South Tees Hospitals NHS Foundation Trust

The James Cook University Hospital

Inspection report

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Ratings

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

Our findings

Overall summary of services at The James Cook University Hospital

Requires Improvement 

How we carried out this inspection

We undertook a responsive inspection due to concerns raised with us by system partners. We looked at the quality of the environment and observed how staff were caring for patients.

In Medical care:

- We spoke with ward managers and senior management team for the service.
- We spoke with 37 other members of staff including all grades of medical, allied health professionals, nursing, and administrative personnel.
- We spoke with 13 patients who were using the service.
- We reviewed five full sets of patient records and several partial records.
- We looked at a range of policies, procedures and other documents relating to the running of the service.

In Surgery:

- We spoke with the ward managers and senior management team for the service.
- We spoke with 35 other members of staff including all grades of medical, allied health professionals, nursing, and administrative personnel.
- We spoke with 22 patients who were using the service.
- We reviewed six full sets of patient records.
- We looked at a range of policies, procedures and other documents relating to the running of the service.

After our inspection, we reviewed performance information about the service and information provided to us by the hospital.

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

Summary of findings

Our rating of this location stayed the same. We rated it as requires improvement because:

- The service did not always have enough staff to care for patients and keep them safe. Staff had training in key skills, however compliance rates did not always meet the trust target, and not all medical staff had the appropriate level of safeguarding training. Staff did not consistently assess risks to patients and act on them or keep contemporaneous care records. Patients were not always safely discharged from the hospital. They did not always manage medicines well.

Our findings

- Staff did not always make sure patients had enough to eat and drink, or document pain assessments consistently. Patients were not always discharged to other services appropriately and key information was not always communicated clearly.
- Staff did not always respect patient's privacy and dignity or have the time to interact meaningfully with patients. Staff were not always discreet, and we saw examples of patient's privacy and dignity not being maintained. Patients families were not always involved in their care.

However:

- Staff understood how to protect patients from abuse. The patient's environments were safe, clean, and well maintained.
- Staff gave patients pain relief when they needed it. Staff worked well together for the benefit of patients across multi-disciplinary teams. Key services were available seven days a week.
- Staff treated patients with compassion and kindness.

Medical care (including older people's care)

Requires Improvement ↓

Our rating of Medical Care went down. We rated it as requires improvement because:

- The service did not always have enough staff to care for patients and keep them safe. Staff had training in key skills, however compliance rates did not always meet the trust target. Staff did not consistently assess risks to patients and act on them or keep contemporaneous care records. Patients were not always safely discharged from the hospital. They did not always manage medicines well.
- Staff did not always make sure patients had enough to eat and drink, or document pain assessments consistently. Patients were not always discharged to other services appropriately and key information was not always communicated clearly.
- Staff did not always respect patient's privacy and dignity or have the time to interact meaningfully with patients. Staff were not always discreet, and we saw examples of patient's privacy and dignity not being maintained. Patients families were not always involved in their care.

However:

- Staff understood how to protect patients from abuse.
- Staff gave patients pain relief when they needed it. Staff worked well together for the benefit of patients across multi-disciplinary teams. Key services were available seven days a week.
- Staff treated patients with compassion and kindness.

Is the service safe?

Requires Improvement →←

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

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it, however training did not reach the trust's target.

Nursing staff received training specific for their role on how to recognise and report abuse, however the trust target of 90% was not met for two safeguarding training modules. Safeguarding adults level two training and safeguarding children level two training was just below the trust target of 90% at 89.59% and 89.44%, giving an overall compliance of 89.53% for nursing staff.

Medical staff received training specific for their role on how to recognise and report abuse, however the trust target of 90% was not met for either safeguarding training module. Safeguarding adults level two training compliance and safeguarding children level two training was below the trust target of 90% at 75.63% for both modules, giving an overall compliance of 75.63% for medical staff.

Medical care (including older people's care)

The service had a safeguarding policy that was version controlled, in date and had a review date of February 2025. It included information to support staff to understand safeguarding and appendices to support them to raise a concern and document any related findings.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff were aware of safeguarding procedures, how to make referrals and access advice; there were safeguarding leads throughout wards and a head of safeguarding in place. Ward staff knew where safeguarding policies were and how to access them. They used online forms to refer safeguarding notifications or queries to the local authority multi-agency safeguarding hub.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. We saw examples in patient records where safeguarding concerns had been escalated in line with local procedures.

Assessing and responding to patient risk

Staff did not consistently assess and manage risks to patients. Staff did not always undertake appropriate assessment or provide support to meet patient's nutrition and hydration needs. Patient risk assessments were not always completed contemporaneously, and the care provided to mitigate risk was not always in line with the assessment. Patients were not always discharged safely or in a timely way.

Staff did not always complete risk assessments for each patient on admission or review this regularly, including after any incident. Staff did not always know about and dealt with specific risk issues.

We reviewed five full sets of patient notes across medical wards and saw gaps in recording patient assessments across wards, including gaps in pressure care risk assessments, pain assessments, Malnutrition Universal Screening Tool (MUST) scores, nutrition and hydration charts, intentional rounding records and repositioning. We also reviewed sections of patients records when looking at examples of poor care we had observed; this was in addition to the five full sets of records.

We looked at seven DNACPR documents across both core services we inspected. We saw that most were appropriately completed, with five of the seven showing sufficient information to provide assurances that decisions had been discussed with the patient or their family. However, in two cases, the document was not of good quality, with one stating the decision had not been discussed with the patient or their family and a second was completed outside the trust and was an old incomplete DNACPR document, referring to an older one completed in 2020, which was not in the patient's records. There was insufficient information on this document to provide assurance to the trust that the correct process had been followed, and the staff had not completed a new document.

Intentional rounding is a systematic and routine check to ensure that each patient is comfortable, has adequate nutrition and hydration and is treated with dignity and respect. We saw gaps in recording on patient records including intentional rounding records, the repositioning of patients and body maps.

We found that some intentional rounding sheets were completed at the end of each day and we were not assured that staff completed them contemporaneously. There was no recording of interactions with patients about the care and support that staff may provide. For example, during patient turns for pressure care, there was no record of which side patients were moved to and what time it was last completed. This meant staff could not be sure what the next turn should be, which could impact on patient's pressure damage and recovery.

Medical care (including older people's care)

We observed meal services throughout the inspection which included breakfast, lunch, and dinner. Patients who were able to eat independently did so, however we saw that for those needing assistance either with positioning or feeding, this was not always offered, or offered too late, which meant staff were not able to meet individual patient needs. This increased the potential risk to patients being unable to eat meals or drinks.

Staff did not always adjust patient beds to be fully upright to assist with their comfort and swallowing at mealtimes. As the trust had visiting restrictions in place during our inspection (which was in line with national guidance at the time of the inspection) only a few patients had one short-term visitor to assist them if required. This meant many patients were at a higher risk of choking and this was not recognised by staff on the wards.

MUST records were not always completed in line with guidance. Patient weight should be recorded on admission and then at a minimum, weekly thereafter; we saw gaps in recording weights.

Between 01 July 2021 and 31 January 2022, the trust reported 15 serious incidents of pressure ulcers meeting the criteria of a serious incident in the acute hospital setting. All incidents identified lapses in care including the following areas; lack of appropriate or timely turning, poor or no completion of body maps, concerns with completion of MUST tools, wound deterioration, staff not following specialist advice or skin bundle. We saw similar concerns in the risk assessments and records we viewed during the inspection.

We checked the records of a patient whose repositioning chart was not up to date. Concerns had been documented in their notes about eating and drinking, and to encourage oral intake, however their fluid balance chart was not always complete.

The service did not have a specific process for medical patients who were being cared for on other wards (outlying patients). The trust had agreed principles for caring for these patients and could identify them as part of their winter pressures position; this information included that there was appropriate medical consultant oversight from a medical speciality. However, the process was not robust and staff on surgical wards told us they had been asked to take patients they felt they could not care for safely.

Staff we spoke with told us about inappropriate patient moves, including a patient moved to ward 26 from another medical ward out of hours. The patient's assessments showed a deterioration in their condition and this had not been escalated to medical staff prior to the move, even though the patient was being moved to a nurse led ward. Ward staff called the medical registrar on call immediately who attended, but no doctor was based on the ward. This meant appropriate medical cover may not always available to patients when they were transferred to alternative wards.

We spoke to staff on the stroke ward who frequently had beds filled with medical care patients who had been relocated from other wards. Staff told us that the acuity and conditions these patients presented with varied and this impacted on their ability to care for all patients on the ward due to the skill mix and numbers of staff. Not all risk assessments were available in the pathway documents for medical patients residing on alternative wards which meant that staff had to find earlier pathway documentation to familiarise themselves with the patient's care needs, which also impacted on the time they had available to care for patients.

We checked the thrombolysis emergency bag on the stroke ward; it did not have a daily checklist in place to ensure that medicines and consumables were readily available in an emergency. We were unclear how staff were assured the correct emergency equipment was always available. This was a risk to patients because there may be equipment or medicines required in a lifesaving situation that were not accessible. This was not best practice.

Medical care (including older people's care)

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Early warning scores were used to monitor patients and detect deterioration and patients who required escalation or additional care or treatment.

The service used an electronic national early warning score (NEWS2) system; the system required staff to login to electronic devices to monitor a patients NEWS2 score. NEWS2 information was not displayed on electronic patient information boards. If patients deteriorated a dedicated support team contacted the ward to highlight the deterioration on the system to ensure action was taken to address this by ward staff. Staff could also use their handheld electronic devices to monitor patient NEWS2 scores.

The trust had a dedicated critical care outreach team; staff knew the process to escalate concerns for deteriorating patients with the team and could give examples of when this had happened. We saw in patient records that the team attended promptly.

Staff had access to recognised tools to complete risk assessments. Staff knew about and dealt with specific risk issues. Where an indicator of sepsis was identified, the trust followed the Sepsis Six model to provide testing and treatment to patients within one hour. We reviewed the trust sepsis assessment form and noted that the trust used an SBAR approach (situation, background, assessment, and situation) to review patients following an acute episode of deterioration.

There was a recognition and management of the deteriorating patient policy, which included sepsis. Staff we spoke with were clear about signs and symptoms of deteriorating patients and gave examples of when and how they would escalate a concern.

The trust was implementing a new discharge team at the time of the inspection and during the inspection we spoke with them. We heard that the team had been in place for approximately four weeks and was rolling out across medical and surgical wards in a phased approach. Although the team were embedding, not all wards had input from this team, including admission wards, which did not have embedded systems in place to always facilitate safe discharge, and this was reflected in recent incidents and safeguarding referrals we reviewed. One of the six wards we visited during the inspection had implemented the new process. The trust provided a roll out plan, where all medical wards were planned to have the process rolled out by March 2022. This meant that the new discharge processes were not yet implemented across the medical wards, however there were plans to roll this out quickly.

In the January 2022 care plan and risk assessment audit, four wards did not meet the compliance target for nursing intervention to achieve safe and effective discharge to be recorded within the discharge care plan; this meant patients were at risk of unsafe discharge and we saw examples of this in the trust's incidents.

We reviewed the trust’s discharge data for patients who were identified as fit for discharge in January 2022. On the six wards we inspected there were 162 patients in total who were identified as discharge ready but were not discharged. The number of patients who had not been discharged when they were ready had improved; we saw that there were 204 patients in November 2021 and 176 in December 2021. Delays included differing factors including system issues in securing social care requirements and care packages. Delays in discharge had an impact on the service's flow and allocating beds to patients waiting for acute care, and impacted patients who no longer needed acute care but were unable to be discharged.

Medical care (including older people's care)

Staff told us if a patient's discharge was planned for later that day, they would ring their care home to ask if there was a cut off time they must arrive by. Staff told us they would not discharge patients into community hospitals after 7pm. Staff could transfer patients awaiting discharge to short stay wards for no more than 72 hours and complete a full handover of their needs and background. Staff would send patients with no memory impairments to the discharge lounge if they felt this was suitable.

We reviewed the trust's information on the time discharges took place on medical wards. Between 01 February 2022 and 14 February 2022, on average only 50% of discharges took place by five pm, meaning that of the 681 discharges in that two-week period, 341 took place after 5pm. This meant that patients who were ready were not always discharged in a timely way and this impacted flow across the hospital. Although ward staff told us they would not discharge patients into community hospitals after 7pm, the number of discharges that took place after 5pm meant that there was not a lot of time to discharge the remaining patients.

From 01 February 2022 to 14 February 2022, 11% of patients on medical wards did not meet the criteria to reside; this was a total number of 710 out of 6255 patients. This meant they no longer needed hospital care but remained in hospital.

We reviewed the trust's readmission rate across the six wards we inspected which showed a readmission rate of 4.55%. This had declined from the readmission rates in November 2021 of 3% and December 2021 of 2.79. In January 2022 a total of 29 patients had been readmitted within 72 hours of discharge. This had declined from 22 patients in November 2021 and 19 patients in December 2021, even though the total number of discharges had decreased from 733 in November 2021 to 638 in January.

We spoke with the new discharge team during the inspection who were working to build visibility across the division and could see how the systems in place would support wards with safe discharge going forwards, however they needed time to embed in the service.

The service had a falls prevention and management policy that was version controlled, in date and had a review date of February 2024. It included information to support staff to understand falls risks, mitigating actions and assessments. However, during the inspection we saw gaps in the recording of falls risk assessments on the wards we visited. This meant risks to patients were not always appropriately assessed and mitigated.

We saw falls prevention displays on all wards we visited to support staff to recognise falls risks.

The service had enhanced observation guidance to support staff to maintain the safety of patients and themselves from identified risks. The guidance was version controlled, in date and due for review in November 2023. It included appendices to support staff decision making and to support effective documentation of observations and decision making. The guidance provided clear roles and responsibilities and included specific training required by staff groups, including security staff, to be competent to be utilised in enhanced observation situations.

Following the inspection, we issued the trust with a section 29A warning notice because they did not have effective systems to ensure patient risk assessments were completed contemporaneously and the care provided to mitigate risk was in line with the assessment and they did not have effective systems to ensure patient discharges were appropriate, safe and that information was shared with partner organisations effectively. The trust responded to the notice with immediate actions they had taken and longer-term actions they had planned to address the concerns.

Immediate actions relating to patient risk assessments included:

- Intentional rounding and body mapping documentation was reviewed and key assessment documentation has been placed at the bottom of the patient's bed to encourage completion.
- An intentional rounding audit tool had been developed and daily audits commenced.
- The trust reviewed their educational delivery plan with a focus on the assessment and standardising a structured risk assessment of a patient's fundamental care requirements to provide accurate evidence of interactions and interventions undertaken.
- A specific agenda item on sharing learning from incidents was added to the weekly matrons and ward managers meeting and the weekly safety and quality briefings were refocused to improve shared learning from incidents.

Immediate actions relating to safe discharges included:

- The trust completed the implementation of the Transfer of Care teams to support all wards.
- The trust had reinforced the use of the discharge checklist and medication checklist and ensured stock of discharge package (posters, leaflets, action cards) on wards was sufficient.
- The trust started work to improve their triangulation of discharge information and have produced a data pack for wards and discharge board which includes learning from discharge related incidents.
- Staff have attended ward manager and matron meetings to raise awareness of the support and resources available to staff.
- Discharge lead staff were included in clinical assurance ward rounds and key discharge items were included in the reviews.
- The Transfer of Care Hub have started a pilot on Wards 29 and 34 to provide telephone follow up to high risk patients after they are discharged from hospital.

Nurse staffing

The service did not have enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix.

The service did not always have enough nursing and support staff to keep patients safe.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance, however the planned staffing numbers was not met on all wards.

We reviewed the trusts average fill rates across the medical wards which was reported in December 2021 and saw that the seven out of the 10 medical wards had struggled to fill registered nursing shifts, particularly on night shift. One ward had faced staffing challenges on night shift. Across the same wards, the service had a better fill rate for health care assistant staff, however one ward had poorer fill rates than the other wards for both staff groups on both day shifts and night shifts.

On one ward we viewed the unfilled health care assistant shift data for 17 January to 06 February 2022; 14 out of 21 day shifts (66.6%) and nine out of 21 night shifts (42.9%) met the health care assistant planned number.

On the same ward, we viewed the unfilled registered nurse shift data for 17 January to 06 February 2022; two out of 21 day shifts (9.5%) and five out of 21 night shifts (23.8%) met the registered nurse staffing planned number. There were two night shifts where there was two registered nursing staff on the ward, out of a planned staffing of five.

There were six day shifts out of 21 (28.5%) and 11 night shifts out of 21 (52%) where both registered nurse and health care assistant staffing numbers was below the planned number. This meant that there were not always enough staff on ward one to meet the needs of patients.

The trust's vacancy rate for registered nurses was reported as 6.89% in the December 2021 board papers, and we saw there were 11.8 vacancies in medical care wards. The whole time equivalent (WTE) worked was below the establishment. This showed that there were less WTE hours worked that the wards were established for, and was reflected in the fill rate of shifts, where we saw gaps.

The trust's vacancy rate for support staff was reported as 19.38 % in the December 2021 board papers, however we saw that in medical care, support staffing whole time equivalent (WTE) worked was above the establishment by 63.67 WTE. This showed that there were more WTE hours worked that the wards were established for, however we still saw gaps in the fill rate on some wards for support staff.

The service had higher sickness rates than the trust target. We reviewed the trusts staff sickness absence for the nursing and support staff in medical care; it was 5.09% for registered nursing staff and 7.82% for support staff. The trusts sickness target rate was 3.90% which was exceeded for both staff groups; managers told us this was often due to COVID-19 related sickness.

Staff told us skill mix was hard to plan for as they had many junior staff. The trust used the safe care acuity tool to secure safe rosters and review skill mix which was reviewed twice yearly.

Staff told us that shortages were reported as red flag incidents and discussed with senior management. Ward managers we spoke with told us they escalated staffing concerns when they could not meet the planned numbers.

The trust had a palliative care team that covered the acute hospital and community services. There were 1.02 WTE band six nurse vacancies trust wide. This meant there was not always enough palliative care nursing cover to match the planned level.

The service had a hyper acute stroke unit (HASU). Although there were challenges across the trust in meeting the required staff numbers in medical wards, the service provided staffing figures for the HASU where we saw they met the required two to one patient to staff ratio on every shift between 01 November 2021 and 31 January 2022. The trust told us that across the stroke ward, which included the HASU, they designed staffing to allow flexible use of the workforce depending on occupancy and the acuity of patients which enabled staff to retain their clinical skills. This meant there were enough nurses with the correct skills to meet the staffing guidelines.

On one ward, staff described caring for patients who were significantly more poorly and with greater needs than in the previous 12 months. They reported low morale and high turnover, and staff with skills that did not meet increasing demand. In this area, staff described working over their hours, yet struggling to meet the needs of their patients.

We observed a bed meeting where matrons and senior staff discussed staffing and acuity across the wards on both hospital sites. They discussed expected admissions and discharges, wards with closed bays and newly cleaned bays that

had previously held patients undergoing screening or isolation following COVID-19 infection. Several bays and specific beds were identified as clean or requiring deep cleaning and patients were moved between bays. The ward manager could request additional staffing levels daily according to the needs of patients. However, they explained that staff were not always provided.

The trust told us their staffing model followed national guidance on staffing for winter preparedness in 2021, and they took action when staffing numbers were low based on the safest staffing they could achieve across all areas. However, these staffing levels did not always meet the needs of the patients receiving care on wards.

On inspection we observed staff working hard to complete tasks for patients; however, we were not assured that staff had the time to always provide person centred care that met individual patient needs.

Medical staffing

The service did not always have enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment, however the risk was mitigated by over establishing cover at other grades.

The service did not always have enough specialist medical staff to match the planned number. Medical staffing vacancies varied across the medical wards. We saw there were 10 whole time equivalent (WTE) consultant vacant posts across medical wards, 8 WTE registrar vacancies and 2 WTE trainee posts. However, there were also posts that were over established across medical wards, which often coincided with vacant posts, for example, there were three WTE equivalent consultant vacancies in acute medical wards and five additional registrar posts and one additional trainee post. This meant that although the acute medical wards had reduced senior clinical decision makers in post, the trust had mitigated some of the risk by providing additional registrar and trainee cover across these wards.

Sickness rates for medical staff were low. The trust had low sickness rates among medical staff; in January 2022 the sickness rate was 0.87% which was below the trust target of 3.90%.

The service always had a consultant on call during evenings and weekends.

The trust had a palliative care team that covered the acute hospital and community services. There was 1.05 consultant WTE vacancies trust wide. There were no speciality doctor vacancies. This meant there was not always enough palliative care consultant cover to match the planned level.

The service had a good skill mix of medical staff on each shift and reviewed this regularly. Senior clinicians and consultants we spoke with said there was no shortage of junior doctors on the wards. We saw sufficient numbers of medical staff on the wards we visited to meet the needs of patients.

Records

Staff did not always keep detailed records of patients' care and treatment. Not all records were clear, contemporaneous, up-to-date, or stored securely, however they were easily available to all staff providing care.

Patient notes were not always comprehensive; however, all staff could access them easily. We reviewed five full sets of patient notes and sections of patients records when looking at examples of poor care we had observed across the medical wards inspected. We saw gaps in recording in patients records including intentional rounding records, the repositioning of patients, body maps and food and fluid balance charts. We found that intentional rounding sheets were sometimes completed at the end of each day and were not assured that staff completed them contemporaneously.

Medical care (including older people's care)

We asked the trust to provide recent records audits where they had checked the completion of care records and the implementation of care plans and risk assessments. We reviewed the January 2022 audit data for 13 medical care wards; we saw that the areas of poor compliance (less than 80%) correlated with the concerns we saw during the inspection. This included recording of safe discharge planning, nursing assessment of patient needs, appropriate actions implemented as a result of a MUST score, and screening for drinking risk levels. We saw particularly poor compliance levels in the audit data for on two wards relating to nursing assessment and recording of discharge planning intervention.

The service had completed an audit of 15 case notes per ward across medical wards in January 2022. The audit checked that records were completed appropriately by clinicians, for example that entries were dated, timed, signed, legible and contained patient identifiers. There were three wards (six, 11 and 28) that did not meet the expected compliance for patient identifiable details on each page, with ward six showing only 7% compliance. During the inspection, we reviewed full and partial sets of records and saw evidence of similar concerns. There was also poor compliance in three wards (11, 12 and 28) in identifying which staff member had written each entry and poor compliance in four wards (11, 12, 28 and 37) of recording professional registration numbers for each staff member where it was required; this was particularly poor in ward 28 where there was a 13% compliance across the 15 records that were reviewed. This meant that records were not always complete.

The service had an action plan to increase the standards of compliance in record keeping for quarter four 2021-2022. There were seven actions; one was completed, five were in progress and one was outstanding. There was no evidence in the action plan how this was monitored. For example, one action was outstanding but there was no commentary in the action plan to identify the issue, or actions being taken, and the completed action had no information about the outcome or next steps. This meant that it was unclear how the action plan was being monitored and managed.

We saw a whiteboard showing patients' 'do not resuscitate' status. This was not up to date as it did not match the records we viewed during the inspection, although we were told (and observed) that this board was updated with patient information on the day we visited.

Records were not always stored securely. We saw examples on all wards we visited that patient notes trolleys were not routinely locked and medical notes were stored underneath trolleys on shelves. Intentional rounding notes on wards we visited were stored on clipboards outside of each bay, or in folders not stored securely in the bay.

When patients transferred to a new team, there were no delays in staff accessing their records; paper records were transferred with patients who moved wards.

Medicines

The service did not always use systems and processes to safely prescribe, administer, record and store medicines. However, pharmacists attended wards to review medicines charts

Staff did not always follow systems and processes to prescribe and administer medicines safely.

We looked at 12 medicine charts across the four wards we visited and found prescribing to not be in with the trust's medicine policy. For example, we found on 11 occasions prescriptions charts were amended after the initial writing, it was not clear when the changes were made or by whom. Dates were not always recorded at time of prescribing, stop dates and indications were not recorded for antibiotics, and we saw incorrect use of units for example mcg rather than milligrams and insulin prescribed in only numbers not words. This was not in line with the provider's medicines policy.

Medical care (including older people's care)

Medicines were often prescribed with multiple routes of administration which meant it was not clear which route the medicine had been administered and no additional notes were recorded to ensure clarity of administration.

We found people did not always receive their medicines as prescribed. In the 12 medicine charts we looked at we found 18 blank doses with no explanation of why the medicines had been omitted. These medicines included critical medicines such as insulin and parkinson's medication which placed people at risk of experiencing adverse effects to their health and wellbeing.

The data provided to us by the trust supported our findings on inspection, for example in January on Ward 1 the trust recorded 4% of omitted doses with 3.7% of these medicines coming under the critical medicines category.

We saw one patient example whose notes stated clearly that their parkinson's medication must be delivered on time. On admission to the ward, their oral medication had not been prescribed for several days as they were nil by mouth and an alternative had not been provided. This had been raised as a concern by the patient's family. The patient's pain assessment chart was not fully completed on two consecutive days in their admission.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines.

Pharmacy staff attended wards to review medicine charts and we could see evidence of pharmacist review on the wards. Pharmacy technicians were available on wards for any queries and could be contacted by ward staff.

Ward staff would go to the pharmacy if patients needed any urgent medications or prescriptions that were not in stock on the wards, for example for patients with parkinson's disease.

Staff did not always complete medicines records accurately or keep them up-to-date. We saw missed doses and blank entries relating to patient medications. This included missed regular medications, medicines reconciliation not completed in a timely way in line with trust processes.

Staff followed national practice to check patients had the correct medicines when they were admitted or they moved between services, however they were not always reviewed in a timely way.

In the 12 charts we looked at, all but one had a medicine reconciliation documented. We found two medicines reconciliation had taken over 48 hours to complete despite this being a weekday admission and a weekend admission which took over 72 hours to complete. This was not in line with the trust's medicine policy.

Data supplied to us supported our findings on inspection with only 53% of medicines reconciliation taking place within 24 hours in January 2022 on ward one and ward 10.

Medical care wards stocked all frequently prescribed insulins for patients with diabetes. Staff said there were occasional delays to source less commonly used insulins from the pharmacist. Ward staff had workarounds where they would ring vascular wards who tended to stock more types of insulin. A senior sister said they would ensure insulin scripts were done as a priority upon starting their shift. We saw insulin chart information on the staff office wall of ward 26 detailing the five different types of insulin and when to use them. Ward managers told us they could access neighbouring ward's stock to borrow suitable medications if they were not commonly used on a specific ward.

Medical care (including older people's care)

Ward staff on one ward told us there had been issues with ward staff transferring patients without their medications from home. We saw a pharmacy focus reminder notice about this issue to ward staff from November 2021 from the medicines management technician. This had two step instructions and reminded staff how medication transfer helped patients. Despite this issue patient feedback for the ward in December 2021 rated medicines and pain management 10 out of a possible 10. However, the ward only had two respondents that month.

Incidents

The service did not always manage patient safety incidents well. Managers did not always investigate incidents thoroughly and share lessons learned. However, staff recognised and reported incidents and near misses.

Prior to our inspection, the trust's incident reporting system showed an increase in the numbers of serious incidents, and other, lower grades of incident where patients had come to harm. We could see similar themes emerging around nutrition and hydration (for example, patients losing a lot of weight unexpectedly while in hospital, or reporting not being fed for several days) and inappropriate discharge (for example, patients going home without important medicines, or a care package in place that would support their needs). Other organisations also voiced their concerns about the types and numbers of incidents the trust had reported. We saw that the frequency of this type of incident had increased over recent months, and this was an important factor in our decision to inspect the trust when we did.

Despite asking the trust for evidence of learning and changes in practice as a result of serious incidents, we saw the same types of incident recurred. We were therefore not assured that the trust was learning from its incidents and had strong systems in place to ensure that this happened.

However, staff we spoke to knew what incidents to report and how to report them.

Is the service effective?

Requires Improvement ↓

Our rating of effective went down. We rated it as requires improvement.

Nutrition and hydration

Staff did not support patients to meet their nutrition and hydration needs. They used special feeding and hydration techniques when necessary, however assessments were not always completed in line with guidelines.

Staff did not always make sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs, and they did not always support patients to maintain their nutrition and hydration.

We observed patients requiring additional support with their meals were not always provided with this. We saw mealtimes were not protected and observed patients being seen by the multi-disciplinary staff during lunch time.

We observed patients whose meals were left at the end of their bed, out of reach and they were not made available to them in a timely way.

We observed patients at mealtimes during the inspection across all wards we visited and did not see consistent support from staff when it was required. Staff did not always adjust patient beds to be fully upright to help with their swallowing.

Medical care (including older people's care)

Most patients were not sat up in chairs to eat meals, which increased the risk to patients of choking or scalding with hot drinks. As the trust had visiting restrictions in place during our inspection only a few patients had one short-term visitor to help them if needed. This was a risk as patients were not always able to ensure they maintained their own nutrition and hydration.

We observed one six bedded bay at breakfast time on 09 February 2022. Three in six patients had breakfast on their tables, but only one patient was eating any. Staff asked one patient who wasn't eating but had breakfast in front of them why; it wasn't to their taste. Staff did not ask the other patient with food if he needed assistance as he wasn't eating.

We observed a patient in a bay receiving food at lunchtime. Their notes said that they were concerned about eating because they felt it was difficult to swallow. Their records stated they needed encouragement to eat. We observed a Therapeutic Care Support Worker (TCSW) returning the patient's food to housekeeping staff, stating that the patient didn't want to eat because they couldn't swallow. They were told to return the food, as "there is nothing else." The TCSW returned the food to the patient, mashed the food into smaller lumps and left the patient. Twenty minutes later no members of staff had entered the bay, and the patient had not eaten any food. The TCSW returned, encouraged the patient to take a sip of water, and left again, having not encouraged them to eat. Five minutes later the TCSW returned and removed their food. We checked the patient's food chart, which said they had received and eaten a teaspoon of soup. They had not been served soup and had not eaten anything. Their evening meal was also observed, and was wrongly recorded, both what the patient had been served, and what they had eaten.

Staff did not always make sure patients could access food and drinks and support was not always given where this had been highlighted as being required by the multi- disciplinary team (MDT).

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition, however it was not always completed fully or in a timely way.

Staff did not fully and accurately completed patients' fluid and nutrition charts where needed. The trust used a combination of two nationally recognised screening tools to monitor a patient's nutritional status. Across the medical care service we saw these tools were often not completed.

We reviewed the records of a patient who was artificially fed for several weeks; appropriate screening and monitoring of their weight and oral intake had not been completed.

Specialist support from staff such as dietitians and speech and language therapists were available for patients who needed it and we saw patients requiring this were frequently reviewed. Where modified diets or fluid were required, assessments of a patient's requirements were detailed above their beds. Patients who were artificially fed had feeding plans in place which were kept in their notes.

We observed examples where patients assessed as requiring thickened fluids had no access to any alternatives to water which may have encouraged them to maintain their hydration.

We observed patients who had feeding tubes that were placed through their nose had the position of the tubes checked daily using recognised techniques which was recorded in a care plan. However, care plans also stated the length of the tube at the nose which should be checked regularly throughout the day and we saw this was not always completed. We saw bottles of opened enteral feed left hanging with no record of when the bottle was opened.

The trust had two nutrition specialist nurses who could support patients receiving artificial nutrition support, however some staff told us they did not know about this resource. This meant that patients may not receive specialist support when it was needed.

The service had implemented a standard operating procedure (SOP) for patients who were nil by mouth. This was approved after the onsite inspection, so we did not see it used on the wards we inspected. The SOP provided additional information or links to other policies that the service had in place to manage patients who were nil by mouth.

We also observed areas of good practice where patients were encouraged to drink, and nutrition support was tailored to meet patients individual needs.

Following the inspection, we issued the trust with a section 29A warning notice because they did not have effective systems in place to ensure patients' nutrition and hydration requirements were assessed and provided in line with their care needs. The trust responded to the notice with immediate actions they had taken and longer-term actions they had planned to address the concerns. Immediate actions included:

- The trust held a priority nutrition and hydration steering group meeting and a Malnutrition Universal Screening Tool (MUST) compliance audit was undertaken on every adult patient within bed holding wards
- The trust prioritised nutrition and hydration and MUST assessments in their plans for electronic patient assessment records and have plans in place to roll this out and provide education and training to staff at pace.
- They recognised strengthened support around protected mealtimes was required and they established a roster to identify non ward based clinical staff to support mealtimes in highlighted priority wards.
- The visitors policy for general patients was immediately reviewed, and in line with easing of restrictions, a managed introduction of visitors for a specified length of time was supported.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain. However, they did not always consistently record pain assessments or give pain relief in a timely way.

Staff assessed patients' pain using a recognised tool. FLACC is a behavioural pain assessment scale used for nonverbal or preverbal patients who are unable to self-report their level of pain. Pain is assessed through observation of 5 categories including face, legs, activity, cry, and consolability. Patients who needed pain medication on an as required basis (PRN) used their call bell to request it. All staff we asked knew about pain assessments and how to score patients level of pain.

However, pain assessment charts were not consistently completed across all wards and did not reflect the use of pain tools available to support patients who were not able to verbalise their pain.

Staff used a patient tracker system which prompted them to complete pain assessments which may prompt more frequent pain relief. For example, a nurse told us if a patient's national early warning score (NEWS) was 0 but they scored high on a pain assessment then staff would review their medications.

Patients received pain relief soon after requesting it. We reviewed two adult pain assessment charts staff had completed for patients after a pain-related nursing intervention. We saw pain relief was administered when the patient's pain score increased from zero to four out of ten on assessment.

All staff we asked knew about the trust's specialist pain management team. They knew how to contact them either by bleep, formal electronic referrals or ringing them for advice. The team could advise doctors, and some members were trained medication prescribers. Staff told us the team were responsive and readily available. Ward staff we asked said the team normally responded in a few hours of referral. We heard the team were very keen for other supernumerary staff or those on secondment to shadow their work and learn more about pain care and treatment options. The team maintained a priority list of patients to visit but ward staff could stress the urgency or request remote pain advice until the team were able to arrive.

Staff did not always prescribe, administer and record pain relief accurately. The service had completed an audit of 15 case notes per ward across medical wards in January 2022. The audit checked that pain assessment charts were present in patient records. Average compliance across medical wards was 76.2%. Three wards, two, six and 37, had a compliance of less than 30%, at 29%, 13% and 10%. This was a concern as it meant that there was no record in patient notes that patient's pain had been assessed appropriately or in a timely way.

The trust had an action plan to address compliance in completing pain assessments. There were six actions, five were in progress and one had been completed. There was no evidence in the action plan that it was monitored. Only two of the six actions had due date, and there was no record of updates or progress against actions on the document. For example, one action was completed, however there was no information about the outcome or next steps. This meant that it was unclear how the action plan was being monitored and managed.

Competent staff

The service made sure staff were competent for their roles. Managers did not always appraise staff work performance to provide support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. However, wards were not always able to maintain the correct skill mix to care for their patients; this was due to staffing numbers, high turnover and moves across the hospital to maintain safe levels of staffing.

Managers supported medical staff to develop through yearly, constructive appraisals of their work. The trust target for appraisals was 80%. Medical staff appraisal compliance was above the trust target at 85.19%.

Managers supported nursing staff, however yearly, constructive appraisals of their work were not always completed. Nursing and support staff appraisals did not meet the target of 80% with an average compliance of 75.21% for registered nurses 74.5% for support staff. This had declined from the last inspection where overall compliance for completion of appraisals was 79.3% for nursing staff and above the 80% target for support staff. Although the target was almost met, nursing and support staff appraisal compliance had declined and was below the trust target.

Managers identified any training needs their staff had however they could not always give them the time and opportunity to develop their skills and knowledge in working hours. Staff told us they often completed training on days off or overtime.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Staff told us their one-to-one meetings were occasionally missed due to wards being short-staffed or under other pressures. Line and ward managers completed annual appraisals including any learning and developments opportunities with their staff and we saw these scheduled on noticeboards.

The trust had recently updated their mandatory training e-learning system which had improved compliance on some wards. We heard ward staff had access to daily safeguarding training from 2pm -2.30pm.

Managers made sure staff received any specialist training for their role. We spoke to ward managers who told us that if staff needed specific skills, such as competencies to care for medical devices, they would discuss the care requirements and staff familiarisation before assigning staff to care for these patients; where staff did not feel they had the skills to carry out a task, managers would support them to gain the skills through training and clinical support.

The service had security guards who assisted ward staff with security services, welfare checks, staff escorts and supporting enhanced patient observations with advice from clinical teams. Their training included physical intervention and restraint, use of force and level 2 safeguarding training; 100% of security guards had completed all mandatory training modules.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care. However, discharge processes were not always robust.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care.

Service staff had access to multidisciplinary team members on all wards we visited. We attended a discharge planning meeting on ward 28 with medical staff of different grades, a range of therapists and allied health professionals, nursing staff and a discharge co-ordinator. On ward 26 for neurological rehabilitation patients we saw timetabled group activities ran by various therapist staff.

Staff worked across health care disciplines and with other agencies when required to care for patients. All staff we asked knew how to contact the pharmacy 24 hours a day seven days a week. The service had an on-call pharmacy at weekends and out of hours. Ward staff could phone to ask any questions about medications, for example, if staff could not locate a specific medicine in the drug cupboard, pharmacy had access to a wider system to locate medicines. The hospital had an emergency pharmacy cupboard nearby so ward staff would call security who had the key. Staff prioritised finding, prescribing and administering time critical medicines.

Ward staff could start patients who needed extra nutrition on supplements while they were in hospital, and they were continued regularly on home or residential visits. The service had wound care bags available containing dressings with a wound care plan which community staff such as district nurses could replicate and review. Ward staff could also provide catheter care disposables for patients upon discharge. A physiotherapist told us they referred patients to DNs for all relevant information and included contact numbers. Their community physiotherapy team could carry out planned and unplanned assessment needs and had an on-call service available at all times for any emergency respiratory relief patients. Community physiotherapy staff assessed non-respiratory patients within three days.

Medical care (including older people's care)

We observed a discharge planning team meeting during the inspection; they were held on wards at different frequencies depending on the speciality. Staff discussed every patient in detail, including the pain levels patients reported and their assessment results, how staff should manage in response, care packages and social support needed; for example staff referred one patient with no fixed abode to the complex discharge team and the local authority's duty to refer service. Staff considered the impact on their partners and family relatives if a patient was discharged home.

Staff told us they sent a discharge letter with any patients leaving hospital. This had a specific section for the GP's information which included any changes to patient's regular medications for review after 28 days. We looked at a discharge pack of information to include for patients with different needs and staff input. For example, swallowing information was completed by the Speech and language therapists and nutrition by nurses.

Staff told us most discharges were carefully planned in advance. Staff considered a patient's home environment before discharge and any ongoing support they needed. Staff made referrals to services outside the hospital and we heard about these arrangements at a discharge planning meeting we observed. Ward 26 had a patient information display which summarised what patients should expect from staff before discharge.

However, we spoke to two patients about discharge planning and they told us no information had been shared with them. We saw their discharge planning was in place, but it had not been clearly communicated to the patients.

Between July 2021 and January 2022, we saw the trust had reported incidents on the on the National Reporting and Learning System (NRLS) and Strategic Executive Information System (STEIS) which highlighted poor discharge practices. CQC also received information relating to patients who had poor discharges in January and February 2022, including medication and equipment not being in place and poor communication. This meant that although there were systems in place, we were not assured that they were robust to provide good quality discharge information.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff did not always support patients to make informed decisions about their care and treatment. They did not always follow national guidance to gain patients' consent. Not all staff knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health and assessments were not documented in line with legislation. Staff used measures that limit patients' liberty appropriately.

Staff did not always understand the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act and Mental Capacity Act 2005

Staff did not always understand how and when to assess whether a patient had the capacity to make decisions about their care.

Across the wards we visited, capacity assessments, best interest decisions and consent to care and treatment was not recorded appropriately. We saw many patients in bed with bed sides in situ and did not see documentation to evidence that this was with patient consent, or at their request, in their medical or nursing notes.

Staff did not consistently recognise and respond to concerns in relation to mental capacity. This was a risk as we were not assured that care and treatment was always being delivered in line with guidelines and legislation and we saw examples of poor record keeping relating to consent and capacity across medical wards. This meant patients did not always receive appropriate care in line with their wishes.

Medical care (including older people's care)

We observed inconsistencies and conflicting information in patient records relating to some patient's cognition and capacity, including the recording of relevant health conditions such as patients living with dementia.

We saw several examples in patient records where capacity was not recorded in line with the Mental Capacity Act (MCA). We saw records which indicated patient's lacked capacity, however there were missing or incomplete capacity assessments.

We observed a patient on one ward attempting to leave to use the wider hospital facilities, however they were stopped by a staff member; they were not subject to a Deprivation of Liberty Safeguard (DoLS) to restrict their liberty and the patient had no capacity concerns documented in their patient record. Approximately 30 minutes later, the patient was allowed to leave by a second member of staff.

We checked records of three patients that had a DoLS in place. We saw that there was relevant documentation was present for the three patients. However, information documented was inconsistent and at times lacking depth of information. Despite the various stages of the assessment being checked as completed, there was no further information provided to highlight the overall assessment and decision-making process. One MCA assessment record did not include information stating what decision was being made in the patient's best interests.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff made sure patients consented to treatment based on all the information available. Staff clearly recorded consent in the patients' records. We reviewed the MCA assessment documentation of a patient who lacked capacity to consent to medical treatment. The documentation highlighted that the patient lacked understanding of the procedure required and set out the potential impacts if it was not undertaken. However, the patient's family were not documented to have been consulted as part of the assessment process and the assessment form was not contemporaneously completed.

Staff received training in the Mental Capacity Act and Deprivation of Liberty Safeguards, however compliance did not meet the trust target. The service provided mental capacity act (MCA) training for staff as part of their safeguarding training. The trust target for compliance was 90%; the trust target was not met for any staff group. Additional clinical services staff had an 80.12% compliance, registered nursing staff had an 88.71% compliance and medical staff had a 72.64% compliance. We saw registered nursing staff exceed the 90% target in eight out of 16 wards, however additional clinical services staff only exceeded the target on four out of 16 wards. Medical staff training was not kept at ward level, but was below the target overall at 72.64%. This meant that staff did not all have the appropriate training in the MCA.

Managers monitored the use of Deprivation of Liberty Safeguards. We spoke to ward managers and we heard an example of them following up a DoLS that was due to expire.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. Staff we spoke with knew where to access support

The trust had a policy for rapid tranquilisation; it was version controlled and in date with a review due in February 2023. The policy included considerations for different patient groups and the post-administration monitoring was in line with national guidelines. The policy included appendices to support staff to make the correct decisions and implement the correct monitoring.

Following the inspection, we issued the trust with a section 29A warning notice because they did not have effective systems to ensure effective systems to ensure staff adhered to the Mental Capacity Act. The trust responded to the notice with immediate actions they had taken and longer-term actions they had planned to address the concerns.

Medical care (including older people's care)

Immediate actions included:

- The trust completed an analysis of mandatory training and identified areas that required focused training sessions and commissioned a provider to deliver them virtually. They also circulated seven-minute briefings to wards for discussion at huddles.
- The trust reviewed DoLS and MCA paperwork.
- The trust MCA steering group received the inspection findings, had audits and training added to their standing agenda and established a task and finish group to review weekly MCA and DoLS audits.
- The trust's learning disability partnership group received the inspection findings and there were plans to complete a case study, review the covert medication policy and learning would be added to the improvement plan.
- The trust commenced twice weekly ward-based audits of patient records to review compliance with DoLS and MCA documentation.

Is the service caring?

Inspected but not rated

Compassionate care

Staff treated patients with compassion and kindness, however they did not always respect their privacy and dignity or take account of their individual needs.

Staff were not always discreet and responsive when caring for patients.

We observed several examples of patients who had not had their privacy and dignity maintained. Most patients we saw in wards were nursed in bed with bed sides in situ. We did not see patients encouraged to sit in their chair for mealtimes, where that was appropriate for their needs, or to get out of bed to wash or dress. We saw that staff did not always have time to provide individualised care or support to patients and this sometimes meant their privacy and dignity was not maintained on medical wards.

We observed most patients during our visit to be wearing hospital night clothing, few patients were dressed and in their own clothes or nightwear. We saw one patient who did not have a gown that fitted. The ward were trying to source one to fit, however the patient was left for several hours wearing a gown only on their front. This meant their privacy and dignity was not respected when mobilising.

We saw patients on an admission ward who had been on the ward for more than 2 days. Although the ward had appropriate facilities, it was not appropriate for longer term care. We saw one patient who had been on the ward for seven days who was on an end of life care pathway. A busy assessment unit was not the most appropriate place to provide end of life care in a dignified way.

On a different ward, we saw a patient who was on an end of life pathway in a six bedded bay. It would have been appropriate for the patient to be moved to a side room, but they were full at the time.

Medical care (including older people's care)

We observed call bells unanswered for long periods of time, for example we heard one alarming for 10 minutes and another for 12 minutes. This meant when patients called for assistance, they were not always responded to in a timely way.

We saw that not all patients had call bells in their reach when they bed sides were up. This meant not all patients could alert staff that they needed assistance or support easily, and they may be unable to mobilise to do so.

Staff did not always have time to interact with patients.

We observed staff interactions on a bay during the inspection; one patient was calling out for help for 15 minutes while two other staff in the bay were providing care to another patient. We saw the patient calling for help was not always responded to; three other staff members entered the bay and ignored their calls while completing other tasks that were not relating to direct patient care. No one provided the patient with reassurance or communicated clearly that they were waiting for equipment to provide the care needed. After 14 minutes, staff told the patient they wouldn't be long, and the patient responded, "yeah you say that". The patient shouted out for help 13 times in a 20-minute period. Staff did not routinely respond to his call for help.

On several occasions we observed patients requiring additional support with meals did not receive this. We observed patients' meals left out of their reach and treatment being given during mealtimes.

We observed one patient who wanted to put additional clothing on due to the bay being cold, and we supported them to do so. Two other patients within the bay stated that they had been cold through the night and had required additional blankets from staff. Staff did not have time to support the patients appropriately to meet their needs.

However, we also observed staff maintaining patient's privacy and dignity by closing curtains when undertaking care.

Patients requiring additional support due to agitation or increased confusion could be supported by a specialist team of staff, and we observed these staff caring for patients with additional needs.

We saw evidence that staff did not always involve those close to the patient when planning a discharge from hospital.

Patients told us staff treated them well and with kindness and they felt safe in their care.

The NHS Friends and Family Test (FFT) was created to help service providers and commissioners understand whether patients are happy with the service provided, or where improvements are needed. The service had received positive FFT scores in January 2022, although the directorate had an overall score of 89%, which was just below the trust target of 90%. All wards scored over 75% and seven out of 13 wards scored above the trust target of 90%. This meant that people who used services and their families had provided positive comments about the service provided to them. However, response rates on some wards were particularly low, and seven wards had less than 10 respondents.

Is the service well-led?

Inspected but not rated

Medical care (including older people's care)

Management of risk, issues and performance

Leaders and teams used systems to manage performance. They identified and escalated relevant risks and issues and identified actions to reduce their impact.

Following our inspection, we issued the trust with a Section 29A warning notice, as we found that staff were not appropriately or consistently assessing and managing risk to patients. Staff were not always providing appropriate assessment and support to meet patients' nutrition and hydration needs; patient risk assessments were not always completed contemporaneously and the care provided to mitigate risk were not always in line with the assessment, and patients were not always discharged appropriately or safely.

In response to our significant concerns, leaders immediately and responsively began to tackle the concerns we had brought to their attention, urgently convening audits and working groups, overhauling documentation in patient records to make it more easy for staff to complete, drafting in staff from elsewhere in the trust to assist patients on wards at mealtimes, and reinstating visiting so that patients could be with and supported by their loved ones. Two weeks after our inspection, the trust provided a list to CQC of the things they had already done to mitigate the most urgent risks, and an action plan setting out what they knew still needed to be addressed, and how they would do this. Leaders continue to respond positively and proactively to CQC's concerns.

Areas for improvement

Action the trust MUST take to improve

In Medical Care:

- The service must ensure that the care and treatment of service users must be appropriate, meet their needs and reflect their preferences. Regulation 9 (1) (a) (b) (c).
- The service must ensure patients are treated with dignity and respect. Regulation 10 (1).
- The service must ensure care and treatment is provided in a safe way for patients, including assessing the risks to the health and safety of service users of receiving the care or treatment and doing all that is reasonably practicable to mitigate any such risks. Regulation 12 (1) (a) (b).
- The service must ensure the proper and safe use of medicines. Regulation 12 (2) (g).
- The service must ensure that where responsibility for the care and treatment of service users is shared with, or transferred to, other persons, working with such persons, service users and other appropriate persons to ensure that timely care planning takes place to ensure the health, safety and welfare of the service users. Regulation 12 (2) (i).
- The service must ensure that the nutritional and hydration needs of service users are met. Regulation 14 (1).
- The service must maintain securely an accurate, complete and 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. Regulation (17) (2) (c).
- The service must ensure there are appropriate numbers suitably qualified, competent and experienced medical staff to enable them to meet the needs of patients in their care. Regulation 18 (1).

Medical care (including older people's care)

- The service must ensure that persons employed receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform and be enabled where appropriate to obtain further qualifications appropriate to the work they perform. Regulation 18 (1), (2) (a) (b).

Action the trust SHOULD take to improve

In Medical Care:

- The service should consider formalising processes for the care of medical patients residing on alternative wards to ensure they receive the most appropriate care and treatment for their needs.
- The service should consider strengthening audit documentation to monitor progress against plans to improve the quality and safety of services and take appropriate action without delay where progress is not achieved as expected.
- The service should continue to make improvements to patient discharge to ensure they are discharged in a timely way with ongoing care or treatment options in place.
- The service should ensure there are appropriate numbers suitably qualified, competent and experienced palliative care staff to enable them to meet the needs of patients in their care.
- The service should work to increase response rates to the NHS Friends and Family Test to understand wider patient views on the service.
- The service should review the Critical Medicines policy and its adherence.
- The service should review medicines reconciliation procedures to bring targets in line with the trusts own policy.

Surgery

Requires Improvement  

Our rating of Surgery went down. We rated it as requires improvement because:

Our rating of this location went down. We rated it as requires improvement because:

- The service did not have enough staff to care for patients and keep them safe. Staff had training in some key skills, however training compliance did not meet trust target for safeguarding to protect patients from abuse. The service did not have effective systems to ensure service user discharges are appropriate, safe and that information was shared with partner organisations effectively. Staff did not always assess risks to patients, act on them or keep good care records. They did not always manage medicines well.
- The service did not have effective systems in place to ensure service user's nutrition and hydration requirements were assessed and provided in line with their care needs. Patients did not always receive pain medication in a timely way. Managers did not always monitor the effectiveness of the service and did not always make sure staff were competent.
- Staff did not always support patients to make informed decisions about their care and treatment. They followed national guidance to gain patient's consent; however, they did not always support patients who lacked capacity to make their own decisions in their best interests.
- Staff did not always treat patients with compassion and kindness in respecting their privacy and dignity or take into account their individual needs when assisting with activities of daily living.

However:

- The service had enough medical staff to care for patients and keep them safe. The patient's environments were safe, clean, and well maintained.
- Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Most key services were available seven days a week.
- Staff provided emotional support to patients, families, and carers.

Is the service safe?

Requires Improvement  

Our rating of safe went down. We rated it as requires improvement.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it; however, training did not reach trust target.

Nursing staff received training specific for their role on how to recognise and report abuse; however, the trust target of 90% was not met for safeguarding training modules for nursing and medical staff. Safeguarding adults level two training for nurses was just below the trust target at 87.41%, and safeguarding children level two was below the trust target at 87.66%.

Surgery

Safeguarding adults level two training for medical staff was below the trust target at 80.06%, with safeguarding children level two at 80.69% compliance. Medical staff compliance for safeguarding level three for children was above trust target at 100% compliance. However, adult safeguarding level three training was 50% and did not reach trust target. Ward managers told us there were plans in place to improve compliance for both nursing and medical staff.

Nursing staff told us they had not completed de-escalation training for patients who may become abusive or at risk of self-harm. We saw examples of patients on wards inspected where patients were abusive to staff and at risk of self-harm. Staff told us they could now access safeguarding training via personal smartphones.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff discussed safeguarding risks during patient handovers and staff huddles.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff were aware of safeguarding procedures, how to make referrals and access advice; there were safeguarding leads throughout wards and a head of safeguarding in place. Ward staff knew where safeguarding policies were for support. They used online forms to refer safeguarding notifications or queries to the local authority multi-agency safeguarding hub. Nursing staff said they would inform their nurse in charge or matron depending on the severity of their concern.

We reviewed the trust's safeguarding adults at risk of abuse and neglect policy which was in date (February 2022), version controlled and had a review date of January 2025.

Staff told us matrons periodically produced safeguarding reports where any learning for staff was included in action planning and disseminated.

Assessing and responding to patient risk

Staff did not always consistently assess and manage risk to patients. Staff did not always undertake appropriate assessment or provide support to meet patient's nutrition and hydration needs. Patient risk assessments were not always completed contemporaneously, and the care provided to mitigate risk was not always in line with the assessment. The trust did not have a systematic approach to assessing risk relating to patient's mental health.

Staff completed risk assessments for each patient on admission / arrival, using a recognised tool; however, risks were not always reviewed or completed in line with trust process. We reviewed six full sets of patient notes and sections of patients records when looking at examples of poor care we had observed across the surgical wards inspected.

The acute surgical orthopaedic wards had additional medical patient outliers to care for alongside surgical patients. Staff on ward 36 told us that the ward did not have medical consultant cover, and therefore was not able to host medical outliers (patients who would normally be cared for on a medical ward). However, in the past week they had been asked to take four medical patients. They did not feel that they were able to offer these patients the best care as doctors on the ward did not usually see these types of patients.

The service did not have a specific process for medical patients who were being cared for on surgical wards (outlying patients). The trust had agreed principles for caring for these patients and could identify them as part of their winter pressures position; this information included that there was appropriate medical consultant oversight from a medical speciality.

Surgery

There were medical patients occupying 15 out of the 34 beds on one surgical ward on the first day of the inspection. The majority of these patients were elderly often with complex care needs and associated risk factors. Patient acuity increased levels of care required from all staff, which reflected in inconsistencies in patient's records, timeliness of pain relief and the time to care for patients who required assistance to eat and drink.

We saw gaps in recording patient assessments across wards, including gaps in pressure care risk assessments, pain assessments, malnutrition universal screening tools (MUST) scores, nutrition, and hydration charts, falls assessments and intentional rounding records.

Intentional rounding is a systematic and routine check to ensure that each patient is comfortable, has adequate nutrition and hydration and is treated with dignity and respect. We saw gaps in recording on patient's records including intentional rounding records, the repositioning of patients and body maps.

The trust used a combination of two nationally recognised screening tools to monitor a patient's nutritional status. We saw these tools were often not accurately completed. We observed a patient who had been admitted with a learning disability and mental health issues. We had concerns regarding their nutrition not being assessed for malnutrition during their stay, at the time of our inspection the patient had been an inpatient for over four weeks. We also saw evidence of diet being encouraged that did not meet the textures recommended by the speech and language therapy team. We escalated this at the time of inspection to senior leaders who instigated an immediate rapid review of this patient's care. We were assured the patients individual needs had been reviewed and a plan of care was in place.

We observed meal services throughout the inspection which included breakfast, lunch, and dinner. Patients who were able to eat independently did so, however we saw that for those needing assistance, either with positioning or feeding this was not always offered, or offered too late, which meant staff were not able to meet individual patient needs. This increased the potential risk to patients being unable to eat meals or drinks.

Staff did not always adjust patient beds to be fully upright to assist with their comfort and swallowing at mealtimes. As the trust had visiting restrictions in place during our inspection only a few patients had one short-term visitor to assist them if required.

We reviewed the trust's clinical falls prevention and management policy issued in February 2021 with a review date of February 2024. We observed staff were not always adhering to policy regarding the use of bed rails. The policy clearly states that patients at risk should be reviewed during the daily risk assessment review and/or whenever a patient's condition or wishes change. We were not assured that all patients were consistently re assessed for the use of bed rails. There was no evidence to support that staff always completed bed rail assessments in line with trust policy. Most patients we observed on inspection were frail/elderly patients, many of whom were nursed in bed with bed rails in situ. Bed rail assessments in patient records that we reviewed were not always completed.

We found falls risk assessments were not always reviewed within set timeframes for patients deemed to be at high risk of falls. For example, we noted gaps in the recording of falls risks. One patient's notes related to a frail/elderly medical patient on a surgical ward who required nursing assistance to mobilise. We noted gaps in falls risk assessments for this patient on the seven-day reassessment document. Another patient's notes related to a frail/elderly patient who had undergone surgical repair of a fractured neck of femur who required nursing assistance to mobilise. We noted gaps in falls risk assessments for this patient on the fragility femur fracture pathway document.

During inspection we observed call bells sounding which were often left unanswered for long periods. We observed some call bells being answered by a clinical matron on ward 36 during our inspection due to staffing pressures.

Surgery

The trust used assessment documents to assess and record patients ongoing risk. The adult and nursing care pathway 1 record was an acute phase pathway for admission to wards only or when length of admission was predicted to be less than 24 hours. The adult and nursing care pathway 2 record was a seven-day document for use from admission to discharge from any acute or primary care hospital. The trust also used a 7 day reassessment document for patients where length of stay was greater than 7 days.

We reviewed the trust's adult nursing care pathways which highlighted inconsistencies in completion across all wards inspected. Where we observed gaps in records this often related to risk assessments not being completed in line with trust policy when using the differing adult patient pathway documents. Risks were not always re assessed or completed when transferring a patient's care from point of admission.

We reviewed the trust's care plan/risk assessment audit for January 2022 which evidenced inconsistencies for the wards we inspected with non-compliance regarding completion of MUST scores, skin assessments, body mapping, Braden assessment completion on admission & Braden re assessment (the Braden Scale is an evidenced-based tool that predicts the risk for developing a hospital- or facility-acquired pressure ulcer or injury). Each ward within the surgical directorate undertakes a care plan audit by screening 15 sets of patient records per month. The trust told us clinical assurance meetings where audit findings would normally be reviewed were stood down during the height of the COVID pandemic, the trust intended to reinstate these meetings moving forward. We saw no evidence to support an action plan log to evidence target dates for actions to be completed.

Between 01 July 2021 and 31 January 2022, the trust reported 15 serious incidents of pressure ulcer meeting serious incident criteria in the acute hospital setting. All of the incidents identified lapses in care including the following areas: lack of appropriate or timely turning, poor or no completion of body maps, concerns with completion of MUST tools, wound deterioration assessment and not following the tissue viability nurse (TVN) advice or skin bundle.

During the inspection we spoke with the discharge team. We heard that the team had been in place for approximately four weeks and was rolling out across medical and surgical wards in a phased approach. Although the team were embedding, not all wards had input from this team, including admission wards, which did not have embedded systems in place to always facilitate safe discharge, and this was reflected in recent incidents and safeguarding referrals we reviewed. The trust confirmed the discharge team had oversight of the two surgical wards we inspected.

We saw a number of unsafe discharges from surgical wards following information shared with us by system partners. For example, a patient was discharged home after receiving care for 10 days on an acute orthopaedic ward. The patient had been assessed as medically fit for discharge. Information to support the discharge included a request for a care package from the care provider to support the patient's partner; however, the care agency was unable to facilitate this.

A rapid response referral was completed, and the patient assessed where the rapid response worker was advised the patient was mobilising on the ward with a zimmer frame and was fit for discharge. The patient was discharged home in the evening by ambulance on the 20 January 2022. The following day the rapid response worker attended the patient's home where they found the patient sat in a chair where the ambulance crew had left the patient the previous evening. The response worker tried to assist the patient to mobilise. The patient was in a lot of pain and when attempts were made to support the patient to stand, they were unable to weight bear for more than a few seconds.

Prior to the fall the patient was independently mobile and would access the community independently. The patient was clearly in need of further rehabilitation and specialist equipment and was at significant risk of harm as this had not been provided. The patient was re admitted for urgent respite care. The patient suffered unnecessary pain, distress and was at risk of further potential falls as a result of this unsafe discharge.

Another example of an unsafe discharge was reported regarding a patient discharged to a care home from an acute orthopaedic ward on the 2 November 2021 following a fall at home where they sustained a fracture of the right wrist. The patient also sustained an open fracture of the right ankle, that required surgical intervention, and a skin graft. The patient was discharged to a care home for rehabilitation, and physiotherapy to assist in them becoming mobile.

The patient's pre-admission assessment from the care home and the nurse to nurse handover lacked a significant amount of clinical information regarding this patient's general health, and ongoing care requirements. There was no information documented or passed over that this patient had a skin graft on the right ankle, and what the care regime for the skin graft site involved. The patient discharge was unsafe potentially impacting on additional risk factors surrounding skin integrity.

We reviewed the trust's discharge data surrounding patients who were identified as fit for discharge in January 2022. On the two wards we inspected there were 98 patients in total who were not discharged due to differing factors which included barriers associated with ongoing social care requirements and care packages. We reviewed the trust's readmission rate across the two wards inspected which evidenced a readmission rate of 2.35% in January 2022 with a total of 4 patients readmitted within 72 hours of discharge.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. The service used an electronic national early warning score (NEWS2) system, the system required staff to login to electronic devices to monitor a patients NEWS score. NEWS information did not show on electronic patient information boards. If patients deteriorated a dedicated support team contacted the ward to highlight the deterioration on the system to ensure action was taken to address this by ward staff. Staff could also use their handheld electronic devices to monitor patient NEWS2 scores.

We looked at seven do not attempt cardiopulmonary resuscitation (DNACPR) documents across both core services we inspected. We saw that most were appropriately completed, with five of the seven showing sufficient information to provide assurances that decisions had been discussed with the patient or their family. However, in two cases, the document was not of good quality, with one stating the decision had not been discussed with the patient or their family (and not indicating that the patient lacked the capacity to understand the decision). A second, completed outside the trust, was an old DNACPR document, referring to an even older one completed in 2020. There was not enough information on this document to provide assurance to the trust that the correct process had been followed, and the trust had not completed a new document.

Staff knew about and dealt with specific risk issues. Where an indicator of sepsis was identified, the trust followed the Sepsis Six model to provide testing and treatment to patients within one hour. We reviewed the trust sepsis assessment form and noted that the trust used an SBAR approach (situation, background, assessment, and situation) to review patients following an acute episode of deterioration.

Early warning scores were used to monitor patients and detect deteriorating patients, or patients who required escalation or additional care or treatment. The trust had a dedicated critical care outreach team, staff knew the process with regard escalating concerns for deteriorating patients with the team and could give examples of when this had happened. We saw in patient records that the team attended promptly.

There was a recognition and management of the deteriorating patient policy, which included sepsis. Staff we spoke with were clear about signs and symptoms of deteriorating patients and gave examples of when and how they would escalate a concern.

Staff had 24-hour access to mental health liaison and specialist mental health support via direct referral, if concerned about a patient's mental health.

Staff shared key information to keep patients safe when handing over their care to others.

Shift changes and handovers included all necessary key information to keep patients safe. We observed hand over sheets on all wards we inspected. The nursing handover document included key information regarding individual patients which included a plan of care, key risks, and discharge plans.

On inspection on ward 34 we observed a display board with falls aims for September 2021. The display included audit results for August 2021 highlighting the need for staff to complete lying & standing blood pressure and ongoing risks on risk assessments. The display also included a section on pressure ulcer goals for September 2021. The goals on display were for staff to ensure admission packs were ready and utilised, early detection and recording of pressure damage and to ensure body maps were completed. We discussed the date of the displays with the ward manager on duty, who told us they intended to update the information on a monthly basis; however current pressures within the system had impacted on this.

We observed out of date display material on all ward entrances that we inspected. Notice boards displayed C Difficile infection rates with dates ranging from November to December 2021. We were not assured that staff were always kept up to date with regard infection control audit results.

We reviewed the trusts policy regarding the recognition and management of the acutely ill and deteriorating patients which was in date (June 2020), version controlled and had a review date of April 2023.

We observed date/time of clocks in several patient bays were incorrect on ward 34. This was a potential risk to patients as staff would need to clarify time of day to complete fluid charts, intentional rounding charts & food charts. This would also be confusing to patients who had received anaesthetic and or were frail/elderly leading to possible misunderstanding surrounding mealtimes, pain management etc.

Following the inspection, we issued the trust with a section 29A warning notice because they did not have effective systems to ensure patient risk assessments were completed contemporaneously and the care provided to mitigate risk was in line with the assessment and they did not have effective systems to ensure patient discharges were appropriate, safe and that information was shared with partner organisations effectively. The trust responded to the notice with immediate actions they had taken and longer-term actions they had planned to address the concerns.

Immediate actions relating to patient risk assessments included:

- Intentional rounding and body mapping documentation was reviewed, and key assessment documentation has been placed at the bottom of the patient's bed to encourage completion.
- An intentional rounding audit tool had been developed and daily audits commenced.
- The trust reviewed their educational delivery plan with a focus on the assessment and standardising a structured risk assessment of a patient's fundamental care requirements to provide accurate evidence of interactions and interventions undertaken.
- A specific agenda item on sharing learning from incidents was added to the weekly matrons and ward managers meeting and the weekly safety and quality briefings were refocused to improve shared learning from incidents.

Immediate actions relating to safe discharges included:

- The trust completed the implementation of the transfer of care teams to support all wards.
- The trust had reinforced the use of the discharge checklist and medication checklist and ensured stock of discharge package (posters, leaflets, action cards) on wards was sufficient.
- The trust started work to improve their triangulation of discharge information and have produced a data pack for wards and discharge board which includes learning from discharge related incidents.
- Staff have attended ward manager and matron meetings to raise awareness of the support and resources available to staff.
- Discharge lead staff were included in clinical assurance ward rounds and key discharge items were included in the reviews.
- The Transfer of Care Hub have started a pilot on Wards 29 and 34 to provide telephone follow up to high risk patients after they are discharged from hospital.

Nurse staffing

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

During inspection we noted the acute surgical orthopaedic wards on 34 and 36 did not have planned staffing to match the actual staffing numbers on duty to keep patients safe. Ward information boards at ward entrances which displayed actual verses planned staffing were not dated on all wards we inspected. We observed additional staff working on wards on day two of the inspection, some of which were overheard stating that they had been requested to work additional hours and or undertake additional shifts to boost staffing figures during the inspection.

On ward 36 we reviewed the nurse staffing rotas for the month before the inspection date. The ward's establishment was five registered nurses (RNs) and five healthcare assistants (HCAs). The wards actual staffing had been four RNs for all other shifts in the month before our inspection; one RN below established/planned numbers. The rota showed that the ward had to drop to two RNs for two-night shifts in early January 2022. The ward manager told us that staffing was constantly re assessed, and explained they understood there were other wards with only one RN at that time. We saw on three dates the ward had been one RN down on both afternoon and evening shifts for the 31 January, 4 and 7 February 2022. The ward manager mitigated the risks to patient safety by putting those patients at higher risk in the A and B bay areas, closer to the nursing station.

The ward manager told us they had escalated concerns regarding nurse staffing with the service manager as a result of not meeting the nurse staffing establishment planned verses actual.

We reviewed the trusts staff sickness absence for the surgical directorate in February 2022 which evidenced a sickness rate of 6.62% for registered nursing staff and 8.28% for support staff. The trusts sickness target rate was 3.90% the target rate was not met in February 2022.

The trust's vacancy rate for registered nurses was 6.89%. The service had over-established support staff by 19.38% to mitigate the risk of vacancies in registered nurse staffing across surgical areas.

Staff told us skill mix was hard to plan for as they had many junior staff. The trust used the safe care acuity tool to secure safe rosters and review skill mix which was reviewed twice yearly.

Staff told us that escalation of under establishment was reported as red flag incidents and discussed with senior management.

We observed a bed meeting where matrons and senior staff discussed staffing and acuity across the wards on both hospital sites. They discussed expected admissions and discharges, wards with closed bays and newly cleaned bays that had previously held patients undergoing screening or isolation following COVID-19 infection. Several bays and specific beds were identified as clean or requiring deep cleaning and patients were moved between bays. The ward manager could request additional staffing levels daily according to the needs of patients. However, they explained that staff were not always provided.

On inspection we observed staff working hard to complete tasks for patients; however, we were not assured that staff had the time to always provide person centred care that met individual patient needs. The acute surgical orthopaedic wards had additional medical patient outliers to care for alongside surgical patients.The majority of these patients were elderly often with complex care needs with associated risk factors. Patient acuity increased levels of care required from all staff, which reflected in inconsistencies in patient's records, timeliness of pain relief and the time to care for patients who required assistance to eat and drink.

The trust staffing model followed national guidance on staffing for winter preparedness in 2021, and they took action when staffing numbers were low based on the safest staffing they could achieve across all areas. However, these staffing levels did not always meet the needs of the patients receiving care on wards.

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

The ward manager could adjust staffing levels daily according to the needs of patients.

All wards inspected had vacancy rates, managers had recruitment plans in place to address vacancies.

Managers made sure all bank and agency staff had a full induction and understood the service.

Medical staffing

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

Medical staff did not always match the planned numbers in the orthopaedic speciality. We reviewed the trusts medical staff rotas for February 2022 which evidenced a total of 159 consultants working across the surgical directorate within the trust at both sites. The rotas showed that the orthopaedic speciality consultants were one whole time equivalent short. Whole time equivalent registrars also showed one short on the rota; however, this was negated by plus two core trainees in post for the speciality.

Sickness rates for medical staff were low. We reviewed the trusts staff sickness absence for the surgical directorate in February 2022 which evidenced a sickness rate of 0.10% for medical staff. The trusts sickness target rate was 3.90%.

Managers could access locums when they needed additional medical staff.

The service had a good skill mix of medical staff on each shift and reviewed this regularly. Senior clinicians and consultants we spoke with said there was no shortage of junior doctors on the wards. We saw sufficient numbers of medical staff on the wards we visited to meet the needs of patients.

The service always had a consultant on call during evenings and weekends.

Records

Staff did not always keep detailed records of patients' care and treatment. Not all records were clear, contemporaneous, up-to-date, or stored securely. Records were easily available to all staff providing care.

Patient notes were not always comprehensive; however, all staff could access them easily. We reviewed six full sets of patient notes and sections of patients records when looking at examples of poor care we had observed across the surgical wards inspected. We saw gaps in recording in patient's records including intentional rounding records, the repositioning of patients, body maps and food and fluid balance charts.

Records were completed legibly, and daily evaluations were evident but there were several gaps in documentation. For example, we observed in intentional rounding records, there was no qualitative information to evidence interactions with patients about their care and support that staff had provided. For example, during patient turns for pressure care, there was no record of which side patients were moved to and when it was last completed. This meant staff could not be sure of the timing of the next turn increasing the risk of potential pressure damage, impacting on recovery.

Intentional rounding is a systematic and routine check to ensure that each patient is comfortable, has adequate nutrition and hydration and is treated with dignity and respect.

On ward 36 we spoke with a patient with a haematoma (blood filled blister) on their heel. The patient asked an inspector for help as they wanted a consultant to discuss it with them regarding the plan of care. We reviewed the records for this patient and saw that the notes recorded a hospital acquired pressure sore on the right heel which had been identified on 04 February 2022, but no plan of care was recorded. The patient was reviewed by a Tissue Viability Nurse (TVN) on 07 February 2022; however, this had not been clearly communicated to the patient and they did not understand their pressure care plan. The role of the TVN is the provision of expert advice in the prevention and treatment of wounds. Following referral, the TVN support clinicians to formulate a treatment plan and support with review if required.

Food and fluid balance charts and MUST charts were not always completed in line with guidance; weight should be recorded on admission and then at a minimum, weekly thereafter, we saw gaps in recording of patient weights.

We saw an example where a patient's documentation was not fully complete on ward 36. It was not clear due to incomplete documentation how often the patient's pressure areas should be reviewed; we saw this ranged from between every two hours and four hours. There had been no review recorded for eight hours. The patient's fluid balance chart was also not complete. The patient had been placed onto a mouth care pilot trial (mouth care to prevent pneumonia in older people) with the consent of their next of kin. However, only the first day of this documentation was complete. The remainder of the document was empty.

Surgery

We checked the records of a patient on ward 34 who was nearing the end of their life. The documentation relating to their pain relief and Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) document were fully completed. Their fluid balance chart and repositioning tool were all up to date. However, a set of patient notes relating to another patient who had passed away that morning was filed within this patient's notes. We escalated this with the ward sister immediately.

We reviewed the records for one patient on ward 34 which showed they had been assessed for a level six diet; however, we saw there was evidence they were receiving nutrition that was not in line with this assessment. We escalated this to the trust who conducted a rapid review of the patient's care and put immediate actions in place. The patient's care plan was reviewed and amended. The patient's notes were not stored securely or in chronological order. Following the review notes were checked to ensure that they are stored securely, in chronological order and so that relevant information can be found more easily. Documentation standards are monitored regularly as part of the ward managers and matron's assurance checks. This process has been strengthened.

We reviewed information shared with us by system partners regarding a safeguarding notification which highlighted inconsistent and poor record keeping impacting on patient care. The subsequent investigation highlighted several contributory factors consisting of lapses in nurse record keeping, lapses in visual infusion phlebitis (VIP) records and poor standards of patient hygiene and management.

We also noted there were inconsistencies with the completion of food and fluid charts for patients and we had concerns that not all information was accurate. We noted one of the fluid charts for the patient in Bed 1, Bay C on ward 34 indicated that they had consumed 200ml of tea that morning. However, the cup was still full and was out of the patient's reach. This meant staff could not be assured the patient's nutrition and hydration needs were always met and that records accurately reflected their fluid intake.

We reviewed the trust's records audit for January 2022 (quarter 4) which evidenced inconsistencies in record keeping for ward 34, We reviewed the trust's action plan which evidenced a due date and clinical lead; however, there was no progress notes within the plan to give assurance re actions and outcome. The audit evidenced that the trust had reviewed the audit tool and data capture and had recorded this as completed with a green rating; however, there were no progress notes to evidence timeliness of the outcome. The action plan showed five actions as an amber rating (in progress) and one action rated as red (outstanding). It was not clear how the action log could be used to track timeliness of outcomes, or measure effectiveness.

We observed robust medical admission and daily review information recorded by the ortho geriatrician and medical team consistently across the records that we reviewed.

When patients transferred to a new team, there were no delays in staff accessing their records.

Records were not always stored securely. Notes trollies were mostly left unlocked and unattended with patient notes stored underneath trollies, easily accessible to visitors.

Medicines

The service did not always use systems and processes to safely prescribe, administer, record and store medicines.

Staff did not always follow systems and processes to prescribe and administer medicines safely.

Surgery

We looked at two medicine charts on the ward we visited and found prescribing was not in line with the trust's medicine policy. For example, we found a medicine prescribed with a variable dose however there was no record of how much was given on administration therefore making it hard for prescribers to review.

Two patients we spoke with stated they received their medicines and pain relief in a timely manner and were happy with how their medicines were managed throughout the stay.

Data provided to us by the trust showed that in January 2022 ward 36 had 5% of omitted doses with none of those being critical medicines.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. We saw evidence of medicines review on the ward by the pharmacy team, however no weekend cover was provided.

Staff did not always follow national practice to check patients had the correct medicines when they were admitted.

Medicine reconciliation was carried out by the pharmacy team based on the ward we visited. We looked at two medicine charts and found that both had received a medicine reconciliation; however, one had not been within 24 hours which was not in line with trust policy. The delay in this reconciliation meant this patient went without their regular medicines for over 48 hours.

Data supplied to us supported our findings on inspection with only 55% of medicines reconciliation taking place within 24 hours in January 2022 on ward 36.

Incidents

The service did not always manage patient safety incidents well. Managers did not always investigate incidents thoroughly and share lessons learned. However, staff recognised and reported incidents and near misses.

Prior to our inspection, the trust's incident reporting system showed an increase in the numbers of serious incidents, and other, lower grades of incident where patients had come to harm. We could see similar themes emerging around nutrition and hydration (for example, patients losing a lot of weight unexpectedly while in hospital, or reporting not being fed for several days) and inappropriate discharge (for example, patients going home without important medicines, or a care package in place that would support their needs). Other organisations also voiced their concerns about the types and numbers of incidents the trust had reported. We saw that the frequency of this type of incidents had increased over recent months, and this was an important factor in our decision to inspect the trust when we did.

Despite asking the trust for evidence of learning and changes in practice as a result of serious incidents, we saw the same types of incident recurred. We were therefore not assured that the trust was learning from its incidents and had strong systems in place to ensure that this happened.

However, staff we spoke to knew what incidents to report and how to report them.

Is the service effective?

Requires Improvement 

Surgery

Our rating of effective went down. We rated it as requires improvement.

Nutrition and hydration

Staff did not always provide patients with enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary; however, we were not assured that all patients requiring assistance were always assisted to eat and drink. Staff followed national guidelines to make sure patients fasting before surgery were not without food for long periods. The service made adjustments for patients religious, cultural, and other needs.

Staff did not always complete appropriate assessment and support to meet service users' nutrition and hydration. During inspection we noted that staff on all wards routinely served patient food. Whilst staff were serving the food, they could not assist patients with positioning or feeding. This meant that food was often cold before staff could then support a patient to eat it. We did not see consistent levels of eating support provided to patients who required assistance. Most patients were not encouraged to sit in chairs at mealtimes, which increased the risk to patients of choking or scalding with hot drinks.

The trust used a combination of two nationally recognised screening tools to monitor a patient's nutritional status. Across the surgery directorate we saw these tools were not always completed consistently in line with trust process.

We observed differing meal services throughout the inspection which included breakfast, lunch, and dinner. Patients who were able to eat independently did so, however we saw that for those needing assistance, either with positioning or feeding this was not offered, or offered too late, so that they were not able to meet individual patient needs. Most patients on the wards were elderly often with complex care needs with associated risk factors.

At breakfast service on the first day of inspection we observed a patient in bed on ward 34 who was slumped over. The table was positioned in front of the patient with a bowl of porridge and hot tea. Staff had put a towel over the patients front which was covered in porridge. The patient clearly required assistance to eat. The patient was unable to pick up the hot drink served in a cup; they asked an inspector for a beaker. This request was escalated to ward staff who provided a beaker, and the patient was then able to manage to drink independently.

Kitchen staff were not always clear on patients' dietary requirements and needs; for example, we observed staff deliver an incorrect meal to one patient at meal service. The meal was meant for a patient with a nut allergy; however, the patient the meal was delivered to had no special dietary requirements. Catering staff told us that it was often difficult when patients were admitted onto the ward at night as information about their dietary needs was often not updated and communicated.

We spoke with a patient regarding the care and treatment they had received since admission. During this time a member of staff brought two slices of toast and a cup of tea at breakfast service. The patient informed the inspector that this was the first meal they had eaten since being admitted to the ward two days previously. Despite being on the ward for two days, the staff member did not know the patient by name and the patient information board above the patient's bed could not be used as a prompt because it had not been updated with the patient's information.

Staff did always make sure patients had enough to eat and drink including those with specialist nutrition and hydration needs. Staff told us there could be overnight emergency feeding delays for patients identified at risk until the dietician was able to review the following day. Staff did not always make sure patients could access their food and support was not always given where this had been highlighted as being required by the multi-disciplinary team (MDT).

Surgery

Staff did not always fully and accurately complete patients fluid and nutrition charts where needed. We observed several charts which were incomplete or had no information recorded.

On admission patients were risk assessed by completing a nutritional assessment, staff described how dietitian services could be accessed for complex cases. Where necessary, food charts were used to monitor intake of food; however, we saw gaps in food chart documentation. We were not assured that all patients were consistently screened when highlighted as a risk of nutritional need.

We reviewed the trusts standard operating policy (SOP) for surgical patients who were nil by mouth. The SOP was in date and due for review February 2024. The policy had information to support staff with a protocol for intravenous fluids and information for pre fasting guidance for patients pre surgery.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. We saw these tools were often not accurately completed. We observed a patient who had been admitted with a learning disability and mental health issues. The patient's records showed nutrition had not been assessed during their stay, at the time of our inspection the patient had been an inpatient for over 4 weeks. We also saw evidence of diet being encouraged that may have not met the textures recommended by Speech and Language Therapy. This exposed this patient to potential risk due to associated choking hazards. We escalated this to senior leaders who instigated an immediate rapid review of this patients care plan. The review evidenced that the patient was assessed as needing to have Level two fluids and Level six diet. The patient was actively encouraged to have foods that they liked. It was documented in the patients learning disability hospital passport that they liked fish and chips; this was transferred onto the patients ward care plan when it should not have been. The care plan was amended to reflect this.

Specialist support from staff such as dietitians and speech and language therapists were available for patients who needed it and we saw patients requiring this were frequently reviewed. Where modified diets or fluid were required, assessments of a patient's requirements were detailed above their beds.

The trust had nutrition specialist nurses to support patients including those receiving artificial nutrition support, for example percutaneous endoscopic gastrostomy (PEG); A PEG feeding tube insertion is the placement of a feeding tube through the skin and the stomach wall. However, staff told us they did not have nutrition specialist nurses.

Patients waiting to have surgery were not left nil by mouth for long periods. We spoke to one patient who gave an example of feeling hungry after being admitted to the ward after surgery following admission into accident & emergency on the 8 February 2022 after a fall; the patient informed staff they were hungry and had not eaten since the evening of the 7 February 2022 before the fall. Despite this, the patient had to wait five hours for food service. The patient showed the inspector a photograph of the food they were given and said it looked like "someone else had had a go before them."

We were not assured the trust had effective systems in place to ensure service users nutrition and hydration requirements are assessed and provided in line with their care needs.

Following the inspection, we issued the trust with a section 29A warning notice because they did not have effective systems in place to ensure patients' nutrition and hydration requirements were assessed and provided in line with their care needs. The trust responded to the notice with immediate actions they had taken and longer term actions they had planned to address the concerns. Immediate actions included:

- The trust held a priority nutrition and hydration steering group meeting and a Malnutrition Universal Screening Tool (MUST) compliance audit was undertaken on every adult patient within bed holding wards

- The trust prioritised nutrition and hydration and MUST assessments in their plans for electronic patient assessment records and have plans in place to roll this out and provide education and training to staff at pace.
- They recognised strengthened support around protected mealtimes was required and they established a roster to identify non ward based clinical staff to support mealtimes in highlighted priority wards.
- The visitors policy for general patients was immediately reviewed, and in line with easing of restrictions, a managed introduction of visitors for a specified length of time was supported.
- Where good practice was identified, the trust updated their standard operating procedure for food and hydration in adults, and this was rolled out across wards.
- The trust reviewed the capacity of the dietetics team and have plans to recruit additional staff to this area.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain; however, they did not always give pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain if required.

Staff assessed patients pain using a recognised tool and gave pain relief in line with individual needs and best practice; however, they did not always give pain relief in a timely way. The trust used differing methods to assess patient pain levels which included FLACC assessment, Burford thermometer and VAS score.

FLACC is a behavioural pain assessment scale used for nonverbal or preverbal patients who are unable to self-report their level of pain. Pain is assessed through observation of 5 categories including face, legs, activity, cry, and consolability. The Burford thermometer assesses pain by asking patients to indicate the intensity or severity of their pain on a diagram of a thermometer. It is a version of a verbal descriptor scale that visually represents increasing degrees of pain along the thermometer. Visual analogue scales (VAS's) are used for subjective ratings of emotion or other sensations such as pain.

Pain assessment charts were not always completed to reflect the FLACC, Burford thermometer or VAS score across all wards.

Patients did not always receive pain relief soon after requesting it. We spoke to patients who had not received pain relief on time or when requested. For example, we spoke to a patient regarding the care and treatment they had received since admission. The patient had been on the ward since the 8 February 2022 and had received no pain relief during the night despite asking staff. The patient was left without urine bottles from 10:30pm at night on the 8 February 2022 until 6:30am in the morning despite not being able to mobilise independently due to pain. The patient told us they had not seen a doctor since being admitted to the ward and were unaware of the plan of care. The patient said that staff were not responsive to call buzzers and they had had to wait on occasions for call bells to be answered.

We spoke with another patient who had recently been admitted to the ward from the intensive care unit (ICU) and appeared to be in pain. The patient told us that they had requested pain relief at 7am and had still not received any pain medication at 8:36am. The patient had been regularly receiving pain relief on ICU up to the point of transferring to the main ward. We escalated this to ward staff who acknowledged the request to administer prescribed pain medication.

Another patient told us they had asked for pain relief on numerous occasions; however, staff did not always respond in a timely way. The patient was immobile due to recent orthopaedic surgery following an accident at work.

Staff prescribed, administered, and recorded pain relief accurately. We saw staff completing records following administration of pain relief during a medications ward round.

All staff we asked knew about the trust's specialist pain management team (SPT). They knew how to contact them either by bleep, formal referrals via the ICE system or just ringing them for advice. For example, if a patient returned from theatre who required an epidural for pain management. The team could advise doctors, and some members were trained medication prescribers. Staff told us the team were responsive and readily available. Ward staff told us the team were reactive to requests for patient review. We heard the team were keen for other supernumerary staff or those on secondment to shadow their work and learn more about pain care and treatment options.

The team maintained a priority list of patients to visit but ward staff could stress the urgency or request pain advice until the team were able to attend. One nursing staff member told us the team asked staff to administer background pain relief medications regularly before they referred patients to them to avoid unnecessary referrals. A physiotherapist echoed they would only handover to the SPT after consultant input and other options had been tried.

Nursing staff completed medication rounds for patients. Pharmacy technicians were available on wards for any queries and could be bleeped if required. We saw pharmacists and technicians named on wards we visited. Healthcare assistants (HCA) or other ward staff could collect prescribed medications from pharmacy if patients needed any urgent pain medications or prescriptions not in stock on the wards.

Managers used information from the audits to improve care and treatment. We reviewed the trusts pain assessment audit for quarter 4. Each ward within the directorate undertakes a pain review audit by screening 15 sets of patient records per month. We reviewed the pain audits for the surgery directorate which evidenced high compliance for orthopaedic wards 34 (93%), ward 36 (100%) and ward 5 (100%). The trust had an action plan in place to improve compliance with the audit, however the action plan was incomplete and did not have target dates for four out of the six actions identified, or commentary relating to progress. It was unclear how the trust was monitoring progress against the plan.

We reviewed the trusts action plan associated with the pain audit which evidenced a due date and clinical lead; however, there was no progress notes within the plan to give assurance re actions and outcome. The audit evidenced that the trust had reviewed the audit tool and data capture and had recorded this as completed with a green rating; however, there were no progress notes to evidence timeliness of the outcome and actions taken. The action plan showed five actions as an amber rating (in progress). It was not clear how the action log could be used to track timeliness of outcomes, or measure effectiveness.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development. However, training compliance did not meet the trust target.

Staff were experienced, qualified, and had the right skills and knowledge to meet the needs of patients; however, due to staffing vacancies, not all wards had the correct skill mix and planned staffing numbers to meet actual versus planned staff numbers.

Managers gave all new staff a full induction tailored to their role before they started work.

Managers supported staff to develop through yearly, constructive appraisals of their work. Staff told us one-to-one meetings with ward managers were occasionally missed due to wards being short-staffed or under other system pressures. Line and ward managers completed annual appraisals including any learning and development opportunities with their staff and we saw these scheduled-on noticeboards on individual wards.

Staff told us the trust had recently updated the mandatory training e-learning system which had improved compliance on some wards. A staff nurse told us that six months into their role they had completed the opportunity to complete training and study days outside their mandatory/revalidation remit. A few weeks before our inspection they had completed an intravenous (IV) study day and another on end-of-life care (EOLC).

We reviewed the trusts staff appraisal data for the surgical directorate from January 2022 which evidenced an appraisal rate of 75.60% for registered nursing staff and 74.91% for support staff. The trusts staff appraisal target rate was 80% the target rate was not met in January 2022. However, the appraisal rate for medical staff was met showing a compliance of 82.32%.

Managers supported nursing staff to develop through regular, constructive clinical supervision of their work. Staff received emails from the human resources (HR) department regarding revalidation requirements.

Managers made sure staff received any specialist training for their role.

We observed security staff within the hospital during inspection. The trust told us the role of the security staff included, regular welfare checks, rapid response to security requests, supporting enhanced observations on the advice of clinical teams and staff escorts.

The security service was outsourced to an external company contracted to provide the security staff at James Cook University Hospital, and deliver the training, with the exception of safeguarding level 2. Each training module had a refresher requirement. Training was undertaken once security staff commenced their role; however, they would not be allocated a task until they had completed role specific task training. The training compliance for security staff evidenced 100% compliance.

We reviewed the general security policy which had an issue date of January 2022 and a review date of December 2024.

Multidisciplinary working

Doctors, nurses, and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. To ensure effective services were delivered to patients, we saw different teams and health professionals working with staff at the service as a multidisciplinary team (MDT).

When we visited the wards and observed a handover, we saw a variety of staff working together, such as nurses and support workers, to benefit patients. Nursing staff said they had good communication between theatre and ward staff. They felt the trust had an informal culture of cross-service collaboration, for example by borrowing equipment and asking advice.

We could see from the handover sheets and records we examined that there was detailed communication between staff of different grades and roles.

Surgery

There was a new discharge team in place that was rolling out across surgical and medical wards. The team had been in place for one month, and they had links with local services, local authorities, and care providers. However, as the team was not yet embedded, we saw there were inconsistencies in the quality of discharge across the directorates.

On the wards we visited, the role of discharge coordinator was a rotational role completed and managed by senior sisters. There was no designated discharge coordinator resource on those wards. Staff told us the hospital had a discharge facilitator who responded when needed.

We saw therapist input and contributions to patients discharge. For example, physiotherapists would undertake rapid assessments and help provide equipment to promote patient independence and safety once they had left hospital.

The service had differing therapy teams which include, physiotherapy, occupational therapy, speech & language therapists (SALT) and dieticians. Some SALT & dietitians only worked weekdays, but ward staff could still make referrals out of hours. In the event staff needed to refer patients late on Fridays then night/weekend staff would cover the patient's interim swallowing or nutritional assessments.

Staff worked across health care disciplines and with other agencies when required to care for patients. Staff told us if a patient's discharge to a care home was planned for later that day, they would contact the care home to clarify if there was a cut off time they must arrive by. Staff told us they would not discharge patients into community hospitals after 7pm. Staff could transfer patients awaiting discharge to short stay wards for no more than 72 hours and complete a full handover of their needs and background. Staff would send patients with good cognition to the discharge lounge if they had no concerns regarding potential risk factors.

The service had wound care bags available containing dressings with a wound care plan in place which community staff such as district nurses (DNs) who could replicate and review. Ward staff could also provide catheter care disposables for patients upon discharge if required.

There was a dedicated discharge desk on ward 34 with discharge processes in place for residential homes, patients own home and community hospital.

There was a trust process in place to ensure discharge letters are completed for all patients when leaving hospital. This had a specific section for the general practitioner (GP) information which included any changes to patient's regular medications for review after 28 days.

A staff nurse told us they only carried out safe discharges adopting a multidisciplinary (MDT) approach up until the early evening. They said they had discharged a patient on the day of our inspection with everything in place but the contracted ambulance service providing patient transport was an hour late due to staffing shortages. Staff told us this then impacted on discharge times and plans.

Staff said most discharges were carefully planned early in advance. Staff considered patient's home environments before discharge and any ongoing support that may be required. Staff made referrals to services outside the hospital.

Nursing staff would confirm with patients next of kin to contact. At the time of our inspection the trust had visiting restrictions. Staff told us families contacted wards more frequently to ask about patients. Staff would use those as opportunities to update or engage the next of kin or relative, for example to clarify specific care packages put in place.

Surgery

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff did not always support patients to make informed decisions about their care and treatment. They followed national guidance to gain patient's consent; however, they did not always support patients who lacked capacity to make their own decisions in their best interests.

Staff did not always understand how and when to assess whether a patient had the capacity to make decisions about their care. We reviewed additional sections of service user records relating to Mental Capacity Act (MCA) assessments and Deprivation of Liberty Safeguards (DoLS) applications. We saw capacity assessments, best interest decisions and consent to care and treatment was not always in line with legislation and guidelines and staff did not consistently recognise and respond to concerns in relation to mental capacity.

Staff did not always consistently assess capacity in a way that was decision-specific and time-specific. We found examples in service user records where staff had recorded that service users had 'no capacity'. Staff did not record the decision prompting the consideration of the service user's capacity or record the mental capacity assessment and decision made in the service user's best interest.

Staff did not consistently recognise and respond to concerns in relation to mental capacity. We saw patients in bed with bed sides in situ and did not see documentation to evidence that this was with patient consent, or at their request and in their best interest in their medical or nursing notes.

On ward 34 staff had not acted in accordance with the requirements of the Mental Capacity Act in the care of a service user with a learning disability and mental health issues. The records showed the service user had been prescribed and administered covert medication after refusing their medication. Staff had not assessed the service user's capacity to establish that the service user lacked the capacity to make the decision to refuse their medication and record a best interest decision in line with the requirements of the Mental Capacity Act. Staff explained that the service user was subject to Deprivation of Liberty Safeguards. Staff did not recognise that this application did not support the use of covert medication. The service user's records did not evidence that staff had assessed the service user's capacity and/or recorded the best interest decision prior to making an application for Deprivation of Liberty Safeguards.

We escalated this patient to trust executives, as there were several concerns about their care, including inappropriate nutrition, covert medication, capacity and best interest decision documentation and care and support provided. The trust instigated a rapid review of this patient following concerns raised. The review highlighted that the (DoLs) principles were applied and it was documented in health records that the covert medication policy was being used; however, the form was not printed out and held within the patient's records in line with the policy. This was rectified. The review highlighted that the Specialist Nurse Learning Disability (SNLD) was in regular contact with the ward and provided input into managing the patient's complex needs. Senior management team agreed to review the learning disability provision to potentially increase this resource moving forward.

All professionals involved in the care and treatment of the above patient commented on the complex and challenging nature of their presentation and felt that they had been stretched in their professional expertise in meeting this patient's needs.

The clinical commissioning group agreed to fund additional 1:1 care within the community and the patient was discharged on the afternoon of the 24th of February 2022. We were assured the patient's individual needs had been reviewed and a plan of care was in place.

Surgery

Staff gained consent from patients for their care and treatment in line with legislation and guidance. We observed staff asking patients for consent to treatment for example when changing dressings, position or taking patient observations.

Staff made sure patients consented to treatment based on all the information available.

Nursing and medical staff received training in the Mental Capacity Act and Deprivation of Liberty Safeguards; however, the trust target of 90% was not met for the training modules. Mental Capacity Act and Deprivation of Liberty Safeguards training for nurses was below the trust target at 83.59%. Other clinical service staff which included healthcare assistants evidenced a compliance rate of 76.34%. Medical staff did not meet the trust target with a compliance rate of 78.07%. The training was incorporated into the safeguarding training as part of the mandatory training programme.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. Staff we spoke with had attended mandatory training surrounding mental capacity act and deprivation of liberty safeguards training and understood capacity was decision and time specific.

Staff did not always implement Deprivation of Liberty Safeguards in line with approved documentation. The mental capacity assessment form contained a stage two assessment and a determination of best interests. It identified if an independent mental capacity advocate was required. Mental Capacity assessment forms were not always fully completed in all the records reviewed. The forms did not always clearly summarise the reasoning behind the best interest decision or identify the names of other people that had been consulted in the making of that decision.

We saw one copy of a DoLS application for a 70 year old male service user who was actively attempting to leave the ward. Although the DoLS documentation was readily available within the service user file, there was no accompanying MCA assessment.

Staff liaised with the psychiatric liaison team (PLT) for all mental health patients and PLT would make decisions about required mental health treatment in conjunction with trust staff. PLT staff undertook mental health assessments to identify if a Mental Health Act Assessment was required.

We reviewed the trusts rapid tranquilisation policy which was in date (February 2020), version controlled and had a review date of February 2023.

Following the inspection, we issued the trust with a section 29A warning notice because they did not have effective systems to ensure effective systems to ensure staff adhered to the Mental Capacity Act. The trust responded to the notice with immediate actions they had taken and longer-term actions they had planned to address the concerns.

Immediate actions included:

- The trust completed an analysis of mandatory training and identified areas that required focused training sessions and commissioned a provider to deliver them virtually. They also circulated seven-minute briefings to wards for discussion at huddles.
- The trust reviewed DoLS and MCA paperwork.
- The trust MCA steering group received the inspection findings, had audits and training added to their standing agenda and established a task and finish group to review weekly MCA and DoLS audits.

Surgery

- The trust's learning disability partnership group received the inspection findings and there were plans to complete a case study, review the covert medication policy and learning would be added to the improvement plan.

The trust commenced twice weekly ward-based audits of patient records to review compliance with DoLS and MCA documentation.

Is the service caring?

Inspected but not rated

Compassionate care

Staff treated patients with compassion and kindness. Staff did not always respect patient's privacy and dignity but worked hard to meet patient's needs. Staff told us due to staffing pressures, they acknowledged they could not always offer the level of care and support they wanted to.

Staff were discreet yet not always responsive when caring for patients. We noted a number of situations where nurse call bells were left unanswered for differing lengths of time.

Staff understood but did not always respect the individual needs of patients. They showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs.

Staff had not acted in accordance with the requirements of the Mental Capacity Act in the care of a service user with a learning disability and mental health issues. The service user's records did not evidence that staff had assessed the service user's capacity and/or recorded the best interest decision prior to making an application for Deprivation of Liberty Safeguards. We observed the patient in bed with cot sides insitu. We saw no evidence in records to support best interest decisions regarding the use of cot sides.

Most patients we saw in wards were nursed in bed with bed sides in situ. We did not see patients encouraged to sit in their chair for mealtimes, where that was appropriate for their needs, or to get out of bed to wash or dress. Patients bed curtains were drawn when providing care and treatment and we saw nursing and surgical staff spoke with patients in private to maintain confidentiality.

We reviewed information shared with us by system partners regarding a safeguarding notification which highlighted inconsistent and poor record keeping impacting on patient care. A patient was admitted with lower limb fractures requiring surgical intervention which impacted their ability to mobilise due to being non weight bearing prior to surgery. The investigation highlighted lapses in the patient's daily care check list assessment impacting on care surrounding hygiene and mouth care. The patient was admitted on the 7 October 2021 and had not been offered an assisted wash until three days following admission. Nothing was recorded regarding what assistance was offered by the nursing team. There were inconsistencies in completion of the care check list regarding mouth care/inspection on day or night shifts. The nursing evaluation did not record any support to meet hygiene needs. The patient told staff that their buzzer went unanswered for long periods and that had made them feel trapped in the side room. The patient was at risk of increased skin integrity risks due to non-weight bearing and reduced mobility.

Surgery

On ward 34 we noted a patient who had died at 06:30am. At approximately 08:00am an inspector observed a door was open to a side room at the end of the ward. The body of the deceased was observed from the corridor covered in a sheet. There was no notice on the door stating do not enter to respect the patient's privacy and dignity at end of life. We noted there was a patient on an end-of-life pathway in the next side room where family were visiting, there was potential for additional distress had the family walked past the room.

On the same ward we observed a female patient being assisted to walk to the toilet with a zimmer frame. The patient's privacy and dignity were not respected as the patient's hospital gown was open at the back. When a nurse noted an inspector had observed; assistance and support was given.

On ward 36 we saw a patient with a large haematoma (blood filled blister) of the heel. The patient asked an inspector for assistance as he wanted a consultant to discuss it with him. The patient had been reviewed by the tissue viability nurse (TVN); however, this had not been clearly communicated to him as he did not understand his pressure care plan. The patient was immobile due to recent surgery and was given warm water and a flannel to wash with which was then left on the side table at breakfast meal service. The patient was not given the opportunity to sit out of bed for breakfast or to undertake morning ablutions.

Patients we spoke with said staff treated them well and with kindness.

We reviewed the friends and family data results from January 2022 for ward 36 which showed a weighted score of 90.3% which met the trust target of 90%. We did not receive scores for the surgical ward on ward 34.

Staff followed policy to keep patient care and treatment confidential. We observed patient intentional rounding charts and prescription records hung on the outside of patient bays. Whilst visiting was restricted due to COVID 19, some patients on end-of-life pathways were allowed visitors. This posed a risk to patient confidentiality.

Staff understood and respected the personal, cultural, social, and religious needs of patients and how they may relate to care needs.

Is the service well-led?

Inspected but not rated

Management of risk, issues and performance

Leaders and teams used systems to manage performance. They identified and escalated relevant risks and issues and identified actions to reduce their impact.

Following our inspection, we issued the trust with a Section 29A warning notice, as we found that staff were not appropriately or consistently assessing and managing risk to patients. Staff were not always providing appropriate assessment and support to meet patients' nutrition and hydration needs; patient risk assessments were not always completed contemporaneously and the care provided to mitigate risk were not always in line with the assessment, and patients were not always discharged appropriately or safely.

In response to our significant concerns, leaders immediately and responsively began to tackle the concerns we had brought to their attention, urgently convening audits and working groups, overhauling documentation in patient

records to make it more easy for staff to complete, drafting in staff from elsewhere in the trust to assist patients on wards at mealtimes, and reinstating visiting so that patients could be with and supported by their loved ones. Two weeks after our inspection, the trust provided a list to CQC of the things they had already done to mitigate the most urgent risks, and an action plan setting out what they knew still needed to be addressed, and how they would do this. Leaders continue to respond positively and proactively to CQC's concerns.

Areas for improvement

Action the trust MUST take to improve

In Surgery:

- The service must ensure that the care and treatment of service users must be appropriate, meet their needs and reflect their preferences. Regulation 9 (1) (a) (b) (c).
- The service must ensure patients are treated with dignity and respect. Regulation 10 (1).
- The service must ensure care and treatment is provided in a safe way for patients, including assessing the risks to the health and safety of service users of receiving the care or treatment and doing all that is reasonably practicable to mitigate any such risks. Regulation 12 (1) (a) (b).
- The service must ensure that where responsibility for the care and treatment of service users is shared with, or transferred to, other persons, working with such persons, service users and other appropriate persons to ensure that timely care planning takes place to ensure the health, safety and welfare of the service users. Regulation 12 (2) (i).
- The service must ensure that the nutritional and hydration needs of service users are met. Regulation 14 (1).
- The service must maintain securely an accurate, complete and 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. Regulation (17) (2) (c).
- The service must ensure there are appropriate numbers of suitably qualified, competent and experienced medical and nursing staff to enable them to meet the needs of patients in their care. Regulation 18 (1).
- The service must ensure that persons employed receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform and be enabled where appropriate to obtain further qualifications appropriate to the work they perform. Regulation 18 (1), (2) (a) (b).

Action the trust SHOULD take to improve

In Surgery:

- The service should consider strengthening audit documentation to monitor progress against plans to improve the quality and safety of services and take appropriate action without delay where progress is not achieved as expected.
- The service should continue to make improvements to patient discharge to ensure they are discharged in a timely way with ongoing care or treatment options in place.
- The service should work to increase response rates to the NHS Friends and Family Test to understand wider patient views on the service.

Surgery

- The trust should review the medicines reconciliation policies and procedures to bring targets in line with the trusts own policy.

Our inspection team

Sarah Dronsfield, Head of Hospital Inspection led this inspection. The team included seven inspectors, two inspection managers and one assistant inspector

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect

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

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	S29A Warning Notice