Derby Teaching Hospitals NHS Foundation Trust

Royal Derby Hospital

Quality Report

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Derby Teaching Hospitals NHS Foundation Trust serves a population of over 600,000 people in and around Southern Derbyshire.

The trust has two hospitals, the Royal Derby Hospital, an acute teaching hospital and London Road Community Hospital. Derby Teaching Hospitals NHS Foundation Trust is one of the largest employers in the region with a workforce in excess of 8,000 staff.

Derby Teaching Hospitals NHS Foundation Trust is registered to provide the following Regulated Activities:

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

Derby Teaching Hospitals NHS Foundation Trust were inspected on 16 and 17 August 2016. We carried out an unannounced visit on 20 October 2016.

This inspection was a focused follow up inspection of following our comprehensive inspection in December 2014.There had been a compliance actions issued against this provider at the time of our last inspection, these were issued under 2010 regulations, which were superseded by new regulations in 2014. These are now known as requirement notices. At this inspection, we inspected the key question of safe in maternity and gynaecology, the key question of safe in medical care (including older people's care) and the key question of effective in end of life care to ensure the service was complaint with the requirement notices we issued at our last inspection. We did not rate the trust overall.

Our key findings were as follows:

- Care and treatment of patients at the end of their lives was effective and delivered in line with legislation and evidence based standards.
- Staff had good access to both the specialist palliative care team and access to comprehensive online information to support them to deliver care to patients at the end of their lives.
- Decisions made regarding cardiopulmonary resuscitation were made in line with the trust's policy and the Mental Capacity Act 2005 in the majority of cases.
- Across the medical wards, there was a good track record in safety.
- There were assurance processes in place for monitoring safety and quality of care.
- There was an open culture, for reporting incidents and evidence of lessons learnt. When something went wrong, patients were given an explanation and received an apology.
- Areas were mostly visibly clean and tidy. Staff took appropriate steps to reduce the risk of hospital-acquired infections. Equipment was readily available and medicines were managed and stored safely.
- Within the maternity and gynaecology service, patients' records were stored securely; documentation was accurate and complete.Risks to patients were assessed and suitable actions taken.
- Staffing levels and skill mix were planned, implemented and reviewed to keep patients protected from avoidable harm. Patients who accessed maternity care had a named midwife.
- There was a lone worker policy in place and staff within the community midwifery team reported they felt safe.

However,

Summary of findings

- Across the medical wards, when patients required a sepsis screen this was not always carried out. Staff did not always escalate or respond to high early warning scores and staff appeared unfamiliar with the use of the electronic observation system.
- Within the medical wards, there was not a robust system in place for checking suitability of resuscitation equipment and patient records were not always stored securely.
- Within the maternity service, not all staff had completed mandatory training, including appropriate safeguarding training. We were not assured that midwives caring for patients in the high dependency unit had received appropriate training to do so.
- Midwifery staff expressed concerns about the electronic patient record, stating that information could easily be overlooked.
- Within the maternity service, there were no formal multidisciplinary meetings to discuss serious incidences and deaths, and consultant presence did not reflect national the recommendations.

We saw one area of outstanding practice:

- Patients on the respiratory medical wards who were receiving oxygen therapy wore colour-coded wristbands to identify how much oxygen they needed. This minimised the risk of patients receiving too much oxygen.

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

Importantly, the trust must:

- Review arrangements for training maternity services staff in level three safeguarding to ensure timely compliance with the intercollegiate guidelines of March 2014.
- The trust must ensure patients' notes are stored securely on medical wards to ensure their confidentiality.
- The trust must ensure all patients who meet the criteria for sepsis screening are screened and any interventions are carried out in line with trust protocol and national guidance.
- The trust must ensure all staff are trained in the screening, management and treatment of sepsis and that all staff are familiar with and have easy access to the sepsis screening proforma.
- The trust should ensure staff on the medical and elderly care wards adhere to and follow the trust guidelines in relation to the escalation of deteriorating patients.
- The trust must ensure compliance with same sex guidance in the monitored bay on the medical assessment unit.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Royal Derby Hospital

Detailed findings

Services we looked at
Medical care (including older people's care); Maternity and gynaecology; End of life care.

Detailed findings

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Background to Royal Derby Hospital

Royal Derby Hospital is an acute teaching hospital and is part of Derby Teaching Hospitals NHS Foundation Trust. The trust serves a population of over 600,000 people in and around Southern Derbyshire. It is one of the largest employers in the region with a workforce in excess of 8,000 staff.

The Royal Derby Hospital was inspected on 16 and 17 August 2016. We carried out an unannounced visit on 20 October 2016.

This inspection was a focused follow up inspection of following our comprehensive inspection in December 2014.There had been a compliance actions issued against this provider at the time of our last inspection, these were issued under 2010 regulations, which were superseded by new regulations in 2014. These are now known as requirement notices. At this inspection, we inspected the key question of safe in maternity and gynaecology, the key question of safe medicine and the key question of effective in end of life care to ensure the service was complaint with the requirement notices we issued at our last inspection. We did not rate the trust overall.

Our inspection team

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

Our inspection team was led by: Helen Vine, Inspection Manager.

The team included CQC inspectors and a variety of specialists; including a midwife, an end of life care specialist nurse, specialist diabetic nurse and a respiratory nurse specialist.

How we carried out this inspection

Before our inspection, we reviewed a wide range of information about Derby Teaching Hospitals NHS Foundation Trust and asked other organisations to share the information they held. We sought the views of the local clinical commissioning group (CCG), NHS England, Health Education England, General Medical Council, Nursing and Midwifery Council. We also spoke with the local Healthwatch team.

The announced inspection took place on the 16 and 17 August 2016. We carried out an unannounced visit on 20

Detailed findings

October 2016. We spoke with a range of staff throughout the trust, including, nurses, midwives, junior and middle grade doctors, allied health professionals, administrative and housekeeping staff.

Facts and data about Royal Derby Hospital

Royal Derby Hospital, is an acute teaching hospital which incorporates the Derbyshire Children's Hospital.

There are a wide range of inpatient and outpatient surgical and medical specialities, intensive care, maternity services, children's services, accident and emergency care.The trust has around 1,100 beds at the Royal Derby Hospital, 200 of which are single rooms for improved privacy and dignity for patients.

The trust treats around one million patients each year. More than 6,000 babies are born in its maternity unit annually equating to an average 17 births each day. There are 35 operating theatres performing approximately 72,000 elective operations each year, this equates to around 280 operations per day.

The emergency department sees and treats around 320 patients each day. At Royal Derby Hospital, there is a roof top helipad.

Derby Teaching Hospitals NHS Foundation Trust has an annual budget of £450 million.

Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care	Requires improvement	N/A	N/A	N/A	N/A	Good
Maternity and gynaecology	Requires improvement	N/A	N/A	N/A	N/A	Good
End of life care	N/A	Good	N/A	N/A	N/A	Requires improvement

Medical care (including older people's care)

Safe	Requires improvement
Overall	Good

Information about the service

Derby Teaching Hospitals NHS Foundation trust provides medical care (including older people's care) at the Royal Derby Hospital (RDH). The hospital has three Divisions in all, Medicine and Cancer, Integrated Care, Surgery Anaesthetics and Diagnostics. The Division of Medicine and Canceris split into three business units; cancer, specialist medicine and acute medicine. The specialities within Medicine and Cancer include; acute medicine, general medicine, haematology, oncology, hepatology, gastroenterology, respiratory medicine, cardiology, endocrinology, nephrology andstroke. The Division of Integrated Care is split into four business units, for the purpose of this report we are looking at the rehabilitation and older people business unit.

The trust has 662 inpatient medical beds across two sites RDH and London Road Community Hospital (LRCH); 576 beds are located across 22 wards at RDH. During our inspection we visited wards, 304,306,401,402, 404,407, 408, 409, coronary care, Medical Assessment Unit (MAU) and the cardiac catheter laboratory.

From January 2015 to December 2015, there were 60,992 medical admissions to Royal Derby Hospital. Of these 50% were emergency admissions, 40% were treated as day case and the remaining 10% were planned admissions. General medicine admissions represented the largest number of admissions at 40%.

This inspection is a focused follow up inspection following a comprehensive inspection in December 2014. At the inspection in December 2014, medical care was rated good overall but required improvement in the safe domain. This was because we found there were insufficient suitably qualified staff working on medical wards, there was not an effective system for checking and servicing medical equipment and patients' notes were not always stored securely. This inspection will focus on the key domain of safe.

During our inspection of RDH, we spoke with 42 staff. This included: junior and senior nurses, health care assistants, junior and senior doctors, allied health professionals, administrative and housekeeping staff.

We considered the environment and looked at 20 medical and nursing care records and, 19 electronic patient observation charts. Before our inspection, we reviewed performance information from and about the trust.

Medical care (including older people's care)

Summary of findings

We rated safety of medical services requires improvement because:

- Systems, processes and standard operating procedures were not always reliable or appropriate to keep patients protected from avoidable harm. When patients required a sepsis screen this was not always carried out.
- Staff were not always escalating or responding to high early warning scores, and staff appeared unfamiliar with how to access the specific screen on the electronic observations system, which displayed the early warning score (EWS) for each recorded vital sign such as blood pressure and pulse.
- Seven out of the ten resuscitation trolleys across the medical wards had out of date items in them,
- Care premises were not always suitable for patient care, bathrooms were used as storerooms, and we saw patients were treated in areas, which resembled storerooms.
- Patient records were not always stored securely in eight out of eleven wards we visited. This was the same concern we raised at our last inspection.
- Staff were not familiar with the major incident and business continuity plans and their roles within these.

However;

- Performance showed a good track record and improvement in safety measures, incidences of pressure ulcers, falls and infections had reduced.
- Staffing levels and skill mix were planned, implemented and reviewed to keep patients protected from avoidable harm.
- Openness and transparency about safety was encouraged and staff understood and fulfilled their responsibilities to raise concerns and report incidents.
- There was a safe system for the checking and servicing of medical equipment.

Are medical care services safe?

Requires improvement

We rated medicine as requires improvement for safe because:

- Systems, processes and standard operating procedures were not always reliable or appropriate to keep patients protected from avoidable harm. When patients required a sepsis screen this was not always carried out. Staff did not always escalate or respond to high early warning scores and staff appeared unfamiliar with the use of the electronic observation system.
- There was not a robust system in place for checking suitability of resuscitation equipment. Despite records showing checks of this equipment had mostly been completed and were up to date, seven out of the ten resuscitation trolleys across the medical wards had out of date items in them.
- Ward environments were not always suitable for patient care, bathrooms were used as storerooms, and we saw patients attending for cardiac pacemaker checks were treated in a room adjacent to the cardiac catheter laboratory which resembled a store room.
- Patient records were not always stored securely in eight out of eleven wards we visited.
- Staff were not familiar with the major incident and business continuity plans and their roles within these.

However:

- Performance showed a good track record and improvement in safety measures. Incidences of pressure ulcers, falls and infections had reduced.
- Staffing levels and skill mix were planned, implemented and reviewed to keep patients protected from avoidable harm.
- Openness and transparency about safety was encouraged and staff understood and fulfilled their responsibilities to raise concerns and report incidents.

Incidents

- There were two never events in the service between June 2015 and May 2016. These were a retained foreign object post-procedure and an overdose of methotrexate for non-cancer treatment. Methotrexate is a medicine used to treat certain types of cancers and severe

psoriasis (a skin condition causing red, flaky, crusty patches of skin covered with silvery scales) and rheumatoid arthritis (a chronic progressive disease causing inflammation in the joints). Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. We saw examples of lessons learned from the never events and systems put in place to avoid these happening again.

- There were 75 serious incidents (SIs) reported to the strategic executive information system (STEIS) from June 2015 to May 2016. Serious incidents are events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, they warrant using additional resources to mount a comprehensive response.
- Pressure ulcers accounted for 55% of all Sis and slips, trips and falls with injury 33%. The number of SIs had reduced from 109 reported between June 2014 and May 2015.
- We reviewed two SI reports and found there had been a full investigation, learning from the incidents had been recorded and agreed actions completed.
- Incidents giving cause for concern or following a specific trend were discussed in teams meetings, shared via email and staff newsletters. We saw evidence of sharing information about incidents in the ward meeting minutes we reviewed.
- There were 2546 incidents reported by the medical and cancer care division at the Royal Derby Hospital site from March 2016 to June 2016. The top three incident themes related to pressure ulcers (inherited and hospital acquired), falls and medication (omission or delay and documentation). The majority of incidents were graded as low or no harm incidents. We reviewed a selection of incidents and were assured they were graded appropriately.
- Staff were aware of, and appeared knowledgeable and confident about reporting incidents. All trust staff had access to the online reporting system. Staff told us agency nurses could access the electronic system; however there were no agency nurses on the ward at the time of our visit.
- Staff gave us examples of when they might report incidents such as a pressure ulcer or falls. Staff said there was a non-blame culture in the trust and they felt empowered to report incidents without fear of reprisal.
- We saw there were policies, systems and processes in place to respond to National Patient Safety Alerts (NPSA), for example the trust had a safety alert liaison officer (SALO) who emailed the alerts to the identified division or business unit contacts or to the allocated lead for the alert to complete an action plan. We saw an example of an action plan in relation to an alert was sent in February 2016, all actions had been completed within five weeks of receiving the alert. NPSA alerts are issued to healthcare providers to update them about critical safety incidents and to provide guidance. Staff on the wards confirmed if they received an alert it would come through email, and be displayed on the staff notice board. The cardiac catheter laboratory had responded appropriately to a safety alert in relation to skin preparation and ensured patients were protected from avoidable harm.
- There were regular mortality and morbidity meetings to share learning from the deaths of patients in the division. The meetings were open for all staff groups to attend. We reviewed the minutes from these meeting and saw an electronic mortality review form had been introduced; this would make it easier to review patient deaths in the meetings. We saw examples of incidents that needed further discussion by the incident review group. Minutes demonstrated lessons learned from incidents with evidence of this being cascaded within the trust.
- Staff were aware of their responsibilities and principles with regard to duty of candour regulation. The duty of candour is a regulatory duty which requires providers of health and social care services to disclose details to patients (or other relevant persons) of 'notifiable safetyincidents' as defined in the regulation. This includes giving them details of the enquiries made, as well as offering an apology. Staff were able to provide examples of when an incident had occurred and how they had informed the patient and their relatives of the incident made an apology and explained how the trust had responded to the incident. We saw evidence of an incident where duty of candour had been appropriately followed.
- Patient safety incidents reported with harm of moderate, severe or death required a duty of candour to

be undertaken within 10 working days of the incident being reported. There were 79 incidents between June 2015 and June 2016 which required duty of candour. Of these 64 (81%) were undertaken within the 10 day standard.

Safety thermometer

- The NHS Safety Thermometer is a national improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care. It focuses on four avoidable harms: pressure ulcers, falls, urinary tract infections in patients with a catheter (CUTIs) and venous thromboembolism (VTE). A VTE is a blood clot, which forms in a vein, often in the leg, which can cause harm to patients.
- From June 2015 to June 2016, 6,289 patients were surveyed in the safety thermometer survey, 92% of patients received harm free care. On a monthly basis this ranged from 89%, in November 2015, to 94% in April 2016.
- From June 2015 to June 2016, less than one percent of patients had a fall resulting in harm or was recorded as having a new VTE. Just over one percent of patients surveyed were recorded as having a CUTIs.
- Six percent of patients surveyed had a pressure ulcer recorded. Harm free care looks at all pressure ulcers (old and new), and therefore some of the pressure ulcers recorded may not have been hospital acquired.
- Information about the incidence of pressure ulcers, infections and falls with harm was prominently displayed on all the medical wards and units we visited. The information identified the number of days since the last pressure ulcer, falls with harm and infection rates. Information was shared with ward managers about the performance of their ward and, when required, actions needed to improve performance.
- There were a total of 67 hospital acquired pressure ulcers between June 2014 and May 2015 compared to 43 between June 2015 and June 2016, showing a reduction over time.
- There was a total of 35 slip, trips and falls with harm between June 2014 and May 2015 compared to 11 between June 2015 and May 2016, showing a decrease over time.
- During our review of records we were assured staff were adhering to National Institute for Health and Care Excellence (NICE) guidance QS3 and QS89 for example patients had a VTE and bleeding risk assessments completed on admission, pressure ulcer risk assessments were completed within six hours of admission and patients admitted with a fall had appropriate risk assessments completed.

Cleanliness, infection control and hygiene

- There were 32 cases of clostridium difficile (C. difficile) infections in medicine from June 2015 to June 2016. C.Difficile is a bacterium affecting the digestive system; it often affects people who have been given antibiotics and has the capability of causing harm to patients. The trust target was to have a C.Difficile a rate of no more than 16 cases per 100,000 bed days or 53 cases. There had been a reduction in the cases over the last year.
- There were two cases of Methicillin-resistant Staphylococcus Aureus (MRSA) recorded between June 2015 and June 2016. MRSA is a type of bacterial infection and is resistant to many antibiotics. The Department of Health adopted a zero tolerance approach to avoidable MRSA bacteraemia cases in April 2013.
- Methicillin-susceptible Staphylococcus aureus (MSSA) differs from MRSA due to the degree of antibiotic resistance. Between June 2015 and June 2016 there were 19 recoded cases of MSSA. This number had increased slightly compared to the East Midlands average however; the trust reviewed all of the cases attributed to them, which did not identify any trends. Each case had a root cause analysis undertaken. These were reviewed at the trust's health care associated Infection (HCAI) review group. Learning from these cases was discussed and monitored at the trust's infection control operational group and infection control committee and was incorporated in staff training.
- Where it was suspected patients had an infection they were cared for in side rooms with signage to alert staff and visitors of the risk of infection.
- All of the areas we visited appeared visibly clean and well maintained; this included the corridors within the hospital. Staff were aware of the current infection prevention and control guidelines.
- Hand hygiene audits were completed on a monthly basis. From July 2015 to June 2016, hand hygiene compliance across all of the medical areas was an average 98% this was above the trust target of 95%.
- Data provided by the trust showed 99% of all staff had completed level one infection control training; this was above the trust's target of 95%.

- The trust carried out monthly mini infection control audits to check compliance against infection control policies, areas assessed included hand hygiene provision, clinical practice for example were staff 'bare below the elbow' and was medical equipment clean.
- From July 2015 to June 2016, the results for the trust's mini infection control audits across all medical areas were on average 97% against a trust target of 95%.
- Cleansing hand gel was available at the entrances to each area and in each room; patients and visitors were encouraged to use it by staff. Posters were prominently displayed encouraging staff and visitors to cleanse their hands and the process to follow to do this effectively. We also observed staff washing their hands between patients.
- Protective equipment, such as gloves and aprons, were available and we observed staff using this appropriately.
- There was a system for the cleaning and decontamination of patient care equipment for example 'I am clean' stickers; however we found across various wards stickers were not present on commodes. Staff told us if there was not a sticker on the item they would clean it prior to use.
- We observed patient care equipment to be visibly clean and ready for use. However, on a number of wards we found patient care equipment such as disposable wash bowls stored on the floor in sluices, this posed an infection risk to patients.
- Processes and procedures were in place for the management, storage and disposal of general and clinical waste including the disposal of sharps such as needles and environmental waste. We observed sharps bins to be closed when not in use.
- We saw there was a policy for MRSA screening. The policy outlined when patients should be screened for MRSA. Staff were aware of and appeared familiar with this policy. On our review of patient records, all patients where required had been screened for MRSA.
- Patients with urinary catheters had appropriate care plans in place so as to minimise the risk of infection, we saw there was specific guidance for the insertion of catheter to minimise the risk of infection in line with NICE guidance.
- Patients with vascular access devices such as cannulas (a plastic tube inserted in the vein for administration of medicines) had a nationally recognised assessment tool completed which indicated specific interventions had been performed during insertion. We observed a nurse inserting a cannula and found them to be adhering to this guidance. Patients on intravenous (IV) antibiotics were placed on oral antibiotics at the earliest opportunity and cannulas removed.

Environment and equipment

- The wards lacked storage space and we found large items of equipment, such as hoists and mattresses stored in patient bathrooms. Staff said if a patient wished to bathe then they would remove the equipment prior to this. We raised this concern at our last inspection. The trust had audited the number of occasions baths had been used and found this to be minimal. Senior leaders told us there had been work done around converting bathrooms to store rooms, but due to cost this was not possible at the current time.
- We saw a treatment room used in the cardiac catheter laboratory vicinity, was cluttered with boxes, and equipment. We asked the manager if this was a store room, or patient treatment room, and they confirmed it was a treatment room for patients having routine pacemaker checks. This was not a suitable environment for treating patients. A pacemaker is a small electrical device which is used to treat some abnormal heart rhythms causing the heart to beat too slowly or miss beats. Following our inspection the trust told us they had taken action to remove items from this room.
- There was not a robust system in place for checking suitability of resuscitation equipment. Despite records showing checks of this equipment had mostly been completed and were up to date, seven out of the 10 resuscitation trolleys across the medical wards contained several out of date items dating back to December 2013. Patients were at risk of significant avoidable harm as lifesaving equipment was not ready for use. We escalated our concerns to managers immediately at ward level, who assured us they would recheck all trolleys and replace out of date equipment. We further escalated our concerns to the chief nurse who took immediate action to ensure all wards across the trust had resuscitation trolley checks and any out of date equipment replaced. The chief nurse also informed us of actions going forward including a weekly detailed resuscitation equipment check being undertaken jointly with the matron and sister and department lead and the results reported through to weekly meetings held with the divisional nurses.

- There was not a robust system in place for stock rotation. Following our escalation of out of date equipment on the resuscitation trolley on one ward, we took the opportunity to check the consumables in the ward store room with the ward sister, we found several out of date items of equipment were present in the store room. This posed a risk to patients.
- Emergency equipment was not always easily accessible to staff. On ward 402 we saw the defibrillator was stored away from the main resuscitation trolley on the opposite side of the corridor.
- Equipment was available for bariatric patients, for example larger commodes, hoists and chairs. A bariatric patient is defined as a patient who weighs over 159 kg (25 stone) or with a Body Mass Index (BMI) of 30 or over.
- Fire-fighting equipment had been maintained and tested.
- Data provided by the trust for 2015/2016 showed 91% of devices were in date with routine servicing and we found there was a safe and effective system for the repair, servicing and maintenance of medical equipment. We checked 36 different pieces of medical equipment across the medical wards which included 17 hoists and found them all to be in date with routine servicing.
- The trust had access to sufficient equipment to meet patient needs such as pressure relieving equipment; staff said they did not have problems accessing this including out of hours and at weekends. We observed patients with pressure ulcers were nursed on specialist mattresses and cushions during our inspection.
- At the last inspection, concerns were raised around the repeated use of single use items. During our inspection we did not see any single use items used more than once.
- During our visit to Medical Admissions Unit (MAU) we found that there was a mixed sex breach. A mixed sex breach is where sleeping accommodation, including areas where patients are admitted and cared for on beds or trolleys, even where they do not stay overnight, the use of bathroom and toilet facilities, are shared by patients of the opposite sex. We discussed this with the senior leaders, who confirmed these patients should not be in the same bay, and there was no formal agreement with the local commissioners for this to occur. There are situations where it is clearly in the patient's best interest to receive rapid or specialist treatments and observation, and same sex accommodation is not required, however this was not the case for this situation.

Medicines

- Medicines were stored securely on the majority of wards we visited and appropriate emergency medicines were available. The keys for medicines cupboards and fridges were held by the nurse in charge and with the exception of the fridge on ward 408 which was in a locked treatment room all of these were locked.
- We found on a number of wards oxygen cylinders were not always stored correctly. We saw on MAU three small oxygen cylinders were stored on the floor in the store room and on ward 408 one was stored by the nurses station, they were not in specialist holders therefore the cylinders were not secure and posed a health and safety risk.
- Contrast media (a substance introduced into a part of the body in order to improve the visibility of internal structures during radiography) in the cardiac catheter laboratory was appropriately stored in dedicated warmers which were locked within the laboratory.
- At our last inspection, concerns were raised in relation to storing of intravenous (IV) fluids. Across all of the wards we visited we found IV fluids to be stored appropriately.
- On ward 408 we found nutritional products used to feed patients were not stored securely.
- Medicines requiring storage at temperatures below eight degrees Celsius were appropriately stored in medicine fridges. Records confirmed fridge temperatures were monitored daily to check medicines were stored at the correct temperatures.
- We looked at the electronic prescription records for 12 patients. We saw appropriate arrangements were in place for recording the administration of medicines. These records were clear and fully completed .The records showed patients were getting their medicines when they needed them as prescribed. Records of patients' allergies were recorded on the prescription chart.
- Nurses were responsible for administering medication, including patients own medicines brought in from home. We observed nurses following the hospital policy

and the Nursing and Midwifery Council Standards for Medicine Management when administering medicines to ensure the safety of patients. This included checking the patient's identity.
- We reviewed the storage and administration of controlled drugs (CDs) on five wards. Controlled drugs are prescription medicines controlled under the Misuse of Drugs legislation. We found them to be stored appropriately and records were accurately completed.
- Doctors had access to an electronic application, which included local microbiology protocols for administration of antibiotics and told us this helped them prescribe appropriately. All of the electronic prescription charts we reviewed confirmed this was the case.

Records

- We looked at 20 patient records across all of the wards we visited. Records were paper based. Patient records were written and managed in a way, which kept patients safe. All records we reviewed were accurate, complete, legible and up to date.
- Patient records were not always stored securely on eight out of 11 wards we visited. For example, on ward 408 records were in unlocked trolleys, in an unattended room with the door propped open. On wards 401 and 304, notes were in unlocked trolleys at the nurses' station, which was not always supervised. This meant there was a risk to patient's confidentiality and possible unauthorised access to records.
- Patient records showed assessments were carried out in a timely manner and documented correctly
- Patients who had pressure ulcers had a documented positioning and repositioning regime. We reviewed three regimes and found them to be up to date.

Safeguarding

- There was an internal system for raising safeguarding concerns and staff were aware of the process and could explain what constituted abuse and neglect
- Staff received safeguarding training as part their mandatory training. Overall completion rates for level one and level two training was 81% below the trust target of 85%.
- We saw the trust policy for Female Genital Mutilation (FGM), it explained the process to be followed within the trust in relation to data gathering and reporting to the Department of Health on incidence of cases. Female genital mutilation/cutting is defined as the partial or total removal of the female external genitalia for non-medical reasons.
- FGM training was provided as part of safeguarding training and updated three yearly.

Mandatory training

- Mandatory training for all groups of staff was comprehensive; modules included moving and handling, infection control, fire safety and resuscitation.
- Mandatory training data for nursing staff showed a completion rate of 89% against a variable trust target rate of between 75% and 95% dependant on the subject. Completion rate for medical staff was lower at 79%.
- Overall compliance rates for mandatory training across all staff groups, which included administration, clerical, estates and ancillary staff and allied health professionals was 86%.
- We saw there were clinical guidelines for the assessment, treatment and management of sepsis or suspected sepsis available on the trusts internal intranet; this was not part of a specific sepsis policy. Sepsis is a severe infection, which spreads in the bloodstream. We asked staff about their awareness of these guidelines and most staff were unfamiliar with them and or could not tell us where they were located.
- With the exception of staff on the Medical Admissions Unit (MAU), staff had not received training in screening and application of a sepsis protocol, however at the time of our inspection; the trust had just started to roll out sepsis training. Information provided by the trust following our inspection showed that 95% of registered nurses, 100% of advanced nurse practitioners, 94% of health care assistants and 75% of clinical support workers on MAU had received this training. There was a plan in place to have achieved 100% with all grades of staff on MAU by 20 September 2016.

Assessing and responding to patient risk

- We saw there was a standard operating procedure and escalation process in place on the Medical Assessment Unit (MAU) for times of peak activity. This meant patients would be protected from avoidable harm, for example if

there were not cubicles or bays available patients could be nursed on trolleys on the ward corridor with a specific nurse allocated to care for them. There were no patients nursed in the corridor during our inspection.

- We saw the trust used an electronic observation system which incorporated a nationally recognised early warning score assessment tool. Early warning scores (EWS) have been developed to enable early recognition of a patient's worsening condition by grading the severity of their condition and prompting nursing staff to get a medical review at specific trigger points. This meant there was a system in place to monitor patient risk.
- The electronic observation system aimed to support staff by ensuring observation and assessment protocols were carried out correctly and consistently. The electronic system automatically calculated early warning scores.
- During this inspection, we reviewed a sample of 19 electronic patient observation records across 11 of the possible 27 medical wards. We found observations were not always appropriately recorded in a timely way or in line with trust guidelines. For example on the coronary care unit, we saw two patients' observations were three hours overdue. We escalated this immediately and they were carried out. On ward 402 we saw a further two patients had scored high EWS scores which would need escalating to a doctor in line with trust guidelines, however we found no evidence this had been completed. We escalated this at the time to the nurse in charge.There was a risk a deteriorating patient may not be identified or escalated.
- Medical staff had not documented in the medical notes any deviation from the trust policy for these patients, which meant staff were not adhering to trust guidelines. We discussed this with senior leaders, who informed us that work was being carried out with consultants during ward rounds, to encourage them to review the parameters of the electronic system and adjust accordingly.
- There was inconsistency in the way staff used the electronic observation system. Staff appeared to lack awareness of how to access the specific screen on the electronic observations system, which displayed the EWS for each recorded vital sign such as blood pressure and pulse.
- Patients with a EWS of three in one vital sign such as pulse or blood pressure or an overall EWS of five were required to be screened for sepsis in line with the trust sepsis screening proforma. Sepsis is a severe infection, which spreads in the bloodstream.
- During our sample review of electronic observation charts, we found nine patients had met the criteria, which would indicate a sepsis-screening tool should be completed. Five out of the nine patients had not had a sepsis screening form completed.
- There were inconsistencies in the way the sepsis proforma was initiated and completed and the sepsis screening forms were not readily available to staff with the exception of MAU. We did note they were available on the trust intranet; however, most staff were unfamiliar with these.
- There were inconsistencies between the NEWS protocol and the sepsis screening proforma. The clinical response on the NEWS protocol stated that for a NEWS of three in one vital sign for example heart rate, a total NEWS of five or above observations should be repeated after one hour and if they remained as total above five or three in one parameter the nurse will inform the medical team. The sepsis proforma stated that patients with a NEWS of three in a single parameter or a total of five or more must be reviewed within 30 minutes.
- On 10 October 2016, we asked the trust to provide us with some additional information to support our assurance around the management of sepsis at the trust. The trust provided us with a report showing the trust's sepsis Hospital Standardised Mortality Ratio (HSMR) was below the national average at 75; and told us they had implemented the "sepsis 6" bundle, as well as the recommendations of the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) report, "Just say sepsis". They told us they were in the process of enhancing sepsis recognition by developing a sepsis-screening tool and training staff on its use. HSMR is an indicator of healthcare quality that measures whether the mortality rate at a hospital is higher or lower than you would expect. Nationally the expected HSMR score for hospitals is set as being 100. The HSMR figure does not represent deaths or percentages – it is a baseline number that statisticians use against which to compare observed performances.
- We returned to the medical wards of the trust on 20 October 2016 to carry out an unannounced inspection

specifically looking at the management of sepsis. We also spoke with staff about their awareness of the sepsis screening proforma and if they had received sepsis training..

- We found 22 out of 27 patients met the criteria when a sepsis screening should have been completed in line with trust protocol; we found these had not been completed. We reviewed the medical notes and found 14 patients would have screened positive for sepsis had this been completed. Despite no sepsis screening form being completed, all 14 patients had received the correct treatment. We did not confirm whether that was within the 60 minutes required by the protocol.
- We spoke with 25 nursing staff and two doctors during our unannounced visit. Twenty-one members of staff told us they had not received specific training in sepsis, two staff confirmed they had done Acute Illness Management (AIMS) courses where sepsis was covered. Two doctors we spoke with were aware of the sepsis screening form, had not used them on the medical wards, but had seen them used on the medical assessment unit (MAU). Both doctors told us they carried out the "sepsis six" but did not record this on the proforma.
- The trust were in year two of their quality strategy at the time of our inspection. The plan for year two was to ensure compliance with "sepsis six", and this formed part of a commissioning for quality and innovation (CQUIN). A CQUIN is payment framework, which enables commissioners to reward excellence, by linking a proportion of English healthcare providers' income to the achievement of local quality improvement goals.
- We reviewed the nursing records of 20 patients. Risks to patients, for example falls, malnutrition and pressure damage, were assessed, monitored and managed on a day-to-day basis using nationally recognised risk assessment tools.
- We saw evidence nurses reviewed and repeated these risk assessments. Staff took action on the results of these risk assessments; for example, patients who were at risk of pressure damage were nursed on pressure relieving mattresses.
- In all of the medical notes we reviewed we saw patients had been assessed by a consultant within 12 hours of admission and assessed by a member of the medical team within 30 minutes of their arrival to MAU. MAU had a dedicated bay on the ward where triage took place; a medical team was allocated to this bay to ensure patients were assessed within 30 minutes.
- In June 2015, we raised mortality outlier alerts with the trust, when routinely collected information showed there were a higher number of deaths than expected for patients with uncomplicated diabetes. We saw the trust had responded to this. The trust had reviewed all of the patients with uncomplicated diabetes and had identified the majority of cases related to a coding error in patient records. For those patients where it had been found not to be a coding error the trust had done a full case review. On the back of the case, review the trust had revised the diabetes pathways and increased the training of staff in diabetes management. We were therefore; assured the trust had appropriately investigated and addressed this outlier.
- We saw patients on the respiratory medical wards receiving oxygen therapy wore colour-coded wristbands to identify how much oxygen they needed. This minimised the risk of patients receiving too much oxygen. Excessive amounts of oxygen can be dangerous for some patients and it is important patients received correct amount of oxygen.
- On ward 402, we saw there was easy access to specialist emergency tracheostomy equipment. A tracheostomy is an artificial opening into the windpipe (trachea) and is held open by a tracheostomy tube.
- There was no standard operating procedure for the management of patients receiving non-invasive ventilation (NIV) outside of the designated respiratory high dependency unit (403) and respiratory ward 402. We saw a patient receiving NIV was not being cared for in an enhanced clinical environment, with a higher nurse to patient ratio; this was not compliant with British Thoracic Society (BTS) guidance. Non-invasive ventilation is the provision of ventilatory support through the patient's upper airway using a mask or similar device.
- The cardiac catheter laboratory used a Five Steps to Safer Surgery safety checklist prior to and during each procedure. This is a process recommended by the National Patient Safety Agency (NPSA) for every patient undergoing a surgical procedure. The process involves a number of safety checks before, during and after surgery

to avoid errors. For each patient's procedure, the checklists were followed and completed in full. An audit of this process had just commenced at the time of our inspection.

- Patients at risk of self-harm were assessed and managed using a specific tool. The purpose of the tool was to provide information, best practice guidance and support for staff assessing, treating and deciding on best courses of action for patients.
- Anaesthetic medicines were kept in the cardiac catheter laboratory to ensure these were easily available to anaesthetic staff. This is considered good practice in this clinical area and could minimised the delay in prompt intubation (a tube placed down the trachea, to control a patients breathing) if required.
- The cardiac catheter laboratory had access to an automatic chest compression device, this meant patients who may have a cardiac arrest could receive continuous chest compressions whilst a cardiac procedure was being carried out, it increased the patients' chance of survival and reduced the risk of increased radiation exposure to staff. A cardiac arrest is a sudden, sometimes temporary, cessation of the heart's functioning.
- The cardiac catheter laboratory performed procedures, which involved making incisions and cavities in the skin of the patient. There was no system in place for counting of equipment, which had the potential to be retained in the patient, for example sponges, needles and instruments. This posed a risk to patients and was not compliant with national standards. We discussed this with the manager who assured us this was being addressed at the time of our inspection; however, we did not see further evidence to confirm this.
- We saw yellow stickers used in the medical notes, which outlined patient management plans, escalation of patients concerns, and discharges. This ensured risk to patient management were minimised, and allowed effective communication amongst multi-disciplinary team members.

Nursing staffing

- During our inspection, we observed staffing levels to be sufficient to deliver safe care in accordance with National Institute for Health and Care Excellence (NICE) guidelines SG1: Safe staffing for nursing in adult inpatient wards in acute hospitals and the National Quality Board publication. There were sufficient numbers of trained nursing and support staff with an appropriate skills mix to ensure patients were safe and received the right level of care.
- In the National Inpatient Survey 2015, 72% of patients with planned and 68% of emergency admissions to the trust said there were always or nearly always enough nurses on duty to care for them whilst in hospital. This is above the national average of 63%.
- The trust had a staffing assurance tool, which was updated twice daily and ensured there was sufficient staff on duty to meet the needs of the patients at the time.
- The trust used a red, amber, green (RAG) system to identify nursing shortfalls. This was reviewed at daily staffing meetings and appropriate actions taken to address shortfalls. The trust had an additional workforce of workforce allocated each day consisting of four registered nurses and four health care assistants who could be deployed to areas where additional staffing was needed. This meant the trust were able to constantly identify where additional support was required and provide it.
- The expected and actual staffing levels were displayed on notice boards in each ward we inspected and these were updated on a daily basis.
- In a response to the national shortage of nurses, the trust had been proactive in its approach to managing nurse vacancies. They had looked at introducing new roles to support nurses, for example, a co-ordinator assistant had been introduced on MAU to carrying out the non-nursing element of the nurse co-ordinator's role, and discharge support officers had been employed to support nurses with the discharge process.
- Ward establishments had been set following a review of acuity using the SNCT. Staffing establishments varied across the medical wards but were sufficient to meet the needs of the patients at the time of our inspection.
- Medical wards with high dependency patients or those wards with hyper acute beds were staff with one nurse to two patient ratios (wards 403, 407 and 410).
- The trust monitored the planned versus the actual nursing staffing levels. From January to June 2016 the actual daytime registered nurse levels versus the planned registered nurse levels were on average 88%. Night time actual nursing staffing levels were on average 95%. Planned staffing levels are the number of nursing

hours planned for a shift, based on numbers of staff agreed with the ward in advance. Actual staffing levels are the number of nursing hours actually worked on a shift.

- There was an extensive use of bank and agency nurses to maintain staffing levels on medical wards. Information from the trust from January to June 2016 showed a total of 4,379 registered nurse shifts had been filled by agency or bank staff.
- An additional nurse to the usual establishment was based on the cardiology ward out of hours (overnight and weekends) to cover the Primary Percutaneous Coronary Intervention (PPCI) service; the nurse was from coronary care and would attend the cardiac catheter laboratory to support the catheter laboratory on call nurse. Staff told us due to staff shortages on the cardiology ward the PPCI nurse was often part of the numbers and would be unable to attend the catheter laboratory to support the on call nurse. Information provided by the trust following our inspection showed between March 2016 and July 2016 there had been 24 out of 153 (14%) occasions when there was not an additional nurse on the cardiology ward, this equated to an average of five shifts per month. Primary Percutaneous coronary intervention (PPCI) is a procedure used to treat the narrowed coronary arteries of the heart and is used as an emergency treatment for patients who are having a heart attack.
- An on call nurse was rostered to cover the cardiac catheter laboratory; this was to cover the period 8pm to 8am and was additional hours worked following a day time shift. Staff told us they could often be called in the middle of the night and be due back at work the following day despite working through the night. Staff told us they did not always receive an 11 hour rest in line with the working time directive. Where possible the manager told us they would roster staff to start their shift later. We discussed this with senior leaders who were unaware of the situation and assured us they would investigate. This was not on the trust risk register. Following our inspection the trust told us the on call system was implemented following benchmarking against other units and under full Consultation with staff and union representatives.
- In line with the London Quality Standards, the medical assessment unit had access to a monitored and nursed facility such as intensive care within the hospital.
- Nurse staffing numbers were reported to the trust board six monthly.
- Nursing staff handovers occurred at each shift change and included discussions about patient needs.

Medical staffing

- The division employed a higher proportion of consultants (43%) compared to the England average (37%) and a similar proportion of junior doctors (22%) compared to the England average (21%).
- Staffing levels and skill mix was planned and reviewed so patients received safe care and treatment. Consultant cover was provided by two consultants on the Medical Assessment Unit (MAU) from 8am to 10pm each day with on-call consultant cover provided outside of these times. Speciality consultants were also allocated as "consultant of the day" to review patients on MAU and attended the unit twice per day. There was additional support from junior and senior doctors. There were plans in place to extend onsite dedicated consultant cover for MAU to 12am.
- There was a consultant based on all wards each day supported by a specialist registrar (SpR) and two junior doctors. A Specialist Registrar or SpR is a doctor who is receiving advanced training in a specialist field of medicine in order to eventually become a consultant.
- The MAU was compliant with the Society for Acute Medicine quality standards for example there was a consultant on-call during the day and night for each specialty and a general medicine on call consultant 8pm to 8.30am. All were able to reach the hospital within 30 minutes.
- Junior doctors told us they were often having to stay late past their shift end times due to an additional afternoon "catch up" round. We discussed this with the senior medical team, who informed us in response to this, they had changed the junior doctor shift patterns to avoid this going forward. In addition to this, advanced clinical practitioners started their shifts later in the day, so they could support junior doctors with any additional tasks from the "catch up" round.
- Health Education East Midlands (HEEM) had raised some concerns with regards to lack of support for junior doctors in oncology. In response to this the trust ensured there was an oncology "consultant of the day" who was based on the wards and supported the junior doctors.

Medical care (including older people's care)

- Medical cover out of hours, including weekends, was provided by a dedicated hospital at night team led by a senior nurse who was responsible for coordinating activity amongst the team. Junior and senior doctors including specialist medical registrars were part of this team. On-call consultant support was provided to individual specialties as required.
- There was a suitably qualified doctor with an advanced life support qualification immediately available at all times; this was compliant with Society for Acute Medicine quality standards.
- There were suitable arrangements in place for medical handovers for example medical handover from the medical wards to the hospital at night team included a summary of all deteriorating patients.

Major incident awareness and training

- There were arrangements in place to respond to emergencies and major incidents. We saw a major incident plan in place specific to medicine. The major incident plan was supported by individual action cards including specific action cards for the senior nurses and doctors and the consultant who were based on the medical assessment unit. Staff we spoke with were unfamiliar with these plans, but said they would call the on call site manager for guidance if required.
- The trust provided us with a presentation 'winter learning' which was a view of winter pressures for 2014/2015 and 2015/2016. This would form the basis of the plans for winter 2016/2017.
- In preparation for winter, the respiratory medicine team had started to plan for an increase in patient numbers, and were looking at how they could work differently to accommodate these without additional resources, and compromising other services.

Maternity and gynaecology

Safe	Requires improvement
Overall	Good

Information about the service

Maternity and gynaecology services at Derby Teaching Hospitals NHS Foundation Trust are part of the Division of Integrated Care and are located at the Royal Derby Hospital.

The maternity unit includes the Pregnancy Assessment Unit (PAU), Fetal and Maternal Medicine Unit and the antenatal clinic. There is a labour ward, which has 14 birthing rooms, including one with a pool room, four high dependency beds, two assessment beds, an induction of labour suite, bereavement suite and two theatres. The Derby birthing centre is a midwife led unit, containing four birthing rooms, one of which is a pool room. The maternity ward, provides 47 beds for antenatal and postnatal care. Five community midwifery teams provide midwifery care and a home birth service.

The total number of births, including home births, between January 2015 and December 2015, was 6118.

The gynaecology service offers an inpatient ward with 21 beds, a day case unit and an outpatients' service.

This inspection is a focused follow up inspection following a comprehensive inspection from December 2014. At the inspection in December 2014, the maternity and gynaecology services was rated good overall but had three essential standards, which were not being met in the safe domain. This inspection will focus on the domain of safe and the actions taken to address those standards for maternity services.

During our inspection, we visited the labour ward, the Derby birthing centre, the maternity ward, PAU and the gynaecology ward. We spoke with 34 members of staff from the hospital and community. These included senior managers, registered midwives and nurses, support workers, doctors and administration staff. We reviewed the records of 10 patients.

Summary of findings

We rated the maternity and gynaecology service as requires improvement for safe.

- Not all staff had completed mandatory training. Compliance with level three safeguarding training did not met the requirements outlined in the Royal College of Paediatric and Child Health intercollegiate document; Safeguarding Children and Young People: roles and competencies for health care staff
- Staff expressed concerns about the electronic patient record. Staff were concerned about the extra time it took to input information into the system and that information could easily be overlooked.
- There were no formal multidisciplinary meetings to discuss serious incidences and deaths as recommended by the Royal College of Obstetricians and Gynaecologists.
- We were not assured that midwives caring for patients in the high dependency unit had received appropriate training to do so.
- Consultant presence within the service did not reflect the recommendations of the Royal College of Obstetricians and Gynaecologist: The Future Workforce.

However,

- There was an open culture for reporting incidents and evidence of lessons learnt. When something went wrong, patients were given an explanation and received an apology.
- Maternity services participated in the maternity safety thermometer and ward assurance checks were performed to monitor the safety and quality of care.
- All areas were visibly clean and tidy. Staff took appropriate steps to reduce the risk of hospital acquired infections. The environment was suitable and equipment was readily available and medicines were managed and stored safely.

Maternity and gynaecology

- Patients' records were stored securely; documentation was accurate, complete, legible and up to date.
- Risks to patients who used the service were assessed and suitable actions taken. Patients were monitored appropriately.
- Staffing levels were in line with national guidance. Any staff shortages were responded to quickly and appropriate action was taken. Patients who accessed maternity care had a named midwife.
- There was a lone worker policy in place and staff within the community midwifery team reported they felt safe when working in the community.

Are maternity and gynaecology services safe?

Requires improvement

We rated safe as requires improvement because:

- Staff expressed concerns about the electronic patient record.
- The service did not meet the requirement for level three safeguarding training as outlined in the Royal College of Paediatric and Child Health intercollegiate document; Safeguarding Children and Young People: roles and competencies for health care staff.
- Not all staff had completed mandatory training.
- There were no formal multidisciplinary meetings to discuss serious incidences and deaths as recommended by the Royal College of Obstetricians and Gynaecologists.
- We were not assured that midwives caring for patients in the high dependency unit had received appropriate training to do so.
- Consultant presence within the service did not reflect the recommendations of the Royal College of Obstetricians and Gynaecologist: The Future Workforce.

However,

- There was an open culture for reporting incidents and evidence of lessons learnt.
- When something went wrong patients were given an explanation and received an apology.
- Maternity services participated in the maternity safety thermometer and ward assurance checks were performed to monitor the safety and quality of care.
- All areas were visibly clean and tidy and staff took appropriate steps to reduce the risk of hospital acquired infections,
- The environment was suitable and equipment was readily available.
- Medicines were managed and stored safely.
- Records were stored securely and documentation was accurate, complete, legible and up to date.
- Staff were aware of their responsibilities in relation to safeguarding however insufficient numbers of staff had completed level three safeguarding training.
- Risks to patients who used the service were assessed and where risks were identified actions were taken.

- Staffing levels were in line with national guidance. Any staff shortages were responded to quickly and appropriate action was taken.
- Patients who accessed midwifery care had a named midwife.
- There was a lone worker policy in place and staff within the community midwifery team reported they felt safe when working in the community.

Incidents

- Staff reported incidents through the trust's electronic reporting system. All staff we spoke with understood their responsibilities to raise concerns and report incidents and near misses. Staff said they were encouraged to report incidents, and said they received feedback.
- Staff we spoke with could give us examples of recent incidents they had reported and the feedback they had received as a result. One registered midwife gave an example of a recent incident, where a new-born baby had needed to be admitted to the neonatal unit. The registered midwife reported this as an incident and had received feedback from their manager. Feedback provided reassurance that the midwife had followed the correct policy, when the baby's condition had deteriorated.
- Staff told us leaning from incidents was discussed at quarterly meetings, which all midwives attended and there was a risk session on the mandatory training day, which again included relevant learning from incidents. Community midwives from the five geographical locations met monthly to share learning from the across the five community teams.
- We saw minutes from the senior clinical midwives meeting from February 2016 that demonstrated that learning had been shared regarding recent serious incidents (SI). Serious incidents are events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response. We saw copies of emails and posters that had been used to inform staff of changes to practice following a SI.
- Between August 2015 and July 2016 there was no never event reported for the service. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
- There were 19 SIs reported to the NHS strategic executive information system (STEIS) between August 2015 and July 2016, although two of the 19 were subsequently downgraded. Maternity services reported fourteen of these and five were reported by gynaecology.
- We reviewed three recent SI reports. We saw the service had completed a root cause analysis (RCA) process in line with the National Patient Safety Agency (NPSA) guidance, action plans had been developed and there was evidence that learning had been shared with staff. This demonstrated a culture of learning from incidents.
- There were no formal multidisciplinary meetings to discuss serious incidences and deaths as recommended by the Royal College of Obstetricians and Gynaecologists (RCOG); however, maternal mortality and morbidity reviews were performed as part of the investigation process and reported to the trust's incident quality assurance group and trust's incident review group. We saw evidence that cases were reviewed and learning identified at the monthly perinatal audit meetings.
- The maternity service was in the process of reviewing their maternity care by participating in a maternity case review process with the Perinatal Institute, which is a national organisation set up to enhance the safety and quality of maternity care.
- The maternity service had developed a safety improvement plan, which reflected a number of national recommendations, such as the National Maternity Review 2016, for example. The improvement plan aimed to develop the quality and safety of care provided.
- Staff we spoke with had a good understanding of the duty of candour regulation, and one midwife could give an example of when they had needed to apply the regulation. The duty of candour is a regulatory duty that requires providers of health and social care services to disclose details to patients (or other relevant persons) of 'notifiable safety incidents' as defined in the regulation. This includes giving them details of the enquiries made, as well as offering an apology. We saw evidence that the service had sent duty of candour letters to patients, which reflected the requirement of this regulation.

Maternity and gynaecology

Safety thermometer

- The maternity safety thermometer was launched by the Royal College of Obstetricians and Gynaecologists (RCOG) in October 2014. This is a system of reporting on harm free care. Data was collected on a single day each month to indicate performance in key safety areas. These were: perineal (area between the vagina and anus) trauma, bleeding following birth, infection, admissions to neonatal units or babies having an Apgar score of less than seven at five minutes (The Apgar score is an assessment of overall new born well-being). The safety thermometer also looked at the proportion of women who reported being left alone at a time that worried them during labour or who reported they had concerns about safety during labour and birth that were not taken seriously
- We reviewed the results of the maternity safety thermometer from September 2015 to June 2016; 100% of the patients reviewed received harm free care for six of the ten months. For March 2016, 89% of patients received harm free care and May 2016, 90% of patients received harm free care. There was no data submitted for two months. The trust informed us that data had been collected for these two months, but had not been submitted due a problem accessing the national database.
- Staff told us results from the maternity safety thermometer were discussed at the monthly perinatal risk meeting, however minutes from these meetings did not include a record of these discussions.
- Within the gynaecology ward, safety data was displayed. This showed there had been 46 days without a patient experiencing harm from a fall, and 376 days without a patient developing a pressure ulcer.
- Each month maternity areas performed ward assurance checks by reviewing certain aspects of care, such as completion of VTE risk assessments, baby checks, medicine charts and resuscitation equipment. This information was publically displayed on the wards. For the labour ward, we saw 100% compliance for all aspects for June and July 2016. For the maternity ward, we saw 100% compliance for all aspects for June and July 2016, except for the review of medicine charts, which was 87% for June 2016 and 81% for July 2016. We spoke with managers about this who described the actions they were taking to address this, including education and training of staff.

Cleanliness, infection control and hygiene

- All areas we visited appeared visibly clean and tidy. We observed clinical and domestic waste correctly segregated and sharps boxes were available and used appropriately.
- Staff followed good hand hygiene and were bare below the elbow.
- There was a good supply of personal protective equipment (PPE) such as gloves and aprons and we saw staff using these appropriately.
- Maternity staff were responsible for cleaning the birthing pools after use. Cleaning instructions were displayed by the pools. During our inspection, only one birthing pool was available for review, this appeared visibly clean.
- Checklists were completed and signed once staff had cleaned beds and bed spaces, to indicate they were clean and ready for use.
- Within maternity services, patients were not screened routinely for MRSA. This was in line with the trust's policy. There were no cases of MRSA reported between August 2015 and July 2016. MRSA is a type of bacterium that is resistant to many antibiotics.
- Between July 2015 and June 2016, four patients were readmitted with puerperal sepsis within 42 days of delivery. Puerperal sepsis is a condition that a mother experiences due to an infection after giving birth.
- Between August 2015 and July 2016, there had been one case of C.Difficile infection on the maternity ward. C.Difficile is a bacterium affecting the digestive system; it often affects people who have been given antibiotics and has the capability of causing harm to patients.
- Safety information was displayed on the gynaecology ward. This showed there had been 976 days without a MRSA bacteraemia. This information also showed there had been 977 days without a C.Difficile infection. The trust performed monthly infection control audits, which included compliance with aseptic non-touch technique ANNT), cross infection, hand hygiene and an infection control mini audit. (ANNT which is a standardised approach to performing procedures in order to reduce the risk of a healthcare acquired infection).
- Between July 2015 and June 2016 both the labour ward and the maternity ward were, on average, above the trust target of 95% for both ANTT and cross infection. The labour ward hand hygiene audit was on average 84%, although results had improved over the past five months and the average for the infection control mini

audit was 93%. The maternity hand hygiene audit was on average 90%, although had been 100% for the past two months. The average for the infection control mini audit was 94%. Results for the gynaecology ward were on average above the trust target of 95% for all four audits.

Environment and equipment

- All maternity services were located in the same unit, obstetric theatres were part of the labour ward and neonatal services were close by. This meant the environment was appropriate in preventing delays in transferring patient and babies to these areas.
- Doors to all areas were locked and staff gained entry via a swipe card system. Visitors gained access via a buzzer and intercom system. This meant patients and babies were kept safe.
- The maternity areas had appropriate equipment available to provide care, such as cardiotocograhy (CTG) machines, which were used to monitor the unborn baby's heart rate and a mother's contractions.
- The labour ward had a blood gas analyser, which meant that staff were able to quickly test blood gas samples.
- Adult resuscitation equipment was available in all areas. On the gynaecology ward and the Derby birthing centre there was evidence that staff had checked the equipment daily in line with the trust's policy. On the maternity ward, there were three days in the preceding 16 days when there was no signature to indicate checks had been completed. In the high dependence unit (HDU) area of the labour ward, signatures were missing for 6 days in the preceding 16 days. On PAU, signatures were missing for three days during July 2016. We spoke with the managers of these areas who explained that staff were required to perform safety checks on other pieces of equipment as well as the resuscitation equipment and were required to sign a separate checklist to indicate they had completed all of these. We reviewed these checklists and saw that signatures indicated that checks on resuscitation equipment had been consistently performed.
- A resuscitaire is a specialist piece of equipment that is used for babies who may need some help with their breathing at birth; these were available throughout the maternity unit. Whilst signatures were not consistently recorded on the resuscitation checklist, there was evidence that these had been checked on the equipment checklist.
- Equipment had been appropriately maintained and serviced. We checked nine pieces of equipment including for example, blood pressure machines, and saw that eight had been serviced within the past year and where necessary had received portable appliance testing (PAT). One piece of equipment had was overdue for PAT testing by five months.
- We saw evidence that temperature checks of the medicine fridge temperatures had been recorded, and were in acceptable ranges. However, on the labour ward we noted that the actual temperatures of the fridge had not been recorded, so there was no assurance that temperature had been in an acceptable range, although on the date of inspection it was.

Medicines

- Medicines including medical gases were stored safely.
- Controlled drugs (CDs) were stored, checked and administered in accordance with legal and policy requirements. CDs are medicines that require additional security and regular checks. We saw that daily stock checks had been completed for CDs and we observed midwives on the labour ward preparing a CD for administration appropriately.
- Medicine for administration via the epidural route (the space just outside the spinal cord) were kept in a separate cupboard and staff recorded the stock in a separate CD register. This was good practice as it reduced the likelihood of epidural medicines being accidently given via the wrong route.
- We reviewed six medicine charts on the maternity ward. All charts were legible and allergies were documented.
- Medicine management was part of the trust's mandatory training and as of June 2016, 100% of staff within maternity and gynaecology had completed this training.

Records

- Records were kept securely in all areas we visited.
- Patients using the maternity service were provided with their own hand held care records to keep with them. These contained a range of information including the results of their antenatal tests.
- The trust had introduced an electronic maternity record in May 2016, which had been rolled out to community midwives throughout June 2016. The trust had seconded a specialist midwife into the information technology department to support the introduction of

this initiative. Staff had received initial training on the electronic record and a group of 'super users' had been developed to provide ongoing support. Throughout the maternity unit, we saw posters displayed which identified actions to be taken if staff required further help, including reporting concerns as an incident if harm or possible harm had occurred.

- However, all the midwives we spoke with expressed concerns about the electronic record. Midwives spoke about the extra time it took to input information into the system, they felt there was no logical sequencing and often they would need to duplicate information. Midwives were worried that information could easily be overlooked. Hospital based midwives were concerned that patient's discharges were being delayed and community midwives were concerned that antenatal clinics were running late because of the extra time it look.
- Since its introduction in May 2016, there had been 17 incidents reported relating to the electronic care record. These included, for example, duplication of a NHS identification number and incorrect patient information labels being generated.
- We reviewed eight sets of paper records for maternity patients and two sets for gynaecology patients. All ten records were accurate, complete, legible and signed.
- Following the inspection in December 2014, the maternity service was required to ensure that all records were written as soon as possible. During this inspection, we reviewed eight sets of paper records for maternity patients and saw all had been completed in a timely manner.
- Mothers were given the personal child health record, often called the red book, before they were discharged home. The red book was used to record the child's health and development.

Safeguarding

- The trust had a safeguarding policy in place and safeguarding training was mandatory for all staff working in the trust.
- Since March 2014, there has been a requirement for midwifery and other clinical staff working with children, young people and/or their parents to complete level three safeguarding training. Additionally over a three-year period, professionals should receive refresher training equivalent to a minimum of 6 hours. This requirement is outlined in the Royal College of Paediatric and Child Health intercollegiate document; Safeguarding Children and Young People: roles and competencies for health care staff. Compliance with this level of training at the time of our inspection was at 57%, against the trust target of 85%. The trust told us they were on target for staff to be compliant within the next three years. However, we were concerned this would mean achieving compliance with their own target would take the trust five years from the introduction of the requirement.
- On the maternity ward, staff told us they had twice-weekly multidisciplinary meetings, where current safeguarding issues would be discussed. In the maternity service, the shift coordinator, senior midwives and on call managers, if appropriate, received an email weekly on a Friday with an update on all patients where safeguarding concerns had been raised.
- Staff we spoke with had a good understanding of safeguarding and could describe the actions they would take if they suspected a patient required safeguarding.
- There was two dedicated midwives for safeguarding and staff were aware of who they were. On the labour ward, we saw posters, which provided staff with contact information if they had safeguarding concerns. Staff spoke positively about the support they received from the trust's safeguarding team.
- Safeguarding alerts were flagged up electronically on the electronic records, and for those patient with safeguarding concerns, there was a system in the paper records to alert staff to the safeguarding concerns.
- Since October 2015, it is mandatory for regulated health and social care professionals to report known cases of female genital mutilation (FGM). FGM is the partial or total removal of the female external genitalia for non-medical reasons. Staff within maternity and gynaecology received specific training on FGM and there was a designated FGM consultant. Staff were aware of the FGM guidance on their intranet and we saw posters displayed in staff areas, reminding staff of their responsibility to report FGM.
- Staff had an awareness of child sexual exploitation (CSE) and received training as part of the mandatory level three safeguarding training. Resources for staff were available on the trust's intranet, which we reviewed. Information was comprehensive and included checklists, risk assessments and referral forms staff could use to escalate concerns, as well as contact details of where further support could be obtained.

- Staff told us domestic violence risk assessments were completed three times during pregnancy, and postnatally as well. We saw evidence in the records we reviewed that this had been completed. Throughout the unit, we saw patient information posters, which provided information as to where people could go for support if they were experiencing domestic violence.
- There was a senior midwife to offer support to patients with a history of substance or alcohol misuse.

Mandatory training

- Staff were required to complete mandatory training. Twenty-nine subjects were included in this training, for example infection control, medicines management, fire, information governance and load handling.
- Many staff had not completed significant elements of their mandatory training. The trust target for compliance with mandatory training was 75%, 85% or 95% compliance, depending on the subject. As of June 2016, for maternity and gynaecology, trust targets were met for 14 of 29 subjects. Compliance for the remaining 15 subjects was below target. For 11 of these, compliance was between two and 13% less than the target. Compliance for falls training for doctors was 50% against a target of 95%. Compliance with prevent training (which helps staff to recognise and protect those people that might be susceptible to radicalisation) was 21.9% against a target of 85%. Compliance with venous thromboembolism (VTE) training was 66.7% against a target of 95%.
- Records of mandatory training were kept on an individual electronic passport for each staff member. Managers of the maternity ward demonstrated how this was accessed and clearly identified staff compliance with mandatory training.
- Midwives caring for patients in the high dependency unit (HDU) were supported to complete a HDU course. The maternity service attempted to ensure HDU trained midwives cared for patients in the HDU area, however could not provide data as to how many midwives had completed this. We were therefore not assured there was a suitably trained midwife always available in this area.

Assessing and responding to patient risk

- A senior midwife was on call for the midwifery service, 24 hours a day, seven days a week. They were aware of the workload, capacity and staffing levels across the maternity unit to ensure there was good patient flow throughout the service and women were allocated to appropriate areas to receive safe care.
- Staff confirmed patients would be moved if they needed a higher level of care. For example patients would move from the Derby birthing centre to the labour ward, if they transferring to consultant led care.
- There was a triage system for unplanned admissions. Patients would be assessed by staff in the Pregnancy Assessment Unit (PAU) by telephone or would be asked to come into PAU for further assessment. Following the assessment, patients would be discharged home, or admitted to the maternity ward or labour ward depending on their needs. We saw evidence staff had documented the telephone assessment calls in the patients hand held records.
- We saw evidence that monitoring in labour reflected The National Institute of Health and Care Excellence (NICE) guidance. For example, in the labour suite, high-risk patients received continuous electronic fetal monitoring. Within the Derby birthing centre midwives used hand held sonicaid devices and pinard stethoscopes, which are specialist devices, to listen to the unborn babies heart beat at regular intervals.
- Within the labour ward, real time electronic display of the cardiotocography CTG tracings were also located in the central area of the labour ward, which meant staff could easily review all the CTG tracings. CTG is used during pregnancy to monitor both the fetal heart and the contractions of the uterus. Staff used a 'fresh eyes approach' to improve the accuracy of CTG interpretation. This meant that CTG tracings were reviewed every hour by a second midwife. CTG training was available monthly. Both doctors and midwives attended this and recent case studies were discussed.
- We observed one team handover and saw risks, such as CTG monitoring and pre-existing medical conditions such as epilepsy, were identified and handed over to staff on the next shift.
- Staff we spoke with demonstrated they had knowledge and understanding of sepsis and would refer to the guidance on the intranet. We observed a hand over between two midwives where the potential risk of sepsis was identified and appropriate care was initiated.
- Early warning scores enable early recognition of a patient's worsening condition by grading the severity of their condition and prompting staff to get a medical

review at specific trigger points. Maternity services used the maternal early warning score (MEWS). We reviewed six MEWS charts and found these had been completed appropriately.

- The World Health Organisation (WHO) surgical checklist, five steps to safer surgery, designed to reduce the number of surgical errors, was in place. We observed four checklist and all were appropriately completed.
- Doctors and midwives received training in obstetric emergencies, we saw training agendas that included topics such as post-partum haemorrhage (excessive blood loss following childbirth) and recognition of the ill obstetric patient. In the past 12 months, 86% of midwives had attended this training. Those who had not attended were either on long-term leave. Forty-three percent 43% of doctors had attended.
- Within the maternity service, risk assessments were carried out on patients during their pregnancy. These included for example assessing patients for their risk of developing venous thromboembolism (blood clot in their vein) and mental health and wellbeing assessments.
- Smoking risk assessments were performed and we saw when this was identified as a risk, appropriate action had been taken and with the patient's' consent they were referred to the specialist smoking cessation midwife.
- We reviewed the notes of two patients on the gynaecology ward and saw, for example, that risk assessments for the risk of malnutrition, falls and the use of bed rails had been completed.

Midwifery/ Nursing staffing

- The trust reported a midwife to birth ratio of 1:28; this was in line with the Royal College of Obstetricians (RCOG) Safer Childbirth Minimum Standards for the Organisation and Delivery of Care in Labour) recommendations.
- On the gynaecology ward, day shifts were planned so that there were four registered nurses for 21 patients, giving a ratio of one nurse to every five to six patients. For night shifts the ratio was one registered nurse to every 10 to 11 patients. This was in line with National Institute for Health and Care Excellence (NICE) guidance, which recommends a ratio of 1:8 registered nurses to patients during the day and a 1:10 ratio at night.
- For the labour ward, maternity ward and gynaecology ward, an average of 87.5% of registered nurse/midwives shifts were covered, between February 2016 and May 2016.
- Staff were aware of the escalation procedures to take if they were short staffed. There was an internal midwifery bank available and senior midwives on the maternity ward demonstrated the use of the trust's everyday safer care electronic tool, which was used to monitor staffing levels.
- NICE guidance: NG4 staffing red flags, recommends that organisations use a red flag system to highlight critical staffing incidents. The trust logged red flags on the safer care electronic tool.
- The senior midwife on call for the maternity unit was aware of workloads and staffing levels across the whole unit. Staff would be moved internally across the midwifery unit, for example, community midwives would work in Derby birthing centre or midwives from the Derby birthing centre would work in labour ward to ensure safe staffing levels.
- The trust employed newly qualified midwives, who completed a preceptorship period, during which time they undertook a 16-month rotation throughout all of the community and hospital maternity areas. Preceptee midwives would often move to support other areas when needed as the rotational nature of their role meant they had recent experience and skills in all areas. They were always supported by experienced staff.
- Staff told us non-clinical midwives and matrons would also help support the areas if there were shortfalls. On the morning of the 17 August 2016, a specialist midwife had been called to help support staffing levels on the maternity ward.
- Following the last inspection in December 2014, the trust were required to ensure the named midwife was consistently implemented. During this inspection we saw women were allocated a named midwife and staff we spoke with confirmed this was so.
- In the community service, the consistency of the named midwife was monitored. We reviewed this information and saw the same midwife was consistently attached to each individual medical centre, in order to provide continuity of care.
- Staff we spoke with confirmed that patients in established labour received one to one care and during our inspection we saw this was achieved.

Maternity and gynaecology

- In line with recommendations from NHS England, expected levels and actual levels of staffing were displayed on notice boards for patients and visitors to see in all ward areas. We noted that the Derby birth centre was fully staffed on the 16 August 2016, but was one registered midwife short for the night shift on the 17 August 2016. The labour ward had two registered midwives short on both the day and night shifts for the 16 August 2016. For the maternity ward, there was one registered midwife short for the night shift on the 16 August 2016, and one registered midwife short for the day shift on the 17 August 2016. For the gynaecology ward, on the 17 August 2016, there was a shortfall of one care assistant on the day shift.
- During our inspection, areas were busy but calm and staff were able to answer call bells in a timely manner.
- Staff across all teams, whilst acknowledging they were busy, told us their workloads were manageable and they were able to deliver a safe standard of care.

Medical staffing

- Between July 2015 and June 2016, there was an average of 73 hours of consultant presence hours per week. Although medical staffing levels were the same as they were for our inspection in 2014, they did not reflect recommendations by the RCOG: The Future Workforce, which states that for service of this size, there should be 168 hours of consultant presence.
- In maternity services, there was a consultant on site Monday to Friday from 9am to 10pm. At weekends, cover was from 9am to 1pm. The trust told us they had secured additional funding to increase the number of hours at the weekends, but were unable to say when this would be implemented.
- The service had a rota for junior doctors, which included two senior doctors being on site 24 hours a day, seven days a week.
- There was 49.2 whole time equivalent medical staff. Consultant staff accounted for 44% of these, which is a higher proportion of consultants compared to the England average of 40%.
- There was a dedicated theatres team available 24 hours a day, seven days a week.
- We spoke to two junior doctors who said there was good support from their senior colleagues in the maternity unit.
- Midwives told us in Pregnancy Assessment Unit (PAU), that often they had to wait for doctors to review patients, as patients in other areas of the maternity unit would take priority. The service did not formally monitor the waiting times in PAU, so were unable to state if patients were waiting longer than the recommended 30 minutes to see a doctor.

Major incident awareness and training

- There were arrangements to respond to emergencies and major incidents. A trust-wide major incident plan was in place to guide staff in responding to any major incident.
- The service had a maternity and neonatal services escalation policy, which was followed in case maternity services needed to be suspended. Staff were able to describe processes and how they would escalate concerns, if there was lack of capacity within the maternity unit.
- Suitable arrangements were in place, if the service needed to suspend homebirth services as a result of increased demand or reduced staffing.
- Following the last inspection in December 2014, the trust were required to ensure that arrangements were in place to ensure that midwives in the community felt safe and secure. During this inspection, we saw that the trust had introduced a lone worker policy and bespoke standard operating procedures (SOP) for each of the five community midwifery teams. We spoke with 15 members of staff from across these teams, who could describe the SOP for lone working and confirmed that they felt safe whilst working in the community.

End of life care

Effective	Good
Overall	Requires improvement

Information about the service

At the Royal Derby Hospital, patients needing end of life care are cared for on the general wards.

The department of palliative care medicine includes a hospital and community specialist palliative care services. The Nightingale Macmillan Unit located at the hospital provides 20 specialist palliative care in-patient beds. These are available for patients who require additional care or support to that provided in local hospices or by the community services. The Nightingale Macmillan Unit also has a day unit, providing specialist palliative care for patients and respite for carers.

From January to December 2015 there were 2330 in hospital deaths at Derby Hospitals NHS Foundation Trust.

Trust wide from April 2015 to March 2016 1529 referrals were made to the specialist palliative care team (SPCT). Of these 1284 were cancer related and 313 were non cancer related.

During our inspection we spoke to 29 members of staff, including junior and senior nurses, members of the specialist palliative care team, mangers, support staff, and junior and senior medical staff. We spoke with two relatives and reviewed relative feedback on the care they and their families had received. We looked at 10 patient records including 10 do not attempt cardiopulmonary resuscitation orders. Before our inspection we reviewed performance information from and about the hospital and trust policy documents.

The hospital was last inspected in December 2014 and the report published in March 2015. This inspection identified aspects of care that did not meet some of the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. In end of life care this solely related to patient records, where we found do not attempt cardiopulmonary resuscitation (DNACPR) order forms were not completed accurately in line with trust policy.

This inspection was a follow up inspection and focused on the effective domain and on establishing whether any changes had been made based on the previous inspection findings.

End of life care

Summary of findings

We rated the effectiveness of the end of life care services as good.

- The service was delivering end of life care based on the five national priorities that had been identified as key for effective patient care.
- Care was based on best practice and current guidance. Patient outcomes were continually monitored to ensure improvement. The service participated in national audit programmes and was able to evaluate its performance against national performance.
- Training programmes had been established and tailored to meet the needs of the staff and staff feedback demonstrated the training was effective in providing them with the required knowledge to deliver good care to patients at the end of their lives.
- Changes had been made since the previous inspection. When a decision was made on whether cardiopulmonary resuscitation (CPR) was an appropriate treatment, patient records were completed in line with trust policy and decisions made in compliance with relevant legislation.

Are end of life care services effective?

Good

We rated effective as good because:

- Individualised personal care planning for patients in their last days or hours of life was being used effectively to deliver evidence based care and support to patients and their families.
- An education programme was in place and being delivered to staff across the hospital which enabled them to become increasingly confident and competent to deliver care to patients at the end of their lives.
- Patient's pain, nutrition and hydration needs were effectively assessed and care was delivered based on these assessments.
- National and local audit findings led to improvements being made to care delivery and informed future audits ensuring continual improvement was made.
- Staff throughout the hospital had good access to both the specialist palliative care team and a comprehensive on line information toolkit. This contained detailed information to support staff in delivering care to patients at the end of their lives.
- When decisions were made on whether cardiopulmonary resuscitation was an appropriate treatment for a patient, these were documented in line with the trust's policy and made in compliance with the Mental Capacity Act 2005 in the majority of cases.

However:

- Staff working on wards where patients were not usually cared for at the end of life had yet to receive their training.

Evidence-based care and treatment

- Patient care and treatment was planned and delivered in line with evidenced based guidance, standards and legislation. Personalised care plans were used for support of the dying person in their last days and hours of life. Care planning was based on the five priorities of care set out by the leadership alliance for the care of the dying person. The five priorities are, recognise, communicate, involve, support, plan and do.
- Local audits were undertaken to ensure care was being delivered in line with trust policies and national best

practice guidance. Care records were audited to assess compliance to the five priorities of care. An annual audit of whether patients were cared for in their preferred place of care was carried out. Preferred place of care is one of the key points to establish when planning individual care as outlined in National Institute for Health and Care Excellence (NICE) NG31 evidenced based guidance on care of dying adults in last days of life.

- In 2013 an independent review of the 2013 Liverpool Care Pathway, identified failings in the pathway and recommended individualised care planning for patients approaching the end of the life. We saw consistent use of the personalised care planning document on all the wards where care was being provided for patients in the last days of their life. On other wards all staff who were asked knew of the trust's personal care planning document and when it was used.
- Policies, procedures and documentation used on the wards were based on nationally recognised guidance. We saw evidence of care planned and delivered in line with the National Institute for Health and Care Excellence (NICE) Quality Standard QS13. Care records included details of holistic patient support, including spiritual as well as social and practical support. Systems were in place and resources available to provide timely specialist palliative care and advice. Relatives we spoke with explained care was provided in accordance with their relative's personalised wishes and support had been provided for their family.
- We saw care records where the AMBER care bundle was used to assist in the planning and delivery of patient care. AMBER is an acronym of **a**ssessment, **m**anagement, **b**est practice, **e**ngagement and **r**ecovery uncertain. This nationally recognised care bundle provided a structured approach to patient care where there was uncertainty about the patient's recovery. It was designed to manage the care of hospital patients who are facing an uncertain recovery and who are at risk of dying in the next one to two months. This ensured appropriate treatment was provided and ensured regular patient assessments were completed. Since our previous inspection there had been wider implementation of this care bundle within the hospital, with only a small number of wards now yet to implement this approach. There were plans to address this within the few months following our inspection.
- A form was completed when it had been recognised a patient may die within the next few days. This ensured the information was communicated clearly and was in line with the first priority of care for the dying person as set out by the leadership alliance for the care of the dying person. We saw this form was being used consistently across the wards in the hospital.
- Care records contained assessments, plans, evaluations and records of care delivery in line with NICE NG31. Care of dying adults in last days of life. Staff described providing individualised patient care which avoided unnecessary investigations or treatment, effective communication with both the patient and their family and prioritised symptom management.
- The trust was signed up to the national programme for transforming end of life care in acute hospitals, so more people were supported to live and die well in their preferred place. A service improvement framework was provided for trusts to make local change for example implementation of the evidence based AMBER care bundle, and advance care planning. From documented work plans supplied by the trust and from speaking to staff the trust demonstrated the commitment to continue to develop their end of life care in line with these and other national best practice guidelines.
- The palliative care team assisted in the management of patients who had an advanced, progressive or life threatening illness and where their care required specialist assessment, advice or treatment. From April 2015 to March 2016, 1529 patients had been referred to the HPCT, of these 1284 (84%) had been diagnosed with cancer.
- Information supplied by the trust showed audits had been carried out to monitor how soon after the specialist palliative care team received a referral they were able to review it and provide advice and/or care. An audit of 100 of the referrals received from April to July 2016 showed 91 of the referrals were reviewed within 24 hours of the referral being made. Of the other nine, three were inappropriate referrals, four referrals or reviews did not contain the time when they were made and two were non urgent out of hours referrals that were responded to the following day. Actual visits were not always required by the team.
- Patients who had previously received care from the palliative care team would be flagged on the electronic records system should they be re admitted to the trust,

so the team would know about the patient's new admission. Where patients were not previously known to the team the team relied on the patient's medical team referring them for an assessment.

Pain relief

- Medical and nursing staff explained they would refer patients with complex pain management needs to the palliative care team. There was also a pain team in the hospital which staff could contact for advice.
- The personalised patient care plan included planning care for patient comfort. Anticipatory medicines were prescribed in case the patient experienced pain. The need to evaluate the effectiveness of any medication that was administered was also contained within the care plan. Anticipatory prescribing of pain relief is when pain medicine is prescribed just in case it is needed at a later date to ensure there is no delay in pain relief being given.
- A local audit of patients was carried out from August to November 2015 to determine if anticipatory prescribing was carried out in line with NICE guidance NG31 Caring for patients in the last days of their life. The results showed anticipatory prescribing was in line with NICE guidance as it was individualised but was not always made available at the earliest possible opportunity. The trust told us training was being provided and a re-audit was due later in 2016.
- Patient care records contained evidence of anticipatory medicines including strong pain relief being prescribed and evaluations were completed to assess their effectiveness. Patients were assessed regularly for any signs of pain and this was recorded on an hourly rounding sheet. An hourly rounding sheet is a document completed every hour by staff to record what care has been given and what assessment have been made. NICE Guidance CG140 Palliative care for adults, strong opioids for pain relief, states patients should have access to frequent review of their pain control.
- We saw patient medicine prescription sheets for a continuous infusion of pain relief medicine that was given via a syringe driver pump. Staff explained standard syringe drivers designed specifically for the purpose of providing pain relieving medication were always available to enable prompt pain relief to be given to patients.
- Staff spoke of assessing pain using a scale of mild, moderate or severe pain. Patient records referred to using a recognised pain assessment tool to enable an assessment to be made where patients were unable to verbalise their discomfort. Patient assessment criteria included facial expression and body language. This was in line with the faculty of pain medicines core standards for pain management which required pain assessment tools to be standardised and available to assess the pain in patients who may be unable to verbally describe their pain.
- Relatives explained they were very satisfied everything had been done to ensure their relative was comfortable.
- Staff reported good access to the palliative care team, including the consultants if they required pain relief medicine prescribing. Consultants were available via an on call system out of hours.

Nutrition and hydration.

- Nurses completed a mouth care and oral assessment tool as part of the individualised care plan to help identify potential reasons why a patient may not be able to eat or drink and to initiate treatment where required. This detailed assessment included the condition of lips and tongue and dental hygiene. We saw where a mouth gel had been prescribed to improve oral comfort.
- Staff explained they were able to offer food and drink at any time of the day or night and how food was easily obtained from the catering department. Meals were available to cater for patients who could only tolerate a soft diet and fluids were thickened to help patients who had difficulty swallowing.
- We spoke with housekeeping staff who knew which patients were able to safely eat and drink and those who could not. They had a sheet containing this information t and if any special diets were required.
- A nationally recognised tool was being used to assess patient's risk of malnutrition, and we saw evidence this had been completed in patient records. We saw patients weight was part of the assessment process and saw this had been recorded in a patient's notes. Support was available from the dietitians if this was required but patients were encouraged to eat what they preferred. Nutritional supplement drinks were available on the wards.
- One of the anticipatory medicines which was made available to patients was to prevent symptoms of nausea and sickness.
- In the national care of the dying audit published in 2016 the trust obtained results better than the national

average for their assessments of patient's ability to drink to eat within the last 24 hours of their life. In the same audit 26% of patients were supported to eat during this timeframe this was worse than the national average of 36%. However this data includes patients who were too unwell to eat or drink.

Patient outcomes

- Staff collected patient outcomes data which was monitored to enable improvements to be made in palliative and end of life care for patients and their families.
- The trust submitted annual data to the national council for palliative care this national data was used to provide information on hospice and specialist palliative care service activity.There was a local audit programme covering all aspects of end of life care.
- The trust had identified areas for improvement in response to their performance in the national care of the dying audit, published in 2016. Actions had been taken to address the four organisational key performance indicators that had not been met. All four indicators related to the trust's communication training. Training at the time of the audit did not cover specific skills for communicating with patients in the last hours or days of their life. Since April 2016, evidence based, nationally recognised communication training workshops had been provided and further training was planned for October 2016. As of July 2016, 8% (77) of staff identified as requiring end of life essential to role communication skills training had completed it.
- The trust did not meet three out of the five clinical indicators in the national audit, Two of these were just below the national result. These were whether it was documented in the last episode of care that the patient would probably die within the coming hours or days and whether that information had been discussed with the patient's nominated person. The third indicator the trust did not meet related to insufficient documented evidence that their visitors had been asked about their needs. The trust met two of the clinical indicators these were whether there was documented evidence that the patient had received the opportunity to have their concerns listened to and whether a documented holistic assessment had been made of the patients' needs We saw evidence that visitors' needs had been discussed and staff spoke of recognising and meeting these needs.
- The palliative care team carried out an annual audit of patients preferred place of care. Three hundred and two patient records were reviewed from April and August 2015. A discussion had taken place regarding preferred place of care with 256 patients (85%) Out of the 42 cases (14%) where this was not discussed 18 patients were too unwell to discuss their preferences. These results were similar to previous years. Two hundred and forty seven of the 302 patients had passed away and 120 had passed away in their preferred place of care.
- The trust obtained information on patient outcomes by asking bereaved relatives to complete a bereavement questionnaire about their and their relative's care experience. From April 2015 to April 2016, 1833 questionnaires were sent to families, 195 (11%) were returned. One hundred and twenty four of these (64%) said a discussion had taken place about a preferred place of care. As a result of the low response rate, the questionnaire sent to bereaved relatives has been shortened.
- The trust's admission document now included a prompt for staff to enquire where patient's preferred place of care was and to document if they had an advance care plan or advanced directive in place. An advance care plan is a documented plan of a patient's wishes regarding their care; they are often made in anticipation of a future deterioration in a patient's condition.
- In the national End of Life Care Audit: Dying in Hospital, based on data from 80 patients submitted from May 2015, there had been recognition when a patient was dying in 81% of the records. Senior medical staff were noted to take responsibility for recognising a patient was dying. A small local audit of 22 patient records completed in November 2015 showed a recognising dying form had been completed for eight of 16 patients who been recognised as dying Following this in April 2016, training had commenced for medical and nursing staff on recognising when patients are dying, this ensured all patients were recognised and appropriate discussions took place as early as possible.
- A local audit was completed by the end of life care team in 2016 of 100 individualised care plans of patients who were in the last days of life and cared for across 19 hospital wards. This audit looked at whether each of the priorities of care were considered in the planning and delivery of patient care. The five priorities of care were recognise, communicate, involve, support, plan and do,

as set out by the leadership alliance for the care of dying people. Three of the priorities were used in 90% of the care plans and the other two priorities were used above 80% of the time.

- A ward accreditation programme was being introduced at the hospital. Ward staff were assessed to establish their level of knowledge and records were audited as part of the accreditation process. At the time of the inspection wards across the trust were at the start of the process and no wards had been accredited.
- As part of the national transformation programme, an end of life care work programme had been developed which was used to support and assess service and quality improvement. Key areas of work included, staff education, documentation and information technology to support an electronic record system.
- There had been a phased introduction of the AMBER care bundle in wards at the hospital over the last three years. From April 2015 to March 2016, 71 staff were asked for their feedback on the AMBER care bundle. Seventy two percent of staff stated the care bundle helped with patient care, 76% stated they thought it had improved patient experience and 78% the patient's family's experience. Senior staff told us the AMBER care bundle was due to be implemented in a further four wards in the coming months.
- An internal audit of 304 patient records from 15 wards completed from April 2015 to September 2015 showed the AMBER care bundle had been used where patient's recovery was uncertain and for patients in the last months or weeks of their life. Of the 304 patients 117 were either discharged or recovered from their illness.
- As part of the evaluation of the AMBER care bundle, the quality of discharge information provided to GPs had been considered. Engagement with GPs had taken place and grading criteria had been established for assessing the quality discharge information. This was to be incorporated into the AMBER care bundle patient outcome review. Following the inspection the trust informed CQC that they were delivering training to medical staff to improve the standard of patient discharge letters.
- The trust had implemented a rapid discharge procedure, enabling patients within the last four hours of their life to be in their preferred place of care when they died. Since this had been introduced nine patients had been rapidly discharged during the last 12 months. The trust were not recording how many patients requested to go home within the last four hours of life but were unable to do so.

Competent staff

- The palliative care was led by a consultant in palliative care medicine with 7.2 whole time equivalent (WTE) clinical nurse specialists. The clinical nurse specialists and palliative medicine consultants provided formal and informal training to staff throughout the hospital.
- From April 2016 a new role had been established within the palliative care team to ensure specialist knowledge and experience was available in the future. The team had recruited three associate nurses in palliative care medicine. These 18 month positions were a training and development role with supernumerary status enabling focus to remain on their training. Experience was obtained from within the hospital and community environment.
- There was a dedicated facilitator in post to implement the AMBER care bundle across the hospital which meant the training and implementation of the care bundle was consistent across the hospital.
- There was an on-going end of life education programme to equip staff throughout the hospital with the skills and knowledge required to provide care to patients at the end of their lives. The training programme was role specific and included a general overview of the trust's approach to care in the last days of life through to a full training programme on the priorities for end of life care for more senior and specialised roles.
- The training programme had commenced in April 2016. Data provided by the trust showed as of July 2016 of the 956 staff requiring essential to role end of life training, 204 (22%) had received recognising dying training, 191 (20%) had received symptom management, 527 (56%) had received care planning training and 71 (8%) had received communication skills training.
- Staff competence was assessed and training attendance monitored as part of the trust's implementation of the national transforming end of life care in acute hospitals programme. We saw the assessment document used to establish whether wards had achieved the required standard to be accredited. The required standard ensured a high level of knowledge.
- Advance care planning was in the process of being established consistently throughout the hospital.

Elements of advance care planning were included within end of life training. Staff were assessed on their knowledge of the advance care planning documentation and of their knowledge of planning care where patients faced an uncertain recovery.

- We asked nursing staff on the wards about the training they had received, all felt the training had helped them in delivering care to patients requiring end of life care and were confident in discussing what the training had included.
- Mandatory training records for 2015 to 2016 were provided for the specialist palliative care team. These showed that the team had met the trust training completion target, which was ranged from 75% to 95% depending on the module, in seven out of the 25 training modules.
- All the hospital palliative care team had received an appraisal within the previous 12 months.
- The trust's Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) had recently been reviewed. We saw examples of educational materials used to train staff which included relevant practical examples to help staff apply these legal requirements correctly. MCA and DoLS training was delivered as part of staff mandatory safeguarding training. Training was delivered by face to face session and via e learning packages. E learning training was a 30 minute training session which was tailored specifically to meet the trust's training needs and included information on restraint.
- Training on do not resuscitate orders was provided in the resuscitation training sessions. There was a prompt on the staff intranet to alert staff there had been amendments to the trust do not attempt cardiopulmonary resuscitation DNACPR documentation.
- Registered nurses received training to ensure their competence in using equipment commonly used to administer medicines to patients receiving end of life care. Records supplied by the trust showed staff throughout the hospital had been assessed as competent in using standard syringe drivers. Training updates were provided every three years.
- Senior staff told us end of life care training had now been included in the induction training for medical staff starting at the trust. We spoke with two doctors who had recently attended their induction training and they spoke very positively about the end of life care training they had received.
- Ward staff had the opportunity to work alongside the clinical nurse specialists to develop their skills in symptom management. One clinical nurse specialist had part of their role (0.4WTE) assigned to the regional training programme for medical students.
- Nursing staff were prioritised for training depending on where they worked. Staff in areas where patients were unlikely to need end of life care, for example day case areas, were a lower priority for training. Link nurses were a high priority for the training.
- Staff working in planned care, for example elective shorter stay surgical wards were a lower priority for receiving end of life care training, they could however be caring for medical patients due to bed pressures within the acute medical wards at certain times of the year.
- Link nurses were based on each ward to enable information to be cascaded effectively to all staff. There was more than one link nurse from each ward or department and these were from varying levels of seniority on the ward. This was to ensure information was cascaded throughout the teams.
- We saw evidence in a ward training record where the link nurse had cascaded information to 75% of the ward staff, both registered and non-registered staff were included.
- There was a quarterly end of life care link nurse meeting, we reviewed minutes of a meeting held in June 2016. Topics of discussion included their role in supporting the ward team in their training as part of the programme for transforming end of life care across the trust and wards achieving accreditation.
- Five of the clinical nurse specialists within the hospital palliative care team were non – medical prescribers, and funding was in place for the other three clinical nurse specialists to have completed their training by 2019. In addition to prescribing new medications, the role enabled existing patient medications to be reviewed and stopped if they were no longer appropriate.

Multidisciplinary working

- There was documented evidence in patient notes of referrals to and reviews by the specialist palliative care team. Their specialist knowledge provided assistance with effective symptom control and patient comfort.
- Medical staff explained the specialist palliative care team were very easy to contact and available to provide the specialist advice they required.

End of life care

- We observed a multidisciplinary team (MDT) meeting on the Nightingale Macmillan Unit. This was attended by a palliative care consultant, a registrar, four specialist palliative care team nurses and a member of the administration support staff. The MDT meeting was held weekly and was an opportunity for the team to discuss the care and management of patients who were receiving end of life care, patients who had been discharged and those who had passed away.
- Staff at the hospital told us the chaplaincy services were always available and often attended the weekly meeting and provided spiritual care as well as religious support. This support was available to patients, their family and friends and to staff.
- Key leaders of the specialist palliative care service explained they had direct links with the regional specialist nurse in organ donation (SNOD) and attended meetings held by the regional organ donation committee. The regional SNOD was available to provide advice and support to staff, patients and families throughout the hospital.
- From reviewing patient records we saw evidence where referrals had been made and patients had been reviewed by the dietitian and speech and language therapy team.
- The trust did not currently have an electronic palliative care coordination system. (EPaCCS) This is an electronic patient record system which provides health professionals both in the hospital and community, including GPs access to a patient's care records. At the time of our inspection the trust was involved in discussions with all relevant partners about the format this shared online record of care should take. In the meantime general practitioners would need to be updated about the care a patient had received in the hospital as they did not have direct access to the care records via an on line system.
- We saw when a patient had been reviewed by the palliative care team a note sticker was used, this provided clear information to other health professionals. This included the name of the member of the team, their contact details, the date of team's next MDT meeting where the patient's care would be discussed, the date of the next planned review and information on how to contact the palliative care consultant out of hours. A detailed plan of care and treatment prescribed was also included.
- When a patient with a personalised end of life plan of care was discharged the patient's GP would be notified by letter about the discharge and their plan of care. If a patient passed away the GP surgery would be informed, this was included in the personalised care plan document for care after their death.
- Medical notes were a paper record. All members of the multidisciplinary team wrote in the medical notes, this ensured all health professionals had access to all the information and plans of care were shared and coordinated.
- Patients referred to the specialist palliative care team remained under the responsibility and care of their admitting consultant. This included general or specialist medical consultants or a surgical or orthopaedic consultant. The palliative care team advised on the patient's care, but did not take over, the patient's total management. On the Nightingale Macmillan Unit, a specialist palliative care inpatient unit provided care for patients whose condition could not be managed in the community or hospital
- We saw evidence of discharge planning in patient notes, and staff explained the rapid discharge process had been introduced to enable patients within the last four hours of their life to be transferred to their own home to die. The rapid discharge flow chart, available to staff on the trust intranet outlined the contact required with the wider multi-disciplinary team to facilitate a safe and prompt discharge. Prompt contact with the community district nursing services via a single point of access, the local ambulance transport services and pharmacy were all key to successful rapid discharge.

Seven-day services

- The hospital palliative care team worked seven days each week, 9am to 5pm.

During this time the team provided face to face specialist advice, information and support to patients and staff throughout the hospital.

- Outside of these hours there was a telephone answer-phone to take messages. Immediate advice during this time could be obtained by contacting the Nightingale Macmillan Unit. (NMU)

End of life care

- The senior inpatient nurse handled the telephone calls to the NMU and provided immediate information, support and advice. Where appropriate the nurse would redirect patients in the community to the community palliative care team.
- There was a consultant in specialist palliative medicine on call 24 hours a day seven days a week. The on-call consultant was contactable via the hospital switchboard.
- The bereavement service was available 8:30 am to 4.30pm, Monday to Friday.
- Physiotherapists and occupational therapists provided planned care to patients throughout the hospital during the weekdays. At weekends there was an on call system in place for urgent physiotherapy treatment.
- The chaplaincy service was available at all times. Out of hours they were contacted via the hospital switchboard and staff we asked were aware of how to contact the chaplaincy service.

Access to information

- Staff had access via the trust's intranet to the Derbyshire Alliance for End of Life toolkit. The toolkit had been developed within the local region and provided a substantial resource of relevant, evidence based, current information on planning and delivering care for people in their last months, weeks and days of life.
- All the staff we spoke with were aware there was information available on the trust intranet to support them to plan and deliver care to patients in the final stages of their life.
- Staff who were asked were able to locate this information. There was limited knowledge on the existence of the actual toolkit with the term Derbyshire Alliance being unfamiliar to several staff. However once on the intranet staff were automatically directed to the toolkit without needing to search for it by name.
- Staff in the emergency department had access to a resource board providing information about caring for patients in the department who were at the end of their life. This contained pocket sized laminated information cards for staff to keep, they included some useful telephone numbers and prompts for key areas of individualised patient care.
- There was detailed information on symptom management including pain relief available via the trust intranet, and medical staff explained the palliative care team were easy to contact and knowledgeable.
- ISBAR is a recognised communication tool which provided a framework for effective communication. This helped information to be shared when a patient was transferred between wards or outside of hospital. ISBAR is for; introduction; of the person providing the information; situation; what is happening at the moment; background; what has led to the current circumstances; assessment what the current problems are and recommendation; what should be done now. We saw handover documentation in patient notes and these had been completed using the ISBAR framework. We saw the resuscitation status of a patient had been included on the document.
- All staff who were asked were very clear they could find information on a patient's resuscitation status in the front of their medical notes. Staff knew this was recorded on a red form. Without exception all the 10 do not attempt cardiopulmonary resuscitation DNACPR forms we reviewed were located at the front of the medical notes.
- Staff explained they would be informed at handover of patients who were not for resuscitation. Where patients were admitted during the shift, and they were not the nurse admitting the patient and taking the patient handover, they would refer to the patient's medical notes for information on the patient's resuscitation status.
- On one ward senior staff spoke of having a discrete symbol on the ward communication board informing staff if a patient was not for resuscitation. We asked three other members of staff on the ward about the use of this symbol, two staff had no knowledge of it, and a third was aware of it but would still use the medical notes to obtain accurate information regarding a patient's resuscitation status.
- A discrete communication symbol was used on the electronic white boards to inform staff when a patient was in the last days of their life. This was a trigger to the nursing staff to complete an individualised care plan for the dying patient and communicate with family and give them a comfort pack. In the emergency department the symbol was used on the room door were patients were being cared for in the final days of hours of their life. Staff we spoke with explained how this ensured all staff, even those not working in the area, took extra special care to make the environment as peaceful as possible for the patient and their families.

End of life care

- Medical notes were stored within the ward areas, notes trolleys were unlocked. The personalised care plan documents were kept in patient areas and were readily available to staff. All members of the multidisciplinary team wrote in the medical notes, this ensured all health professional had access to all the information and plans of care were coordinated. Where AMBER care bundles were in place stickers were used in patient's notes to inform all staff it was in use. We saw AMBER care bundle stickers in patient's notes.
- We saw end of life care resource folders on the wards and in the emergency department and staff were knowledgeable about the information they contained. Staff spoke of their end of life link nurses being a source of information and support to the ward team. Each ward had more than one link nurse to ensure differing levels of staff seniority were represented and had a point of contact.
- In the emergency department information was readily available to assist staff caring for patients immediately after they had passed away. A resource pack contained documentation including the form used for a coroner's referral and a check list for staff. This was used to ensure consistent support was provided for relatives and all the trust and legal processes were followed.
- Staff had immediate access to information leaflets to support relatives and friends following bereavement. The emergency department had an information booklet 'What to do when someone has died in the Emergency Department' which was completed with the names of staff who had been caring for the patient and a contact number for relatives to use.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We reviewed 10 medical records of patients who were receiving care in the last days or hours of their life. The patients were being cared for in eight different wards. All the patients had a do not attempt cardiopulmonary resuscitation decision in place which were recorded on the trust's do not attempt cardiopulmonary resuscitation (DNACPR) form. These forms were all easily identifiable, being red, located at the front of the medical notes, and were legible and accessible to staff. The trust's DNACPR forms had been reviewed and amended. The forms now incorporated a two stage assessment required by the Mental Capacity Act to determine whether a patient had mental capacity and if not why this was the case.
- The two stage test on the form specifically related to the one decision, whether a patient had the mental capacity to hold discussions about their DNACPR decision.
- Of the 10 DNACPR forms we reviewed, six had a documented decision that the patient had mental capacity at the time the decision regarding resuscitation was made. On the other four forms, where a decision had been documented that the patients didn't have mental capacity three had the two stage mental capacity assessment fully completed. On the remaining form, the stage two question, why the patient lacked capacity had not been completed.
- Where possible, discussions had taken place with the patient and these were documented on the forms. Records of discussions that had taken place with relatives were recorded on the form on all but one form, where this had been recorded elsewhere in the notes.
- One of the patient's notes had a record of an MCA assessment being completed when a decision had been made as part of the discharge planning process. This was in line with the trust's policy for consent & the mental capacity act (lawful authority for providing examination, care or treatment). A Mental Capacity Act 2005, capacity assessment evidence and documentation tool had been completed.
- The trust carried out quarterly audits of DNACPR forms, the most recent was completed in July 2016. Fifty five forms were reviewed alongside the patient's medical notes. Ninety-four percent of patients had a mental capacity assessment completed during the DNACPR decision making process. This was consistent with 91% in April 2016 and 96% 2016 in January 2016. Discussions had taken place with patients who had capacity 98% of the time, and discussion with families in 92% of the cases reviewed. A consultant had reviewed and countersigned the decision 90% of the time. These results were comparable with our findings on inspection and showed consistent improvements in compliance in all areas of the DNACPR process
- Patient admission documents had been recently amended to prompt staff to consider if a patient may

lack capacity in relation to a specific question at the time of their admission. That question was whether they were able to understand the information being provided to them about what the nursing care may entail.

- At the time of the inspection no end of life patients on the wards we visited were under a Deprivation of Liberty Safeguards. Managers spoke of being aware and taking note of the Department of Health Guidance issued in October 2015 on the Deprivation of Liberty Safeguards. This document provided specific guidance on taking a proportionate and sensitive assessment when considering whether a DoLS application was required for patients cared for in their last days of life. The patient admission documentation had been amended to include a prompt for staff to consider whether a patient was under a Deprivation of Liberty at the time of their admission.
- There was a documented trust procedure if a patient lacked capacity and a best interest decision needed to be made. By following this procedure and using the trust's documentation staff would ensure the correct person would make the decision by taking into account any advance decisions made by the patient.
- Consent training was provided to all junior medical staff. The trust provided us with a copy of the training material which was comprehensive and relevant for their role.
- On the front of the patient's record of care documentation there was a statement it could only be read by their family and friends with the patient's permission.

Outstanding practice and areas for improvement

Outstanding practice

- Patients on the respiratory medical wards who were receiving oxygen therapy wore colour-coded wristbands to identify how much oxygen they needed. This minimised the risk of patients receiving too much oxygen.

Areas for improvement

Action the hospital MUST take to improve

- Review arrangements for training staff in maternity services in level three safeguarding to ensure timely compliance with the intercollegiate guidelines of March 2014.
- The trust must ensure patients' notes are stored securely to ensure their confidentiality.
- The trust must ensure all patients who meet the criteria for sepsis screening are screened and any interventions are carried out in line with trust protocol and national guidance.
- The trust must ensure all staff are trained in the screening, management and treatment of sepsis and that all staff are familiar with and have easy access to the sepsis screening proforma.
- The trust should ensure staff adhere to and follow the trust guidelines in relation to the escalation of deteriorating patients.
- The trust must ensure compliance with same sex guidance in the monitored bay on the medical assessment unit.

Action the hospital SHOULD take to improve

- The trust should consider implementing formal multidisciplinary meetings to discuss serious incidences and deaths as recommended by the Royal College of Obstetricians and Gynaecologists (RCOG).
- The trust should review the concerns raised by midwives regarding the electronic patient record to ensure there is no negative impact on patient care.
- The trust should consider how to improve compliance against their own targets for staff mandatory training topics.
- The trust should review arrangements for ensuring midwives caring for patients in the high dependency area have completed relevant training.
- The trust should consider how to increase the number of hours a consultant is present within the service to reflect recommendations of the Royal College of Obstetricians and Gynaecologist: The Future Workforce.
- The trust should continue to prioritise training in end of life care for all staff to enable them to provide appropriate care for patients at the end of their lives.
- The trust should ensure it reviews the National Early Warning Score (NEWS) clinical response guidance to ensure that this is consistent with the sepsis screening proforma.
- The trust should ensure there is a robust system in place for checking suitability of resuscitation equipment.
- The trust should ensure there is sufficient storage available to enable equipment to be appropriately stored and enable safe access to bathrooms on medical wards.
- The trust should ensure there is a system in place in the cardiac catheter laboratory for counting of equipment, which has the potential to be retained in line with national guidance.
- The trust should ensure they review the on call nurse provision within the cardiac catheter laboratory to comply with the working time directive.
- The trust should ensure there is a standard operating procedure for the care of patients requiring non-invasive ventilation outside of the respiratory high dependency unit.

Outstanding practice and areas for improvement

- The trust should ensure staff are familiar with major incident and business continuity plans and their roles within these.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **Regulation 10 (2)(a)** Service users must be treated with dignity and respect ensuring the privacy of the service user **How the provider was not meeting this Regulation:** • The provider did not adhere to the Department of Health guidelines regarding same sex accommodation. During our visit to Medical Admissions Unit (MAU) we found that there was a mixed sex breach.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12 (2)(a)** Care and treatment must be provided in a safe way for service users - assessing the risk to the health and safety of service users of receiving the care or treatment. **How the provider was not meeting this Regulation:** • Staff did not always respond appropriately to the deteriorating patient based on their early warning scores. **Regulation 12 (2)(b)** Care and treatment must be provided in a safe way for service users - doing all that is reasonably practicable to mitigate any such risks **How the provider was not meeting this Regulation:**

This section is primarily information for the provider

Requirement notices

- Staff did not follow trust protocol and national guidance in relation to screening patients for sepsis.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17 (2)(c)** Systems or processes must be established and operated effectively to maintain securely an accurate, complete and a contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided **How the provider was not meeting this Regulation:** • Patient records were not always stored securely on medical wards.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **Regulation 13 (2)** Systems and processes must be established and operated effectively to prevent abuse of service users. **How the regulation was not being met:** The service did not meet the requirement for level three safeguarding training as outlined in the Royal College of Paediatric and Child Health intercollegiate document; Safeguarding Children and Young People: roles and competencies for health care staff.