Care Quality Commission

# Sherwood Forest Hospitals NHS Foundation Trust

# Newark Hospital

## Quality Report

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

## Ratings

| | |
|---|---|
| Overall rating for this hospital | Requires improvement |
| Minor injuries unit | **Requires improvement** |
| Medical care (including older people's care) | **Requires improvement** |
| Outpatients and diagnostic imaging | **Requires improvement** |

# Newark Hospital

## Detailed findings

**Services we looked at**
Urgent and emergency services; Medical care (including older people's care); Outpatients and diagnostic imaging.

# Detailed findings

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## Background to Newark Hospital

Newark Hospital provides a range of treatments, including consultant-led outpatient services, planned inpatient care, day-case surgery, endoscopy, diagnostic and therapy services and a 24 hour minor injuries unit. There are two medical wards and a GP led rehabilitation unit.

## Our inspection team

Our inspection team was led by:

**Head of Hospital Inspections:** Carolyn Jenkinson, Care Quality Commission

**Inspection Manager :** Helen Vine, Care Quality Commission

The team included CQC inspectors, inspection managers, clinical fellows, a paramedic operations officer, nurse practitioner, a geriatrician, a junior doctor, a head of nursing and midwifery, an associate director, a non-executive director, a director of nursing and a mental health act reviewer.

## How we carried out this inspection

This was a focused unannounced follow up inspection to check progress against our findings from our inspection of June 2015. We inspected:

- Emergency and Urgent Care Services at Newark Hospital looking only at the safety of these services.
- Medical Services at Newark Hospital looking only at the safety and effectiveness of these services.
- Outpatient (but not diagnostic) Services at Newark Hospital looking only at the safety of these services.

Before visiting, we reviewed a range of information we held including information from clinical commissioning group, NHS England, NHS Improvement, Health Education England and the local Healthwatch.

We carried out an unannounced inspection from 18 – 20 July 2016. We inspected three of the trust's locations; Kings Mill Hospital, Newark Hospital and Mansfield Community Hospital.

We talked with patients, their carers and staff from support services, ward areas and outpatient areas. We also reviewed patient records.

# Detailed findings

## Facts and data about Newark Hospital

Between July 2015 and June 2016 the minor injuries unit treated 21,168 patients, 28.5% of these were children.

There were 3,137 admissions to medical services at Newark Hospital between July 2015 and June 2016. Of these admissions 79% were day cases, 7% elective cases and 14% emergency cases. Most admissions were in gastroenterology and dermatology specialities.

Between July 2015 and June 2016, 80,984 outpatient appointments were booked at Newark Hospital.

# Minor injuries unit

| | |
|---|---|
| Safe | Good |
| Overall | Requires improvement |

## Information about the service

Newark Minor Injuries Unit and Urgent Care Centre is open 24 hours per day, seven days per week. Patients are offered assessment and treatment for minor injuries and illnesses such as sprains and strains, broken bones, wounds, lacerations, minor burns and scalds, minor head injury, insect and animal bites, minor eye injuries and conditions. X ray and blood testing facilities are available on site. Patients presenting with serious injury or illness are stabilised as appropriate and arrangements made to transfer them to the nearest acute hospital.

Between July 2015 and June 2016 the unit treated 21,168 patients, 28.5% of these were children. During our inspection we spoke with four staff, and we reviewed two sets of patient records.

During our inspection we noted that refurbishment work was taking place in the department and took this into account in our findings.

## Summary of findings

# Minor injuries unit

## Are minor injuries unit services safe?

Good

**We rated the safety of Newark Minor Injuries Unit as good because:**

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses; they were fully supported when they did so. Learning from incidents and near misses was shared across the trust.
- When something went wrong, patients received a sincere and timely apology and were told about any actions taken to improve processes to prevent the same happening again.
- There were clearly defined and embedded systems, processes and standard operating procedures to keep patients safe and safeguarded from abuse. Staff were aware of safeguarding procedures and worked effectively with other relevant organisations.
- Staff had received up-to-date training in all safety systems.
- Staffing levels and skill mix were planned, implemented and reviewed to keep people safe at all times. Any staff shortages were responded to quickly and adequately. There were effective handovers and shift changes, to ensure staff could manage risks to patients who used the service.
- Risks to patients who used the service were assessed, monitored and managed on a day-to-day basis. These included signs of deteriorating health, medical emergencies or behaviours that challenged.
- Plans were in place to respond to emergencies and major incident situations. All relevant parties understood their role and the plans were tested and reviewed.

**However we also found:**

- The inter-facility transfer protocol with the local NHS ambulance trust had not been updated since 2012 despite the concerns we raised at our last inspection about delayed patient transfers.
- The trust did not have a protocol for the management of the sick child in the minor injuries unit.

**Incidents**

- The unit was linked to the trust electronic incident reporting system. Staff told us they were aware of how to report an incident and received individual feedback and shared learning on incidents occurring across the trust. They gave the example of the introduction of oral medicine syringes which was an action from a recent incident that took place in the emergency department at Kings Mill hospital.
- The nurse in charge of the unit attended the emergency medicine clinical governance meeting and shared the information with Newark minor injuries staff through e mails, one to ones and through an information folder. We saw the folder which contained information about new policies and procedures and other relevant clinical information such as the minutes from a sepsis task meeting. Staff signed to indicate they had read the information.
- There were no never events reported between June 2015 and May 2016. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
- We saw from the minutes that information about mortality and morbidity was shared through the emergency medicine clinical governance meeting.
- We asked staff about the duty of candour. All staff were able to demonstrate that they were aware of, and understood, the duty of candour. They also referred to the trust duty of candour policy on the intranet. We saw this information had been included in the 'sign off' folder which was used for staff communication. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.

**Cleanliness, infection control and hygiene**

- Despite the on-going refurbishment works the areas of the unit in use which we inspected were visibly clean and tidy. Additional weekly cleanliness checks were taking place to ensure the refurbishment work was not having a detrimental effect on cleanliness.
- We saw the domestic service audit sheet for June 2016 which scored the unit 100% for cleanliness.

- Hand sanitising gel was readily available throughout the unit and we observed staff performing good hand hygiene practice, bare below the elbow in line with trust policy. Personal protective equipment, gloves and aprons, were available for use and we saw staff use them.
- Mandatory training for staff included sessions on infection prevention and control and hand hygiene. Training compliance was 85% which was above the trust target of 80%.
- All patients were routinely asked about methicillin resistant staphylococcus aureus (MRSA) as part of their patient assessment. MRSA is a bacterium responsible for several difficult-to-treat infections.
- All staff had successfully completed competencies in aseptic (sterile) procedures and could access information about these on the trust intranet.

**Environment and equipment**

- The reception area was light and airy with plenty of space for patient seating. There was a separate waiting area for children which was suitably decorated and furnished with child friendly art work and a selection of toys. Although most of the children's waiting area was visible to both the reception staff and nursing staff a small 'blind spot' had been identified in the children's area. This was being rectified by the positioning of a large mirror.
- There was a dedicated paediatric treatment room.
- AT our last inspection we raised concerns that emergency lifesaving equipment was insufficient and in some cases unsafe for use in the minor injuries unit. During this inspection we found resuscitation equipment was supplied and sealed by the medical emergency management device department based at Kings Mill hospital. If the trolley was used a spare was kept as a replacement and the used trolley replaced with a new one from Kings Mill Hospital. The trolley tag was in date and the equipment we checked was in date. The paediatric resuscitation equipment contained a range of different sized equipment and was checked regularly.
- We found at our last inspection that ligature risk assessments had not taken place and ligature risks were visible in the department. A ligature point is anything which could be used to attach a cord, rope or other material for the purpose of hanging or strangulation. Ligature points include shower rails, coat hooks, pipes and radiators, bed frames, window and door frames, ceiling fittings, handles, hinges and door closures. This had been addressed since our last inspection.
- Curtain rails were collapsible and pull cords in the toilets had been enclosed in a rigid plastic sleeve.
- Ligature cutting equipment was available and staff knew where this was stored.
- There was a safe and effective system for the repair and maintenance of equipment.
- We saw the most recent patient led assessment of the care environment report dated May 2016. The report did not highlight any areas of significant concern.
- The clinical waste area was in the refurbishment area but was still visibly clean and tidy. Waste was segregated and managed according to trust policy.
- The radiology department was situated close to the unit and services were available 24 hours per day.

**Medicines**

- We found medicines and medical gases were stored and managed safely. All medicines and intra venous fluids were stored in a locked room. This was an Improvement since our last inspection when we found intra venous fluids were not stored securely. The unit was supported by a pharmacist who checked and replenished stocks once a week.
- We inspected the medicines cupboard, medicines fridge and the controlled drug record. All were secured appropriately, checked and documented accurately and up to date. Some prescription medicines are controlled under the Misuse of Drugs legislation. These medicines are called controlled medicines or controlled drugs.
- Prescription pads were kept in a locked cupboard and a log kept of all prescriptions used.
- Staff were aware of the trust policy for the administration of medicines.
- Medical staff were aware of the microbiology protocols for the administration of medicines which was available on the trust's intranet. This included what antibiotic to prescribe in different scenarios, for example what to prescribe for someone who had a dog bite.
- Nurses in the area used a patient group direction (PGD) for the prescription of simple pain relief and antibiotics. They were also able to administer respiratory medicines and eye drops. PGDs provide a legal framework that allows some registered health professionals to supply

and or administer specified medicines, such as painkillers, to a predefined group of patients without them having to see a doctor. PGDs were all correctly completed, authorised and in date.
- Allergies were recorded routinely and the red wrist band alert system was in place.

**Records**

- Patient records were kept electronically and in paper format. The electronic system was also used by general practitioners in the area which meant information could be accessed and shared.
- We reviewed two sets of notes. The documentation was complete including history taking, drug administration and discharge plan.
- The paper records of patients attending the minor injuries unit were stored securely in locked filing cabinets in the reception area. Older records were archived off site. If full medical records were required these could be obtained easily from Kings Mill hospital.
- The layout of the new reception area and patient waiting area meant the electronic patient records were not visible to the public.
- We reviewed two sets of patient records; both were completed in accordance with the trust policy.
- The unit used the same documentation as Kings Mill hospital emergency department which included a full range of risk assessments and checklists.

**Safeguarding**

- Staff told us they were aware of safeguarding procedures and knew how to raise concerns regarding adults and children. They had 24 hour support from the safeguarding team at Kings Mill hospital. Policies and procedures were available on the intranet. This included the recognition and management of domestic abuse.
- All staff working in the unit had level three safeguarding training and in addition attended the Nottinghamshire children's safeguarding board training. Safeguarding training included information about female genital mutilation. Female genital mutilation/cutting is defined as the partial or total removal of the female external genitalia for non-medical reasons.
- The paediatric assessment notes included six detailed questions about the presentation of the child. If the answer was yes to any of the questions a safeguarding concern was raised. For example one of the questions was 'Does the history fail to fit injury/presentation?'
- Safeguarding issues were highlighted on the electronic record system by a specific icon next to the child's name. This meant staff had access to previous safeguarding information relating to the child. Information was sent to general practitioners about all child attendances at the unit via the electronic record system.

**Mandatory training**

- We saw a copy of the trust's mandatory training policy dated May 2016. Along with the trust corporate induction course the topics covered were in line with UK core skills training framework recommendations. Mandatory training is training which is essential to comply with legislation or to maintain key standards.
- Mandatory training included; safeguarding for children and adults, moving and handling, mental capacity act, mental awareness, major incident planning, infection prevention and control, adult life support and paediatric life support.
- The trust reported that in June 2016, 95% of staff at the minor injuries unit had attended their mandatory training against a target of 90%.

**Assessing and responding to patient risk**

- Patients reported to the receptionist who quickly took personal details and located patient information on the electronic record system. Patients were prioritised in time order unless their condition required immediate review by a nurse. Administration staff were able to recognise this because the computer registration system prompted them to do so.
- The assessment documentation contained all the relevant risk assessment and checklists to ensure safe care. These included pain assessment, mini mental test for the over 75s, falls assessment, safeguarding questions, national early warning score (NEWS), sepsis screening tool, fluid balance chart, handover checklist, domestic violence prompts and stroke assessment.
- All children had a paediatric observation priority score calculated (POPS). Children with a POPS of 3 – 6 were commenced on paediatric early warning score (PEWS) observations to monitor their condition.

# Minor injuries unit

- NEWS and PEWS enable early recognition of a patient's worsening condition by grading the severity of their condition and prompting nursing staff to get a medical review at specific trigger points.
- There was a clear pathway in place to identify which children were suitable for referral to the primary care centre.
- At our last inspection we were concerned about the pathway for the care of patients with mental health conditions and patients who self-harm.
- At this inspection we saw management pathways for patients who self-harm, dated November 2015. The pathway covered assessment, care planning and discharge including liaison with other health professionals such as mental health, GP and social services. The trust also had a policy for the assessment and management of patients at risk of self-harm and a patient at risk observation chart. Staff told us that if a patient was in the high or extremely high risk categories they would be observed on a one to one basis in one of the treatment rooms. The treatment room would be cleared of any objects that might pose a risk to the patient such as sharps bins. The patient would not be left unattended.
- In response to our concerns about ligature risk at our last inspection we found all staff had attended ligature risk and ligature cutter training and were aware of where to find the ligature cutter.
- We reviewed the notes of a self-harm patient who was assessed as low risk. The patient was referred to the self-harm team.
- Staff were able to request x rays and we observed one child with a hand injury being referred for an x ray. The radiology department was available 24 hours a day, on call after 22.00hrs until 08.00hrs. A wide range of blood analysis was carried out in the unit using on site blood testing equipment. This meant x rays and blood tests could be carried out quickly.
- Sufficient PGDs were in place to support the treatment of common injuries and ailment.
- We observed a patient being assessed who triggered the sepsis protocol and we witnessed the sepsis bundle being implemented within 30 minutes of the patient presenting at the unit.
- The local ambulance NHS Trust service had a copy of the referral criteria for patients who were not suitable to be seen at the minor injuries unit in each ambulance. We saw a copy of the referral criteria.
- Staff reported there were delays in ambulance transfers to the acute hospital. The local ambulance NHS Trust inter facility transfer protocol dated September 2012, described response times as four hours, one hour or emergency. Staff told us that they were able to escalate the requested response time if the patient's condition deteriorated whilst waiting for the ambulance. Staff had raised this issue with senior managers.
- The trust was unable to provide a protocol for the management of the sick child in the Newark minor injuries unit. There was a protocol in place, 'Paediatric Presentations Suitable for Streaming to Primary Care Services' but this document was produced by the previous GP out of hours provider.

**Nursing staffing**

- The unit employed one department leader and one deputy, three emergency nurse practitioners and eight staff nurses (whole time equivalent).
- The unit had one emergency nurse practitioner vacancy. This was covered by the use of bank staff. The bank nurse on duty at the time of our visit was a qualified paramedic undergoing nurse training and had worked at the unit on several occasions so was familiar with the unit's policies and procedures and working practices.
- There was a clear process in place for the induction of bank nurses.
- There were three nursing staff on duty in the daytime and two staff on duty overnight.
- A nursing handover meeting took place between shifts and information was recorded on a hand over sheet.
- At our last inspection we were concerned that the MIU did not have any qualified paediatric nursing staff. Since our last inspection the trust had dedicated significant training resources to ensure the current nursing staff had the skills and knowledge to manage paediatric patients.
- A registered nurse development pack had been developed and staff were attending training sessions delivered by the paediatric practice development matron from Kings Mill hospital. Each member of staff had a paediatric competency booklet and was due to complete the training package by September 2016.
- In addition further support had been put in place including safeguarding leads working across the sites, weekly visits by the paediatric team and two MIU staff becoming paediatric champions.

# Minor injuries unit

- Senior nursing teams were also exploring the possibility of rotating staff between emergency departments and MIU and developing joint training programmes including paediatrics.
- All minor injuries nursing staff had attended the annual mandatory training programme which included adult and paediatric life support training. In addition to this and in accordance with the trust policy and depending on the seniority of the member of staff the trust reported that in June 2016 50% of nursing staff had advanced life support (ALS) and 31% European paediatric life support (EPLS). Staff told us there was always one member of nursing staff on duty who had attended ALS or EPLS training.

**Medical staffing**

- The medical staff rotas were managed from Kings Mill hospital.
- There were sufficient medical staff on duty at the MIU throughout the 24 hour period. The associate specialities consultant worked between Kings Mill hospital and the MIU, and was present at the unit two days per week. We saw the medical staff rota for May, June and July 2016 which confirmed there were two medical staff on duty during the daytime and one overnight which included the consultant two days per week.
- The trust used between 42% and 65% of medical locums per month between January and July 2016. This is a significant number. However the locums working at the unit were long term and so were familiar with the trust policies, procedures and working practices. Since our last inspection the trust had introduced the presence of the associate specialities consultant two days per week to support the locums.
- Doctors participated in one to one medical handover between shifts. We observed one shift handover which included verbal and written information on patients in the MIU.
- The trust reported in June 2016 all medical staff had ALS, APLS (Advanced Paediatric Life support) and EPLS training apart from one doctor whose EPLS training had expired however he was due to attend refresher training in November 2016.

**Major incident awareness and training**

- The unit had suitable major incident plans in place and information was available to all staff on the trust intranet.
- There was one entrance to the unit. Offices and most staff areas were kept locked and there was a closed circuit television camera. There was only one on site member of security staff supported by a porter. They could be reached on a dedicated telephone number. Staff told us they felt safe working at the unit and that security responded promptly if there was an issue. Security staff would request police back up if required.

# Medical care (including older people's care)

| | |
|---|---|
| Safe | Good |
| Effective | Requires improvement |
| Responsive | Requires improvement |
| Overall | Requires improvement |

## Information about the service

Sherwood Forest Hospitals NHS Foundation Trust provides medical care (including older people's care) at Newark Hospital as part of the Speciality Medicine division. Newark hospital has two medical wards, Sconce and Fernwood and an endoscopy department which provides medical care. Sconce ward mainly provides care for the elderly with some admissions from the hospital's minor injury unit. Fernwood ward is a GP led rehabilitation unit where patients can stay for up to 21 days before being discharged.

There were 3,137 admissions to medical services at Newark Hospital between July 2015 and June 2016. Of these admissions, 79% were day cases, 7% elective cases and 14% emergency cases. Most admissions were in gastroenterology and dermatology specialities.

We conducted an unannounced inspection of the trust between 18 July and 20 July 2016. During our visit to Newark Hospital, we visited Scone and Fernwood ward and the endoscopy department. We spoke with 10 members of staff including nurses, therapy staff and medical staff.

## Summary of findings

- The service protected patients from avoidable harm. There was evidence of an open and transparent culture in relation to the reporting of incidents and we saw evidence of staff learning from investigations.
- There were well embedded systems in place to recognise a deteriorating patient and we saw evidence of patients being assessed, monitored and managed for a variety of potential risks. Staff knowledge of sepsis and the ability to identify a patient who was at risk of developing sepsis was improving with high numbers of staff completing the sepsis training.
- There were good safety measures taken within the endoscopy department which protected the patients accessing that department.
- There was minimal evidence available for demonstrating patient outcomes at this hospital which made it difficult to benchmark the effectiveness of the care given against other providers. The data that was available demonstrated they were performing lower than the England average.
- Staff knowledge around the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards was variable although staff had attended training.
- Nutrition and hydration was well assessed on admission and actions taken to provide adequate nutrition and hydration for patients.
- We saw evidence of staff taking a cohesive team approach to patients' care involving all members of the multi-disciplinary team, including discharge planning and transferring to other teams.

# Medical care (including older people's care)

## Are medical care services safe?

Good

We rated safe good because:

- There was good use of the national early warning score (NEWS) in the areas inspected and good recognition of a potentially deteriorating patient.
- There was a good incident reporting culture and evidence of shared learning from incidents.
- There were regular infection prevention and control (IPC) risk assessments, especially around MRSA and the requirement for screening, with no evidence of transmission.
- Good medicines management and storing of medical gases.
- Good use of the World Health Organisation (WHO) checklist for endoscopy procedures.

However:

- There was no standardised process for highlighting when equipment was clean and ready for use.
- Risk assessments for known infectious patients who had their doors left open could not be located.
- Antimicrobial stewardship audits were not conducted which demonstrates non-compliance with criterion three of the Health and Social Care Act (2008) code of practice on the prevention and control of infections and related guidance and National Institute for Health and Care Excellence (NICE) guidelines.

### Incidents

- There were 163 incidents reported on Sconce ward and 98 incidents reported on Fernwood ward during the period of May 2015 to May 2016. The highest incidents were related to falls and medication incidents for both wards.
- There were a total of three serious incidents reports during the period of May 2015 to May 2016. One of these was on Fernwood ward and two were reported on Sconce ward. All of these serious incidents were related to patient falls. Serious incidents are events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant they warrant using additional resources to mount a comprehensive response.
- There were no reported never events in the last 12 months relating to medical services at this hospital. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
- Staff told us there was a positive incident reporting culture within the service and when they raised incidents, they received feedback from them. They also told us they were informed about significant incidents across the trust where there were lessons to be learnt and actions to be implemented. We saw evidence on our inspection of ward displaying information about incidents reported where there were lessons to be learnt across the trust.
- There was a monthly clinical staff forum meeting where mortality and morbidity reviews were discussed to share learning from significant cases. Any correspondence from the coroner's office regarding any patients that had been under their care was also discussed.
- Staff had an awareness of the duty of candour and could give examples of situations where it had been used. The Duty of Candour is a regulatory duty relating to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person.
- In the endoscopy department, there was a flow chart demonstrating when and how the duty of candour should be used. Staff told us they had received regular training about this and were open and honest department anyway.

### Safety thermometer

- The NHS safety thermometer is a national tool used to measure, monitor and analyse common causes of patient harm. Measures include percentage of patients experiencing harm free care, pressure ulcers, falls causing harm catheter associated urinary tract infections (CAUTI) and venous thromboembolism (VTE).
- Both Sconce and Fernwood Ward displayed information on their performance on notice boards. Safety data

included figures from previous months incidence of falls, pressure ulcers, medication incidents and Clostridium difficile (C. difficile) rates. They also included a running monthly tally of these items which highlighted in real time when a harm was identified or reported. C. difficile is a bacterium that can infect a person's bowels. It is also commonly associated with people who have had courses of antibiotics but can also be easily transmitted to other people.

- Sconce ward reported eight months of harm free care provided to patients during the period of May 2015 to May 2016. The highest new harms were reported in March 2016 where three new harms were reported. The other months that registered a new harm were October 2015, February 2016 and May 2016. These months recorded one, two and one new harms respectively.
- Fernwood ward reported 11 months of harm free care provided to patients during the period of May 2015 and May 2016. In May 2015 two new harms were recorded.

**Cleanliness, infection control and hygiene**

- All areas inspected were visibly clean and tidy. Recent cleaning audits from May 2016 showed both Sconce and Fernwood Ward were compliant with the national cleaning standards. These ward were identified as significant risk areas and therefore had to meet standards of 85%.The endoscopy department was identified as a high risk area and therefore was required to achieve a compliance of 95% on the cleaning audit. Results from the audit completed in May 2016 showed that they were achieving this standard of cleanliness. Results from the 2015 Patient-led Assessments of the Care Environment (PLACE) for cleanliness supported the trust's own cleanliness audits as they performed better than the England average. PLACE audits are a self-assessment of non-clinical services which contribute to healthcare delivered in both the NHS and independent/ private healthcare sector in England.
- Staff from the infection prevention and control (IPC) team were located at Kings Mill hospital and would visit Newark once per week. If staff had any concerns about a patient, we were told they were easy to get hold of for telephone advice, and would come and review a patient if required.
- Information provided by the trust showed hand hygiene compliance at the hospital was around 97% compliance for all staff groups in all areas of the hospital. Further information provided from July 2015 to July 2016 showed that Sconce ward achieved 98% compliance with hand hygiene and Fernwood ward achieved 100% compliance with hand hygiene. All audits were based on the World Health Organisation (WHO) five moments for hand hygiene. The WHO five moments for hand hygiene are guidelines for all staff working in healthcare environments and define the key moments when staff should be performing hand hygiene.
- During our inspection, we saw staff adhering to the bare below elbow policy. This policy insists that all clinical staff should wear no items which can prevent the staff member from carrying out correct hand hygiene procedures. Information provided by the trust showed from July 2015 to July 2016 98% of staff on Sconce ward were compliant with the bare below policy and 98% of staff were compliant on Fernwood ward.
- There were no cases of Meticillin resistant Staphylococcus aureus (MRSA) bacteraemia reported from July 2015 to June 2016 for the medical services at the hospital. MRSA is a bacterium responsible for several difficult-to-treat infections. The trust trajectory (target) is zero for the financial year (April 2016 to March 2017).
- We saw evidence of regular MRSA screening in patient notes although results were not always entered on to the screening document. Each patient was risk assessed for the presence of MRSA and a rescreening frequency determined on this risk. Most patients on Sconce and Fernwood ward were rescreened every 21 days. Staff told us there was no evidence of MRSA transmission demonstrated from the regular screening, however information provided by the trust showed there had been one new case of MRSA identified in a patient who had been admitted for 21 days or more from April to June 2016.
- There were two cases of C. difficile in July 2015 on Sconce ward which were identified 48 hours after the patients admission which meant that these were trust apportioned. The post infection reviews for both patients identified that there were learning points for the ward staff which included prompt isolation of patients, collection of stool samples and completing the required nursing documentation for patients with C. difficile. The trust trajectory (target) is 48 for the financial year (April 2016 to March 2017).
- We observed equipment being cleaned after use on patients and then being stored before the next patient use. The use of the 'I'm clean' stickers was not

consistent in all areas in the hospital. The endoscopy department used it for all equipment ready to use on another patient, however the medical ward did not do this.

- There was one patient on Sconce ward receiving care in a single room for isolation purposes with the door open. The sign on the door had highlighted that a risk assessment had been completed for the door being open, however it could not be identified in the notes where and why this had happened.
- Staff in the endoscopy department collected weekly water samples which were then tested by an external company. Reports were sent in a timely manner to highlight if there were any concerns about the quality of water in the department, actions were taken to rectify the water issue and re-sampling of the water completed. The department had measures in place to minimise the impact that any remedial action had on patients and the procedures scheduled in the event of water safety concerns being identified.
- All area we inspected had appropriate containers available to collect specimens in. These containers minimise the risk of blood and body fluid exposure to the person collecting them when transporting them to the laboratory for testing.
- Staff were aware of a deep cleaning programme for the hospital; however they could not recall the last time this was conducted. Staff told us when patients with certain infections have been on the ward, a deep clean of that room would be completed on discharge.
- The decontamination process followed Health Technical Memorandum 01-06: Decontamination of flexible endoscopes.
- As there were no rooms in the endoscopy department where known infectious patients could wait and recover after their procedure, staff told us they would usually schedule known infectious patients at the end of the session. This would allow for additional precautions to be taken and full decontamination of the environment to be completed.
- Data provided by the trust showed 88% of staff on Sconce ward and 88% of staff on Fernwood ward had completed their IPC mandatory training including practical hand hygiene training.

**Environment and equipment**

- Sconce ward had permanently reduced their ward capability to 24 beds. The additional space was still the responsibility of the ward manager for Sconce so they made sure that regular cleaning and flushing of all water outlets was completed and recorded.
- There was one procedure room within the endoscopy department; this meant that staff would stagger the admissions throughout the list so that there would be no crowding within the department and no single sex breaches. There was a lavage room available for patients undergoing bowel preparation before their procedure. The recovery area had enough space for four patients at a time; however staff told us it was unusual to have that many patients in there at the same time. The recovery area would always maintain single-sex standards.
- Resuscitation equipment was available in all areas inspected. All trolleys had been regularly checked and recorded on the check sheet. Staff told us following an audit of resuscitation trolley checking, all ward had to submit their records weekly to the resuscitation officer. All trolleys are consistent throughout the hospital with internal sealing of each draw and external sealing present. When the seal is broken on the trolley, this was then returned to the medical devices team to be checked and resealed.
- The drying cabinets that hold clean endoscopes had the time extended for which the endoscopes could be kept in there from 72 hours to seven days. This meant that endoscopes were readily available throughout the week for staff to use during endoscopy lists. The company that provided the cabinets completed regular tests and audits of the efficiency of the cabinets to assure the department that the endoscopes were safe to use.
- Sconce and Fernwood ward both used sensor mats for patients identified as a risk of falling. Staff told us there were no problems getting these items when required. Due to issues identified when used on one of their patients, staff on Sconce ward told us they were looking at trialling different models.
- Six items of equipment were randomly checked for evidence of electrical safety testing and servicing within the past 12 months. All six items had evidence of this, with details clearly displayed.

- Pressure relieving equipment was available for all patients identified as requiring this equipment after thorough risk assessment. Staff told us there was enough equipment available for patients that required these items.

**Medicines**

- Two qualified members of staff conducted daily controlled drugs (CD) checks in the endoscopy department. The department also received quarterly audits on their CD checking and documentation.
- All medication trolleys were locked and attached to the walls in the ward areas. All trolleys appeared to be clean and tidy and the temporary closure mechanism in place on all sharps bins.
- Information provided by the trust showed there had been 18 medication incidents for Sconce ward for the period of May 2015 to May 2016. For the same time period, there had been 17 medication incidents reported on Fernwood ward. Information provided by the trust showed these two wards had lower numbers of medication errors than other medical wards in the trust. From the analysis of the incidents the prescribing and dispensing of to take out (TTO) medication on discharge, and the handing back of patients own medication were the two main themes identified.
- Patients admitted to Fernwood ward would be assessed for self-administration of medication. There were three levels of competency which patients would be assessed as being, and appropriate support and supervision identified for each level.
- Staff completing medication rounds would wear red tabards to prevent interruption during this important task. Interruptions during the medication rounds have been associated with increased numbers of medication errors. We saw that staff were not usually interrupted whilst wearing these unless absolutely necessary.
- All patients on Fernwood ward had their medications stored in a lockable cabinet at their bedsides and any additional medication stored in the clean utility room. Any medication required by the patients would be dispensed from their own stock.
- CDs on Fernwood were stored in a lockable, wall mounted cabinet in the clean utility room. All CDs were allocated to patients and there were two books which staff would have to complete to maintain accurate records for these medicines. One book was for signing in and out of the lockable storage and the other book was used regularly when dispensing CD medication to the patient.
- All spare oxygen bottles were stored securely in a trolley next to the resuscitation trolley which was compliant with Health and Safety Executive (HSE) guidance.
- The trust was unable to provide information on antimicrobial stewardship audits. This demonstrates non-compliance with the Health and Social Care Act (2008) code of practice on the prevention and control of infections and related guidance and National Institute for Health and Care Excellence (NICE) guidelines. Criterion three states that there should be regular monitoring through audit on the use of antimicrobials, and feedback given to prescribers and the trust board. A new system had been implemented and audit work on antimicrobials was due to start in October 2016.

**Records**

- Nursing and medical documentation was completed on paper records. Medical records were located in locked notes trolleys at each end of the ward. Detailed nursing records which included the admission documentation with confidential details were located at the end of the patient's bed or outside the patients' room if isolated. Although confidentiality was maintained for the medical notes, the same could not be assured for the notes which were kept at the end of the bed.
- We reviewed four complete sets of patient records and found evidence of thorough risk assessments being conducted. The risk assessments included falls assessment, nutrition and hydration assessments, skin integrity assessments, infection control risk assessment and manual handling assessment. There was evidence of timely assessment on admission and ongoing reviews of the assessments to assure there had been no changes in the patient's condition.
- Patient records had entries made by members of the multidisciplinary team (MDT) including physiotherapists, occupational therapists, speech and language therapists and dietetic staff.

**Safeguarding**

# Medical care (including older people's care)

- All staff we spoke with had a good awareness of their responsibility of safeguarding for both vulnerable adults and children. One staff member was able to confidently talk us through a case of financial abuse which they had raised to the hospital safeguarding team.
- Staff were aware of who the lead for safeguarding adults was, however all safeguarding staff were located at Kings Mill hospital and staff told us this could sometimes impact on the time taken for safeguarding staff to review patients.
- All patients who were admitted into Fernwood ward had a full body mapping assessment completed to check for any skin integrity issues. Staff told us that if they also found evidence of injuries or bruising which could be non-accidental, they would alert the safeguarding team about this and complete an incident report form.
- Arrangements were in place to safeguard women or children with, or at risk of, Female Genital Mutilation (FGM). Female genital mutilation/cutting is defined as the partial or total removal of the female external genitalia for non-medical reasons. An iCARE poster was sent to all areas in the trust which raised the awareness of FGM and staff reporting responsibilities.
- Information provided by the trust showed 95% of staff on Sconce Ward and 96% of staff on Fernwood ward had completed their safeguarding adults training. The level of training was not specified by the trust.
- Information provided by the trust showed 86% of staff on Fernwood ward and 92% of staff on Sconce ward had completed their level two safeguarding children training.
- The trust had implemented PREVENT training. Prior to changes to the delivery of the session in April 2016, compliance was recorded as 91% of staff trust wide completing this training. PREVENT training is around safeguarding people from the threat of terrorism or radicalisation.

**Mandatory training**

- Staff received training in mandatory topics such as infection control, fire safety, basic life support, medical devices, slips, trips and falls, medicines management, patient safety and emergency planning, blood transfusion, tissue viability, alcohol and drugs, information governance, manual handling, health and safety, safeguarding adults, mental capacity act, conflict resolution, safeguarding children (level one, two and three) and equality and diversity.
- The trust target for compliance with mandatory training was 80% for all topics covered. Information received after our inspection showed as of June 2016 mandatory training compliance within medical care services, trust-wide, exceeded the trust target for nursing staff (86%), medical staff (84%) and allied health professional staff (89%).
- Sepsis training was considered mandatory at this trust. As of 31 March 2016 training compliance (trust wide) in sepsis was; consultant 99%, nursing staff 90% and junior doctors 100%.
- Information provided by the trust showed staff on Fernwood ward were compliant with safeguarding adults training, infection prevention and control training, medicines management training, slips, trips and falls training and blood transfusion training, however they were non-compliant with information governance training. The information showed in May 2016, 79% of staff were compliant with this subject, this is only just worse than the trust target.
- Information provided by the trust showed staff on Sconce ward were compliant for all mandatory training topics reported on the nursing metric database, including safeguarding adults, infection prevention and control, information governance, medicines management, slips , trips and falls training and transfusion training.

**Assessing and responding to patient risk**

- The use of a national early warning score (NEWS) had been introduced to all areas that we visited. We saw evidence of staff using this score on each set of observations performed and escalation of a higher NEWS score (above three) to the relevant medical staff and a review of the patient had taken place.
- Information provided by the trust showed 100% compliance with performing observations since introduction of the computerised database for observation monitoring. The results did not break down into specific hospital sites or include information about the NEWS calculation or escalation where deemed appropriate and necessary.
- Staff on Sconce ward told us there was a deteriorating patient policy for patients on their ward. Staff would contact the medical staff in charge of their care or the out of hours medical staff if they were concerned about a patient, especially if they were triggering on the NEWS

chart. If a patient required high dependency care, intensive care or non-invasive ventilation (NIV), they would be transferred by ambulance to Kings Mill hospital where this would be provided.

- Staff on Fernwood ward had a strict policy about the deteriorating patient. If they had concerns about a patient, they would request a review from one of the GPs who covered the service, or if this was out of hours, a practitioner from the out of hours service. If patients required care above the threshold of what could be delivered on the ward, they would be transferred to Kings Mill hospital. Staff also told us as part of their initial admission screening, if a patient had a NEWS of above three, they would automatically transfer the patient to Kings Mill hospital. They were able to provide examples where this had occurred recently with a patient who was referred to the ward as a step up in care. On arrival to the ward, the patient was scoring a seven on the NEWS chart, so the staff on Fernwood called for an emergency transfer.
- Staff in the endoscopy department assessed the risk of their patients during their initial consultation. If the patient was deemed low risk, they would be offered the opportunity to have their procedure at the hospital. Staff told us the last time they transferred a patient following concerns about the patients clinical condition was two years ago. The rigorous assessment during their initial consultation has reduced the likelihood of a patient deteriorating during or after the procedure.
- In all of the areas we inspected, staff told us if they had to transfer a patient to Kings Mill hospital due to their condition deteriorating, they would raise this as an incident using their incident reporting system.
- Patients with a suspected infection or a NEWS of three or more were screened for sepsis, a severe infection which spreads in the bloodstream, using an Adult Sepsis 6 Screening Tool.
- Staff told us for all procedures conducted in the endoscopy department; they completed a World Health Organisation (WHO) safety procedures checklist to ensure each stage of the patient's journey was managed safely. Audit results from June 2016 showed 100% compliance with the use of the checklist.
- As part of the falls pathway a postural hypotension assessment was completed on all new admissions to medical care services. Postural hypotension is a form of low blood pressure in which a person's blood pressure falls when suddenly standing up or stretching. We saw evidence of where this had been completed, however they had also highlighted that this assessment needed embedding more.
- All observations were recorded on an electronic database. This database calculated a patient's NEWS according to the information inputted. Individual parameters can be set for patients which were in relation to their previous medical history. An example of this staff gave was for a patient with chronic obstructive pulmonary disease (COPD) who may have lower oxygen saturations but this would be normal for them. Staff told us the use of the electronic observations has improved their management of a potentially deteriorating patient.

**Nursing staffing**

- On Sconce ward, staff told us now they had reduced their beds permanently to 24 due to previous staffing issues. They were fully established for both registered nurses and health care assistants.
- An establishment review of Sconce Ward had not been completed since they reduced their beds to 24; this was something which had been identified as needing to be completed by the senior nurses.
- Patient acuity and dependency data was collected through the use of a nationally recognised Safer Nursing Care Tool. The data collected was considered alongside staffing information from the electronic rostering system and patient centred information including admissions and discharges and additional tasks undertaken in different clinical areas. All of this information was used to provide a staffing ratio which would enable staff to provide safe and effective care.
- Staffing levels were displayed in all areas we visited. All areas we visited displayed information that their actual staffing levels met planned staffing levels.
- Handovers occurred twice per day on the ward. All staff would gather for an overview of the patients before staff then went to their areas for an accountability handover. Accountability handover involved the named staff identified to care for a group of patients. The handover process required both trained staff to sign an accountability sheet at the point of handover (change of shift). The signature was confirmation for example, that all care had been given, significant changes had been handed over and medication charts had been reviewed.
- Staff told us there was minimal agency usage on the ward. Sconce Ward staffing had improved since

reducing the number of beds, so there was minimal requirement for agency staffing. Information provided by the trust confirmed that agency usage by Sconce ward was low, with only 22 shifts in the period of January to June 2016 covered by agency staff.

### Medical staffing

- Two medical consultants provided consultant cover for Sconce ward. Both attended for ward rounds twice a week. One of the consultants was based at Newark hospital as they conduct endoscopy procedures and reviewed patients regularly in the gastroenterology clinic.
- There are three staff grade doctors available to provide cover for the ward during the day. One would be solely responsible for care provided to patients on the ward, whilst one would be available to help on the ward if required, but would also cover the minor injuries unit MIU and outpatients department.
- As Fernwood ward was a GP led rehabilitation ward, medical cover was provided by the GPs who supported the unit.
- Out of hours, medical cover for Sconce ward was provided by doctors from the MIU. Weekend cover was provided by staff grade doctors and a consultant on a rota basis.
- Out of hours medical cover for Fernwood was provided by the out of hours GP service. If staff wanted medical advice for their patients, they would ring the out of hours number to seek attention. If a patient became acutely unwell, the staff would call for an ambulance to transfer the patient to Kings Mill for further medical attention.
- Staff told us there was no locum medical staff working at Newark hospital. Information supplied by the trust did not identify if medical locum usage included Newark Hospital.

### Major incident awareness and training

- There was a trust wide major incident and business continuity plan which was available to all staff on the intranet. Staff were able to tell us what their involvement would be if a major incident was declared. An example of this was the endoscopy department would be used for the assessment and treatment of the walking wounded patients.
- There were contingency plans available for the hospital for disruption of electricity and water. Backup generators were regularly tested to provide assurance of the continuity of service should there be a power failure.

## Are medical care services effective?

**Requires improvement**

We rated effective as requires improvement because:

- There was minimal data collected on patient outcomes at Newark hospital which meant care could not be benchmarked against other providers.
- The most recent data provided for the heart failure audit from 2013-14 showed Newark hospital were performing below the England average for specialist input for patients admitted and discharging. There was no action plan completed following this audit of how improvements would be made.
- Staff did not consistently demonstrate knowledge of the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards.
- Therapy services were not provided seven days per week on either of the ward, however therapists produced patient plans for nursing staff to deliver at weekends.
- At the time of inspection, the endoscopy department had not received renewal of their Joint Advisory Group (JAG) accreditation. However, information provided after the inspection showed accreditation had now been awarded.
- The hospital had a higher than expected readmission risk for patients in specialities for both elective and non-elective admissions.
- Staff were not allocated time for clinical supervision and formal records of clinical supervision were not maintained.

However:

- The nutrition and hydration of patients was appropriately assessed and actions taken where necessary. The food provided by the ward scored better than the national average on the Patient-led Assessments of the Care Environment (PLACE) audit conducted in 2015.
- There were high levels of compliance with staff appraisals, which exceeded the trust target of 90%.

- Evidence-based policies and procedures were in place for staff to follow.

**Evidence-based care and treatment**

- Patients being treated for sepsis were treated in line with the Sepsis Six Bundle, key immediate interventions that increase survival from sepsis. There is strong evidence that the prompt delivery of basic aspects of care detailed in the Sepsis Six Bundle prevents much more extensive treatment and has been shown to be associated with significant mortality reductions when applied within the first hour.
- The Sepsis Clinical Lead for the trust was aware of latest National Institute for Health and Care Excellence (NICE) guidelines (NG51); Sepsis: recognition, diagnosis and early management and told us there were plans to review the current sepsis policy in line with these guidelines by April 2017.
- It was difficult to establish if the trust were following NICE guidance (NG15) for antimicrobial stewardship as there was a lack of evidence provided to demonstrate they routinely review practice and follow their own trust antimicrobial policy.
- Staff followed NICE guidance (CG92) in the assessment and management of venous thromboembolism (VTE). We reviewed four patient care records. All records demonstrated where patients had received a venous thromboembolism (VTE) risk assessment and had prophylactic venous thromboembolism (VTE) medication if indicated.
- Trust policies and procedures were all located on the trust's intranet and all staff told us they had access to these. All policies and procedures were based on evidence-based care and treatment and recommended best practice.
- The ward are responsible for conducting local audits on documentation, accountability, sepsis, resuscitation weekly checks, safety thermometer, safer nursing tool and friends and family test (FFT). Results of these audits were discussed at ward meetings and some results (safety thermometer and FFT) were displayed on the ward.

**Pain relief**

- All patients had regular pain assessments taken as part of their routine observations. The ward both used the zero to three scale, and this was recorded on the electronic observations chart.
- Patients who were identified as having increased pain levels had specific pain care plans in place which were regularly reviewed and progress or deterioration documented on them.
- We observed one patient complaining of pain to ward staff, and staff responded in a timely manner to the patient's pain and provided the patient with pain relief.
- Nursing metrics for both Sconce and Fernwood ward showed that in May 2016, 100% of their patients were given good care in response to pain management.

**Nutrition and hydration**

- The hospital performed better than the England average on the PLACE assessment for food. The hospital scored 95.8% for their overall provision of food compared to the national average score of 87.2%.
- The nursing metric completed in March 2016 showed 100% compliance with all aspects on the metric which specifically looked at nutrition and hydration for Sconce ward, and 100% compliance for the areas that were applicable for Fernwood ward.
- On admission, all patients had malnutrition universal screening tools (MUST) completed to assess their nutritional needs. The MUST tool is a five-step screening tool which is used to identify patients who are malnourished, at risk of malnutrition or are classed as obese. We reviewed four MUST assessments and all had been completed within 24 hours of the patient's admission, with each assessment including an admission weight.
- We saw evidence of assessments forming the basis for individualised care plans for patients in relation to nutrition and hydration, with staff regularly reviewing these care plans and documenting patient progress.
- On both ward, there were magnetic boards behind the patients' beds which were used to highlight if patients required any additional nutrition and hydration support. Signs included special diet, red jugs, fluid restriction, thickened fluids, encourage fluids and nil by mouth. We saw good use of these signs during our inspection.
- For patients who required additional support and assistance with nutrition and hydration, there was equipment available to identify this. This included the use of red jugs which demonstrated that a patient required encouragement for hydration purposes.

**Patient outcomes**

# Medical care (including older people's care)

- The trust had one open mortality outlier alert. This is when there have been a higher number of deaths than expected for a defined condition. The trust received notification from Dr Foster Intelligence that they had shown a higher than expected hospital standardised mortality ratio (HSMR) in the area of fluid and electrolyte disorders. There were 13 deaths whose primary diagnosis of admission was coded under fluid and electrolyte disorders, against a calculated expected number of 9.05. The Hospital Standardised Mortality Ratio (HSMR) is an indicator of healthcare quality that measures whether the mortality rate at a hospital is higher or lower than you would expect.
- The medical and nursing notes for all thirteen patients were reviewed, along with their pathology and radiology results and their observation charts. Each case had been reviewed to see whether the primary diagnosis (in this case fluid and electrolyte disorders) was appropriate and to look at the care of those patients and their cause of death.
- Results of the review were discussed at the trust mortality group (TMG) in July 2015. At that point all the patient notes had been reviewed and the outcomes identified. The final report was presented at the TMG on 10th November 2015. The review indicated all cases were unavoidable deaths and where an electrolyte imbalance had been identified there was a significant underlying cause. We were therefore, assured the trust had appropriately investigated and addressed this outlier and were satisfied this case could be closed.
- The endoscopy department were previously awarded with Joint Advisory Group (JAG) accreditation however, an inspection in 2014 identified that improvements were required in regards to the timeliness of appointments. A re-inspection in 2015 found that improvements had not been made and therefore renewal of accreditation was not given. An action plan was devised in response to this and the department have completed their actions and are awaiting a re-inspection. Following our inspection we received information from the trust confirming that they had now been awarded JAG accreditation.
- Newark hospital had participated in some aspects of the heart failure audit for 2013/14. The data submitted surrounded the input from specialists whilst patients were in hospital and showed that 50% of patients had received this specialist input. This was worse than the England average of 78%. For heart failure patients who were discharging, showed 48% of patients were referred to the heart failure liaison service which was below the England average of 59%. This was the most recent data produced for the heart failure audit. Information provided by the trust recorded no action plan was completed in response to the findings.
- The therapy staff kept local records on patient outcomes. This recorded what level the patient was at when they were first admitted and then documented the standard they were at when discharged. This information was discussed at weekly therapy meetings and hospital meetings, however this was not used to benchmark therapy outcomes against other providers.
- From the period of December 2014 to November 2015 medical patients at this hospital had a higher than expected risk of readmission for elective admissions in dermatology and general medicine. However, dermatology patients were not admitted at Newark hospital. For the same period, the hospital had a higher than expected risk of readmission for non-elective patients in intermediate care and rehabilitation.

**Competent staff**

- Staff told us they were up-to-date with their appraisals and that they were meaningful as they gave them the opportunity to discuss any personal goals for them to work toward. Data from the trust showed 95% of staff on Sconce ward and 95% of staff on Fernwood ward were in date with their appraisals at the end of May 2016. The trust's own target of compliance was 90%.
- Nursing staff told us they had attended trust run revalidation sessions to help them prepare for going through this process. None of the nurses that we spoke with had completed the process yet, although there were links within the hospital to nurses who had completed it and who were able to help those about to go through the process. From April 2016, all registered nurses are required to revalidate with the Nursing and Midwifery Council (NMC) in order to continue practicing.
- Clinical supervision is a formal process of professional support and learning. Following our inspection we asked the trust to provide information confirming whether registered nurses in medical care services were accessing clinical supervision. The trust told us they did not keep formal records of staff undertaking clinical supervision. Staff were directed to clinical supervision at various points in their career at induction, proud to care days and Preceptorship. There was no specific time

allocated on duty rosters for clinical supervision. Work was underway to improve the effectiveness and efficiency of rostering to help provide the allocated time for staff to undertake clinical supervision if they wished. The trust currently had 17 clinical supervisors, with one clinical supervisor located at Newark Hospital. Staff would be supported to travel to Kings Mill Hospital if they wanted to conduct supervision there.

**Multidisciplinary working**

- There were weekly multidisciplinary team (MDT) meetings on Sconce and Fernwood ward. We observed two of these meetings and found they were well co-ordinated and there was in-depth discussion on each patient and any significant issues were raised and discussed.
- MDT meetings would usually include medical and nursing staff from the ward, community nursing and medical input (this was more relevant for patients located on Fernwood ward), physiotherapists, occupational therapists, social workers, pharmacy, discharge co-ordinators and other specialist professionals if there are complex cases being discussed.
- There was a therapy room located on Sconce Ward which was used for individual and group therapy sessions. Patients from Fernwood Ward were also brought up to the therapy room to participate in rehabilitation sessions.
- Therapy staff told us there was a good working relationship between them and the nursing and medical staff. The presence of the therapy room on Sconce Ward had a beneficial effect on the relationship between them and the ward staff, and they felt more part of the team located on the ward.
- Speech and Language therapists (SALT) were employed under a service level agreement (SLA) with a nearby trust. An SLA is a contract between a service provider and the end user that defines the level of service expected from the service provider. SALT provided cover 8am to 4pm Monday to Friday. There was no SALT provision out of hours.
- We saw evidence of specialist referrals being made and staff told us they were quick to respond to referrals. An example of this was for patients who had a diagnosis of cancer following an endoscopy procedure, referrals were made immediately to specialists such as colorectal nurse specialists and first contact would usually be made within 24 hours of referral. We also saw evidence of dietitian involvement with patients who were referred for high malnutrition universal screening tool (MUST) scores.

**Seven-day services**

- The endoscopy department at the hospital did not offer a seven day service on-site, however occasionally they would open up lists on the weekend if they had a large number of patients waiting for a specific procedure.
- Physiotherapy and occupational therapy (OT) presence was available from 9am to 5pm, Monday to Friday. There had been a service provided seven days a week during winter pressure, however this was stopped when demand on the service was not as pressurised. Patients had a plan produced by the therapy staff which nursing staff would supervise over the weekends.

**Access to information**

- Discharge summaries were completed and sent electronically to patients' GPs on Sconce ward. This meant GPs were able to access patient information relating to their hospital care and treatment in a timely fashion.
- Patients discharging from Fernwood ward were also sent with a paper copy of the discharge summary. This meant staff providing care to the patients in the community would have easy access to this information.
- Fernwood Ward had access to a database which is used by community based staff. This enabled swift access of information for patients located on the ward, which would also benefit the multidisciplinary team (MDT) involved in the patients care for discharge planning.
- A written report was produced for patients who had undergone an endoscopy procedure and the practitioner who performed the procedure would review the results with the patient prior to discharge. Results of any samples taken took two weeks to come back to the consultant in charge of the patient's care. If there were any high risk samples, these could be reported on and back with the consultant within five days.

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

- A Deprivation of Liberty Safeguards policy (for adults 18 years and over) was available to all staff at the trust. The purpose of the guidance was to inform staff about the procedural arrangements for working with patients with

impaired mental capacity who were 18 years and older and for whom care or treatment was given in circumstances that might amount to Deprivation of Liberty. There were no patients with Deprivation of Liberty Safeguards in place during on the ward at the time of our inspection.

- Staff knowledge of the Deprivation of Liberty Safeguards process was variable within the areas we inspected. On one ward, a member of staff told us they would have to ask the senior nurse to complete a Deprivation of Liberty Safeguards application as they did not know how to do this. There was also variable knowledge as to when a Deprivation of Liberty Safeguards would be required.
- Staff told us there had been training around Mental Capacity Act and the assessment of patients and Deprivation of Liberty Safeguards. Information provided by the trust showed 85% of medical staff and 99% of nursing staff had completed this training. This information was provided for all staff who worked in the medicine service and was not broken down into hospital site.
- All nursing admission documentation had a section to complete which prompted them to consider whether a patient had capacity or not. If nurses had indicated that they thought patients did not have capacity, a two stage assessment would be completed and a best interests care plan put into place. These documents would only be used for nursing care, if there were issues with a patient's capacity and there were medical decisions required, doctors would be required to complete an assessment of the patient themselves to inform what measures they would need to take. The four sets of records checked had this documentation completed appropriately.
- All patients undergoing endoscopy were consented outside of the procedure room. Staff told us most patients would be consented during their pre-assessment consultation, if they were referred directly into the department, they would complete the consent form in the consultation room prior to the procedure.

## Are medical care services responsive?

Requires improvement

# Outpatients and diagnostic imaging

| | |
|---|---|
| Safe | Good |
| Effective | |
| Overall | Requires improvement |

## Information about the service

Outpatient services at Newark Hospital are provided mostly from the main outpatient department at the hospital site. The Diagnostic and Outpatient Division is responsible for the delivery of outpatient services. Newark Hospital has 26 clinic rooms providing clinics for a range of specialties, including orthopaedics, ophthalmology, urology, neurology, ear nose and throat (ENT), podiatry, and therapy services. Between July 2015 and June 2016 Newark Hospital had 80,984 outpatient appointments booked.

During our inspection of outpatient services we spoke with five patients and 20 staff members. Staff we spoke with included medical, nursing, allied health professional, administrative and clerical, reception and patient appointment booking staff. We did not inspect diagnostic services.

We observed the care and treatment of six patients in various clinics. We looked at equipment, controlled drugs storage and three patient records. We reviewed information provided by the trust during and after the inspection.

## Summary of findings

We did not rate all domains for outpatient services. We rated safety as good. We found:

- Staff knew how to report incidents. They gave us examples of the types of incidents reported and we saw investigators identify actions and learning. The trust regularly monitored and assessed all incidents for severity of harm. Staff received feedback and learning from incidents through team meetings and emails. Staff knew about their responsibilities regarding openness and transparency with patients when things went wrong.
- Staff adhered to infection control policies including hand hygiene and 'bare below the elbows'. Staff checked emergency resuscitation equipment daily and they knew how to access it in an emergency. All staff had received safeguarding training and knew their responsibilities to identify and report concerns.
- Medicines were stored securely in locked cupboards, in locked rooms, with access limited to clinical staff. Controlled drugs were stored appropriately in locked fridges and cupboards. The outpatient service had processes for securely storing and handling patient records. Staff locked records in storerooms and trolleys.
- Since our last inspection, the outpatient service had made significant improvements in reviewing patient outcomes and reducing the number of overdue appointments. The trust had changed the way they booked appointments. They had introduced regular risk assessment, audits and monitoring to ensure the patients most at risk had appointments.

However we also found:

- The inspection team had concerns regarding booking arrangements for ophthalmology. Ophthalmology had the largest numbers of incidents reported and largest numbers of patients overdue for

# Outpatients and diagnostic imaging

an appointment. Information on the trust's equipment maintenance programme showed 73 out of 183 pieces of equipment had not received their scheduled annual check.

## Are outpatient and diagnostic imaging services safe?

Good

Overall, we rated safe for outpatient services as good.

We found:

- The majority of staff knew how to report incidents and provided examples of when they had done so. We saw evidence of senior nurses sharing learning and feedback from incidents. Staff understood the requirement to be open and transparent with patients.
- The majority of staff followed infection control policies and procedures including bare below the elbows and hand hygiene. Staff cleaned equipment between patients.
- Staff stored medicines and controlled drugs securely and in line with trust policies. Staff checked the storage of medicines and fridge temperatures regularly.
- Staff stored records securely in locked cupboards and storerooms. Staff used lockable trolleys to store records outside clinic rooms.
- All staff received safeguarding training and knew of their responsibilities in identifying and escalating concerns.
- Since our last inspection, the outpatient service had made significant improvements in reviewing patient outcomes and reducing the number of overdue appointments.

However we also found:

- The inspection team had concerns regarding staffing and booking arrangements for ophthalmology. Ophthalmology had the largest numbers of incidents reported and largest numbers of patients overdue for an appointment.
- Information on the trust's equipment maintenance programme showed 73 out of 183 pieces of equipment had not received their schedules annual check.

**Incidents**

- Between June 2015 and May 2016, the outpatient service reported 457 patient related incidents. Of these,

451 (98.6%) were classed as causing no or little harm to patients. Incidents included appointment and booking errors, transport delays, patient incorrectly identified and equipment failure.

- There were no never events reported for this service for the period of June 2015 and May 2016. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
- There was evidence of sharing and learning following a serious incident at Kings Mill Hospital. Serious incidents are events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, they warrant using additional resources to mount a comprehensive response. Staff knew about the incident and told us senior nurses shared learning through team and one to one meetings. For example, the service made changes to patient outcome forms to highlight urgent appointments. This change was made following an incident where a patient suffered complications as a result of a delayed urgent appointment.
- Data from the trust showed incidents in ophthalmology accounted for 11.4% (52) of all incidents, more than any other department between June 2015 and May 2016. The majority of incidents involved booking errors, documentation (wrong or missing), and patients not informed of cancellations. We spoke with bookings staff who said this was due to using a different booking system. Ophthalmology was due to move to a new process shortly after our inspection.
- During our previous inspection, the trust had not systematically and routinely reviewed or assessed a significant number of incidents for severity of harm caused to patients. We reviewed all incidents reported between June 2015 and May 2016 and saw all incidents had been assessed for severity of harm. Therefore, the trust had reviewed and improved their process of assessing and reviewing incidents.
- The majority of staff knew how to report incidents and were encouraged to do so. Clinical and support staff we spoke with described the incident reporting system and felt comfortable using it. They gave us examples of reported incidents such as missing patient records, falls, and patient transport not arriving.
- Data from the trust showed managers and staff implemented actions and identified learning from investigations. The outpatient service had ways to feedback learning from incidents via monthly team meetings and through staff bulletins. We saw in copies of team meetings managers discussed incidents with staff. The majority of staff said they had received feedback from incidents they had reported.
- The Diagnostic & Outpatient division did not have mortality and morbidity meetings for Newark outpatients. The medical and surgical specialities undertook all activity in the outpatient department, and mortality and morbidity meetings took place within those specialties.

**The Duty of Candour**

- The Duty of Candour is a regulatory duty relating to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person.' We saw from incident investigations that incident investigators involved patients and their families through the investigation process.
- Staff understood the duty of candour and the need to be open and transparent. Staff gave us examples of when they had used duty of candour or when they had been open and honest with patients and their relatives when things went wrong. Staff gave examples of when they were open and honest with patients including apologising for clinic delays if clinic ran late.

**Cleanliness, infection control and hygiene**

- The departments we visited were visibly clean and tidy, with uncluttered clinics, utility rooms, corridors and doorways. We saw completed cleaning rotas for different areas, which confirmed the required cleaning had taken place.
- Nursing staff followed trust policies on infection control and hygiene in the clinics. We observed staff using appropriate hand washing techniques and personal protective equipment, including aprons and gloves. Hand alcohol gel dispensers were readily available in clinics and patient waiting areas. Staff cleaned equipment between patients with alcohol wipes.

# Outpatients and diagnostic imaging

- We observed the majority of medical staff cleaning their hands before and after clinic sessions. However, we observed one consultant who did not regularly wash their hands before and after seeing patients in clinic.
- We observed all staff were bare below the elbow, in keeping with trust policy to help prevent the spread of infection.
- The outpatient service conducted regular infection prevention and control (IPC) audits, for example in relation to the environment and hand hygiene. The latest audits supplied by the trust showed there was a staff compliance rate of 100% with hand hygiene procedures and 100% for the overall cleanliness of the environment.
- Staff undertook IPC and hand hygiene training as part of their mandatory training programme. Data from the trust showed 89% of staff completed both IPC and hand hygiene training. All staff we spoke with knew their responsibilities regarding infection control and hand hygiene.
- There were effective arrangements for the disposal and management of sharps (used needles) in line with the trust policy. All sharps boxes were accessible and close to where staff needed them in order to prevent injury. In addition, we saw full sharps boxes sealed and awaiting collection in a secure dirty utility room. The outpatients department had arrangements for managing waste and clinical specimens. Doors to dirty utilities were locked and we found them to be tidy with separate bins for different types of waste. Waste was collected on a daily basis.
- In the fracture clinic we saw staff encourage patients to clean their hands and the skin under plaster casts after their removal.
- Staff had procedures for isolating infectious patients. Staff could examine patients in private clinic rooms and we saw staff prioritise patients so they did not spend time in waiting areas with other patients. Staff could also visit inpatients on wards rather than bringing infectious patients to the outpatient departments.

**Environment and equipment**

- The trust used audits to check equipment availability and monitor when equipment needed a maintenance test. An external company checked, tested and maintained equipment. All equipment we saw during our inspection was in date, tested and checked within the last year. All staff said they had no concerns regarding the maintenance and availability of equipment.
- However, data from the trust showed the maintenance company had not seen 73 out of 183 pieces of equipment in the last year. The trust said patients borrowed the majority of equipment for home use and therefore this relied on the patient bringing them back into hospital for annual checks to be done.
- There were protocols for specific pieces of equipment throughout the department, which staff could access on the trust's internal computer systems. In addition nursing staff had competency assessments signed off by senior nurses after observations. One nurse showed us their competency pack for using saws and taking off plaster casts.
- Clinics had access to emergency resuscitation equipment and staff checked the equipment daily to ensure the equipment was well maintained and safe to use. Staff knew where the nearest resuscitation equipment was and how to obtain it. The nearest resuscitation equipment for main outpatients was located in the adjacent x-ray department. Where outpatient services delivered clinics in other areas of the hospital, they had access to their own resuscitation equipment.
- Staff attended medical devices training as part of their mandatory training programme. Medical devices training helped staff keep up to date with how to use medical equipment for example, electrocardiogram machines (ECG). Data from the trust showed 87% of staff had completed this training.
- The design of the outpatient department at Newark hospital meant the reception area was situated in the corner of the room and served all of the adjacent clinics. Staff were aware of their proximity to waiting patients and minimised the risk of personal information being overheard by using appropriate questioning, for example 'are you still resident at the same address'?
- There was a separate space in main outpatients to record patient observations such as weight and height. Staff took patients behind a screen in a disused patient waiting area in a corridor and although not enclosed, did provide some privacy. However this could not be guaranteed.

**Medicines**

- Medicines were stored securely in locked rooms and cupboards with access limited to clinical staff. Senior nurses kept the keys to CD and medicine cupboards in order to ensure they were secure and their use monitored. Staff kept accurate and up to date medicines checks and monitored fridge temperatures when medicines need to be stored at certain temperatures to maintain their effectiveness.
- Controlled drugs (CDs) are medicines requiring additional security. CDs were stored and locked in fridges or cupboards. Records staff checked them daily and the CD check records were complete. Pharmacists checked the fridge every month and replaced stock or disposed of out of date medication.
- Nursing staff explained any medications to patients and gave them advice about how to take them and any likely side effects. They gave patients information leaflets to support this.
- Nursing staff attended medicines management training as part of the mandatory training programme. Data from the trust showed 93% of staff were up to date with medicines management training. This was better than the trust standard of 90%.
- Outpatient services had processes in place for the management of prescription pads (FP10). Pads were stored in in locked cupboards and clinicians signed them in and out each day.

**Records**

- Records were stored in locked cupboards and storerooms to ensure patient confidential information was not inappropriately accessed. During clinics staff kept records on shelves awaiting collection from nursing staff behind the reception desk. While records were not stored securely reception staff occupied the reception desk at all times and all notes were turned upside down so patient details were not visible. Outside clinics staff stored records in locked trolleys.
- At our previous inspection, we saw medical records stored in several different areas within the hospital. However, the trust had created a new central store, to keep all records in one location. In addition, the service had a transport plan to support transferring notes from one site to another. This led to improved availability of records at clinic. Staff told us the availability of patients' medical records had improved since our last inspection. Data from the trust for the period 20 June 2016 to 1 July 2016 showed the availability of notes varied each day. An update provided by the trust for the period 11 July to 22 July 2016 indicated there had been no missing clinic notes for this period. However, there had been seven occasions when medical notes arrived late for clinic.
- Outpatient clinics had processes in place if a patient's notes did not arrive in time for a clinic. Staff could print off information and consultant letters to GP from an electronic patient record system and create a temporary set of notes. This meant the consultant could still see and review patients and have access to information.
- We reviewed three sets of patient records. Records were tidy, in date order, legible and signed and dated in line with General Medical Council (GMC) standards.
- We saw evidence in patient records to indicate treatment followed agreed care plans and consultant letters were sent to the patient's general practitioner (GP) following each clinic visit.
- We observed all staff locking their computers when walking away from desks, especially in public areas. This meant staff kept confidential patient information secure and unauthorised persons could not access it. All staff we spoke with knew about their responsibilities to keep patient information confidential and secure.
- We observed reception staff always asking patients for up to date personal details and confirming GP, phone, and home address details**.** This helped to make sure letters, reminders and other information were sent to the correct patient. Reception staff received alerts on their electronic patient record system which highlighted if key information such as GP details were incorrect. This allowed staff to clarify details with patients so consultant letters could be sent to the correct GP.

**Safeguarding**

- All staff we spoke with in outpatients said they had completed training in safeguarding adults and children. This included nursing and non-nursing staff. Data from the trust showed 100% of nursing and non-nursing staff had completed level two training in safeguarding adults.
- Staff had access to the trust safeguarding policy. Staff we spoke with knew of the procedures to follow should they need to report a safeguarding concern. Nursing staff demonstrated good understanding of safeguarding procedures and could identify their local safeguarding lead. Staff said they would discuss concerns before

making a referral to the appropriate agency. Nursing staff were confident in escalating concerns as needed and staff showed us a copy of escalation numbers they could call.

- Staff knew about potential signs of abuse and knew how to escalate concerns. Staff said they would discuss concerns before making a referral to the appropriate agency or telephone the safeguarding team. Nursing staff said they were confident in escalating concerns as needed. Staff knew how to access policies and procedures on female genital mutilation and domestic violence.

**Mandatory training**

- Mandatory training included moving and handling, health and safety and equality and diversity training. The trust target was for 90% of staff to have completed their required training. All of the managers and staff we spoke with confirmed they were up to date with annual mandatory training. Data from the trust showed 93% of all staff across outpatient departments at Newark Hospital had achieved mandatory training compliance.
- All staff we spoke with said senior nurses sent them on study days to Kings Mill Hospital to complete mandatory training.

**Assessing and responding to patient risk**

- In January 2015, the trust identified a significant number of patients, around 19,500 in total, where staff did not record the outcome of their outpatient appointment in the electronic system correctly or they were overdue for a review appointment. This included patients attending at Newark Hospital. This meant there was a risk to patients not accessing the correct care and treatment in a safe, timely manner.
- In response, the trust started an outpatient improvement programme in April 2015. This included projects which significantly reduced the number of patients awaiting recorded outcomes for their appointment. By July, the number of patients without outcomes had fallen to 1,038. Staff started to audit outcome collection for patients to ensure all patients received an outcome. During our inspection, we saw clear procedures for collecting and inputting outcomes for patients.
- During this period the numbers of patients with an overdue appointment also decreased. This meant patients were more likely to receive timely access to care and treatment. In June 2015, the outpatient service had 6,375 overdue appointments. The trust reduced the number of overdue appointments to 2,427 during our inspection. Staff prioritised patients most at risk. They did this by reviewing action plans, booking processes, and monitoring arrangements. We saw the majority of waits were overdue by one to four weeks.
- Ophthalmology had the most numbers of overdue appointments with 798 (33%). Reasons for this included the number of patients needing appointments, medical staffing and flow of patients. Managers had an action plan, agreed by the trust board during the inspection. The action plan identified urgent actions staff needed to take to address this issue for example, an urgent review of patient pathways. The trust assured the inspection team they prioritised the patients most at risk through demonstrating governance and booking arrangements to manage the issue. The booking team offered patients in Newark the option to travel to Mansfield which had shorter waiting times for appointments. Newark had a smaller outpatients department and had less capacity to see a large number of patients. The service also put on extra clinics in the evening and at weekends at Kings Mill Hospital to manage demand.
- We saw consultants checking images, reading patient notes before clinic, and asking patients questions to assess the risk associated with medications and further treatment types. This enabled consultants to make decisions on safe care and treatment for the patient.
- Clinical staff observed patients and recorded physiological observations such as blood pressure and heart rate. Staff knew about the side effects of tests and kept patients under close observation. Staff used early warning scores for adults to ensure they managed and cared for patients appropriately. Staff told us of incidents when patients were transferred to the Minor Injuries Unit if they deteriorated.
- Staff undertook basic life support training as part of their mandatory training programme. Data from the trust showed 93% of staff were up to date with basic life support training.
- Staff knew the procedures for escalation and calling for help when patients became seriously ill. Staff could call a designated number in an emergency and dispatch a crash team to the department to treat the seriously ill patient. Outpatient services also had access to resuscitation equipment and oxygen for patients with breathing difficulties.

# Outpatients and diagnostic imaging

### Nursing staffing

- Data provided by the trust showed Newark Hospital to have an establishment of 19.6 whole time equivalent (WTE) nursing staff (qualified and unqualified) and for June 2016 there was one healthcare assistant (HCA) vacancy. Sickness was recorded as 6% for June 2016.
- A senior nurse told us there were plans to recruit to the HCA position.
- Staffing for clinics was dependent upon the number of consultants running clinics each day. A trained nurse or HCA supported each consultant... A senior nurse was responsible for staffing numbers and allocated staff to clinics. We saw clinics had enough staff to ensure they ran smoothly and to time.
- The service was not using bank or agency staff at the time of inspection as there were enough staff to support clinics. A senior nurse told us they had made some bank and temporary staff permanent. The service used bank nurses only for extra clinics.
- Each clinic had a clinic coordinator. A member of qualified nursing staff undertook this role and it rotated between staff. The coordinator had the responsibility of raising any staffing concerns and ensuring clinics ran smoothly.

### Medical staffing

- Medical staff were provided for clinics by the relevant divisions in the trust. Medical consultants and registrars worked in outpatient clinics on a rota. Most of the medical staff worked at both Newark and Kings Mill hospitals and a small number at Newark Hospital only. Medical Staff are employed by each clinical division and undertook outpatient clinic sessions for their speciality. Medical vacancy and sickness rates are managed within their specific division and monitored by the trusts medical task force. The trust reported a medical sickness rate of 1%.
- The trust employed locum doctors to cover clinics at Newark Hospital as required for staff holidays or other leave. The relevant divisions managed the number of sessions covered by locums for outpatient clinics.

### Major incident awareness and training

- The trust had a major incident plan which set out department procedures and responses to follow in the event of a major incident. The plan had processes for Newark Hospital to support operations at Kings Mill Hospital and potentially take patients who were safe to be cared for at Newark. The nurse in charge and hospital manager at Newark Hospital was responsible for liaising with key staff at Kings Mill.
- Clinic managers could tell us about local business continuity plans in the case of inadequate staffing, power failure, bomb threat, IT failure, fire and flood. Staff knew about procedures to follow in the event of major impacts on the service.

## Are outpatient and diagnostic imaging services effective?

# Outstanding practice and areas for improvement

## Areas for improvement

### Action the hospital MUST take to improve

- The trust must ensure that staff understand the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards in relation to their roles and responsibilities.

### Action the hospital SHOULD take to improve

- The trust should embed a standardised system for identifying when equipment is clean and ready for use.
- The trust should ensure there are clear risk assessments for patients isolated for infectious reasons.
- The trust should ensure patient outcomes are monitored and reviewed to ensure the medical services are meeting the needs of the patient.
- The trust should continue to identify relevant national audits which can be completed to benchmark the quality of care provided.
- The trust should consider identifying results for Newark Hospital in specific audits to demonstrate monitoring of site effectiveness in the medicine service.
- The trust should consider the suitability of the treatment room as a place to observe high or extremely high risk mental health patients in the minor injuries unit.
- The trust should continue to liaise with the local ambulance trust to revise the inter facility transfer protocol.
- The trust should consider developing a paediatric care management pathway in the minor injuries unit.
- The trust should ensure the process of reconciliation continues for outpatients without identified outcomes.
- The trust should continue to ensure outpatients most at risk are not unnecessarily waiting for appointments.
- The trust should continue its programme to reduce the numbers of overdue appointments for outpatients.
- The trust should review arrangements for retrieving equipment borrowed by outpatients so it can be tested annually.

This section is primarily information for the provider

# Requirement notices

## Action we have told the provider to take

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

| Regulated activity | Regulation |
|---|---|
| Treatment of disease, disorder or injury | Regulation 11 HSCA (RA) Regulations 2014 Need for consent<br><br>**Regulation 11(1)**<br><br>Care and treatment of service users must only be provided with the consent of the relevant person<br><br>**How the regulation was not being met:**<br><br>Staff did not always understand the requirements of the Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards in relation to their roles and responsibilities. |