Care Quality Commission

# Chesterfield Royal Hospital NHS Foundation Trust

# Chesterfield Royal Hospital

## Quality Report

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

## Ratings

| | |
|---|---|
| **Overall rating for this hospital** | **Good** |
| Medical care (including older people's care) | |
| Surgery | |
| Critical care | Good |
| Maternity and gynaecology | Good |
| Services for children and young people | |
| End of life care | Requires improvement |
| Outpatients and diagnostic imaging | Good |
| Child and adolescent mental health services (CAMHS) | Requires improvement |

# Summary of findings

## Letter from the Chief Inspector of Hospitals

Chesterfield Royal Hospital NHS Foundation Trust was one of the first hospitals in the country to become a Foundation Trust in January 2005, and serves a population of around 441,000 across the Bolsover, Chesterfield, Derbyshire Dales and North Amber Valley, High Peak and North East Derbyshire districts.Chesterfield Royal Hospital is a medium sized District General Hospital based a mile outside the centre of Chesterfield in an area known as Calow. The hospital is the town's largest employer with a workforce in excess of 3,500 staff and has a total revenue of £221.2 million.Chesterfield Royal Hospitals NHS Foundation Trust is registered to provide the following Regulated Activities:

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

Chesterfield Royal Hospital NHS Foundation Trust were inspected between 13-14 July 2016. Unannounced visits were carried out on 20 July 2016. This inspection is a focused follow up inspection following a comprehensive inspection in April 2015. The purpose of this focused follow up inspection was to inspect domains that had previously been deemed to require improvement.We did not rate the trust overall. We looked at domains that had previously been rated as less than good. We made judgements about seven services across the trust as well as making judgements about the five key questions that we ask.

Our key findings were as follows:

- There was an effective incident reporting system. However, there were incidents that had not been closed on the reporting system. There was an open and honest culture, and people who used the service were told when something went wrong.
- The environment where care was delivered was visibly clean. There were systems, processes and procedures in place for infection prevention and control which were adhered to by the majority of staff.
- The day time ward staffing levels were planned in line with the National Quality Board guidance published in 2013 and 2016.
- There was ongoing, and on occasions, significant numbers of bank and agency staff being used.
- Generally systems were in place to assess and respond to risks where patients were identified as deteriorating.
- There was no critical care outreach team within the hospital, although one was being established.
- Medications were stored appropriately and administered safely.
- An assessment tool was used to assess patient's pain. Where patients experienced pain this was managed well.
- Most equipment, including resuscitation equipment was checked, serviced and safe for use, however some resuscitation equipment was not checked in line with trust policy.
- The trust had recently introduced a new system for staff to access and record their training activities. At the time of the inspection the trust was experiencing difficulties accessing current accurate data of the number of staff who had attended their mandatory training, therefore the trust was not certain on how many staff were currently trained.
- Patient care and treatment was planned and delivered in line with current evidence based guidance, standards, best practice and legislation.
- There were a significant number of patients being moved between wards in the hospital and moves routinely happened after 10pm. These were predominantly from the initial assessment wards to inpatient wards.

# Summary of findings

- Since our last inspection in April 2015 the trust had achieved the appropriate level of suitably qualified nursing staff per shift with the European paediatric life support (EPLS) qualification.
- There was effective multidisciplinary working to deliver patient care.
- Patients were supported, treated with dignity and respect. Relatives and friends were involved in patients care. We saw staff carrying out care with a kind, caring and compassionate attitude.
- Systems were in place to acknowledge complaints within three days. A triage system was in place to establish response times to complaints depending on the complexity. Response times to complaints had improved since our last visit after an action plan was put in place.
- Concerns resolved at ward level were not reported on the incident reporting system; therefore opportunities for learning could be missed however a pilot was taking place to start capturing this information.
- High bed occupancy levels above the trust target was identified as an operational risk with the potential to impact on staffing levels and the quality of patient care. This was being managed on the trust's risk register and a weekly report was being prepared for the commissioners.
- Staff we spoke with were aware of, and understood, the vision and values of the trust. Staff identified the "proud to care" initiative to look after patients.

We saw several areas of outstanding practice including:

- The neonatal gentamicin prescription sheet that had been produced because of lessons learnt from gentamicin medication errors was outstanding. This has reduced the number of incidents to zero within the department and ensured that all patients received the correct management.
- "Toolbox talks"- had been developed and trialled amongst porters with the aim of increasing knowledge of end of life care. "Toolbox talks" were short talks developed and delivered to the porter service manager who then delivered this to their teams. There was a plan in place to roll this out to other non-clinical staff within the trust.
- Members of staff on Markham Ward had written a poem to provide support to relatives of end of life patients. "The palliative approach" poem was sensitively written and described how the ward would care for relatives and their loved ones on the ward.
- Markham Ward had created a "comfort tin" for relatives of patients in the last days or hours of life which included biscuits and tissues had been developed.
- A "comfort tin" for relatives of patients in the last days or hours of life, which included biscuits and tissues, had been developed. We also saw the use of "comfort packs" , which included essential toiletries, such as toothbrushes and cleansing wipes.

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

- The trust must ensure the resuscitation equipment provides a full range of equipment to meet all sizes of children, young people and adults.
- The trust must ensure that in areas where children are treated, appropriate safeguarding measures and staff training are in place.
- The trust must ensure nursing staff who deliver end of life care are familiar with and receive training in the Mental Capacity Act (2005).

In addition the trust should:

- The trust should ensure all DNACPR order forms are completed accurately and in line with trust policy.
- The trust should improve infection control training within the medical division.
- The trust should ensure there are consistent processes in place to assure cleanliness of equipment including the birthing pools within maternity and gynaecology services.
- The trust should ensure cleaning records are maintained for the milk fridges within maternity and gynaecology services.

# Summary of findings

- The trust should ensure all staff are compliant with trust targets and intercollegiate standards in regards to safeguarding level three training.
- The trust should ensure there is a consistent process for assuring the safety of electrical items and they are clearly marked with details of when safety checks are next required. It should be ensured staff are aware to the process for ensuring equipment is checked and safe to use.
- The trust should ensure there is a formalised risk assessment produced for the paediatric resuscitation trolley on Nightingale Ward remaining unlocked.
- The trust should ensure all investigations involving a child or young person should have representation from the Women and Children's division.
- The trust should ensure the sepsis management of children and young people is fully embedded within the service.
- The trust should ensure they work closely with the local hospice in finalising the service level agreement.
- The trust should ensure they continue with the plan to monitor how rapidly patients are discharged from hospitals once identified for "fast track".
- The trust should ensure they audit the achievement of patient's preferred place of death.
- The trust should ensure the legal process of the Mental Capacity Act 2005 is followed where a patient lacks the capacity to make decisions, particularly in relation to 'Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR) orders.
- The trust should consider reviewing the process for transferring obese deceased patients to the mortuary.
- Consider the environment in Hollywell Day Case Unit to ensure the environment where trolleys are located and equipment is washed is suitable to ensure effective infection prevention and control measures can be adhered to.
- Ensure that all ward and department staff receive information on the policy for the monitoring and recording drug fridge temperatures including details of any actions they are accountable for.
- The trust should continue to prioritise reviewing the open incidents, ensure actions are taken to minimise risk ,and ensure actions are completed, learning is shared and records updated.
- Should ensure that the surgical department morbidity and mortality quarterly meetings are established and that there is a robust system is in place to secure attendance and enable learning to be shared.
- Ensure all staff receive annual appraisals.
- Ensure all staff attend mandatory training days.
- Ensure all staff complete safeguarding training suitable to their role and grade.
- The trust should ensure there is a consistent process for assuring the safety of electrical items and they are clearly marked with details of when safety checks are next required. It should be ensured staff are aware to the process for ensuring equipment is checked and safe to use.
- Ensure where resuscitation trolleys are shared between two wards both wards carry out and document the checks as per the trust policy.
- Ensure VIP scores are recorded in a consistent manner and that there is no duplication of information.
- Ensure data is captured when complaints/concerns are resolved at ward level, and ensure that learning is shared.
- Ensure patient transfers are effectively managed to minimise the number of patients transferred after 10pm.
- Ensure sufficient medical staffing is available to meet periods of increased demand and to cover staff absences.
- Ensure the safer steps to surgery check list is fully completed and audit monthly to achieve 100% compliance.
- Ensure the safer steps to surgery check list is used for invasive procedures.
- Ensure all of the divisions have shared governance structures which are consistent and collective.

**Professor Sir Mike Richards**
**Chief Inspector of Hospitals**

# Summary of findings

## Our judgements about each of the main services

| Service | Rating | Why have we given this rating? |
|---|---|---|
| Medical care (including older people's care) | | This was a follow up focussed inspection and therefore we did not rate the medical service overall. At this visit we inspected the safe and responsive domains.<br>The safety of medical services requires improvement.<br>There was ongoing, and on occasions, significant numbers of bank and agency staff being used, which did not ensure wards would be always be adequately staffed with suitably experienced staff.<br>There were incidents from throughout 2015 which were not reviewed. Equipment was not labelled in a way that assured staff that it had passed its safety tests.<br>Resuscitation trolleys were not always checked in line with the trust's resuscitation policy.<br>Staff did not always fully comply with the infection prevention and control measures.<br>There was an open and honest culture, and people who used the service were told when something went wrong. Risks were identified and managed, where patients were identified as being at a particular risk there were procedures available to help keep them safe.<br>The environment where care was delivered was visibly clean.<br>Services were planned to meet the individual needs of patients and longer term planning was in place to ensure local people received the care they would need in the future. Individual needs were assessed and staff planned and delivered care based on their assessments.<br>The responsiveness of medical care services was good.<br>Services were planned to meet the individual needs of patients and longer term planning was in place to ensure local people received the care they would need in the future. Individualised care was provided by the enhanced care team and activity coordinators. |

# Summary of findings

Discharges were planned and procedures were in place to enable patients to be discharged at a weekend. The discharge lounge supported patients on the day of their discharge.
There were a significant number of patients being moved between wards in the hospital and moves routinely happened after 10pm. The winter escalation ward had remained open and this was being used as an outlier ward for medical patients but there were also other medical outliers on surgery wards. The trust was not meeting all the cancer waiting time targets or the diagnostic six week referral target every month.

## Surgery

This was a follow up focussed inspection and therefore we did not rate the surgical service overall. At this visit we inspected the safe and effective domains.
The safety of surgical services was good. There was an open and honest culture, and people who used the service were told when something went wrong. Procedures and systems were available to help keep patients safe. Patient areas were visibly clean and equipment was checked to make sure it was safe for use. In one clinical area the cleaning of equipment was not carried out in a designated area.
Theeffectiveness of surgical services was good. Patient care and treatment was planned and delivered in line with current evidence based guidance, standards, best practice and legislation. Service performance and patient outcomes were evaluated to inform improvements. However, some staff were not receiving regular appraisals to ensure they had the appropriate skills and support to perform their current role and to identify areas of personal and professional development. .

## Critical care

Good

This was a follow up focussed inspection and therefore we did not rate the critical care service overall. We inspected the safe domain only and rated the critical care provision at Chesterfield Royal NHS Foundation Trust as good for safe. We found there had been improvements to the service since our previous inspection in 2015.

# Summary of findings

Staff knew how to use the trust electronic incident reporting system, could demonstrate learning form incidents and understood the principles of duty of candour. However, staff told us they did not always receive feedback from reported incidents.
Patient records were legible, signed and dated in accordance with General Medical Council (GMC) guidance and included a comprehensive range of patient assessments. Care plans were clear and we saw evidence of staff working with them.
Staff adhered to trust policies on infection control and hygiene and both ITU and HDU had positive infection control audit results. Equipment was well maintained. There was access to resuscitation equipment, which was checked regularly and ready for use. Staff were trained in safeguarding and were confident about escalating any concerns.
A key improvement since our last inspection was patients were reviewed in a timely manner and the service had established systems to audit and challenge the timeliness of response by medical staff. There was a plan to move to a new model of critical care in September 2016, which meant HDU patients would be managed by critical care consultants. The service had escalation procedures for managing deteriorating patients and for discharging patients to wards. The service had introduced new procedures for monitoring and managing patient discharges which was audited.
Staffing levels met recommended guidelines and handovers for medical and nursing staff were effective.
However, issues identified were critical care consultants did not receive feedback from mortality and morbidity meetings and staff were frequently moved to support staff shortages in other areas of the hospital, resulting in a risk ofstaff not working to recommended guidelines and staffing ratios.
There was no critical care outreach team, although recruitment was taking place in preparation for commencing this service in September 2016.

| | | | |
|---|---|---|---|
| **Maternity and gynaecology** | **Good** |  | This was a follow up focussed inspection and therefore we did not rate the maternity and gynaecology overall. At this visit we inspected the safe domain. |

# Summary of findings

Since our last inspection staff in maternity and gynaecology services had worked hard to improve the quality of the investigation of serious incidents with root cause analysis. All staff had been involved in training to conduct such investigations and many staff told us they had been involved. This resulted in better quality investigations and reports. The process provided staff with clear actions and lessons to be learnt where applicable.

A recent staffing acuity review was completed using a recognised staffing tool which highlighted the number of registered midwives and unregistered staff required to provide a safe and effective service. There were sufficient number of required registered staff; however, there was a gap in unregistered staff of 10 whole time equivalent (WTE). Despite the outcome of the review and the service having the required number of midwives, there were 55 red flags raised in the birthing centre from January to June 2016 due to staffing issues as a result of high demand. This resulted in the supernumerary co-ordinator taking on patients.

There had been improvement in the dedicated consultant hours provided to the birthing since our last inspection. Dedicated consultant hours now exceeded the recommended 60 hours of the Royal College of Obstetrics and Gynaecology (RCOG) Safer childbirth- the future workforce.

Staff used the maternity early warning score (MEWS) effectively and this had helped to improve the recognition of the deteriorating patient. An early warning scoring system was designed to enable staff to recognise and respond to acute illness and deterioration, and to trigger a clinical response proportionate to the severity of deterioration. There was evidence of good use of risk assessments for patients being admitted. Staff generally had good access to equipment when required, with the exception of the access to resuscitation equipment in the pregnancy assessment centre. Access to the resuscitation equipment in the pregnancy centre had been risk assessed was scored as a low risk.

# Summary of findings

## Services for children and young people

This was a follow up focussed inspection and therefore we did not rate the children's and young people's service overall. At this visit we inspected the safe domain.

Since our last inspection in April 2015 the trust had achieved the appropriate level of suitably qualified nursing staff per shift, with the European paediatric life support (EPLS). This was in line with the Royal College of Nursing (2013) best practice guidance in relation to nurse staffing levels on general children's wards.

However, the trust did not meet the Royal College of Paediatric and Child Health (RCPCH) standards for onsite consultant presence at the time of our inspection, although there were plans for how this would be achieved.

Resuscitation equipment on the children's ward was accessible, although the section containing emergency medications were locked. The resuscitation policy for the paediatric services did not contain details on whether the whole trolley should, or should not be locked. The resuscitation trolley was consistently checked and records demonstrating these checks were reviewed. Basic airway management equipment for older children and adults on the resuscitation trolley was not immediately available, however additional equipment was located in a store cupboard.

Level three safeguarding children training did not meet intercollegiate guidance and the trusts own target of 100%, with the staff on the neonatal unit achieving 81% and staff on Nightingale ward achieving 83% however there were individual plans in place for staff to complete this. Knowledge of safeguarding within the ward areas was generally good and improvements had been made in the adult fracture clinic. There were, however no assurances about the level of safeguarding training in other outpatient areas where children may be seen.

There had been a significant improvement in the completion of patient records and a risk assessments quality. There were good infection prevention and control measures within the service and this was reflected in the low numbers of healthcare acquired infections.

# Summary of findings

## End of life care

**Requires improvement**

Overall, we rated the end of life service as requires improvement. However, there had been clear improvements made since our last inspection.
We rated end of life as requires improvement because
Nursing staff were unaware of the trust's two stage assessment for assessing patients' mental capacity in line with the Mental Capacity Act 2005 (MCA).
During our review of 'Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR) forms, we found that it was recorded on the DNACPR forms that 32 patients did not "have capacity to make and communicate decisions about CPR, nine (28%) of these did not have a Mental Capacity Act (MCA) assessment form completed and, where CPR was a potentially successful treatment which might have been offered to the patient had they capacity, a best interest decision recorded in the notes. This meant the trust's DNACPR policy was not being adhered to, and the legal process of the Mental Capacity Act 2005 was not always followed
Nursing staff were unfamiliar with the Derbyshire Alliance End of Life Care Toolkit, which contained evidence based guidelines (including NICE guidelines) to underpin the care provided. Staff were not familiar with or adhering to the Adult Cardiopulmonary Resuscitation' policy dated December 2014 in relation to review of DNACPR forms from previous admissions.
The trust did not have a process for identifying non-cancer patients requiring end of life, and or, palliative care support. The service did not monitor how rapidly patients were discharged from hospital if they wished to be cared for at home. The service did not monitor if end of life patients died in their preferred place of death. At the time of our inspection, the trust did not separately monitor.
Patients were supported, treated with dignity and respect, and were involved as partners in their care. Feedback from patients and their families was positive and comments included "nothing is too much trouble" and "staff do what they can to help".
We saw staff carrying out care with a kind, caring and compassionate attitude. Staff spoke to patients politely and respected their privacy and dignity by knocking on doors and asking for consent to proceed with tasks.

# Summary of findings

The leadership of end of life care was good. The leadership, governance and culture promoted the delivery of high quality person-centred care. There was a credible end of life strategy in place with well-defined objectives linked into an end of life care improvement plan. We saw the end of life strategy had been widely communicated across the trust. There was an effective and comprehensive process in place to identify, understand, monitor and address current and future risks to end of life services through the end of life strategy group. The quality of care was being monitored in most areas. Where robust monitoring wasn't in place, there were robust plans in place to achieve this. There was a positive culture amongst staff that were committed to providing safe and caring end of life care.

## Outpatients and diagnostic imaging

**Good**

We rated outpatient and diagnostic imaging services as good overall.
Staff reported patient safety incidents and there was evidence of learning from incidents and patient complaints. Senior staff had oversight of risks in their areas. Emergency equipment and resuscitation trolleys were not consistently checked. The patient waiting areas were attended by staff so patients could be observed.
Outpatient departments appeared visibly clean and staff used personal protective equipment (PPE), such as gloves and aprons. Patients care and treatment was delivered in line with current national standards and legislation. Staff demonstrated a commitment to patient-centred care. Patients were treated with dignity and respect and spoke highly of the staff. Patient input and feedback was actively sought and several areas had established patient focus and support groups.
There were some areas that provided a proactive service to patients which included several one-stop clinics which provided efficient co-ordinated care.
Quality governance knowledge was shared amongst staff at team meetings. Staff felt supported by immediate line managers and clinicians. They said they were listened to and able to raise concerns.

## Child and adolescent

**Requires improvement**

We rated CAMHS overall as requires improvement because;

# Summary of findings

**mental health services (CAMHS)**

There were high caseloads within core CAMHS without a clear process or management tool being used to manage or monitor them. It was not clear if risk assessments and care plans were being updated as any updates were recorded within the body of the clinical notes.
Some staff were not receiving regular clinical supervision and it was not always recorded as per the clinical supervision policy.
They did not take self-referrals. There were long waits for specific interventions and there was not a clear process for how young people's mental health should be monitored while waiting. The service relied on the young person or their family to contact CAMHS. The service operated Monday to Friday 0900 to 1700.
However, we also found;
The environment was clean. Clinical staff participated in clinical audit.
All staff were trained in safeguarding children level 3. Staff completed comprehensive assessments in a timely manner.
There was good participation of young people and their parents throughout service delivery.

# Chesterfield Royal Hospital

## Detailed findings

**Services we looked at**

Medical care (including older people's care); Surgery; Critical care; Maternity and gynaecology; Services for children and young people; End of life care; Outpatients and diagnostic imaging and Child and Adolescent Mental Health Services (CAMHS).

# Detailed findings

## Contents



## Background to Chesterfield Royal Hospital

Chesterfield Royal Hospital was built in the 1980s and became a foundation trust in 2005. The hospital serves five local districts with a population of approximately 441,000. There is a small ethnic minority population, with over 96% of the population belonging to a white ethnic group. Life expectancy for both men and women in two districts (Chesterfield and Bolsover) is worse than the England average. In all five districts, the smoking status for mothers at time of delivery is worse than the England average.

The hospital provides 547 inpatient beds, and employs over 3,950 staff. In the year 2015 -16 there were more than 24,735 inpatient admissions, and 409,286 outpatient attendances.

The deprivation in the areas served by the Trust varies considerably with the highest levels of deprivation seen in Bolsover and Chesterfield ranked 58th and 91st most deprived local authorities out of 326, respectively. The three other districts serviced by the Trust have much lower levels of deprivation with East Derbyshire ranked 169th, High Peak ranked 189th and Derbyshire Dales ranked 241st.

## Our inspection team

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

**Our inspection team was led by:** Bridgette Hill, Inspection Manager

The team of 20 included a CQC inspection manager, inspectors and a variety of specialists; including a medical consultants, a surgical consultant, a consultant obstetrician, a consultant paediatrician, a critical care doctor, specialist end of life nurses, a psychologist, a child and adolescent mental health nurse, outpatient nurse and doctor and an experts by experience.

## How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?

# Detailed findings

• Is it well led?

Before our inspection, we reviewed a wide range of information about Chesterfield Royal Hospital and asked other organisations to share the information they held. We sought the views of the clinical commissioning group (CCG), NHS England, National Health Service Intelligence (NHSI), Health Education England, the General Medical Council, the Nursing and Midwifery Council, the Royal Colleges and the local Healthwatch team.

The announced inspection took place on the 13 and 14 July 2016. We did an unannounced visit on 20 July 2016. We spoke with a range of staff throughout the trust, including, nurses, midwives, junior and middle grade doctors, consultants, administrative and clerical staff, physiotherapists and occupational therapists, porters and ancillary staff.

We also spoke with patients and relatives of those who used the services at Chesterfield Royal Hospital.

## Facts and data about Chesterfield Royal Hospital

Chesterfield Royal Hospital NHS Foundation Trust serves five local districts with a population of approximately 441,000.

It has 547 beds: 501 general and acute, 31 maternity and 15 critical care.

The trust employs 3,266 whole time equivalent (WTE) staff.

The trust has a total revenue of £221.2 million and its full costs were £220.4 million. It has a surplus of £0.8 million.

There were 24,735 inpatient admissions, and 409,286 outpatients (total attendances) between November 2015 and April 2016.

## Our ratings for this hospital

Our ratings for this hospital are:

# Detailed findings

| | Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|---|
| Medical care | Requires improvement | N/A | N/A | Good | N/A | N/A |
| Surgery | Good | Good | N/A | N/A | N/A | N/A |
| Critical care | Good | N/A | N/A | N/A | N/A | Good |
| Maternity and gynaecology | Good | Good | N/A | N/A | N/A | Good |
| Services for children and young people | Requires improvement | N/A | N/A | N/A | N/A | N/A |
| End of life care | Good | Requires improvement | Good | Requires improvement | Good | Requires improvement |
| Outpatients and diagnostic imaging | Requires improvement | N/A | Good | Good | Good | Good |
| Child and adolescent mental health services (CAMHS) | Requires improvement | Good | Good | Requires improvement | Good | Requires improvement |
| Overall | N/A | Good | N/A | Good | N/A | Good |

# Medical care (including older people's care)

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

## Information about the service

Chesterfield Royal Hospital NHS Foundation Trust provides medical care services (including older people's care) at Chesterfield Royal Hospital. Medical care services are managed by the Division of Medicine and Emergency Care. Specialities include acute and general medicine, clinical haematology, cardiology, respiratory medicine, gastroenterology elderly care and stroke care.

The trust has 311 medical beds which are located across 10 wards. During 2015, there were 31,151 medical admissions to Chesterfield Royal Hospital; the majority of these were emergency admissions.

During our inspection we visited 14 clinical areas. These included nine medical wards, two surgical wards where medical patients were being cared for, the endoscopy department, the discharge lounge and the cardiac catheterisation suite.

During our inspection we spoke with 34 staff, five patients and interviewed the divisional management team. The staff we spoke to included managers, senior and junior nurses, consultants and other medical staff, health care assistants, student nurses, facilities staff, allied health professionals and pharmacists.

We looked at 13 patient records including medical and nursing records, patient observation charts and medicine administration charts.

Before our inspection we reviewed performance information from and about the trust.

This was a focused inspection following a comprehensive inspection that had taken place in April 2015. At this time medical care was rated as requires improvement for safe and for responsive, therefore this inspection was focused on these key questions.

## Summary of findings

The safety of medical services required improvement and responsiveness of medical services was good.

We found:

- There was on going, and on occasions, significant numbers of bank and agency staff being used, which did not ensure wards would be always be adequately staffed with suitably experienced staff.
- There were a significant number of incidents that had not been closed on the reporting system from throughout 2015. Although actions had been take to address this there had been a delay in sharing any learning that had been identified with staff.
- Resuscitation trolleys were not always checked in line with the trust's resuscitation policy. Records of when resuscitation trolleys had been checked were incomplete on four out of the seven trolleys we checked. Not all equipment was labelled in a way that assured staff that it had passed its safety tests.
- Staff did not always fully comply with the infection prevention and control measures which were intended to protect patients from the risk of infection.
- There were a significant number of patients being moved between wards in the hospital and moves routinely happened after 10pm.

However, we also found

- Risks were identified and managed, where patients were identified as being at a particular risk there were procedures available to help keep them safe. There was an open and honest culture, and people who used the service were told when something went wrong. Individual needs were assessed and staff planned and delivered care based on their assessments.

# Medical care (including older people's care)

- The environment where care was delivered was kept clean. Waste management systems were in place to support staff to safely and effectively manage waste.
- Medications were stored appropriately and administered safely. Documented assessments were used effectively to identify risks, appropriate measures were put in place to keep patients safe. There were dedicated teams of staff helping to prevent patients from falling and keeping them safe.
- Services were planned to meet the individual needs of patients and longer term planning was in place to ensure local people received the care they would need in the future. Individualised care was provided by the enhanced care team and activity coordinators.
- Discharges were planned and procedures were in place to enable patients to be discharged at a weekend. The discharge lounge supported patients on the day of their discharge.

## Are medical care services safe?

**Requires improvement**

We rated safety of medical services as requires improvement because

- Incident records had not all been closed, this meant we could not be assured that all learning from incidents had been shared. Where learning from incidents was available sufficient priority had not always been given to discussing the lessons learnt with staff.
- Although nurse staffing levels were closely managed; the number of vacancies, the reliance on bank and agency staff and the current level of demand meant safe staffing levels were not assured at all times.
- Although there were systems in place intended to keep equipment maintained and safe for use, equipment was not always marked in such a way to assure staff that it was safe to use.
- Checks on resuscitation equipment were not always carried out at ward level in line with documented procedures. On both the announced and unannounced inspection we found records that on the checks carried out on resuscitation trolleys to be incomplete.
- Staff did not always make sure that the risk of infection was minimised and the training on infection prevention and control had only been attended by 59% of staff.

However, we also found that

- Staff had a good understanding of the incident reporting process, incidents had been reported from all areas of the medical services.
- There was an open and honest approach to the delivery of care and staff understood their responsibilities under the duty of candour.
- The environment was visibly clean. Waste management systems were in place to support staff to safely and effectively manage waste.
- Confidential information was handled appropriately. Written records were kept safe, information sharing at ward level was handled sensitively, and confidential information that was no longer required was stored securely prior to destruction.

- There were clear and documented systems in place to support staff to ensure patient risks were identified and managed.

**Incidents**.

- An online reporting system was used to report incidents and all staff were familiar with the process for reporting incidents, near misses and accidents. Staff were encouraged to report incidents. Staff on the Emergency Management Unit (EMU) gave examples of reporting pressure ulcers via the electronic reporting system.
- Staff received an automated acknowledgement following submission of an online incident report and an additional update where an investigation was carried out by a senior member of staff, usually the ward matron. Senior nursing staff confirmed their investigation findings were shared via the online system.
- From April 2015 to March 2016, 2904 incidents had been reported by the Medicine and Emergency Care Division. Data submitted by the trust showed as of July 2016, 256 of these incidents had not been closed. Initial actions were recorded for all of the incidents. We could therefore not be assured all investigations were complete, or that learning had been identified and shared. Following the inspection the trust confirmed that any incidents which remained open within the Medicine and Emergency Care Division were being actively managed by the division's governance matron. The delay in sharing learning from incidents had the potential to have a negative impact on patient safety.
- Additional data submitted by the trust for the reporting period April 2016 to June 2016 identified a further 683 incidents had been reported, there were documented actions following incident reviews. Incidents that were waiting for review were, in the majority of cases were those which had been reported in June 2016.
- There were no never events in this service from June 2015 to May 2016. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systematic protective barriers are available at a national level, and should have been implemented by all healthcare providers.
- There were 30 serious incidents reported in the division of Medicine and Emergency Care from June 2015 to May 2016. Serious incidents are events in health care where there is potential for learning or the consequences are so significant that they warrant using additional resources to mount a comprehensive response.
- The most frequently reported serious incident type was pressure ulcers, which accounted for 19 (63%) of the serious incidents, with an average of two per month since November 2015. Slips, trips and falls accounted for a further eight (3%) of the serious incidents.
- We reviewed an investigation report into a hospital acquired pressure ulcer. This was a detailed report which identified the root cause and areas for learning. An action plan had been developed to address the key points and progress was monitored via the divisional quality governance framework.
- We reviewed the endoscopy team meeting minutes from April and May 2016 and noted incidents were a standing agenda item. In the May 2016 meeting hard copies of the incident details were provided to staff but it was in the minutes that due to time constraints staff were asked to look at the common themes for themselves.
- On Eastwood Ward, we reviewed notes where a patient had fallen recently. The patient's medical notes contained a very noticeable sticker which contained details of the date, time, incident number and the nature of incident. A current falls care plan was in place for this patient.
- National Patient Safety Alerts (NPSA) were issued to healthcare providers to update them about critical safety incidents and to provide guidance. An NPSA was issued in 2015 recommending the use of closed application systems for skin preparation liquids. Nationally there had been three serious incidents where skin preparation liquids had been mistaken for medicine and been given as an injection to patients. The cardiac catheterisation suite had ensured the skin preparation products they used complied with the safety alert and helped to keep patients safe.
- Medical mortality meetings were held quarterly to review patient deaths. We reviewed minutes from three of these meetings which had been very well attended by medical staff. There was no record that other members of the multi-disciplinary team had regularly attended these meetings. Discussions included case reviews and

feedback from a trust wide mortality audit. Morbidity and mortality meetings enable health professionals to formally review and discuss individual cases to identify and share learning.

- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. All staff were aware of the need to be open and honest with patients and their relatives. Senior nursing staff identified where the duty of candour process had been implemented following a patient fall. Staff also spoke of how a duty of candour prompt and associated documentation was linked to the online reporting system.

**Safety thermometer**

- The NHS Safety Thermometer is a local improvement tool for measuring, monitoring and analysing patient harms and harm free care. It provides a monthly snap shot of four avoidable harms; pressure ulcers, falls, urinary tract infections in patients with a catheter and blood clots or venous thromboembolism (VTE). Patient safety thermometer data was prominently displayed on the wards we visited, for patients, relatives and for staff to view.
- The Division of Medicine and Emergency Care safety thermometer results from March 2016 to June 2016 showed the division achieving 98.1% to 99% harm free care.

**Cleanliness, infection control and hygiene**

- All the wards and departments we visited on inspection were visibly clean. We observed facilities staff cleaning throughout the day. There was a system in place to ensure patient toilets were cleaned and checked, staff signed check sheets located in the toilets to confirm the work had been completed. On the EMU we checked the check sheets in three toilets and these had been fully completed for the previous two weeks.
- All equipment was visibly clean. Labels were applied to commodes to identify when they had been cleaned and commodes that had been identified with a 'clean' label were visibly clean. On Eastwood Ward an infusion pump and syringe driver which were not in use had been left on the floor, these were removed immediately when they were seen by a senior member of staff.
- Staff did not take all possible steps to minimise the risk of infection. In the cardiac catheterisation suite, cardiac monitor cables had been washed after being used during a procedure and were waiting to be sent for sterilisation, these had been left draining over the scrub sink. A scrub sink is a sink designated to be used by staff when washing their hands prior to them putting on sterile gloves and gowns. We raised this concern at the time of inspection and were informed this was usual practice.
- On Pearson Ward, a patient was being nursed in a side room to protect them from any potential infections on the main ward. We noted that the door to this room had been left open. We raised this during the inspection and the matron explained this should have been closed and took immediate action and closed the door
- Data supplied by the trust stated 59% of staff working within the medical service had completed infection control training against a trust target of 90%. Waste bins were located in all areas of the wards and departments and clear signs and colour coded bags identified which bins were for clinical and which were for domestic waste.
- Prominent and audible reminders to staff and visitors on the importance of good hand hygiene were noted throughout the wards and departments and hand washing and hand gel were readily available.
- All staff, without exception, were bare below the elbows. We observed medical, allied health professionals and nursing staff using the appropriate personal protective equipment (PPE) and washing their hands before and after delivering care and when entering and leaving the ward areas.
- Side rooms were used to care for patients where a potential or actual risk of infection had been identified. During the inspection we visited one ward where a bay area had been used to isolate a known infection risk. Signs were in place giving information on the precautions to be taken before entering the isolated areas and rooms
- Sharps bins were signed and dated when being used and stored appropriately when sealed and ready for collection. Access to dirty utility rooms from publically accessible areas was restricted.
- Confidential waste was disposed of in clearly labelled locked storage bins which were located in areas where the public either did not have access or where there was constant observation.

- Between January and April 2016 within the Medicaland Emergency Care Division there had been no cases of hospital acquired Methicillin-resistant Staphylococcus aureus. (MRSA) MRSA is a type of bacterial infection and is resistant to many antibiotics. There were four cases of Clostridium difficile infection. Clostridium difficile is a bacterium affecting the digestive system; it often affects people who have been given antibiotics.

**Environment and equipment**

- Patient Led Assessments of the Care Environment (PLACE) are annual assessments of care environment; part of the assessment is of the condition, appearance and maintenance of the care environment including the décor, fixtures and fittings, tidiness, signage and lighting (including access to natural light).
- The trust performance in the PLACE audit published in August 2015 on the condition, appearance and maintenance of the environment was 91.6%.This was above the national average performance of 90.1%. The 2016 audit carried out in April showed further improvement in the trust's performance to 97%.
- The trust had conducted an internal environment audit in April 2016, medical inpatient areas obtained between 93.7% and 100%. The Discharge Lounge had achieved a score of 100%.
- During the inspection we noted some ward environments, for example; the EMU and Eastwood Ward had limited space, especially for the storage of equipment. On Eastwood Ward wheelchairs were stored in the dining room/dayroom and on EMU the main corridor contained trolleys storing packaged sterile equipment. Whilst this made the equipment accessible the corridor was cluttered. Eastwood Ward also had limited desk space available for the multidisciplinary team to comfortably sit and update patient records.
- There was no piped oxygen and suction in the cardiac catheterisation suite, this had been noted on the previous inspection. In March 2016, a clinical risk assessment had been carried out and a decision made that piped oxygen and suction would not be installed. We saw four large oxygen cylinders located within the suite, and senior staff informed us these were replaced as they were used. There had been no incidents where a patient's condition had been adversely affected by piped oxygen and suction not being installed. The Health Building Note 01-01 Cardiac Facilities 2013, provides 'best practice" guidance on the design and planning of new healthcare buildings and on the adaptation/extension of existing facilities. It states 'one of the key engineering considerations' for cardiac catheterisation laboratories 'medical oxygen, medical compressed air and medical vacuum, together with nitrous oxide and active anaesthetic gas scavenging, should be provided from wall-mounted outlets or a ceiling-mounted pendant.' The trust had considered the health building note as part of their formal risk assessment process.
- The trust had identified, on their risk register that five temporary pacing boxes, which were being used, had expired their recommended lifespan. A temporary pacing box provides electrical impulses for a patient's heart when there is a problem with their own electrical impulses. These needed to be replaced as they could not be repaired should they stop working. We were told, that replacement of this equipment was expected during September 2016, and saw one of the pacing boxes in the cardiac catheter laboratory /suite was marked for replacement
- Adjacent to Eastwood Ward there was a large, well equipped therapy suite. This contained a bedroom, bathroom, toilet and kitchen which enabled thorough assessments to be made of a patient's needs prior to discharge. The suite had sufficient room for physical activities and exercises to be undertaken as part of patient's rehabilitation.
- We looked at 20 pieces of electrical equipment across several wards, which included electronic devices for measuring blood pressure, monitoring devices and resuscitation equipment, 13 pieces of equipment were fully labelled, identified with a unique serial number and had appropriate safety checks completed. Of the remaining seven, one did not have a unique serial number, one had passed the date on which a safety check was due and the other five had no date displayed on when the next service/safety check date was due. Staff on the ward were therefore not aware of when this equipment was due for the next safety check.
- All resuscitation trolleys had equipment drawers secured with tags and the date recorded when the seal needed to be broken and items checked. There were clear instructions on how this system worked on each trolley. The date on the tags was hand written and when thick marker pen had been used the date was not always easy to decipher.

- We reviewed seven resuscitation trolleys, a current daily checklist for July 2016 was available on each trolley. There were fully completed checklists on three out of the seven trolleys. On the remaining four trolleys three had three or less check signatures missing during June 2016. Checks for July were all complete on these trolleys.
- On the seventh trolley which was located adjacent to Eastwood and Durrant Ward records were available for June and July 2016. This trolley was used by both wards and checks were carried out twice every day, once by each ward. There were signatures missing from the check list on 19 occasions in June and once in July. These dates had already been highlighted on the check sheet. Staff were aware the sheets were audited.
- On our unannounced inspection we re-checked this trolley, during the six days following our inspection the trolley had been checked every day, there was one day when only one check had been signed.
- Staff could access the equipment they needed to care safely for patients and specialised equipment was obtained where it was required, for example, mattresses with enhanced pressure relieving features.

**Medicines**

- We saw medicines including intravenous fluids were stored appropriately and safely in designated rooms with secure access. Medicine fridges were also located in these rooms.
- Medicines storage at the patient bedside was secure and was re-secured after use.
- Medicine fridges contained a display which showed the internal fridge temperature. There were inconsistencies across the medical wards on the staffs' understanding of the procedure for monitoring and recording fridge temperatures. We raised this during our inspection with the senior management of the trust. We were informed that the fridge temperatures were now centrally monitored by the pharmacy department. Wards were not required to record daily fridge temperatures and that ward staff would be updated with this information. Documentation supplied by the trust after the inspection provided evidence that fridge temperatures were monitored centrally.
- Medicines to be returned to pharmacy were segregated from ward stock medicines and placed in secure 'return to pharmacy' storage containers which were located in the locked medicine preparation rooms.
- On Eastwood Ward we observed a pharmacist ensuring the correct dose of an antibiotic was prescribed prior to it being given to a patient.
- Medical staff told us that information on medicines including antibiotic prescribing protocols was accessible via the trust intranet.
- Patient medicine administration records for intravenous fluids were accessible. We looked at two records and both were clear, dated and signed with the times recorded of when the fluids had been commenced.
- We observed the administration of an oral medicine on Eastwood Ward, the nurse administered the medicines safely, seeking patient consent and checking their personal details before the administration.Medicine administrationwas in line with the Nursing and Midwifery Council's 'Standards for Medicines Management.'
- There were ward based pharmacy services available. In the Discharge Lounge the pharmacy technician explained patients take home medicines to them, this helped to ensure patients understood the medicines the needed to take and why they were taking them. We observed the technician answering a patient's questions and they were giving very clear information.
- An out of hours pharmacy service was available as well as an emergency medicine cupboard which was accessed via one of the site matrons.
- Medicines management and medical gases training were both on the mandatory training requirements for nursing staff.
- During the reporting period April 2015 to March 2016, 367 medicine related incidents were reported by theMedicine and Emergency Care Divisionvia the online reporting system. This accounted for 13% of all the incidents reported during this period. These included; medicines not being prescribed, and where the wrong drug or quantity of drug had been prescribed or administered.

**Records**

- Patient nursing care and medical records were in paper format. Nursing and observation records were located in

patient areas and medical records were stored in notes trolleys. Notes trolleys were not locked but all were seen located in highly observable areas and none were in public thoroughfares.

- Wards had electronic white boards which displayed minimal personal information and colour coding was used to provide detailed information to staff. On Eastwood Ward we saw the information on the electronic board being used to inform the multidisciplinary team during a board huddle.
- Patient records contained entries from all members of the multidisciplinary team, including physiotherapists, occupational therapists and dietitians.
- There was a large amount of nursing documentation with some duplication of information. The visual infusion phlebitis score, (VIP Score) assessment tool was used to identify any vein inflammation when an intravenous line was in place was recorded on both the cannula assessment record by some staff and on the patients daily care record by others.
- There were template documents available including for the assessment of a patients risk to falls, nutritional needs and pressure area condition. The national early warning scoring (NEWS) system was used to monitor patient observations and to determine when an escalation of treatment was required.
- Nursing staff informed us patients past medical records were readily available at all times. Temporary sets of medical notes were compiled on initial admission.
- New nursing documentation was just being phased in by the trust and staff 'drop in' sessions were being held to update staff on the changes. The documentation consisted of two separate documents instead of three. Changes had been made to the assessment and recording of the screening and monitoring for sepsis and delirium. Delirium is a state of mental confusion that can occur as a result of illness, surgery or with the use of some medicines. Sepsis; (septicaemia) is apotentially life threatening condition triggered by an infectionor injury. Without quick treatment, sepsis can lead to multiple organ failure and death.
- The trust used the SBAR (Situation, Background, Assessment, Results) communication tool. A proforma SBAR document was available. This gave structure and detail to the sharing of information. Staff explained that it was used predominantly when patients were transferred. The new nursing documentation contained an updated version of the pro-forma. We reviewed a completed SBAR form used for a patient transfer and it was fully completed.

**Safeguarding**

- Data supplied by the trust stated safeguarding training was part of the mandatory training programme. We were unable to report on the number of staff that had received safeguarding training as the trust were unable to provide reliable data as to the number of staff that had attended training. This was due to a new training record system being introduced.
- Staff we spoke to had a good understanding of what their safeguarding responsibilities were. They were able to identify what types of concerns led them to make a safeguarding referral, these included signs of physical and mental abuse. Staff were aware their responsibilities extended to patients relatives and carer's as well as for the patients themselves.
- One member of staff gave an example where a safeguarding referral had been made following an emergency admission which left a young teenager without an adult at home.
- The trust's adult safeguarding policy 2016 directed staff to the trust's female genital mutilation policy (FGM). FGM is defined as the partial or total removal of the female external genitalia for non-medical reasons.
- The safeguarding adult's operational group met on a bi monthly basis, minutes from these meeting confirmed theMedicine and Emergency Care Division was represented at these meetings and previous safeguarding referrals had been raised, discussed and learning shared.

**Mandatory training**

- The trust had recently introduced a new system for staff to access and record their training activities. At the time of the inspection the trust was experiencing difficulties accessing current accurate data of the number of staff who had attended their mandatory training, therefore the trust was not certain on how many staff were currently trained.
- Annual mandatory training was provided over two training days. Training updates included information on infection control, The Mental Capacity Act 2005, Deprivation of Liberty Safeguards (DoLs), dementia,

health and safety, equality and diversity, information governance, resuscitation, blood transfusion and medicines management. Safeguarding training was also included.

**Assessing and responding to patient risk**

- The national early warning score (NEWS) system was used to monitor and record patient's physiological observations including blood pressure, heart rate and temperature, these were being recorded at least once every 12 hours. This was in line with the National Institute for Health and Care Excellence (NICE) guidance CG50 on the care of Acutely Ill Adults in Hospital – Recognising and Responding to Deterioration.
- The NEWS system was designed to enable staff to recognise and respond to acute illness, for example, possible septicaemia and acute clinical deterioration, and to trigger a clinical response proportionate to the severity of deterioration.
- We reviewed nine NEWS observation charts and found eight charts had all observations recorded and decisions had been made regarding the necessity to escalate concerns were documented in nursing records. On one chart the frequency the observations had been recorded was not in line with the NEWS guidelines. We raised this at the time of inspection with a senior member of staff who confirmed observations should have been carried out more frequently.
- The same observation chart had one of the 'total scores' not added up and documented. This meant it was not easy to immediately establish the exact level of risk.
- We looked at the sepsis screening criteria for four of these patients and saw they had been screened where indicated for sepsis. Internal sepsis screening audit data supplied by the trust for the reporting period April 2015 to March 2016 showed that 27 of the 411 patients (6.6%) who needed to be screened for sepsis did not have this carried out.
- The visual infusion phlebitis score (VIP Score) assessment tool was used to identify any vein inflammation when an intravenous line was in place. There were inconsistencies across the medical wards on where the VIP score was recorded. On Hasland Ward checks were comprehensively recorded and a specific cannula assessment document was used.
- On EMU the patient's daily care progress chart was used to record the VIP score. VIP scores were recoded three times in 24 hours. One member of staff spoke of the unit using the specific cannula assessment record but was unable to locate it for two patients who had a cannula. A cannula is a small plastic tube placed in the vein to enable medication or fluid to be given. In another patient record three VIP score checks had been recorded over the previous three days. These were recorded on the patient's daily progress record.
- During our unannounced inspection we observed the clinical handover meeting which took place at 9pm every evening. Medical staff handed over to medical staff and matrons covering the hospital overnight. This was a comprehensive handover, where detailed information was provided of patients who required senior reviews following their recent admission, and patients whose condition had deteriorated or needed increased observation or investigations. Details included treatment and escalation plans and when outstanding investigation results would be available. Following the handover, medical staff took accountability for each of the outstanding pieces of work. A record was made of the meeting. The matrons were fully informed of the patients who were at greatest risk.
- There was no critical care outreach team within the hospital, although one was being established. An outreach team are a critical care based team of nursing staff who respond to patients who were deteriorating on the wards and review patients who have been discharged from critical care. There was a high dependency and intensive care unit on site which provided more intensive observation, treatment and nursing care than was possible on a general ward. The matron who was part of hospital at night team provided support for ward staff where a patient's condition was unstable.
- On the emergency management unit (EMU) senior nursing staff explained fluid balance charts had not always been fully completed. A piece of work had been done to establish why staff did not complete these charts. In an attempt improve completion rates patients were individually assessed to establish whether they needed a fluid balance chart maintaining or not. Shift leaders also reviewed the charts each shift.
- We reviewed five patients' medical notes for evidence of the venous thromboembolism assessment process, in all five records this was completed and appropriate actions had been taken in response to any identified risk.

- An accountability check sheet had been recently introduced, this document was used to help give structure and completeness to the nurse handover process. We reviewed a completed checklist for one patient and it contained key information on the patient's current and planned care. A senior member of staff explained after a physical check of the current care and patient condition both nurses would sign the sheet
- Patients were assessed and risks documented for the risk of falls,malnutrition and skin condition. A care bundle was used to minimise the risk of falls and a risk assessment tool to assess the condition of pressure areas. The malnutrition universal screening tool was used for the assessment of patient's nutritional needs.
- Where patients were identified as being at an increased risk of harm, for example from falls, additional care was provided by the enhanced nursing team. The enhanced care team, worked primarily on a one to one or one member of staff to two patients, depending on patient need. We observed this additional support being provided and the patient appeared reassured and relaxed by the enhanced nursing team having the time to sit with them.

**Nursing staffing**

- A recognised nursing acuity/dependency tool was used for determining the actual number of nursing staff required to deliver safe care and treatment taking into account the actual current numbers and dependency levels of patients on the wards.
- The ward nurse staffing levels were planned in accordance with the National Quality Board guidance published in 2013 and 2016. We reviewed the planned night shift staffing levels for registered nurses on eight medical wards. On Durrant ward the planned staffing level was two registered nurses to 30 patients.
- During our evening unannounced inspection we spoke with staff on Ashover Ward, a 32 bedded ward which was full. There were two trained nurses on the shift. One of these nurses was an agency nurse who had not worked on the ward previously. There were two health care support staff also on the shift.Staff told us these were the usual numbers of staff rostered on nights for this ward. The data supplied by the trust reported that there were three trained nurses on this ward overnight. Following the inspection the trustprovided information that the ward was funded for tworegistered nurses andthreeunqualified staff.One of the patients on this ward had been highlighted as needing additional observation, investigation and treatment overnight due to a sudden unexpected change to their condition. One of matrons in the hospital at night team was providing support with this patient.
- Following the inspection the trust informed CQC that the planned staffing on Durrant ward and Ashover ward of two registered nurses and three un qualified nurses had taken into account the high physical dependency of the patients on these two wards.
- A hospital at night team was available from 9pm to 7:30am this was covered by two matrons working a slightly staggered shift pattern. This team provided overnight site cover, and managed patient flow and staffing. There was an escalation plan in place for contacting senior management out of hours if additional support was needed.
- Where there was a shortfall in the rostered number of nurses or due to increasing numbers or patient acuity, which was not covered by existing staffing levels, additional staff were sought. A request for hospital bank staff was made and if this unsuccessful, an agency nurse would be sourced.
- During our unannounced inspection there was a higher than usual frequency of staff sickness, this meant the matron had moved staff between the wards to ensure the optimum skill mix and numbers of staff from those available.
- Some shifts were overfilled where more nurses than were planned were on the rota due to the increase in the dependency or numbers of patients In March 2016 shift fill rates for registered nurses ranged from 95.4% to 101.6% and for care staff they ranged from 81.3% to 112.1%. In April 2016 the lowest fill rates improved for registered nurses to 96.2%, and for care staff to 85.8%.
- The medical division had recognised a potential risk to patient safety where staff were being moved to cover shortfalls, potentially leaving another area with less staff than was planned. This risk was being managed on the trust risk register. Actions included close ongoing management of staffing every day.
- A daily medical division meeting was held to manage the staffing requirements for the next 24 hour period. All wards were represented at the meeting usually by the matron. Staff would be redeployed within the division to help manage any increasing dependencies or staffing shortfalls.

- A procedure was in place to enable staff to escalate their concerns regarding staffing levels. A 'red flag event' was recorded. A red flag event could be raised for a variety of staffing reasons, less than two registered nurses per shift, or if qualified staffing levels were more than 25% short this would generate a red flag. When patient related outcomes were evaluated, for example; falls or medicine errors any red flag events would be noted. Red flag data was presented to the board of directors as part of the monthly nursing & midwifery staffing levels report**.**
- Senior staff on EMU explained following a review of staffing requirements two additional qualified staff were now rostered on the night shift. The staffing reviewhad taken into account several pieces of information includingfindings from a care contact study and staff feedback on the ward staffing requirements.Senior staff reported that there had been positive feedback from staff and a qualified nurse could now be allocated to each bay area on the ward.
- Planned and actual staffing numbers on each shift were displayed on all the ward areas we visited during the day. This information was updated during the inspection period and reflected the number of staff on the shift.
- Senior staff on Eastwood Ward explained that if the nurse in charge of the shift was needed to respond as part of the thrombolysis team then the matron would provide additional support for the ward. For the reporting period April to June 2016 there were six incidents reported regarding shortage of staff on Eastwood Ward, this related to both trained and untrained staff where staff had escalated their concerns.
- We observed part of a shift handover between the nursing staff on the EMU. Handover took place in the ward area, and nurses handed over directly to each other using the patient nursing records and observation charts.
- From speaking to staff on the wards they reported different levels of bank and agency staff being needed on the wards. Some ward staff explained they had used low numbers of agency staff, for example Hasland Ward. Some wards for example Pearson Ward which had been opened to meet the winter period demand and had remained open were using bank and agency staff on a daily basis. Where wards were able to retain staff and planned staffing levels were usually met staff explained they were moved to other wards. This adversely affected staff morale.
- In April 2016 there were 51 nursing staff vacancies within the medical division. The potential impact of the nurse vacancies within the division was being managed on the divisional risk register. Because of the trust's inability to recruit and retain sufficient numbers of trained staff, the staff rotas were being planned eight weeks in advance to ensure bank and agency staff could be sought as early as possible.
- The enhanced nursing team currently consisted of a team of eight carers with the intention of increasing the team up to 12. A recruitment plan was in place for these additional staff. Staff on the wards told us there were not enough staff in the team to meet the demand and patient need was prioritised.
- Bank and agency staff completed an induction process when they first worked on an unfamiliar ward. We saw completed signed copies of the essential information and checklist for agency staff. We spoke to an agency nurse who confirmed they had received an induction and had good support from trust staff. Student nurses we spoke to had been well supported on the wards that they were currently working on.

**Medical staffing**

- The trust's medical staffing showed 38% of the skill mix was made up of consultants. This was higher than the national average which was 34%. The trust had a lower number of middle grade doctors; 2%, than the England national average; 6%, for acute trusts. In addition, the trust had a lower than average number of registrars with 35% compared to the England average of 39%, and higher than average number of junior doctors, 25% for this trust; 22% England average.
- The average medical locum usage for October 2015 to March 2016 in the Medicine and Emergency Care Division was 13.2% compared to 30.3% in the previous six months. In the first three months of 2016 there had been significantly less use of locum medical staff than in the previous three months. In April 2016 there were 20 medical staff vacancies within the Medicine and Emergency Care Division.
- The planned medical staffing was one consultant per ward covering 9am until 5pm and until 9pm on the EMU. Junior medical cover was planned for each ward to have

a minimum of two junior doctors. The on call cover was provided by one consultant, in the day the team consisted of nine doctors of varying grades, at night this was reduced to three.

- On our unannounced inspection we observed the clinical handover meeting between medical staff. This included a comprehensive handover of the medical patients identified as being at the highest risk of deterioration overnight and the patients who required treatment, investigations or assessments to be carried out.
- The senior leads of the service explained that a new way of providing senior medical cover was currently being trialled one day a week on the EMU. Instead of one consultant reviewing all the patients that had been admitted after 4pm the previous day, up to four consultants were covering this role. Initial outcomes had shown to be promising, patients received an earlier senior review and this had helped with patient flow and the round was usually completed by 9:30am in comparison to late morning with the existing approach.
- We spoke with eight medical staff, including consultants and junior staff. Overall, junior doctors felt access to consultants was good. Some felt there could, on occasions, have been better consultant support, with clearer communication and better documented treatment plans to ensure key decisions were made by senior staff.
- Some junior staff also felt due to leave cover and other absences the workload was at times extremely busy and difficult to manage although not unsafe
- Medical staffing was a risk that was being managed on the divisional risk register. There were insufficient numbers of consultants to ensure acute medical patients admitted to the trust would be reviewed within 14 hours by a consultant if their admission was over the weekend period. This also had the potential to delay discharges, increasing the number of medical inpatients and affecting patient flow.

**Major incident awareness and training**

- There was a trust wide major incident plan in place to guide staff of all levels, and in all locations, as to what actions they needed to take in the event of a major incident being declared.
- The trust had devised a training plan to ensure staff were able to manage a significant incident whilst maintaining services to patients. The frequency of the training was set out the training strategy for 2016/2017 and was in line with the 2015, NHS England, Core Standards for Emergency Preparedness, Resilience and Response.
- The trust had a trust resilience plan for the 2015/16 period to ensure the effective and consistent management of all in-patient beds. This incorporated the trust plans to deal with the seasonal winter bed pressures which included an increased number of medical patient beds and severe weather contingency plans.
- Staff we spoke to understood what could be considered a major incident at the trust and understood their initial role should the plan be implemented. Staff knew where they could find the information they needed and, depending on their level seniority what response was required. One member of staff recalled watching of a major incident video, this was part of the trust's training plan. Another member of staff recalled attending a specific training day on planning for a major incident.

## Are medical care services responsive?

Good

We rated the responsiveness of medical care services as good because:

- Medical services were planned, taking into account the future needs of the local people. Plans to extend both endoscopy and cancer care services had been delivered as planned, to be available this later year.
- There were documented plans in place to meet service needs in an emergency. Patients requiring immediate care following a stroke had access to a designated team of staff providing immediate care. There were established means of corroborative planning of care services with local partners.
- Patient's individual needs were assessed and care was planned to meet individual patient needs. The enhanced care team provided individualised care to the patients who most needed it. Activity coordinators worked with small groups of patients to assist their recovery.
- Patients and relatives were encouraged to provide feedback, whether positive or negative about their experience.

- Discharges were planned and plans were documented to enable decisions to be made and discharges to take place at the weekend. The discharge lounge supported and facilitated a smooth discharge process and met individual patient needs.

However we also found;

- There were a significant number of medical outliers which made effective patient management difficult and impacted on the number of times patients that were moved from one ward to another during their hospital stay. Patients were moved within the hospital after 10pm at night.
- Feedback and learning shared from complaints was not consistently recorded on the complaint record. Concerns resolved at ward level were not reported on the incident reporting system; therefore opportunities for learning could be missed however a pilot was taking place to start capturing this information.

**Service planning and delivery to meet the needs of local people**

- The trust's on-going commitment for planning services to meet the needs of local people was set out in the trust's 2014 to 2019 clinical services strategy. It recognised that the local health care needs were changing, with a growing number of elderly people, an increase in the number of long term conditions, and that the demand for healthcare was rising. The divisional plan for medicine and emergency care sets out the division's priority objectives.
- The provision of medical services is a key part of the trust's vision to deliver high performing, sustainable and appropriate services to the local people of North Derbyshire. Integrated medical services were being planned in partnership with local commissioners and other key stakeholders including local authorities as part of the 21st Century #JoinedUpCare programme.
- By being part of the Working Together Project, in corroboration with six other acute trusts, arrangements were strengthened for consultant delivered interventions. For example, urgent endoscopy services for gastrointestinal bleeding was provided for local people as part of a regional network.
- Medical care services were planned to meet both the long and shorter term increases in demand. To meet the demand for bowel screening and improve the cancer pathway, additional capacity in endoscopy unit was planned and the £4.7million refurbishment programme has been delivered, with final completion planned within the next two months**.** The new cancer centre, due to open this year, was planned to meet the needs of the local community with a significantly increased capacity for treatment, therapy, and support for local patients with cancer.
- Service planning to meet seasonal variations in demand for medical services were in place over the winter period. The trust's resilience plan 2015/2016 contained the plan to deal with the anticipated increase in demand for medical inpatient beds in December and January 2016. The escalation ward; Pearson Ward, was opened to meet this demand and had remained open and was visited on inspection.
- Senior staff explained that as part of a Working Together Transformation Programme they had been involved in the review of stroke services currently provided across the region. The review was the first stage of a transformation programme of Hyper Acute Stroke Unit services focused on improving the health outcomes for local people.
- Ambulatory care, provided care for patients who did not require admission into a hospital bed to receive observation, investigation or treatment. This service was available from 8am in the morning until 9pm at night providing a service into the evening.

**Access and flow**

- Access to the inpatient medical services was via the hospital emergency department, via a GP (general practitioner) or from a transfer or referral from within this hospital, or other hospitals.
- The number of medical beds was adjusted to meet the anticipated and actual patient demand. From January 2016 the number of available medical beds had been consistent at just over 340. Trust data showed that from November 2015 to April 2016 bed occupancy rates for medical wards was between 92.6% and 99.7%, with an average occupancy rate of 96.6%. It is generally accepted that if bed occupancy goes above 85% then this may start to affect the quality of care, 85% was the trust's bed occupancy target.
- High bed occupancy levels above the trust target was identified as an operational risk with the potential to

impact on staffing levels and the quality of patient care. This was being managed on the trust's risk register and a weekly report was being prepared for the commissioners.

- A patient flow team was available daily within the hospital and focused on optimising bed usage and managing patient flow. A current and anticipated bed state for each ward, including details of planned patient admissions and planned and potential discharges was reviewed every morning. Bed meetings were held throughout the day as required.
- A list of patients who were being cared for outside their speciality area was created, also referred to as outliers. An outlier is a patient who is not nursed on the ward that they would usually be admitted to due to a shortage of beds. This list was updated by the patient flow team and distributed to the wards and medical staff. We used this list to determine where medical outliers were on two days of our inspection. We found the information on the list was accurate for the two surgical wards that we visited.
- There were 14 medical patients being cared for on three surgical wards when we reviewed the list and a further 29 patients on Pearson Ward. This ward had been opened to meet patient demand over the winter period and had remained open because of the continuing demand. Patients on Pearson Ward remained under the care of the consultant under which they were admitted. At the time of inspection 10 different consultants had patients being cared for on Pearson Ward.
- We were told that Pearson Ward was due to remain open for the foreseeable future and a designated consultant was scheduled to start in post the following week. We saw this as a positive action to ensure patents received consistent and effective care in a timely manner and to potentially reduce the number of times patients needed to move between wards. The trust had set a target for the number of medical outliers each consultant would have at a maximum of six, from records supplied by the trust during the inspection these levels had not been exceeded.
- During the course of our announced and unannounced inspection we reviewed the medical notes of seven patients who were medical outliers and all had received a medical review that day. Staff explained that medical reviews of outlying patients were sometimes completed quite late in the day but that medical staff were always immediately accessible if the patient needed an urgent review. Medical staff explained that when they had outliers on several wards this made it difficult to make a timely review of all the patients.
- Staff explained that there was good access to acute stroke care. The thrombolysis team were pre alerted by the emergency department when the hospital received notification that a patient having potentially suffered a stroke was due to arrive. (Thrombolysis is when medicine is given directly into the blood with the intention of dissolving a blood clot). During the inspection we saw the team respond immediately to the needs of two patients who had come into the hospital to be assessed for the need for thrombolysis treatment.
- The Emergency Management Unit (EMU) provided 29 beds for patients admitted directly by their general practitioner or via the emergency department. Patients were admitted and assessed, investigations carried out, treatment established. Patients were then either discharged or transferred to a ward appropriate for the type of care they needed.
- During the unannounced inspection we observed the clinical handover between medical staff covering the medical wards and the EMU. The handover was structured and included the prioritisation of the patients. Patients in need of prompt treatment, those at the most risk of becoming unstable and those that had recently been admitted and needed a senior review were all highlighted and prioritised by the night team.
- Delays to inpatient discharge can have a negative impact on bed occupancy and patient flow. We saw evidence in patient notes that discharge planning was part of the in-patient care planning process. We were shown a copy of the 'ward round weekend plan document' this was completed each Friday to ensure that there was a clear documented plan including any discharge arrangements which were then facilitated on the weekend discharge ward rounds.
- At the time of the inspection, the discharge lounge service was located on Staveley Ward. The discharge lounge accommodated patients who were ambulant and able to sit and wait in a chair, and those who were more comfortable in, or needed to be in bed.
- The discharge lounge was open from 8:30am to 6pm Monday to Saturday and 9:30am to 6pm on a Sunday. A pharmacy technician assisted the team with getting patient'smedicines to take home as soon as possible.

Patients who were waiting to be discharged waited in the discharge lounge enabling their ward bed to be used by another patient. This was to allow patient flow through the hospital.

- The discharge lounge had direct access to the transport providers live screen which enabled them to keep up to date with the expected time of arrival of the patients transport. This also helped to plan the latest time that a patient requiring transport could be admitted to the lounge.
- For the reporting period November 2015 to April 2016, 67% (16,646) of medical patients did not move wards during their admission, 23% (5,804) moved once, 6% (1551) moved twice, 2% (481) moved three times and 1% (253) moved four times or more.
- The trust's system resilience plan 2015/16 stated 'only in exceptional circumstances should there be any transfers of patients, either internally from one ward to another or home, between the hours of 10pm and 6am.' Data for the reporting period January 2016 to April 2016 showed across nine medical wards (not including EMU) there were between 198 and 299 patient transfers had occurred after 10pm each month. There were on average 370 bed moves from EMU per month over this period.
- For the reporting period January 2015 to December 2015 the average length of patient stay for emergency general medical admissions was on average 5.4 days which was lower than the England average of 6.3 days. Patients stayed in this hospital for less time compared to other hospitals.
- For elective general medical patients the average length of stay was 4.8 days compared to the England average 4.2 days. Patients stayed in this hospital longer than in other hospitals.

**Meeting people's individual needs**

- Patient's records showed that individual patient's needs were assessed and care was then planned based on this information. Care documentation templates were individualised and included personal preferences, for example, patients preferred name and food choices. Information was relayed to all staff on small information boards adjacent to bedsides.
- Specialist staff were available to support patients, for example, on Eastwood Ward we saw an activities coordinator sat with a small group of patients supporting them to complete some artwork. The coordinator organised events and pictures of a previous garden party, and information regarding quiz events were seen on an information board.
- The trust had established an enhanced support team, which were a small team of health care support staff. Where individual patients support to maintain their safety and well-being, either because of an existing health need, for example, a patient living with dementia, or a new concern, for example, a high risk of falling.Depending on the patient's care needs one member of the team looked after one or a small number of patients within the same area of theward. To ensure the patients with the greatest needs received the support, an assessment was carried out by the older person's team.
- The enhanced support staff were part of the 'older person team' which was led by the dementia specialist nurse. Staff explained that this team were usually accessible and that the enhanced care team had helped to keep individual patients safe.
- Staff from the enhanced care team were observed sitting with patients, spending time talking and explaining what was happening on the ward, and observation was provided to help keep a patient safe who was at high risk of falling.
- An electronic system was used to identify patients over the age of 75, the older person's team carried out a review of the care ensuring all risks were identified and appropriate care and treatment established. This system was also used to ensure patients with learning disabilities were highlighted.
- Staff on EMU explained that there was direct access to obtain mental health services 24 hours a day and that these services were accessible. We saw in one patient notes where there had been a review by the mental health liaison team, there was a clear documented review and plan. The patient's family had been involved in the referral process.
- Nursing staff explained that there was good access to the lead learning disability nurse. Carers and family of patients with learning disabilities were able to accompany their relatives and stay at the hospital. One nurse explained that it could help the patient if their carers stayed and helped deliver their care as this reassured patients. Information provided by Healthwatch from a 2015 survey into the access to

health services for people with learning disabilities supported this. Patient feedback following admission to the hospital confirmed carers were able to stay and that this was good.

- A PLACE audit in 2016 had considered the environment throughout the trust against the dementia friendly environment standards. There had been improvement since the previous audit; the current score of 77.5%, so was 1% below the national average.
- We were told there was good access to services providing support for patients where English was not their first language, or where patients had existing, or new difficulties with speech or hearing. A third party provided interpretation services and we were told that a Polish interpreter had recently supported a patient when a best interest meeting was being arranged.
- On EMU during nurse handover, information was discussed regarding a patient's own auditory device to ensure it was being used to ensure staff communicated effectively with the patient.
- Specialist equipment was available to meet patients' individual needs. Specialist baths and hoists were used for patients who were unable to sit in the bath unaided, and beds were used which could be positioned very low to the ground, to help keep patients safe.
- Prior to discharging patients, individual needs were assessed by occupational therapists and physiotherapists. A separate kitchen, bedroom, bathroom and toilet were available in the therapy department, known as theSpeedwell room. Home adaptations or aids were then provided based on the patient's personal needs.
- An early supported discharge team was part of the stroke rehabilitation care pathway. Patients who were assessed and suitable to be discharged early and received ongoing support to their recovery at home were cared for by this team. Staff from Eastwood Ward were on a week's rota to be part of this team which helped to ensure a smooth discharge process.
- Information was available throughout the wards and hospital providing guidance and signposting patients and relatives to additional support and information.
- There was a designated 25 bedded ward for caring for patients who were medically fit for discharge but who had more complex discharge needs. For example, needing extra care or equipment to keep them safe at home, or on-going nursing or residential care. We were unable to visit this ward on inspection as specific infection control measures were in place.
- Facilities for relatives and carers were provided including private rooms and waiting areas, drinks facilities and overnight facilities.
- The wards provided separate toilet, bathroom and sleeping areas for male and female patients, and there had been no occasions reported were this had not been the case in the medical in-patient areas in the last 12 months. In the cardiac catheterisation suite there was one toilet facility available adjacent to the recovery room and this was used by male and female patients. Staff used curtains in the recovery area to provide separation of male and female patients.
- Spiritual care and support was available 24 hours a day, staff explained that the hospital chaplaincy were accessible day or night. The hospital chapel was available to patients and relatives and we saw that this was open during our evening visit to the hospital.

**Learning from complaints and concerns**

- The Patient Advice and Liaison Service (PALS) had been introduced in July 2015, their office was located centrally in the main reception area of the hospital. Since the introduction of PALS the trust had reported a reduction in thenumber of complaints received.
- Systems were in place to acknowledge complaints within three days. A triage system was in place to establish response times to complaints depending on the complexity. Response times to complaints had improved since our last visit after an action plan was put in place.
- Patients were offered face to face meetings routinely to discuss their concerns.
- Staff on the wards spoke of resolving any concerns at the time they were raised wherever possible; this was in line with the trust's complaints policy. The policy also stated that concerns resolved in this way were recorded on the trust's risk management system. In the complaints data supplied by the trust there were no records of concerns resolved at ward level. This may prevent learning from concerns taking place. However one ward was piloting an online system for recording concerns resolved at ward level and details of the compliments they had received.

# Medical care (including older people's care)

- We reviewed two formal complaints regarding outpatient services. Prompt acknowledgements of complaints were sent to patients with proposed final response dates. If timescales for the resolution of complaints slipped letters were sent to inform patients of new timescales.
- In the two complaints we reviewed timescales were met to inform patients/friends or relatives about the investigation outcomes.
- Where complaints had been made by friends or relatives we saw that consent had been obtained from the patient before the complaint progressed
- One member of senior staff had received a complaint from a relative recently and this was now being handled by the assistance and complaints service.
- The trust's complaints procedure graded complaints and specific response timeframes were in place dependent on the level of investigation required. From January 2016 to March 2016, 62% of complaints across the trust had been resolved within the specified timescale compared to 43% from October 2015 to December 2015.
- The trust's complaints, concerns, comments and compliments policy was available to staff via the intranet and defined the difference between a concern and a complaint.
- There was clear information displayed on the wards about raising a concern and asking to speak to a member of staff. Feedback cards were available.
- From data supplied by the trust for complaints received from May 2015 to May 2016 there were 74 complaints specifically related to medical inpatient care. Complaints covered a variety of reasons but more common themes were communication and medical and nursing care. Fifteen complaints remained open; these had been received between February 2015 and May 2016. There were a small number of complaints where the documented outcome included feedback to the ward or actions to prevent re occurrence. The majority did not include this information.

# Surgery

| | |
|---|---|
| Safe | Good |
| Effective | Good |
| Overall | |

## Information about the service

The surgical services division provides 150 inpatient bed across five surgical wards and 51 day case beds. Inpatient services included general surgical with specialties including; upper gastrointestinal, colorectal, urology, breast and trauma/orthopaedics. Patients are cared for during outpatient consultation sessions, in the pre-operative assessment unit, day surgery and inpatient wards.

There are 13 operating theatres for surgical services and a recovery area. Two theatres are designated for emergency operations. From January 2015 to December 2015, the trust treated 23,292 surgical patients. Approximately 60% of the 23,292 surgical patients were day case patients.

During the inspection we inspected all five surgical wards, operating theatres, recovery, surgical admissions unit and the day case unit.

We spoke with five patients and 20 staff, including junior and senior nurses, doctors, managers and pharmacy staff.

We looked at 10 patient records including medical and nursing records, patient observation charts and observed staff providing patient care.

We reviewed performance information from, and about the trust. We also received comments from people who contacted us about their experiences. We reviewed the arrangements in place to support the delivery of elective and emergency surgery, including the environment.

## Summary of findings

The safety and effectiveness of surgical services was rated as good because;

- There was an open and honest culture, and people who used the service were told when something went wrong. Procedures and systems were available to help keep patients safe.
- Patient areas were visibly clean and equipment was checked to make sure it was safe for use. However, in one clinical area the cleaning of equipment was not carried out in a designated area.
- Patient care and treatment was planned and delivered in line with current evidence based guidance, standards, best practice and legislation.
- Service performance and patient outcomes were evaluated to inform improvements. Enhanced care pathways were used to help improve patient outcomes.

However, we also found:

- Some staff were not receiving regular appraisals to ensure they had the appropriate skills and support to perform their current role and to identify areas of personal and professional development.
- There were incidents during 2015 that had not been closed we could therefore not be assured that all learning was shared in a timely manner.

# Surgery

## Are surgery services safe?

Good

We rated surgical services as good because:

- Incidents had been reported from all areas of the surgical services division and were of varying severity and incident type with the majority (97%) of incidents being low or no harm.
- Clinical areas were visibly clean, staff adhered to infection prevention and control guidelines and to the trust's waste management policy, this included the correct disposal of confidential waste.
- Resuscitation trolleys were checked in line with the trusts policy and records were up to date.
- There were clear and documented systems in place to ensure patient risks were identified and managed. These systems supported the safe delivery of care to patients.
- There were systems in place for monitoring staffing and patient dependency levels. Staff used an escalation procedure to highlight when staffing levels were adversely affecting patient safety. This information was used to inform decisions about current and future staffing requirements.

However, we also found;

- On the day case unit, clinical equipment was washed in an area not specifically designated just for that purpose, and trolleys used for the preparation of theatre equipment were in general use in the unit.
- There were a number of incidents that had not been closed following the initial review or investigation, therefore we were not assured that all actions had been taken to minimise future risks and share learning.

### Incidents

- An online reporting system was used by staff to report incidents. Data provided by the trust showed 1325 incidents had been reported by the surgical services division from April 2015 to March 2016. As of August 2016, 214 of these incidents remained open. Initial actions that had been taken were documented, and where further investigation had been required outcomes had been recorded. Senior managers monitored the number of open incidents on a monthly basis and ward leaders had been asked to prioritise reviewing all open incidents. Where incident records had not been closed we could not be assured that learning had taken place.
- Of the 1325 incidents, the majority; 1281 (97%), were reported as causing low or no harm, 31 (2%), causing moderate harm, four incidents were graded as severe and nine were not graded.
- There was one never event in this service from June 2015 to May 2016. This was reported as a wrong implant or prosthesis. Never events are serious incidents that are wholly preventable. Guidance or safety recommendations that provide strong systematic protective barriers are available at a national level and should have been implemented by all healthcare providers.
- We reviewed the trust's report following their investigation of this never event. The report established the cause of the incident, the lessons learnt and the recommended changes to help minimise the risk of the incident happening again.
- Service leaders explained; following the never event in 2015, the checklist used throughout an operative procedure had been revised to reduce the risk of further patient harm.
- There were 10 serious incidents reported in surgical services from March 2015 to February 2016. Serious incidents are events in health care where there is potential for learning or the consequences are so significant they warrant using additional resources to mount a comprehensive response.
- The trust was required to investigate the cause of each serious incident. We reviewed records to establish that this had taken place.
- The most frequently reported serious incident type was pressure ulcers, which accounted for five of the serious incidents reported. We reviewed two investigation reports into the cause of patient pressure area damage. These investigations were comprehensive, involved senior staff and the specialist tissue viability nurse (TVN). Areas for learning were identified and plans documented to share the learning.
- Staff meetings on the wards were not handled consistently. On Murphy Ward we saw minutes from monthly staff meetings where incidents had been

discussed, and feedback from incidents had been provided to staff. On Barnes Ward, staff were required to sign to say they had read meeting minutes and had seen updates following incidents.

- Staff explained how learning from incidents had led to changes, for example, patient falls. On Robinson Ward an additional nurses' station had been provided which had improved the observation of the patient areas. A recent falls review group had been established, this was a cross divisional initiative to reduce the number of falls across the trust. The project was new, so evaluation had not yet been completed.
- We reviewed the Department of General Surgery mortality and morbidity minutes from a meeting held in March 2016. This meeting outlined how cases would be reviewed and presented at future quarterly meetings. Prior to this date no surgical department mortality and morbidity meetings had taken place. Morbidity and mortality meetings are a way for health professionals to formally review and discuss individual cases to identify and share learning.

**Safety thermometer**

- The NHS Safety Thermometer is a local improvement tool for measuring, monitoring and analysing patient harm and harm free care. It provides a monthly snap shot of four avoidable harms; pressure ulcers, falls, urinary tract infections in patients with a catheter, and blood clots or venous thromboembolism (VTE).
- Patient safety thermometer data was prominently displayed on all the wards we visited, for patients, relatives and staff to view.
- We reviewed the surgical ward safety thermometer figures for the period June 2015 to July 2016 and found the main safety concerns still related to new pressure ulcer rates; new pressure ulcers 1.6% (target 1%) however over the period the monthly figures showed an improving trend. There had been an overall improvement in the rates of falls with harm; 0.3%, patients with new venous thromboembolism; 0.4% (target 0.5%), and catheter new urinary tract infections; 0.2% (target 0.5%).

**Cleanliness, infection control and hygiene**

- On Holywell Day Case Unit we saw equipment that was used in surgical procedures being washed in an area not designated for the cleaning of theatre equipment. We noted there was general ward cleaning equipment adjacent to this area.
- The operating theatre changing area was located outside the main operating theatres on the main hospital corridor. Staff were observed moving between the operating theatres, the day case ward, and changing rooms and not seen to use any additional over covering on their clothes or shoes while outside of the theatre environment. NICE guidance CG74 Surgical Site Infections, Prevention and Treatment recommends staff wearing non-sterile theatre wear should keep their movements in and out of the operating area to a minimum. (NICE – National Institute for Health and Care Excellence).
- On Holywell Day Case Unit we saw trolleys were prepared for procedures in an area not designed for this type of work, the area resembled a storage area of the unit. Trolleys that were used for theatre equipment were not segregated and kept specifically for that use; we saw staff crockery left on one of these trolleys.
- In the main operating theatre efforts had been made to minimise the impact of on-going refurbishment work on the theatre services. Cleaning times had been extended to ensure sufficient cleaning took place within the operating theatres.
- There had been an improvement in the number of emergency surgical patients being screened for MRSA colonisation with the trust reporting in March and April 2016 100% of patients were screened. The same improvement was reported for elective surgical patients with the trust reporting in February, March and April 2016, 100% of patients were screened.
- There had been one case of Methicillin-resistant Staphylococcus aureus (MRSA) detected in a patient's blood within the last 12 months and this was reported in December 2015. MRSA is a type of bacterial infection and is resistant to many antibiotics. There were no cases of Clostridium difficile infection reported from December 2015 to March 2016. Clostridium difficile is a bacterium affecting the digestive system, it often affects people who have been given antibiotics and causes diarrhoea and vomiting.
- The trust applied the Houdini protocol for patients who had a urinary catheter inserted after admission. The

Houdini protocol ensures patients are fully assessed to determine if they need an indwelling urinary catheter, the patients are reviewed daily so the catheter is removed as soon as possible. This reduces the risk of a urinary tract infection. There was an improving trend in the number of patients assessed using the Houdini protocol. Since January 2016 the monthly average was 81% to 96% with two months showing above 95%.

- Surgical site infection surveillance (SSIS) is mandatory for all trusts, although not all categories of surgery are required to be included. The trust reported on surgical site infections for hip and knee replacement surgery. The trust had reported three surgical site infections from January to June 2016 following 357 replacement knee and hip operations.
- Staff complied with hand hygiene procedures and the correct use of personal protective equipment, for example; aprons and gloves.
- Staff used clear signs to inform visitors patients and colleagues where there was known risk of infection, and protective equipment was adjacent to side rooms used to isolate patients with known infection risks.
- Dirty utility areas were tidy and waste was segregated correctly in line with the trust's waste management policy. Stickers were used to identify when equipment had been cleaned and was ready for use.
- All surgical wards and theatre areas attained above the trust target of 95% in an internal audit of the environment completed in April 2016.

**Environment and equipment**

- There were on going refurbishment improvements in the operating theatres which were due to be completed in May 2017. We found theatre corridors were cluttered with equipment as we had found on our previous inspection, but noted the additional cleaning was in place to ensure the environment was kept clean and equipment dust free.
- Equipment in the operating theatres was well maintained, and the recovery room was well equipped including the area designated for the recovery of children.
- On the Surgical Admissions Unit the waiting area was under refurbishment and not available to be used by patients. The ward environment appeared overcrowded. There were separate areas for male and female patients including designated toilet facilities. We were told however, it was sometimes necessary to allocate one toilet to patients undergoing treatment leaving one toilet for male and female patients. Up to 20 patients could be in the department at any one time.
- We looked at three resuscitation trolleys located in the ward areas. One ward, Robinson, had its own resuscitation trolley. Elmton Ward and Barnes Ward shared a resuscitation trolley, as did Murphy Ward and Elizabeth Ward. Where trolleys were shared they were located in the corridor adjacent to both wards and checked twice a day.
- The trust had completed a risk assessment in 2015 which considered if there was any risk from the trolleys being located in a publically accessible area. A decision was made that the current location of the trolleys made them accessible to staff and that it was a safe location for the trolleys.
- We checked all three trolleys and found the checks to have been completed and records were up to date. Security tags were in place on all draws which ensured the contents were in date. The tag informed staff when the contents of the draw next needed checking.

**Medicines**

- Medicine storage on all five surgical wards was secure and medicines were stored in a designated room where access was restricted and gained by a swipe card.
- On Murphy Ward staff explained the allocation of medicine keys and swipe card access to the medicine storage area was tightly controlled. Signatures were obtained from staff to ensure there was traceability of who had access to the medicines on the ward.
- Controlled drugs were stored in a designated cupboard and checks were carried out daily to ensure stock balances were correct. Intravenous fluids were stored in locked cupboards.
- Fridges were used for medicines that required temperature controlled storage. There were inconsistencies across the surgical wards on the procedure for monitoring and recording fridge temperatures. We raised this during inspection with the senior management of the trust. We were informed the fridge temperatures were now centrally monitored by the pharmacy department. Wards were not required to record daily fridge temperatures and ward staff would be updated with this information.

- On Elmton Ward staff explained antibiotic prescribing and administration was monitored on a twice weekly ward round by the pharmacist, pharmacy technician and microbiologist.
- A pharmacist was observed checking the medicines of a patient who had recently been admitted to ensure they received the correct medicines whilst they were in hospital. This process involved looking at the patients existing medicines and any new medicines that had been prescribed whilst the patient had been in hospital.
- During the reporting period April 2015 to March 2016, 180 medicine related incidents were reported by the surgical services division. This accounted for 14% of all the incidents reported during this period. These included; medicines not being prescribed, and where the wrong drug or quantity of drug had been prescribed or administered. Actions were recorded of steps that had been taken to minimise the risk of reoccurrence, for example, medical and nursing staff reflecting on their practice and training records were reviewed to ensure staff were up to date with current practice.

**Records**

- Patient nursing care and medical records were in paper format. We reviewed 10 patient records which included medical notes and nursing records.
- In all the notes, the name and grade of the person who had made the entry in notes was clear. Risk assessments had been completed, and pro-forma risk assessment documents were used and completed with patient specific details.
- Pro–forma documentation was also used when a patient had been admitted with a possible fracture of their leg bone. The document was a comprehensive tool for a full patient assessment process. It included investigations and results, multidisciplinary team (MDT) records, risk assessments and doctor's records. This pro-forma covered the pre-operative assessment information of a patient who required an operation.
- Data supplied by the trust stated to date that 57% of the surgical services staff had completed information governance training. Training data was currently being reviewed by the trust to ensure it was accurate as a new recording system had recently been introduced.
- Confidential records were disposed of appropriately. On Barnes Ward staff placed the handover sheets into the secure confidential waste bin at the end of their shift.
- Medical records were stored securely in locked notes trolleys which were located in the main ward areas.

**Safeguarding**

- Data supplied by the trust, stated safeguarding training was part of the mandatory training programme. Records showed 56% of surgical services staff had completed level one safeguarding for adults training and 38% had completed level one safeguarding for children. Training data was currently being reviewed by the trust to ensure it was accurate as a new recording system had recently been introduced, therefore the trust was not certain on how many staff were currently trained.
- Incident data supplied by the trust included records of appropriate safeguarding referrals that had been made by staff on all the surgical wards. Referrals included; concerns of physical abuse, financial abuse and neglect. Immediate action was taken to safeguard the patients.

**Mandatory training**

- Mandatory training was provided over two training days. Training updates included information on; infection control, The Mental Capacity Act 2005, Deprivation of Liberty Safeguards (DoLs), dementia, health and safety, equality and diversity, information governance, resuscitation, blood transfusion and medicines management. Safeguarding training and 'Prevent' training were also included. 'Prevent' is the government's counter terrorism policy.
- Data supplied by the trust showed surgical services division staff had current training completion rates for the various training topics of 21% to 83%. Trust training records showed 66% of surgical services staff had attended dementia awareness training.
- Training data was currently being reviewed by the trust to ensure it was accurate as a new recording system had recently been introduced. Current data was reported as being unreliable therefore the trust was not certain on how many staff were currently trained.

**Assessing and responding to patient risk**

- One of the operating theatres was designated as the general surgery emergency theatre and this was always kept available so emergency operations could take place as soon as possible. The consultant surgeon on call was also available to carry out emergency operations and did not have any planned operations to perform whilst on call.

- Staff in the operating theatres used a document based on the World Health Organisation (WHO) safety check list. This was a process recommended by the National Patient Safety Agency for every patient undergoing a surgical procedure. The process involves a number of safety checks before, during and after surgery to avoid errors. This ensured each stage of the patient journey, from ward through to anaesthetic procedures, operating room and recovery, was managed safely. We found the checking procedures in the operating theatre to be in line with the WHO five steps to safer surgery process. This tool was used to reduce harm in peri-operative care with safety checks carried out at critical time points in the patient's intraoperative pathway.
- The National Early Warning System (NEWS) was designed to enable staff to recognise and respond to acute illness. For example; septicaemia and acute clinical deterioration, and to trigger a clinical response proportionate to the severity of deterioration. We reviewed 10 patient observation charts across the five surgical wards and all patient observations were recorded on NEWS charts and the score was calculated. The NEWS escalation protocol was available for staff to consult; this ensured the correct escalation process was followed.
- We reviewed 10 patients' medical notes for evidence of the venous thromboembolism assessment process, in all 10 records this was completed and appropriate actions had been taken in response to any identified risk.
- There was a high dependency and intensive care unit on site. These units provided more intensive observation, treatment and nursing care than was possible on a general surgical ward. Surgical patients who required this higher level of care were transferred to these areas. There was no critical care outreach service available at the hospital, specialist nurses, matrons and site matrons provided initial additional support to ward staff and medical staff were contactable via a bleep system if they were not on the ward.
- Risk assessments were carried out enabling appropriate care to be provided to help keep patients safe. Documentation was available to assess patients for the risk of falls,malnutrition and their skin condition. Recognised risk assessments tools were used these included; the recognised risk assessment to assess the condition of pressure areas, and the malnutrition universal screening tool (MUST) for the assessment of patient's risk of malnutrition.
- On Robinson Ward and Barnes Ward where patients were at risk of falls, staff raised awareness of this by placing information above the patients' bed.
- On Murphy Ward staff explained the steps taken to minimise the risk of harm. Every morning the ward had a 'stop moment' where potential key risks were considered on the ward. The trust provided us with a completed stop moment sheet from the ward. This included any risk of patient falls and any sick patients and special dietary requirements. This process gave staff a few moments to stop and highlight any concerns. Highlighted risks were then managed to minimise harm.
- We reviewed seven patient notes and all seven had a pre-operative ASA grade recorded in their notes. The ASA grade is a physical status classification system to describe a patient's fitness to undergo a general anaesthetic. ASA is The American Society of Anaesthesiologists.
- In the pre-operative assessment unit, we observed comprehensive information obtained from a patient, this ensured potential risks were identified and the pre op VTE assessment was completed.
- Where risks had been identified we saw action had been taken. In the operating theatres additional fire drills and cleaning were being carried out due to the corridors being less accessible during the refurbishment programme.

**Nursing staffing**

- The recognised nurse staffing acuity/dependency tool was used to determine the actual number of nursing staff required to deliver safe care and treatment. This took the actual current numbers and dependency of patients into account.
- The trust reported in April 2016 the planned staffing level for surgical specialities was 214.33 whole time equivalent (wte) and the actual was 198.65 wte. However, Robinson, Murphy and Devonshire wards all had in excess of five whole time equivalent vacant posts, (Robinson 5.15, Murphy 6.08, and Devonshire 5.25). This resulted in these wards having a higher bank staff usage (Robinson 19.1%, Murphy 13.9% and Devonshire 17.9%).
- A Red Flag system provided a framework for nursing staff to highlight at the start of or during a shift, when a

ward area was short of qualified nursing staff based on various indicators. For example, unplanned delays in patient medicines being provided, a delay of more than 30 minutes in providing pain relief, and patient vital signs not assessed or recorded as outlined in the care plan.

- Staff we spoke to on the wards understood the red flag process and used it to raise concerns.
- We looked at the number of red flags reported per month from July 2015 to April 2016. The average number per month was 27, in January 2016 there had been 52.
- The safe staffing report dated May 2016 showed Elmton Ward had significant overfill of unqualified nurses on both day and night shifts.
- During our unannounced inspection we visited Barnes Ward, there were two registered nurses and two health care support workers on the night shift, with an additional registered nurse working a twilight shift who finished at 11:30pm. The ward had 32 beds. The staff explained they had taken three admissions that evening since coming on duty, and they had another four admissions expected. It was 10pm and staff were just about to start administering medicines, they explained this was an hour later than usual as they had attended to the patients that had been admitted.
- Staff we spoke to knew that if the delay had an impacted on patient care they would raise a 'red flag'.
- There was a team of eight health care assistants who were the enhanced nursing team. Where patients were identified as being at an increased risk of harm, for example, from falls, additional care was provided by the enhanced nursing team. This was usually on a one to one basis, these staff were in addition to the staff rostered to work on the wards.

**Surgical staffing**

- The trust's medical staffing showed 38% of the skill mix was made up of consultants. This was higher than the national average which was 34%. The trust had a lower number of middle grade doctors 2% than England's national average 6% for acute trusts. In addition, the trust had a lower than average number of registrars with 35% compared to the England average of 39% and higher than average number of junior doctors (25% for this trust; 22% England average)
- The use of locum medical staff had increased compared to the last reporting period. For the period April 2015 to March 2016 there were high levels of locum doctors in ophthalmology 48%, general surgery was 24% and anaesthetics 16%. However the overall trend for the year was showing reducing levels of locum usage.
- Consultants were available via an on-call system 24 hours a day and had no planned surgery commitments when they were on-call.

**Major incident awareness and training**

- There was a trust wide major incident plan in place to guide staff of all levels and in all locations as to what actions they needed to take in the event of a major incident being declared.
- The trust had devised a training plan to ensure staff were able to manage a significant incident whilst maintaining services to patients. The frequency of the training was set out in the training strategy for 2016/2017 and was in line with the 2015, NHS England, Core Standards for Emergency Preparedness, Resilience and Response.
- We saw a copy of the trust's major incident plan dated April 2016 which clearly identified the actions staff should take in the event of a major incident.

## Are surgery services effective?

Good

We rated the effectiveness of surgical services as good because :

- Patient's care and treatment was planned and delivered in line with current evidence based guidance, standards, best practice and legislation.
- There was planned and completed local and national audit activity, key findings were shared and actions taken to improve patient care.
- The enhanced recovery pathway was used to help improve patient outcomes.

However we also found:

- Staff appraisal rates for surgical services division nurses from April 2015 to March 2016 were 49% for qualified staff, and 45% for unqualified staff against a trust target of 90%.

**Evidence-based care and treatment**

- Care and treatment was delivered in line with National Institute of Health and Care Excellence (NICE) quality standards. The National Early Warning System (NEWS) was used on the surgical wards to record observations and triage the level of response required. This was in line with NICE Guidance on the acutely ill adults in hospital: recognising and responding to deterioration.
- Policies and procedures and documentation used on the wards were based on nationally recognised guidance. The fractured neck of femur pro-forma document had a designated section for an orthogeriatric consultant review. This is a consultant who specialises in the care of elderly orthopaedic patients usually following a fractured hip bone. This was in line with NICE Guidance 124 on Hip fracture management. NICE guidance on the prevention of pressure ulcers recommends the use of a validated risk assessment tool. A validated risk assessment tool was used on all the surgical wards.
- A recognised communication tool was used to provide structure to the communication process when patients were transferred and care handed over. The Situation, Background, Assessment and Recommendation (SBAR) tool is recommended by NHS innovation and Improvement for use in a variety of situations including patient transfer.
- In the operating theatre the check sheet that was used to help to keep patients safe was based on the World Health Organisations (WHO) evidenced based safety check list. The checks carried out were in line with the WHO five steps to safer surgery process. Having a procedure and checklist in place ensured the safety checks were performed at the same point during every operation.
- Internal audits of the 46 point safety check sheets were carried out on two occasions in 2015. In one week in April 2015, 91 completed checklists were reviewed and one week in November 2015 a further 64 were reviewed. Not all 46 check points were applicable to all operative procedures. Both audits showed that the check sheets had an overall completion rate of greater than 95%.

**Pain relief**

- In all 10 patient records we reviewed, a pain assessment tool had been used to assess the patient's pain level.
- There was a designated pain team at the hospital that could be contacted by any of the surgical wards and departments if required.
- Staff explained part of the enhanced recovery pathway was to improve outcomes for patients. Part of this pathway is to remove physical stress caused by post-operative pain. Effective pain management was a priority both pre and post operatively. The enhanced recovery pathway was used for more complex surgery for example planned bowel surgery. A key aspect of the enhanced recovery pathway was the patient's involvement in their care.
- On the wards we observed staff responding promptly to patients who were uncomfortable or who had pain.

**Nutrition and hydration**

- Patients were assessed for their risk of malnutrition using the malnutrition universal screening tool (MUST). The MUST tool calculates the overall risk of malnutrition. We saw in two patient records the MUST score had triggered a referral to a dietician. Nutritional supplements were provided to ensure sufficient calorie intake
- There was an assessment process used to identify patient's additional eating and drinking needs. Information was displayed at the bedside regarding the level of assistance required.
- On Robinson Ward we saw information cards informing staff which patients needed assistance and encouragement with their diet.
- Meal orders were based on patients own choice and were ordered directly using the wards information technology system. Diet choices included gluten free and vegetarian options.
- We reviewed six fluid balance charts, four were fully complete, one was partially complete, and one was not complete. Fluid balance charts are used to monitor how much fluid a patient receives and how much fluid they pass out.

**Patient outcomes**

- The trust participated in several national audits, including the Royal College of Surgeons and NHS Blood Transfusion national comparative audit of lower gastrointestinal bleeding and the use of blood. This audit was conducted from September to December 2015 and the trust was waiting for the outcome of the audit.
- The trust submitted 189 cases for the national bowel cancer audit. The bowel cancer audit results were published in December 2015 the trust ascertained a rate

and data completeness ranking of good. Ninety five per cent of the 189 patients had been seen by a clinical specialist nurse, this was slightly higher than the national average of 93%. The outcomes for patients undergoing major bowel surgery for cancer were all in line with expected outcomes. This included the number of patients requiring re admission within three months of their surgery, and the mortality rate at two years and three months following their surgery

- In the 2016 National Emergency Laparotomy Audit, the trust improved their performance on the previous year in two of the ten measures (final case ascertainment improving from red to amber and having a consultant surgeon present in theatre moving from amber to green). The trust was rated as red for one of the ten measures, amber for six measures, and green for the remaining three measures.
- The trust submitted 375 cases for the national hip fracture audit. In the hip fracture audit the trust was performing better than the national average in six of the ten indicators
- For the reporting period December 2014 to December 2015 the standardised relative risk of readmission for both elective and non-elective surgical patients was in line with the national average. Patients risk of re admission after surgery wasthe sameas at most other NHS hospitals.
- The trust's performance in Patient Reported Outcome Measures was similar to the national results for the period April to December 2015.Patient Reported Outcome Measures (PROMs)assess the qualityof care delivered to NHS patients from the patient perspective; it covers patients who have undergone planned surgery for four common groups of procedures: total hip replacement, total knee replacement, groin hernia repair and varicose vein surgery.
- For the reporting period January to December 2015 the average length of patient stay for elective surgical admissions was on average three days which was lower than the England average of 3.6 days. For non-elective surgical patients the average length of stay was 5.8 days higher than the England average of 5.2 days.
- On Robinson Ward staff explained monthly meetings were held to review patient outcomes which included length of stay following a fracture to their leg.
- Service leads told us of one of the local audits and how it had improved patient outcomes. An audit of patient temperature during the perioperative period had led to the patient warming blanket being used more effectively to improve temperatures and minimise the risk of hypothermia.
- Surgical service leads reported improved outcomes for patients with the number of pressure ulcers falling, this was as a result of the introduction of a specialist team of pressure ulcer champions and increased staff education which had improved patient positioning, documentation completion and nutrition. Emphasis had also been placed on closer team working between medical and nursing staff.

**Competent staff**

- Managers were not meeting the trust's targets for providing staff with an annual performance appraisal. From April 2015 to March 2016, 55% of all staff had had an appraisal against the trust target of 90%. In the surgical specialities appraisal rates for the same period were as follows, qualified nurses 49%, unqualified nurses 45% and medical staff 87.5%.
- Staff on Robinson Ward explained qualified nurses who had been recruited by the trust from other European countries were working as health care assistants whilst there registration process with the Nursing Midwifery Council was completed. This process involved completing an English language course.
- Staff spoke of development opportunities within the trust, and competency frameworks were in place to improve and assess clinical skills.
- We saw where role specific training had been completed by a member of staff working within the surgical services division.
- Senior leaders explained additional nurse educator roles had been developed and team training sessions were held on the ward. We observed one of the nurse educators explaining the new nursing assessment documentation to a small group of staff from the surgical wards in an informal drop in session.
- Staff in the operating theatres explained records of staff training and competencies were managed centrally by the trust. There were information technology difficulties with the newtraining passport that was being developed. Operating theatres kept a record of staff training within the department in addition to the centrally held record.

**Multidisciplinary working**

- We saw the multi-disciplinary team (MDT) delivering patient care during our inspection. On Robinson Ward we observed physiotherapy being provided to a patient, clear instructions were used and the information and treatment was delivered at a suitable pace.
- Nursing and medical documentation were combined with the MDT patient assessment and progress documentation.
- We reviewed eight patient records and MDT care had been recorded in six of the records.
- On Robinson Ward we were told there was an MDT meeting every morning including weekends and a full MDT ward round every week. The MDT ward round involved a comprehensive patient assessment. Attendees included; the ward sister, physiotherapist, occupational therapist, consultant (Ortho geriatrician) and hip fracture nurse practitioner. Patient reviews included their health state, liaison with family and carers and liaison with general practitioners. Where appropriate a patient's mental capacity status would be discussed or concerns raised. A discharge coordinator usually joined in the MDT round.

**Seven-day services**

- The operating theatres were available at all times, consultants were available on call 24 hours a day, there was a resident on call theatre team for emergencies and a second team for emergencies in the maternity department, for example, for caesarean sections.
- Staff on one of the surgical wards explained the consultants were on call at the weekend and registrars carried out the ward rounds.

**Access to information**

- Staff were able to demonstrate how they accessed information on the trust's electronic system including the current bed occupancy levels. There were computer terminals throughout the ward areas to access patient information including test results, diagnostics and electronic medicine administration records.
- Access to the trust's information technology systems was restricted by passwords, agency staff were given access on a shift by shift basis.
- All members of the MDT had access to patient records which were available within the ward area.
- We were told that radiologists on call had remote access to patient scan results which enabled timely review of investigation results.

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

- Senior leaders confirmed that Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) training were included as part of staffs' annual training.
- Data supplied by the trust showed that 64% of surgical services staff had attended MCA training and 56% had attended DoLS training. Training data was currently being reviewed by the trust to ensure it was accurate as a new recording system had recently been introduced.
- Staff on Robinson Ward explained that additional training had been made available to staff which covered both the MCA and dementia awareness training. Senior leaders informed us that additional nurse educators were now in post and were holding team training events on the wards. Several staff recalled having mental health awareness training.
- We reviewed seven patient consent forms, all were completed correctly. A patient signature had been obtained on five of the forms. On the other two forms it had been documented that the patients lacked the mental capacity to sign their own consent form. Consent form four had been used correctly for these two patients. This consent form is used for adults who are unable to consent to investigation or treatment.

# Critical care

| | |
|---|---|
| Safe | Good |
| Overall | Good |

## Information about the service

The critical care unit at Chesterfield Royal NHS Foundation Trust consisted of an intensive therapy unit (ITU) with seven beds and a high dependency unit (HDU) with eight beds for patients over 18 years old. The unit provided level three care for patients requiring one-to-one support (such as those requiring mechanical respiratory support), and level two beds for the care of high dependency patients. There was no outreach service to provide support for critically ill patients on other wards; however, this was due to start in September 2016. The ITU had consultant cover 24 hours a day, seven days a week. The critical care unit had 1349 admissions between April 2015 and March 2016.

During the inspection, we visited ITU and HDU. We talked with four patients, 23 members of staff which included nursing staff, student nurses, junior and senior doctors, pharmacists, housekeeping staff and managers. We observed care and treatment and looked at four care records. Before the inspection, we reviewed performance information from, and about, the hospital.

## Summary of findings

The safety of critical care services was good.

We found:

- This was a follow up focussed inspection and we found there had been improvements to the service since our previous inspection in 2015.
- Staff knew how to use the trust electronic incident reporting system could demonstrate learning form incidents and understood the principles of duty of candour.
- Patient records were legible, signed and dated in accordance with General Medical Council (GMC) guidance and included a comprehensive range of patient assessments and care plans.
- Staff adhered to trust policies on infection control and hygiene and both ITU and HDU had positive infection control audit results.
- Equipment was well maintained. There was access to resuscitation equipment, which was checked regularly and ready for use.
- A key improvement since our last inspection was patients were reviewed in a more timely manner and the service had established systems to audit and challenge the timeliness of response by medical staff. There was a plan to move to a new model of critical care in September 2016, which meant HDU patients would be managed by critical care consultants.
- The service had escalation procedures for managing deteriorating patients and for discharging patients to wards. The service had introduced new procedures for monitoring and managing patient discharges which was audited.
- Staffing levels met recommended guidelines and handovers for medical and nursing staff were effective.

However, we also found:

# Critical care

- Staff told us they did not always receive feedback from reported incidents.
- Critical care consultants did not receive feedback from mortality and morbidity meetings.
- Staff were frequently moved to support staff shortages in other areas of the hospital, resulting in a risk ofstaff not working to recommended guidelines and staffing ratios should patient numbers increase.
- There was no critical care outreach team, although recruitment was taking place in preparation for commencing this service in September 2016.

## Are critical care services safe?

Good

Overall, we rated safe as good because.

We found:

- Staff knew how to use the trust electronic incident reporting system and could give examples of the types of incidents they had reported. Staff knew about the duty of candour and demonstrated how they were open, honest and transparent.
- Staff completed pressure ulcer, venous thromboembolism (VTE), urinary tract infection (UTI) and falls assessments appropriately and in a timely manner. All records were legible, signed, and dated in accordance with general medical council (GMC) guidance. Care plans were clear and we saw evidence of staff working to them.
- The majority of equipment had been tested and checked regularly. Staff had access to resuscitation equipment, which staff checked regularly in accordance with trust policy.
- Staff stored and managed medicines appropriately. We saw staff used controlled drugs (CD) books in accordance with guidance. Pharmacy technicians regularly monitored fridge temperatures.
- There had been improvements since our last inspection of ensuring patients were reviewed in a timely manner. The service had systems to audit and challenge the response of medical staff.
- The service had developed escalation procedures for managing deteriorating patients and for discharging patients to wards.
- Staffing levels met recommended guidelines for staff to patient ratios. We saw senior nurses ensure skill mix for staff was at safe levels for patients. There was appropriate medical cover for ITU during the day and out of hours. Handovers for medical and nursing staff were effective.

However we also found:

- Not all staff received feedback and learning about incidents.

- Critical Care consultants said they did not receive feedback and learning from mortality and morbidity meetings.
- The service did not have a critical care outreach team (CCOT) but staff had been recruited in order to implement a CCOT from September 2016.
- Managers moved nursing staff to work on other wards when they needed to fill gaps in rotas in other areas. This presented risks if the number of patients increased in critical care because it meant staff would not be working to recommended staffing guidelines and ratios.

**Incidents**

- The service reported 161 incidents between June 2015 and June 2016. Of the 161 incidents, 149 were recorded as having low or no harm. There were two serious incidents for the same period. Serious incidents are events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, they warrant using additional resources to mount a comprehensive response. Evidence provided by the trust demonstrated appropriate and robust investigation of the two serious incidents. One was a pressure ulcer where no lapse in care was identified this incident was subsequently downgraded. The other was a failure to communicate with the coroner following a patient death, an action plan which included sharing and learning was evident in the documentation.
- There were no never events reported for this service for the period of June 2015 to May 2016. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
- Staff on both critical care units knew how to use the trust's electronic reporting system. They knew the types of incidents to report such as medication errors, equipment failures, delayed discharges to wards and staffing capacity.
- Not all staff received feedback about the incidents they reported. A small number of staff, including three consultants, told us they had not received any feedback. Most staff said they received email acknowledgement of incidents but they had to request feedback. Data from the trust showed managers and staff implementing actions and identified learning from investigations. Staff could give examples of sharing and learning from incidents. For example, a number of staff told us about a prescribing error, which led to extra vigilance and checking of prescriptions for patients. Most staff said they discussed incidents at regular monthly meetings. Senior nurses discussed trends and numbers of incidents at meetings to ensure staff knew about common themes and concerns. Patient safety, including incident investigation was noted to be an agenda item in two of the three monthly staff meeting minutes provided from April to June 2016.
- The trust had a mortality review group, led by the Medical Director. The group reviewed mortality data to identify any themes and trends. The group initiated reviews of practice within the relevant clinical area and ensured staff took actions to address them. In addition, the trust conducted mortality audits and a mortality review process, which ensured all deaths in hospital were assessed. A minimum of 10% of trust deaths were subject to in-depth review.
- All consultants we spoke with said they either did not know about these meetings or said there was no feedback or learning from them. One consultant said they were not sure if the meetings were still happening. This meant consultants seemed to be unaware of learning and feedback from mortality and morbidity meetings. We were provided with two mortality and morbidity annual reports which include 'highlights' of the quarterly meetings and indicated an attendance by eight to ten critical care professionals. Minutes from the mortality and morbidity meetings were requested but not provided.

**Duty of Candour**

- The duty of candour is a regulatory duty relating to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person. There had been no incidents that had triggered the duty of candour between June 2015 and June 2016.
- Staff we spoke with knew about the duty of candour, demonstrated how they were open, transparent and provided support to the patient. For example, one

member of staff told us about a medication error where they informed both the patient and the family as soon as the error was realised. Duty of candour was included in staff mandatory training.

**Safety thermometer**

- The NHS Safety Thermometer was a monthly snapshot audit of the prevalence of avoidable harms that included new pressure ulcers, catheter related urinary tract infections (UTIs), venous thromboembolism or blood clots (VTE), and falls. Between January 2016 and June 2016 there had been no reports of catheter related blood stream infections. For the same period, there had been two urinary tract infections, one fall resulting in low harm and three VTEs out of 87 patients. The low numbers for UTIs, falls, and VTEs demonstrate a good safety culture within critical care.
- Both HDU and ITU clearly displayed up-to-date safety thermometer information at their entrances. Senior nurses shared safety thermometer information at team meetings identifying good practice but also areas of improvements. Staff we spoke with said senior nurses and managers shared this information with them. We reviewed three sets of team meetings for April to June 2016, which had patient safety as an agenda item; however, safety thermometer information did not appear in the minutes reviewed.
- Between June 2015 and June 2016 there had been 19 reported incidents of patients with pressure damage to the skin (pressure sores). The pressure damage varied in severity, with most reported pressure sores scored at grade two. Pressure sores were graded from one to four (four being the most severe). Grade two sores were superficial, presenting clinically as an abrasion, blister or shallow crater. Reports included both hospital and non-hospital acquired pressure ulcers.
- A band six nurse or matron conducted safety thermometer audits every month. We saw documentary evidence to support this.

**Cleanliness, infection control and hygiene**

- Data from the trust showed between May 2015 and February 2016 there were 16 Clostridium Difficile (C. Difficile) cases reported trust wide. C.Difficile is a bacteria affecting the digestive system; it often affects people who have been given antibiotics. The prevalence rate has been consistently better than the national average, bar two months in this period.
- The trust reported two incidents of Methicillin Resistant Staphylococcus Aureus (MRSA) between May 2015 and February 2016. MRSA is an infection that can cause problems if it gets into wounds or into the bloodstream. The threshold for MRSA is set at zero for all trusts. None of these incidents occurred in critical care.
- The trust reported 18 cases of Methicillin-Susceptible Staphylococcus Aureus (MSSA) for the period May 2015 and February 2016. MSSA can cause infections called Septicaemia (blood poisoning) if it gets into the bloodstream. The prevalence rate of MSSA fluctuated around the England average for the same period. There were two incidents of infections in the blood in critical care for the same period.
- Staff followed the trust policy on infection control. Staff adhered to the 'bare below the elbow' policy. There were hand washing facilities and personal protective equipment (PPE) such as gloves and aprons available. We observed staff using gloves and aprons in accordance with best practice for infection control policies.
- Hand washing facilities were available by each patient bed space and we saw staff and relatives using hand gels in both ITU and HDU.
- There were effective arrangements for the disposal and management of sharps (used needles) in line with the trust policy. All sharps boxes were accessible and close to where staff needed them in order to prevent injury. In addition, we saw six full sharps boxes, sealed and awaiting collection in a secure dirty utility room.
- On the inspection, we saw comprehensive cleaning logs and there was appropriate use of stickers to indicate staff had cleaned equipment. We saw domestic staff fill out and sign the logs to confirm they had cleaned the areas identified.
- The critical care service monitored infection control practices using audits. Infection control nurses or matrons conducted the audits and fed back to staff. Hand hygiene compliance for HDU and ITU was 100% between April 2016 and June 2016. The overall standard of cleanliness over the same period was 99% for HDU and 98% for ITU. This meant both units achieved a high standard of cleanliness.
- The critical care service conducted ventilator acquired pneumonia (VAP) audits to ensure staff treated patients in line with good practice, for example keeping a patient's head at an angle of 45 degrees. An audit undertaken in February 2016 concluded staff acted in

accordance with the VAP care bundle (actions undertaken by staff to care for patients) for the majority of patients and therefore protecting patients from further illness because of being on a ventilator. An undated audit of 27 level three patients over five days indicated 42% of care bundles were completed and signed.
- The conclusion included a recommendation , to increase awareness of the ventilator care bundle and the importance of signing as part of daily checks.

**Environment and equipment**

- We found equipment to be visibly clean, fit for purpose and staff told us there was enough equipment available. We checked 10 pieces of equipment ranging from heart monitors to blood pressure machines. All equipment we looked at had labels to signify they had been tested and checked. The trust had regular equipment maintenance and replacement programmes to ensure equipment was up to date safe to use.
- Both HDU and ITU had access to resuscitation equipment. The trust had systems to record the daily checks required to ensure it was complete and ready for use. We checked the resuscitation equipment for both units and saw the equipment was complete, sealed and checked daily as per trust policy.
- The layout of the environment enabled nurses to see all patients from the nurse's station. The nurse's station on ITU had electronic screens displaying all the vital statistics, including heart rate and blood pressure of patients so staff could identify any concerns quickly. Staff could work and monitor patients from the end of patients beds or the middle of the unit.
- The environment was visibly clean. Corridors and unit areas were free of clutter meaning there was plenty of space for staff to move around and respond quickly in an emergency.
- The storage space was limited, but was well organised. During our previous inspection, we saw there was insufficient space to store electrical equipment which needed to be charged. However, since our last inspection the service had installed storage racks and more electrical sockets so equipment could remain on charge and used instantly.
- We saw two flow meters in storerooms overdue for testing. There were other flow meters available to use on the critical care units. However, we raised this with senior nurses and they acted immediately arranging for the meters to be tested just in case staff needed to use them.
- There was emergency intubation and ventilation equipment available as per intensive care society standards. Both ITU and HDU had access to ventilators and staff knew where to locate them. Both ITU and HDU had two cubicles used for isolating patients with actual or suspected infections. Staff could use the cubicles to separate male and female patients when required. Personal protective equipment (PPE) was available outside the cubicles so staff could access this quickly and easily.
- Staff could access policies and procedures regarding the use of equipment. We saw policies and procedures accessible in folders at the end of every bed on HDU and ITU so if in doubt staff could refer to guidelines to operate equipment effectively. Staff also completed competency frameworks for equipment and we saw these completed in two staff files.
- The trust took into consideration Health Building Notes (HBN's) and Health Technical Memorandum (HTM's) concerning the critical care environment. The trust had compliance working groups for all specialist services including medical gas, electrical systems, and ventilation ensuring services met with appropriate guidance.
- Both ITU and HDU were located next to theatres. This meant staff could transport patients requiring enhanced levels of care after surgery quickly and easily to ITU or HDU. If urgent support was required, staff could call additional medical staff and anaesthetists from theatres if it was safe for them to do so. This was in accordance with the escalation procedure for deteriorating patients.

**Medicines**

- Medicines in both ITU and HDU were stored securely in locked rooms requiring a code or key card for access. Controlled drugs (CDs) are medicines requiring additional security. We saw CDs were stored and locked in fridges or cupboards. We noted from records that staff checked them daily and the CD check records were complete.
- Some medicines require refrigeration to maintain their effectiveness. Pharmacy staff remotely controlled and

monitored fridge temperatures as per trust policy. Staff also checked fridge temperatures when required and knew about escalation procedures if the alarm on the fridge sounded.

- A pharmacyassistant checked the stock of the fridges three times a week and disposed of any out of date and unused medicines including any medicines no longer required or left behind by patients.
- The critical care units had their own allocated pharmacist who worked as part of the multidisciplinary team and attended ward rounds. A pharmacist was available to both HDU and ITU seven days a week meaning there was good access to medication supply.
- Staff kept patient's own medication in dedicated drawers or lockers in the medicines storage room. Staff kept keys for the lockers at the nurse's station on HDU. Therefore, patient medication was stored securely until nurses needed to administer it.
- We looked at the prescription and medicine administration records for four patients on the critical care units. Staff fully and legibly completed prescription charts and documented all appropriate activity where necessary, including patient allergies. Administration records showed people received their medicines as prescribed, including those medicines required at specific timings outside of usual medicine rounds.
- Staff used controlled drug books to sign out medicines and keep a record of what CDs had been used. Staff fully and correctly completed the books and made corrections appropriately as per Safe and Secure Handling of Medicines (Royal Pharmaceutical Society) guidance.
- The hospital had an antibiotic prescribing policy which covered all specialties including critical care. Pharmacy and the consultant microbiologists jointly produced the policy with input from relevant specialty consultants. The trust distributed the policy using a smartphone or tablet application (app) to allow it to be accessible to staff.

**Records**

- We reviewed four sets of patient records. All the records we reviewed were legible, signed, and dated in accordance with GMC guidance. Care plans were clear, followed and any actions updated in the notes. Risk assessments, including VTE, falls, and pressure damage had all been completed and regularly reviewed. Staff had documented the time from decision to admit to arrival on ITU in accordance with NICE CG50: 'Acutely Ill Adults in Hospital: recognition and response to acute illness in adults in hospital' .
- Patient records on both units were stored in a trolley at the end of the patient's bed. This allowed them to be accessible quickly by all staff needing them. Because there was a large number of staff on the unit, who monitored patients constantly, there was a low risk of inappropriate access to patient records.
- During our previous inspection, a large proportion of the critical care template documentation was poorly photocopied and had no version control, making it difficult for staff to know they were using the most up-to-date records. Since the last inspection, the critical service introduced controls and used a printing company to ensure documentation was clear and legible for staff. We saw staff using the latest versions of documents, and all documentation used was clear.
- The VAP audit conducted in February 2016 showed that while staff acted in accordance to good practice they did not always document their care of patients. In particular, 11 out of 33 care bundles were not completed and signed. Not completing the documentation meant staff could not be certain what care and treatment the patient had received. Managers and senior nurses identified any required actions including reminding staff of their roles in relation to completing this documentation. The VAP records we reviewed during the inspection were all complete and signed.

**Safeguarding**

- Staff undertook safeguarding training as part of the trust mandatory training programme. All staff we spoke with said they were up to date with their safeguarding training. Data from the trust showed 72% of nursing and non-nursing staff had completed safeguarding training with a further 20% due to attend in September and October 2016. The remaining eight percent of staff were unable to undertake safeguarding training due to maternity leave.
- We spoke with staff about protecting patients from abuse. All the staff we spoke with could describe types of abuse and what constituted abuse. Staff were

confident in escalating any concerns they had and gave us examples of when they had followed safeguarding procedures or escalated an issue. This meant staff raised safeguarding concerns appropriately.

- There was a safeguarding lead for the trust. The executive lead for safeguarding was the Director of Nursing and Patient Care (DNPC). There was a nursing lead for safeguarding adults reporting to the Deputy Director of Nursing and Patient Care (DDNPC). However, most staff (including all medical staff) we spoke with could not tell us who the safeguarding lead was. The majority of staff said they would escalate to a sister, matron or contact the safeguarding team if they had concerns.
- The trust had a Female Genital Mutilation policy with appropriate documentation and escalation procedures to the safeguarding team. However, only three staff we spoke with knew about the policy

**Mandatory training**

- Mandatory training at the trust was known as essential training. Essential training consisted of two full days training which staff were required to attend. Essential training included safeguarding adults and children, basic life support, information governance and infection control. There was a mix of classroom and online learning sessions. All staff we spoke with said they were up to date with their mandatory training.
- Data from the trust showed 72% of nursing and non-nursing staff had completed their mandatory training with a further 20% due to attend in September and October 2016. The remaining eight percent of staff were unable to undertake mandatory training due to maternity leave.
- The trust said the data provided to us prior to and during the inspection was not reliable and there were more staff who had completed their training than data suggested. This was due to issues with electronic systems which managed the data. The trust said they were in the process of resolving these issues at the time of inspection.
- The critical care service had a dedicated senior nurse who monitored and managed staff mandatory training for both HDU and ITU. The senior nurse sent staff reminders and supported them to attend by booking staff on training and ensuring rotas were covered.

**Assessing and responding to patient risk**

- During our last inspection, we found there was no consultant critical care oversight for the HDU. In HDU, nursing staff told us it was difficult to get patients reviewed in a timely way as they remained in the care of the consultant who admitted them. During our current inspection, we saw improvements regarding the review of patients by medical staff. We saw from medical records and speaking to staff, consultants reviewed patients more promptly. Staff said there were regular rounds by anaesthetists and there had been improvements in the response of medical staff to ill patients.
- However, staff said there were still times they had to chase consultants for responses and reviews. Managers regularly audited and monitored the response by medical staff to review patients. If any issues were identified this would be escalated to divisional managers and the appropriate consultants. Managers of the critical care service had plans to move to a fully consultant led and 'closed' HDU unit by September 2016. A closed unit meant staff could coordinate and prioritise the most ill patients. Therefore, patients would no longer be looked after by a medical specialty and all patients should receive timely reviews and deteriorating patients transferred quickly to ITU.
- Guidelines for the provision of intensive care services core standards state patients need a clear and safe pathway for escalation of care from level two to level three. A standard operating procedure (SOP) had been developed and circulated for the safe care of patients in HDU. The SOP described the current day-to-day management of patients on HDU, the means for escalation and de-escalation of care. It also described how staff alerted the intensivists to patients in HDU who were deteriorating. Staff knew about the SOP and could give examples of when they had used it. We saw evidence of this in medical records.
- During our last inspection, we found there had been no Critical Care Outreach Team (CCOT) since 2007. Instead, the trust had an emergency medical team who provided support to wards. We found no evidence this had affected patient safety. We saw on inspection this was still the case. However, the trust was recruiting a critical care outreach team at the time of our inspection to work in line with the new operation model for critical care.

The service had recruited three members of nursing staff and the CCOT were due to start in September 2016. Managers had also budgeted for physiotherapy input into CCOT.

- Nursing staff throughout the trust used an early warning system, based on the National Early Warning Score (NEWS), to record routine physiological observations such as blood pressure, temperature and heart rate. Early warning scores enable early recognition of a patient's worsening condition by grading the severity of their condition and prompting nursing staff to get a medical review at specific trigger points.
- In December 2015, the trust conducted an audit to assess the proportion of patients who had an early warning score calculated within the last 24 hours and whether staff took appropriate action. Data showed 99.2% of patients had had an early warning score calculated within 24 hours and staff took appropriate action in 94.5% of cases. We saw from medical records patients had received timely assessments and staff recorded actions.
- We reviewed four sets of patient notes and all risk assessments of patients for venous thromboembolism (VTE), were undertaken appropriately as per National Institute for Health and Care Excellence (NICE) Quality Statement 3 (all patients, on admission, receive an assessment of VTE and bleeding risk). Risk assessments identified required actions to minimise any potential risk to patients.
- Staff used a recognised tissue viability tool assessment tool for identifying and assessing the risk of pressure ulcers developing. All patients in ITU and HDU had pressure ulcer risk assessments carried out daily. Staff referred any concerns about pressure areas to the tissue viability nurse. Staff carried out risk assessments for nutrition daily on all patients in critical care.
- The critical care service had two pressure ulcer champions. Pressure ulcer champions were members of nursing staff on ITU and HDU. Pressure ulcer care was a priority for both units and we saw it had been included on the service action plan. Pressure ulcer champions received protected time for training and for educating staff in reducing avoidable harm. The trust had a tissue viability nurse (TVN) who worked with pressure ulcer champions on each unit. The service conducted monthly audits on pressure ulcer care and weekly assurance rounds. This was evidenced through the safety thermometer audits.
- Early warning score proformas documented the vital signs which would alert staff to the possible signs of sepsis. Sepsis is a life-threatening condition that happens when the body's response to an infection injures its own tissues and organs. Guidance on treating sepsis states patients should receive antibiotics and/or intravenous (IV) fluids within an hour of staff identifying symptoms. We saw from medical records staff identified and treated patients in line with sepsis guidance.
- Staff demonstrated a good knowledge of the risks associated with sepsis. Staff recognised sepsis as a clinical emergency. The majority could tell us the actions they would take if they suspected a patient was deteriorating and showed signs of sepsis. If not recognised and treated early sepsis can lead to death.
- We found there had been improvements in the number of occasions when patients were delayed in being discharged back onto wards. Between April 2015 and March 2016 there had been 21 incidents of delayed discharge compared to 41 the previous year. The trust classed delayed discharge for critical care as patients who were still on the unit eight hours after being reported ready for discharge. The trusts rate of bed days of care post eight hour delays was better than the England average. The rate for ITU was 0.7% and HDU 1.9% of all patient bed days were post eight hour delays compared to 5.3% England average. Seventy six percent of patients in ITU and 67% in HDU reported fit for discharge left the units within four hours.
- However, delayed discharges meant there was a potential risk of staff not being able to admit seriously ill patients to HDU or ITU. In addition, this could lead to a mixed sex breach where female and male patients are inappropriately mixed. Staff confirmed with the inspection team mixed sex breaches did occur. We saw from the trust incident reporting system there had been three reported incidents of mixed sex breaches between June 2015 and June 2016.
- The critical care service had developed escalation procedures to inform bed management who were responsible for sending patients back to the appropriate specialty ward. The trust had agreed these procedures with commissioners. We saw staff used this procedure and recorded in a logbook the time and date of when the patient was ready for discharge. Staff knew they had

to report any mixed-sex breaches or delayed discharges to the incident reporting system. If there was capacity, staff moved patients into a side room to mitigate mixed sex breaches.

- A consultant, physiotherapist and a nurse would follow up any patients who had been in ITU and discharged onto HDU or the ward. The service had procedures in place regarding joint care for patients between critical care and the ward until the consultant was happy with the patient's progress. Staff followed up patient's psychological state using a questionnaire inviting patients back for a group session a year after their discharge to offer follow up contact.
- Some band six and band five nursing staff were trained in advanced life support. However, all staff had received basic life support training as part of essential learning. The training lead for nursing staff said they were in the process of training all staff on HDU on recognising and monitoring the seriously ill (RAMSI) patient. The next group of staff were due to attend in September 2016. The training lead estimated all staff would have completed the training by the end of the year.
- We requested data from the trust regarding staff completion rates for advanced life support training. However, the trust could not provide us with this data due to data collection issues and problems with electronic systems recording staff training.

**Nursing staffing**

- Staffing met the recommended guidelines for the provision of intensive care services (GPICS) of a ratio of one nurse to one level three patient and one nurse to two level two patients. We saw from staff rotas for ITU and HDU between February 2016 and June 2016 this was the case. All patients we spoke with said the staff were "excellent" and they felt there was enough staff on the units.
- Senior nurses calculated rotas by using an an electronic e-rostering system. The nurse funded establishmentswere embedded in the e-rostering system. The system automatically calculated the skill mix and numbers of staff by banding. The e-rostering system produced rotas based on the maximum number of patients on the units. Staff and senior nurses found the system useful but could also be flexible if staff needed to swap shifts or change the skill mix in terms of experience.
- We reviewed staffing rotas from February 2016 to June 2016 and saw where there were gaps in actual staffing levels; senior nurses had provided staffing cover to ensure there were the correct numbers of qualified staff working on the units. The critical care service had procedures in place to escalate where staffing was below the required numbers. Staff knew about the procedures and where to access them. Staff could give examples of when they had used them.
- Our last inspection showed staffing was a risk because critical care had a high level of inexperienced and newly appointed nurses. We found there was still a high turnover of staff, which meant new nurses required supernumerary practice and competency assessment. For the period April 2016 to September 2016 the critical service had eight qualified nursing staff leave. This equated to a 10% turnover rate. This created additional pressures on experienced nursing staff. Senior nurses and managers said there was no issue in recruiting, however, vacancies arose because newly qualified nurses found critical care a difficult job and sometimes left quickly.
- The critical care service reported 4.4 whole time equivalent (WTE) band five nurse vacancies. In order to recruit a stable work force senior nurses wanted to employ experienced nurses to reduce turnover. They had recruited three experienced nurses at the time of our inspection.
- In the event of sickness or when emergency cover was required, senior nurses used bank or agency staff. Between April 2015 and March 2016, the use of bank and agency staff varied, ranging from 6% to 40%. From August 2015, data from the trust showed a decline in bank and agency usage from 40% to 13% meaning the service had more substantive staff in place.
- The critical care service had orientation and induction processes for bank and agency staff. This included capturing their training, being shown where key equipment it, competency to use equipment, and how to contact key medical staff. Proof of induction was recorded on a checklist with competencies and processes signed off by senior nurses once completed.
- The majority of staff, including medical staff, expressed concerns regarding managers moving nurses from critical care to fill gaps on other wards. Managers sent nurses to other wards if the number of patients in critical care were low. Senior nurses and managers confirmed this happened on an ad hoc basis. On our

unannounced visit, we saw an ITU manager had sent one nurse to work on a different ward. This presented a risk to patient safety in critical care if the numbers of patients suddenly increased and staff were unable to return to the unit.

- Data from the trust showed between January 2016 and July 2016 there were 41 occasions where managers sent nursing staff to support other departments. We saw one occasion had been reported on the trust incident reporting system. Managers recalled a staff member when the number of patients increased.
- Senior nurses responsible for rotas could change them to ensure there was enough experienced and senior nursing staff on shift to ensure inexperienced staff had support and patients were cared for appropriately. Managers moved staff between the critical care units to provide the correct level of skill mix cover when required. We saw from rotas this happened when required and met 'National Standards for Critical Care Nurse Education Guidance 2012', with at least 50% of experienced nurses on each shift.
- The critical care service had introduced nurse management objectives and competencies to support nurse's development and learning. This was an additional measure to create a more experienced workforce and improve skill mix of staff. Senior nurses signed off the competencies when they were happy nurses could work at the appropriate level. This meant nurses who had completed the objectives could be more confident in their roles on ITU and HDU.
- A dedicated nurse educator supported new staff through induction to achieve competencies and further training to enable them work to the required level. Part of this support included regular one to ones and clinical supervision for all new staff.
- Each unit had a clinical co-ordinator for each shift. Senior nurses took turns and rotated the role between them. In the absence of band six nurses, a senior band five nurse would undertake the role. The coordinator role ensured the skill mix and numbers of staff reflected the acuity of patients. They also identified any concerns regarding the bed management of patients. If the coordinator had concerns, they fed back to the Matron and the bed management meetings.
- Guidance for critical care nursing staff from the Francis Report 2013 states the coordinator role should be supernumerary 24 hours a day, seven days a week. The coordinator role for ITU was supernumerary.
- Nursing staff received a competency framework to complete on induction, including healthcare assistants (HCA). The competency framework helped to orientate new staff but also develop the skills and knowledge to work at the required standard within the critical care units. Staff demonstrated knowledge and competency through observations and discussions with senior and experienced nurses. We saw a completed framework for a nurse and a HCA and saw senior nurses signed them as completed.
- Staff conducted nursing handovers every shift change at 7am and 7pm. Staff discussed new and existing patients, their medical history and care plans, highlighting any key information, including potential risks to the patient. A senior nurse led a group handover followed by individual patient handovers at the bedside.

**Medical staffing**

- The ITU had 11 consultants. This enabled a consultant intensivist to be in the ITU at all times, with cover arrangements in place to allow patients to be reviewed by a consultant twice daily, seven days a week. The critical care service had recently recruited three more consultants to add to the establishment in anticipation of the changes to the model of critical services, i.e. becoming a 'closed' critical care unit. This meant consultants could deliver continuity of care as per Guidelines for the Provision of Intensive Care Services (GPICS) guidelines.
- GPICS standards state there must be rapid 24/7 availability of a doctor with advanced airway and resuscitation skills. Core Standards for Intensive Care 2013 state there must be immediate access to a practitioner who is skilled with advanced airway techniques. The trust assured themselves of meeting these standards by having a middle grade anaesthetist with advanced airway skills/resuscitation skills on site 24 hours, seven days a week.
- The critical care units complied with the consultant to patient ratio on ITU and HDU of 1:8 to 1:15 respectively. This was as per GPICS guidance.
- Locum anaesthetic consultant cover within general anaesthesia remained relatively constant for the reporting period April 2015 to March 2016. Locum usage ranged between 11% and 17% with the exception of

August 2015 (27.9 %). Information provided by the trust indicated, at the time of the inspection, critical care had no locum consultants but had two specialist registrars covering rotational slots due to vacancies.

- Critical care consultant cover ran from 8am to 6:30pm Monday to Friday for ITU. At weekends, a consultant was available on site 8am to 3:30pm. Out of hours and after 3:30pm at weekends, an on call consultant provided cover on ITU and a registrar was available on site. Managers said they were working towards 24-hour cover once new consultants were in post.
- In the HDU patients remained under the care of the consultant under which they were admitted. This included out of hours cover, and a daily review of all patients in HDU. Nurses described there were still issues in obtaining medical support out of hours on HDU, particularly from medical specialties. Audits undertaken by critical care departments showed there were still some delays. However, managers said this would no longer be an issue once HDU becomes a closed consultant led unit in September 2016.
- There were three medical handovers every day. Between 8am and 9am, the night registrar would hand over to the day registrar and two consultants, the pharmacist and ITU senior nurse. At 5pm, consultants held ward rounds to discuss each patient, risks and planned care. At 8pm, the day registrar would hand over to the on call consultant and night registrar.
- Hospital at night consisted of eight band seven nursing staff that coordinated the night time tasks for the trainee doctors. There was a hand-over meeting at 9:30pm to the hospital at night team and a further handover in the morning to the daytime team.

**Major incident awareness and training**

- The trust had a major incident policy, which described specific roles and responsibilities for key staff and departments including critical care. Staff knew about their roles and responsibilities in the event of a major incident and described actions they would take.
- Patients, who could be moved from critical care, would be, to make bed capacity and extra staff mobilised to support the wards and the emergency department. Staff knew about the major incident procedures and knew where to access them if they needed them.

# Maternity and gynaecology

| | |
|---|---|
| Safe | Good |
| Effective | Good |
| Overall | Good |

## Information about the service

Maternity and gynaecology services at Chesterfield Royal Hospital Foundation Trust are part of the Women and Children's division. In the period April 2015 to March 2016, there were 2,871 babies born and 3,224 admissions into the gynaecology services.

The maternity service consists of community midwives, a pregnancy assessment centre, birthing centre and combined antenatal and post-natal ward with17 beds, and two side rooms. There was one designated maternity theatre located in main theatres.

The Women's Health Unit cared for outpatient and day case gynaecology patients, early pregnancy and unplanned gynaecology referrals. Gynaecology patients requiring an inpatient stay are admitted on to Barnes ward in the surgical specialities division.

Community based midwives are employed by the hospital and work at community locations with rotation to the birthing centre to maintain clinical competencies, they also support the birthing centre at times of high activity. Hospital based midwives worked on rotation across the antenatal and post-natal ward in addition to the birthing centre to maintain clinical competencies.

This inspection is a focused follow up inspection following a comprehensive inspection in April 2015. At the inspection in April 2015 maternity and gynaecology services was rated good overall but required improvement in the safe domain. This inspection will focus on the key domain of safe. During our inspection, we spoke with 14 staff including senior managers, medical staff, registered staff and unregistered staff. We also reviewed five complete sets of records.

## Summary of findings

We rated the safety of maternity and gynaecology services as good because:

- Staff in maternity and gynaecology services had worked hard to improve the quality of the investigation of serious incidents with root cause analysis. All staff had been involved in training to conduct such investigations and many staff told us they had been involved. This resulted in better quality investigations and reports. The process provided staff with clear actions and lessons to be learnt where applicable.
- There had been improvement in the dedicated consultant hours provided to the birthing centre since our last inspection. Dedicated consultant hours now exceeded the recommended 60 hours of the Royal College of Obstetrics and Gynaecology (RCOG) Safer childbirth- the future workforce.
- Staff used the maternity early warning score (MEWS) effectively and this had helped to improve the recognition of the deteriorating patient. An early warning scoring system was designed to enable staff to recognise and respond to acute illness and deterioration, and to trigger a clinical response proportionate to the severity of deterioration. There was evidence of good use of risk assessments for patients being admitted.
- Staff generally had good access to equipment when required, with the exception of the access to resuscitation equipment in the pregnancy assessment centre. Access to the resuscitation equipment in the pregnancy centre had been risk assessed and was scored as a low risk.

However:

- A recent staffing acuity review was completed using a recognised staffing tool which highlighted the

# Maternity and gynaecology

number of registered midwives and unregistered staff required to provide a safe and effective service. The service had the number of required registered staff; however, there was a gap in unregistered staff of 10 whole time equivalent (WTE). Despite the outcome of the review and the service having the required number of midwives, there were 55 red flags raised in the birthing centre from January to June 2016 due to staffing issues as a result of high demand. This resulted in the supernumerary co-ordinator taking on patients.

## Are maternity and gynaecology services safe?

Good

We rated safe as good because:

- An improved root cause analysis (RCA) process, which demonstrated thorough, multi-professional investigation into serious incidents.
- The provision of dedicated consultant cover hours per week exceeded the recommended 60 hours for the number of births within the service.
- Improved usage of the maternity early warning score (MEWS) resulting in improved recognition and interventions for the deteriorating patient.

However, we also found:

- Emergency medicines and sharps equipment was easily accessible to patients and visitors on the post-natal ward. This was immediately rectified at the time of the inspection.
- There was an inconsistent approach to demonstrating when clean equipment had been cleaned and was ready for use.
- Level three safeguarding training had been completed by 76% of the required staff, which was not in line with intercollegiate standards.
- Staffing levels within the birthing centre were not reviewed despite the consistent use of the red flag system when the supernumerary band seven midwife was allocated patients.

### Incidents

- In the period June 2015 to May 2016, 584 incidents were reported which included eight serious incidents. Serious incidents are events in health care where there is potential for learning or the consequences are so significant that they warrant using additional resources to mount a comprehensive response.
- There were no never events reported for this service from June 2015 to May 2016. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.

- Staff told us there was a good incident reporting culture, which included specific obstetric incidents for example an unexpected admission to the neonatal unit requiring an automatic submission. The head of midwifery said processes were in place within the midwifery service to provide assurance that all incidents, which had triggers, were reported. We saw examples of incidents that had been reported which included specific obstetric incidents which had thorough investigation and learning identified from them.
- We reviewed five serious incidents reports. The trust used a multi-disciplinary standard root cause analysis (RCA) process that followed the National Patient Safety Agency (NPSA) guidance Following the previous inspection, staff told us that there had been a lot of work completed on improving the RCA process within the service.
- There were monthly perinatal paediatric and obstetric meetings which included mortality and morbidity cases. Minutes produced from these meetings showed a thorough investigation of significant cases which resulted in significant harm to either the child or mother, or death with clear proposals for actions to be taken where necessary. The clinical lead for obstetrics and gynaecology informed us there have been no recent maternal deaths in the trust. The last maternal death was in 2012.
- Staff that we spoke with had some awareness of the requirement for them to be open and honest when things went wrong and to offer an apology, however senior staff were not assured all staff fully understood the duty of candour. The duty of candour is a regulatory duty which relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person.
- In the five RCAs selected for review, there was evidence duty of candour was followed. Staff told us that duty of candour was completed at the time of the report and was followed along the RCA process.
- All staff told us they received feedback from incident reports submitted. They also told us they were aware of incidents across the trust and the lessons learnt from them. These were usually discussed at ward level meetings, however if there were more serious actions to be implemented from incidents, this information was disseminated with emails. During our inspection, we saw evidence of learning through incidents, displayed on information boards.

**Safety thermometer**

- The NHS safety thermometer is a national tool used to measure, monitor and analyse common causes of patient harm. Data provided by the trust showed there had been no patient harm for gynaecology or maternity service from June 2015 to May 2016. The patient harms were identified as pressure ulcers, catheter associated urinary tract infections (CAUTI) and falls.
- The Royal College of Obstetrics and Gynaecology (RCOG) launched the maternity safety thermometer in October 2014. This was a system for reporting harm free care for key areas which included perineal and/or abdominal trauma, post-partum haemorrhage (PPH) and infection. Separation from baby, psychological safety and Apgar scores of six or less at five minutes after birth were also reported within the safety thermometer framework. The Apgar score (appearance, pulse, grimace, activity and respiration) is an assessment of overall new-born wellbeing.
- In addition to the key areas, which the service should be reporting on, the trust also reported on the number of babies born at term admitted into the neonatal unit. Information reported by the trust showed a spike in the number of admissions in September 2015 and December 2015 although no trend was identified. Since January 2016 to June 2016, there have been no term babies admitted into the neonatal unit.
- From July 2015 to June 2016, the service performed better for combined harm free care than the national average apart from September 2015 where they reported 37.5% of patients received harm free care.
- The maternity safety thermometer required trusts to report on the number of women who had a PPH of 1000mls or more. From July 2015 to June 2016, the trust performed better than the national average for the majority of this period, however they did spike above this in November 2015, February 2016 and June 2016. If a woman has a PPH of above 1500mls, the trust will complete a formal investigation in line with the trust policy. From the investigations conducted, there were no reasons identified why there had been an increase.
- The information provided by the trust for women who had a third or fourth degree perineal trauma showed

they spiked above the national average of 2.5% in August to September 2015, November 2015, January 2016 and May 2016. The service had conducted extensive reviews of this information to identify if there were any trends. So far, there have been trends or correlations with the findings of the reviews.

**Cleanliness, infection control and hygiene**

- All areas within the maternity services appeared visibly clean and tidy during our inspection. There were cleaning schedules available for all areas, which were completed regularly.
- Most equipment within the unit was single use. Items that were not single use were sent for decontamination. The level of decontamination was dependant on the infection risk that the items posed An example of this was suture kits used on patients, reusable items were sent to the sterile services department for sterilisation.
- There was one case of Clostridium difficile (C. difficile) associated diarrhoea on Trinity ward in February 2016. As this was identified within 72 hours of the patient being admitted, this was not attributed to the trust. C. difficile is a bacterium that can infect a person's bowels. It is also commonly associated with people who have had courses of antibiotics and could be easily transmitted to other people.
- There were no cases of Meticillin resistant Staphylococcus aureus (MRSA) bacteraemia within the maternity and gynaecology services in the last 12 months. MRSA is a bacterium that is resistant to a number of widely used antibiotics.
- Staff told us maternity staff were responsible for completing a clean of the four birthing pools within the birthing centre after they had been used. After this, domestic staff had disinfected these facilities and marked them as clean using the 'I am clean' system. During our announced inspection, only one birthing pool was available for review, this appeared visibly clean and had a sticker in place. During the unannounced inspection two of the four pools we looked at did not have a sticker in place, however all four pools appeared to be visibly clean. There was therefore no consistent assurance process in place for identifying when the pools were clean and ready for use.
- We found equipment that was clean and tidy, however the green 'I am clean' tape was not consistently used throughout the areas we visited to identify that equipment was clean and ready for reuse. This corroborated that there was no consistent assurance process in place for identifying when equipment was clean and ready for use.
- All areas within the maternity services completed a regular flushing programme, which included the birthing pools. This was to ensure the water supply to the departments was at a reduced level of risk of containing waterborne organisms (bugs) such as Legionella and Pseudomonas aeruginosa. Legionella and Pseudomonas aeruginosa are both waterborne bacteria, which can contaminate water supplies and cause infections in patients if measures such as water flushing are not completed regularly.
- Staff adhered to the World Health Organisation (WHO) five moments for hand hygiene during our inspection and was bare below elbow. The WHO five moments for hand hygiene are guidelines for all staff working within healthcare environments and define the key moments when staff should be performing hand hygiene in order to reduce risk of cross contamination between patients.
- There was a good supply of personal protective equipment (PPE) in the maternity services, which included a plentiful supply of filtering face pieces (FFP) three respirator masks for potentially infectious respiratory infections. Staff told us they had received training on how to use these correctly, and were required to use them regularly during winter when they had potential cases of influenza.
- Infection prevention and control screening was completed on all patients on admission. If a patient was identified as a high risk, screening would be completed as part of the admission process. An example of this was if a patient was admitted for an elective caesarean, they would be screened for MRSA.

**Environment and equipment**

- The birthing centre and post-natal ward had undergone refurbishments, which were in accordance with Health Building Note (HBN) 09-02 Maternity care facilities. Staff on the pregnancy assessment centre told us that the area had not been refurbished. However, staff told us there were plans to improve the services provided by the centre, which could include a potential refurbishment at some point to accommodate the additional work that would be included in the plans for the service.

- There was no resuscitation equipment including a defibrillator in the pregnancy assessment centre. If resuscitation equipment was required, staff were be required to collect it from either the day surgery unit through a swipe access door or from the birthing unit This was identified as a risk on the previous inspection. A risk assessment had been completed and was deemed low risk. Action to address the risk had been taken for example the introduction of a 'grab bag' which contained basic equipment necessary to support a patient whilst the resuscitation trolley arrived.
- Baby resuscitation equipment was located in one of the bays within the post-natal ward. This contained medicines to be used in an emergency and other items of equipment including sharps and a sharps container attached to the outside. This was not locked and was not constantly supervised by staff on the ward. We highlighted this as a potential risk to the executive team and this was rectified immediately.
- A milk kitchen was on the post-natal ward for parents to prepare feeds for their baby. The kitchen had a breast milk refrigerator, which was locked and only accessible by staff. There was constant temperature checking and recording of the refrigerator and strict rules for how long the milk inside could be kept. Staff told us this refrigerator was regularly checked and cleaned by the housekeeper but no documentation was found to corroborate this.
- The resuscitation equipment in the birthing centre was located in a cupboard, which was unlocked and easy to access. There was also an epidural trolley located in this cupboard, which had been put together by an anaesthetist who regularly worked in this area. This was to reduce the amount of time that a patient had to wait for equipment to be gathered by staff to perform this procedure. Both pieces of equipment were checked daily and a record of these checks were found with the pieces of equipment. An epidural is an injection of local anaesthetic or painkiller into an area around the spine, which temporarily numbs the nerves and stops a patient experiencing pain.
- There was a blood gas-monitoring machine located in the birthing centre. The staff on the unit performed daily quality checks on this piece of equipment and recorded this. There was a system for periodic checks and servicing to provide assurance of its performance and we saw evidence of these checks and services that had taken place.
- The birthing centre had two cooling mats available for the use of parents who had delivered a stillborn baby. This enabled parents to spend time with their baby prior to leaving the hospital therefore reducing the distressing task of visiting the mortuary. Staff told us they thought they had enough of these items to enable them to provide grieving parents the time with their infants without having to rush this process.
- There was an adequate supply of cardiotocography (CTG) machines available within the maternity services. CTG machines measure foetal heartbeat and contractions during labour and can give an interpretation of foetal well-being.
- The storeroom on the post-natal ward contained a mixture of items. There were sterile and non-sterile items stored, stationary and equipment some of which had the 'I'm clean' stickers on them, some that did not. Boxes of items were also observed as being stored on the floor, making it difficult for domestics to regularly clean the room. All items should be stored off the floor to prevent the build-up of dust and dirt which could be a potential infection control risk.
- The post-natal ward was responsible for an additional two side rooms out of hours when the women's health unit (WHU) closed. Patients were cared for in these rooms who had undergone gynaecological procedures such as medical or surgical termination of pregnancy or were experiencing a miscarriage. Staff told us there had been no complaints raised about this process and an audit completed by the service showed that they had given women who had stayed in these rooms the opportunity to highlight if they were unhappy with this. The nurse call bells for these rooms were audible on Trinity ward and there was a light, which highlighted which room was calling.

**Medicines**

- Medicines were stored and administered appropriately according to the trust drug management policy. All five of the medication administration records (MARs) that we reviewed were clearly written dated and signed and allergies recorded where applicable.
- Staff told us they were required to complete medication competencies for administering medications, intravenous administration competencies and

competencies for dispensing medication from the ward on patient discharge. They continued that they completed regular reviews of these competencies each year.

- Staff told us they reported medication errors through the incident reporting system. We saw evidence of this including a full investigation of an error made and the recommendation of lessons to be learnt from this. We also saw evidence of medicine errors discussed at the quality and governance group meeting in the meeting minutes submitted.
- Controlled drugs (CDs) were stored, checked and administered in accordance with legal and policy requirements. Two registered nurses completed all checks of CDs. CDs are medicines that require additional security and regular checks.
- Staff told us discharge medication could sometimes be delayed due to prescribing delays although they try to prevent this by requesting the doctors complete the documentation as far in advance as possible. This could sometimes cause problems with patients who wanted to be discharged. During our inspection, we observed staff on the post-natal ward dealing with a patient who had gone home before their medication was available against the advice of the staff on the ward. Staff were very clear about the risks that the patient could face if they decided to leave before their medication was available and clear documentation surrounding this was observed.

**Records**

- Staff told us plans were in place to transfer all records to a computer-based system and there had been several trials performed within the service. At the time of our inspection, this had been suspended and all areas were using paper-based records.
- Women who used the maternity services were all provided with their own sets of notes that they would bring with them when attending for appointments. These records included details of the booking in process where thorough initial risk assessments were completed, antenatal checks performed by community midwives, scans and screening results.
- Once a patient was admitted into the hospital for care, midwives would complete hospital notes for the mother. When the baby had been born, a set of notes would be created for the baby. Any treatment or care provided to either the mother or baby would be documented in these notes and a discharge summary would be provided when they were discharged.
- We reviewed five completed sets of records for patients during our inspection. We saw that staff documented accurately, up-to-date and legible in accordance with professional bodies recommendations for standards of documentation.

**Safeguarding**

- There was a named midwife for safeguarding who also had responsibility for alcohol and substance misuse. All staff were able to identify the named midwife for safeguarding.
- The named midwife was involved in a patient's care from a safeguarding perspective from referral until the first case review after the baby had been born. For those where it was required, a discharge plan was completed to assure a safe process. This was filed in the patient's hospital notes in the front section. We saw evidence of the plans produced by the lead midwife for safe discharge of patients and their babies. If a patient was discharged between Monday and Friday, the named midwife tried to visit them before they left.
- Intercollegiate standards state that all clinical staff that work with children, young people, and/or their parents and carers should be trained to level three safeguarding for children. Compliance with training had improved since the last inspection, with 76% of staff now compliant with this standard; however the trust standard for compliance was 100% which was in line with intercollegiate guidance. The named midwife for safeguarding had already identified where the non-compliance was and had initiated training plans for these people.
- The maternity services had an abduction policy, which was in date, and testing of this policy was completed annually in all areas. When a test of the policy was conducted, a full report of the incident was produced and any lessons, which come from this, were shared with all areas that the policy covered. All babies within the birthing centre and post-natal ward were tagged.
- The named midwife told us there were high volumes of referrals made each year from community and hospital

midwives. Social vulnerability was assessed on initial booking for each patient and was continued to be assessed throughout a patient's antenatal care. In 2015 there were 1,008 patients referred for safeguarding.

- Recent information had shown an increase in concealment of pregnancies, which the named midwife for safeguarding had raised awareness of. No trends were identified in the cases which had occurred at the trust. All were of different ages and backgrounds. The named midwife continued this is representative of a national picture with the concealment of pregnancies.
- The named midwife led on raising awareness of female genital mutilation (FGM) and was responsible for policy development in the trust. Female genital mutilation/ cutting is defined as the partial or total removal of the female external genitalia for non-medical reasons. Since the Department of Health guidelines were released in 2015 requiring all healthcare professionals to report cases of FGM, the trust had reported five cases of FGM. Knowledge of FGM and the requirements to report any cases was high within all staff members at the trust.
- Staff within maternity services were aware of child sexual exploitation (CSE) and were able to identify where cases had been identified and reported within the trust. The named midwife told us this was more evident within the children and young people's services, and her counterpart for that service was more involved in the cases identified within the trust.
- The named midwife has previously been involved in serious case reviews as both presenting a case and part of the panel. The named midwife would disseminate any lessons, which could improve the safeguarding experience for patients at the trust. They also looked at national cases for evidence of where lessons could be learnt.
- There was a policy at the trust, which provided specific guidance on the steps to take for a girl under the age of 13 who presented for a termination of pregnancy. As this would be completed on the women's health unit (WHU), the named midwife would not usually be involved in any specific cases, however a referral to the named children's safeguarding nurse would be completed.
- The named midwife told us they had good contacts with the local authority and other trust safeguarding teams. These links had helped to improve the sharing of information on patients who may move during their antenatal care. If they had cases, where they can no longer locate a patient who is known to the social services or safeguarding team, the named midwife completed as much information gathering as possible before putting out an alert.

**Mandatory training**

- Maternity specific essential training was completed on a 12 to15 month's basis and the trust target for compliance of completion was 75%. Data received in June 2016 showed 85% of midwives were compliant for this training and 77% of obstetric consultants were compliant for this training.
- Information provided by the trust identified that there were issues collating non-maternity specific mandatory training figures due to a new system being used. The trust could only provide the details of staff that had attended training this year rather than looking at staff whose mandatory training was in date.
- Information provided showed 44% of midwives had completed ET1 training this year and 59% of maternity assistants had completed this training. ET1 training consists of resuscitation training, dementia training, prevent training and transfusion training.
- Information provided by the trust showed 19% of midwives had completed ET2 training this year and 58% of maternity assistants had completed this training. ET2 training consisted of fire and health and safety, infection prevention and control, safeguarding adults and children, Mental Capacity Act 2005 (MCA) training and Deprivation of Liberty Safeguards training.

**Assessing and responding to patient risk**

- In all five sets of notes, we saw evidence of thorough risk assessment of the patients, which would be repeated on admission into hospital. Additional risk assessments on admission included an infection control risk assessment for MRSA, tuberculosis (TB) and Carbapenemase producing organisms/enterobacteriaceae (CPO/CPE) and a modified skin integrity risk assessment for maternity specific patients. TB is an infectious respiratory disease, which can be passed from person to person through contact with aerosolised droplets. CPO/ CPE are highly infectious bacteria (bugs) which can be passed on from person to person through poor standards of hand hygiene or decontamination of equipment.
- We saw evidence that all women who were admitted had further risk assessments to make sure their level of

risk had not changed which could mean they required a different level of care than previously identified. One example was for women who were due to have midwife led care, to ensure that there were no concerns, which would prevent this from going ahead.

- All five sets of notes checked had evidence of risk assessments for venous thromboembolism (VTE) completed and where necessary, prophylaxis was prescribed for patients.
- The two-bedded maternity observation unit (MOU) in the birthing centre was situated in front of the staffing station so any patient who required closer observation by the midwives received this. Staff told us patients located in this area were not level two patients, who are patients requiring high dependency care. If a patient required this level of care, they were transferred to the HDU located in the intensive care unit (ICU). The patients who were located in this area would be well enough for a post-natal bed, but due to complications during birth received a period of observed care before transferring to the post-natal ward. Examples of patients commonly requiring care in this area were those who experienced a large post-partum haemorrhage which is high blood loss following birth. Women with eclampsia or those receiving infusions, which required closer observation during infusion. Eclampsia is a rare but serious condition in pregnancy that causes seizures due to high blood pressure.
- The maternity services used a maternity early warning score (MEWS) tool on a selection of their patients to identify if they were deteriorating. The criteria for a patient to be on a MEWS chart included admissions after 24 weeks of pregnancy, labouring women, postnatal readmissions, those returning from ITU/HDU and any patient where there were abnormal events or complications, for example sepsis, PPH. During the inspection, we saw evidence of staff using the MEWS chart effectively to help identify if a patient was deteriorating and then acting upon their concerns.
- Local audits on the use of MEWS within the maternity services had shown an improvement in their use. The most recent audit completed in June 2016 showed that staff were scoring patients correctly and had acted on any higher scores appropriately. The only occasion where there was a deficit was in regards to a rotating in member of staff who was not used to using this scoring chart.
- Staff on the birthing centre used an adapted version of the World Health Organisations (WHO) checklist for safer surgery (maternity cases only). This checklist had been embedded within the birthing centre's theatre pathway. Staff told us that these documents were well utilised within the birthing centre, however there were no audit results available to support this.
- There was a direct route to theatre from the birthing centre, which would allow swift transfer of a patient if there was an emergency whilst giving birth. Patients requiring a general anaesthetic were recovered in the post-operative recovery unit before being transferred back to the birthing centre.
- The unit placed stickers in the notes of patients who had an intra-uterine foetal death (IUFD). This highlighted the risk of these patients if they have further pregnancies so that measures could be taken during subsequent pregnancies to try to reduce the risk of further IUFDs. IUFD refers to the death of a foetus after 24 weeks gestation whilst still in a woman's uterus.
- Patients found to be positive for Group B Streptococcus (GBS) had an alert sticker placed in their notes to inform any staff involved in their care of the risks. GBS is a bacterium (bug) which can be found in the vagina and bowels of women and can be passed on to a baby around the time of childbirth, which can cause an infection in the child.
- The maternity services had introduced the 'fresh eyes' approach to responding to patient risk. This required the co-ordinator or registrar to review patients who were undergoing CTG monitoring to review the patient every other hour. This enabled another professional to review a patient's condition and identify any concerns earlier so they could be dealt with.
- In response to incidents, which had previously occurred, all junior doctors (SHO and GP trainees) completed additional training on the management of a bleeding gynaecology patient. All registrars completed the essential skills and drills training package as well as neonatal resuscitation.

**Midwifery staffing**

- The maternity services participated in the birthrate plus workforce planning from December 2015 to February 2016. This recommended that the service required a total of 108.2 whole time equivalent (WTE) staff with a skill mix adjustment of 90% registered to 10%

unregistered. At the time of our inspection the service had 98.66 WTE registered staffing with no availability of band three or four staffing. The service had 20.8 WTE band two midwifery support workers.

- Following the birthrate plus review, the service was in the process of recruiting five WTE band three midwifery support workers who would be predominantly employed in the community service to support the community midwives. The service would review whether the additional five that were also recommended would be recruited once the first five were in place.
- An additional five band seven matrons were responsible for quality and governance, clinical education, antenatal screening, safeguarding and women's health unit. A band seven matron was also in-charge of both the postnatal ward and birthing centre, and a band eight A senior matron was responsible for community midwifery and maternity outpatient services.in-charge of the pregnancy assessment centre.
- Nationally approved guidance recommended that in order to ensure a safe service, there should be sufficient midwives to provide one to one care during established labour and a midwife to local birth ratio of 1:28. Data provided by the trust demonstrated that maternity services were providing a ratio of 1:29 although not quite meeting national recommendations; this was reflective of a true national picture of what trusts are currently providing.
- All midwives were able to provide one to one care for their patients, as maternity services always provided a named midwife for their care.
- Community midwives caseload was well within the national average of 1:96. The ratio of community midwives to patients ranged from 1:65 to 1:80.
- The maternity service used the red flag system for highlighting to the midwife in charge when there were potential concerns with midwifery staffing which could or did affect patient care and treatment. From January to March 2016, there were 36 red flags raised for maternity services, 35 of which were raised because the band seven supernumerary positions on the birthing centre was not supernumerary. The most recent quality governance group meeting minutes reported a continued trend of high numbers of red flags being raised because the supernumerary position does not remain supernumerary. Staff on the birthing centre told us that staffing had been stretched on a number of occasions with community midwives being tasked to cover at times of high activity. Despite this being highlighted, staff were unaware of any plans to look at staffing on the birthing centre to overcome these issues and there had been no direct impact on patient care.
- Further information provided by the trust showed 19 red flags were raised between April and June 2016.
- There were eight supervisors of midwives at the trust. The caseload for each supervisor was between 13 to 18 midwives. The ideal ratio to provide appropriate supervision to midwives was 1:15.

**Medical staffing**

- Medical staff at the time of our inspection consisted of nine consultants, eight registrars and nine junior doctors.
- Since October 2015, the trust had provided over 60 hours of dedicated consultant cover per week for the birthing centre, with recent months reporting 78 hours per week of dedicated consultant cover for the birthing centre. This met the safer childbirth standard of 60 hours presence for the total annual births of 2500-4000.
- Dedicated obstetric anaesthetic cover was available between 8am and 6pm, Monday to Friday with the availability of an on-call team outside of these hours.
- There was a consultant on-call out of hours for the maternity and gynaecology services. The on-call consultant was on call from home between 5.30pm and 8.30am and could be up to 30 minutes away from the hospital. Out of hour's one registrar and one junior doctor provided cover on site.
- There were three handovers between the medical staff, Monday to Friday which were conducted at 9am, 5pm and 9pm.
- A full time locum consultant had worked in maternity and gynaecology for the last 12 months; however their position was due to end soon. The reliance on locum usage had reduced recently as staffing had improved within the trust.
- There was seven consultant led morning clinics operating within the pregnancy assessment centre Monday to Friday, with an additional two afternoon clinics being run on Wednesday and Thursday.

**Major incident awareness and training**

# Maternity and gynaecology

- All staff were aware of the escalation policy if the services experienced high levels of demand or staff shortages. The service had not experienced any suspension of services in the last 12 months.
- There was a trust major incident policy available to all staff which was dated June 2016. All staff were aware of this and what would be expected of them if a major incident was declared.

**Are maternity and gynaecology services effective?**

Good

# Services for children and young people

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

## Information about the service

Chesterfield Royal Hospital provides children's and young people's services. There are 20 In-patient beds for children of varying specialities that are admitted into hospital.include 20 beds, two high dependency beds and six day case beds available Monday to Friday. Twelve of the beds on Nightingale Ward are for paediatric in-patients of varying speciality. Children's outpatient services were mainly located in the designated children's outpatient area known as 'The Den'.

The neonatal unit has capacity for 14 cots and provides one cot for level two care (for moderately ill babies) and two cots for level three care (for complex and severely ill babies). The remaining 11 cots provide level one care for newborn infants requiring additional nursing (special care). At the time of our inspection, trust data showed nine of the 11 level one cots were available.

In the period May 2015 to May 2016 there were 6,961 inpatient admissions into the children's and young people's services. Of these 4,855 were emergency admissions, 241 planned admissions and 832 were treated as day case admissions. In the same reporting period there were 277 neonatal admissions. There were 24,210 paediatric outpatient episodes in the period July 2015 to June 2016; the majority of these were conducted in 'The Den'.

This inspection is a focused follow up inspection following a comprehensive inspection in April 2015. At the inspection in April 2015 children's and young people's services was rated good overall but required improvement in the safe domain. This inspection will focus on the safe domain.

During our inspection we visited Nightingale Ward, the neonatal unit and the children's outpatient department 'The Den'. We spoke with five medical staff and six nursing staff. Before our inspection, we reviewed performance information from, and about the trust.

## Summary of findings

We rated the safety of children's and young people's services as requires improvement because:

- The trust did not meet the Royal College of Paediatric and Child Health (RCPCH) standards for onsite consultant presence at the time of our inspection, although there were plans for how this would be achieved.
- Resuscitation equipment on the children's ward was risk assessed and remained unlocked on the ward, although the section containing emergency medications were locked. The resuscitation policy for the paediatric services did not contain details on whether the whole trolley should or should not be locked. The resuscitation trolley was consistently checked and records demonstrating these checks were reviewed. However, basic airway management equipment for older children and adults on the resuscitation trolley was not immediately available; however additional equipment was located in a store cupboard.
- Level three safeguarding children training did not meet intercollegiate guidance, with the staff on the neonatal unit achieving 81% and staff on Nightingale ward achieving 83% however there were individual plans in place for staff to complete this. Knowledge of safeguarding within the ward areas was generally good and improvements had been made in the adult fracture clinic. There were, however no assurances about the level of safeguarding in other outpatient areas where children may be seen.
- There was a never event in October 2015 that involved a child which was reported on under the core service of surgery. No staff members of the children and young people's service were involved in the investigation of this incident.

However, we also found:

# Services for children and young people

- Since our last inspection in April 2015 the trust had achieved the appropriate level of suitably qualified nursing staff per shift, with the European paediatric life support (EPLS) qualification. This was in line with the Royal College of Nursing (2013) best practice guidance in relation to nurse staffing levels on general children's wards.
- There had been a significant improvement in the completion of patient records and risk assessment quality.
- There were good infection prevention and control measures within the service and this was reflected in the low numbers of healthcare acquired infections.

## Are services for children and young people safe?

**Requires improvement**

We rated safe as requires improvement because:

- Medical staffing did not meet the standards for a minimum of 12 hours onsite consultant presence at the time of the inspection.
- The resuscitation equipment on Nightingale Ward was unlocked, unlike other trolleys in the trust, and basic airway management equipment for older children and adults were not immediately available.
- Trust training statistics confirmed that the children's safeguarding level three training attendance was 83% for the Nightingale ward and 81% for the neonatal unit. Safeguarding training was provided to staff in the adult fracture clinic that also saw children and young people; however, assurance could not be provided that all adult outpatient areas treating children had adequate safeguarding training in place.
- There was a never event involving a child in October 2015, however no staff from the children and young people's service were involved in the investigation process.
- Data provided by the trust showed sepsis management was not fully embedded.
- There was no assurance about the safety of medical devices.

However we found:

- There were suitably qualified nurses on each shift within Nightingale ward who held a qualification in European paediatric life support (EPLS).
- The use of the paediatric early warning score (PEWS) was embedded within the service and aided timely recognition of the deteriorating patient.
- The neonatal unit had introduced a gentamicin (an antibiotic) prescription chart to improve standards of correct gentamicin prescribing.
- There was a positive incident reporting culture. Staff received feedback and lessons learned were disseminated.

**Incidents**

- Systems were in place to ensure that all incidents were appropriately reported, investigated and learnt from. Staff told us that incidents and complaints were regularly discussed at ward meetings, training sessions and quality and governance meetings.
- In the period June 2015 to May 2016, 143 incidents were reported. One incident was graded as moderate harm, the remainder were graded as no or low harm. No serious incidents were reported during this period. Serious incidents are events in health care where there is potential for learning or the consequences are so significant that they warrant using additional resources to mount a comprehensive response.
- From June 2015 to May 2016 there were no never events reported for this service in the period June 2015 to May 2016. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
- However, there was one reported for the surgical services, which involved a child having the wrong tooth extracted in October 2015. Senior staff from the service had not yet been involved in any investigations as this had been attributed to the surgical services in the trust. The completed root cause analysis (RCA) did not involve any members from the children and young people's service and there were no actions identified as a result of the RCA which involved the service.
- Staff told us they were knowledgeable in the incident reporting system and felt confident in the reporting processes. All staff told us they received feedback from the incidents they submitted and lessons learned were shared.
- Within the service, there were automatic triggers which required an incident form to be completed. There were processes in place, which provided assurance that all these triggers have appropriately been reported through the incident reporting process.
- Children's services had previously conducted regular paediatric mortality meetings; however, there had been no meetings in the last 12 months as there had been no cases that required a review at these meetings. Staff now regularly attended the perinatal paediatric and obstetric meeting instead where cases were discussed. Mortality meetings are multi-disciplinary meetings to review deaths as part of professional learning.
- Staff were involved in the RCA training provided by the trust. Staff told us this training was a useful tool to improve how investigations into incidents were conducted.
- The duty of candour is a regulatory duty relating to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person. All staff were aware of the requirement to be open and honest when incidents occurred and offered an apology for errors made on behalf of the service. In the selection of incident reports that were forwarded by the trust, there was evidence of the duty of candour being exercised.
- National safety alerts were received at ward level and where appropriate, had been actioned.

**Safety Thermometer**

- The children's and young peoples' safety thermometer is a national tool designed to measure commonly occurring harms in children. It provides a monthly snapshot audit of avoidable harms including deterioration, extravasation, pain and skin integrity. Extravasation in this instance is a leakage of intravenous fluid into the tissues surrounding the infusion site which can cause damage.
- The trust had been submitting children and young peoples' safety thermometer data since January 2015. During our inspection, we saw safety thermometer data clearly displayed on entrance to the ward.
- With exception of July 2015, December 2015 and February 2016 where they scored 77%, 60% and 90% respectively, the trust had performed better than the national average of 85% with regards to the proportion of patients in the children and young people's service receiving harm free care. In May 2016, 100% of patients received harm free care.
- Data provided on harm as a result of extravasation for children and young people showed a spike in February 2016; however all other months from July 2016 to May 2016 reported no harm as a result of extravasation. Information provided by the trust showed that this spike was attributed to just one patient and no long-term harm was identified.

- The results of the safety thermometer for children and young people with pressure ulcers and moisture lesions which were new or old showed no patient harms during the period of July 2015 to May 2016.

There was evidence in the four sets of notes that we reviewed that venous thromboembolism (VTE) risk assessments were performed and prophylaxis treatment given to those children and young people considered to be at risk. VTE is the formation of a blood clot in a vein. Prophylaxis is the treatment given to a patient to prevent something from happening, in this case to prevent a blood clot**Cleanliness, infection control and hygiene**

- During our inspection, all areas within the service appeared to be visibly clean and cleaning schedules were available for review and had been completed.
- Between June 2015 and May 2016 there had been two cases of Clostridium difficile (C. difficile). Both of these cases were identified before72 hours of the child's admission to hospital and were therefore not attributed to lapses in care by the trust. C. difficile is a bacterium that can infect a person's bowels. It was also commonly associated with people who had courses of antibiotics and could also be easily transmitted to other people.
- From June 2015 to May 2016 there had been no cases of Meticillin resistant Staphylococcus aureus (MRSA) bacteraemia which is a blood stream infection. MRSA is a bacterium resistant to a number of widely used antibiotics.
- There was one case of MRSA acquisition in March 2016 identified on the neonatal unit. On investigation, there were no lapses in care or poor practice identified which contributed to the transmission.
- Staff adhered to the World Health Organisations (WHO) five moments for hand hygiene during our inspection. The WHO five moments for hand hygiene are guidelines for all staff working in healthcare environments and define the key moments when staff should be performing hand hygiene
- Hand sanitiser was available at the point of care and adequate amounts of hand washing sinks for staff use. On Nightingale Ward, consideration was given to the risk of having hand sanitiser at levels where children could access this. It had been placed at a height, which could not be accessed by children, but was still available at point of care.
- Audit results provided by the trust showed 100% compliance with the hand hygiene audit and bare below elbow from January 2016 to April 2016.
- Children and young people admitted into the service were risk assessed for a variety of potential infections which included MRSA, Carbapenemase producing organisms (CPO) and Tuberculosis (TB). If the child was considered a potential risk, appropriate infection prevention and control actions were undertaken which included isolation and screening. CPOs are organisms which is highly resistant to a wide range of antibiotics including Carbapenems which are usually used to treat serious infections and can be easily spread between patients if careful infection control practices were not carried out. TB is a bacterial infection which mainly affects the lungs and can be passed on to others through breathing in tiny droplets from the cough of an infected person.
- We found equipment to be visibly clean. The equipment was identified as being visibly clean with green 'I'm clean' tape. For items, which were not regularly used, they were regularly cleaned and green tape replaced each time this had been carried out.
- There was an adequate amount of personal protective equipment (PPE) available in all areas and we saw staff using them to perform tasks in accordance with trust policy.

**Environment and equipment**

- The environment within the children and young people's services was representative of the advice in 'Health Building Note (HBN) 23' hospital accommodation for children and young people. This included separate bays for different age ranges rather than bays designated on single sex. Staff told us they gave children and young people and their relatives and /or carers the opportunity to specify if they would rather be amongst children and young people of similar age or of the same sex.
- Baby incubators on the neonatal unit were checked daily and we saw a record of these checks. Each day staff had checked that the suction, ventilation and oxygen equipment were all working.
- There was no longer a transfer bag which accompanied the transport incubator. Staff told us on review of the situation following the last inspection; they preferred to have equipment boxes for specific emergencies, which were kept in the treatment room. Staff checked the

boxes daily reducing the risk of out of date items being found in the future and key items going missing. We checked the boxes for difficult airway management and the neonatal emergency box and found all items present and in date.

- We checked the resuscitation equipment on Nightingale Ward and found that unlike the other resuscitation trolleys in the trust, this was unlocked apart from the draw containing the medication. The matron of the department told us following the previous inspection, there had been discussions as to whether they should lock their trolley or not, however all staff agreed they would prefer to leave this unlocked and would just lock the draw containing the resuscitation drugs. There was no formal risk assessment available to demonstrate the risk of this had been considered. On review of the policy, there was no information contained in this about the requirement for the trolley to be locked and practice was not consistent with practice throughout the trust.
- On the announced inspection, the resuscitation trolley did not contain any oropharyngeal airways above a size one which meant that for older children and adults there would not be an effective way to maintain an open airway in an emergency situation. An oropharyngeal airway is a device that is placed into a patient's mouth if they lose consciousness to maintain an open airway. The only devices available for maintaining an airway on an unconscious patient were endotracheal (ET) tubes which were available in sizes suitable for older children and adults. An ET tube is a device that is placed down the trachea through the mouth to maintain a patient's airway. The policy for paediatric resuscitation trolleys contained an equipment list which only stated that there should be a paediatric and adult airway tray, sizes of items was not specified.
- On the unannounced inspection, the resuscitation trolley on Nightingale Ward did not have any oropharyngeal airways above a size one or any other airway equipment other than the ET tubes found on the announced inspection. However, in a respiratory support cupboard nearby there was a bag or airway equipment that contained oropharyngeal airways in sizes that would be appropriate for use in older children and adults. One staff member told us they knew there was more emergency equipment available in this cupboard, however this was not apparent on the announced part of the inspection when the concern was originally identified.
- Staff told us all paediatric resuscitation trolleys were standardised throughout the trust and the resuscitation officer had decided what equipment must go the trolley.
- All equipment that we checked was in date with routine servicing. Staff told us when external companies serviced items of equipment; they were usually given prior notice about the service. An example of this was for the blood analyser on the neonatal unit.
- There was an inconsistent process for portable appliance testing (PAT) of electrical equipment. Some items had a sticker on them which annotated the date it was tested; other items had colour coded stickers applied to them which corresponded to a particular period of time it was tested. Staff were unable to tell us the dates, which related to the different colour codes therefore could not be assured that all items were safe to use.
- We saw that all the refrigerators and freezers located within the children's and young person's services had their temperatures checked and recorded daily. Staff were able to tell us what actions they would take if they found the temperatures were out of range which was in line with trust policy.
- On the neonatal unit, the breast milk refrigerator was not locked as it was in other areas of the trust. Staff told us this had not occurred to them as a potential problem, but could understand the risk as the refrigerator was in an unlocked room and accessible to members of the public. This meant there was a risk of theft or contamination of items in the fridge. As the keys were immediately available, the staff member locked the refrigerator.
- A yearly ligature point survey was conducted on Nightingale ward by the trust health and safety lead. This was to ensure that the environment was safe for children and young people who were a risk of harming themselves. Following a recent incident, staff told us they had removed headphones from the overhead televisions and would only be given out to those patients not considered as a potential risk of accidental or intentional harm.
- Nightingale Ward had one pair of anti-ligature scissors, which were kept in a designated location, which all staff knew about.
- A checklist had been developed for patients at risk of self-harm or suicide, which included looking out for

potential environmental risks and minimising them. However, staff told us they had not had many patients who met these criteria and were therefore were unable to assess the effectiveness of the checklist.
- All areas had secure and restricted access into the department which meant there was no access to unauthorised personnel.

**Medicines**

- Following an audit on gentamicin (an antibiotic) prescribing within the neonatal unit which highlighted significant concerns, a new prescription chart was devised to minimise the risk of medicines errors. The chart contained guidance on gentamicin prescribing and monitoring. Following the introduction of the new prescribing chart, the number of gentamicin errors had reduced.
- Doctor's induction programmes included a training session on paediatric prescribing. Staff also told us if they required any specific advice surrounding paediatric prescribing, the pharmacists were very visible and available to give advice.
- The antimicrobial audit for April 2016 and May 2016 showed inconsistent practice amongst medical staff in relation to the inputting of information about antibiotic use in the children's' medical notes. Data provided by the trust did not include information about the details in the medication administration record (MAR). Although documentation within the child's notes is considered best practice. Details about indication stop and review dates must also be documented in the MAR as part of best practice for prescribing, trust policy and Public Health England (PHE) antimicrobial stewardship competencies.
- The trust used a paper record for prescribing medications. We reviewed four MARs and saw evidence of good prescribing practices within the records. This included clear patient details, allergies, height, weight and drug omissions.
- The trust policy for safe management of medicines was in line with best practice.
- We saw evidence of staff adhering to the Nursing and Midwifery Council's (NMC) standards for medicine management whilst administering medication.
- Controlled drugs (CD) are medicines that require additional security and regular checks. During our inspection we reviewed records on the ward and neonatal unit which demonstrated daily CD checks. Medicines were in date, and were located in locked cupboards or refrigerators and the nurse in-charge held the keys to the CD cupboard.
- The neonatal unit had implemented a system called 'guardrails' which was a system for safe administration of intravenous (IV) medication. The system provided safe limits for a range of IV medication to be administered safely. If the dose was outside the limits, this would prompt staff to think about the dose and if necessary get this reviewed by the prescribing clinician. Staff told us the system provided them with a very safe IV administration record. This was reflected in the lower number of IV related medication errors reported.

**Records**

- We reviewed four sets of complete records during our inspection. Whilst there was clearly an improvement in the quality of record keeping since the previous inspection, there were still inconsistencies regarding doctors completing their designation details at the end of their notes. The standard is that entries are signed, name printed, General Medical Council (GMC) number recorded and the grade of the doctor recorded. Not all entries by doctors in the four sets of notes reviewed had the GMC number added to their designation details. The clinical lead for the service had discussed the possibility of providing each doctor with a stamp containing his or her details however; this was not supported by the trust. It was confirmed however, that all doctors were informed about the requirements of adding their GMC details to their designation details.
- The last documentation audit completed by Nightingale Ward in December 2015 showed a general improvement in the documentation standards compared to the previous audit completed in August 2015. The areas where improvement was identified was not completing hospital numbers on all documents, not completing height and weights for all children, plotting them on the growth chart, and not completing all domains on the continuation of care document. There was no date given on the results for when a re-audit was expected to be completed, however there was an action plan in place which included further training for staff around documentation expectations.
- The last neonatal unit documentation audit was completed in September 2015. The results had generally shown an improvement in the quality of documentation

for the patients, this included 100% for all documents within the notes being secured, an improvement in the completion of fluid balance charts and 100% compliance with recording the first medical consultation. However, the areas, which had been highlighted as requiring improvement, had seen a drop in compliance. This was in relation to growth charts being filed in notes and recording dry spot information. In response to this audit, it was intended that the neonatal unit would complete regular snap audits and a full re-audit would be expected within six to 12 months.

- Snap audits from April to June 2016 demonstrated a high level of compliance with documentation standards in relation to the completion of care plans, fluid and observation charts.
- An incident raised on Nightingale Ward highlighted an issue with the provision of records for a patient during the weekend. Staff told us this was not an uncommon problem and that there could be a delay in receiving the full medical notes for children on admission out of hours, or on at a weekend. They considered this had never impacted on the care provided for a patient; however they would raise incident reports if this continued to happen. The ward did not keep records on how many times they had experienced problems with the provision of records.
- Staff on Nightingale Ward continued to record the handover process on a digital voice recorder and each member of staff received a printed handover sheet. The recordings of each handover were deleted before the next handover so there was no auditable trail for the handover recordings. However, the printed handover sheets were saved on computer systems, so should there be queries raised about a specific handover, staff could refer back to these documents.

**Safeguarding**

- There was a named nurse for paediatric safeguarding and a named doctor. All staff that we spoke with were aware of who the named nurse was, however there was no mention from staff about the named doctor despite being asked about the leads for paediatric safeguarding.
- There was an electronic alert system in place for children and young people with known safeguarding plans in place. All paediatric and young people who were known to the safeguarding team had a specific safeguarding section within their medical notes, which contained details about their safeguarding plans including documentation around safeguarding interventions or meetings.
- Data provided by the trust showed 83% of paediatric nursing staff and 81% of neonatal unit nursing staff had completed their safeguarding children level three training. The trust had set their own target for compliance of 100% which was in line with intercollegiate guidance. There were plans devised for staff to complete their safeguarding training.
- The clinical leads of the service told us that since the last inspection, all staff in the fracture clinic had completed safeguarding training to level three. Level three training is more in-depth training which all staff involved or who could potentially be involved in assessing, planning, intervening and evaluating the needs of a child or young person should receive. However when asked about staff in other adult outpatient areas which may see children and young people, assurance of the level of safeguarding training could not be provided.
- All junior doctors received safeguarding awareness training during their induction and were updated on their mandatory rolling programme. Those working in the service will complete e-learning and had attended face to face training monthly from the named doctor.
- All staff were aware of child sexual exploitation (CSE) and processes were in place to escalate cases of suspected child exploitation to the local authority. Previous exposure to cases of CSE had taught the staff a lot about the behaviours exhibited by children involved in this and has been instrumental in helping to identify other potential cases.
- Awareness of female genital mutilation (FGM) and its relevant policy was high within the service. Female genital mutilation/cutting is defined as the partial or total removal of the female external genitalia for non-medical reasons. Since October 2015, it is mandatory for regulated health and social care professionals to report known cases of FGM, in persons under the age of 18, to the police.
- The named midwife led on FGM and training was provided for all staff as part of the on-going safeguarding training programme. There had been five cases of FGM reported to the police on a non-emergency number by the trust.

- The service abduction policy was in date, and testing of this policy was completed annually in all areas. When a test of the policy had been conducted, a full report of the incident was produced and any lessons to be learned were shared with all areas that the policy covers. The last test of the policy occurred on Nightingale Ward in January 2016. Areas identified for improvement included improved communication between all relevant parties involved, the use of the emergency buzzer to alert people to an incident occurring and better involvement of medical staff. An action plan was produced following the test and was implemented across all areas where the abduction policy was in place.

**Mandatory training**

- The trust mandatory training compliance target was not identified in the information provided by the trust.
- We spoke with staff of all professions and they confirmed they received regular mandatory training on a range of subjects including information governance and infection control. They also told us they received role based specific training which included paediatric resuscitation and care of the critically ill child.
- Mandatory training data for the core service was requested, the trust was not able to provide data specific to the service, this meant the trust could not provide accurate data on the level and compliance of mandatory training. This was currently being reviewed by the trust to ensure it was accurate as a new recording system had recently been introduced.
- The senior staff on the neonatal ward and Nightingale Ward maintained their own records of staff that had completed training. On the neonatal unit, there was good compliance for most subjects of the mandatory training programme, apart from infection prevention and control training which had 52% compliance and fire training which also had 52% compliance. All other subjects had above 80% compliance. On Nightingale ward, records showed they had 100% compliance for all elements of mandatory training.

**Assessing and responding to patient risk**

- Staff used a paediatric early warning score (PEWS) to monitor children and to ensure early identification of a deteriorating child. The trust had modified of the PEWS charts and staff commented on how this had improved compliance. There were three separate charts which had specified age ranges for their use. All charts we reviewed had an appropriate PEWS calculated, where specific interventions were required, we saw that this had been actioned.
- The monthly snap audit reviewed the use of PEWS and had showed an increase in compliance with the early warning score. The audit however failed to follow through to establish if the patient had triggered, was appropriate action taken.
- The neonatal unit were trialling a neonatal version of an early warning score for their special care patients, which they had adapted from the post-natal ward. This had so far been successful. The tool was about to undergo another modification to make it user friendly.
- Nightingale Ward had a two bedded high dependency unit (HDU) for children and young people who required high dependency care. The matron for the service told us of two members of staff had completed the paediatric critical care course and would usually be selected to work in this area if there were patients admitted into the HDU. If these two members of staff were not on shift, senior members of staff would work in this area.
- The head of nursing and the matron of the children's and young people's services told us all band six nursing staff on Nightingale Ward had completed the European paediatric life support (EPLS) course and the matron for children's services had completed the advanced paediatric life support (APLS) course. This meant there was always a member of staff on shift to provide specialist support and intervention to a rapidly deteriorating patient, and was in accordance with RCN guidance. There were plans in place for allmore qualified staff to attend an EPLS course to enhance the care that could be provided to a rapidly deteriorating child.
- There were five members of staff waiting to complete the care of the critically ill child training. These staff members were currently waiting for a course date for when they could attend.
- On the neonatal unit, two members of staff were coming up to their renewal date for neonatal life support (NLS) which was included in the neonatal training day. All other staff were in date for their NLS training. This meant that all staff would be able to respond appropriately to a neonatal emergency.

- From November 2015 to May 2016 there had been 15 calls made to the paediatric emergency team. There was no information supplied about the locations of these calls or outcomes of these emergency calls.
- The service had completed a significant work on identifying sepsis in their patient group. Sepsis is a life threatening condition that arises when the body's response to infection injures its own tissues and organs. An audit from August 2015 to October 2015 of the children's and young people's services showed a requirement for improvement in administering high flow oxygen and measuring urine output. Only one patient out of eight had received the full six interventions which all septic patients should receive. However, all eight patients included in the audit had received antibiotics; although only two patients received the antibiotics within the first 60 minutes which is the recommendation for increasing the survival rate of sepsis.
- A re-audit of the identification and treatment of sepsis from October 2015 to March 2016 showed a general improvement in all six areas of sepsis management. All patients had blood cultures performed and received antibiotics within 60 minutes. However, only four patients out of 17 received the full six interventions which all septic patients should receive. In response to these recent audit results, the trust reviewed the proforma to try and improve the management and documentation of sepsis diagnosis and treatment.
- For patients who had deteriorated and required a higher level of care or specialism which the trust couldn't provide, they worked with 'EMBRACE' the paediatric and neonatal network that would transfer these patients to other hospitals.

**Nursing staffing**

- A band six (senior) nurse presence was available on Nightingale Ward over 90% of the time. Staff told us they occasionally reached 100% however, this was not consistent. At the time of our inspection, there was a band six nurse present on shift. We reviewed staffing rotas from February to May 2016 which confirmed that there was senior nurse presence on all shifts. This met best practice staffing guidance from the Royal College of Nursing (RCN) which states that experienced nurse support should be provided throughout the 24 hour period.
- The increase in the provision of band six nurses being on each shift had been completed through internally upgrading experienced band five nurses to band six posts and then recruiting newly qualified band five nurses. Staff told us this had worked well and the transition to a higher band had not impacted on them negatively as they felt competent with this higher band. Band six development had been provided for new band six nurses to help with this transition.
- Regular reviews of the nurse staffing took place in all areas and was mapped against the RCN guidance. This information was forwarded to the executive team for review through the six month staffing papers.
- The neonatal unit was compliant with the British Association of Perinatal Medicine (BAPM) guidelines (2011) for example one qualified to one patient in the intensive care area, one qualified to two patients in the high dependency areas and one staff member to four patients in the special care areas. This was regularly recorded using the unit's information system, which was then benchmarked against other local providers. We saw continued evidence that the unit complied with these standards.
- There was an effective system for handover between each shift, this included accountability handover at the patient's bedside. An afternoon 'huddle' (meeting) was held each day as a way of nursing staff receiving updates from doctors ward rounds
- Staffing figures, which included the actual numbers versus the planned numbers on each shift, were displayed in all of the areas we visited. During our inspection all areas met the planned staffing levels.
- In the reporting period March 2016 to May 2016, there were between 11 to 26 occasions of staff shortfalls on Nightingale Ward. There were between four and seven occasions when an overfill of a shift had occurred. Incident reports were only completed for shortfalls when there was a patient impact which was in line with guidance.
- On the neonatal unit, there had been between six and 13 occasions when a shortfall in staffing had occurred, and between four and 14 occasions when overfilling of staff had occurred. This meant that on these occasions, staffing had not met the planned level and could potentially have impacted on patient care. Incident reports were only completed for shortfalls when there was a patient impact which was in line with guidance.
- A red flag system was used to highlight when a reduction in the number of staff had affected the care provided. From April 2016 to July 2016 there were three

red flags raised on the neonatal unit. Information on the number of red flags raised for Nightingale ward was not provided. Unlike other areas, staff told us they would only raise a red flag if they thought that this directly impacted on patient care which was in line with guidance.
- Staff told us agency usage had reduced and that their own staff working on the NHS bank covered most shifts. This was confirmed by the data that was forwarded by the trust.

**Medical staffing**

- Paediatric consultant presence was from 9am until 5.30pm. Although this was their official working hours from Monday to Friday, staff told us that they were usually still around until 7pm on weekdays. This did not provide the required amount of consultant cover as detailed by the Royal College of Paediatric and Child Health (RCPCH) facing the future guidance which expected 12 hours of consultant paediatrician onsite presence for seven days a week, with extended evening work until 10pm. There were plans to increase consultant presence to 8.30pm by November 2016 and by April 2017; consultant presence was expected to be to 10pm during weekdays.
- Consultant led ward rounds were carried out daily, Monday to Friday.
- On Saturday and Sunday, consultant presence was provided from 9am until 2pm. Outside of these hours; consultants were available for telephone consultations immediately and were able to respond in person within 30 minutes.
- Consultants worked a one in eight on call rota with a plan to increase to one in nine by September 2016. By November 2016, the plan was for a one in 10 the paediatric consultants on call rota.
- The trust had implemented the consultant of the week initiative which is in line with RCPCH 'Facing the future: standards for acute general paediatric services'. This ensured a safe method of providing continuity of care as the consultant will have no other clinical duties during their week.
- To cover the shortfall of paediatric consultant presence, there was an experienced doctor of senior registrar status present on site from 5.30pm until 9am. There was also a doctor of the same grade present to cover the weekend hours on site.
- Two senior registrars or middle grade doctors provided an inpatient service from 9am to 5.30pm, Monday to Friday supported by two tier one paediatric doctors 9am until 9.30pm seven days a week. Tier one doctors were either GP trainee registrars or junior doctors of foundation year one or two.
- There were three medical handovers within each 24 hour period with a consultant presence for at least two out of the three handovers. All medical staff has printed handover sheets.
- There was one full time locum in place at the time of the inspection. They completed a full range of hours so therefore provided continuity to the service.
- Following an incident, a paediatrician was now always made aware of a child undergoing care and treatment within the hospital, away from the paediatric department. Although the paediatrician would be involved in the child or young person's care, they would not be in charge of the care, they would still remain under the speciality of the admitting consultant.
- There was a designated lead consultant for the neonatal unit. Consultant cover for the unit was provided for eight hours of the day, which did not meet the British Association of Perinatal Medicine standards of 12 hours.
- There were nine middle grade doctors on a rotation that provided neonatology cover only between 9am and 5pm, Monday to Friday.
- One junior doctor provided neonatology cover only from 9am to 9pm, Monday to Friday with the support of two other junior doctors who also covered the postnatal ward and paediatric ward. One junior doctor provided neonatology specific cover from 9am to 9pm on a Saturday and Sunday.

**Major incident awareness and training**

- All staff we spoke with were aware of the trust major incident plan and could locate this on the trust intranet. Staff told us the ward would be tasked with sending staff to the Emergency Department if there was an increase in paediatric patients being admitted.

# End of life care

| | |
|---|---|
| Safe | Good |
| Effective | Requires improvement |
| Caring | Good |
| Responsive | Requires improvement |
| Well-led | Good |
| Overall | Requires improvement |

## Information about the service

Chesterfield Royal Hospital provides end of life care throughout the trust. Patients with palliative or end of life care needs are nursed on general wards throughout the hospital. Palliative care services are provided and managed by a local hospice. End of life and palliative care services are provided as part of the medicine and emergency care division of the trust and are supported by the mortuary, chaplain, and bereavement services.

A local hospice provides three band seven palliative clinical nurse specialists and two band six nurses in developmental post, all of whom work from Monday to Friday 8.30am to 4.30pm, excluding bank holidays. The trust employ one specialist palliative care consultant and one specialist registrar who work Monday to Friday 9am to 5pm, excluding bank holidays. There is a rota of consultants and specialist registrars on call 24/7; these are shared with neighbouring organisations to provide telephone advice, and in exception, face to face visits.

In the reporting period June 2015 to June 2016 there were a total of 1,296 deaths at Chesterfield Royal Hospital; 427 of these patients were known to the specialist palliative care team (SPCT).

We visited 16 wards where end of life care was provided including critical care, the bereavement centre, the chapel and the mortuary. During our inspection we spoke with one patient, four relatives and 26 staff, including staff nurses, sisters / charge nurses, matrons and senior matrons, the specialist palliative care team, porters, housekeepers, junior doctors, senior doctors, mortuary staff, volunteers, bereavement staff, allied health professionals and a pharmacist. We interviewed the service leads responsible for end of life care, observed interactions between patients, their relatives and staff, considered the environment, and looked at 48 'Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR) orders. We reviewed 11 medical and nursing care records. Before our inspection, we reviewed performance information from, and about, the hospital.

This inspection was a focused inspection following a comprehensive inspection that had taken place in April 2015. End of life care in April 2016 was rated as requires improvement overall. As part of this focused inspection, we looked at all five domains, safe, effective, caring, responsive and well led.

# End of life care

## Summary of findings

We rated end of life care services as requires improvement overall.

We rated safe, caring and well led as good. Effective and responsive were rated as requires improvement because:

- The trust did not have a process for identifying non-cancer patients requiring end of life, and or, palliative care support.
- Nursing staff were unaware of the trust's two stage assessment for assessing patients' mental capacity in line with the Mental Capacity Act 2005 (MCA).
- During our review of 'Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR) forms, we found that it was recorded on the DNACPR forms that 32 patients did not "have capacity to make and communicate decisions about CPR", nine (28%) of these did not have a Mental Capacity Act (MCA) assessment form completed and, where CPR was a potentially successful treatment which might have been offered to the patient had they capacity, a best interest decision recorded in the notes. This meant the trust's DNACPR policy was not being adhered to, and the legal process of the Mental Capacity Act 2005 was not always followed.
- Nursing staff were unfamiliar with the Derbyshire Alliance End of Life Care Toolkit, which contained evidence based guidelines (including NICE guidelines) to underpin the care provided.
- Staff were not familiar with or adhering to the Adult Cardiopulmonary Resuscitation' policy dated December 2014 in relation to review of DNACPR forms from previous admissions.
- The service did not monitor how rapidly patients were discharged from hospital if they wished to be cared for at home.
- The service did not monitor if end of life patients died in their preferred place of death.
- At the time of our inspection, the trust did not separately monitor delayed transfers of care for end of life patients; these were collected with other specialities, for example, medicine

However, we also found;

- Patients were protected from avoidable harm and abuse. Performance showed a good track record of safety; staff understood and fulfilled their responsibilities to report incidents and near misses, and there were systems and processes in place to learn from incidents. Staff recognised and responded to the changing needs of patients with anticipatory medications readily available and care needs assessed and reviewed appropriately.
- End of life care was mostly managed in accordance with the National Institute for Health and Care Excellence (NICE) guidelines. Patients approaching end of life were identified appropriately, symptoms of pain were suitably managed and staff were proactive in assessing the patient's nutrition and hydration needs. There was a comprehensive audit plan in place for end of life care. There was effective multidisciplinary working.
- Patients were supported, treated with dignity and respect, and were involved as partners in their care. Feedback from patients and their families was positive and comments included "nothing is too much trouble" and "staff do what they can to help". We saw staff carrying out care with a kind, caring and compassionate attitude. Staff spoke to patients politely and respected their privacy and dignity by knocking on doors and asking for consent to proceed with tasks.
- The leadership, governance and culture promoted the delivery of high quality person-centred care. There was a credible end of life strategy in place with well-defined objectives linked into an end of life care improvement plan. We saw the end of life strategy had been widely communicated across the trust.

# End of life care

## Are end of life care services safe?

Good

We rated safety of the end of life service as good because;

- Performance showed a good track record of safety.
- Staff understood and fulfilled their responsibilities to report incidents and near misses, and there were systems and processes in place to learn from incidents.
- Arrangements to minimise risks to patients were in place with measures to prevent falls, malnutrition and pressure ulcers. We observed staff following good infection and prevention control practices.
- Specialist equipment needed to provide care and treatments to patients who were in their last days or hours of life was appropriate and fit for purpose so patients were safe. Syringe drivers were maintained and used in accordance with professional recommendations.
- Staff recognised and responded to the changing needs of patients with anticipatory medications readily available and care needs assessed and reviewed appropriately.
- Systems and processes were in place to prioritise the referrals of patients referred to the specialist palliative care team (SPCT).
- Plans were in place to respond to emergencies and major situations.

### Incidents

- There were no never events in relation to end of life care services between June 2015 and June 2016. Never events are serious, largely preventable patient safety incidents, which should not occur if the available, preventable measures have been implemented.
- The mortuary staff had raised 14 patient safety incidents between April 2015 and April 2016. One incident involved tissue damage to a deceased patient and had been reported to the Human Tissue Authority (HTA). The HTA is a regulator set up in 2005 to regulate organisations that remove, store and use human tissue. Following this incident the relative of the deceased had been contacted; an explanation was given in addition to an apology on behalf of the trust. Other incident themes included communication and documentation errors.
- Between April 2015 and April 2016, there had been five incidents reported across all wards related to end of life care. Four of the incidents related to staffing shortages on the wards resulting in a delay in care to patients who were end of life. One related to a transport failure resulting in a delayed discharge of a dying person.
- Staff were aware of, and appeared knowledgeable and confident about reporting incidents. All staff had access to the online reporting system; staff gave us examples of when they might report incidents such as a pressure ulcer or fall.
- Incidents giving cause for concern or following a specific trend in the mortuary were discussed in the department meetings and through the daily "mortuary huddle". We saw evidence of this in minutes we reviewed.
- Incidents across the wards relating to end of life patients were discussed as part of each divisional area. Staff attending the end of life care strategy group were encouraged to take any end of life incidents to the meeting to share and discuss. Discussions would then be cascaded down to each of the divisions.
- Mortuary staff were aware of their responsibilities and principles with regard to duty of candour regulation. The duty of candour is a regulatory duty that requires providers of health and social care services to disclose details to patients (or other relevant persons) of 'notifiable safety incidents' as defined in the regulation. This includes giving them details of the enquiries made, as well as offering an apology. Staff were able to provide examples of when an incident had occurred and how they had informed the patient and their relatives of the incident, made an apology and explained how the trust had responded to the incident. We saw evidence of an incident where duty of candour had been appropriately followed.

### Safety thermometer

- There were no dedicated wards for the provision of end-of-life care at the hospital. The trust used the NHS Safety Thermometer information, which was ward specific and did not directly relate to the end of life team.

### Cleanliness, infection control and hygiene

- All of the areas we visited where end of life care was being delivered, appeared visibly clean and well maintained.

# End of life care

- The specialist palliative care team (SPCT) and mortuary staff wore visibly clean uniforms and were 'bare below the elbow'. We saw staff wearing the correct personal protection equipment (PPE) such as gloves and aprons as per trust protocol and we observed PPE to be accessible throughout the areas we visited.
- Cleansing hand gels were available on all wards we visited, with clear instructions displayed on when and how to use this. We observed staff encouraging visitors to use the cleansing gel on entering and exiting the wards.
- We saw there were appropriate safety precautions and reliable systems in place to prevent and protect patients and staff from a healthcare-associated infection, there were specific guidance for mortuary staff to ensure undertakers were aware of, and followed, all local safety regulations. A copy of the 'Universal Precautions' hand out information sheet and leaflet was given to the funeral director. We saw a formal notice of infection was completed and handed over to the funeral director who countersigned this and took a copy away for their records.
- The trust provided us with the "Dealing with the deceased policy**"** which outlined the procedure to follow when dealing with deceased patients who had contagious diseases and required a post mortem.
- Porters said they were aware of the PPE protocol for the mortuary and said they were able to access and dispose of the necessary equipment as required.
- To minimise the risk of infection to bereavement staff, deceased patients' property that posed an infection risk was placed in a dissolvable bag and then packed in a separate plastic bag, this enabled the bereavement service to offer to dispose of these items for relatives. Bereavement staff were also alerted to any potential infection risk on the bereavement form they received from the ward. The dissolvable bag enabled safe transport of any soiled or infected linen for washing in the home environment. It ensured laundry did not have to be handled prior to washing, as the entire sack can be placed in the washing machine, therefore eliminating any risk of cross infection and reducing any unpleasant odours.
- As part of the last offices procedure, (the process involved when preparing the body for transfer to the mortuary), nursing staff would complete a 'last offices checklist'. Information contained within the checklist would alert any member of staff, dealing with a deceased patient of a possible infection. Copies of the 'last offices checklist' we reviewed in the mortuary confirmed this.
- The mortuary had sufficient facilities for hand washing, bins for general and clinical waste, and appropriate signage.

**Environment and equipment**

- The mortuary had swipe card access and closed circuit television (CCTV) surveillance in order to protect the security of the area. Porters had to attend formal training before they were given access to the mortuary.
- The storage capability of the mortuary was 121 bodies. One hundred and seventeen refrigerators for general body storage and four deep-freeze for long-term storage. Of this total, eight were for use with bariatric (heavier) deceased patients (four general and four deep-freeze).
- The trust used a specialist syringe pumps for end of life patients who required a continuous infusion to control their pain. Syringe driver equipment met the requirements of the Medicines & Healthcare Regulatory Agency (MHRA). We saw the policy relating to the use of the specialist syringe pumps. Staff across all of the wards we visited confirmed the specialist syringe pumps were readily available. Wards using the pumps routinely, kept one on the ward for further ease of access. We saw two syringe drivers in use during our inspection and we found them to be in date with routine servicing.
- The trust provided evidence of a robust maintenance schedule and asset list of syringe drivers including next service dates.
- Equipment was available to meet patient needs such as pressure relieving equipment.
- The trust did not have a bariatric concealment trolley (specialist trolley for removing deceased patients from the ward to the mortuary). Porters and mortuary staff said deceased bariatric patients were transferred to the mortuary on the hospital bed. Pillows would be packed around the deceased patient and the patient fully covered during the transfer. Staff we spoketofelt this was a dignified practice, and said there were only a few occasions over the last 12 months when this had happened.

**Medicines**

# End of life care

- The hospital used an electronic prescribing and medication administration record system, which reduced the number of errors and omissions.
- There was guidance for prescribing palliative medication and guidance for use of anticipatory medication at end of life.
- The trust participated in the National Care of Dying Audit (2015). For prescribing of anticipatory medication the trust scored 71%, this was better than the England average of 65%.
- We accessed the electronic prescribing and medication administration record system and reviewed nine electronic charts of those patients identified as being in the last hours or days of life. We saw where palliative care and anticipatory medications, medications prescribed for the key symptoms in the dying phase (i.e. pain, agitation, excessive respiratory secretions, nausea and vomiting, and breathlessness), were prescribed and administered appropriately.
- Specialist palliative care medication and anticipatory medications were stocked on all of the wards we visited where end of life care was being provided and staff confirmed there were no problems in obtaining these.

**Records**

- During our inspection we saw medical and nursing notes for end of life patients were stored securely in lockable cabinets or were supervised by medical, and / or, nursing staff.
- Staff used paper patient records. We reviewed the medical and nursing notes for nine patients who were receiving end of life care. Patient records were structured, accurate, complete, legible and mostly up to date.
- The last days of life (LaDOL) care plans we looked at were complete, legible, and up to date and stored in a folder by the patient's bedside.

**Safeguarding**

- Staff demonstrated an awareness of potential safeguarding issues and procedures to follow for suspected or alleged abuse. Staff could tell us whom the safeguarding lead was or who they would go to for further advice if required.
- There had been no reported safeguarding concerns relating to end of life care between June 2015 and June 2016.
- All hospital staff had to undertake safeguarding children and adult training. The level of training required was determined by the role

**Mandatory training**

- Training related to end of life care was mandatory and covered in essential training for all trust staff from April 2016.
- On the "Royal Way" induction for new registered nurses, there was an hour session on end of life care including communication, dignity, documentation and hydration.
- The majority of the specialist palliative care team staff were employed by the local hospice however they undertook mandatory training at the trust. Data provided to us by the trust confirmed 100% compliance with mandatory training for this staff group.
- There were two members of staff employed by the trust for this core service; training figures confirmed that the compliance rate for mandatory training was 75%.

**Assessing and responding to patient risk**

- We saw the trust used a nationally recognised early warning score assessment tool for recording the observations of patients admitted to the hospital, this was incorporated into the observation chart. Early warning scores have been developed to enable early recognition of a patient's worsening condition by grading the severity of their condition and prompting nursing staff to get a medical review at specific trigger points. This meant there was a system in place to monitor patient risk, including those patients receiving end of life care.
- We reviewed the nursing records of nine patients receiving end of life care. Risks to patients, for example; falls, malnutrition and pressure damage, were assessed, monitored and managed on a day-to-day basis using nationally recognised risk assessment tools.
- We saw evidence nurses reviewed and repeated these risk assessments. Staff took action on the results of these risk assessments, for example; patients who were at risk of pressure damage were nursed on pressure relieving mattresses.
- Staff said patients requiring end of life care were identified at ward rounds and during discussions at the "daily huddle".

# End of life care

- SPCT had a triage and prioritising system for their referrals. Staff made referrals through an electronic system. Urgent referrals could be made directly to the SPCT using a specialist pager and followed up electronically.
- The SPCT met each morning to discuss their caseload and any new referrals. They used this meeting to discuss diagnostic challenges and management options, any other pertinent issues relating to their current patients could be discussed collectively in this meeting, after which the caseload was allocated appropriately between all available team members.

**Nursing staffing**

- Patients requiring end of life care were nursed on general wards, throughout the hospital. Nursing staff we spoke to on these wards said they were able to provide end of life care and would always prioritise those patients in the last hours or days of life.
- There was one whole time equivalent (WTE) senior matron employed by the trust who supported end of life care.
- A local hospice provided a Specialist Palliative Care Team (SPCT) to the trust, this consisted of three band seven palliative clinical nurse specialists, and two band six nurses in developmental posts, all of whom worked from Monday to Friday 8.30am to 4.30pm.
- A link nurse programme had been implemented on all adult inpatient wards. Link nurses shared relevant end of life information and enabled two-way communication between the specialist teams and nurses in the clinical area. Information received from the trust confirmed there were 17 link nurses across the trust at the time of our inspection – these were based across a number of wards where the majority of end of life care was delivered. We spoke with five link nurses during our inspection.
- Ward staff said the SPCT and end of life matron were very visible on the wards and always available to provide advice and support when required.

**Medical staffing**

- There was one whole time equivalent (WTE) palliative care consultant and one WTE specialist registrar available Monday to Friday, 9am to 5pm. There was also a rota of consultants and specialist registrars on call 24 hours a day, seven days a week. This rota was shared with neighbouring organisations to provide telephone advice and face to face visits where required. This met the commissioning guidance for specialist palliative care.
- We were told by nursing and medical staff there was good access to medical support Monday to Friday. Staff said the palliative care consultant was visible and accessible.
- The palliative care consultant reviewed patients as clinically indicated.
- Nursing staff said out of hours and at weekends there was reduced cover of the hospital, at times there may be a delay to patients being reviewed, but said end of life care patients would be prioritised where possible.

**Major incident awareness and training**

- The trust had a major incident plan and mortuary staff were aware of contingency plans and their role within these. The major incident plan was supported by individual action cards and specific, linked contingency plans. We saw specific action cards for the mortuary on call technician and healthcare chaplain.
- The trust was not a response / resilience mortuary for mass fatality incidents; however plans for this had been drawn up with the local county council.
- Chaplaincy / counselling services were also identified in the trust's major incident plan.
- The service manager for the mortuary was a member of the local resilience forum.

## Are end of life care services effective?

Requires improvement

We rated effective of the end of life service as requires improvement because;

- Nursing staff were unaware of the trust's two stage assessment for assessing patients' mental capacity in line with the Mental Capacity Act 2005 (MCA).
- During our review of 'Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR) forms, we found that it was recorded on the DNACPR forms that 32 patients did not "have capacity to make and communicate decisions about CPR", nine (28%) of these did not have a Mental Capacity Act (MCA) assessment form completed and, where CPR was a potentially successful treatment which

might have been offered to the patient had they capacity, a best interest decision recorded in the notes. This meant the trust's DNACPR policy was not being adhered to, and the legal process of the Mental Capacity Act 2005 was not always followed

- Nursing staff were unfamiliar with the Derbyshire Alliance End of Life Care Toolkit, which contained evidence based guidelines (including NICE guidelines) to underpin the care provided.
- Staff were not familiar with or adhering to the Adult Cardiopulmonary Resuscitation' policy dated December 2014 in relation to review of DNACPR forms from previous admissions.

However, we also found;

- Doctors demonstrated a good understanding of the principles of the MCA and described the two stage test to us during the inspection .We observed a doctor carrying out an MCA two stage test during our inspection.
- End of life care was mostlymanaged in accordance with the National Institute for Health and Care Excellence (NICE) guidelines.
- A 'recognising dying' form was completed by a senior doctor who assessed that the patient may be in the last days of life.
- Patients' symptoms of pain were suitably managed and staff were proactive in assessing the patient's nutrition and hydration needs.
- The trust had a comprehensive audit plan in relation to end of life care. Audits included the rapid improvement audit, fast track audit and recognising dying audit. The trust participated in the national care of the dying audit.
- The learning needs of staff had been identified and training had been put in place to meet these needs, for example, the end of life competency framework.
- We saw evidence of effective multidisciplinary working, with staff, teams and services at the trust,

**Evidence-based care and treatment**

- Health care professionals involved in delivering end of life care at the trust had access to the Derbyshire Alliance for End of Life Care Toolkit, which contained evidence based guidelines (including NICE guidelines) to underpin the care provided, however most nursing staff were unfamiliar with this link.
- The toolkit included guidance in; symptom management; recognising dying and last days of life; advance care planning, and care after death. There was a link embedded in the trust's end of life intranet page to access this guidance. The toolkit was designed collaboratively by professionals had received national recognition.
- Staff were not familiar with the toolkit, the trust expected to familiarise themselves with this as part of the competency framework rolled out in April 2016. No completion time had been set. We spoke to several link nurses who said they were starting to raise awareness of this resource through the competencies and the end of life resource folders. We saw the resource folders in all of the ward areas we visited. Staff said they found these useful. End of life link nurses were responsible for keeping these up to date.
- End of life care was mostlymanaged in accordance with the National Institute for Health and Care Excellence (NICE) guidelines. For example; a review of nine prescription charts showed symptom control for end of life patients had been managed in accordance with the relevant NICE Quality Standard. This defines clinical best practice for the safe and effective prescribing of strong opioids for pain in palliative care of adults.
- We saw the trust were adhering to NICE guideline NG31; 'Clinical care of adults in the last days of life' for example, we saw medicines were reviewed, and after discussion and agreement with the patient and their family medicines not providing symptomatic benefit, or that may cause harm to the patient were stopped. Routine non-essential observations and tests were discontinued for end of life patients when appropriate.
- The review of care pathways and our observations of care confirmed the trust was delivering care and treatment to patients in the last days of their life and in line with Improving people's experience of care in the last few days and hours of life "One chance to get it right" publication by the Leadership Alliance (2014). Records we reviewed considered the five priorities for care. The five priorities of care put patients and their families at the centre of decisions about their treatment and care.
- Patients approaching the end of life were identified appropriately. A 'recognising dying' form, was completed by a senior doctor who assessed that the patient to be in the last days of life. This was a collaborative decision made in discussion with the

patient and or family and relevant healthcare professionals. We saw these present in the records of all 11 of the patients identified as being in the last days or hours of life, we saw they were reviewed by the doctors on each ward round.

- The trust's end of life strategy and action plan included actions to address and implement 'Ambitions for Palliative and End of Life Care: A national framework for local action 2015/2020', for example, ambition three, maximising comfort and wellbeing of the patient aligns with the trust action plan priority one; recognising dying, which aimed to promote a culture of responsiveness to patient's needs and wishes. The trust were are also working with partners in the community, primary care, social care and the voluntary sector to deliver on the ambitions that required partnership working through the 21st Century Joined up Care end of life work stream group. The 21st Century Joined up Care initiative is a working partnership between various care organisations in North Derbyshire.
- The trust had a 'care of the patient in the last days of life' policy. This policy described how the trust would deliver care and treatment to patients in the last days of their life and was in line with the recommendations published by the Leadership Alliance for the Care of Dying People (2014).
- Dedicated 'last days of life', (LaDOL) care plans for patients believed to be dying were used to communicate care and treatment. We looked at nine LaDOL care plans during our inspection. Care plans were patient centred and included essential care such as; hygiene, symptom management, nutrition and hydration, and communication.
- Results from the national care of the dying audit 2015 showed that 97% of patients in the last 24 hours of life had a documented holistic assessment of their needs and an individual care plan. Care plans we reviewed were patient specific and took into account the individual needs of the patient, for example, we saw, patients nursed in side rooms for privacy, the provision of regular support and reassurance to families.
- We saw staff using specific checklists prompts. For example; doctors during the ward rounds, nursing and allied health professionals whilst caring for patients. The checklist prompts were in line with the Leadership Alliance (2014) and ensured care was delivered in line with the five priorities for care.
- In the reporting period June 2015 to June 2016, 94% of patient's referred to the SPCT were seen within 24 hours, and 100% of patients within 48 hours of referral.
- The specialist palliative care team (SPCT) received 1,235 referrals between March 2015 and April 2016, 859 (70%) had a diagnosis of cancer and 376 (30%) had non-cancer diagnosis.
- In the period June 2015 to June 2016 there were 609 referrals within the trust for end of life care
- The mortuary had been licenced by the Human Tissue Authority (HTA) to allow post mortem examinations and storage of bodies.
- In response to the national care of the dying audit (2015), the trust had created an action plan; as a result of the action plan the trust had completed their own recognising dying audit to look at their progress. For example, in the local audit there was evidence that the probability of dying had been discussed with families in 95% of the patients audited, compared to 72% in the national audit.

**Pain relief**

- Guidelines for the assessment of pain were available through the Derbyshire Alliance End of Life Care (EOLC) Toolkit. These included guidelines for the use of a pain scale for the measurement of pain in patients who could not verbalise and/or may have a cognitive (memory) disorder.
- The LaDOL care plan prompted staff to assess the patient's pain and we saw this was carried out when we reviewed these. We saw where a patient who had symptoms of pain was given pain relief and staff were seen to assess the effectiveness of this following administration.
- Staff gave us an example of when they might consider getting SPCT advice, for example, if the patient was requiring several episodes of pain relief over a 24 hour period, they were aware they could consider a syringe driver.
- Nursing staff said specialist palliative care advice in relation to symptom control was available 24 hours a day, seven days a week.
- In the trust "Recognising Dying Audit" June 2016 18 out of 19 (95%) of patients had a documented assessment of pain.

# End of life care

- In the “recently bereaved” trust patient experience survey April to June 2016, 90% of respondents described staff providing good or excellent support in relation to the relief of pain.
- Relatives said they felt their loved ones were not in pain and said if they were staff would respond appropriately.
- One patient who was admitted for symptoms of their condition, confirmed staff were quick to administer pain relief if they asked for it.
- We saw on one ward, there had been a delay in the administration of a pain relief patch due to confusion as to when a new patch could be placed following the removal of the previous patch. We escalated this to the nursing staff and this was immediately rectified. We spoke with the patient, although they had received more medication than usual for “breakthrough” pain, they had not encountered any undue suffering. “Breakthrough” is a sudden flare of pain that "breaks through" the long-acting medication prescribed to treat moderate to severe persistent pain.

**Nutrition and hydration**

- The trust had participated in the national care of the dying audit (2015). The results showed the trust performed better than the England average for assessing the patient’s ability to take oral nutrition in the last 24 hours of life (81% compared to the England average of 67%). Worse than the England average for assessing the patient’s need for clinically assisted (artificial) nutrition (CAN) between the time of the final admission and the patient’s death (15% compared to the England average of 34%).
- The trust performed in line with the England average of 43% for patients who had clinically assisted (artificial) hydration (CAH) in place in the last 24 hours before they died.
- We saw in one set of notes where a lengthy discussion had taken place with relatives about the use of CAH. The patient was receiving CAH during our visit.
- The trust scored 43% which was better than the England average of 36% for evidence that patients were supported to eat in the last 24 hours of life and had a larger proportion of patients eating in the last 24 hours of life (40% compared to the England average of 26%).
- The LaDOL care plan provided prompts for staff specifically about nutrition and hydration for dying patients. It prompted staff to assess the patient between one and four hourly that they had received food and fluids to support their individual needs. It stated patients were to be supported to take food and oral thickened fluids for as long as they were able.
- In one set of notes we reviewed there had been a referral to dietetics. We saw dietetics had visited and advised on what the patient could eat and drink. We discussed this with staff who said they would support the patient to make suitable menu choices.
- We saw evidence of completed adult enteral feeding decision algorithm in the notes of two patients who were in their last days or hours of life; this showed nutritional support for these patients had been considered.

**Patient outcomes**

- The trust had a comprehensive audit plan in relation to end of life care. Audits included the rapid improvement audit, fast track audit and recognising dying audit. The rapid improvement audit was a snap shot of care on the day, findings would be reported immediately to the team on the ward, and improvements made immediately.
- The trust had taken part in the National Care of the Dying Audit (2015). They achievedabove the national average 97% versus 665) forone of the five clinical indicators.The trust had created an action plan following the results of this audit; the action plan was part of the trust wide end of life improvement plan. We saw some of the actions had been completed, and the trust were carrying out their own recognising dying audit and rapid improvement audits to monitor improvement.
- The trust achieved seven of the eight organisation indicators in the national care of the dying audit (2016).The trust did not achieve the eighth indicator because there was no lay member on the trust board with a responsibility/role for end of life care.
- The trust contributed data about end of life care to the national minimum data set. The national minimum data set (MDS) for Specialist Palliative Care Services is collected by National Council for Palliative Care on a yearly basis.
- The aim of the MDS was to provide an accurate picture of hospice and specialist palliative care service activity. Information collected includes numbers of patients using the services, mean length of stay, care,

demographic information: sex, age and ethnicity, a breakdown of diagnosis, particularly in the case of conditions other than cancer and contacts between staff and patients / carers.

**Competent staff**

- An end of life care competency based framework had been implemented across all wards within the trust; this was facilitated and supported by 17 end of life link nurses.
- "Toolbox talks"- had been developed and trialled amongst porters with the aim of increasing knowledge of end of life care. "Toolbox talks" were short talks developed and delivered to the porter service manager who then delivered this to their teams. There was a plan in place to roll this out to other non-clinical staff within the trust. Porters said they found these useful.
- The SPCT nursing and medical team provided sessions on end of life care for junior doctors at induction and as part of their on-going training programme. One doctor told us they had attended a talk on DNACPR and end of life care delivered by the palliative care consultant and found this to be useful.
- Staff had access to end of life care training provided through e-learning and had full access to an external programme of over 150 end of life modules . Figures provided by the trust showed that 71% of staff had completed some of the optional e-learning modules which included introductions to end of life care.
- Staff were required to undertake an annual update and the update varied each year. This year (April 2016 to April 2017) the focus was on communication, for example, registered clinical staff were completing, 'What will it be like talking about the dying process? Non-clinical staff that had patient contact, face to face or over the telephone were completing, 'Communication skills for administrative staff, volunteers and other non-clinical workers'.
- Figures provided by the trust showed that as of in the period April 2016 to 1st July 2016 40% of staff had completed e-learning modules in communication.

**Multidisciplinary working**

- Nursing staff on the wards had good working relationships with the palliative care team. They were able to refer patients to the team for review promptly, and call the SPCT for advice on patient care.
- There was a multi-disciplinary team (MDT) approach which enabled care to be delivered in a coordinated way. Allied health professionals such as occupational therapist, dietetics and physiotherapists worked well with the nursing and medical teams.
- We saw a multi-disciplinary team approach to the 'Fast Track' patient discharge process (a fast track process is where a patient has a rapidly deteriorating condition, and who may be entering the final stages of their life). This approach included input from specialist palliative care, continuing healthcare, occupational therapy, district nurses, the voluntary sector, and local commissioners of the service.
- We saw good working between the heart failure nurse team and the SPCT when discussing the ongoing management of an end of life heart failure patient.
- The SPCT attended a number of other specialties' multidisciplinary meetings such as the lung specialty and unknown primary cancer, to provide support and guidance.
- A weekly MDT meeting took place with the SPCT which included the SPCT nurses, consultant and registrar.
- The trust worked closely with the local hospice to deliver the SPCT service.

**Seven-day services**

- The mortuary was staffed from 8am to 4pm Monday to Friday, excluding bank holidays. An out of hour's service was available 24 hours each day.
- Porters provided out of hours cover for viewing arrangements, which was normally from 4pm to 8am Monday to Friday, and for the full 24 hour period Saturday, Sunday and during bank holidays.
- The SPCT team provided advice and face to face visits Monday to Friday, 8.30am to 4.30pm. The trust recognised they were not providing a SPCT seven days a week. In order to address this, the SPCT service specification had been written and was awaiting approval of a formal service level agreement (SLA) with the local hospice to provide a seven day service for the SPCT. Funding had been secured. A service level agreement (SLA) is a contract between a service provider (either internal or external) and the hospital that defines the level of service expected from the service provider.
- There was a rota of consultants and a specialist registrar on call 24 hours a day, seven days a week to provide advice and face to face visits where required.

- There was 24/7 access to the hospital chaplain service and the hospital chapel.

**Access to information**

- Information needed to deliver effective care and treatment was available to all staff in a timely and accessible way. For example, inpatient wards had access to an end of life resource folder .There was good access to specialist palliative care support and relevant guidance was available through the Derbyshire Alliance End of Life Care (EOLC) Toolkit.
- Information regarding patients who were known to the palliative care team in the community was held on the gold standard framework register and included a right care plan; this plan identified the wishes of patients, what their wishes were and what actions should happen in a particular set of circumstances. Patients may come into the hospital with their plan with them or the teams in the emergency department and emergency medical unit were able to check if a plan had been placed on file, if so this was printed out and attached to the patients' medical notes. The SPCT were able to access this system, which helped communication between the hospital and community. ED and EMU also had access to the system.
- We saw on a discharge plan a consultant had informed the patient's general practitioner (GP) they had been identified as being in the last 12 months of life; this would ensure the GP could facilitate the patients care needs and care could be co-ordinated as required.

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

- Staff demonstrated an understanding of the issues around consent. Records we reviewed confirmed consent to care and treatment was obtained in line with legislation and guidance.
- We spoke with seven members of ward-based nursing staff of different grades about the Mental Capacity Act 2005 (MCA) all were unaware of the two stage assessment, however said that they would assume a patient had capacity unless it was established they hadn't. Staff described carrying out care as long as it was in the patient's best interest and said if they were unsure in any circumstances and they felt a further assessment was required, they would seek guidance from the doctors.
- Doctors demonstrated a good understanding of the principles of the MCA and described the two stage test to us during the inspection .We observed a doctor carrying out an MCA two stage test during our inspection. A review of documentation following this confirmed it had been carried out in line with guidance. The two stage test is used to decide whether an individual has the capacity to make a particular decision.
- There were no end of life patients being deprived of their liberty during our inspection. Staff demonstrated an understanding of deprivation of liberty safeguards, and gave us examples of when they may need to apply these.
- Patients admitted to adult wards at the trust who were deemed to be at risk of cardiac arrest were assessed within 24 hours of admission. Where a decision was taken that a 'Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR) order was appropriate then a DNACPR form was completed and placed at the front of the patient records. A trust wide audit of DNACPR forms dated April 2016 to June 2016 showed the percentage of forms that were complete was 100%; this was an increase from 98% in the period January to March 2016.
- In the trust's DNACPR audit April to June 2016, 53% of the patients audited in this time frame did not have capacity compared with 57% of patients in January to March 2016. Eighty per cent of the patients who did not have capacity did have a capacity assessment. This compares with 58% in the previous audit between January and March 2016. The audit showed continuous improvement over the same time period.
- The trust recognised patients must be involved in DNACPR decisions, and it is best practice to involve families as well. In the DNACPR audit April to June 2016 97% of forms included documented evidence of communication with the patient this showed an improvement from the 84% in January to March 2016. Ninety one percent of forms had documented evidence of communication with patient's relatives or friends, an improvement from the score of 83% in the period January to March 2016. The audit showed continuous improvement over the same time period.
- We reviewed 48 DNACPR forms across 16 ward areas, and the corresponding medical notes. We saw the

# End of life care

DNACPR forms were stored in paper form in the front of the patients' notes. The forms had a red edging so they were easily identifiable. All the forms we reviewed were signed and dated as per hospital policy.

- Of the 48 DNACPR forms we reviewed, 32 (74%) patients were not considered to have capacity, that is, they lacked the ability to make their own decision because of an illness or disability. Of the 32 patients who did not have capacity, nine (28%) did not have a Mental Capacity Act (MCA) best interest decision recorded in the notes. This meant the trust's DNACPR policy was not being adhered to, and the legal process of the Mental Capacity Act 2005 was not always followed. Where MCA had been carried out this was carried out appropriately and accurately and had considered the patients best interests.
- We saw a DNACPR form in use that was signed over 12 months ago. The DNACPR form was completed during the patient's previous admission and stated the patient did not have capacity. We discussed the DNACPR with staff who said they would not resuscitate this patient as they had a DNACPR in place. They said the patient had a community DNACPR in place and trust policy meant they did not have to renew the trust's DNACPR form on each admission. We saw no evidence of a community DNACPR in the patient's notes. We discussed with the consultant in charge of the patient's care, who appeared unsure as to the process to follow for reviewing DNACPR on each admission. We asked for the form to be reviewed immediately. We returned to the ward the following day and found a new DNACPR form had been fully completed including discussion with the patient and relatives. The new form assessed the patient as having capacity.
- Following our inspection we reviewed the 'Adult Cardiopulmonary Resuscitation' policy dated December 2014. The policy was clear, patients may be admitted with a community DNACPR form and the presence of this form should prompt the patient's DNACPR status to be reassessed, and if this is verified, the trust DNACPR form should be signed and dated to confirm this. We were not assured that staff were aware of, or adhering to this policy in relation to review of DNACPR forms from previous admissions.

## Are end of life care services caring?

Good

We rated caring of the end of life service as good because;

- Feedback from patients and their families was positive and comments included,"nothing is too much trouble", "staff do what they can to help ".
- We observed staff carrying out care with a kind, caring and compassionate attitude. Staff spoke to patients politely and respected their privacy and dignity by knocking on doors and asking for consent to proceed with tasks.
- The specialist palliative care team (SPCT), chaplaincy team and bereavement team, provided support for patients and those close to them at end of life.
- Emotionally, relatives were well supported by the nursing staff and were appropriately signposted to external sources where required.
- Patient records included psychological or spiritual wishes in their care plans.

### Compassionate care

- We spoke with one patient and four relatives. They were all positive regarding the care provided, they said they, or their relative, were cared for in a kind and compassionate manner by staff. Our own observations supported this. Relatives said "nothing is too much trouble", "staff do what they can to help" and described one ward as "brilliant".
- We saw staff carrying out care with a kind, caring and compassionate attitude. Staff spoke to patients politely and respected their privacy and dignity by knocking on doors and asking for consent to proceed with care or treatments.
- The trust carried out a patient experience survey. A questionnaire was handed out to recently bereaved friends and relatives to ask them a number of questions about their experience and that of their loved one. The trust's latest results dated April 2016 to June 2016 were mostly positive with 85% of family and friends responding their friend or relative was always treated with respect and dignity by hospital doctors and nurses, this was an improvement on the 75% scored between January and March 2016.

# End of life care

- We observed staff had positive relationships with patients and those close to them. We saw staff spent time talking to patients and those close to them.
- We observed a housekeeper talking to an unconscious patient who was in their last days or hours of life as they cleaned their room.
- The hospital had a chaplaincy service. Staff said they were aware of, and appreciative of the chaplaincy service. Staff were aware how to refer patients to them. Staff said the chaplaincy team were helpful and easy to access.
- We reviewed the storage and handling of deceased patient's property. We saw the trust improvements which included improved storage, special tote bags for property and small bags for valuables. This showed a respectful and sensitive approach to handling deceased patient's property.
- We saw staff on Markham Ward were giving a "comfort tin" to relatives of patients in the last days or hours of life. The tin contents included biscuits and tissues.
- During the week of our inspection the trust were rolling out "comfort packs" for patients in the last days or hours of life. Contents of thesepacks included essential toiletries such as a toothbrush and cleansing wipes. Each ward was provided with two "comfort packs".
- During our inspection we were told of many examples where staff had gone 'the extra mile' for patients their carers and relatives. These included, facilitating a patient's dog to visit the ward, and wheeling an end of life patient outside to the garden in their bed for some fresh air.
- Nursing staff on Markham Ward gave us an example of caring for an end of life patient and their spouse who had a learning disability and required significant support. The nurses made sure the relative's needs were accommodated during and following visits and after their spouses' death, this included making appropriate referrals to other services. The staff said how they had allowed the relative to spend as much time as possible with their spouse in the last days of their life.
- We saw staff carrying out comfort rounds. Comfort rounds enable staff to see patients at specific intervals to address the needs of each individual in an organised way. We saw staff repositioning patients, checking for signs of pain and agitation and also providing support to relatives.
- We were given examples of staff sitting with patients who did not have any relatives and were in the last hours of life, so the patient would not die alone.
- We saw a staff member on Markham Ward had written a poem to provide support to relatives of end of life patients. "The palliative approach" poem was sensitively written and described how the ward would care for relatives and their loved ones on the ward.
- Porters in the hospital informed us when they were requested to collect a deceased patient from the ward; this task was prioritised, in order to maintain the dignity and respect of the deceased patient. We observed this to be the case when we were on one ward when a patient had died.
- We saw how the process for collecting the deceased body from the ward took into account the needs of the deceased patients, those on the ward and any individuals on the corridor.
- We saw how noise was kept to a minimum on the ward following a patient's death in order to respect the family visiting the deceased patient.
- Staff throughout the hospital had joined the 'Hello my name is' campaign, aimed at improving communication with patients and each other. This is recognised as a key part of building trust and supports providing compassionate care. During our inspection we heard staff introducing themselves to end of life patients including those that were unconscious using 'Hello my name is'. Relatives told us they appreciated the 'Hello my name is'.

**Understanding and involvement of patients and those close to them**

- As part of the trust's 'recently bereaved' questionnaire dated April 2016 to June 2016, 94% of family and friends said they felt they and the patient were involved in decisions about their loved one's care as much as they wanted to be, this was an improvement on the 65% between January to March 2016.
- The SPCT, chaplaincy team and bereavement team, provided support for patients and those close to them at end of life.
- We reviewed the care records of a patient at the end of their life and saw comprehensive documentation by a doctor around a long discussion with the patient's family around the end of life care of their loved one.
- We saw on the Last days of Life (LaDOL) care plan there was family and carer communication diary for relatives

to communicate with the nursing and medical team if they wished. We did note relatives did not always choose to write on these, and on others nursing staff had used this section to record nursing care.
- Relatives said staff would explain things to them about their loved ones in a way they could understand, and staff were always available to talk if required.
- We saw a housekeeper provide tea and biscuits to relatives of an end of life patient. The housekeeper had brought in cups and tea pots from home for relatives to use on the ward. The housekeeper described to us when relatives were on the ward they were "my family".
- We were given examples of where staff had supported relatives who wished to carry out last offices for their loved one. Last offices is the process involved when preparing the body for transfer to the mortuary.

**Emotional support**

- Relatives told us they felt emotionally supported by all the staff involved in their loved ones care.
- In the "recently bereaved" trust patient experience survey April to June 2016, 50% of respondents described the emotional support provided by staff as excellent with a further 20% saying this was good, no respondents described emotional support as poor.
- We saw staff sensitively managing a family of a deceased patient, providing support as required.
- In the "recently bereaved" trust patient experience survey April to June 2016, 94% of respondents said that staff dealt with them in a sensitive manner following the death of their loved one.
- A weekly MDT meeting took place to discuss all deaths of those patients known to the SPCT. Any families of concern were discussed for early follow up initially by the Clinical Nurse Specialist who had seen the patient, with an offer of early referral to the Patient and Family Support Team (PFST).
- Patients and relatives could access a range of specialist nurses, for example; cardiac nurses and SPCT nurses. These staff could offer appropriate specialist support to patients and those close to them in relation to their psychological needs.
- Patient's records included psychological or spiritual wishes in their care plans.
- We saw that the mortuary facilitated viewings of deceased patientsbetween the hours of 12:00 and 15:00. This allowed enough time for the morning post mortem examinations to take place, (the viewing room was not sound proof and noises from the fridge room and post mortem room may be heard).
- A member of nursing staff or bereavement service officer escorted the next of kin to the viewing room and remained with them until they left. Mortuary staff said it was possible to make ad-hoc viewing arrangements with relatives, and if relatives arrived unannounced they would be treated sympathetically and every effort would be made to facilitate the viewing of the deceased.
- We saw relatives attending the bereavement office were supported by the bereavement team. We saw the team facilitate a meeting with a doctor for a family who wished to speak to a doctor about their loved ones care when their death had been sudden, this helped relatives emotionally.

## Are end of life care services responsive?

Requires improvement

We rated responsive of the end of life service as requires improvement because;

- The service did not monitor how rapidly patients were discharged from hospital if they wished to be cared for at home.
- The service did not monitor if end of life patients died in their preferred place of death.
- At the time of our inspection, the trust did not separately monitor delayed transfers of care for end of life patients; these were collected with other specialities, for example, medicine

However we also found;

- The needs of different people were taken in to account when planning and delivering services.
- Waiting times for the specialist palliative care team (SPCT) were minimal and managed appropriately.
- Numbers of complaints in relation to end of life care were low; complaints were taken seriously and discussed at the end of life strategy meeting to ensure improvements were made.

**Service planning and delivery to meet the needs of local people**

# End of life care

- End of life care was delivered on all the hospital's wards across the trust.
- The trust had implemented a rapid discharge process to support patients to be discharged at an appropriate time and when all necessary care arrangements were in place. Rapid discharge process is a model of care to support healthcare professionals to coordinate the rapid discharge of a patient from hospital to home.
- There were facilities and arrangements in place for families and other loved ones to stay overnight. Relatives were offered the use of a dedicated room or were able to stay in the room with their relative. Some wards had the use of "camp beds".
- Normal visiting times were flexible for relatives of patients who were end of life.
- Patients at end of life were provided with a side room where possible; staff said this was normal practice. All patients in their last days or hours of life during our inspection were nursed in side rooms. During our evening unannounced visit, we saw following the discharge of a patient with a previous infection, priority was given to cleaning a side room to accommodate a dying patient.
- There had been some funding by the hospital charity to improve quiet space throughout the hospital for relatives of end of life patients. Plans were underway to refurbish 11 of these rooms. Phase one of the constructions of the first two rooms was due to commence in August 2016 and the plan was to roll out the other rooms in pairs with an expected completion date of April 2017.
- Patients known to the specialist palliative care team (SPCT) presenting to the emergency department (ED) would be seen by the SPCT to see if their admission could be avoided. SPCT could refer to the community SPCT to offer additional support if required. Emergency department (ED) staff said the SPCT were responsive when they were called, they also attended the "ED huddle". We saw contact numbers and bleep numbers for the SPCT displayed on the boards in the emergency department.
- Two members of staff had completed specialised licenced training known as "Sage and Thyme". This was an evidence based foundation level communication training course which the trust planned to deliver to staff groups across the trust in collaboration withDerbyshire Alliance for End of Life Care.

**Meeting people's individual needs**

- There were information packs on bereavement on all adult inpatient wards and the emergency department (ED).
- We saw a "supporting families and carers" leaflet which detailed facilities within the hospital, including information on 20% discount on food at the café. Staff said the leaflet would be given to relatives and friends of patients who were receiving end of life care. Copies of the vouchers were present in the resource folder.
- We saw "please pray for" cards available in the chapel for relatives or patients to write on. Completed cards were then clipped to a board in the room, so people could pray for loved ones, this provided patients and relatives with comfort.
- We saw the "Dealing with the deceased" policy outlined what staff should consider when undertaking last offices, for example, the deceased's religious and cultural beliefs, the policy included the impact on a range of issues including washing the body, removal of jewellery and undergarments and pointed staff to discuss requirements with the deceased's relatives.
- The viewing room within the mortuary was non-denominational and did not have any religious articles although relatives could bring their own if they wished.
- Mortuary services demonstrated an understanding and respect of patients' cultural and religious needs. We saw where there were facilities within the mortuary for washing the body for religious and cultural reasons. Mortuary staff also said relatives of the deceased person were given the opportunity to dress the body if they had requested to do so.
- We saw a patient who was end of life and was living with dementia. The patient had a 'This is me' record completed. 'This is me', is for people living with dementia receiving professional care in any setting. It is a practical tool that people living with dementia can use to tell staff about their needs, preferences, likes, dislikes and interests. It encourages health care professionals to see the person as an individual and deliver person-centred care tailored specifically to the person's needs.

# End of life care

- A ward matron said how they had approached a well-known tea company to ask for support with supplies for a comfort tin for relatives. They had received a reply and were expecting the tea to arrive following our inspection.
- Bereavement staff would support relatives to make an appointment at the registry office to register the death of their loved ones. Although the policy was not for staff to make these appointments for loved ones, we were given examples of when they would go the extra mile and make appointments on behalf of relatives, for example, those who were elderly, had a language barrier, or were travelling long distances.
- We saw a patient and their relatives had made a request should there be any further deterioration in the patient's condition the priest should be called. Staff were aware of this.
- Relatives we spoke to said car parking at the hospital was difficult, and it was expensive if they wanted to stay for long periods of time with their loved ones.
- We saw some wards had created end of life resource boards for staff and for relatives. Resources included contact numbers for support.
- Staff had access to a learning disability specialist nurse for support if required.

**Access and flow**

- Patients who were known to the SPCT at the hospital or by the community SPCT team were flagged on admission through the trust's information system, in turn an alert would be sent to the SPCT team so they could support the patient if required. We saw there was a referral criterion for all patients referred to the SPCT.
- At the time of our inspection, the trust did not separately monitor delayed transfers of care for end of life patients; these were collected with other specialities, for example, medicine.
- There was a project underway to improve and streamline rapid discharges at the end of life in March 2016 this included establishing a base line, process mapping and priority setting. A task and finish group has been established to take action forward. The trust had also identified opportunities through the Transforming End of Life programme to access what was happening in other Trusts, staff visited another trust, where they had really good practice with regard to rapid transfer of patients, was planned.
- We were provided with the baseline results from the rapid discharge audit in March 2016 but we were unable to establish the number of patients discharged within 24 hours of being identified as fast track. The trust was working to decide on, and establish, a method of measuring and monitoring fast track performance at the time of our inspection.
- In the recognising dying audit June 2016, the trust identified eight out of 18 patients had their preferred place of death documented. For six of the eight patients who identified a preferred place of death there was documented evidence of attempts made to arrange transfer, however the trust did not have an audit if the patient died in their preferred place of death. The trust were working to decide on, and establish, a method of measuring and monitoring performance at the time of our inspection.

**Learning from complaints and concerns**

- There was a formal policy for managing concerns and complaints. Staff were aware of the policy and how to access it.
- We reviewed two formal complaints regarding end of life services. Prompt acknowledgements of complaints were sent to patients with proposed final response dates. If timescales for the resolution of complaints slipped letters were sent to inform patients of new timescales.
- We saw meetings with relatives had been held, although one was not documented so it was not possible to establish what steps had been taken to resolve the complaint.
- As part of the investigation process we saw a summary of learning/action points were collated to improve the service patients received.
- Information received from the trust showed there were four complaints in the period June 2015 to June 2016 relating to end of life care. Themes from the complaints related to poor communication and poor care, including dignity, respect and privacy. One complaint referred to the lack of pain relief.
- Teams attending the end of life strategy group were encouraged to bring a complaint to the meeting if it related to end of life care, this gave the opportunity to discuss and learn from the complaint. Information would be cascaded through the division.
- We heard how a relative of a deceased patient who had received end of life care at the trust had been invited to

the end of life strategy meeting to share their experiences of end of life care at the trust. This was shared with the divisions in a bid to learn from the relative's experience. The complaint related to communication. The trust had opted to concentrate on communication as part of the e-learning modules in 2016.

## Are end of life care services well-led?

Good

We rated well leadership of the end of life service as good because;

- There was an end of life strategy in place with well-defined objectives linked into an end of life care improvement plan. We saw the end of life strategy had been widely communicated across the trust.
- There was an effective and comprehensive process in place to identify, understand, monitor and address current and future risks to end of life services through the divisions and the end of life strategy group.
- There was evidence the quality of care was being monitored in most areas. Where robust monitoring wasn't in place, there were robust plans in place to achieve this.
- Throughout all areas delivering end of life care, staff consistently told us of their commitment to provide safe and caring end of life care.

### Vision and strategy for this service

- The trust had an end of life strategy for 2015 to 2018. The strategy set out three broad high level aims which were; to provide personalised care at the end of life for patients and the people identified as important to the dying person (their family, loved ones and friends), ensure patients were cared for with compassion, dignity and respect and their needs for comfort were met, and to care for families, loved-ones, others identified as important to the dying person and the bereaved with compassion and sensitivity.
- An end of life strategy group met bi-monthly chaired by the Deputy Director of Nursing and Patient Care. A wide range of disciplines attended this meeting, including: palliative care consultant, medical consultant, nursing leads (surgery and medicine), head of education and professional development, along with representation from community partners from the local hospice. The end of life strategy was monitored through the end of life strategy group.
- We saw an education and training strategy had been developed based upon the framework drafted by the North Derbyshire 21st Century end of life care work-stream to support the delivery of the trust end of life care strategy. The education and training strategy covered three objectives which included; development and implementation of a competency framework, development and delivery of priority training, and development of an infrastructure to enable sustainability of staff in end of life care training and education.
- There was not a non-executive director lead for end of life care at the trust, although we saw this was part of the end of life improvement plan 2016/2017 and was for discussion at the quality assurance committee.
- Staff said end of life care was an important part of their role.

### Governance, risk management and quality measurement

- The quality, risks and performance issues within end of life care were monitored through the medicine and emergency care division governance framework. We reviewed minutes of the governance meetings between February and April 2016 and noted end of life care had been represented and issues pertinent to end of life care discussed.
- We saw there were two risks on the medicine and emergency care division risk register in relation to end of life care. One risk was scored as moderate and related to the service level agreement (SLA) in place between the trust and local hospice which was in draft form and ran only until 31/3/15. The risk was that the trust had no protection from the service being withdrawn, or recourse in the event of services not being delivered in line with expected quality standards. We discussed this with the end of life care leads, who said they had completed a new service specification, secured funding and were awaiting approval from the local hospice. There were regular meetings held with the hospice to discuss the SLA. We asked the end of life leads if there was a date when this would be complete. They said there was no definitive date in place, however, expected the SLA to be in place within the next month or so. There

were plans to continue regular meetings with the local hospice to monitor the SLA once this had been approved. A service level agreement (SLA) is a contract between a service provider (either internal or external) and the hospital that defines the level of service expected from the service provider.

- The second risk was scored as low and related to lack of access to specialist palliative care advice/assessment out of hours following a decision by the local deanery to repatriate the registrar post, meaning there was lack of cover on the registrar on-call rota. The trust had included additional support from the local hospice in the service specification to ensure there would be no lack of access going forward.
- We saw evidence the risks on the register had been reviewed regularly and target dates, actions and progress had been reviewed and updated.
- The end of life team carried out regular rapid improvement audits of end of life care across the wards. This was a snap shot of care on the day, findings would be reported immediately to the team on the ward, and so improvements could be made immediately, other findings were shared at the matrons meetings, so they could then feed this back to the nursing teams. Rapid improvement audit- followed similar lines to national care of the dying audit therefore allowed benchmarking of the service.
- A meeting had been held and it was planned the trust was planning to be involved in the 'Transforming End of Life Care in Acute Hospitals' programme. The transform programme aims to improve the quality of end of life care within acute hospitals across England, enabling more people to be supported to live and die in their preferred place. The programme focuses on the quality of care provided by acute hospitals, as well as the important role acute hospitals have, as one of many organisations may provide care for people who are approaching end of life.
- We saw there was an end of life improvement plan for 2016/2017 in place, this covered improvement from areas identified in the previous CQC visit in 2015, national care of the dying audit, and was linked to the trust end of life strategy 2015-2018. We saw many of the actions had been completed and some were expected to be complete by the end of 2016. End of life leads said they were making good progress with the improvement plan.
- We saw the end of life strategy had been widely communicated across the trust. This was in the resource folders and one of the roles of the link nurses was to bring this to this attention of their colleagues. Some wards had given their teams shortened summaries of the strategy in paper form. This meant staff and stakeholders had sufficient understanding to support the delivery of the trust's end of life care objectives.
- There was a service improvement lead in post supporting improvements in end of life care.
- There was evidence the quality of care was being monitored in most areas. Where robust monitoring wasn't in place, there were robust plans in place to achieve this, for example, preferred place of death and rapid discharge. We were told by the end of life leads these areas were seen as a priority.
- The trust carried out regular 'Lets care together' visits. The 'Lets care together' involved a group of senior staff visiting a variety of wards on a given day with a set focus to look at quality of care of different subjects. Following the reviews, feedback was given to the wards, and further actions created to improve care. We saw that some of the 'Lets care together' focuses for June 2016 related to end of life care and included a review of end of life patients including looking at the care plans and spiritual care
- During our inspection we took the opportunity to attend the end of life strategy group meeting, items on the agenda included; rapid transfer project, end of life improvement audit and end of life education. There were also discussions around any items or concerns needing escalation to the quality delivery group, for action by senior trust members. The items on the agenda and items discussed in the meeting showed a strong focus on service improvement and quality measurement of end of life care at the trust. We were assured from the meeting end of life care improvement was a high priority for the trust.

**Leadership of service**

- Leadership of end of life care services at this hospital was provided by the palliative care consultant, Deputy Director of Nursing and Patient Care, end of life care matron and specialist palliative care team (SPCT).
- The Director of Nursing and Patient Care was the board representative for end of life care.

# End of life care

- Staff described the palliative care consultant, end of life matron and SPCT as highly visible, approachable, and supportive.
- There was strong leadership and vision for the service.

**Culture within the service**

- Throughout all areas delivering end of life care, staff consistently told us of their commitment to provide safe and caring end of life care.
- Ward based staff showed a positive attitude towards caring for end of life patients.
- Several members of staff said end of life care at the trust had improved dramatically over the last two years**.**

**Public engagement**

- Members of the public were part of the end of life strategy group who met bi-monthly.
- The bereavement team provided an information pack to bereaved families, within this pack there was a questionnaire which gave families the opportunity to feedback on the care staff provided.
- Patients and carers had been involved in the work around the design and refurbishing of the "quiet rooms" across the trust.
- Relatives were invited to share their experiences of end of life care at the trust at the end of life strategy meetings.
- The trust carried out a "recently bereaved" questionnaire, to gather feedback on end of life services at the trust.

**Staff engagement**

- We saw a newsletter displayed on the notice boards in staff areas. This had been produced to keep end of life link staff up to date with pertinent issues. We saw the April 2016 issue discussed the findings from the national care of the dying report.
- The link nurse programme was working to raise awareness and deliver training in end of life care. They were also raising the awareness of the trust end of life care strategy.
- We saw that at the trust's 'Nursing & Clinical Nurse Specialist Professional Development Day, the way forward' in May 2016 discussions had been held around being part of an 'Always Event' in relation to end of life care. An Always Event is a process for laying the foundation for partnering with patients and their families to ensure optimal patient experience and improved outcomes. 'Always Events' are aspects of the patient experience that are so important to patients and family members that health care providers must aim to perform them consistently for every individual, every time.

**Innovation, improvement and sustainability**

- There had been clear improvements made since our last inspection. Link staff and the end of life strategy group were committed to end of life care. There were link staff in place across all wards and they met regularly. Staff had the resources to support delivery of end of life care. Training had been provided to staff in end of life care and an end of life care matron had been appointed.
- At the time of our inspection, the palliative care consultant had received confirmation the trust had been successful in its application to take part in a research trial into the amber care bundle**.** The amber care bundle is a simple approach used in hospitals when clinicians are uncertain whether a patient may recover and are concerned they may only have a few months left to live. The research would aim to evaluate the effectiveness of the amber care bundle. If the bundle showed to be effective, the trust would roll this out across all ward areas. A meeting of key stakeholders within the trust and with the research team the project was scheduled for August 2016 to plan the next stage of the project.
- To improve the breaking of bad news to patients and relatives the trust were about to roll out a training video to support doctors undertaking this task.
- There was a plan to recruit doctors to become "end of life champions".
- The SPCT team carried out daily checks of the emergency departments to identify palliative patients and prevent hospital admissions.
- "Toolbox talks"- had been developed and trialled amongst porters with the aim of increasing knowledge of end of life care. "Toolbox talks" were short talks developed and delivered to the porter service manager who then delivered this to their teams. There was a plan in place to roll this out to other non-clinical staff within the trust.
- Two members of staff had completed specialised licenced training known as "Sage and Thyme". This was an evidence based foundation level communication

training course which the trust planned to deliver to staff groups across the trust in collaboration in collaboration with the Derbyshire Alliance for End of Life Care.

- We saw staff on Markham Wardwere giving a “comfort tin” to relatives of patients in the last days or hours of life. The tin contents included biscuits and tissues.
- During the week of our inspection the trust were rolling out “comfort packs” for patients in the last days or hours of life. Contents of these packs included essential toiletries such as a toothbrush and cleansing wipes. Each ward was provided with two "comfort packs".

# Outpatients and diagnostic imaging

| | |
|---|---|
| Safe | Requires improvement |
| Caring | Good |
| Responsive | Good |
| Well-led | Good |
| Overall | Good |

## Information about the service

Outpatients (OP) services at Chesterfield Royal Hospital consist of nine outpatient suites covering a wide range of specialities including audiology, general surgery, urology, ear nose & throat (ENT), maxillofacial surgery and orthodontics, dermatology, medical outpatients, physiotherapy, pain management, pathology, orthopaedics and ophthalmology. The trust's services are split between four divisions - clinical specialist services, medicine and emergency care, surgical specialties and women's and children's services.

Diagnostic imaging services include routine x-rays, magnetic resonance imaging (MRI), nuclear radiology, computerised tomography (CT), ultrasound scans and breast imaging service.

From January 2015 to December 2015 there were 299,289 outpatient attendances of which 32% were first attendances and 68% were follow up attendances.

There is a reception area at the main entrance of the hospital for outpatient suites one to four. Patients for the remaining clinics such as audiology, urology, general surgical outpatients, ENT, maxillofacial, orthodontics, dermatology,therapy services and medical outpatients are checked in at the clinics individual reception area.

During our inspection we visited the following areas:-

Fracture clinic in orthopaedic outpatients

Pain clinic

Surgery

Dermatology

Audiology

Maxillofacial

Medical

Orthopaedics

Pathology

Imaging

MRI

CT

Ultrasound

General x-ray plain film

Therapy Services: Dietetics, Occupational Therapy, Orthotics, Podiatry and Speech and Language Therapy.

As part of our inspection, we observed patients' care and their treatment and spoke with 10 patients, two relatives and 48 staff. These included senior and junior medical staff, nursing staff (registered and non-registered), managers, matrons, physiotherapists, radiographers and support staff. We looked at 16 sets of patient records and reviewed performance information provided by the hospital.

# Outpatients and diagnostic imaging

## Summary of findings

We rated outpatient and diagnostic imaging services as good overall.

We found:

- Staff reported patient safety incidents and there was evidence of learning from incidents and patient complaints.
- Senior staff had oversight of risks in their areas.
- In accordance with intercollegiate standards staff were trained to level three safeguarding for children.
- Managers and section heads were aware of their responsibilities under the duty of candour legislation. Staff we spoke with were also aware of their responsibilities under the legislation.
- The patient waiting areas were attended by staff so patients could be observed.
- Outpatients appeared visibly clean and staff used personal protective equipment (PPE), such as gloves and aprons.
- Patient's care and treatment was delivered in line with current national standards and legislation.
- Staff demonstrated a commitment to patient-centred care tailored to individual needs.
- Patients were treated with dignity and respect and spoke highly of the staff.
- Patient input and feedback was actively sought and several areas had established patient focus and support groups.
- There were some areas that provided a proactive service to patients which included several one-stop clinics which provided efficient co-ordinated care.
- Quality governance knowledge was shared amongst staff at team meetings.
- Staff felt supported by immediate line managers and clinicians. They said they were listened to and able to raise concerns.
- Staff were committed to improving services for patients accessing outpatients

However, we also found:

- Emergency equipment and resuscitation trolleys were not consistently checked.

## Are outpatient and diagnostic imaging services safe?

**Requires improvement**

We rated safety of the outpatients & diagnostic imaging service as requires improvement.

We found:

- Emergency equipment and resuscitation trolleys were not checked and signed daily in all areas.
- The safer steps to safer surgery checklist audit for imaging demonstrated that some were non- compliant with the completion of the forms, there was no consistency with the information not completed.
- Minor invasive procedures in medicine OPD did not use the safer steps to safer surgery checklist. Information was given verbally, but not documented.
- The service was not able to provide training attendance. There was an issue with the recording system that was implemented.

However, we also found:

- Staff knew how to report incidents and could describe the requirements of the duty of candour. There was good evidence of learning from incidents.
- People were cared for in a visibly clean, hygienic environment. There were effective systems in place to reduce the risk and spread of infection. There was sufficient well-maintained equipment to ensure people received safe treatment.
- Appropriate arrangements were in place for obtaining, recording and handling medicines and there were arrangements in managing emergencies.
- Accurate and appropriate patient records were maintained and stored securely.

**Incidents**

- Thedirectorate reported one serious incident from June 2015 to May 2016. We reviewed the root cause analysis report for this incident which identified the cause. Lessons learnt were shared with the department, and duty of candour had been implemented (the patient was informed and apologies made.) The action plan for this incident had been completed and signed off.

- The service had reported 358 incidents from 2015 to 2016. All of these had been categorised as either low or no harm, six were moderate.
- There were no 'never events' reported in the past 12 months. Never events are serious, largely preventable patient safety incidents, which should not occur if the available, preventable measures have been implemented.
- All staff we spoke with were aware of how to report incidents. Incident management and response was reported through the trust's online reporting system. There was evidence of learning from incidents; investigations took place and appropriate changes were implemented. For example, in radiology an increased radiation dosage was administered to a patient. The incident was escalated staff reported it on datix, the outcome and learning was discussed with all staff at their daily meeting, and support and training was given to the member of staff involved.
- Staff told us managers were trained to manage and investigate incidents within their own areas. The managers and section heads told us they encouraged staff to openly report incidents.
- Learning from incidents was communicated through team meetings and emails circulated to all staff. Staff we spoke with confirmed incidents and any lessons learnt were discussed at staff meetings.
- Imaging services monitored the numbers of radiation incidents reported to the Care Quality Commission (CQC) under (Ionising Radiation (medical exposure) Regulations 2000) IR(ME)R . The service had been visited in April 2016 by CQC inspectors to conduct a short notice inspection to check compliance against IR(ME)R. An action plan had been developed following receipt of the inspection recommendations and was in progress, this would be monitored by the CQC's IR(ME)R clinical specialist inspectors.
- In radiology, the clinical, scientific and nursing directors worked together with the matron, division and governanceleads, all of which had attended the department'smonthlyquality governance committee meetings. We saw from the meeting minutes that the committee had routinely reviewed all incidents to identify trends.
- Managers and section heads were aware of their responsibilities under the duty of candour legislation. Staff we spoke with were also aware of their responsibilities under the legislation. Duty of candour was part of the trusts induction programme and was included as part of the electronic incident reporting system for completion by staff.

**Cleanliness, infection control and hygiene**

- The trust had only provided partial training data that was not robust. This was due to a new system where the data was still being migrated. The trust recognised these issues and were working to address them.
- The environment was visibly clean in all of the areas we visited. Hand sanitiser was readily available and we observed staff washing their hands and using hand wash gel appropriately. The majority of staff practised good hand hygiene before and after contact with each patient. In one clinic we observed a clinician who did not hand sanitise between patients.
- Posters were on display reminding staff and visitors about hand hygiene. We also observed infection control notices and information on display. We saw staff wearing personal protective clothing such as disposable gloves and aprons. All staff adhered to the 'bare below the elbow' policy.
- Clinical and domestic waste was disposed of correctly, and sharps boxes were not overfilled. Appropriate containers for disposing of waste including clinical waste were available and in use across the imaging departments. Waste was safely managed and staff disposed of sharps items safely.
- The service cleanliness levels for April 2015 to March 2016 demonstrated that they had met the target of being 95% compliant.
- The radiology waiting and recovery areas appeared clean, tidy and uncluttered. Patient waiting and private changing areas were clean and tidy. Single sex and disabled toilet facilities also appeared clean and tidy.
- Staff in radiology were responsible for maintaining the cleanliness of the radiology equipment in accordance with infection prevention and control (IPC) standards. Imaging and examination room cleaning schedules were available in all areas and were up to date.

**Environment and equipment**

- Staff, within the majority of outpatient areas, carried out daily checks of resuscitation trolleys and emergency

equipment with the exception of one suite where these checks were not consistent. This meant that there was a risk that emergency equipment was not being maintained and safe for immediate use.

- All radiation premises had secure access. In Magnetic Resonance Imaging (MRI) there were safety notices on the doors into the suite which stipulated safety measures such as restrictions with regard to loose metal.
- During the course of our inspection, we observed specialised personal protective equipment (PPE) was available for use within radiation areas. Staff wore personal radiation dosimeters (dose meters), and these were monitored in accordance with legislation. A radiation dosimeter is a device that measures exposure to ionizing radiation.
- Radiation warning signs were displayed along with the use of illuminated do not enter signs within all areas using radiation.
- Radiation local rules were displayed and described the duties undertaken by staff in accordance with the local rules. Local rules were written to enable work with ionising radiation to be carried out in accordance with the 'Ionising Radiations Regulations (IRR99)'. It was the primary responsibility of the radiation protection supervisor (RPS) to supervise work and observe practices to ensure compliance with these regulations.
- Radiation protection advisors (RPAs) were employed within the radiology service. They attended the meetings and undertook annual risk assessment inspections of the radiology services.
- The purpose of the inspections and reports was to evaluate compliance with legislative requirements associated with the radiation safety of patients, members of staff and the public. Staff told us the findings from inspections were communicated to them.
- The service had developed a curtained waiting area, designed to enable three in-patients to wait in a private area. However, during our visit we observed more than three patients waiting in this area on two occasions. We spoke with staff who told us that this was a frequent occurrence. There were plans to increase the waiting bays to accommodate five patients. Plans were agreed and the department was waiting for work to begin.
- Wheel chair access remained restricted in certain areas; a request had been made to estates to change the heavy doors to a lighter version.

**Medicines**

- Medicines were stored securely in locked cupboards. We randomly checked medicines, which were all in date. No prescription pads were kept in the department.
- Controlled drugs (CDs) were all stored correctly. The senior nurses were responsible for checking CDs and medicines. They were also responsible for the safe management and control of medicine keys.
- In radiology, the CD registers and order book were all checked and signed correctly. Staff checked the drug fridge temperatures in the x-ray department; records of these checks were up to date. We saw that medical gases and contrast media were stored safely.
- There was a range of safety and security procedures in place to ensure compliance with national legislation. The radio-pharmacy service was inspected annually by all of the relevant radio-pharmacy professional, safety and regulatory agencies.
- The pharmacy service was situated in suite one and provided a seven day service for the trust. There was a partitioned area of two booths to promote privacy, where pharmacy staff could give one to one medication advice to patients. Pharmacy also operated a bleep system where patients were provided with a bleep to be contacted when prescriptions were ready.
- There was dedicated radio-pharmacy provision for nuclear medicine. The dispensing room was grade C standard. This meant it was suitably designed to the expected level for preparation and dispensing, in accordance with the Ionising Radiations Regulations 1999 (IRR99) and the Medicines Act regarding safety of radiopharmaceuticals. Staff were monitored for levels of exposure via an approved finger dose monitoring.

**Records**

- Medical records were prepared ahead of clinics with the exception of suite five therapy services and delivered to the suites the day before by medical records staff. Suite five therapy services had a specific electronic patient record system.A computer tracking system logged patient records into and out of the medical records department. However, the suites did not have a system to book receipt of the records. This meant there was not a system to track records that went missing.
- If medical records were not available, temporary notes were provided. Medical records staff commented on the tracking system that they had made a temporary set

and would collate at a later point once original notes were found. Staff did not tell us that there was a problem with missing records. There was no audits of missing records for us to review.
- Clinical filing backlog was identified as a high risk under the surgical specialties on the divisional risk register. The trust has placed escalation pathways in place to monitor and improve the filing issues.
- Medical records were kept securely in all areas we visited.
- During clinic times, medical records were with members of the nursing team or held within the clinic room.
- People's care records were written and managed in a way that kept people safe. We observed medical lists for the clinic were stored and used so they could not be seen.
- We reviewed eleven sets of patient notes. All were in good condition; pages were secure and could easily be found as they were sectioned off. The writing was legible, dated, and signed in compliance with national guidance.
- In radiology, we found staff managed and handed over inpatient case notes safely. We reviewed five electronic patient records to check whether radiology staff had completed the safety checks for pregnancy. All patients of reproductive age 12-55 years old were risk assessed for pregnancy.
- The division had not performed any records audits to share with us.

**Safeguarding**

- The service protected patients from the risk of abuse, because the trust had taken reasonable steps to identify the possibility of abuse or harm. Mandatory and statutory training courses included adult and children safeguarding. Intercollegiate standards state that all clinical staff that work with children, young people and/or their parents and carers should be trained to level three safeguarding for children. Safeguarding training for all staff was completed at level three.
- Staff we spoke with were able to describe to us the action they would take if they had any safeguarding concerns for a child or an adult. Staff were aware of the trust safeguarding policies and thetrusts safeguarding lead they could contact for advice and support if they had any concerns.
- Staff in the pain clinic told us the suicide risk among the patient group nationally was increased due to living with a chronic illness, and safeguarding was a high focus within the service. Staff told us they had good links with the trust mental health teams.
- Staff said they were aware of how to identify child related safeguarding cases. We were told an example of a child whose parent was texting during the appointment and there was no interaction between the parent and the child. This was shared with the safeguarding team, it was reported back to clinic staff that the child was assessed and identified as a child in need.
- Safeguarding issues were highlighted on the electronic patient health record, and staff documented this on the patient's care pathway.
- Training data was currently being reviewed by the trust to ensure it was accurate as a new recording system had recently been introduced.

**Mandatory training**

- All staff we spoke with confirmed they were up to date with their mandatory and statutory training. The trust's mandatory training and local supervisions were completed within the departments.
- Mandatory training data for the core service was requested, the trust was not able to provide data specific to the service. This was currently being reviewed by the trust to ensure it was accurate as a new recording system had recently been introduced.
- Staff we spoke with in radiology confirmed they were up to date with their mandatory and statutory training. A number of new staff we spoke with showed us their personal induction records, which included appraisals, trust mandatory training and supervision completed within the departments.

**Assessing and responding to patient risk**

- The outpatients and radiology services completed risk assessments and responded appropriately in order to maintain patient safety. An emergency call would be made and as soon as the patients was stabilised they would be transferred to the appropriate department for further observation.

# Outpatients and diagnostic imaging

- The support workers told us they transferred patients with hospital porters and they had introduced 'Situation, Background, Assessment, Recommendation (SBAR)' forms. This was to improve handovers from the ward staff to the receiving health professional.
- In radiology, we looked at five patient electronic records on the reporting information system (RIS) to ensure pregnancy safety checks were completed prior to exposures being undertaken. We saw pregnancy checks were completed.
- We observed a radiographer recognise an abnormality on a computed tomography (CT) scan; they called the consultant to attend which sped up the report process.
- The World Health Organisation (WHO) developed safety checklists after 'extensive consultation aiming to decrease errors and adverse events, and increase teamwork and communication in surgery'. The last audit in August 2015 showed an improvement from 34% to 78% of the checklist completion; this highlighted further improvement was needed. Actions were decided but no allocation to individual members of staff was documented. We did not receive more up to date data despite requesting it from the trust.
- We reviewed records in the dermatology clinic or department where minor invasive procedures took place. Staff told us that they did not use a safety checklist but were in the process of developing one. Staff explained the process prior to commencing procedures, which meant the questions from the checklist were asked but were not documented. This meant the service was not protecting patients from errors or adverse events fully.
- We observed that staff were available to observe patients in waiting areas, which meant that if a patient's condition deteriorated it would be escalated appropriately.
- All results in suite four were triaged as urgent and non-urgent by staff qualified to review them.

**Staffing**

- The majority of departments we visited told us their staffing was good. For example, staff in urology, rheumatology, and medical speciality clinics told us there were no vacancies in the department.
- The departments across outpatientsemployed staff with expertise in clinical sciences and medical engineering, nuclear medicine, medical physics, nursing, administration, interventional radiology, multi imaging and diagnostics for MRI, CT, fluoroscopy, cardiac, neurology and vascular angiography, breast screening, general X-ray and ultrasound.
- Radiation protection advisors (RPA's) and radiation protection supervisors (RPS's) were employed within the department.
- Radiology had1.5 whole time equivalent (WTE) vacancies and one member of staff on maternity leave. Shifts were covered using bank or agency radiologists. Agency and bank radiographers completed local induction and equipment training which was signed off before they were allowed to work unsupervised.
- There was an escalation process the senior staff followed if the service had staffing difficulties. Staff told us that they were confident in escalating difficulties to the senior team.

**Medical staffing**

- There were consultant radiologists employed by the directorate who covered the range of specialisms and supported the multi-disciplinary teams (MDT). Arrangements for on call and out of hours cover were in place.
- The trust had difficulties recruiting a head and neck radiologist and had failed to recruit on two occasions. At the time of our visit they were trying to recruit again. To maintain patient safety they were considering referring patients to other trusts. To reduce referring out to other trusts the service had a plan to train up a radiologist to take on this role.

**Major incident awareness and training**

- The trust major incident plan in place included actions staff should take. There were paper copies of the incident plan within the individual outpatient suites, including the central radiographers' station in the clinical imaging department, with individual action cards for each department.
- Staff we spoke with were aware of the major incident procedure, and told us where they could find it.
- Major incident (MAJAX) training was part of the mandatory and statutory training programme for front line staff.

## Are outpatient and diagnostic imaging services caring?

# Outpatients and diagnostic imaging

Good

We rated the care in the outpatients & diagnostic imaging service to be good.

We found:

- Patients were treated with compassion, dignity and respect.
- Services were patient centred which meant patients were treated holistically rather than as a condition.
- Staff explained the consultation and information fully in a manner patients could understand.

**Compassionate care**

- Staff treated patients with compassion, kindness, dignity and respect. Staff were professional, respectful and kind towards patients.
- We observed sensitive interactions between staff and patients in both OP and radiology. Staff were supportive, friendly and courteous when caring for patients. Staff introduced themselves to the patients and we heard staff explaining treatments to patients.
- The breast screening service provided areas of privacy for breaking bad news to patients. For procedures that took time, there was a memory garden for patients to access and spend time whilst awaiting biopsy results and further procedures.
- One patient told us that they were very happy with staff and previous appointments; they were always respected by the nurses and doctors.
- We observed that reception staff were welcoming to all patients checking in.
- We observed inpatients in wheel chairs and beds waiting in a corridor in the in-patient x-ray area prior to, and following, their procedures. Staff monitored the area and told us patients usually waited no longer than ten minutes.
- Details of conversations held within clinic rooms could not be overheard externally.
- The phlebotomy department had large treatment rooms which ensured patient privacy In the dermatology clinic, two patients continued to be seen in the treatment room which was separated by curtains. This provided no privacy because conversations with these patients could be overheard.
- The trust had a chaperone policy whereby chaperones were provided when requested or required. Staff told us that providing chaperones was not a problem, they practised an opt out process.

**Understanding and involvement of patients and those close to them**

- People who used the service were given appropriate information and support regarding their care or treatment. Staff told us they provided patients and their families with the information they needed, both verbally and in the written leaflets.
- In the fracture clinic, we heard staff giving excellent explanations and assurances to patients.
- Almost all patients we spoke with told us they were all happy with the service and spoke highly of the care provided. One patient told us that they felt their appointment and treatment was rushed.
- Patients provided feedback by completing the friends and family test (FFT) surveys. Data showed that the percentage of patients that would recommend the services to family or friends was generally over 90%. Department scores were 97% for the imaging department, and for medical outpatients the majority was over 90%.The therapies department was 100% and the majority for surgery was over 90% with one speciality the pain clinic scoring 69%.
- Staff accessed translation services when required. Leaflets could be arranged in different languages for patients whom English was not their first language.

**Emotional support**

- Staff told us that patients were given emotional support privately within the consulting rooms when required. At the time of our visit we did not observe patients requiring support.
- Patients received emotional and psychological support to help them cope with their care, treatment and diagnosis. The pain clinic would assess patients' psychological welfare and would refer to the mental health team for further support if necessary.
- A patient information and support assistant provided a five day service that provided non-clinical support to patients. It included information relating to welfare information and support with disability entitlements such as benefits and "blue badge" provision.

# Outpatients and diagnostic imaging

- The pain clinic planned to commence meditation and relaxation treatments at the end of summer 2016 to support patient's emotional welfare.

## Are outpatient and diagnostic imaging services responsive?

Good

We rated the responsiveness of outpatients & diagnostic imaging service as good.

We found:

- Staff provided visible information for patients on how long they might have to wait.
- There were some areas that provided a proactive service to patients.
- Several one-stop clinics provided holistic care to patients.
- Referral to treatment times were consistently met.
- There were sensitive quiet rooms within the service to deliver bad news to patients.

However, we also found:

- Waiting times for follow up appointments in pain clinic continued to be more than nine months. The staff in this department had commenced an action plan to improve waiting times for patients

### Service planning and delivery to meet the needs of local people

- At a local level, in each outpatient suite, activity figures were unknown. Suite five therapy services staff could view the electronic patient record to assess patient activities.There were regular meetings with performance and planning managers and extra meetings arranged between the operational managers and the matrons when breaches were near. Extra clinics were arranged to prevent patients waiting for longer than recommended. This meant that the matrons and sisters had good oversight of any impact to patients care and treatment.
- The urology service ran one-stop services for patients with prostate cancer, which provided nurse led clinics. Audiology had one-stop clinics for patients with tinnitus. Patients were diagnosed and treated at the same time if they were suitable, improving patient experiences and reducing visits to the clinic.
- Walk in services for x-ray plain film examinations were provided.
- We attended a well-organised exercise class provided by the cardio rehabilitation service. It was very well attended with 13 patients in the first class and 15 in the second class.
- The radiology department was staffed from 8am to 6.30pm Monday to Friday. Radiologists provided on-call cover from home, during daytime hours there was a duty radiology consultant.

### Access and flow

- The trust met both the 31 and 62 day targets for referral to treatment from March 2015 to February 2016 and was above the England average for the majority of the time period.
- From March 2015 to February 2016 the trust consistently met the 95% non-admitted referral to treatment standard that was in place until June 2015.
- Between April 2015 and December 2015, the percentage of people seen within two weeks of an urgent GP referral had increased and was now higher than the national average. This enabled patients to receive timely appointments.
- The trust consistently met the following cancer targets between January 2015 and December 2015. More than 96% of people waited less than 31 days from diagnosis to first definitive treatment, and more than 85% of people waited less than 62 days from urgent General Practitioner (GP) referral to first definitive treatment.
- Between March 2015 and February 2016, the percentage of patients who waited less than 6 weeks for diagnostic tests was generally lower than the England average. Only between July 2015 and September 2015 did the trust have a higher percentage of patients waiting 6 weeks or more than the England average.
- Three per cent of clinics cancelled within six weeks in 2015/2016, which was an improvement on 10% during 2014/2015. This was due to sickness absence, study leave, retirement of clinicians and maternity leave. Other issues were planned industrial action and compassionate leave.
- The imaging turn around reporting time within 24 hours from April 2015 to March 2016 consistently met the trust target of 80% for CT and ultrasound, however MRI

reporting was 45% - 70% within 24 hours. To mitigate this further the service outsourced work, trained MRI reporting Radiologists and continued to recruitment where possible to improve performance.
- Clinic waiting times were displayed on white boards by the clinic staff. Staff updated the boards throughout the day and announced any delays to keep patients informed.
- Waiting time for appointments within the pain clinic was a concern new patients had to wait for approximately six weeks for an appointment. Following our last visit there continued to be a nine-month wait for patients who required a follow up. Appointments were allocated in ten minute sessions and patients told us they often waited for over one hour to be seen.

**Meeting people's individual needs**

- Within the eye centre, there were one-stop clinics for people with cataracts and age related macular degeneration (ARMD). The nurses saw patients whose vision was assessed and the appropriate eye drops administered. They were then seen by the doctors. Patients with ARMD received injections to treat their condition on the same day.
- We were told at our last visit that there was a development plan in the pain management service which included more patient choice and group sessions for patients. At the time staff were not able to tell us when these planned changes would start. We did not see any evidence of change when we visited the service.
- The haematology service was busy however, we did not observe the waiting area to be crowded or delayed. Staff told us that the plans for relocation to a new building to open in October 2016 were on track.
- The mammography service tracked patients to provide appointments within the national two week target. Patients suspected of having cancer received a one week follow up appointment with a surgeon. There was a system in place which gave patients the option to receive results via telephone. This prevented the need for an additional follow-up appointment.
- There was a second CT scanner which was close to the emergency department; this enabled a quick transfer for emergency scans. The facility had separate waiting areas for inpatients and outpatients and a separate reporting area, which maintained patients' privacy and dignity.
- A recent significant demand for prostate MRI had reduced; however, staff told us that it continued to be difficult to meet the demand which had been identified on the risk register. The imaging and urology team had worked together to stratify the referral pathways to ensure consistent service provision.
- Staff used translation services to book interpreters for patients whose first language was not English.
- There was a temporary fix to enable a separate waiting area for outpatients and inpatients attending the ultrasound and CT2 departments. Three curtained bays were created to provide privacy and dignity to patients brought to the department in beds and wheelchairs. We observed that staff maintained patients' dignity by ensuring they were fully covered with gowns and blankets.
- Nurse escorts were not always in attendance but the radiology department had imaging assistants to accompany patients whilst in the department when required.
- Each suite held a number of clinic specialties and had separate waiting areas for each of these. Staff told us that during busy periods each area may need to merge, for example, urology patients sitting in the general surgery or audiology area.
- Physiotherapy services opening hours were extended to provide more availability. Joint appointments were available for patients who required physiotherapy and occupational therapy. This meant patients were seen promptly with a joint package of care in place.
- The physiotherapy clinic provided a walking aid assessment and provision service for patients from the emergency department. This was a Monday to Friday service. During evenings and weekends this was provided by the emergency department staff who had been trained by physiotherapists.
- The December 2015 report on 'Access to health services for people with learning disabilities' highlighted the following; that the service was flexible and enabled the patient to attend appointments at a time of day that suits them.
- The eye department had yellow marking on signs as recommended by the Royal National Institute for the Blind.
- The eye department had a diabetic specialist nurse to provide support and advice to staff and patients regarding their condition.

# Outpatients and diagnostic imaging

- Within a number of suites, there were quiet rooms available for private conversations with distressed patients.

**Learning from complaints and concerns**

- The trust website has a section for patients to leave feedback on their experience. It asked patients if they would recommend the hospital to others.
- The provider took account of complaints and comments to improve the service. Staff we spoke with were able to describe the trust's complaints process.
- Staff told us that common themes were usually about waiting times.
- All staff we spoke with could describe the complaints process and would try to address a verbal complaint locally with the support of their matron.
- Systems and processes were in place to acknowledge, investigate and respond to complaints within a defined period. Complaints were discussed to share findings and identify learning outcomes at departmental and governance meetings.
- In some outpatient departments white boards were used to convey, "You said, we listened," comments and actions undertaken. For example, patients wanted advice on how to shower with a plaster cast on. The department designed a leaflet to provide this information to patients.

## Are outpatient and diagnostic imaging services well-led?

Good

We rated leadership of the outpatients & diagnostic imaging service as good.

We found:

- Clinical leadership at a local level was good.
- Support and leadership was given with clinicians, matrons and senior staff working alongside junior staff.
- Staff in both outpatients and diagnostic imaging felt listened to and well supported by their immediate line managers.
- Staff were aware of the trust's vision and values.

However, we also found:

- We met with the senior teams for the divisions and it was not evident that the four divisions had a joint strategy to take the servicesforward.
- We were not assured that the divisions met to share practices and there was not one identified lead that had overall oversight of the service.

**Vision and strategy for this service**

- Staff we spoke with were aware of, and understood, the vision and values of the trust. Staff identified the "proud to care" initiative to look after patients. Nursing staff were clear about their role and behaviours that would achieve these values.
- We observed the trust's vision was on display in outpatient areas.
- The four divisions did not have a joint strategy or vision to combine thespecialities to take the department forward as a unified service.

**Governance, risk management and quality measurement**

- The accountability for the management and performance of outpatients was delegated to four clinically led divisions. The divisional director and their management teams had responsibility for oversight and management of performance for outpatient services within their clinical remit.
- The governance structure was defined within the clinical specialist services division. Matrons we spoke with could explain local quality governance processes and how they shared governance information at their team meetings.
- We reviewed three sets of minutes for the surgical division governance meetings. Issues were discussed, and actions allocated to staff to complete. For example, in the March 2016 meeting, it was minuted that there were no outstanding ophthalmology lists, which reduced the risk of patient harm.
- Medicine and Emergency Care Divisional Quality Governance meeting minutes demonstrated evidence of a good outcome from an outpatient complaint, following the process the complainant sent a letter of thanks once the complaint had been addressed.
- Pharmacy and therapy services governance meetings identified issues to be escalated and shared lessons learned. We reviewed three sets of minutes actions were identified and staff held to account to update the group on progress. The format of the meetings was structured

by using the CQC's five domains as headings, 'Safe, Effective, Caring, Responsive and Well-led'. Imaging used the same framework and structure as pharmacy and therapy services and both of these meetings fed into the 'Divisional Quality Governance' meeting. We reviewed three sets of minutes of these meetings and did not see representation of the surgical or medical division. The OPD service continued to appear fragmented without a named overall lead at a senior level.

- Matrons had monthly one to ones with the sisters and discussed their completed assurances template, which included headings such as: cancellations, DNA's, additional clinics, incidents, complaints, risks, vacancy, sickness, appraisals, and staff training. This gave the matrons oversight of good practice and improvements that needed to be made. Matrons would then escalate and discuss at their one to ones with the lead nurse.
- Matrons had ownership of risk management within the various individual outpatient suites. Staff working within their areas could tell us of risks within the service. For example, they told us that the design of OPD and staffing were high on the risk register.

**Leadership of service**

- Staff told us in all departments that there had been a change of culture and felt that the senior team listened to their concerns. Feedback was open and honest and was shared with them.
- Locally, managers led their services and had plans in place for improving services for patients. However, we were not assured that the senior team had oversight and an agreed vision for the future of the whole department.
- Governance meeting minutes varied amongst the specialities; imaging, therapies, phlebotomy, surgery and medicine divisions. Therefore, it was very difficult to review the data provided to determine how the divisions managed their governance collectively and escalate issues to the trust board.

**Culture within the service**

- Staff told us they were happy and felt supported in their roles. They also told us team working was good within the multidisciplinary team.
- We observed staff in OP's, therapy and imaging services working well together as a team and valuing each other.
- The internal development of the trust's imaging service was still in progress at the time of inspection. Senior managers envisaged this process was likely to continue for several months.
- The majority of the staff we spoke with had a positive, optimistic and confident view about the future of the OP's, therapy and imaging services.
- Staff informed us that they felt there was an open, supportive and transparent culture within the trust. Staff felt confident that they could raise concerns without fear of reprisal and were aware of the whistle blowing policy.

**Public Engagement**

- During the build of the eye centre, the service held two public events. Consultants delivered presentations and the public were invited to ask questions.
- The trust patient reader panel reviewed leaflets and made comments before they were signed off and published.
- Staff told us that the service had acted upon the friends and family comments and had installed water fountains in the clinic areas.

**Staff engagement**

- Staff told us that 'Listening into Action' groups were established within the department / speciality. Staff told us managers and senior staff asked for their ideas and solutions through local engagement.
- Staff felt more involved in the trusts processes and decisions since our last inspection.
- Staff were committed to develop services in the pain clinic. They identified that if staff were trained as nurse prescribers this would reduce the waiting times for the service. Work had begun with the nurses linking into a successful pain clinic in another trust.

**Innovation, improvement and sustainability**

- Significant investment had been made by the trust to enter into a regional 'Picture Archive and Communication System (PACS) and Radiology Information System (RIS)' as part of the East Midlands Radiology Project. This collaborative project will provide the hardware infrastructure to support the delivery of regional radiology networking.
- The department achieved accreditation for audiology services to provide private work.

# Outpatients and diagnostic imaging

- A nurse led service has been developed for ophthalmology to provide clinics for patients with 'Age-related macular degeneration' (ARMD).

# Child and adolescent mental health services (CAMHS)

| | |
|---|---|
| Safe | Requires improvement |
| Effective | Good |
| Caring | Good |
| Responsive | Requires improvement |
| Well-led | Good |
| Overall | Requires improvement |

## Information about the service

Chesterfield Royal Hospital NHS Foundation Trust provides tier 2 and 3 community child and adolescent mental health services across North Derbyshire to young people under 18 years old.

CAMHS describe the levels of intervention required by each young person and family as tiers:

- Tier 1 describes universal services that are accessible to all; GPs, school nurses, health visitors.
- Tier 2 describes more targeted services around general well-being and mental health. These would usually be accessed via referral from a universal service and include tier 3 services offering training and consultation to tier 2 and 1 services.
- Tier 3 is specialist outpatient mental health intervention, which includes specialised assessment, and treatment of complex and comorbid mental health difficulties in children under 18 years of age.
- Tier 4 is inpatient mental health. The trust did not provide a tier 4 service.

The trust provided the following specialist CAMHS services across North Derbyshire;

- Tier 3 and tier 2 services. They were based at two locations; The Den at Chesterfield Royal Hospital and New Spring House in Buxton but also see children, young people and their families in a variety of settings such as schools, children's centres and GP surgeries.
- Intellectual disability CAMHS service based at The Den that provided a service to children, young people under 18 years of age and their families of children with moderate to severe learning disabilities who have challenging behaviour and/or mental health problems.
- Child development psychology team offered a service to children and young people under 16 years of age who have complex developmental difficulties and/or for children following acquired brain injury. They provide neuro developmental assessment and early intervention around management of behavioural and emotional difficulties.
- Young person's outreach service based at The Den, Chesterfield Hospital.

All of the teams accepted referrals from any professionals, each team screen their referrals daily for risk, and then they go to a referral meeting once a week to discuss the most appropriate pathway for that young person.

# Child and adolescent mental health services (CAMHS)

## Summary of findings

We rated CAMHS overall as requires improvement because;

- There were high caseloads within core CAMHS without a clear process or management tool being used to manage or monitor them.
- It was not clear if risk assessments and care plans were being updated as any updates were recorded within the body of the clinical notes.
- Some staff were not receiving regular clinical supervision and it was not always recorded as per the clinical supervision policy.
- They did not take self-referrals.
- There were long waits for specific interventions and there was not a clear process for how young people's mental health should be monitored while waiting. The service relied on the young person or their family to contact CAMHS.
- The service operated Monday to Friday 0900 to 1700.

However, we also found;

- The environment was clean.
- All staff were trained in safeguarding children level 3.
- Staff completed comprehensive assessments in a timely manner.
- There was good participation of young people and their parents throughout service delivery.
- Clinical staff participated in clinical audit.

## Are child and adolescent mental health services (CAMHS) safe?

**Requires improvement**

We rated safe as requires improvement because;

- There were high caseloads within core CAMHS without any evidence to demonstrate they were being managed effectively.
- There were staff vacancies at New Spring House which was impacting on service delivery as the waiting lists had increased.
- It was not clear from the clinical notes if risk assessments were being updated.
- There was not a clear process for monitoring young people on the waiting lists.

However, we also found;

- The environment was visibly clean and well maintained.
- There were records that demonstrated cleaning was done regularly.
- Staff were all trained in safeguarding level 3 and had a good understanding of what and how to report a concern.
- There was a good lone working policy that staff followed.

### Safe and clean environment

- At The Den, CAMHS was situated upstairs above the rest of the children's directorate services. It was accessed via the main reception downstairs or by a side door that rings up to the CAMHS reception. Both entrances were secure and ensured only young people with a CAMHS appointment could gain access. The CAMHS waiting room was bright and colourful and had noticeboards on the walls with information and services appropriate to young people. New Spring House was a health centre and CAMHS were based in part of it. The waiting room was large and was for all of the health services provided in the centre, including adult clinics. The waiting room was in full view of the reception desk and there were notices up advising not to leave young people unattended. On the CAMHS side of the waiting room, there were toys and a noticeboard with similar information on as The Den.

# Child and adolescent mental health services (CAMHS)

- The environment was visibly clean and the furnishings were in a good condition. We saw cleaning records demonstrated regular cleaning took place. There was an audit completed in June 2016 and it had identified areas that were damaged or required extra cleaning. The actions of this audit had been completed by the time of inspection.
- There were hand-washing posters up and staff had been trained in good hand hygiene techniques. There was an infection control lead within the trust.
- There was not a specific clinic room at either base but there were scales, height measures and BP machines available in one of the therapy rooms. These had stickers on to show they had been safety tested. It would be unusual for a young person to require a physical examination as part of a community CAMHS appointment but if this was required, the paediatrician rooms at the Den could be booked.
- There were no alarms fitted in any of the CAMHS therapy rooms. The staff were aware of where to safely position themselves in the rooms.

**Safe staffing**

- At the time of inspection, the whole time equivalent establishment levels for qualified nurses was 25. There were three vacancies for band 6 nurses and two vacancies for band 7 nurses. There were 14 allied health professionals in post and one vacancy for a band 7 member of staff. The service was using four agency staff at the time of inspection but these were booked on three month contracts to give consistency. The majority of the vacancies were at New Spring House. The vacancies and the increase in referrals had an impact on the number of young people waiting for a CAMHS treatment. There were no waits for the Intellectual Disability team.
- The team at New Spring House were particularly short staffed due to staff leaving and posts being held awaiting clarity about a redesign of the role in the 12 months prior to inspection.
- The turnover of staff had been low but in the 12 months prior to inspection, two members of staff had left. We were told one was because their primary mental health worker post was under threat and the other person had become unhappy in their role. The withdrawal of funding for primary mental health workers was on the risk register as a high risk.
- The staff sickness rate was low at 2%.
- The average caseload was 50 per full time care coordinator. This is above the recognised average of 30 - 40 patients per caseload. In New Spring House, we saw hand written records showing that caseload management was discussed with each individual clinician on a monthly basis. The average caseload was 15-20 per full time care coordinator in Intellectual Disability CAMHS.
- There was rapid access to a psychiatrist both in and out of hours. Out of hours cover was provided in the first instance by adult mental health.
- The service manager was unable to demonstrate all of the staff had received mandatory training, as there had been a trust wide issue with the eLearning platform. However, he was confident that all staff were up to date with their training and it was just in the process of being recorded. The staff we spoke to confirmed they were up to date with their training.

**Assessing and managing risk to patients and staff**

- Staff used a nationally recognised tool for assessing risk. Records showed initial risk assessments had been completed but it was not clear if the risk assessments had been updated. Staff gave us an explanation and told us that changes to risk were written in the body of the clinical notes, this meant updates were not easy to find.
- Staff carried out a case file audit in June 2016. The recommendations and actions indicated all staff should attend record keeping training and ensure staff updated the risk assessments; not just write in the notes.
- Staff, the young people and their families' we spoke with said they used crisis plans where appropriate and responded to a sudden deterioration in a young person's mental health by arranging an earlier appointment or advising they attend Accident and Emergency
- At The Den, there were waiting lists between five and nine months, for some non-urgent interventions. This meant that young people's mental health was at risk of worsening and becoming more complex. There were no waiting lists for intervention in Intellectual Disability CAMHS.
- At the initial assessment, which was called a choice appointment, these patients were given information regarding self-help resources and whom they can contact if their mental health worsens before being

placed on the waiting list. It was then the choice clinicians' responsibility to phone the young person every six weeks to monitor their mental health. It was not clear from the records if this was being done all of the time and if the choice clinician was an agency member of staff who had then left there was not an agreed process of who is then responsible. The service manager was aware of this and was taking steps to resolve this by giving specific clinicians' responsibility for managing the waits.

- At New Spring House, there were central hand written records showing who was waiting for what intervention. In order to better manage the list the service manager was going to divide the list up between the clinicians, and they would be responsible for contacting each young person on their list.
- All referrals were screened daily for risk and there was a duty rota for self-harm assessments and taking phone calls.
- All staff were trained in safeguarding level 3 and had a good understanding of the process and when they would need to report a safeguarding.
- Staff we spoke with were aware of the lone working system, processes and followed policy. There was an effective system in place to manage staff safety on and off site.

Staff wore an ID card with a built in electronic call system which could activated when support was needed.

**Track record on safety**

- There was one serious incident requiring investigation in the twelve months prior to inspection in July 2015. This was being investigated at the time of inspection. There were two further incidents rated as moderate by the trust and 17 more incidents reported between April 2015 and March 2016.

**Reporting incidents and learning from when things go wrong**

- All of the staff we spoke with knew what to report and how to report an incident. They explained they inform young people and their families when things go wrong. One of the incidents reported was around confidentiality; one young person had received an appointment letter meant for another young person. The young person and their family whose confidentiality was compromised were contacted and a full investigation was completed.
- Staff received feedback from incidents via email and their team meetings. Staff said they were not routinely debriefed following incidents but they felt supported by their team and if a serious incident occurred then they would be debriefed. We saw records that showed a staff member had been assaulted by a young person and had been debriefed.
- The paediatric team and CAMHS developed a standard operating procedure for children and young people when considering the use of the Mental Health Act. This was because of a recent incident of a young person being admitted to the acute paediatric ward due to their mental health deteriorating. The young person wanted to leave but it was felt they would be at risk so the staff prevented from leaving.

## Are child and adolescent mental health services (CAMHS) effective?

Good

We rated effective as good because;

- There were comprehensive assessments completed in a timely manner.
- Initial care plans were holistic and recovery focused.
- Clinical notes were stored safely and securely but were accessible to staff.
- Staff followed National Institute of Health and Care Excellence guidelines when providing care and treatment.
- There was a good use of outcome measures and clinical audit to support service development and delivery.
- The staff were experienced and qualified.
- There was good multi-disciplinary team working and joint working with other agencies.

However, we also found;

- There was not a Mental Health Act administrator within the trust at the time of inspection.
- Clinical supervision was not always recorded.
- There were staff vacancies that were impacting on patient care.

- Care plans were not written in the first person or updated regularly and were not always easily identifiable as clinicians'' did not use a standardised proforma.

**Assessment of needs and planning of care**

- We saw comprehensive assessments were completed during the initial appointment and initial care plans were developed following this. The care plans were holistic and recovery focused. However, it was not clear from the clinical notes when and if the care plans were updated regularly. The staff we spoke with explained some staff describe the plan of care within the clinical notes, others put it in a letter to the GP and some use a care plan pro forma. There was a place on the proforma for the young person to sign the care plan but this was not often completed and it was not clear if the young person had received a copy. The care plans were also not written in the first person. All of the families we spoke with said they knew what their plan of care was and sometimes they had been offered copies of it. Their recent case file audit had identified the need for a standardised care plan and this was being introduced at the time of inspection.
- All of the clinical notes were stored securely and were easily available to staff if they were at that particular base. As the records were paper files, they could not be accessed if the member of staff was at a different base. In order to support the functioning of the outreach team and to reduce risk; risk assessments were saved onto the shared drive so the outreach team could access these regardless of which base they were at. The team had put forward a business case for an electronic patient record system and this was to be discussed at the next hospital leadership team meeting.

**Best practice in treatment and care**

- The medics followed The National Institute for Health and Care Excellence (NICE) guidance when prescribing medication. One nurse prescriber was supervised by a psychiatrist and prescribed medication for Attention Deficit Hyperactivity Disorder.
- The service was working towards offering a pathway model ready for when they join their local children and young peoples improved access to psychological therapies (CYP-IAPT) collaborative in 2017. This included a small range of psychological therapies offered which were recommended by The National Institute for Health and Care Excellence; cognitive behavioural therapy, family therapy and interpersonal psychotherapy. However, there were not any clinicians' trained in dialectical behaviour therapy which is the recommended treatment for young people who have developed self-harming behaviours and suicidality. The staff we spoke with had identified this as a need but had been unable to secure funding for training.
- Height, weight and blood pressure was monitored regularly for the young people on medication. For young people with eating disorders CAMHS worked closely with the paediatric team to manage the physical health problems alongside the psychological issues.
- The service was a member of the Child Outcomes Research Consortium (CORC) and used recognised outcome measures to assess severity and collect patient feedback. The most recent CORC report showed the service had a higher than national average return for their child and parent strengths and difficulties questionnaires and the feedback showed the young people's difficulties had significantly improved.
- A range of clinical staff including nurses, psychologists and psychiatrists participated in clinical audits. Since January 2016, there had been a number of audits, for example, clinical records audit, audit of CAMHS interventions with ADHD against NICE guidance and audit of eating disorder cases.

**Skilled staff to deliver care**

- There was a range of experienced and qualified mental health disciplines including psychologists, nurses, psychiatrists, primary mental health workers, social workers and outreach workers. The local authority had withdrawn funding for primary mental health workers in the last year; this may have led to a couple of members of staff leaving.
- Permanent staff received a trust induction and a more CAMHS specific role induction. Agency staff received a local induction and shadowed a regular clinician for a couple of choice appointments before being able to work alone.
- At New Spring House, we saw records showed staff were receiving regular clinical and managerial supervision. However, there was not any evidence in the young person's clinical notes that discussion around their care and treatment had taken place. At The Den staff said they were receiving supervision but we did not see evidence this was recorded routinely. A couple of

members of staff kept their own written records of who they had delivered supervision to but there was not a clear process for whose responsibility it was to record supervision and where it should be recorded.
- We had difficulty in accessing accurate data around training, supervision and appraisals.
- The service manager told us poor staff performance would be addressed promptly and the team lead said they had support from human resources to address it.

**Multi-disciplinary and inter-agency team work**

- At both bases, there were regular weekly team meetings and a joint monthly clinical leadership team meeting. The minutes from these showed that quality governance was discussed, feedback from the divisional leadership team was fed back, audits were talked about and any compliments or complaints or learning from incidents was passed on.
- The location of The Den on the main hospital site and the fact they were run by the same trust helped relationships between all of the children's directorate. We spoke with the nurse in charge on the acute paediatric ward and she explained how CAMHS worked jointly with the acute paediatric nurses when young people were admitted to the ward. CAMHS and paediatric staff both nursed young people on the ward until they were physically well enough to be discharged. This often prevented the young person needing to be admitted to a psychiatric ward.
- The intellectual disability team worked closely with local special schools in order to provide continuity of care.
- We saw records showed all teams worked well with the local authority and other local organisations and services.

**Adherence to the Mental Health Act and the Mental Health Act Code of Practice**

- All of the staff we spoke with had an understanding of the Mental Health Act and some had received training but it was not part of their essential training except for medical staff and 100% of medical staff had received training. There had been a recent incident on the paediatric ward around whether the Mental Health Act could be used. However, in a community CAMHS team it would be unusual for a young person to be on a community treatment order.

**Good practice in applying the Mental Capacity Act**

- There was a Mental Capacity Act policy and 100% of staff were trained in the Mental Capacity Act and could explain the difference between assessing capacity in over 16 year olds and thinking about Gillick competence in under 16 year olds. Gillick competence is a term used in law to describe whether a child is able to consent to his or her medical treatment.
- There were capacity and consent forms completed at the beginning of treatment but there was no evidence within the clinical notes to show these were updated or thought about on a decision by decision basis.

## Are child and adolescent mental health services (CAMHS) caring?

Good

We rated caring as good because;

- All of the young people and their families' we spoke with said they were always treated with dignity and respect and felt supported by CAMHS.
- There was good participation and involvement of young people and parents throughout the service delivery and development.

**Kindness, dignity, respect and support**

- Young people and their families told us that CAMHS staff were very kind and responsive to their needs. They said staff always treated them with dignity and respect and they felt supported.
- The staff we spoke with had a good understanding of their patients' needs. We observed a referral meeting and staff discussed young people and their families' needs in order to gain a better understanding of which service would be most appropriate.
- We saw confidentiality was maintained throughout the inspection; files were not left on desks, doors were closed to prevent others overhearing telephone calls.

**The involvement of people in the care they receive**

- There was little evidence found in the clinical files that young people and their families' were actively involved in their care, but from speaking with young people and their families' they felt involved.

# Child and adolescent mental health services (CAMHS)

- The service wants to join their local children's, young peoples improved access to psychological therapies (CYP-IAPT) collaborative in 2017, and participation (the involvement of people in their care) is one of CYP-IAPT's main principles.
- Chesterfield CAMHS had created young people and parent groups to support service development and actively collected feedback from young people and their families' in a number of ways. At the time of the inspection, they were interviewing young people about their experience of choice appointments and they used experience of service questionnaires as part of CORC.
- The outreach and intellectual disability team had involved a young person and a parent in the recruitment of staff.
- Views and ideas were gathered from the parent group to aid the development of the transition policy and the eating disorder pathway.

Chesterfield CAMHS had also worked closely with their commissioner to ensure young people's voices were heard across the trust.

- In both waiting rooms, there was a box to collect feedback and a 'you said, we did' poster, which was changed every three months.

## Are child and adolescent mental health services (CAMHS) responsive?

Requires improvement

We rated responsive as requires improvement because;

- There were long waits for some interventions, which may result in the young person's mental health deteriorating while waiting for an intervention and then the intervention may not be as effective.
- The core CAMHS team operated Monday to Friday 0900 to 1700, which could be a barrier for some young people in accessing the service.
- The advice is to attend A and E out of hours with self-harm or suicidal thoughts or in a psychiatric crisis. This means a clinician with adequate knowledge and training may not see the young person until the next working day and may result in a young person being admitted to a paediatric ward inappropriately.

However, we also found;

- Waiting time for a routine appointment from referral to initial choice appointment was within their target of seven weeks.
- The team responded promptly to urgent referrals.
- There was a clear criteria for which young people will be offered a service.
- The Intellectual Disability team and Outreach were commissioned to offer more flexible appointments outside of 0900 to 1700.

### Access and discharge

- The waiting time for a routine appointment from referral to initial choice appointment was within their target of seven weeks. If it was more urgent they would be seen within two weeks or quicker if necessary. In the six months prior to inspection, the staff had introduced additional clinics in order to get the waiting list down for new appointments. This had resulted in a higher number of young people on the waiting lists for further intervention.
- Following the choice appointment if the young person was assessed to be low risk they would then be put on a waiting list for the most appropriate intervention. For family therapy, it was five weeks. For cognitive behavioural therapy, it was six months. For neurodevelopmental assessments, it was nine months. If the young person needed a non-urgent appointment with a medic, they would wait for one month.
- While the young person was on the waiting list, they remained the responsibility of the choice clinician and they aimed to phone each young person on the waiting list every six weeks. At New Spring House, the team lead kept hand written records showing the young person's pathway from referral to discharge. This ensured no young person could get lost in the system. At the Den, it was harder to track where young people were on their journey through CAMHS as there was not one single system. The team lead kept spread sheets of young people on different waiting lists. The staff were aware this system was not perfect and felt this process would be safer and more efficient if CAMHS had electronic patient records. The waiting lists were on the risk register as a high risk.
- There was a clear criteria for young people who will be offered treatment. The primary mental health worker role filled that gap between CAMHS and other targeted and universal services to ensure no young person can fall through a gap in service criteria. There was a policy

for young people who did not attend their appointments or were difficult to engage. Staff were proactive in their approach, for example, they would attempt contact. If after several attempts contact was not possible then the service would write a letter to the young person and copy to the referrer informing them they would be closed to CAMHS.

- The service was open Monday to Friday, 0900 to 1700 hours but has previously opened during weekends and ran evening clinics to respond to the long waiting list for initial choice appointment. Young people said they felt staff were flexible within these hours when arranging appointments and appointments were rarely cancelled and ran on time.
- CAMHS staff and the community paediatricians worked together to develop the new autism spectrum disorder pathway. This aims to ensure a reduction in the current waiting times for assessment.

**The facilities promote recovery, comfort, dignity and confidentiality**

- There were sufficient rooms at both bases to support treatment. The rooms were comfortable and adequately soundproofed. Some staff reported at busy times it could be difficult to find a room but this had not affected young people's care. There were toys and art equipment in each room plus a fully stocked art room in The Den.
- There were noticeboards in each of the waiting rooms which had age appropriate leaflets and information around young people's rights and treatments on.

**Meeting the needs of all people who use the service**

- Both bases would be accessible for people requiring disabled access.
- We were told information leaflets in different languages, signers and interpreters could be accessed easily when required.

**Listening to and learning from concerns and complaints**

- There were four formal complaints between April 2015 to April 2016. Two were upheld but none were referred to the ombudsman.
- There were age appropriate leaflets in the waiting rooms explaining to young people how to make a complaint but the young people and their families' we spoke with did not recall being told how to make a complaint if they needed but all said they would feel comfortable raising any issues with their clinician.
- The staff we spoke with knew the complaints policy and where to direct the young people to.
- The service manager discussed the outcome of any complaints in the clinical lead meeting and then any learning was passed down to the team meetings.
- The main way of gathering feedback about the service was through the experience of service questionnaires used.

## Are child and adolescent mental health services (CAMHS) well-led?

Good

We rated well-led as good because;

- There was good communication between staff and senior leaders and staff knew how to submit items to the risk register.
- Staff spoke positively about the CAMHS leadership team.
- Clinical staff participated in clinical audit.
- The service manager had enough authority and administration support to do their job.

However, we also found;

- There was not a robust process in place for managing the waiting lists.
- Risk assessments were not updated regularly.
- There was a lack of oversight regarding how staff training was monitored and recorded.

**Vision and values**

- The staff we spoke with knew the organisations values and felt the CAMHS service reflected them.
- Staff knew who the senior managers were and said the senior managers within the children's directorate were familiar and had visited the team in the past. The team lead and service manager worked closely with the children's directorate lead and knew who the senior managers were in the wider trust.

**Good governance**

# Child and adolescent mental health services (CAMHS)

- There was evidence to show good two-way communication between staff meetings, clinical lead meetings and senior management meetings where learning from incidents and investigations were shared.
- There was good use of clinical audits and participation of young people and families' to support service delivery and development.
- Staff said they receive supervision and appraisals but this was not recorded anywhere at The Den.
- Throughout the service, there was good use of outcome measures used to gauge progress and gather feedback from young people and their families.
- The team manager said they had sufficient authority and administration support to do their job. The administration team were directly line managed centrally within the trust and it was felt this could sometimes cause difficulties when asking staff to carry out tasks.
- Staff told us they knew how to submit items to the risk register.
- The commissioners set a target of seven weeks from referral to first appointment and this was being met at the time of inspection.
- There was a lack of oversight regarding recording and monitoring supervision and training.
- There was not a robust process in place for managing the waiting lists.

**Leadership, morale and staff engagement**

- There were team leads for each of the CAMHS services; core CAMHS, intellectual disability team and psychology team. The team leads reported to the CAMHS service manager. Alongside them, there were also clinical leads for psychology and psychiatry.
- All of the staff spoke positively about the leadership team. The consensus was despite the service being low on staff and increased referrals everyone felt it was a good team to be part of and felt supported by one another.
- Staff said they were aware of the whistle blowing policy and how to use it.
- There were no bullying and harassment cases at the time of inspection.
- There had been opportunities in the past for leadership development but more recently funding for external training was not accessible. The team lead had been given time to complete a course they had paid for themselves.
- Staff were aware of the duty of candour policy and were open and transparent when things went wrong.

**Commitment to quality improvement and innovation**

- The service was part of the clinical outcomes and research consortium (CORC). The consortium is a collaboration between CAMHS across the UK with the aim of implementing a common model of routine evaluation and analysing the data collected.

# Outstanding practice and areas for improvement

## Outstanding practice

- The neonatal gentamicin prescription sheet that had been produced because of lessons learnt from gentamicin medication errors was outstanding. This has reduced the number of incidents to zero within the department and ensured that all patients received the correct management.
- "Toolbox talks"- had been developed and trialled amongst porters with the aim of increasing knowledge of end of life care. "Toolbox talks" were short talks developed and delivered to the porter service manager who then delivered this to their teams. There was a plan in place to roll this out to other non-clinical staff within the trust.
- We saw a staff member on Markham Ward had written a poem to provide support to relatives of end of life patients. "The palliative approach" poem was sensitively written and described how the ward would care for relatives and their loved ones on the ward.
- We saw the use of a "comfort tins" for relatives of patients in the last days or hours of life which included biscuits and tissues. We also saw the use of "comfort packs" for patients in the last days or hours of life. The contents of these packs included essential toiletries such as a toothbrush and cleansing wipes.

## Areas for improvement

### Action the hospital MUST take to improve

- The trust must ensure the resuscitation equipment provides a full range of equipment to meet all sizes of children, young people and adults.
- The trust must ensure that in areas where children are treated, appropriate safeguarding measures and staff training are in place.
- The trust must ensure nursing staff who deliver end of life care are familiar with and receive training in the Mental Capacity Act (2005).

### Action the hospital SHOULD take to improve

- The trust should ensure all DNACPR order forms are completed accurately and in line with trust policy.
- The trust should improve infection control training within the medical division.
- The trust should ensure there are consistent processes in place to assure cleanliness of equipment including the birthing pools within maternity and gynaecology services.
- The trust should ensure cleaning records are maintained for the milk fridges within maternity and gynaecology services.
- The trust should ensure all staff are compliant with trust targets and intercollegiate standards in regards to safeguarding level three training.
- The trust should ensure there is a consistent process for assuring the safety of electrical items and they are clearly marked with details of when safety checks are next required. It should be ensured staff are aware to the process for ensuring equipment is checked and safe to use.
- The trust should ensure there is a formalised risk assessment produced for the paediatric resuscitation trolley on Nightingale Ward remaining unlocked.
- The trust should ensure all investigations involving a child or young person should have representation from the Women's and Children's division.
- The trust should ensure the sepsis management of children and young people is fully embedded within the service.
- The trust should ensure they work closely with the local hospice in finalising the service level agreement.
- The trust should ensure they continue with the plan to monitor how rapidly patients are discharged from hospitals once identified for "fast track".
- The trust should ensure they audit the achievement of patients preferred place of death.
- The trust should ensure the legal process of the Mental Capacity Act 2005 is followed where a patient lacks the capacity to make decisions, particularly in relation to 'Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR) orders.

# Outstanding practice and areas for improvement

- The trust should consider reviewing the process for transferring obese deceased patients to the mortuary.
- The trust should consider the environment in Hollywell Day Case Unit to ensure the environment where trolleys are located and equipment is washed is suitable to ensure effective infection prevention and control measures can be adhered to.
- The trust should ensure that all ward and department staff receive information on the policy for the monitoring and recording drug fridge temperatures including details of any actions they are accountable for.
- The trust should continue to prioritise reviewing the open incidents, ensure actions are taken to minimise risk ,and ensure actions are completed, learning is shared and records updated.
- The trust should ensure that the surgical department morbidity and mortality quarterly meetings are established and that there is a robust system is in place to secure attendance and enable learning to be shared.
- The trust should ensure all staff receive annual appraisals.
- The trust should ensure all staff attend mandatory training days.
- The trust should ensure all staff complete safeguarding training suitable to their role and grade.
- The trust should ensure where resuscitation trolleys are shared between two wards both wards carry out and document the checks as per the trust policy.
- The trust should ensure VIP scores are recorded in a consistent manner and that there is no duplication of information.
- The trust should ensure data is captured when complaints/concerns are resolved at ward level, and ensure that learning is shared.
- The trust should ensure patient transfers are effectively managed to minimise the number of patients transferred after 10pm.
- The trust should ensure sufficient medical staffing is available to meet periods of increased demand and to cover staff absences.
- The trust should review staffing to ensure planned levels are in line with safer staffing guidelines including night shifts.
- The trust should ensure the safer steps to surgery check list is fully completed and audit monthly to achieve 100% compliance.
- The trust should ensure the safer steps to surgery check list is used for invasive procedures.
- The trust should ensure all of the divisions have shared governance structures which are consistent and collective.

This section is primarily information for the provider

# Requirement notices

## Action we have told the provider to take

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

| Regulated activity | Regulation |
|---|---|
| Treatment of disease, disorder or injury | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br><br>**Regulation 12 (2)(e)**<br><br>Care and treatment must be provided in a safe way for service users ensuring that the equipment used by the service provider for providing care or treatment to a service user is safe for such use and is used in a safe way<br><br>**How the regulation was not being met:**<br><br>Emergency equipment in the paediatric ward was found to be lacking equipment suitable to meet the requirements of all sizes of child, young person and adult. |

| Regulated activity | Regulation |
|---|---|
| Treatment of disease, disorder or injury | Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment<br><br>**Regulation 13(1)(2)**<br><br>Safeguarding service users from abuse and improper treatment<br><br>**How the regulation was not being met:**<br><br>• The trust could not assure there were appropriate safeguarding measures in place in areas where children visited which included appropriate level of training.<br><br>Regulation 13(2) Systems and processes must be established and operated effectively to prevent abuse of service users<br><br>**How the regulation was not being met:** |

This section is primarily information for the provider

# Requirement notices

- Nursing staff delivering end of life care did not appear familiar with or have training in the Mental Capacity Act (2005)

| Regulated activity | Regulation |
| --- | --- |
| Assessment or medical treatment for persons detained under the Mental Health Act 1983<br><br>Diagnostic and screening procedures<br><br>Treatment of disease, disorder or injury | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br><br>**Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part.**<br><br>**2.Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to —**<br><br>**a. assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services);**<br><br>**b. assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity.**<br><br>**How the regulation was not being met:**<br><br>• There was a lack of oversight regarding whether all staff had received clinical supervision and it was not clearly recorded when it had taken place.<br>• There was not a robust process in place for managing the waiting lists.<br>• Risk assessments were not updated regularly.<br>• There was a lack of oversight regarding how staff training is monitored and recorded.<br><br>**These are breaches of regulation 17 (2) (a) (b)** |