Care Quality Commission

Wye Valley NHS Trust

The County Hospital

Inspection report

County Hospital
Union Walk
Hereford
HR1 2ER
Tel: 01432355444
www.wyevalley.nhs.uk

Date of inspection visit: 12 October 2022
Date of publication: 21/12/2022

Ratings

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

Our findings

Overall summary of services at The County Hospital

Requires Improvement 

We carried out this unannounced focused inspection within the surgical and medicine core services. We checked the quality of services in response to a warning notice we issued following our inspection of the services in December 2019. In the warning notice, we set out areas where improvement was needed including infection control, risk assessments, mandatory training, culture and governance. This focused inspection was to see if improvements had been made within these services.

During this inspection we inspected the surgical and medical core services using our focused inspection methodology. We did not cover all key lines of enquiry; however, we have re-rated some key questions based on the findings from our inspection. Overall, we rated safe and well-led as requires improvement in the surgical services. We did not rate the effective, caring or responsive domains. This means we rated surgery as requires improvement overall. Overall, we rated safe and effective as requires improvement in the medical services. We did not rate the caring, responsive or well led domains. This means we rated medicine as requires improvement overall.

Our rating of The County Hospital stayed the same. We rated them as requires improvement because:

- We found that risk assessments for venous thromboembolism and falls were not completed and updated in a timely manner.
- Theatre briefs were not always completed thoroughly and efficiently which meant that patient data could be missed.
- We found that patient notes were not locked away therefore, patient's data was not protected.
- Mandatory training levels for the staff did not meet trust target.
- We found that World Health Organisation (WHO) checklist monitoring was not robust and there was confusion over its validity.
- Staff were stressed and concerned about the newly implemented reverse boarding and the impact it was having on the service.
- We found that missed doses of medicine were occurring on the medication charts and this was not audited. This meant that the service did not have an understanding of the impact of these missed doses.
- Staff could not easily access basic life support training. This meant that training levels were low in most areas.
- In medicine, Mental Capacity Act assessments were not routinely completed for patients who required them.
- Deprivation of Liberty Safeguards were not effectively completed or reviewed in a consistent manner across medicine.

However:

- The service had enough staff to keep patients safe.
- Staff had training and understood how to protect patients from abuse, and managed safety well.
- The hospital generally controlled infection risk well.

Our findings

- The service managed safety incidents well and learned lessons from them.
- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities.
- Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately.

How we carried out the inspection

We inspected this service on 12 October 2022. This was an unannounced focused inspection looking at the surgical and medical service. We inspected 5 surgical and orthopaedic wards, the operating theatres and pre-operative assessment unit. We inspected 6 medical wards.

The team that inspected the service comprised 4 CQC inspectors, including a pharmacy specialist and a specialist advisor with expertise in surgical services.

During our inspection we spoke with 40 staff members including nursing staff, healthcare assistants, allied healthcare professionals, theatre practitioners, doctors and managers. We reviewed patient records.

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

Medical care (including older people's care)

Requires Improvement ➔➔

Our rating of medicine remains the same. We rated them as requires improvement because:

- Mental Capacity Act assessments were not routinely completed for patients who required them.
- Deprivation of Liberty Safeguards were not effectively completed or reviewed in a consistent manner across medicine.
- Mandatory training levels for the staff did not meet trust target.
- Mandatory training in basic life support (BLS) did not meet the trust target of 85%.
- We found that risk assessments for venous thromboembolism and falls were not completed and updated in a timely manner.
- We found that missed doses of medicine were occurring on the medication charts and this was not audited. This meant that the service did not understand the impact of these missed doses.
- Handovers were not always completed for patients between wards.

However:

- Staff had training and understood how to protect patients from abuse, and managed safety well.
- Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately.
- Patients could reach call bells and staff responded quickly when called.
- Staff followed systems and processes to prescribe and administer medicines safely.

Is the service safe?

Requires Improvement ➔➔

Our rating of safe stayed the same. We rated it as requires improvement.

Mandatory Training

The service provided mandatory training in core subjects but did not always make sure that staff had completed it.

Nursing and medical staff received and kept up to date with their mandatory training and this training was comprehensive and met the needs of the patients and staff.

The trust target for completion of mandatory training in core subjects was 85%. The overall compliance across the service was 86%. However, in some areas of mandatory training, such as safeguarding, compliance for medical staff on the stroke ward was 0%. The trust told us that the training targets for completion were not where they would hope due to COVID-19 and that these would be monitored at the next divisional meetings.

Mandatory training in basic life support (BLS) did not meet the trust target of 85%.

Data provided by the trust showed that the overall compliance rate for BLS across the service was 63%. Compliance was 25% for nursing staff in the discharge lounge and medical day case. Other wards like Garway and Dinmore had a BLS training compliance under 40%. Medical teams, such as diabetes and lung function the clinical nurse specialist's compliance was under 40% compliant.

The trust told us that the lack of compliance was a result of COVID-19 and not being able to train more than 3 staff at any one time. We were told training was prioritised for new starters and those staff members whose training was over 12 months old. Some of the nursing staff completed additional training which was essential to their role, such as advanced life support.

All staff were required to complete Mental Capacity Act and Deprivation of Liberty Safeguards mandatory training. The trust did not provide staff with mandatory training in the Mental Health Act.

Staff did not always show understanding of the Mental Health Act, Mental Capacity Act or Deprivation of Liberty Safeguards and how to apply them to patients who may require assessment. The medical division had a 46.6% compliance with Deprivation of Liberty Safeguards training and an 83.6% compliance with Mental Capacity Act training. The trust provided information to state that they did not provide Mental Health Act training as statutory and mandatory and therefore, this was not captured on staff record. Although, during 2021 and 2022, the trust delivered bespoke Mental Health Act training to the board, clinical site management team, consultant body and juniors in a variety of forums using the mental health lead nurse.

The safeguarding team told us that staff had been offered bespoke training on the Mental Capacity Act and Deprivation of Liberty Safeguards but the response had been poor, particularly on the Acute Medical Unit (AMU). They identified that this area needed additional training and this was going to be raised with the executive team.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Nursing staff received training specific for their role on how to recognise and report abuse.

Staff demonstrated good knowledge of safeguarding principles particularly around physical and mental abuse. They made referrals to the safeguarding team, as well as relevant third-party agencies where necessary.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them.

All staff should have received training in safeguarding so that they could recognise and report abuse. The trust target for completed training was 85%. The nursing staff group were 92% overall compliant in safeguarding adult level 2. The medical staff were 87.7% overall compliant in safeguarding level 2. However, only 3 out of 13 medical division departments had compliance levels that met trust targets. These were dermatology, rheumatology and medical GP staff. Stroke (0%), plastics (33%) and gastroenterology (56%) had the lowest rates of compliance.

In departments where compliance met the trust target, staff were able to tell us how they were able to identify patients at risk of, or suffering, significant harm and how they worked with other agencies to protect them. Staff were in general, knowledgeable about safeguarding. Staff could give examples of how to protect patients from harassment and

discrimination, including those with protected characteristics under the Equality Act. We identified one patient who was at risk of abuse. Staff showed us the safeguarding measures that they had taken to protect the patient and assured us that mitigating actions were in place whilst a safeguarding referral was processed by the local authority and other relevant agencies responded.

If patients displayed inappropriate behaviour, they were risk assessed and appropriately managed for their own safety and that of others. We saw appropriate and comprehensive risk assessments completed for several patients across the hospital where a risk was identified.

Safeguarding posters were on display in ward areas and staff also knew where to find the trust's safeguarding policies and procedures which were located on the intranet. The safeguarding policy was up to date.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff were aware of information on wards to guide them about when and who to contact to make a safeguarding referral. There were safeguarding link nurses on the wards who had received further training and could assist staff with referrals. The safeguarding lead and their team carried out ward rounds on most days to enquire about any potential safeguarding issues and to support the ward team if necessary.

Cleanliness, infection control and hygiene

Staff mostly used equipment and control measures to protect patients, themselves and others from infection. They generally kept equipment and the premises visibly clean. However, we identified a lack of consistency in the completion of infection, prevention and control audits.

Ward areas were clean, however, furnishings were not always well-maintained.

All ward areas that we inspected were mostly visibly clean and tidy. However, Lugg ward had two bays where the bathrooms had outstanding maintenance issues with the shower flooring. The flooring had slightly lifted and was torn which presented as both a trip and infection control hazard. We were shown that these issues had recently been reported to the estate team and were awaiting a date for repair.

Majority of staff followed infection control principles including the use of personal protective equipment (PPE). Most staff were seen to wash hands, use antibacterial gels and PPE. Masks were worn in line with trust policy. Handwashing facilities were located throughout all wards that we inspected. Hand hygiene audit compliance from April to September 2022 the medical division was between 95 and 99%.

We observed a range of staff including nurses, doctors and allied health professionals follow best practice for PPE and being 'bare below the elbows' when delivering care. Bare below the elbow compliance for the medical division from April to September 2022 was 95 to 100% for 5 out of 6 months, with one month being 88%.

The trust provided us with the recent IPC audits for several medicine wards. Each audit identified areas of concern with a pass or fail. Six of those recognised that Dinmore, Acute Medical Unit (AMU), Garway, medical escalation, Lugg and Arrow had dust on equipment, soiled commodes, poor IPC assurance, and items stored on the floor.

We identified a lack of consistency in the completion of these audits between wards. Only one out of the 9 audits we reviewed had been fully completed. The remaining audits were not completed and lacked a record of whose responsibility it was to take away the actions of the audit or who the actions had been reported to.

Medical care (including older people's care)

Staff followed infection control principles including the use of personal protective equipment PPE.

Nursing and medical staff wore appropriate PPE for the tasks that they were undertaking. Where patients were identified as infectious, staff donned and doffed the appropriate PPE and showed good practice for hand washing.

Patients with infectious diseases and illnesses were identified early and trust policy was followed to isolate patients into side rooms or whole bays should there be a outbreak. Side rooms were clearly signed to inform staff and visitors of an infection risk and the relevant infection control measures needed for that specific room. However, we saw on Dinmore ward 2 sets of porters at separate times arriving with COVID-19 positive patients. The porters did not wear any PPE and did not wash their hands until challenged by the CQC inspector. This was also escalated to managers.

Staff cleaned equipment after each patient contact and a green an 'I am clean' sticker was applied and dated from when it was cleaned.

The infection prevention reports were discussed at the infection, prevention and control committee and reported to board. As of from April to September 2022 the medical division had no case of healthcare acquired MRSA bacteraemia; 8 cases of healthcare acquired E.coli bacteraemia against a trust threshold of 39; and 8 externally reportable hospital acquired Clostridium difficile cases.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

Patients could reach call bells and staff responded quickly when called.

On each ward that we inspected call bells were appropriately attached to the patient's bed and within the patients reaching distance. We saw that where calls bells were pressed, they were attended to within 3 minutes.

The service had suitable facilities to meet the needs of patients' families.

All the wards were suitable for their purpose and mainly clutter free. However, in the Acute Medical Unit (AMU) the corridors appeared cramped due to the amount of equipment stored within them, such as the workstation on wheels, patient record trolleys and monitoring equipment. This meant that when patients arrived via the trusts boarding policy the corridors were further restricted in space.

On Dinmore ward a patient had recently deceased and the family were offered the use of the family room. When they arrived at the family room, they witnessed nursing and medical staff using the room for the break. The nurse in charge asked the staff to leave the room once they were informed.

The trust had recently started a reverse boarding policy for patients. This meant that the wards often had a higher number of patients than bed spaces at certain times of the day. Patients who were waiting to be discharged and were fit to sit, were moved from their bed to a chair. Then another patient would be admitted into that bed space. Staff told us that patients did not always have a bed space and therefore, not all the facilities were available to them and dignity was not always maintained. We were told that some patients were nursed in the corridors whilst they awaited discharge or a bed to become available. However, we did not see this at the time of our inspection.

The trust had processes in place for the maintenance and checking of electrical equipment in accordance with Managing Medical Devices (January 2021), and other national guidance.

All equipment that we checked contained evidence of in date electrical safety testing and servicing. Managers told us that safety alerts were disseminated to them and any recalled equipment was removed and sent to the procurement team.

Assessing and responding to patient risk

Staff did not always complete and update all risk assessments for each patient. Handovers for patients moving between wards were not always completed. Staff identified and acted upon patients at risk of deterioration.

Staff generally completed risk assessments for each patient on admission, using a recognised tool. However, these were not always reviewed regularly. Risk assessments to assess a patient's risk of developing blood clots while in hospital were not always completed in line with national guidance or trust policy. National Institute for Health and Care Excellence guidance (NG89) March 2018, states that all patients should be assessed to identify the risk of venous thrombo-embolism (VTE) or blood clots as soon as possible after admission to hospital, or by the time of the first consultant review and that reassessments for VTE should be at the point of consultant review or if their clinical condition changes.

Between March and October 2022, 58% of patients had not received a VTE assessment within 24 hours. and there was no second reassessment within 48 hours for 75% of patients. Within this same period 37 patients had a hospital acquired VTE's whilst being in hospital. The trust reviewed these patients and found that low or no harm had occurred because of the hospital acquired VTE.

A patient in the Acute Medical Unit (AMU) who had arrived from the emergency department as part of the reverse boarding policy was placed into the ward family room, as there was no space on the corridor. On re-visiting the AMU 7 hours later the patient was still in the family room. When the ward sister was asked about a bed space for the patient, we were told there was not a bed space available. We checked to see if the patient had been given any observations or had welfare checks in those 7 hours and they had not. We escalated this to the ward sister who asked a nurse to attend to the patient.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately.

Staff used a nationally recognised tool to identify deteriorating patients and generally escalated them appropriately. The National Early Warning Score (NEWS2) was used for adults when required, dependent on the presenting condition. This was a quick and systematic way of identifying patients who were at risk of deteriorating. Clinical observations, such as blood pressure, heart rate, and respirations were recorded and contributed to a total score. Once a certain score was reached a clear escalation of treatment was commenced. Any patients with a NEWS2 of four or more would trigger a review from the doctor. NEWS2 were automatically calculated on the newly introduced electronic system. NEWS2 were displayed on the electronic patient board behind the reception desks. Managers told us that they could see any high scores and prompt action if needed. They felt they had good oversight of a patient's clinical condition. The trust told us that they were devising an auditing approach for the new electronic system.

Comprehensive risk assessments were mostly carried out on patients when they were admitted.

Nursing staff used nationally recognised tools to assess patient's risk of developing for example, pressure ulcers (waterlow), nutritional risks, falls, as well as risks associated with moving and handling. Patients identified at risk were

placed on care plans and were monitored more frequently by staff to reduce the risk of harm. We reviewed 12 sets of patient notes across 5 wards. The waterlow and falls risk assessments were completed in 11 out of the 12 patient notes. Where the scores for these assessments showed that the patient was at risk, an individual care plan was in place. In the records that we reviewed there was evidence of regular waterlow reviews for patients who had extended hospital stays.

We reviewed patients on each ward in order to identify patients at risk of sepsis. Patients who were at risk of sepsis had been identified and the sepsis pathway had been implemented. In September and October 2021, a comprehensive retrospective thematic review of deaths was undertaken as a result of a sustained higher than expected hospital standardised mortality ratio for sepsis during the period April 2020 to March 2021 inclusive. The review identified 7 patients who had received poor sepsis care in the following ways:

- Poor initial assessment and clerking of septic patients making the subsequent management difficult.
- Initial diagnostic uncertainty lingering throughout the patient's hospital admission.
- Assuming the wrong source of infection and subsequent choice of wrong antibiotics.
- Delay in escalation.
- Not seeking advice from microbiology or respected department.
- Blood culture is ignored nor requested in most of the cases.
- Over hydration in severe heart failure and renal patient.

We reviewed 10 patient risk assessments where sepsis had been queried or identified in AMU and Lugg ward. We saw examples of early referral of suspected patients with sepsis, correct use of infection severity score and escalation of management according to score, with same day senior medical reviews of patients with suspected sepsis. We saw that the re-assessment had taken place at the end of 48 hours to assess the patient's antibiotic response and reassess the patient if not they were not responding.

In various staff areas on the wards we saw prompts for clinical staff when considering sepsis. For example, we saw signs that stated; urosepsis is the most common diagnosis in sepsis patients, routine urinalysis and midstream specimen of urine is very important to confirm diagnosis and reminders to be vigilant for fungal or atypical infection in immunocompromised patients who are not responding to current antibiotics.

Staff did not always share key information to keep patients safe when handing over their care to others.

We observed patient handovers between wards on AMU, Dinmore and Lugg. On Dinmore and Lugg wards, patients were welcomed on to the ward by the nurse in charge. Patients notes and a brief verbal handover were given. However, on AMU, 2 patients arrived from the emergency department and were left by the nurse's station on both occasions by the staff transporting the patient. The notes were left with the patient and no verbal handover was given. Of these 2 patients, 1 waited 35 minutes before being spoken to and their notes reviewed. The second patient was spoken to within 10 minutes. Both patients were part of the reverse boarding process.

The nurse in charge was asked why a handover had not taken place and they stated that they did not know but that this would have to be reported as an incident, as it was not policy to leave patients without handing over.

A locum staff nurse told us that patients regularly arrived on to AMU without being properly handed over. When we spoke to management, they stated they were not aware of this problem and nothing had been reported. They told us that that all staff would be reminded about the importance of proper and effective patient handovers.

Medical care (including older people's care)

Medicines

The service used systems and processes to safely prescribe, administer and record medicines.

Staff followed systems and processes to prescribe and administer medicines safely.

An electronic prescribing and medicine administration (EPMA) system was used. The reason for prescribing medicines was documented on the EPMA. Documentation of medicines administration including routes of administration and specific times of administration were clear on all medicine records reviewed.

Allergy statuses of patients were routinely recorded on all medicine records we saw.

Venous thromboembolism (VTE) risk assessment outcomes and prescribing were completed on admission. There was no automatic reminder for re-assessing VTE risk on the EPMA system. We were told that pharmacy staff prompted any missed VTE assessments, however we found that these were not always completed.

Weights of patients were recorded on medicine administration records which was important for calculating weight-based medicines prescribing.

The principles of antimicrobial stewardship were implemented which included review dates for re-assessing prescribed antibiotic treatment.

Staff reviewed each patient's medicines as regularly as possible and provided advice to patients and carers about their medicines when resources were available.

Due to ongoing national difficulties in the recruitment of hospital pharmacists there was a reduced clinical pharmacy service across the trust. Pharmacy staff worked hard to provide support to staff and patients and ensure that monitoring, reviewing and providing clinical advice continued across the frailty wards and Acute Medical Unit (AMU). This ensured medicines safety.

Staff did not always complete medicines records accurately and keep them up to date.

Patients prescriptions and medicines administration records were accurate however, staff did not always record the reason for a missed dose. This is important information when reviewing patients' treatments to ensure there is an up to date accurate medicine history. Following a request to review missed doses it was reported that there were less than 0.2% of doses missed that had no reason documented from July to October 2022. However, the trust was aware that there needed to be a process in place to review and follow up any missed doses with staff. The audit of missed doses was to be included in the medicines safety report which would be presented to the patient safety committee every two months.

Staff generally stored and managed medicines and prescribing documents safely.

Medicines were mostly stored in locked clinic rooms with secure access to authorised staff. However, we did observe on AMU that some fluids we stored in an unlocked room where the door was constantly wedge open. We asked a staff nurse why these were not in a secure area and we were told because they are not controlled drugs. The risk for intentional tampering was possible and this was raised with the nurse in charge. We were told that this would be raised with the pharmacists but when asked, we received no update on whether this was actioned.

Medical care (including older people's care)

Medicine stocks were generally stored or managed in line with standard operating procedures.

Medicines room and fridge temperatures were within the recommended range, checked and recorded daily. Appropriate action would be taken if deviation occurred.

Emergency medicines were available and stored in tamper proof trolleys or boxes. Checks were recorded and undertaken daily to ensure equipment and medicines were within date and safe to use in an emergency.

Controlled drugs (medicines requiring more control because of their potential for abuse) were managed effectively and stored safely and securely.

Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services.

Medicines reconciliation should be completed as soon as possible when people move from one care setting to another and within 24 hours of admission. It is the process of accurately listing a person's medicines when they are admitted or when their treatment changes. Due to the pharmacy staffing issues medicine reconciliation was being undertaken less than 50% during an inpatient stay. However, there was a dedicated pharmacy team based on AMU and a pharmacy hub located within the frailty wards. The pharmacy team ensured that all new patient admissions and any newly prescribed medicines were checked on AMU and on the frailty wards.

Staff learned from safety alerts and incidents to improve practice.

There was a system in place for reporting incidents and for receiving and dealing with medicines safety alerts. Staff attended huddle 'safety bites' where they received updates or information on medicine safety incidents at both ward and trust level.

Is the service effective?

Requires Improvement 

Our rating of effective stayed the same. We rated it as requires improvement.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff did not always complete Mental Capacity Act and Deprivation of Liberty Safeguards assessments where there was a potential need.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care.

Ward management on each ward that we inspected were asked about the understanding of the Mental Capacity Act and Deprivation of Liberty Safeguards. Each staff member that we spoke to was able to effectively tell us what the process for each was and when to apply them. However, we found that Mental Capacity Act and Deprivation of Liberty Safeguards assessments were not routinely carried out where there was a potential need as identified on the patient list.

Medical care (including older people's care)

On Acute Medical Unit (AMU), we identified several patients that had been admitted with dementia or delirium. We initially reviewed the patient records of 3 of these patients and found no reference to a capacity assessment. When the nurse in charge was asked for a justification for no Mental Capacity Act assessment being completed, we were told that there was not time and that the process was laborious.

In response to this comment was asked for a safeguarding lead staff member to attend the AMU to review the patients that we identified with us. We were told by the safeguarding lead that within internal audits AMU been identified as not always being compliant with the Mental Capacity Act. In total we reviewed 9 patients records who we feel should have been given a Mental Capacity Act assessment but had not received one. We asked for these patients to be reviewed and escalated our concerns to the executive team.

Following our inspection, the trust told us that they intend to re-audit AMU and take appropriate action to ensure policies are followed so that Mental Capacity Act assessments were completed and where appropriate referrals were made for a Deprivation of Liberty Safeguards.

On Lugg and Dinmore wards we found good use of the Mental Capacity Act and Deprivation of Liberty Safeguards and best practice followed by involving family and friends in decision making processes where appropriate. Patient records were comprehensively completed. Where patients may have needed a Deprivation of Liberty Safeguards but did not have one, the nursing staff gave reasonable justification as to why it was not completed but acknowledged that they would challenge themselves again and adopt a second check process to ensure the risk of any missed patients was minimised.

Staff implemented Deprivation of Liberty Safeguards in line with approved documentation.

Where Deprivation of Liberty Safeguards were applied to a patient, they were done so in conjunction with risk assessments to identify the impact of any measures put in place to safeguard the patients such as bed rails or restraint. However, in AMU we identified that the main door to the unit was permanently locked and required a member of staff to open the door for patients and visitors. There was signage to inform visitors of the need to ask to leave but there was not always an available member of staff to let them out. We also identified that the only fire escape on the ward was blocked. When we asked staff why the fire exit was blocked, we were told it was to stop patients leaving. We escalated this to management on the grounds of fire safety and as a deprivation of liberty.

The main entrance remained locked the fire exit was unblocked.

Areas for improvement

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

Action the service MUST take to improve:

- The provider must ensure that staff complete mandatory training, including basic life support (Regulation 18(2)(b)).
- The provider must ensure that all risk assessments including the venous thromboembolism risk assessment and falls risk assessments are carried out in line with national guidance (Regulation 12(2)(a)(b)).

Medical care (including older people's care)

- The provider must ensure that patients receive timely observations (Regulation 12(2)(a)(b)).
- The provider must ensure that all flooring is well maintained to prevent trip hazards and reduce the spread of infection (Regulation 12(2)(h)).
- The provider must ensure all staff wear personal protective equipment in line with trust policy, including porters (Regulation 12(2)(h)).
- The provider must ensure patients receive a Mental Capacity Act assessment and a Deprivation of Liberty Safeguards where there was a potential need (Regulation 12(2)(a)(b)).

Action the service SHOULD take to improve:

- The provider should consider the impact that reverse boarding is having on the patients and staff.
- The provider should consider implementing a process for reviewing and following up missed medication doses.
- The provider should always ensure medicines are stored securely.
- The provider should ensure handovers are always completed for patients between wards.
- The provider should ensure that fire exits are never blocked.
- The provider should ensure audits are completed fully, for example infection control audits.

Surgery

Requires Improvement 

Our rating of this service improved. We rated it as requires improvement because:

- We found that risk assessments for venous thromboembolism and falls were not completed and updated in a timely manner.
- Theatre briefs were not always completed thoroughly and efficiently which meant that patient data could be missed.
- We found that patient notes were not locked away therefore, patient's data was not protected.
- Mandatory training levels for the medical staff were poor.
- We found that World Health Organisation (WHO) checklist monitoring was not robust and there was confusion over its validity.
- Staff were stressed and concerned about the newly implemented reverse boarding and the impact it was having on the service.
- We found that missed doses of medicine were occurring on the medication charts and this was not audited. This meant that the service did not have an understanding of the impact of these missed doses.
- Staff could not easily access basic life support training. This meant that training levels were low in most areas.

However:

- The service had enough staff to keep patients safe.
- Staff had training in key skills, understood how to protect patients from abuse, and managed safety well.
- The service controlled infection risk well.
- The service managed safety incidents well and learned lessons from them.
- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities.

Is the service safe?

Requires Improvement 

Our rating of safe improved. We rated it as requires improvement.

Mandatory training

The service provided mandatory training in key skills to all staff but did not always make sure everyone completed it.

Nursing staff received and kept up to date with their mandatory training and this training was comprehensive and met the needs of the patients and staff. Across all subjects and staffing groups training completion figures were high and above the trust target with most in excess of 90%. The trust target for compliance was 85%. Training data was discussed in the monthly surgical speciality governance meeting and team meetings.

Nursing managers told us they addressed any gaps in training compliance by prompting staff to complete the training within a specified time frame. They were given time to complete e-learning training either whilst at work or as paid time at home. This meant systems were in place to maintain and improve training compliance rates. On Frome ward, staff had a clinical lead whose focus was around education and training. They would also assist on the ward clinically to allow staff members to complete their training in work time. Theatre staff told us they had time to complete training during downtime when lists had been cancelled.

Managers said that it was hard to access basic life support (BLS) training which was delivered face to face. Only 3 members of staff were able to attend the course at one time and there had been sickness in the training department. This meant that across most areas the training compliance for BLS was low. Training figures provided by the trust following our inspection showed 68% of staff in the surgical services were compliant with adult basic life support training.

The nursing staff did additional training which was essential to their role. On Frome ward, the nurses had recently all been trained on the insertion of a nasogastric (NG) tube (a tube placed through the patient's nose into their stomach to assist with feeding). This NG training was introduced following an incident on the ward which highlighted a lack of training.

Medical staff did not always receive and keep up to date with their mandatory training. Medical staff training showed an overall mandatory training compliance rate of 71%. The lowest compliance rate was 45% for medical urology staff and the highest compliance rate was 82% in ophthalmology medical staff. Medical staff said that they had dedicated administration time to complete their mandatory training. Some medical staff had just started in the trust which meant they had mandatory training modules outstanding. We spoke to a registrar who had started one week prior to the inspection and still had a high number of outstanding modules. They said that they had been given administration time to enable them to complete these.

The mandatory training was comprehensive and met the needs of patients and staff. Mandatory training covered the appropriate subjects including safeguarding, resuscitation, infection prevention and control and moving and handling.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. Staff could access support from specialist teams and nursing staff when needed.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Nursing staff received training specific for their role on how to recognise and report abuse. Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff were knowledgeable about safeguarding and some could give examples of when they had needed to act to safeguard patients.

The services training compliance data for nurses and support staff for the surgical wards and theatre showed that the overall mandatory training compliance mostly fell between 90% and 100% for safeguarding children (covering levels one, two and three); and 85% and 100% for safeguarding adults (covering levels one and two). The trust target was 85%.

Medical staff did not always receive training on how to recognise and report abuse. Medical staff compliance for safeguarding adults (level 2) was 69% and for safeguarding children (covering levels two) was 68%.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff were aware of information on wards to guide them about when and who to contact to make a safeguarding referral. There were safeguarding link nurses on the wards who had received further training and could assist staff with referrals.

Safeguarding posters were on display in ward areas and staff also knew where to find the trust's safeguarding policies and procedures which were located on the intranet. The safeguarding policy was up to date.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Theatre staff demonstrated a good knowledge of safeguarding and had completed the appropriate levels of safeguarding training. They understood how to support patients suffering from abuse and how to refer a patient if needed.

Cleanliness, infection control and hygiene

The service controlled infection risk well. The service used systems to identify and prevent surgical site infections. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

Ward areas were visibly clean and had suitable furnishings which were clean and well-maintained. Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned.

Staff followed infection control principles including the use of personal protective equipment (PPE). Staff were seen to wash hands, use antibacterial gels and PPE. Masks were worn in line with trust policy. Handwashing facilities were located throughout all wards that we inspected. We observed a range of staff including nurses, doctors and allied health professionals follow best practice for PPE and being 'bare below the elbows' when delivering care. All audits completed on the wards between July and September 2022 had 100% compliance with staff being bare below the elbows. However, we did see one theatre practitioner who had a bracelet on. This was not in line with the infection prevention and control (IPC) policy.

Theatre areas were noted to be visibly clean and procedures adhered to including those enhanced for COVID-19. We saw staff cleaning down equipment appropriately following theatre cases. There were separate scrub, anaesthetic and preparation rooms for each theatre.

Monthly audits were completed to assess staffs' compliance with infection prevention and control standards and guidance. Compliance was generally good on all the wards and theatres. Most areas for September 2022 had above 90% compliance. There was poor compliance for some areas. For example, the clinical cleaning scores in July and August 2022 for Redbrook ward were 78% and 85% respectively. The manager told us that there were no housekeepers in these months, and compliance had increased to 97% in September 2022 since recruiting a new housekeeper. The wards and theatres were assessed using a star rating system for cleanliness. We saw 3 of the surgical wards had received a 5-star rating for cleanliness and 2 wards and theatre had received a 4-star rating for October 2022.

Staff were supported by the IPC team. They attended the wards daily including the weekends to provide IPC advice and support to the ward teams.

Staff received training about IPC and hand hygiene training during their initial induction and annual mandatory training. The trust provided up to date training compliance data following our inspection which showed that 85% of nursing staff and 62% of medical staff had completed level 2 IPC training. Where level 1 IPC training was required, all areas were 100% compliant apart from the theatre logistics team who were 64% compliant.

Surgery

Trust data showed that from April to September 2022 the average staff compliance rate with hand hygiene across the surgical services was 98%. Audits showed the actions were taken to address areas of poor practice. Each ward area undertook weekly audits and results were discussed at safety huddles. The IPC team also conducted spot check audits on a monthly basis for further assurance.

Side rooms were available when isolation was required, and staff told us how they would manage the risks associated with transmittable infections. The information staff told us was in line with best practice.

Staff worked effectively to prevent, identify and treat surgical site infections. There were procedures in place to reduce the risk and monitor for signs of surgical site infections (SSI) in line with The National Institute for Health and Care Excellence CG 74 Surgical site infections: prevention and treatment. SSI's were investigated and discussed at divisional level and within the IPC committee. The service collected data on SSIs for hip and knee replacements in line with national requirements. The total SSI rate for hips for April to June 2022 was 1.7% and for knees was 0%. This was better than the national average.

All patients who had a pre-assessment were screened for Methicillin-Resistant Staphylococcus Aureus (MRSA) before admission. All infections were reviewed by the director of IPC supported by the IPC team to ensure learning was implemented. The surgical division reported no hospital acquired MRSA bacteraemia (blood stream infection) from April to September 2022. There were 6 instances of other reportable infection attributed to the surgical service from April to September 2022. This included 3 trust apportioned clostridium difficile infection and 3 e-coli MSSA bacteraemia's.

There were 4 outbreaks of healthcare associated COVID-19 across the surgical wards from April to September 2022, with a total of 20 patients testing positive for COVID-19. There were measures in place for managing patients and staff who tested positive for COVID-19.

Reusable surgical instruments were decontaminated on site by a third party contracted by the trust using the trust's own decontamination unit. We did not inspect this service. The theatre manager told us that they were happy with the service that was provided.

We saw that there was good sharing of information regarding prevention of spreading of infectious diseases. For example, Frome ward clinical governance newsletter from July 2022 detailed the symptoms of Monkeypox and what to look out for and updated guidelines for the management of COVID-19.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment mostly kept people safe. Staff were trained to use them. Staff managed clinical waste well.

The design of the environment followed national guidance. All the wards and theatre were suitable for their purpose and mainly clutter free. The theatre corridors were visually kept very clean and tidy and all equipment stored appropriately.

The service had enough suitable equipment to help them to safely care for their patients. Staff carried out daily safety checks of specialist equipment. We saw that all equipment, such as blood pressure monitoring equipment were tested regularly to ensure their safety and effectiveness. We checked resuscitation trolleys on Frome and Redbrook wards and in the theatre suite. Daily checks were completed correctly in all areas. Theatre had specialist emergency equipment available, such as a difficult airway trolley and these were checked daily.

The service generally had suitable facilities to meet the needs of the patients and their families.

Surgery

The trust had processes in place for the maintenance and checking of electrical equipment in accordance with Managing Medical Devices (January 2021), and other national guidance. All equipment we checked contained evidence of in date electrical safety testing and servicing. Managers told us that safety alerts were disseminated to them and any recalled equipment was removed and sent to the procurement team.

There was good availability of equipment within the theatres. Staff said that there was good advanced planning of schedules which had reduced the issues they had previously found related to equipment. Most single use equipment that we checked was in date. However, we found some out of date blood gas syringes in the anaesthetic room in theatre; they were disposed of immediately.

An environmental audit was completed on a monthly basis within the infection control audit. We saw the results on Frome ward which were 95% compliant for September 2022. The service had suspended Patient-Led Assessments of the Care Environment (PLACE) audits due to the COVID-19 pandemic in line with national guidance to suspend. We were told this was restarting with a PLACE inspection scheduled for 1 November 2022.
We saw that staff followed safe and effective systems to dispose of clinical waste.

The service had enough suitable equipment to help them to safely care for patients. Wards had access to specialist mattresses and chairs to reduce the risk of pressure ulcers for those patients who needed them. We were told that bariatric equipment was available when required.

The airflow systems in the operating theatres were validated and checked against standards set out in national guidance Health Technical Memorandum (HTM) 03-01; "Specialised ventilation for Healthcare Buildings" 2021. However, these inspections were out of date for all the theatres. The airflow systems should be inspected on an annual basis. We were told that due to theatre access issues, the most recent monitoring had been delayed. The air quality monitoring inspections were being arranged and the trust expected them to be completed within the next 6 months. This was on the theatre risk register. The air validation inspection was undertaken in September 2022 and the filters were changed and all tests within the system showed that it met the HTM 03-01 requirements.

The theatre manager, when they first joined, reported they found that scrub trolleys were disorganised and messy. They implemented a 'trolley of the day' which included a prize at the end of the month. Since this, managers reported that the theatre teams have had a very high standard of trolleys and feel encouraged to maintain high standards by the competition and monthly prize.

Assessing and responding to patient risk

Staff did not always complete and update risk assessments for each patient and did not remove or minimise every risk. Staff identified and acted upon patients at risk of deterioration.

Staff generally completed risk assessments for each patient on admission, using a recognised tool. However, this was not always reviewed regularly. Risk assessments to assess a patient's risk of developing blood clots while in hospital and after surgery were not always completed in line with national guidance or trust policy. National Institute for Health and Care Excellence guidance (NG89) March 2018, states that all surgical and trauma patients should be assessed to identify the risk of venous thrombo-embolism (VTE) or blood clots as soon as possible after admission to hospital, or by the time of the first consultant review and that reassessments for VTE should be at the point of consultant review or if their clinical condition changes.

We saw that some patients had not received a VTE assessment. VTE assessments were completed by the doctors electronically. Ward administrators produced a daily list for doctors which listed the outstanding patients who required

their first and second VTE assessment. For example, on Frome ward on 12 October 2022, 5 patients had not had a VTE assessment and 8 patients were outstanding a reassessment. On Redbrook, 2 patients required an initial assessment and 3 patients required a reassessment. On Teme ward, there were 4 patients requiring a second assessment. We highlighted that these patients needed an assessment to staff. The trust sent data regarding the completion of VTE assessments following our inspection. The completion rates for the surgical service from April to September 2022 were between 86.6% and 89.8%. The trust target was 95%. Within the monthly governance report for October 2022, this was broken down into specialities and wards. The areas for concern were gynaecology who had 56.2% compliance and ear, nose and throat (ENT) surgery who had 78% compliance. The ward completion rates were poor in some areas. In September 2022, compliance was 52.9% for Teme ward, 81% for Frome, 78.8% for Redbrook, 15.3% for Primrose and 88.6% for Gilwern. Day case was 100% compliant with the completion of VTE assessments in September 2022. The trust data showed that between April and October 2022, there were 22 patients who had a hospital acquired VTE. These were under review to determine if they were avoidable or unavoidable; 7 of these had been classed as unavoidable and the rest were pending review. These incidents were categorised to show the level of harm the patients received; 19 out of 22 received low harm which required extra observations or minor treatment and the other 3 had no harm.

The ward managers said that they were aware that completion of VTE assessments was an issue and the assessments were often not completed. On the electronic system's ward list there was an icon that demonstrated if the first VTE assessment had not been completed, however, there was no automatic alert to prompt the doctors to complete the assessment. The system also did not always allow the assessment to be completed as it was time sensitive. We fed this back to the trust who said that the system was due to be upgraded in November 2022 to include this prompt. Ward managers said that they regularly prompted the doctors to complete VTE assessments. One doctor told us that they were rarely reminded to do the reassessments. All junior doctors were trained on VTE completion in their induction. We saw VTE completion results were shared in a staff governance newsletter in July 2022.

Following our inspection, the trust sent information which was shared with all staff regarding the learning points for VTE. These were the points that the thrombosis committee had found following the review of serious incidents relating to VTE. These included timely completion of the assessments, considering mechanical prophylaxis, such as Thrombo-Embolus Deterrent (TED) stockings, also known as compression stockings, and reviewing decisions after clinical changes.

Staff used a nationally recognised tool to identify deteriorating patients and generally escalated them appropriately. The National Early Warning Score (NEWS2) was used for adults when required, dependent on the presenting condition. This was a quick and systematic way of identifying patients who were at risk of deteriorating. Clinical observations, such as blood pressure, heart rate, and respirations were recorded and contributed to a total score. Once a certain score was reached a clear escalation of treatment was commenced. Any patients with a NEWS2 of four or more would trigger a review from the doctor. NEWS2 were automatically calculated on the electronic system. During our review of the NEWS2 charts, we did not always find that the scores were escalated when required. On Redbrook ward, 2 patients had a NEWS2 of 4. We spoke to nursing staff about this and these patients had not been escalated to the doctor. The staff redid the NEWS2 and the score changed to 2 for both patients. All other records we checked we found appropriate escalation. NEWS2 were displayed on the electronic patient board behind the reception desks. Managers told us that they could see any high scores and prompt action if needed. They felt they had good oversight of a patient's clinical condition.

Comprehensive risk assessments were mostly carried out on patients when they were admitted. Nursing staff used nationally recognised tools to assess patient's risk of developing for example, pressure ulcers (Waterlow), nutritional risks, falls, as well as risks associated with moving and handling. Patients identified at risk were placed on care plans and were monitored more frequently by staff to reduce the risk of harm. We reviewed 9 sets of patient notes and the Waterlow and falls risk assessments were completed in 7 out of the 9 notes. Where the scores for these assessments

showed that the patient was at risk, an individual care plan was in place. A documentation audit was completed monthly which looked at these risk assessments. The overall results across surgery were between 92 and 99%. The main area which the wards had reduced compliance was the completion of falls risk assessments. Both Frome and Teme ward had 76% compliance and Redbrook had 62% compliance for falls risk assessment completion between July and September 2022. We were told that these audit results were discussed in daily huddles.

Risk based pre-operative assessments were carried out in line with national guidance. Patients for elective surgery attended a nurse led pre-operative assessment clinic prior to their operation. The pre-operative assessment included risk assessments to ensure that patients were fit for surgery. The nurse contacted an anaesthetist if required. However, we were told that preoperative assessment appointments were often scheduled close to the patients planned surgery date. Best practice was to review patients at approximately 12 weeks pre-operatively. This meant patients with previously unknown health issues, for example, high blood pressure, potentially had their surgery cancelled until their health issue was controlled. This was on the surgical risk register.

The service used the American Society of Anaesthesiologists (ASA) grading system to pre-assess patients' level of risk for general anaesthesia. This was completed by the nurses during the pre-operative assessment. There were 5 grades within the ASA system. Grade 1 patients were normal healthy patients and grade 5 patients were patients not expected to survive more than 24 hours with or without surgery. The hospital had level 2 and 3 critical care facilities for critically ill patients to recover in following surgery. This allowed them to treat patients of all ASA grades safely.

Staff shared key information to keep patients safe when handing over their care to others. We did not observe a handover. We were told that handovers included all necessary key information to keep patients safe. Nursing staff on the surgical wards also included a 'huddle' at each handover. Staff highlighted workload issues, incidents, and any reminders for staff around patient care. For example, we saw in Frome huddle book, staff were reminded that all patients needed a wound care plan for each wound. Each ward recorded the meeting in a logbook. Theatre staff had a huddle every day prior to the theatre list starting.

The trust used the '5 steps to safer surgery', World Health Organisation (WHO) surgical safety checklist, in line with National Patient Safety Agency (NPSA) guidelines. These were recorded electronically. We looked at 3 set of patient notes in theatre and these were all completed. Daily data was automatically generated which showed compliance to the WHO checklist. The theatre recovery staff also completed daily checks to ensure completion of the checklist; these were 100%. However, the daily completion data which was automatically generated showed that they were not always completed. For the week ending 18 September 2022, the overall compliance was 93%. There was some confusion around the data's validity. Managers were unable to state why there was not consistency with the results. They had raised it with the trust to review the systems to ensure validity with the results. The pre-operative checklist had a completion rate as low as 19% on some weeks. We were told that this was due to some of the checklists still being on paper and therefore, not on the electronic system. This meant that it was difficult to audit due to some checklists being completed on paper and some electronically.

Staff stated that they did get feedback from the WHO audits. One staff member told us that audits results had highlighted that the debrief was poor in the emergency theatre and they had worked to try and improve this. The theatre manager said that WHO completion had been poor at the start of the year. In April 2022, the theatre manager did a teaching session and presentation to look at the issues and low scores for the WHO checklists. For example, the safety brief completion was 7% for one theatre and all theatres had a completion rate below 50% for the debrief. This was highlighted to all staff and the theatre manager had seen improvements.

Surgery

The theatre staff completed a quarterly WHO audit to establish if the five steps to safer surgery were being completed in line with the recommendations. These audits were not observational audits and only looked at the completion of the checklist. The quarterly WHO audit report showed an overall compliance of 98.4% for July to September 2022. The sign out section was the main reason for the slight fall in compliance, although 5 of these cases were completed in eye outpatients and not within theatres. Actions to make improvements included informing staff via a social media application that facilitated secure real-time communication and to discuss at the team meetings. Managers stated that the team leaders observed the WHO checklist completion on an ad hoc basis, but this was not documented.

We found that there was not a consistent approach to the completion of the brief within the 5 steps to safer surgery. We observed a brief being completed and the staff had a verbal discussion about the patient which did not follow the outline of the briefing document. The scrub nurse completing the form ticked 'Group and Save' and 'antibiotics' prior to these being discussed within the brief by the team. We observed another brief where no checklist was used for its completion and it was not documented formally by the team. A staff member told us that it would be documented afterwards. This meant that there was a chance that vital information would be missed.

The trust had started reverse boarding patients. This meant that the wards often had a higher number of patients than bed spaces at certain times of the day. Patients who were waiting to be discharged and were fit to sit, were moved from their bed to a chair. Then another patient would be admitted into that bed space. Staff told us that patients did not always have a bed space and therefore, not all the facilities were available to them and dignity was not always maintained. We were told that some patients were nursed in the corridors whilst they awaited discharge or a bed to become available. We did not see this at the time of our inspection. This process was a recent development to manage the flow through the hospital. There was a standard operating procedure in place and patients were identified appropriately using a clear inclusion and exclusion criteria.

The trust had a hospital wide approach to managing deteriorating patients. This involved a critical care outreach service who provided services to patients outside the unit. They reviewed surgical patients on wards to help with interventions to stabilise them and prevent them becoming more ill. There was 24-hour access to emergency surgery teams, including theatres and doctors.

Nurse staffing

The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

The service had enough nursing and support staff to keep patients safe. Ward managers and the theatre manager told us they had good staffing levels and were able to manage their staffing rota well. The number of nurses and healthcare assistants matched the planned numbers. Managers were not always able to limit their use of bank and agency staff but always requested staff familiar with the service. For example, we spoke to an agency staff member in theatre recovery who had worked weekly shifts since 2018. Managers made sure all bank and agency staff had a full induction and understood the service. New bank and agency staff received a local induction to each area on their first shift. This ensured staff were familiar with ward layouts and emergency procedures.

Surgery

Ward and theatre managers told us they often had difficulty managing their nurse staffing rota due to having a largely junior, or new team of nurses. This meant that although they had the correct number of nurses on each shift, not all staff were trained in all the skills required. Frome ward had employed an extra band 7 nurse to support with the education and training on the ward. Theatre staff told us that there was an onus on the experienced staff to supervise and train the new staff and this caused added stress.

Theatre staff felt that there was a gap in the staffing levels at the handover times for the wards. They said that there were regularly no staff members available to collect the patients between 7 and 8pm at night. This meant that patients were staying in recovery for a long time and recovery staff had an increased number of patients.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance.

Managers could adjust staffing levels throughout the day and night according to the needs of patients. Staffing was discussed throughout the day at management meetings and staffing moves were made to ensure safe staffing across the surgical service. Staff said that they were often moved to other areas to cover staff shortages. We were told that the trust was bringing in an acuity tool to enable managers to identify the number of staff required to keep patients safe. This tool considered the acuity and needs of the patients. This was not yet in place within the trust.

The service had low vacancy rates. There was a combined vacancy rate for the surgical service of 3.22%. Most wards told us they were almost fully staffed and had few vacancies. Ward and theatre vacancies were filled by using bank and agency staff. The service had varying rates of bank and agency nurses. Frome used 20.65% of agency staff in August 2022 and day case used 14.84% of agency in September 2022. Teme, Gilwern and Redbrook wards had below 8% agency rates for September 2022. Managers said that they used regular agency staff members who knew the wards. Managers were taking appropriate steps to address vacancy gaps. This included an ongoing overseas nursing recruitment programme. Managers told us that this had been hugely beneficial and around 60% of their staff nurses had been recruited from this programme. The staff nurses had a varying level of experience but were supported by the education team. They had several study days and had protected study time. They were supernumerary on the ward until their had completed their qualifying examinations. We spoke to 4 staff nurses within the wards and theatre who were part of the overseas recruitment programme. They felt very supported. They said they had a good induction and were given time to complete competencies and their exams.

The service had varying sickness rates. The sickness rate for registered nurses on the wards was 3.63% and for non-registered clinical staff was 8.62%. The theatre had an overall sickness rate of 4.96%. The trust target was 3.5%.

The trust had recently implemented ‘reverse boarding’. This meant that patients who were identified as ready for discharge would be moved from their bed to a chair to wait for the completion of their discharge. These patients were selected if they were low risk and able to be cared for in a chair whilst waiting for their discharge. Their bed was then utilised for a patient from the emergency department. This assisted with the flow through the hospital. Nurses told us that it was difficult to manage the workload on the wards when they had very sick patients, or they had a lot of post-operative patients when boarding patients were sent to the ward. This also meant that the nurses had more patients to look after than planned. The managers said that at times, the patients who had been moved to the chair were not always discharged and they had to find a bed for the patient later in the day. This created a higher workload for the nursing staff and meant that patients were nursed in the corridors or in a chair rather than a bed.

Surgery

Medical staffing

The service did not always have enough medical staff with the right qualifications, skills, training and experience. However, the service used locum and physician associates to help keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave locum staff a full induction.

While the service did not always have the planned number of staff, staff told us that the wards felt safe. Service leaders told us some wards had access to a physician's associate (PA) who covered doctors in their absence. Physician's associates carry out some junior doctors' roles but are usually unable to prescribe medicines. There were 3 within the surgical service and staff reported that they were an excellent support to their day-to-day clinical workload.

The medical staff mostly matched the planned number. The service had a vacancy rate of 4.9% for medical staff. There were 6.37 whole time equivalent (WTE) medical staff vacancies within surgical services. 4.32 WTE of these vacancies were at consultant level. The surgical governance meeting minutes for October 2022 showed that the division had concerns regarding the recruitment of medical staff. In particular, the middle grade tier within orthopaedics were struggling to meet the demands of the speciality. This had exacerbated sickness, cancelled clinics, reduced quality of care and increased turnover of staff. The orthopaedic team had the highest locum usage. This was on the surgical risk register. Interviews for medics were scheduled for later in October 2022. Managers told us they were addressing the vacancies through several avenues including a review of the incentive packages, escalation of hard to fill vacancies to senior management, working groups to discuss the hard to fill vacancies and continued use of international recruitment.

The service mostly used low levels of locum staff. Locum doctors were used to temporarily fill medical vacancies as required. The overall usage from July to September 2022 was between 5 and 8%. The majority of the usage was between the breast surgery and orthopaedic teams. In September 2022, the orthopaedic team had 17% of shifts filled with locum doctors and breast surgery had 11%. All other areas were either 0 or 1%. Managers told us locum staff received a full induction on arrival at the service.

The service mostly had a good skill mix of medical staff on each shift and reviewed this regularly. Each surgical specialist had a mixture of consultant grade doctors, registrars and junior doctors. There were no foundation year 2 (FY2) doctors on the wards. One foundation year 1 (FY1) doctor told us that this did not impact on their level of support. There was an FY1 doctor based on each ward from 8am to 5pm every day. If the junior doctors were not available, the registrar was available for help and when the registrar was unavailable, staff contacted the consultant.

Sickness rates for medical staff were low and reducing. Data received showed that sickness levels had reduced from 7.6% in July 2022 to 5.86% in September 2022.

Doctors ward rounds occurred daily in the morning and was led by a consultant surgeon. The medical staff also reviewed surgical patients who were on a non-surgical ward (outliers).

The service always had a consultant on call during evenings and weekends. A consultant was on call for emergencies 24 hours a day, seven days a week. Junior doctors told us that the consultants were supportive and accessible. Consultant led ward rounds took place on Saturdays and Sundays. Senior staff told us every patient was seen daily at ward rounds. Nurses said access to on call consultants was effective and reported very positive working relationships with them.

Surgery

We spoke to a registrar who had just joined the trust and they said that their induction was very good. The induction schedule included a handover from their predecessor who had been very positive about the role. Junior medical staff told us they were able to attend their mandatory training and their weekly junior teaching sessions. The physician's associates covered their time on the ward to allow them to attend teaching sessions.

Records

Patient records were not always stored securely. Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and most were easily available to staff providing care.

Records were not stored securely. Although most patient records were stored in lockable trolleys on each ward, records trolleys were not locked on any of the wards during our inspection. Records trolleys were lockable using a key and staff told us this made it difficult for everyone to gain timely access to notes when required, and therefore, the trolleys were usually open. This meant unauthorised personal were able to access confidential information. However, the electronic records were stored securely, and computers were locked when not in use.

Patient notes were comprehensive, and all staff could access them easily. They were both paper and electronic. We reviewed 9 sets of patient records. We found that they were mostly complete. They included pre-operative information, risk assessments, care plans and consent forms. The records clearly stated the possible risks, complications and side effects of the specific procedures.

When patients transferred to a new team, there were no delays in staff accessing their records. Patients notes were transferred with the patient between wards and theatres. There were processes in place for sharing and transferring information between teams, services and organisations. For example, when a patient was discharged.

The service regularly audited their medical records. The compliance was for July to September 2022 for the inpatient wards was between 92% and 99%. The falls assessment was the area that needed improving for 3 out of the 4 wards; compliance was between 62% and 76%. We found in 2 out of the 9 notes that we checked that the falls risk assessment had not been completed.

Medicines

The service used systems and processes to safely prescribe, administer and record medicines. However, medicines were not always stored appropriately, and fridge temperatures were not always checked. Pharmacy staffing levels were low which impacted on the reconciliation of medicines and timely discharges.

Staff followed systems and processes to prescribe and administer medicines safely. An electronic prescribing and medicine administration (EPMA) system was used. The reason for prescribing medicines was documented on the EPMA. Documentation of medicines administration including routes of administration and specific times of administration were clear on all medicine records reviewed.

Allergy statuses of patients were routinely recorded on all medicine records seen.

Venous thromboembolism (VTE) risk assessment outcomes and prescribing were completed on admission. There was no automatic reminder for re-assessing VTE risk on the EPMA system. We were told that pharmacy staff prompted any missed VTE assessments, however we found that these were not always completed.

Weights of patients were recorded on medicine administration records which was important for calculating weight-based medicines prescribing.

Surgery

The principles of antimicrobial stewardship were implemented which included review dates for re-assessing prescribed antibiotic treatment.

Staff reviewed each patient's medicines as regularly as possible and provided advice to patients and carers about their medicines when resources were available. Due to ongoing national difficulties in the recruitment of hospital pharmacists there was a reduced clinical pharmacy service across the trust. Pharmacy staff worked hard to provide support to staff and patients. This ensured medicines safety.

Staff did not always complete medicines records accurately and keep them up to date. Patient's prescriptions and medicines administration records were accurate however, staff did not always record the reason for a missed dose. This is important information when reviewing patients' treatments to ensure there is an up to date accurate medicine history. Following a request to review missed doses it was reported that there were less than 0.2% of doses missed that had no reason documented from July 2022 to October 2022. However, the trust was aware that there needed to be a process in place to review and follow up any missed doses with staff. The audit of missed doses was to be included in the medicines safety report which would be presented to the patient safety committee every two months.

Staff did not always store and manage all medicines and prescribing documents safely. In theatre, we found two injectable medications that were not locked away. We raised this with the room leader, and they were immediately locked away. Medicine stocks were not always appropriately stored or managed in line with standard operating procedures. For example, on Redbrook ward there were two boxes of intravenous antibiotics stored on the workbench and not stored in a locked medicine cupboard. We were told it was due to a lack of cupboard space. There were two bags of prescribed medicines for two patients on the workbench which had not been placed in locked patient bedside lockers. When this was pointed out to staff the medicines were removed and immediately put in the bedside lockers.

The service ensured that medicines requiring refrigeration were stored at the recommended fridge temperatures with daily records available. However, the process for checking medicine/clinic room temperatures to ensure safe medicine storage was not always followed. For example, on Redbrook ward there were no records of the clinic room temperature documented and no room thermometer available to take a temperature reading.

Emergency medicines were available and stored in tamper proof trolleys or boxes. Checks were recorded and undertaken daily to ensure equipment and medicines were within date and safe to use in an emergency.

Controlled drugs (medicines requiring more control because of their potential for abuse) were managed effectively and stored safely and securely.

Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services. Medicines reconciliation should be completed as soon as possible when people move from one care setting to another and within 24 hours of admission. It is the process of accurately listing a person's medicines when they are admitted or when their treatment changes. Due to the pharmacy staffing issues medicine reconciliation was being undertaken less than 50% during an inpatient stay. However, the pharmacy team were working hard to provide a limited service to review all new admissions, newly prescribed medicines and check medicines ready for discharge.

Staff learned from safety alerts and incidents to improve practice. There was a system in place for reporting incidents and for receiving and dealing with medicines safety alerts. Staff attended huddle 'safety bites' where they received updates or information on medicine safety incidents at both ward and trust level. On Redbrook ward there was a dedicated board for 'Medicine Management' with reminders about safe practice with medicines.

Surgery

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with the trust policy. Staff received feedback from investigation of incidents, both internal and external to the service. Throughout the surgical service, we noted a positive incident reporting culture and evidence of learning from incidents through our discussions with staff. For example, we were told about a specific incident on Frome ward where a patient did not receive adequate nutrition and had delays to care due to a poorly managed nasogastric tube (NGT) (a tube placed through the patient's nose into their stomach to assist with feeding). Following this, the manager did a timeline of events in the learning room and invited staff to put sticky notes onto its detailing areas of good practice and areas of improvement. All staff reported that this enhanced their learning with this incident. NG training was highlighted as an action and staff had since completed training and competencies on this. We saw recent incidents reviewed and actions at handover, these were documented in the huddle books for staff who did not attend. All wards were participants in a social media application that facilitated secure real-time communication between the members. They used this application to share incidents and learning; this was monitored by managers.

Never events were reported as required. Never events are serious incidents that are entirely preventable because guidance or safety recommendations providing strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. Managers debriefed and supported staff after any serious incident. NHS England's web-based serious incident management system known as Strategic Executive Information System (StEIS) showed that between September 2021 and September 2022, the trust reported 1 never event that was related to surgical services. It related to wrong site treatment within the ophthalmology service.

Staff raised concerns and reported incidents and near misses in line with trust policy. Incidents were investigated in a timely manner. Lessons learned were identified and shared within the service to reduce the risk of similar incidents from occurring. Staff received feedback from the investigation of incidents. We saw that themes and learning from incidents were effectively filtered down to staff through safety huddles, newsletters and emails. This also included the sharing of national patient safety alerts that had resulted from incidents from other external sources. However, the pre-assessment team did not feel they heard about incidents within the service and were not always aware of lessons learned for other areas within the service.

Staff understood the duty of candour They were open and transparent and gave patients and families a full explanation if and when things went wrong. 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 patient. We saw a reminder about the duty of candour for staff within a 'safety bite' from 3 October 2022. A safety bite was a weekly release of information for staff which related to patient safety.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. On the day of our inspection, the matron was meeting with a family to discuss an incident that had occurred, the learning and provide them with ongoing support.

Surgery

Is the service well-led?

Requires Improvement 

Our rating of well-led improved. We rated it as requires improvement.

Culture

Staff mostly felt respected, supported and valued. They were focused on the needs of patients receiving care. The service had an open culture where patients, their families and staff could raise concerns without fear.

We saw there was a positive open culture. Staff told us and we saw that they openly reported incidents as there was a no blame culture at the trust. Staff told us they felt incident reporting was an opportunity to improve care and reflect on their practice. We saw that incidents were discussed openly during safety huddles and reflection and learning was encouraged in response to incidents.

Most staff we spoke to said they were proud to work for the trust and believed they worked as part of a team which was valued. Staff told us that the managers within the surgical service were very supportive. Theatre staff said that the manager was “very focussed” and “forward thinking”.

Within the 6 months prior to this inspection, there had been a lot of changes to the infrastructure of the surgical service which involved team and ward moves. We were told that the executive team listened to the staff and made ward changes following concerns raised. There was an additional matron and general manager employed which enabled focus on the structure and support needed. Staff felt settled in their wards and teams. Staff and managers told us that staff were frequently moved from their usual ward to cover on other wards and some of them found this stressful.

The recent reverse boarding process had created a challenge within the service, and this had affected the morale. However, the staff felt that the managers were raising their concerns and trying to find a mutual resolution. In the most recent sisters meeting, they had discussed the dip in morale following the reverse boarding implementation and ideas on how to improve it. This included recognising staff members through a star of the month; this had not yet been implemented. Some managers felt that changes were not always communicated by the senior leadership in a timely manner. For example, we were told that the ward staff were informed about the reverse boarding the day before it was due to be implemented. They felt that this did not give enough time to ask any questions and understand the process.

Staff were focused on the needs of patients receiving care. We found that the staff morale was generally good, but it had been recently affected by the new reverse boarding process. The most recent staff survey results from 2021 showed that staff working within surgery had a lower morale score than the trust average. The 2021 staff survey results were also compared to the average across the UK and in some areas, such as staff engagement and always learning, they scored better than the national average. We saw an action plan to improve some of the areas which included increasing senior visibility, well-being newsletters and improving the culture around appraisals.

The overseas nurses reported that they felt part of the teams and the culture was excellent. They felt very supported and enjoying the working environment.

Each ward were participants in a social media application group that facilitated secure real-time communication between the members. They shared concerns, audit results, incidents, learning and good news. Staff felt that this was an effective way to communicate. Team meetings did not occur as the service found it was difficult to capture staff without impacting on patient care. However, we found that they shared learning in many other ways. Staff were knowledgeable about their area and felt informed by their managers.

Managers found that the team leader role within the theatres was not clear. They asked the staff to complete a diary for a month and used it alongside the job description to create a role profile with detail on their daily tasks. The team leaders found that their role improved greatly, and they were much clearer on their expectations and support needed.

The theatre had a mental health wellbeing board which displayed the contact for mental health first aiders and had information around the signs of stress. Staff told us that they generally felt well supporting regarding their mental health.

We reviewed the surgical governance meeting minutes for September 2022 and the Freedom to Speak Up Guardian had received 23 concerns in April to June 2022. This was discussed with the managers the themes and how the areas of concern could be improved. There was Freedom to Speak Up information sent out in October 2022 as part of the trust's weekly safety bites newsletter. This gave the staff details about how their information would be used and who they could speak up to if required.

Governance

While leaders operated effective governance processes throughout the service and with partner organisations, it did not always have a systematic approach to continually improve the quality of its services.

Systems were in place to assess, monitor and improve the quality of care within the surgical service. The senior staff said that the service had made progress around strengthening its governance and risk frameworks. We were told that there was a clear focus on governance in the surgical service. There was a clinician responsible for governance and they were given protected time to focus on governance. There was a monthly surgical service governance meeting, general surgical business meeting and a surgical specialities meeting. We reviewed minutes from these meetings and saw that incidents, staffing, guidance and audits were discussed. There was an action plan which showed actions being completed in a timely manner. The governance report for August 2022 was displayed within staff areas on the wards.

We found that improvements had been made in relation to concerns raised at our previous inspection. However, not all of these had been fully addressed on this inspection. For example, venous thromboembolism (VTE) assessments were still not completed thoroughly, the theatre brief was not completed in a consistent way and medical staff mandatory training completion was still low.

There were daily divisional meetings which followed a capacity meeting. This meant that the surgical division leaders reviewed the daily activity and made decisions together regarding staffing, boarding patients and the safety of the wards.

Theatre held a weekly governance meeting which discussed cases and incidents from the previous week within theatres where there were learning needs identified. These meetings were not documented.

Surgery

There was a quarterly division quality committee report. The report for April to June 2022 detailed learning from incidents. This included the results of an audit following an incident where a patient had been lost to follow up for 2 years. The service investigated this over a 6-year period to ensure all patients were followed up correctly. They found that 45 patients were identified as requiring further review, of which 10 patients were identified as lost to follow up. These patients were reviewed, and no patient harm was identified.

We saw the surgical governance report for September 2022. This showed that actions were not always addressed in a timely manner following a serious incident (SI). The action plan for serious incidents had 41 overdue actions with the oldest action from 30 April 2020. This action was for the medical teams to be reminded of the importance of reviewing patients when asked and adhering to the National Early Warning Scores (NEWS) escalation process. The untimeliness of completion of actions was discussed within the governance meeting and recognised that improvement was needed.

Regular audits were completed to assess and monitor the quality of care. However, we did not always see that there was not always an action plan within the audit. For example, the trust sent us documentation audits which showed compliance was 76% for patient falls risk assessments. However, there were no actions to improve the completion of these assessments.

Some of the systems in place to assess, monitor and improve quality were not always effective in identifying safety concerns. Staff told us that compliance with completing Vvenous Tthromboembolism (VTE) scores was a continuous challenge despite nurses and pharmacists on wards prompting medical staff for VTE assessments to be completed. Senior leaders were aware that this was an issue, but improvements had not been made. We were told that they were hoping to see improvements when an automatic prompt was added to the electrical notes system in November 2022. This was not noted on the risk register as an ongoing risk to the patients and there was no improvement plan on the wards.

There was a lack of oversight regarding missed doses within the medicine charts. We found blank boxes in several medicine charts throughout the surgical wards with no reason documented for this missed dose. We were told that this was looked at if managers had time. This was not consistently audited and there was no ownership from the managers of this issue.

Weekly sisters' meetings were held with matrons. Staff who attended these meetings described them as an effective two-way communication where safety, staffing, feedback from senior nurse meeting, local ward feedback and governance were discussed. We were told that concerns could be raised and information from senior leaders was cascaded down to wards. Following these meetings, ward managers shared updates with the staff on the wards through handovers, huddles and communications on team boards.

Across the theatre suite there were daily briefings at 8am and outside of this there were noticeboards and all staff emails. Theatres also had a monthly rolling half day audit programme which included sharing of information, audit results and training opportunities.

The theatres were completing a theatre improvement project. They had completed a series of engagement days with the focus on observing and listening to all staff in theatres and recovery areas. A team was formed with two consistent improvement leads to ensure impartiality. The quarterly governance report highlighted that staff engagement had been fantastic and they had raised concerns but also potential solutions. The main themes from their sessions with the team included communication, workforce, information technology systems, wards and health and wellbeing.

Surgery

Management of risk, issues and performance

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

Organisation and patient safety risks were identified and recorded on the service's risk register. Each risk was assigned a risk score and level based on its severity and a mitigation plan was put in place to mitigate the risk. For example, environmental risks were in place such as the clean utility temperature increases over the threshold in the summer months. There was a mitigating plan, however, the infrastructure of the building did not allow for air conditioning to be fitted. We saw this was discussed in August 2022 surgical governance meeting, as well as other risks within the service. Managers were all aware of their risks and had acted upon these appropriately. Not all staff were aware of the risk register but were aware of the risks within their areas.

The wards and theatres said that the new reverse boarding procedure had created new risks within the service. This had been implemented 6 days prior to our inspection. They felt that it led to poor patient experience with corridor care, increased stress on the ward and an increase in patient to staff ratio. Staff said that there were no criteria for the patients who were being boarded. However, the enabling proactive flow standard operating procedure detailed the criteria for patients who could be boarded. It stated that these patients must be level 0 or 1 level care only. It was not on the ward level risk register.

Minutes of governance and board meetings showed that the highest level of risks within the service were discussed on a regular basis which showed there was senior management and board level oversight of extreme risks.

Mortality and morbidity reviews were regularly completed to review and learn from deaths and other adverse incidents. Staff told us learning was shared from these meetings to ensure learning was shared.

A monthly exception report was produced. Items covered included; complaints, incidents, safeguarding and risk. Senior leaders told us this provided key information to enable them to have effective oversight of quality and safety within the division. The clinical lead on Frome ward was completing a quality service improvement course to implement quality improvement in the workplace. There was a focus on driving improvement within the service.

Managers monitored staffs' compliance with training, and they were aware of gaps in training compliance rates. Where gaps were identified, appropriate action was taken to address these.

During our inspection, the trust was becoming increasingly pressured from an emerging COVID-19 wave. There was a coordinated response across the site as managers worked to reintroduce measures including as the enhanced wearing of masks within the clinical areas.

Areas for improvement

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

Action the service MUST take to improve:

Surgery

- The provider must ensure that all risk assessments including the venous thromboembolism risk assessment and falls risk assessments are carried out in line with national guidance (Regulation 12(2)(a)(b)).
- The provider must ensure that briefs are completed thoroughly and efficiently so that data on the patient is not missed (Regulation 12(2)(a)(b)).
- The provider must ensure confidential information is not accessible to unauthorised people (Regulation 17(2)(d)).
- The provider must ensure that systems for monitoring quality of care are effective to identify risks and drive improvements (Regulation 17 (2)(a)(b)).

Action the service SHOULD take to improve:

- The provider should review the process for monitoring World Health Organisation (WHO) checklists and ensure that the data is valid.
- The provider should consider the impact that reverse boarding is having on the patients and staff.
- The provider should ensure that medical staff have completed their mandatory training
- The provider should ensure that staff have access to basic life support training.
- The provider should arrange for theatre airflow systems to be inspected on an annual basis.
- The provider should ensure that patients pre-operative assessments are completed in a timely manner.
- The provider should consider implementing a process for reviewing and following up missed medication doses.
- The provider should always ensure medicines are stored securely.
- The provider should make sure that clinic room temperatures are taken daily to ensure the safe storage of medicines.

Our inspection team

The team that inspected the service comprised of three CQC inspectors, one CQC pharmacy inspector and a specialist advisor. The inspection team was overseen by Sarah Dunnett, Head of Hospital Inspection.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 CQC (Registration) Regulations 2009 Statement of purpose