaison services g. clinical psychology h. social services i. transplant services	Y	i. Not applicable
EN-304	Laboratory communication Units should have agreed arrangements for rapid transfer of samples to laboratories and availability of results: Urgent within 1 hour Routine within 2 hours.	N	Laboratory services were available but not within the expected timescales.

Ref	Quality Standard (QS)	Met?	Comments
EN-305	Pharmacy communication Units should have agreed arrangements for ensuring: Availability of non-stock drugs within 1 hour Availability within 1 hour of additional stock items at times of peak demand.	N	Pharmacy services were available but not within the expected timescales.
EN-401	Bed spaces There should be at least 20m2 for each bed and 2.5m of unobstructed corridor space beyond the working area.	Y	
EN-402	Isolation facilities There should be: a. at least one single room for every six beds in open areas, or b. agreed arrangements for minimising the risk of cross infection.	Y	
EN-403	Mattresses and bed frames All units should have access to mattresses and bed frames that are appropriate for the clinical needs of the patients.	Y	
EN-404	Piped oxygen and air There should be at least four oxygen and two air outlets for each bed.	N	Adequate for the level provided
EN-405	Electricity supply At least 24 electricity sockets per bed should be available. At least three of these sockets should have an uninterruptible power supply.	N/A	Level 2 facility
EN-406	Scavenging Scavenging points should be situated in all areas where anaesthetic gases or vapours may be used.	N/A	Level 2 facility
EN-407	Suction Each bed should have at least two suction outlets. In addition, each unit should have two portable suction devices.	N	Only one portable suction unit was available.
EN-408	Telephones The following telephones should be available: a. at least 1 per patient area capable of being moved to each bedside b. main nurses' station phones appropriate to the size of the unit and with sufficient capacity to handle an emergency incident. c. one in each office d. relatives room (internal phone).	N	Insufficient were available
EN-409	Intubation equipment An intubation tray equipped for immediate use should be available in each unit.	Y	
EN-410	Emergency ventilation Emergency ventilation equipment, including a self-inflating bag, should be available at each bed.	N/A	Not a Level 2 facility.

Ref	Quality Standard (QS)	Met?	Comments
EN-411	Monitors (1) Each bed space should have the capacity for: a. ECG, respiration, saturation and non-invasive blood pressure monitoring b. transducing 3 pressure traces c. temperature monitoring at 2 sites d. access to facilities to measure cardiac output.	N	a) yes b) yes c) yes d) not available.
EN-412	Monitors (2) The monitors listed in A2.11 should be available in a modular unit capable of integration with A&E, theatre and portable monitoring systems.	Y	
EN-413	Pumps (bedside) For a level III admission each bedside should have access to at least: a. One feed infuser b. Two volumetric infusers c. Four syringe drivers.	N/A	Level 2 facility
EN-414	Pumps (unit) Each unit should have easy access to: a. A rapid infusion device b. Patient controlled analgesia devices as required.	Y	
EN-415	Ventilators (level 3 care) There should be one ventilator immediately available for each bed space normally used for level 3 care. For each 10 bed spaces there should be one extra ventilator available in case of breakdowns. All ventilators should be less than 10 years old.	N/A	Level 2 facility
EN-416	Ventilators (level 2 care) Units providing level 2 care should have a mechanism for accessing additional ventilatory assistance at times of peak demand.	Y	
EN-417	Patient chairs One patient chair should be available for: a. every 4 beds normally used for level 3 care b. every 2 beds normally used for level 2 care.	Y	
EN-418	Relatives chairs There should be 2 non-wheel, non-fabric, stackable chairs for every bed space.	Y	
EN-419	Seating for staff Each bed space should have one stool or non-fabric chair for staff use.	N	Staff do not sit by the beds.
EN-420	Lighting All patient areas should have: a. Adequate lighting with brightness control b. Procedure lamps c. Night lighting, preferably at a low height. Ideally, patient and staff areas should have natural lighting and patients should be able to see out of the windows.	Y	

Ref	Quality Standard (QS)	Met?	Comments
EN-421	CPAP CPAP capability should be available for each bed space	N/A	BIPAP was available.
EN-422	Non-invasive ventilation Each unit should have non-invasive ventilation available in appropriate numbers for the case-mix of the unit.	Y	BIPAP facilities were available.
EN-423	Continuous renal replacement therapy device In critical care units that perform Renal Replacement Therapy (RRT), every four beds potentially used for level 3 care should have one continuous renal replacement therapy device. Isolated units providing level 1 and 2 care should have access to a continuous renal replacement therapy device.	N/A	
EN-424	Defibrillators There should be one defibrillator for each patient care area, dedicated for use in that area.	Y	
EN-425	Sinks One sink should be available for every two beds in open areas and for every bed in a single room.	Y	
EN-426	Infection control Gloves, aprons, hand hygiene gel, a sharp disposal bins and a clinical waste bin should be available at each bed space. Hand hygiene gel should be available at the unit entrance.	Y	
EN-427	Laundry The unit should have clean bed linen, towels, curtains and patient gowns/clothing available at all times. Adequate arrangements should be in place for laundering staff working clothes.	Y	
EN-428	Air management All patient areas, including single rooms, should have air conditioning capable of both heating and cooling. There should be at least the following air changes per hour: Single rooms 15 Other patient areas 3 Lab and 'dirty' areas 5 Staff areas 2.	Y	

Ref	Quality Standard (QS)	Met?	Comments
EN-429	Other facilities Other facilities should be available and comply with nationally recognised standards: a. Sluice b. Clean and dirty preparation areas c. Storage for waste, bulk equipment and bedside equipment d. Laboratory e. Relatives areas (at least two rooms) f. Offices g. On call rooms h. Staff rest area i. Seminar room j. Entry phone and security arrangement k. Internet access.	N	All aspects of the QS were met except relatives rest area and seminar room. a) yes b) yes c) yes d) yes e) no f) yes g) yes h) yes i) no available but away from HDU j) yes k) yes
EN-430	Manual handling Each unit should have: a. one hoist capable of lifting 150kg b. one hoist capable of lifting over 150kg c. appropriate manual handling devices for lifting haemofiltration fluids and other heavy loads.	Y	
EN-431	Resuscitation drugs Resuscitation drugs should be available and checked in accordance with the Trust's resuscitation committee policy.	Y	
EN-432	Blood fridge The unit should have access to a blood refrigerator.	Y	
EN-433	Patients' bathroom An appropriately equipped patients' bathroom should be available in all units normally providing level 2 care. Units normally providing level 3 care only should have access to such a facility.	N	There was only 1 toilet facility for patients and staff. No shower or bath facilities were available.
EN-501	Unit Guidelines (1) Appropriate multidisciplinary guidelines should be in use within the unit, covering at least: a. consent to treatment b. infection control c. nutrition d. medicines management e. pain management f. nursing care (for example, mouth and bowel care) g. withdrawal and limitation of treatment h. organ donation. i. Rehabilitation after critical illness	Y	

Ref	Quality Standard (QS)	Met?	Comments
EN-502	Unit Guidelines (2) Appropriate multidisciplinary guidelines should be in use within the unit, covering at least: a. sedation b. brain stem death c. spinal injuries d. traumatic head injury e. sepsis f. antimicrobial use g. tracheostomy care	N	Some guidelines were not available including c,e and f.
EN-503	Saving Lives Campaign In compliance with the "Saving Lives Campaign" the principles of Care Bundles should be applied to address the following High Impact Changes: No1: Central venous catheter care No2: Peripheral intravenous cannula care No3: Renal dialysis catheter care No4: Preventing surgical site infection No5: Care of ventilated patients No6: Urinary catheter care No7: Reducing the risk of C. Difficile.	Y	
EN-601	Admission The unit should have agreed arrangements for admission of patients covering at least: a. types of patient admitted b. referral process c. assessment of patients d. review by a consultant within 12 hours.	N	Policy was in draft form.
EN-602	Consultant rounds There should be a consultant-led multi-disciplinary 'round' of the critical care unit at least daily.	N	There was no nurse or pharmacy involvement.
EN-603	Visiting arrangements There should be an agreed policy on visiting arrangements. This should include: a. the first time relatives see the patient b. arrangements for visiting dying patients c. arrangements for children to visit.	N	Policy was being developed.
EN-604	Communication with families The unit should have written guidelines on communication with patients and families, including respect for patients' privacy and confidentiality.	N	Guidelines were In draft form. See also main report.
EN-605	Feedback from patients and families The unit should have a system for reviewing and learning from patients' and families' complaints and letters of thanks.	Y	.
EN-606	Specialist team liaison Arrangements should be in place for liaison with appropriate specialist teams involved in the care of patients on the unit.	N/A	
EN-607	Handover The unit should have structured arrangements for handover of patients at each change of responsible consultant, non-consultant medical staff, nursing staff and other staff.	Y	Productive Ward Module on handover had been completed.

Ref	Quality Standard (QS)	Met?	Comments
EN-608	Care plans For each patient there should be a multidisciplinary daily plan of care that is updated each day. This should include the expected level of monitoring and mobilisation.	Y	More in-depth care planning may be helpful.
EN-609	Discharge The unit should have agreed arrangements for discharge of patients covering at least: a. Preparation for discharge b. Including medical and nursing summaries of clinical information in patients' notes prior to discharge from the unit.	N	Policy was in draft form.
EN-610	Long-term follow up The unit should have agreed arrangements for long term follow-up of patients discharged from the unit.	N/A	
EN-611	Death certification Arrangements should be in place to ensure availability of a death certificate and release of the body within 24 hours of death (exceptions may be made at weekends and bank holidays), except where the coroner is involved.	Y	
EN-612	GP notification of death Following a patient's death, arrangements should be in place to notify their GP by the end of the next working day.	N	Arrangements were not in place.
EN-613	Communication with primary care There should be agreed arrangements for communication with primary care, which should include communication of follow-up arrangements.	N	Locally agreed arrangements were in place but not formalised.
EN-614	Updating The unit should have a mechanism in place to review and disseminate published scientific evidence relating to critical care.	Y	
EN-615	Multi-disciplinary meetings There should be an agreed structure of multi- and uni- disciplinary meetings to ensure that all staff are involved in the running of the unit. These meetings should include appropriate arrangements for review of morbidity, mortality, transfers and outcomes.	Y	See main report.
EN-616	Equipment maintenance The unit should have agreed arrangements for maintaining an overview of service contracts for equipment and for ensuring regular maintenance. Responsibility for equipment maintenance should be clearly defined.	Y	
EN-617	Cleanliness The unit should be clean and tidy.	Y	

Ref	Quality Standard (QS)	Met?	Comments
EN-618	Capacity management The unit should have systems in place to monitor and manage capacity and patient flows. These systems should include: a. Arrangements for flexing level 2 and 3 capacity b. Monitoring delayed discharges and refused admissions c. Escalation policy.	N	a) N/A b) Done, but admissions and patient flows could be looked at in more detail. c) was being discussed. Reasonable system was in place but it was not documented.
EN-619	Care of Children The unit should comply with the standards relating to general intensive care for children in Section C, Standards for The Care of Critically Ill and Critically Injured Children in the West Midlands (Version 3).	N	Based on the information available, the unit was not fully compliant. Back up was available from the paediatric ward and paediatric consultants visited the unit daily. Children are routinely nursed in side rooms. Should ward beds be required then children are cohorted and segregated from the adult beds by large portable screens
EN-701	Audit Regular, multi-disciplinary audit should take place within the unit. This should cover the whole audit cycle, including implementing and auditing changes in practice.	Y	Local audits available were available
EN-702	Activity and staffing data Critical care unit data should be collected routinely on: a. nursing staff allocation b. patients' level of care c. available capacity.	Y	Basic information only was available.
EN-703	Bed register The unit should contribute data to the network bed management system or the live bed register.	N/A	
EN-704	ICNARC data The unit should collect and submit ICNARC data in accordance with ICNARC quality standards for collection and submission and participate in the ICNARC case mix programme.	N/A	
EN-705	CCMDS The unit should collect and submit the critical care minimum dataset.	Y	
EP-101	Short-term follow-up There should be agreed arrangements for routine follow-up of patients who have been discharged from the critical care unit. These arrangements should cover: a. information b. support and advice on physical and psychological problems c. referral to other support services d. visits to the unit.	Y	Follow-up arrangements were undertaken but the policy was not finalised.

Ref	Quality Standard (QS)	Met?	Comments
EP-201	Outreach team There should be an outreach team (or equivalent) able to cover all areas where level 1 care may be provided. This team should be available 24 hours a day and comprise a minimum of one nurse per shift per hospital site.	N	Outreach was available 8am – 4pm, Monday to Friday. Only 1.0 WTE was available with 1.0 WTE post vacant. Staff were trying to appoint for an additional nurse and extra hours so they could do more training.
EP-202	Medical lead A named critical care consultant should have lead responsibility for ensuring medical support is available to the outreach team.	Y	
EP-203	Qualifications All nurses working in the outreach team should have a formal qualification in critical care and two years critical care experience after achieving this qualification.	N	Work was in progress.
EP-501	Operational policy The outreach team should have an agreed operational policy. This should cover, at least: a. admission b. retrieval c. communication with and accessing multi-disciplinary support and advice from the critical care service. d. referral to critical care services e. communication mechanisms f. responsibility of outreach and 'parent' teams g. referral for long-term follow-up h. education and training.	N	Policy was in draft form.
EP-502	Triggering Referral The mechanism for referral to the outreach team should be easily available on adult wards and in other potential risk areas.	Y	
EP-701	Data collection A minimum data set should be collected.	Y	
EQ-501	Transfer policy The network transfer guidelines and policy should be in use within the hospital.	Y	

Ref	Quality Standard (QS)	Met?	Comments
EQ-502	'Outlier' policy The Trust should have a policy covering the care of level 2/3 patients if level 2/3 care is not immediately available. This policy must ensure that a level 2/3 patient is cared for by a member of staff with appropriate critical care skills and that, if the patient is in an isolated environment, this member of staff is never unaccompanied. The policy must cover: a. nursing staff b. medical cover c. access to equipment d. communication with the critical care unit e. process for clinical and managerial escalation with specified time limits f. any area-specific variations to the above reflecting the differing needs of, for example, A&E, wards and theatres.	N	Policy was in draft form.
EQ-701	Transfer audit The hospital should be submitting copies of transfer forms to the network office for inclusion in the network transfer audit.	Y	
EQ-702	Level 1 competency There should be an agreed process for ensuring that nurses and junior medical staff working in potential risk areas have training in the recognition and immediate management of acutely ill and deteriorating patients.	Y	