Gloucestershire Hospitals NHS Foundation Trust

Cheltenham General Hospital

Inspection report

Sandford Road
Cheltenham
GL53 7AN
Tel: 08454224721
www.gloshospitals.nhs.uk

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Ratings

Overall rating for this location	Requires Improvement
Are services safe?	**Requires Improvement**
Are services effective?	**Good**
Are services caring?	**Good**
Are services responsive to people's needs?	**Requires Improvement**
Are services well-led?	**Requires Improvement**

Our findings

Overall summary of services at Cheltenham General Hospital

Requires Improvement  

Gloucestershire Hospitals NHS Foundation Trust received authorisation on 1 July 2004. It was formed from Gloucestershire Hospitals NHS Trust, which was established following a reconfiguration of health services in Gloucestershire in 2002. The Trust provides acute hospital services from two large district general hospitals, Cheltenham General Hospital (CGH) and Gloucestershire Royal Hospital (GRH). Maternity Services are also provided at Stroud Maternity Hospital. Outpatient clinics and some surgical services are provided by Trust staff from community hospitals throughout Gloucestershire. The Trust also provided services at the satellite oncology centre in Hereford County Hospital.

We carried out this short announced focused inspection because at our last inspection in April 2022, we rated the trust overall as requires improvement and two warning notices were issued for Surgery and Maternity

Surgery

Inspected but not rated

- Staff told us that they felt there had been an improvement in staffing since last inspection and we note that vacancies across the directorate and been reduced.
- Staff informed us that they had a positive relationship with their directorate managers who were visible on the units at Gloucester and Cheltenham sites.
- Staff and patients told us that they liked the design of the Chedworth Unit.

However:

- We were informed that children undergo non-specialist emergency surgery at CGH, and the standard operating procedure may not meet national guidance.
- We visited the Chedworth Surgical Unit Cheltenham General Hospital and found that multiple oxygen bottles were stored in the discharge unit which was currently not in service.
- On the day of the visit the temperature of the Chedworth unit was very warm in places, the room temperature where medications are stored were not recorded.

Is the service safe?

Inspected but not rated

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not always keep people safe. Staff were trained to use equipment. Staff managed clinical waste well.

The service had recorded a risk around the transportation of patients across the hospital to inpatient units. We were informed that these moves could take up to 30 minutes, which risked staff fatigue, muscular skeletal injuries and burnout of staff. We were informed that equipment has been purchased to help mitigate the risk and the Trust is currently waiting on delivery.

Chedworth day surgical unit;

On our previous inspection we found that the location used as a recovery unit did not have suitable facilities for patients requiring ward-based care.'

This unit was opened following our last inspection. In parts of the unit the temperature was uncomfortably high despite all heating on the unit being switched off. Staff stated that this was due to the unit being positioned above the central

sterile services department (CSSD) and that the autoclaves created a high degree of heat. We were informed that thermometers had been ordered for the unit; however, there was no evidence of room temperature measurement, and this included the room where medication was stored. This would mean that the staff were unable to monitor whether medication was being stored at the manufacturers recommended temperature.

We were told the day surgery unit was designed so as not to accommodate overnight patients preventing the routine boarding of patients. The waiting areas were pod shaped with doors which made them intentionally narrow so that a bed would not fit, and a trolley fitted with difficulty. There was no piped oxygen or suction in the pods. In the event of an emergency, there was portable oxygen and suction available. In the 2 single sexed bays, every trolley space had piped oxygen, air and suction if required. Patients were not boarded overnight on the unit.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

On our last inspection we found that staff were using a nationally recognised tool to identify deteriorating patients. However, we observed that risks to patients were not always escalated appropriately and that some patient care was not managed in accordance with guidance.

On this inspection we found that staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately

Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident.

Staff knew about and dealt with any specific risk issues.

Shift changes and handovers included all necessary key information to keep patients safe.

Results of an early warning score audit for surgical division in April 2023 reported the following results. Of the 20 patient observations audited the following was reported:

70% observations recorded within the first hour of arrival to the ward.

100% included all six recommended observations and calculations of NEWS2.

100% of observations were recorded within a track and trace system.

100% of patients had observations and NEWS2 completed at least every 12 hours

This was an improvement on previous audit results. We found that 3 patients had a NEWS2 score greater than 5 during the inpatient admission to date. A medium NEWS2 score (5–6) is a key trigger threshold and should prompt an urgent review by a clinician. Of these patients, all had increased their levels of observation in accordance with the trust protocol. All 3 clinical plans documented the increased level of intervention. This was an improvement on our findings in our previous report of 2022.

Surgery

We reviewed the notes of 10 patients. All patients were found to have a NEWS2 chart in place which had been fully completed. Risk assessments for falls were 100% completed, Moving and handling was 80%, pressure damage was 100%, Malnutrition was 100%, Bed rails was 100%, and Venous thromboembolism (VTE) was 100%. There was evidence on the wards of the results of these being disseminated to the staff and lessons learnt were highlighted for learning purposes.

The trust provided a copy of the clinical standard operating procedure (SOP) for the operation of both Gloucester Royal Hospital and Cheltenham General Hospital recovery units. There was a SOP published in November 2022 which provided details of working practices in hours and out of hours anaesthetic and medical cover including on-call provision. This also directed staff to use the incident reporting tool if the patient stay exceeded 4 hours post recovery completion. The document contained details of the discharge escalation process together with a matching SOP response card which referred to single sex accommodation breach reporting procedure.

Medicines

Not all medicines practices were safe and potentially placed patients at risk of harm.

The medicines storage room on the Chedworth Day Surgery unit did not have a means for recording room temperature.

The discharge room on the Chedworth surgical unit, which was not in use, was being used for the storage of oxygen. This was not stored in accordance with the Safe Use of Oxygen Cylinders NHS England January 2023.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service.

Staff knew what incidents to report and how to report them.

Staff raised concerns and reported incidents and near misses in line with trust policy.

The service had reports having had no never events report across the surgical directorate since 19 December 2021. Never events are defined as incidents that are wholly preventable because guidance or safety recommendations had not been followed.

Managers shared learning about never events with their staff and across the trust. Staff spoken with confirmed that there were weekly reviews of risks, and that there were reviews at quality Board and divisional board levels. There were fortnightly escalation reports which were circulated in a twice weekly drop-in support covered learning points from incidences.

Is the service responsive?

Inspected but not rated

Access and flow

People could always access the service when they needed it and received the right care promptly.

Surgery

On our last inspection we were informed that the theatre recovery data illustrated that out of 120 days, there were 46 days in which patients stayed overnight.

On this inspection we found that managers monitored that patient moves between wards/services were kept to a minimum.

We were informed that there had been no patients staying overnight in recovery since May 2022. Most patients treated at the hospital were day cases. We were told by staff that since the last inspection more streamlined processes have been put in place to ensure patient flow was more responsive.

Anaesthetic cover after 9pm is provided by a 1st and 2nd on call consultant.

On this inspection we found that there was no designated surgical paediatric recovery area at Cheltenham General Hospital during normal operating hours. We were informed that there was an area used for paediatric cases out of hours and that 6 paediatric patients had been admitted to CGH since May 2022, all out of hours. When we reviewed cases of children presenting with testicular torsion (when the testicle rotates), we found when a case was presented at the emergency department CGH, the band 7 nurse was expected to nurse / discharge the paediatric patient. We were informed by staff that there was no paediatric staff in recovery or theatres, with no paediatric surgeon or paediatric consultant, paediatric anaesthetist on site. Theatre nurses were trained in paediatric life support. The anaesthetic consultant on call would attend out of hours admissions but left once the patient was awake. This did not conform to national guidance.

We were informed that there is currently an external review being undertaken by the Southwest Regional Paediatric Team of National Health Service England (NHSE) at the request of the Trust to identify steps that can be taken to improve care for children in time critical emergencies.

Is the service well-led?

Inspected but not rated

Leadership

They were visible and approachable in the service for patients and staff.

The staff stated that the Divisional Leads and Senior Management were visible on the units and there were regular team and mentor meetings. Staff spoken to stated that the executive team was not as visible but social media and virtual teams' meetings were in use.

The executive team provided details of ward visits and scheduling of future visits. The Chief Executive Officer (CEO) had gone to considerable lengths to address perception of visible leadership. And members of the executive board had spent time working and visiting the surgical services.

We were shown an example of a ‘we said, you did’ initiative for the Post-Anaesthesia Care Unit (PACU). This gave details of the format for proposals to provide extra training for staff working with more complex cases.

Surgery

Governance

Leaders operated effective governance processes, throughout the service. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

On our last inspection we found that the trust did not have an effective governance process in place.

At this inspection we found that the trust governance processes provided a review of the trust action plan sent to CQC. A standard operating procedure for governance processes had been implemented which included a tracking system to ensure policies were kept under timely review. The number of overnight stays in recovery had been significantly reduced to none since May 2022… '

and the NEWS2 audit program had now been established.

The Electronic Patient Record (EPR, 24-hour patient documentation) was reported as having risen from 78% compliance by staff, in April 2022 to 84% in January and 86% compliance in March 2023. Work was ongoing to create a seamless EPR system across the patient pathway.

All SOP and policies were in place for theatres. Currently there were 21 SOPs with 3 awaiting review and a further 3 were in draft.

Management of risk, issues and performance

Leaders and teams identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

On our last inspection we found that there was a lack of assessment of risks to the health and safety of service users receiving the care and treatment.

The Trust had a cross county clinical governance meeting for anaesthetics, theatres, critical care and pain services. Chaired by the consultant anaesthetist and clinical governance lead, staff attended from all areas and include consultant anaesthetists, matrons and senior nursing staff. The meeting reviewed the risk register and provided details of incidents and progress reports.

This meeting reviewed operating practices, presented learning from complaints, incidents and risk escalation and safety alerts. A copy of the CQC action plan was also included.

A review of risks was undertaken with the risk team, then it was reviewed at both the quality board and the divisional board. A fortnightly escalation report was circulated, and ward areas were supported by a twice weekly drop-in session with risk lead managers. The trust had resumed its deteriorating patients committee and there was currently a review of the workforce and needs taking place.

Each area had a Surgical directorate clinical governance board. This board was in a prominent place for all staff and had headings that included incidents, shared learning, identified risks for the trust and the surgical division. We were shown updates of clinical audits, patient experience, training compliance, training and education improvement opportunities and vacancies. The directorate also produced a SOP newsletter which was distributed to staff, which provided updates on any changes to standard operating procedures. There was also a shared drive where staff had access to agreed policies, incident reviews and information note.

Surgery

The Trust had a guideline for paediatrics – urgent and emergency treatment which required any child requiring a general surgical option to be admitted to GRH children's inpatient unit. The trust also had guidance around anaesthesia and intensive care for paediatrics review date June 2024 which provided guidance for paediatric anaesthesia for children age birth to age 16.

Outstanding practice

We found the following outstanding practice:

- The Chedworth Surgical Unit has been designed specifically for day surgery purpose and has design features that make it difficult for it to be used for overnight stay.
- The trust has sustained zero never events for its surgical division for 256 days. This has been achieved through a multi-disciplinary, multi stranded improvement project and the adoption of a culture of continuous quality improvement within the surgical division.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

- The trust must ensure that its provision for paediatric surgery at Cheltenham General Hospital follows the standards of Royal College of Surgeons. In this document it lists the standards for specialist emergency surgical care of children. (Regulation 17(1)(2)(a)
- The trust must ensure there is a method of recording the temperature of the medication storage room on the Chedworth Day Surgery Unit (Regulation 12(2)(g)

Action the trust SHOULD take to improve:

- The trust should ensure that oxygen cylinders are stored correctly with the correct signage. Regulation 12.

Our inspection team

How we carried out the inspection

The inspection team consisted of 1inspector and 1 specialist advisor with expertise in surgery.

The inspection was overseen by Catherine Campbell Deputy Director of Operations.

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

We reviewed documents and records kept by the service. For surgery we spoke with 12 staff and 2 patients at Cheltenham General Hospital. In addition, we reviewed 10 sets of patient notes.

You can find further information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Surgical procedures	Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulated activity	Regulation
Surgical procedures	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment