# University Hospitals of Morecambe Bay NHS Foundation Trust

# Royal Lancaster Infirmary

**Inspection report**

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## Ratings

### Overall rating for this service

Inspected but not rated

# Our findings

## Overall summary of services at Royal Lancaster Infirmary

**Inspected but not rated**

The Royal Lancaster Infirmary is a part of the University Hospitals of Morecambe Bay NHS Foundation Trust. It provides acute hospital services including urgent and emergency care, medical care, surgery, maternity, critical care, pediatrics and out-patients for people in the North Lancashire and South Cumbria areas.

We visited Royal Lancaster Infirmary as part of our unannounced inspection during 3 to 4 August 2021. Our inspection was unannounced after receiving concerns about patients being put at risk (staff did not know we were coming) to enable us to observe routine activity.

We visited medicines core services as part of the inspection.

Attendances at the emergency departments within the trust averaged around 10,000 per month.

The hospital had capacity for 203 medical beds and 106 inpatient surgical beds.

As part of the inspection, we spoke with ten patients. We observed care and treatment and looked at 19 care records and 15 prescription drug charts. We also spoke with staff members across the department including staff nurses, senior nurses, a pharmacy technician, junior doctors, consultants, care support workers, matrons, clinical service managers and the associate director of nursing, the associate director of operations, and the clinical director.

Following this inspection, under Section 31 of the Health and Social Care Act 2008, we sent the trust a letter of intent in respect to the regulated activity, treatment of disease, disorder and injury and diagnostic screen procedures. We took this action as we believed a person would or may be exposed to the risk of harm if we had not done so. The trust provided actions at the time of inspection that assured us people were kept safe.

# Medical care (including older people's care)

**Inadequate** 

The Royal Lancaster Infirmary is a part of the University Hospitals of Morecambe Bay NHS Foundation Trust. It provides acute hospital services including urgent and emergency care, medical care, surgery, maternity, critical care, paediatrics and out-patients for people in the North Lancashire and South Cumbria areas.

We visited Royal Lancaster Infirmary as part of our unannounced inspection during 3 to 4 August 2021. Our inspection was unannounced after receiving concerns about patients being put at risk (staff did not know we were coming) to enable us to observe routine activity.

We visited medicines core services as part of the inspection.

Attendances at the emergency departments at Royal Lancaster Infirmary averaged around 4,500 per month, in the previous 12 months.

The hospital had capacity for 203 medical beds.

As part of the inspection, we spoke with ten patients. We observed care and treatment and looked at 19 care records and 15 prescription drug charts. We also spoke with staff members across the department including staff nurses, senior nurses, a pharmacy technician, junior doctors, consultants, care support workers, matrons, clinical service managers and the associate director of nursing, the associate director of operations, and the clinical director.

Following this inspection, under Section 31 of the Health and Social Care Act 2008, we sent the trust a letter of intent in respect to the regulated activity, treatment of disease, disorder and injury and diagnostic screen procedures.

We took this action as we believed a person would or may be exposed to the risk of harm if we had not done so. The trust provided actions at the time of inspection that assured us people were kept safe.

## Is the service safe?

**Requires Improvement** 

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

### Mandatory Training

**The service provided mandatory training in key skills to all staff and made sure everyone completed it.**

Staff received and kept up to date with their mandatory training.

The mandatory training was comprehensive and met the needs of patients and staff.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia.

# Medical care (including older people's care)

Managers monitored mandatory training and alerted staff when they needed to update their training. We saw managers were proactive in requesting additional face to face training for overseas nursing staff to improve their knowledge and understanding, if they felt this was needed.

## Safeguarding

**Staff did not always understand how to protect patients from abuse and the service did not always work well with other agencies to do so. Staff had training on how to recognise and report abuse, but we found they did not always know how to apply it.**

Staff we spoke with knew how to identify adults at risk of, or suffering, significant harm and knew how to make a safeguarding referral but we found actions to prevent incidents from occurring again were not robust.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. However, we saw that the appropriate actions to ensure patients were kept safe after safeguarding concerns were raised had not been taken immediately. Although some mitigation had been put in place, we found this to be insufficient. The trust introduced further measures after we raised concerns that their approach was not robust enough. However, two weeks after serving the trust with a letter of intent further allegations of safeguarding were raised at the trust. A letter of intent is a letter sent to a healthcare provider, when we are proposing to take urgent civil enforcement action. As a direct consequence of the concerns raised with external agencies, the trust implemented further actions and reviews to ensure patients were kept safe.

Medical staff received training specific for their role on how to recognise and report abuse. However, compliance rates across the care group were low.

The care group reported 87% of staff had received safeguarding level 2 training but only 63% of medical staff had received safeguarding level 3 training and only 60% had completed safeguarding children level 3 training.

Nursing staff received training specific for their role on how to recognise and report abuse. The care group reported overall 95% of staff had received safeguarding level 2 training, apart from staff working on the Huggett suite, where 87.5% of the staff had completed safeguarding level 2 training.

Staff received training on how to recognise and report abuse relating to a child. The care group reported an overall 91% of staff had received safeguarding children level 3 training.

Staff had access to the duty safeguarding team from 9am- 5pm, Monday to Friday and staff could call for advice.

Safeguarding alerts for adults were flagged on patient records and were also picked up by reception staff.

Safeguarding training also included PREVENT, (part of the government anti-terrorism strategy about safeguarding vulnerable people from being radicalised) and child sexual exploitation and female genital mutilation.

## Cleanliness, infection control and hygiene

**The service did not control infection risk well, not all areas of the premises was visibly clean. Most staff used equipment and control measures to protect patients, themselves and others from infection however, we did observe equipment and areas that were dirty.**

# Medical care (including older people's care)

The cleanliness of wards varied across the service we visited, and some did not have suitable furnishings which were clean and well-maintained. We found cleanliness on some wards where care and treatment were delivered was not maintained and equipment used to deliver care and treatment was not always suitable for the intended purpose, maintained, stored securely and used properly.

Cleaning records were not up-to-date and did not demonstrate that all areas were cleaned regularly on some wards. Cleaning schedule records and observations on inspection showed appropriate infection prevention control measures were not in place to prevent outbreaks in the future. For example, there were gaps in day and night cleaning records on ward 23. The day cleaning records indicated cleaning had not taken place on 15 out of 30 days in June, and on 14 out of 31 days in July. In May 2021, there was no records to show night cleaning had taken place on 11 occasions out of 31. In June 2021, there was no records showing night cleaning had taken place on 16 out of 30 nights. In July 2021 there was no records showing cleaning had taken place for 26 out of 31 nights.

We observed significant amounts of black and grey dust on several items of equipment when we visited the medical assessment unit. We spoke with senior staff on the unit about this at the time, however they seemed unconcerned about this.

Staff did not always follow the infection control principles including the use of personal protective equipment (PPE) on some of the areas we visited. Staff we spoke with said the recent Covid-19 outbreaks on ward 23 were avoidable.

Information from the trust showed that 10 patients tested positive on 8 July 2021, of these 10 cases, the trust reported five patients acquired Covid-19 in hospital, four were probably acquired in hospital and one case was undetermined. Nine of the ten patients had been fully vaccinated, the tenth person had received one vaccine. This meant patients residing on ward 23 were all at risk of acquiring COVID-19 whilst being an inpatient.

There had also been outbreaks of Clostridium difficile. Information given to us by the trust showed that six patients tested positive in wards 22 and 23 during May and June 2021. Of these cases, it was reported that four patients tested positive on ward 22 and two on ward 23. Staff we spoke with said the high numbers of mobile patients contributed to outbreaks on the wards. Staff told us patients often wandered and staff were too busy to keep attending to them.

All patients admitted through the emergency department had a Point of Care (POC) test in the department. The patient would then have a subsequent PCR test when they were admitted and arrived on a ward. Staff we spoke with said patients would be retested every three days. The COVID-19 status of patients was highlighted on handover sheets and discussed at handover to ensure everyone was kept up to date.

We saw that 100% of nursing staff in the department had undertaken infection prevention and control training and hand hygiene training. All staff we observed were compliant with arms bare below the elbow.

### Environment and equipment

**The design, maintenance and use of facilities, premises and equipment did not always keep people safe. Staff did not always manage clinical waste.**

Not all wards had suitable facilities to meet the needs of patients. On entering ward 23 we noted that the visibility of patients from the nurse's station was very poor. The nurses station was in front of a wall between two bays. The side rooms could not easily be viewed from the station and there was no visibility into the bays if staff were sat at the desk.

# Medical care (including older people's care)

Across all wards we found there was a lot of equipment around the communal areas with large hoists blocking access to the electrical cupboards. This presented a health and safety hazard to staff and patients.

There were no dedicated therapy areas in the medical wards of medical unit 2, but the hospitals physiotherapy unit was located on the ground floor of medical unit 2. The unit was meant to be a rehabilitation area for older patients, however, there was no physiotherapy gym, and no occupational therapy assessment areas. This lack of facilities meant the staff were very limited in how they could assess, treat and support the rehabilitation and recovery of patients.

We were sent results of environmental audits on the 30 July 2021 and we reviewed these prior to the onsite visit. Audits undertaken on 18 June 2021 and 2 August 2021 showed no scoring system such as red, amber, green to measure adherence to standards. Some of the issues found on the 18 June 2021 environmental audit such as ripped floor tape, damaged crumbling walls and broken and rusty bins were still present during our inspection. The trust reported 339 defects had been reported in the previous 12 months and that 299 of these had been resolved.

Damaged flooring, bathroom panels and plaster work had already been reported by the ward and were on the estates team defect list.

The audits highlighted that these issues had not been addressed and we saw no evidence of reported issues being followed up as part of actions from the audits.

During the inspection we identified hard to clean areas on Ward 23. There were cracks and gaps in flooring and on the lower walls in patient bathrooms. There were gaps in wall panels behind hand wash basins in patient bathrooms. There were damaged walls with crumbling plaster on the floor and there were clinical waste bins with rusty metal lids.

Staff did not always dispose of clinical waste safely; on three wards we saw sharps bins were not used appropriately. For example, needles were protruding which could cause a needlestick injury.

We saw waste management systems were in place to ensure waste was appropriately disposed of. However, we found clinical waste bags were hanging from trolleys that held clean equipment on them.

All cleanliness and infection prevention and control (IPC) issues were immediately raised with the trust after inspection. The trust provided actions on how they were going to address the concerns raised. These included undertaking daily IPC reviews and weekly audits, deep cleaning of the medical unit 2 wards 20, 22 and 23 and we were told all curtains had been replaced.

However, since the last inspection in April 2021, the trust had made improvements to the environment where care and treatment was delivered to stroke patients. A review of the capacity and demand for the overall stroke pathway had resulted in a proposal to provide 12 additional beds at the hospital. The trust proposal included moving the current stroke unit (Huggett Suite) to a larger 32 bedded area on the ground floor of the Centenary building. The unit was planned to be co-located to the emergency department which would also mean staff in the emergency department had access to stroke staff. The trust reported on 7 August, that logistical planning was underway with the planned relocation date of 30 August 2021. However, the move had not been completed by this date.

Staff carried out daily safety checks of specialist equipment. There were resuscitation trolleys for adult patients on each ward. We saw that daily checks of the trolleys had been completed. Defibrillators and other equipment had undergone electrical safety testing to ensure that they were safe for use.

On ward 22 we saw bins were not overfilled, equipment was in service and the ward appeared clean and tidy.

### Assessing and responding to patient risk

**Staff did not always complete and update risk assessments for each patient. However, staff identified and quickly acted upon patients at risk of deterioration but were not always able to acquire doctors to review patients in a timely way.**

Since the last inspection in April 2021 the trust had made improvements to the stroke service in line with the action plan provided post inspection. During our inspection we saw that most of the necessary changes had been implemented. However, there were still challenges on the Huggett unit. These included completions of fluid balance charts, completion of the malnutrition universal screening tool (MUST) within 4 hours of arriving on the ward and seven days after the initial review.

Patients at high risk were placed on care pathways and care plans were put in place so patients they received the right level of care. Staff carried out 'intentional rounding' observations at least every four hours to check patients were comfortable.

Staff completed risk assessments for each patient on arrival, using a recognised tool but did not review this regularly. Although we saw risk assessments were used to record and act on risks to reduce pressure sores, falls, venous thromboembolism (blood clots), safeguarding vulnerability and delirium (confusion), they were not completed regularly. The patient record system prompted staff to consider risks and provided instructions should the risk be present. However, records we reviewed on ward 20 showed seven patients had not been reassessed for VTE for seven to 14 days.

A key diagnostic procedure in the stroke pathway is an urgent CT scan to check for either a bleed or a blood clot in the brain. If a CT scan shows no evidence of a bleed, patients undergo further testing by way of a CT angiogram. The Sentinel Stroke National Audit Programme (SSNAP) found not all patients had a CT scan within 1 hour between April and June 2021 but an improving trend could be seen. The trust recognised the need for ongoing monitoring to sustain the improving compliance rate for the benefit of patient safety.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. All wards used a national early warning (NEWS2) system to identify deteriorating patients. These systems scored a set of observations and prompted an appropriate response dependent on the score or whether the score was increasing. We saw from patient notes that staff used the scoring system. However, staff told us they also relied on an informal social media group to escalate concerns to the medical team because they felt the current trust system was not working well. We did not find any examples of patients not being seen if they deteriorated.

The service had 24-hour access to mental health liaison and specialist mental health support if staff were concerned about a patient's mental health.

Staff shared key information to keep patients safe when handing over their care to others. Shift changes and handovers included all necessary key information to keep patients safe. We reviewed handover documentation and saw necessary information relating to patient care was highlighted, so that staff taking over could easily read it.

# Medical care (including older people's care)

The trust had developed a live dashboard to track and monitor key metrics across the stroke pathway as part of their immediate actions to address the concerns raised in the April 2021 inspection about the care delivered to stroke patients. During the inspection we saw that staff used the live dashboard to track patients and the care and treatment they had received.

The trust reported 100% of stroke patients had a dysphagia (difficulty swallowing) screening test and a four-hour swallowing assessment between May 2021 and July 2021. This was noted as an improvement.

### Nurse staffing

**The service did not have enough nursing staff to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix, and gave bank and agency staff a full induction.**

The service did not always have enough nursing and support staff to keep patients safe. The ward used a staffing acuity tool (safe care acuity tool) in which the patients acuity scoring was measured against the safer nursing care evidence-based tool, reportable through "Safecare". The online Safecare tool highlighted any concerns around staffing levels. The clinical site manager and matron had the responsibility to ensure the wards had the correct numbers of staffing.

However, the tool did not take in to account the number of staff required to meet the holistic needs of patients. For example, staffing did not reflect the additional support needed to care for patients suffering with delirium or those who require support when mobilising. In ward meeting minutes, we saw staff raise their concerns about unsafe staffing levels and gave examples of why staffing was unsafe. They had escalated their concerns to senior managers but said nothing had been done.

Managers said they calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. However, we saw that each shift did not always have the right number of staff. For example, the July 2021 safer staffing report showed wards across the medical care group did not meet 100% fill rates. At times some wards worked with 80% of staff, which impacted upon the delivery of care.

Nursing staff on the wards did not all have the skills to keep patients safe and free from harm. For example, whilst on inspection on 4 August we heard during a ward handover, that a patient had a urinary catheter removed as planned during the morning of the previous day, 3 August. The patient had not passed urine all day on 3 August. Night staff performed ward based bladder scans on three occasions overnight. When the levels of urine showed over 500mls, as per the trust policy, they contacted the on-call doctor around 5 am on 4 August to request re insertion of a urinary catheter. The doctor was not able to attend due to other priorities. Nursing staff told us there was no nurse with advanced skills able to carry out the catheterisation. This meant the patient was put at risk of harm.

During the last inspection staff told us they felt there were insufficient nursing staff on the stroke unit at night. During that inspection we found the stroke ward was staffed with 4 registered nurses at night, however only one staff member had completed stroke training. Since the last inspection, the trust reviewed the staffing arrangements on the Huggett Unit. On 7 August 2021 the trust reported they were still awaiting approval from board to recruit extra staff. Therefore, the staffing concerns on the stroke unit raised in April 2021 had not been completely addressed.

The service reported a reducing sickness rate, between March 2020 and March 2021 we saw that sickness rates had reduced to 3.6% from over 7%.

# Medical care (including older people's care)

## Medical staffing

**The service did not have enough medical to keep patients safe from avoidable harm and to provide the right care and treatment. Managers did not regularly review and adjust staffing levels and skill mix.**

The service did not have enough medical staff to keep patients safe. Staffing levels at the time of inspection did not always ensure patients received safe care and treatment at all times. We found many gaps in the medical staffing rotas we reviewed. The week commencing 5 July 2021, ward 23 was covered by internal medical trainee (IMT) junior doctors and non-trainee grade (NTG) junior doctors. On 9 July 2021 there was no planned cover after 1pm. We found surge ward 3 was covered by two foundation year two (FY2) junior doctors and on 7 and 9 July there was only one doctor on the rota.

The medical staff on the wards did not match the planned number. For example, we also found surge ward 2 was covered by a combination of locum FY2 and FY2 doctors; on 5, 6, and 9 July, there was only one doctor instead of the planned two doctors. The rota showed gaps for planned cover the week beginning 12 July 2021. Ward 20 had been covered by two junior doctors the week before, however there was one NTG on 12, 13, 14, 15 July, and one FY1 planned for 16 July. Ward 22 had only one FY1 on 12 July, one FY3 on 14 July and one FY3 on 15 July. Surge ward 2 had only one locum FY2 on 12,13, 14, and 16 July. Surge ward 3 had only one locum FY2 on 12 and 13 July.

The service reported a high number of vacancies for medical staff. We observed on one ward that medical staff were not on the ward until 9.45am and were joined by an advanced nurse practitioner (ANP) at 11am. ANPs were deployed to elderly medicine wards to support medical staff. However, this meant they were unable to support the emergency department with reviewing patients to avoid unnecessary admissions.

The service had high rates of bank and locum medical staff. We found there was a reliance on locum doctors and doctors cross covering wards. During the inspection on the 3 August 2021, a locum consultant was covering Ward 20 and Ward 22 to cover annual leave. This meant this doctor had 48 patients to review across both wards.

Staff could not always access medical staff when they needed them. When reviewing records, we saw three patients had not been seen on ‘post take’ ward rounds within 12 hours of admission. Staff we spoke with said medical staff did not always come on to the ward. Staff in different areas of medicine had formed informal social media groups in order to pass messages to doctors asking them to review patients who needed medical attention.

We found patients were not always reviewed by a senior doctor as per trust policy. We found one patient record did not evidence a daily ward round including a senior review. Doctors we spoke with said shortfalls in medical staffing resulted in them prioritising which patient they reviewed. A note left in the same patient’s notes stated a lack of time prevented the number of times the patient was reviewed. Medical staff confirmed twice weekly ward rounds were achievable, but they would prioritise seeing new patients and unwell patients. Data reviewed in the command centre showed patients from other specialities were not always reviewed. One patient did not receive a review for 26 days. This put patients at risk of harm.

The service did not have a good skill mix of medical staff on each shift, this was not regularly reviewed. We were told FY1 doctors were put onto the night rota which meant they took days off in the week after nights shifts. This meant they were unable to see patients regularly which caused a lack of continuity when caring for patients. They also raised concerns about not getting sound learning opportunities and not getting their breaks because there were not enough senior staff.

Nursing staff and medical staff we spoke with said there was no senior doctor based in medical unit 2 overnight, only an FY1 doctor, who was not always able to respond. Staff said the clinical site manager would often base themselves in the unit at night for additional support.

Since the inspection the trust told us they had put in place mitigation to reduce the risk to patients. They had put in place a further two locum doctors, which meant there was now one consultant and two trainees for every medical ward.

The trust also confirmed ward 2 had been closed, providing additional medical capacity for release on other wards and a full review of the out of hours cover for Medical Unit 2 was being undertaken in conjunction with the clinical lead to ensure sustainability moving forward.

**Allied health professional staffing**

There were significant vacancies in the physiotherapy team who covered the medical wards. This impacted upon the ability of the team to provide care for patients. In 2020, there had been a full seven-day service, however a number of the team had since left and there were recruitment challenges, maternity leave and staff on long term sick leave. Some locum physiotherapy posts were ending in September 2021 which would further impact on the service.

During the inspection, physiotherapists told us they struggled to provide ongoing treatment for patients and needed to prioritise assessment and care prior to patient discharges or for acutely ill patients with chest problems. This put patients at risk of harm as there were not enough physiotherapy staff to meet the assessment, planning and treatment needs of all the patients.

The physiotherapy team for the medicine care group used locum physiotherapists to fill gaps in their staffing rota. The medicine care group reported full establishment for the physiotherapy was 52.5 whole time equivalent (WTE) but as of August 2021 there were 49.5 WTE contracted. This meant there was a vacancy of 3.0 staff. At the time of inspection, there were five locums in place however those contracts were due to end in September 2021. The 'rehab' physiotherapy team also covered the additional 'surge' wards 2 and 3 to assess patients who were deemed ready for discharge; the team also covered orthopaedics. This meant they were not able to provide a full program of physiotherapy for all patients who needed the service.

## Records

**Staff did not always keep detailed records of patients' care and treatment. Records were clear but were not always stored securely.**

We reviewed nineteen sets of adult patient records, the name and grade or doctor, management plan and identified care needs were well documented in all notes. However, five records were incomplete, and we found one record contained incorrect information about the patient's accommodation status which potentially could affect decision making and treatment plans.

Patient handover records were not securely stored, we saw on two wards, documentation was left unattended. This meant there was a risk unauthorised people could access the records.

Patient notes were comprehensive, but some staff said they were not always easily accessible because they were held on different systems.

Records contained the relevant risk assessments and allergies. Records contained summaries from the patient's General Practitioner (GP) these were informative and included Covid vaccination history.

The provider had an electronic record system in place. The electronic records system included prescription charts, observation charts using the National Early Warning Score 2 (NEWS2), and nursing and medical documentation.

### Medicines

**The service used systems and processes to safely prescribe, administer, and record medications, but not all medicines were stored at the right temperature.**

We reviewed 15 prescription charts and found they were all up to date, where a patient was on oxygen this was included in the medicines chart.

Staff followed systems and processes when safely prescribing, administering and recording medicines. Medicines requiring refrigeration were stored securely, the maximum and minimum temperatures had been recorded in accordance with national guidance. However, the ambient room temperature on ward 22 where medicines were stored was 28 degrees. We raised this with the ward manager on inspection, who said there was no ventilation system in place. We were told pharmacy and estates were aware of the issue but there was nowhere else to relocate the medicines.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about medicines. Staff on the ward said medicines were reviewed by the pharmacist to ensure they were appropriate. In the 15 drug charts we reviewed, we saw evidence of a pharmacy review.

Staff followed current national practice to check patients had the correct medicines. For example, we saw a protocol for use of gentamycin displayed in the clinical room in the ambulatory care unit. Controlled drugs were managed appropriately, and accurate records were maintained in accordance with trust policy. We saw medicine balance checks were regularly updated. We checked a sample of controlled drugs across the wards and found them to be balanced correctly. Dispensed doses were recorded accurately and in line with national guidance.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. Alerts were put on records to ensure staff were aware of allergies. Red aprons were worn indicating the nurse was busy administering medication to prevent them being interrupted. This helped to minimise the risk of errors.

Decision making processes were in place to ensure patients behaviour was not controlled by excessive and inappropriate use of medicines. The wards were visited by the pharmacist every day to check stock levels. Medicines were dispensed using an electronic dispensing system which required fingerprint technology to access the system. This system allowed for staff to audit the pathway and have oversight of the inventory.

### Incidents

**The service did not always manage patient safety incidents well. Staff mostly recognised and reported incidents and near misses. However, managers did not always investigate incidents and share lessons learned with the whole team and the wider service in a timely manner.**

Incident reporting varied across the wards we visited. We found on some wards there was a positive learning culture and on others there was no learning or support provided to staff. The national staff survey reported 43.3% of staff felt the organisation did not treat staff involved in errors/ near misses or incidents fairly.

# Medical care (including older people's care)

We were not assured all staff knew what incidents to report and how to report them. For example, we identified shortage in staffing and environmental issues causing harm to patients that had not been reported as incidents.

However, on one ward we saw the manager had disseminated feedback from a recent incident involving a patient fall. Information about learning outcomes was displayed on the ward for all staff to read. The ward manager had introduced board rounds and safety huddles, where information from incidents could be disseminated.

Incidents were reported through an electronic system, staff graded incidents in relation to the severity of harm.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong. A review of duty of candour incidents we saw all included an apology to the patient and their family and follow up actions.

## Is the service effective?

**Requires Improvement** 

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

### Evidence-based care and treatment

**The service did not always provide care and treatment based on national guidance and evidence-based practice. Staff protected the rights of patients subject to the Mental Health Act.**

Staff did not always follow up-to-date policies to plan and deliver high quality care according to best practice and national guidance. We were concerned that the discharge pathway and national guidelines were not being followed effectively. For example, staff did not follow the National Institute of Health and Care Excellence (NICE) guidelines 'Transition between inpatient hospital settings and community or care home settings for adults with social care needs' [NG27].

Pathways and policies were based on guidelines and standards set by organisations such as NICE. The documents were easily accessible to all staff on the intranet.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers.

### Nutrition and hydration

**Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.**

Handover documentation captured patient dietary requirements, this included specialist nutrition and hydration.

Specialist support from staff such as dietitians and speech and language therapists were available for patients who needed it. The records we looked at showed that there was regular dietitian involvement with patients that were identified as being at risk.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. Staff used the *Malnutrition* Universal Screening Tool (*MUST*). Where patients were identified as at risk, staff fully and accurately completed patients' fluid and nutrition charts where needed.

Meals were ordered using an electronic system and optional menus were available for patients with specific requirements. Wards observed protected mealtimes. On ward 22 we saw staff took time to assist patients with mealtime.

However, completion of fluid and nutrition charts varied across wards. We saw from records we reviewed, total amounts on fluid charts had not been documented. Staff we spoke with said there was a focus on fluid balance sheets since an audit was undertaken in May 2021. We reviewed the audit which showed only 60% compliance rate on one ward.

### Pain relief

**Staff assessed and monitored patients to see if they were in pain. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain**.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. A universal pain assessment tool for patients that were able to communicate or the Abbey pain score for patients who were unable to clearly articulate their needs was used across all wards.

However, during the inspection we observed one patient had not received pain relief when expressing discomfort. This patient was noted to be complaining of shoulder pain and seemed quite confused, which was acknowledged by the nurse. However, when reviewed by the consultant the painful shoulder was mentioned to the doctor, but the doctor did not further question the patient's complaint and no pain relief was administered.

### Patient outcomes

**Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. The service had been accredited under relevant clinical accreditation schemes.**

The service participated in relevant national clinical audits. We reviewed clinical audits undertaken by the service between 2019 and 2020. The action plans to address the audit outcomes had accountable officers and completion dates. For example, in the national asthma audit, the trust reported an action to increase the awareness of the smoking cessation service.

In the 2018/2019 Dementia Audit (72 case notes reviewed), the trust scored better in six out of the seven scoring items. However, their governance processes were worse than the national range.

The trust participated in the national bowel cancer audit and reported 100% of patients were seen by a clinical nurse specialist which was better than the national average (86%) and the regional network (93%).

Although managers used information to improve care and treatment, they did not monitor patient outcomes of those patients placed on outlying wards. These patients required specialist care and treatment but at times were not clinically reviewed by the doctor. We saw three examples of patients being placed on different wards and not being reviewed. On

# Medical care (including older people's care)

2 August 2021, there were 10 outliers on orthopaedic wards, five on general surgery, three on the gynaecology ward and three on the acute surgical unit. Data from the command centre showed one patient was reviewed after three days of being admitted on to an orthopaedic ward, another patient had been on a different speciality ward for 26 days and was not reviewed until the 26th day.

### Competent staff

**The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.**

Overall, staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients.

Managers gave all new staff a full induction tailored to their role before they started work. Staff said they received a local and trust induction.

Managers supported nursing staff to develop through regular, constructive clinical supervision of their work.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work. Although junior doctors reported not always having access to senior doctors for learning and did not have time to learn because them were busy supporting the senior clinicians.

Managers identified additional training for nursing staff to upskill themselves, giving them the time and opportunity to develop their skills and knowledge. However, staff we spoke with said they had no time to complete courses.

Managers made sure staff received any specialist training for their role. We saw from meeting notes that staff attended these compulsory courses.

Managers identified poor staff performance promptly and supported staff to improve. We saw from team meetings, that ward managers addressed poor performance.

Managers supported staff to develop through yearly, constructive appraisals of their work. However, appraisal rates varied between 42% - 100% across the care group.

### Multidisciplinary working

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

Staff held regular multidisciplinary team (MDT) meetings to discuss patients. However allied health professionals (AHP) told us they were not always included in MDT working on ward 23. Planning meetings for patients were held without inviting AHPs. Some AHPs told us they were made to feel unwelcome on ward 23. AHPs documented rehabilitation plans for patients for over the weekend when there was limited AHP cover. They told us that after the weekend, the plans had not always been followed; this meant patients rehabilitation and recovery was impacted upon on ward 23. AHPs told us there was a focus on getting patient medically optimised for discharge out of hospital, but not on making sure they were therapy optimised. This had resulted in some patients falling soon after discharge home and needing to be re admitted, or patients being discharged when they were not at their best levels of function.

There were no dedicated therapy facilities such as a physiotherapy room with equipment, or occupational therapy assessment kitchen in medical unit 2. This meant there was a lack of MDT provision which impacted on the rehabilitation needs of patients. We found there was a lack of MDT focus on the discharge planning process.

The ward 23 handover sheet on 4 August 2021 indicated 19 patients out of 24 had gone past the planned date of discharge (PDD) yet this data had not been updated. Some PDDs were over a week past the planned date and one PDD was still recorded as 13 July. Following our inspection, the trust told us they were following guidance from NHS England by not updating the PDD. Nursing staff told us discharge planning was the role of the discharge coordinator. When the discharge coordinator was on leave, there was little focus from the nursing team on ward 23 on safe and timely discharge. The gaps in senior doctor cover meant decision making around the discharge process was not robust. Shift handover and ward rounds did not always include members of the hospital based multidisciplinary team; we saw no evidence of how staff updated their colleagues on the progress of patients who were nearing hospital discharge.

Following the inspection, the trust provided written assurance to us about the lack of MDT oversight at the inspection. The trust confirmed the board round MDT decisions would in future be documented and updated in the electronic records on a daily basis to ensure clarity of plans. They also confirmed clinicians had been instructed to document clinical criteria for discharge and agreed dates at MDT ward rounds.

Staff referred patients for mental health assessments when the patients showed signs of mental ill health or depression.

### Seven-day services

**Key services were not always available seven days a week to support timely patient care.**

Consultants did not always lead daily ward rounds on all wards, including weekends. Patients were not always reviewed by consultants depending on the care pathway. However, there was a consultant on call 24 hours every day in the acute medical unit (AMU). The consultant on call was on site from 8am to 8pm seven days a week and then on call from home until 8am the following day.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week.

A pharmacist visited the department seven days a week and were contactable out of hours.

The trust bereavement team were available to provide specialist support for families and loved ones. They operated from 9am to 5pm between Monday and Friday and on and on a call basis outside of these times.

Advanced nurse practitioners supported the respiratory team on ward 37. However, they were only available six days a week between 8 am and 6.30 pm.

There was a lack of physiotherapists available during the week and at the weekends. There were a number of vacancies which impacted on the ability of the physiotherapy team to provide care for patients. This was raised with the trust at the time of the inspection. Following our inspection, the trust had put mitigation in place which included redirecting physiotherapy staff from the outpatients on to the medical wards whilst the trust began recruitment. The trust had also commissioned a full review of allied health professional staffing which was planned to be completed in September and was looking at increasing the number of staff at a weekend.

# Medical care (including older people's care)

### Health promotion

**Staff gave patients practical support and advice to lead healthier lives.**

The service had relevant information promoting healthy lifestyles and support on the wards. We saw that there were leaflets available on health promotion and lots of advice sheets to take home.

The action plan devised on 5 August 2021 to address the chronic obstructive pulmonary disorder audit outcomes in 2019, showed the trust planned to improve the stop smoking service and educate nursing staff to be able to identify patients eligible for a referral.

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

**Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used measures that limit patients' liberty appropriately.**

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

Staff gained consent from patients for their care and treatment in line with legislation and guidance. We heard staff explaining treatments and diagnoses to patients, checking their understanding, and asking permission to undertake examination and perform tests.

Alerts were placed on patients notes where there had been an application for Deprivation of Liberty Safeguards (DoLS) so that staff were aware and could monitor the validity of the application.

When patients could not give consent, staff made decisions in their best interest, considering patients' wishes, culture and traditions. Mental Capacity Act assessments were clearly documented in all records we reviewed on site.

Staff made sure patients consented to treatment based on all the information available. We spoke with nursing and medical staff who were able to describe the relevant consent and decision-making requirements relating to the Mental Capacity Act 2005 (MCA) and the DoLS in place to protect patients.

Staff clearly recorded consent in the patients' records. All records showed staff had gained consent from patients including those who lacked capacity to provide informed consent to care and treatment. They followed national guidance to gain the patients' consent.

Staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS). Training in the Mental Capacity Act 2005 and DoLS was included within the mandatory safeguarding training.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004. They knew who to contact for advice.

Staff could describe and knew how to access the relevant policy and get accurate advice on Mental Capacity Act and DoLS. The MCA policy and DoLS policy could be accessed on the intranet. The MCA policy had clear definitions of staff responsibilities, enabling staff to make decisions, capacity assessments, documentation required, consent, best interest decisions and statutory duties.

# Medical care (including older people's care)

The DoLS policy defined what is a deprivation of liberty, who is covered by DoLS, when a DoLS should be used, how to apply for standard and urgent authorisations and details of available support.

Patient records had alerts where there was a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) in place and we were advised that the paper copy of the DNACPR was held separately in a secure filing cabinet. We reviewed six DNACPR records, they all documented the reason for the DNACPR. One stated that age was the reason for the DNACPR and one stated that age/frailty was the reason. This meant there was no evidence that the decisions were based on health and the needs of the patient.

One of the DNACPRs was a pre-existing community DNACPR which had not been reviewed. Two forms contained no indication that the patient had been included in the decision although in one case it advised that the patient's relative had been included. The other form did not have evidence of a mental capacity/best interest assessment. The decision as to whether to discuss the decision was recorded on two of the records. All forms were signed by a consultant or associated specialist.

## Is the service caring?

**Requires Improvement** 

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

### Compassionate care

**Staff did not always treat patients with compassion, respect their privacy and dignity, or take account of their individual needs.**

We observed two episodes of care where staff were not discreet and responsive when caring for patients. We observed these patients being assessed in open areas. This meant confidential discussions between patients and the staff were overheard.

We observed some staff supporting their patients compassionately, for example we saw that a patient was re-positioned by staff during the ward 22 round so that they could be better positioned to make eye contact with the consultant. However, in other areas patients were left on their own without any interaction from staff.

Staff did not always take the time to interact with patients in a respectful and considerate way. We observed one consultant assessing a patient amongst other patients nearby. We observed the patient becoming agitated when being asked questions and the consultant at times being abrupt with the patient.

On ward 23 there were several patients dressed in hospital pyjamas who were sat in a main open area. We asked staff about patients wearing their own clothes as part of rehabilitation. We were told staff didn't always ask families to bring clothes in, or clothes that had been brought in and worn needed washing. There was no robust provision of day clothes for patients to wear to maintain their identity and dignity.

On ward 23 we overheard most staff referring to patients by their bed number rather than their name. Staff told us this was to maintain confidentiality, however as these conversations took place between ward staff, we found this wasn't a plausible reason to not refer to patients by name.

# Medical care (including older people's care)

We spoke with three patients who said staff treated them well and with kindness on one ward.

Staff understood and respected the individual needs of patients and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs.

### Emotional support

**Staff provided some emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.**

Wards had not been modified for the patient group and the environment was not engaging. We carried out observational assessments regarding the quality of interactions with patients on ward 23 and found of the 12 assessments, three were observed to be tasked orientated and nine patients had no interactions. Staff told us a supply of books and magazines had been removed due to COVID- 19. We saw from meeting minutes that staff raised concerns of not having enough staff to provide support to patients. An activity coordinator had been appointed in recent weeks. They covered three wards in medical unit 2 so this impacted on the time they could spend with patients.

However, staff we spoke with said they gave emotional support and advice to patients and those close to them when they needed it. At the time of inspection 'John's campaign' was still in place. This is a national initiative to encourage carers to support and stay with patients living with dementia while they are in hospital. The trust gave lanyards to carers and these enabled carers open access to those they were supporting.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. Staff told us they could contact the hospital's palliative (end of life care) team for support and advice during bereavement.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. A multi-faith chaplaincy service was available for spiritual or religious support to patients of all faiths and beliefs.

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

**Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.**

Staff made sure patients and those close to them understood their care and treatment. We listened to conversations between staff and patients and heard staff answer questions and explain differently to those that did not understand certain elements of their treatment plan.

Due to the visiting restrictions we were unable to speak with families and carers of patients on the ward. However, staff told us they routinely discussed patients' care with their relatives. We did not see any evidence of this on patients notes.

## Is the service responsive?

**Inadequate** 

Our rating of responsive went down. We rated it as inadequate.

# Medical care (including older people's care)

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

**The service did not plan and provide care in a way that met the needs of local people and the communities served. It did not always work with others in the wider system and local organisations to plan care.**

Managers did not plan and organise services, so they met the changing needs of the local population. During the inspection we found there were on-going problems in recruiting medical staff (consultant and junior grades), this meant the medical wards faced significant challenges in meeting its target WTE levels for medical staff and providing sufficiently skilled rota cover. This impacted on the service delivery and meeting staffing level standards.

The challenges in the community impacted on the medical service provision at the hospital. This meant staff were unable to discharge patients to the most appropriate place of care. However, we did not see evidence of how the service was reviewing their current care provision to minimise the impact on patients who could quickly lose functional abilities when they were in hospital for long periods.

The facilities and premises were not always appropriate for the services being delivered. We found the facilities were not supportive to those with cognitive disabilities.

Staff could access emergency mental health support 24 hours a day, seven days a week for patients with mental health problems, learning disabilities and dementia.

## Meeting people's individual needs

**The service was not always inclusive and did not always take account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.**

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports.

New documentation to capture risks and the needs of patients with disabilities had been introduced on the wards. For example, after completing a risk assessment, staff increased the number of observations they carried out on patients with disabilities.

Staff understood and applied relevant policies on meeting the information and communication needs of patients with a disability or sensory loss.

The service had information leaflets available in languages spoken by the patients and local community.

Staff made sure patients living with mental health problems, learning disabilities and dementia received the necessary care to meet all their needs. Staff also used a 'traffic light' passport document for patients admitted to the hospital with dementia or a learning disability. Staff could contact the trust-wide safeguarding team for advice. We saw an example of this in care records we reviewed.

Patients were given a choice of food and drink to meet their cultural and religious preferences.

Where relevant records of those patients living with dementia had 'forget-me-not' passports, dementia assessments had been undertaken where required and the findings documented. The service also used the Butterfly scheme.

However, on inspection we found patients were not always encouraged to follow their usual daily routines during their hospital stay because there were not enough staff to support them when mobilising.

Wards were not designed to meet the needs of patients with complex needs. Staff said there was one activity coordinator who worked across all wards. However, at times they could not always attend the ward because their workload. This meant patients were left disengaged because they had no activities to occupy them if the coordinator did not visit the ward.

### Access and flow

**People could not access the service when they needed it and receive the right care promptly.**

During the inspection, we observed significant concerns relating to patient access and flow, which was escalated to senior managers of the trust.

We raised concerns with senior managers about the trust not following best practice in relation to the discharge planning process. Patients were not always being supported appropriately whilst waiting to be discharged. The trust informed us their biggest challenge for not being able to discharge patients was because provision in the community was limited. However, we found no evidence of the service looking at ways to reduce the impact of extended hospitals stays on patients and their health.

Staff we spoke with said patients were rarely moved after 9pm. However, the trust reported between January 2021 and July 2021, that 231 patients were discharged after 9pm and of these 25% were sent out of hospital just before midnight. This meant elderly patients were disturbed from sleep, and transferred to transport during the night, which placed them at risk of injury and harm. For example, at risk of a fall because they potentially could be disorientated and confused.

Patients were moved from ward to ward during the night; the trust reported 109 bed moves between 10pm and 6 am. The report showed 39 moves (36%) had taken place between 10pm and midnight and 70 moves (64%) had taken place between midnight and 6 am between May to July 2021. Following our inspection, the trust told us their guidance was that patients should not be moved between 10pm and 6 am. Moving patients during the night meant they could become disorientated and confused which could potentially put them at risk.

We found no evidence of managers and staff working to make sure that they started discharge planning as early as possible. Nursing staff told us the ward discharge coordinator was the lead for discharge planning. However, at the time of inspection the discharge coordinator was on leave and there was a lack of emphasis on shared responsibility for discharge planning. This service was usually available Monday to Friday. Following our inspection, the trust told us they planned to review the discharge coordinator roles and were looking to put arrangements in place to cover leave.

Staff did not always plan discharges carefully, particularly for those patients with complex mental health and social care needs. We found there was limited evidence of discharge planning as soon as patients with complex needs were admitted to hospital. This meant discharge planning became an event rather than an ongoing process. We saw on one ward there were 11 out of 24 patients medically ready for discharge or transfer but who were still in hospital. This put them at risk of falls, hospital acquired infections and pressure ulcers.

# Medical care (including older people's care)

We attended the 8am virtual patient flow meeting and an 8.15am complex care meeting on 4 August 2021. The numbers of patients in the hospital who were on the 'discharge to assess' pathway zero (simple discharges to usual place of residence) were not discussed. The number of 'stranded' (a length of stay over 14 days) and 'super stranded' (with a length of stay over 21 days) patients were not discussed. This meant there was no oversight of how many patients had been in hospital with long lengths of stay.

The medical services experienced ongoing high levels of demand and bed pressures which resulted in patients being placed on different wards outside of the speciality; for example, medical patients being cared for on a surgical ward. 'Outlier' wards may not have staff who were appropriately trained and experienced staff to provide full and safe care to patients from other areas. This meant there was a risk that staff could deviate from standardised patient pathways, causing an adverse impact on patients.

Patient transport services were used to transfer patients to and from medical unit 2. This was because medical unit 2 was away from the main hospital building. This meant when patients required diagnostic tests such as X rays or admission onto the unit, they needed to be transferred by ambulance which often caused delays and late transfers.

### Learning from complaints and concerns

**It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.**

Patients, relatives and carers knew how to complain or raise concerns.

The service clearly displayed information about how to raise a concern in patient areas. The ward had information leaflets displayed showing how to raise complaints. This included information about the Patient Advice and Liaison Service (PALS). The patients we spoke with were aware of the process for raising their concerns with the staff.

Managers investigated complaints and identified themes. The trust complaints policy stated that complaints would be acknowledged and responded to within 35 working days for routine formal complaints. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. Complaints were reviewed and investigated by the matron. At the time of inspection, the trust reported one complaint was outside the 35-day policy window. However, this was because it was part of a root cause analysis investigation and the patient was kept up to date.

Managers shared feedback from complaints with staff and learning was used to improve the service. Learning from complaints was discussed at senior meetings and departmental staff meetings.

We saw from team meetings managers gave staff and update of the outcomes from complaints and talked through any changes as a result of a complaint.

## Is the service well-led?

**Inadequate** 

Our rating of well-led went down. We rated it as inadequate.

# Medical care (including older people's care)

## Leadership

**Leaders did not demonstrate that they had the skills and abilities to run the service. They did not demonstrate they understood and managed the priorities and issues the service faced. They were not always visible and approachable in the service for patients and staff.**

Medical care was provided within the medicine care group. The care group was also responsible for the provision of emergency care. The medical triumvirate leadership team consisted of a clinical director, associate director of nursing and associate director of operations. They were supported by a governance business partner and two deputy associate directors of nursing.

At departmental level, the wards were led by a matron and a ward manager. Staff we spoke with said ward managers and matrons were visible and supportive. However, they also told us senior managers were not visible or approachable. They felt their concerns were not heard and felt limited actions were taken to mitigate risks to patients.

Although the care group executive leads had an overview of some of the issues facing the medical wards there were no overarching action plans to mitigate the risks and manage the priorities. For example, the service acknowledged the lack of staff within the rehabilitation team and the impact on staff but did not escalate this to the relevant care group or have an action plan to address the shortfalls.

We raised significant concerns about the leadership of ongoing safeguarding concerns. We found concerns had not been appropriately actioned by senior staff leading to a further two safeguarding incidents which put patients at risk of harm. Following the inspection, the trust began working with external providers to minimise the risk to patients.

## Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders.

The trust vision was “We will consistently provide the highest possible standards of compassionate care and the very best patient and colleague experience. We will listen to and involve our patients, service users, colleagues and partners.”

The vision and strategy were focused on sustaining the service and aligning the current provision to local plans within the wider health economy. Senior trust leaders met with senior leaders of the Lancashire and Cumbria integrated care system (ICS). The ICS is a new partnership between the organisations that meet health and care needs across the area, to coordinate services and to plan in a way that improves population health and reduces inequalities between different groups.

## Culture

**Staff did not always feel respected, supported and valued. They focused their efforts on meeting the needs of patients receiving care, but this compromised morale and their wellbeing at times.**

The trust provided a colleague support booklet to all staff. It contained information about mental health, how to deal with stress levels and details to services needed to support their wellbeing.

Staff spoke positively about the service they provided for patients but said limited resources placed pressure on their workload resulting in low morale and feeling exhausted.

The staff survey reported 33.3% of staff in the medicine care group said they were not enthusiastic about their job.

Staff we spoke said they had been deployed to support the ward they worked on and did not have the job satisfaction they did before. Some were unable to attend meditation sessions put on by the trust because the ward they worked on was unsafely staffed.

Staff had access to the freedom to speak up guardian, however 45% of staff who responded to the staff survey reported they did not feel safe to speak up about anything that concerned them.

We found there was a poor culture amongst staff on some wards. Staff we spoke with said there was an uncomfortable atmosphere between registered nurses and care support workers (CSW) about workload. We saw from ward meeting minutes that this had been addressed by the ward managers. Ward managers worked hard to build positive relationships with their staff, we saw from ward meeting minutes they promoted working together. For example, handovers had now become a team handover meeting instead of a separate handover for nurses and CSW's.

### Governance

**Leaders did not operate an effective governance processes, throughout the service and with partner organisations. Staff at all levels were not clear about their roles and accountabilities.**

The medical care group did not have clear governance channels into the wider organisational management structure. The medical care group governance was clinician driven with the input of multi-specialism input. We found the governance and assurance framework did not permeate all levels within the care group and was not embedded throughout. For example, we raised concerns about the actions taken to ensure patients were kept safe on medical wards, including but not limited to medical unit 2 previously. However, we found poor systems were in place to effectively govern the action put into place to prevent safeguarding incidents.

Poor levels of governance meant leaders of the service did not interact with each other appropriately. We spoke with leaders of the service on 12 August 2021. During this triumvirate interview, we raised with the senior leadership team the limited allied health professional staffing provision across medical wards, which potentially could lead to patient harm. Leaders did not recognise the need for cross working with the core clinical services care group, even though they were aware that the staff group managed the AHP provision. Leaders we spoke with were unable to say what the current provision looked like and what plans were in place to increase the AHP input. The triumvirate confirmed an AHP review was underway since receiving feedback from the inspection. Leaders had not escalated concerns about limited AHP input and the potential harm to patients on medical wards to their colleagues who led the Core Clinical service group.

It was recognised by the triumvirate during the interview that the lack of AHP's input could cause potential harm to patients. Senior members acknowledged this should have been escalated and placed on the risk register to monitor the risks associated with limited AHP input.

We found there was a lack of oversight and awareness regarding clinical and internal audit amongst the senior leadership team and managers at ward level. Therefore, we were not assured if senior leaders had a full understanding of the actions in place to address audits that show deteriorating outcomes. For example, audit results from June 2021 were reviewed by us three days prior to inspection and showed the environment was not safe for patients and potentially increased the risk of spreading infection. On 2 August 2021 we found the issues raised from the environmental audits had not been addressed. This meant there was no effective governance process in place to monitor the actions from the audits by managers.

# Medical care (including older people's care)

Following the inspection, we were provided with some assurance in terms of consultant cover, including out of hours cover. However, we found there were poor systems in place for staff to seek support from senior staff when a patient required medical attention. On inspection staff told us they relied on alerting senior medical staff through messaging each other on their phones. We found no effective governance system to monitor if senior staff attended to patients in a timely way.

### Management of risk, issues and performance

**Leaders and teams used systems to manage performance effectively. However, they did not identify and escalate relevant risks and issues and identified actions to reduce their impact. They did not have robust plans to cope with unexpected events.**

The care group had a risk register which recorded concerns, rated according to risk/priority, along with control measures and action plan progress. However, it did not capture the risks we raised on inspection and at the triumvirate meeting this was acknowledged.

The management team stated their three main concerns were surrounding medical staffing, patient flow issues and the emergency department. These were recorded on the risk register and we were told of progress made by the care group to mitigate risk. However, the senior management team were unable to tell us how they were mitigating risk related to reduced AHP staffing provision and risks of patients being deconditioned after long periods of hospital stays. They acknowledged the impact of both concerns.

We found the trust did not follow best practice in relation to discharges and transfers between inpatient hospital settings and community or care home settings. Management of delayed discharges was poor; patients were not always supported appropriately whilst waiting to be discharged. The trust informed us their biggest challenge for not being able to discharge patients was due to the lack of provision in the community. However, we found patients were not always encouraged to follow their usual daily routines during their hospital stay because there were not enough staff to support them when mobilising. Senior managers were all aware the timeliness of discharging patients into the community was an issue but could not provide actions of how the care group were going to reduce the risk to patients.

Known risks were discussed at care group governance meeting. The meeting was attended by matrons and service managers who were asked to cascade information to their team.

### Information Management

**The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. However, all information was not kept secure.**

We observed computer screens with patient information details were left switched on when staff moved away from the computers. This was observed three times by three different staff in medical wards and on the medical assessment unit. We also saw staff leaving smart cards in computers. However, practice differed on ward 22, computers were locked when they were unattended.

Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements.

The information systems were integrated, data or notifications were consistently submitted to external organisations as required

# Medical care (including older people's care)

The command centre gave an overview of where the trust was going to fail to meet national standards, allowing staff to facilitate a plan of action. The command centre is the trust's data centre, it provided staff with real-time information to help them make informed decisions on managing patient flow across the trust however we found this did not work well in practice.

### Engagement

**Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.**

Leaflets about the friends and family test, and the Patient Advice and Liaison Service (PALS) were available on all wards. Internet feedback was gathered along with complaint trends and outcomes. We saw thank you cards, and letters displayed at the entrances to wards.

The trust worked with the ICS to support the COVID-19 recovery plan. This was an integrated systemwide plan to support the recovery of services provided by health and social care providers after the pandemic.

Due to the current visiting restrictions, patient groups were placed on hold.

### Learning, continuous improvement and innovation

**All staff were committed to continually learning and improving services. They had an understanding of quality improvement methods and the skills to use them.**

All staff we spoke with were committed to continually learning and improving services but felt they were not listened to. The staff survey reported 74% of staff said senior managers did not act on feedback and 73% of staff said senior managers did not involve staff in important decisions.

However, the trust had made many improvements in the stroke pathway after being issued conditions during the April 2021 inspection. The improvement plan was reviewed on a monthly basis which meant gaps and challenges were addressed.

The trust recognised that the most frequently reported incident affecting inpatients was falls and had continued to undertake monthly reports detailing the number of falls, the area of the fall occurred and the actions to improve patient care. We heard from senior staff an improvement project was underway to develop the falls service. This included looking at ways to reduce the number of inpatient falls and deliver against key performance indicators quality standards number 86 for falls (NICE). A recent documentation trial showed 88% of staff reported they preferred using a new form which had been introduced. Other improvements indicated 71% of patients received a medical assessment within 30 minutes of falling.

## Areas for improvement

**MUSTS**

The service must ensure effective systems are in place to assess and mitigate individual patient safety risks. Regulation 12 (1)(2)(a) and (b): Safe care and treatment.

# Medical care (including older people's care)

The service must ensure people are kept free from harm. Regulation 13(5) Safeguarding service users from abuse and improper treatment.

The service must ensure nurse staffing levels meet the minimum standards of the National Institute of Health and Care Excellence. Regulation 18 (1): Staffing.

The service must ensure medical staffing levels meet the minimum standards of the Royal College of Physicians. Regulation 18 (1): Staffing

The trust must ensure there is full oversight of services offered by the care group through robust governance processes. Regulation 17(2)(a): Good Governance.

The service must ensure effective systems are in place to monitor discharges to prevent patients from becoming deconditioned. Regulation 17 (1)(2)(b): Good governance

The service must ensure there are effective systems are in place to consistently assess, monitor and improve patient safety and the quality of care. Regulation 17 (1)(2)(a) and (b): Good governance

**SHOULDS**

- The trust should ensure that all records are securely stored
- The service should ensure they complete MUST documentation

# Our inspection team

The inspection was chaired by the Head of Hospital Inspections and the Inspection Managers, led it.

The team included 3 inspectors and 2 specialist advisers.
Specialist advisers are experts in their field who we do not directly employ.

This section is primarily information for the provider

# Requirement notices

## Action we have told the provider to take

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

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

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

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

| Regulated activity | Regulation |
|---|---|
| Treatment of disease, disorder or injury | Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment |

This section is primarily information for the provider

# Enforcement actions

## Action we have told the provider to take

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

| Regulated activity | Regulation |
|---|---|
| Treatment of disease, disorder or injury | Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment |

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

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

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